City of Westminster

# Children, Adults, Public Health and Voluntary Sector Policy and Scrutiny Committee

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| **Date:** | 21 September 2023 |
| **Classification:** | General Release |
| **Title:** | Plan for the consultation on acute mental health services for the residents of Westminster and RBKC |
| **Wards Involved:** | All |
| **Report Author and Contact Details:** | **Sally Milne** **sally.milne@nhs.net** |

## 1. Executive Summary

This paper summarises the work to date to develop options for the consultation around acute mental health services for residents of the City of Westminster and the Royal Borough of Kensington and Chelsea and sets out plans for the consultation that will be running from October 2023 to January 2024.

This builds on previous updates that have been given to this committee to share information about the progress of pre-consultation engagement.

## 2. Background

### 2.1 Introduction

In 2020, the Covid-19 pandemic necessitated the temporary closure of the inpatient wards at the Gordon Hospital in Westminster. Inpatient provision for Westminster and the Royal Borough of Kensington and Chelsea (RBKC) was consolidated at the St Charles Centre for Health and Wellbeing in RBKC, resulting in a significantly reduced number of inpatient beds. A network of alternative, community-based services was put in place across the area to compensate for the reduction in inpatient beds.

We are now working to go out to consultation on the future of acute MH services in Westminster and RBKC. We have been working with partners through a number of workshops to agree the options for consultation.

## 2.2 Options appraisal process

In order to develop the options for the consultation a series of workshops were held with partners to go through the process of options appraisal. Details of each workshop are:

- Workshop one discussed the care model that we aspired to for our service users in Westminster and RBKC
- Workshop 2 looked at configurations of inpatient facilities to review options for where the care could be delivered
- Workshop 3 went through data to understand what is being delivered and the proposed options for consultation
- A follow up data workshop was then held to run through data from partners and the costs of the options.

Reports on all the workshop content and discussion can be found on the ICB website at the links below, and have been included as appendices to this paper.

- Workshop 1a and 1b
- Workshop 2
- Workshop 3

A final workshop is being held on the 13th September to share the outputs of the previous workshops and the options that will be taken to consultation. The outputs of this workshop will be published on both the ICB and CNWL's website and the link will be shared with the Committee.

The options that have been considered through the appraisal process for potential inclusion in the consultation are in the table below

| **Options considered for inclusion** | |
|---|---|
| **Model A. 2019 model – highest bed base (117 beds), lowest level of community alternatives** | |
| A1 | ***Two site inpatient service with facilities at the Gordon meeting "safe" standards only (eg not providing en-suite bathrooms) and shifting investment from community back to inpatient.*** 67 beds at the St Charles and 51 at the Gordon. Alternative services would be stood down or reduced, including: the HBPoS at St Charles, Step Down beds, MHCAS, and VCSE partnerships investment. There would also be a reduction in the multi-disciplinary support to other wards, which has been enhanced. |
| **Model B. Transformed model as now – lower bed base of 67 beds, and a higher level of community alternatives.** | |
| B4 | ***Single site service with all 67 beds at the St Charles and an extensive range of community alternatives.*** Maintain community alternatives, including all of those reduced/stood down under A1. |
| **Model C. Transformed model as above with enhanced crisis assessment service with crisis inpatient unit** | |
| C | ***Two site service (at St Charles and the Gordon) and an extensive range of community alternatives –*** option keeps most services as they are now in 2023, but includes the transfer MHCAS from St Charles to Gordon Hospital, and expand it from being able to support 8 people to 12 people at any one time. This would include 4 additional short-term assessment beds which will enable people to receive intensive support for a longer period. |

| Model D. A partially transformed model. Mid-range bed base of 80 beds, with some reductions in community and crisis alternatives but less than under A. | |
|---|---|
| ***D*** | ***Two site inpatient service (67 beds at St Charles and 13 at the Gordon), beds split across two sites with both facilities meeting most key national standards for quality.*** The 13 beds would deliver a single additional ward at the Gordon. There would be a need to stand down some community services to be able to redeploy staff and resources back to the inpatient wards. For the purposes of examining this option, we are assuming that the service that would be stood down to open the ward would be the MHCAS (because this service is most closely matched in terms of patient need); and there would be reduced additional capacity created in Brent, so some people from the outer boroughs would continue to use inner borough beds. |

*Table 1: Options considered for inclusion (numbering of the options relates to their position in the long list)*

So far all discussions have formed part of the pre-consultation development and engagement. Following the launch of the consultation the engagement will be expanded to cover all residents to ensure everyone is able to input and respond. This paper sets out the details of the strategy for consultation.

**2.3 Consultation plan**

*2.3.1 Services in scope*

The services within the scope of the consultation:

- Serve those people with a mental health problem who might require admission to an inpatient mental health bed
- Serve the population living in the City of Westminster and the Royal Borough of Kensington and Chelsea. The consultation also considers the potential impact on residents of the London Borough of Brent; a small number of Brent residents have, in the past, come to Westminster and/or Kensington & Chelsea
- Are used by the diverse, urban communities living in the bi-borough.

Inpatient services for these communities have been provided by CNWL at the Gordon Hospital (51 beds over 3 wards temporarily closed in 2020) and the St Charles Centre for Health and Wellbeing (67 beds over 4 wards).

The consultation plan has been developed by and on behalf of both CNWL and NWL ICB. It will be led by the ICB Communications and Engagement Director and team, and be delivered according to these principles:

- Through a structured process, with shared management across the system to ensure that the consultation aligns with other strategic programmes in Westminster and Kensington and Chelsea
- Working with the networks of NHS organisations and relationships with local groups and communities
- Encompassing both communications and engagement – to ensure that people are able to find out about the consultation and how to participate, those likely to be particularly impacted are reached through a range of relevant channels, and comments and feedback are considered in depth

- With the active involvement of a Steering Group of communications and engagement specialists.

Analysis has showed that in 2019/20, prior to the temporary closure of the inpatient wards at the Gordon, 72% of admissions were residents from Westminster or RBKC, and 81% from CNWL boroughs. While a majority of patients who used the service were from Westminster or RBKC, and as such these are the boroughs within the scope of the consultation, we will be providing regular updates to the Joint Health Overview and Scrutiny Committee to ensure that all eight North West London boroughs have an opportunity to input.

*2.3.2 Consultation objectives*

The objectives of the consultation are:

- To gather feedback from service users, staff, stakeholders and local residents, making it as easy as possible to comment through a choice of channels and reaching out effectively to ensure people are aware of the consultation and how they can contribute
- While retaining flexibility for how people can participate and valuing all contributions, aim to secure feedback about our preferred consultation option– relevant to views on its respective strengths and weaknesses, how they will impact on services and service users, and issues relevant to implementation for each
- Secure a mix of both quantitative feedback (e.g. through a questionnaire) and qualitative feedback (e.g. through noting discussion at meetings) to develop insight into participants' views which are as rich and detailed as possible
- Where rooted in the data, indicate where there is majority agreement and where they are differences of view held by different groups
- Meeting statutory duties, ensure that inclusion in the consultation process is as broad as possible and that those individuals and groups most likely to be impacted by the service change are fully engaged and their voices are particularly clearly heard
- Capture all feedback from the consultation within a single analysis and report to enable the ICB's decision to be fully informed.

*2.3.3 Information included*

There will be a variety of information made available to inform participants and enable them to make meaningful comments. These will be hosted on the ICB website, with links from relevant partners, and will include:

- Core consultation information and questionnaire, which will set out:
- Summary of case for change and current service configuration
- Preferred Consultation Option
- Information about the process so far
- How to contribute views, including schedule of events
- Next steps following consultation
- Main consultation document and summaries for download
- Including materials available in accessible formats
- Detailed background documents, including:

- Travel time and other modelling data
- Pre-consultation Equalities Impact Assessment
- Pre-consultation Business Case (PCBC).

The groups that we plan to consult with include:

Geographic data analysis and mapping shows population density across North West London for the following characteristics:

- Service users of both acute and community mental health services
- Deprivation by locality
- Distance from closest inpatient mental health service (current).

*2.3.4 Priority groups for consultation - equalities*

As required by law, the key groups for consultation are:

- Users – or potential users - of adult acute mental healthcare in Westminster and Kensington and Chelsea
- Users – or potential users – sharing protected characteristics under the Equality Act (or otherwise at risk of health inequality) who may be disproportionately impacted by the proposed changes.

Following a structured Equality Impact Assessment, Integrated Impact Assessment, review by the London Clinical Senate and a workshop of local clinical leaders, the following groups have been identified as the highest priorities:

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

The Integrated Impact Assessment used a weighted vulnerability index to identify populations that may be particularly vulnerable in the proposed service change. The index is an equally weighted average of the rank of the percentage of ethnic minorities, deprivation and poor health outcomes. Therefore, we will also be paying attention to engaging people in these areas who might face more challenges compared to other areas in Westminster and Kensington and Chelsea. These areas include:

*Royal Borough of Kensington & Chelsea*
Kensal Town

*Westminster City Council*
Church Street
Pimlico South

We will consult with all areas of both boroughs, but there will be a focus on these areas to ensure there is good representative feedback.

*2.3.5 Other groups for consultation – service users, stakeholders, and residents*

In addition, other groups we would seek to prioritise for engagement, include stakeholders, and local organisations, plus networks and media who have been 'scoped in' because they will carry information about the consultation. These include:

- Anyone who is currently using acute mental health care services in Westminster or Kensington and Chelsea
- Anyone who has previously used acute mental health care services in Westminster or Kensington and Chelsea
- Families and carers of people who use, have used, or might use these mental health services
- Residents of the Royal Borough of Kensington and Chelsea, the City of Westminster and neighbouring areas who are eligible to use services in these boroughs
- Professional representative bodies such as trade unions, local medical committees, and the Royal College of Psychiatrists
- Community representatives, including the voluntary sector
- Local authorities.
- Health and Social care partners including the ambulance service and NHS 111.

*2.3.6 Consultation Report*

Following the consultation, a report will be produced. This report will summarise:

- The consultation response
- Views on the preferred option, highlighting where justified by the data differences of views between different groups
- Analysis of comments more broadly relevant to the proposals, such as views in the clinical model, issues for implementation of Option.

The report will be published and will form an appendix to the Decision-making Business Case, and formally considered by the ICB.

The consultation report will also inform the second Equality Impact Assessment (post-consultation).

**2.4 Next Steps:**

Key dates and next steps for the consultation are

- 13th September - final pre-consultation workshop with partners
- 19th September – Stage 2 Assurance panel with NHS England
- 28th September – ICB Strategic Commissioning Committee for sign off
- Early October – Launch of the Consultation

When the NHS advances proposals for service change that significantly affect the residents of more than one local authority, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require the affected local authorities to form a Joint Health Overview and Scrutiny Committee. It is that JHOSC that must comment on the proposals, can require information from the NHS, and can make a decision (or not) to refer proposals to Secretary of State. We believe the local authorities most affected are the City of Westminster and the Royal Borough of Kensington and Chelsea. There remains an open question as to whether residents of the London Borough of Brent are also significantly affected. A decision is required on the final structure of this group.

The consultation will be live for 12 weeks, it will be closed in January 2024 and will be extended to take into account the winter holiday period. Regular updates will be shared with the agreed Joint Health Overview and Scrutiny Committee as well as the Local Health Overview and Scrutiny Committees.

**If you have any queries about this Report or wish to inspect any of the Background Papers, please contact Report Author x0000**

## Appendix 1: Workshop 1a and 1b report

**Preparation for consultation on the future of acute mental health care for residents of Westminster, Kensington & Chelsea, and Brent**

**Background**

Following temporary closure of mental health wards in the Gordon Hospital in 2020, plans for consultation on the future of acute mental health care for residents of Westminster, Kensington & Chelsea, and Brent have been considered by the North West London Integrated Care Board (NWL ICB), which is the consulting body.

In developing plans, NHS commissioners are required to consider a full range of service change options that can improve outcomes and identify those which are viable and sustainable. These will be developed into options for formal consultation, which is expected to happen later this summer. The list of options must always include a "no change" configuration, so that it can be compared properly with whatever changes are proposed.

The development of these options is informed by detailed analysis which incorporates clinical evidence, views of service users and staff gathered during pre-consultation engagement, insights from other stakeholders, patients flows, financial and workforce considerations. The options will all be set out in a comprehensive Pre-Consultation Business Case (PCBC) document, with detailed assessment of each against the agreed criteria and objectives which will be agreed in advance of the appraisal, taking account of input from stakeholders.

Following agreement by the Board, the NWL ICB would submit the PCBC to NHS England, which is the body responsible for authorising public consultations to proceed.

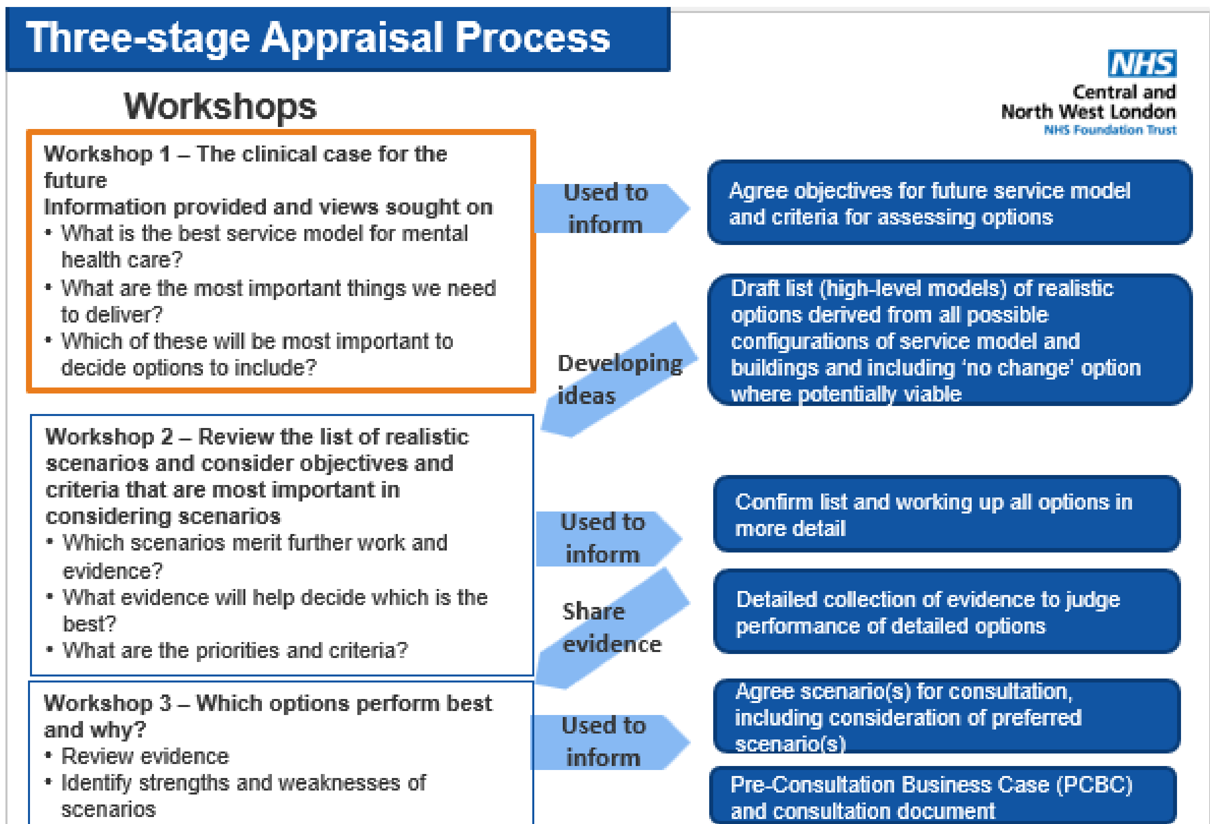


**Table 1. The options appraisal process**

Appraisal is a structured process through which all a full range of possible service solutions are considered and evaluated - and a range of options put forward for public consultation, all of which must be realistic and viable. It is important that we do not offer for public consultation any options which we know to be undeliverable or unaffordable.

The appraisal process that we are using is summarised in the flow diagram at Table 1.

It is based on three workshops to which stakeholders bringing a broad range of relevant perspectives are invited (service user, clinician, service manager, commissioner, statutory partner). Individuals work together to discuss "what good looks like" and over, the course of the workshops, inform the process by which the final list of possible options is determined.

It is important to emphasise that these workshops are not the only way – or the only opportunity – for services users and other stakeholders to give their views.

**The first stakeholder workshops**

The first workshop was held on Monday 27 March 2023 at 09.00-11.00 in the Dawson Room, 110 Rochester Row, London, SW1P 1JP.

Thirteen stakeholders participated, along with four members of the CNWL team, in facilitated discussions – both breakout groups and in plenary.

The first workshop was repeated on Tuesday 18 April at the same venue, to enable a wider range of stakeholders to participate. 17 people attended, plus 13 members of the CNWL team.

The purpose of these workshops was to focus on the service model and draw out themes to establish what "good" would look like. This will support the development of measurement criteria which will be used to evaluate options. Key points that emerged relevant to developing the service model were:

Need for services which are community-based and flexible, including:

- Local and "part of the community"
- A spectrum of services – clinical MH (including psychiatric, psychology, wide range of therapies), physical health (e.g. health information, links to GPs), social prescribing at the heart (i.e. referrals to social support, vol.orgs., employment etc.)
- A holistic approach incorporating physical and mental health needs and integrated with social care and enablers such as housing
- A good model of care needs to have sufficient provision for patients experiencing a mental health crisis – with appropriate and streamlined referral routes, including through A&E and under MH Act section, and provide a range of appropriate services, including options which aim to avoid admission, such as crisis houses
- Base for multi-disciplinary teams, with escalation routes to inpatient care – aiming to support people earlier
- Self-referral – for when service users are first feeling unwell.

The importance of inpatient services, including:

- Should always be available for those who need it
- Modern buildings – flexible spaces to offer a range of services to those inside (e.g. exercise classes, things to do), with pleasant ambience and outside space
- A patient-centred environment, with activities which are normal in home environments
- Less secure / less locked / fewer admissions via MH Act section
- Really strong focus on maintaining links with families / social networks while in hospital, and emphasis on high quality discharge – i.e. to prevent readmissions
- Need to build the service around much shorter period of inpatient stays
- Planned discharge enabling patients to access appropriate services in the community, with links to support recovery and independence for example social care and housing.

General issues, including:

- The need to consider a potential increase in mental health issues within the survivor community of the Grenfell Tower Fire and the surrounding areas.
- Person centred care - appropriate for individuals, and needs led with patients shown compassion and respect.
- Model must reflect diverse needs – specifically address BAME needs, and generally offer patients more choice and control over the service – strong feeling that the poor experience of BAME (especially Black Caribbean/African) is in part linked to the physical settings and models of care
- Also more sensitive and responsive to needs e.g. language barriers for people without good English, full range of disabilities e.g. neuro-diversity.
- High quality communication needed by patients and families including knowing who and how to contact services
- Having sufficient workforce capacity is important, with professionals working in mental health well supported.

Healthwatch's *Voice Exchange* service user engagement report strongly influenced the agenda (as well as being an important piece of input informing our option development), and following suggestion at the first workshop, it was agreed that Healthwatch representative should be invited to attend the remaining workshops.

**Next steps**

The aim is that participation across all three workshops will include the same organisations and – if possible – the same individuals. We are seeking to define "what good looks like" in acute mental health care and apply the characteristics of high quality care to potential options through a structured process. We are therefore seeking to work with a consistent group of stakeholders to inform this through the three sessions.

Workshops 2 and 3 are scheduled to be held on Tuesday 25 April and Thursday 18 May to enable sufficient time for analysis and evidence-gathering necessary between each session.

A summary report, like this one, will be published for both Workshops 2 and 3.

It is anticipated that the options for consultation will be announced early in June, and the options appraisal process will be reported fully when the PCBC is published.

## Appendix 1: Workshop 2 report

**Preparation for consultation on the future of acute mental health care for residents of Westminster, Kensington & Chelsea, and Brent**

**Background**

Following temporary closure of mental health wards in the Gordon Hospital in 2020, plans for consultation on the future of acute mental health care for residents of Westminster, Kensington & Chelsea, and Brent have been considered by the North West London Integrated Care Board (NWL ICB), which is the consulting body.

In developing plans, NHS commissioners are required to consider a full range of service change options that can improve outcomes and identify those which are viable and sustainable. These will be developed into options for formal consultation, which is expected to happen later this summer. The list of options must always include a "no change" configuration, so that it can be compared properly with whatever changes are proposed.

The development of these options is informed by detailed analysis which incorporates clinical evidence, views of service users and staff gathered during pre-consultation engagement, insights from other stakeholders, patients flows, financial and workforce considerations. The options will all be set out in a comprehensive Pre-Consultation Business Case (PCBC) document, with detailed assessment of each against the agreed criteria and objectives which will be agreed in advance of the appraisal, taking account of input from stakeholders.

Following agreement by the Board, the NWL ICB would submit the PCBC to NHS England, which is the body responsible for authorising public consultations to proceed.

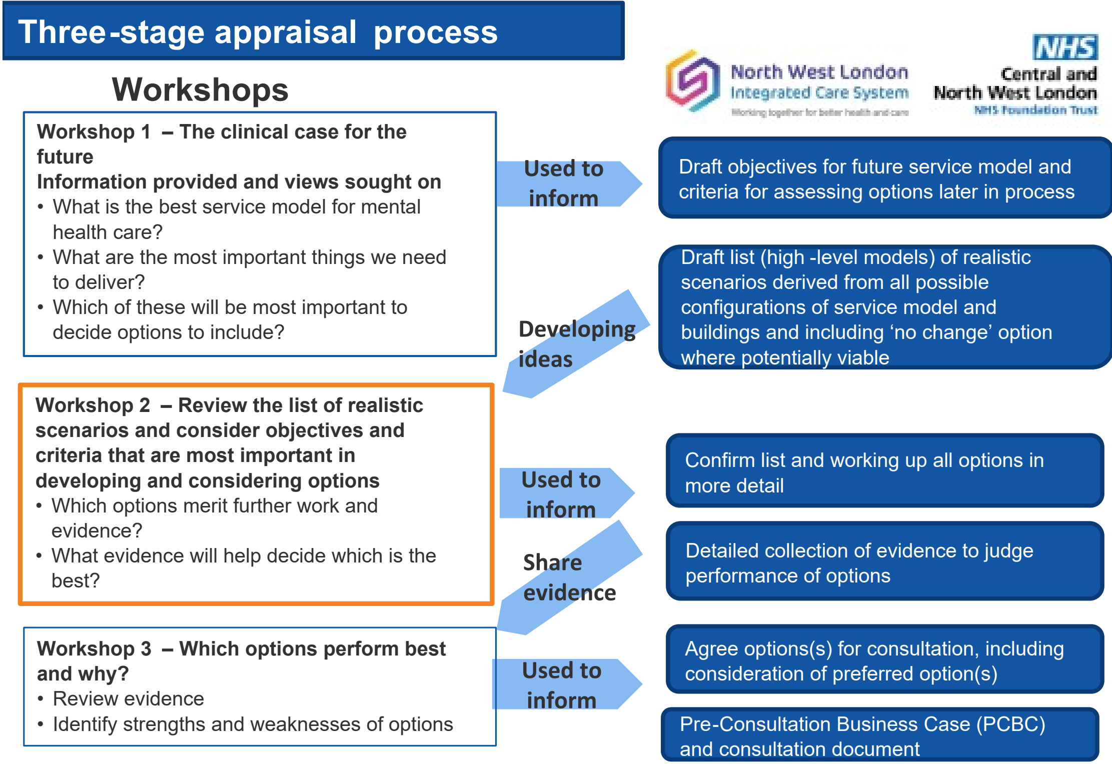


**Table1. The options appraisal process**

Appraisal is a structured process through which all a full range of possible service solutions are considered and evaluated - and a range of options put forward for public consultation, all of which must be realistic and viable. It is important that we do not offer for public consultation any options which we know to be undeliverable or unaffordable.

The appraisal process that we are using is summarised in the flow diagram at Table 1.

It is based on three workshops to which stakeholders bringing a broad range of relevant perspectives are invited (service user, clinician, service manager, commissioner, statutory partner). Individuals work together to discuss "what good looks like" and review realistic scenarios and criteria which are important when considering options to inform the process by which the final list of possible options is determined.

It is important to emphasise that these workshops are not the only way – or the only opportunity – for services users and other stakeholders to give their views.

Two workshops (consistent in content) were held with stakeholders on 27/03/23 and 18/04/23 to identify what good looks like in the provision of acute mental health services. The outputs of those workshops supported the development of a set of scenarios for discussion in workshop 2.

Workshop 2 was held on 25$^{th}$ April 2023, between 11am-1.00pm in the Hindle and Wild rooms at 110 Rochester Row, SW1 1JP.

Thirty five stakeholders participated in the workshop.

The aim of workshop 2 was to review a list of realistic scenarios and to consider objectives and criteria which are important in developing and consider options. The two key questions for this workshop were:

- Which options merit further work and evidence?
- What evidence will help decide which is the best?

### Break-out session 1

The workshop started with a presentation three potential care models with variations of configuration totalling six different scenarios. Following the presentation breakout groups of approximately 5 participants discussed the scenarios; there were opportunities during the breakout session for people to ask the presenters for clarity on points they had made. The breakout groups were asked to consider the scenarios from the following perspectives:

- Were the scenarios clear and understandable?
- Do they represent the full range of realistic alternatives?
- Are there additions or variants which could be considered?

Each table were supplied with sticky notes which they could use to highlight things they thought were important.

After the breakout groups there was a plenary session where participants fed back their views.

The key points made about the scenarios, under the headers for discussions, were:

#### *Were the scenarios clear and understandable?*

- The scenarios were more understandable to those involved in CNWL mental health services than to other stakeholders.
- Stakeholders said they would have preferred more information and data to support the models, including the wider implications for each scenario.
- It was suggested that more data will be needed as these scenarios are developed into options for consultation, for example on the impact of the rise from 3,000 to 9,000 CMHT referrals, referral waiting times, the number of occupied bed days, the average length of stay in hospitals, what finances are available, the current waiting times for inpatient beds – and that all this information should be shown to relate directly to the local area and be considered when developing the models
- Some participants said that the scenarios need to consider the ratio of investment between inpatient beds and community care
- There was a view that Scenario C was incomplete – more detail was requested
- Community services were thought to need more consideration
- Stakeholders assumed that demands on services will increase – and that relevant assumptions should clearly be set out for consultation options.

#### *Do they represent the full range of realistic alternatives?*

- There was scope for some cross over between scenarios A and B
- Some participants said there should be more flexibility in the scenarios, rather than a binary choice between pre-Covid and current inpatient bed availability of 180 and 70 respectively – with bed capacity based on the needs of the community, perhaps by putting in extra beds at the hospitals
- It was noted that there were no scenarios which considered reopening the Gordon as it currently is or closing all beds and basing all services in the community, although some participants thought the scenarios were too heavily 'loaded' towards care in the community, and did not take enough consideration of the percentage of people for whom community care is unrealistic
- There was a view that the current numbers of inpatient beds are insufficient to meet service needs, so the scenarios and future models should reflect this and increase the number of beds
- Several people expressed the view that there should be provision in the south of the area (bi-borough)
- There were suggestions for providing inpatient beds in smaller settings, spread across local communities; a community care centre with a small number of beds; or two to three bed facilities located close to community resources (this was described as sitting between scenarios B2 and C1)

***Are there additions or variants which could be considered?***

- Provision of acute beds in the new build at St Mary's
- Short term acute beds at the Gordon whilst the long term planning is happening
- The longer term solution should include for temporary beds in Westminster
- Higher numbers of inpatient beds, particularly in the south of the borough, with wrap around community services
- Include a model with 'recovery type' options, such as that in Drayton Park – with self-referral
- Use some of the Gordon's community space, such as the roof garden, to benefit community support

***Other comments from participants:***

- How do the options presented tie in with the Mayor's 6 tests when closing inpatient beds?
- Equity should be a headline objective, as well as promoting equality as some groups might need more resources as well as access to services
- No specific criteria for differences and similarities between Kensington & Chelsea and Westminster were mentioned, except that tourists and homeless people are attracted to the centre of London
- There could be learnings from other consultations, e.g. stroke and major trauma

- Some participants considered the scenarios presented binary options between community based care and inpatient care – and there was a preference for providing a blend of the two
- How do we know if community provision is working effectively, or not?
- If the current system were meeting demand for beds wating times for admission would be shorter. How does a 12% reduction in length of stay generate a 35% reduction in beds?
- Will there be a feasibility study? If so, will this include capital investment in the Gordon? How will options be defined?
- Discharge and readmission data should be considered

### Break-out session 2

After feeding back from the table discussions in a plenary participants were shown a series of draft objectives which the consultation options might seek to achieve. These had been derived from comments received during Workshop 1a and 1b.

To consider these in more depth, participants were invited to visit each of six stations set up around the room and leave their comments on sticky notes on flip charts. Five stations presented an objective for the provision of mental health services, and one a viability test of deliverability; people were asked to comment on what each element meant to them and what information would be useful for assessing them.

The objectives were:

1. Service quality – a pattern of services in place that results in the best possible outcomes and experience for our service users
2. Access to inpatient care – to ensure that access to inpatient services is available whenever needed
3. Access to community support – to deliver community-based services that are accessible to our patients and service users where they live
4. Quality of inpatient facilities – to deliver our inpatient services from facilities that are therapeutic and safe
5. Promoting equality – to reduce inequalities in outcomes, access and experience
6. This station asked people to consider deliverability as a viability test

The data from the stick notes is presented below.

***Service quality***

- Further considerations for the patient journey
  - Delayed Transfer of Care (DToC) must be considered in terms of making sure that beds are available
  - Make sure that 'medically optimised' patients (the point at which care and assessment can safely be continued in a non-acute setting) are not waiting for transfer out to therapeutic, MDT, inpatient support etc
  - Quality of patient journey in accessing inpatient care – not having to wait in inappropriate settings
- Flexible access to pathways
  - A 'swift return' of any patient should not be undermined
  - Some patients do need further support

    - Discharge should be patient centred, not service centred
- Environment
    - Inpatient environment must be safe, therapeutic, high quality
- Staff
    - Appropriate level of qualification, training and experience
- Joined up care considerations
    - What does 'pattern of services' actually mean?
    - Meeting physical needs as well as mental health is important
- Descriptions of pathways needed
    - Pathways that include both community and inpatient care
    - Mental health's role in Integrated Neighbourhood Team (INTs)
- Other
    - Need temporary beds in WCC
- Useful information for assessment
    - Data needed in all areas for participants of engagement to fully engage and make comment
    - Service quality depends on building quality data – i.e. intelligence within communities
    - E.g. revolving doors
    - Data should be balanced – both positive and negative
    - Service user feedback data
    - Cost effectiveness
    - Need to involve social workers, nurses, clinicians, psychiatrists, psychologists

***Access to inpatient care***

- Speed of access
    - Time taken to access a bed should mean an acute mental health bed, not a place of safety bed
    - Would ideally improve on current waiting times in A&E – currently there can be difficulties obtaining beds via this route
    - There should be quick access, in borough and close to support networks
- Location of beds
    - There is a need for some beds in the south of Westminster
- Data needs
    - Need for information about waitlist for referrals to inpatient care
    - Impact of Covid surge and fallout over the last 2 years – may need to benchmark this against regional/national data
        - Time taken to access beds from the community, A&E, police cell, prison – before 2019 and now (2023)
    - Benchmarking bed numbers is not a good idea – other areas are not well services, but this does not mean that CNWL should follow suit
    - Useful information should include outcomes for people who were not able to access a bed
    - Data/evidence insight for numbers who do not engage with services currently
- Other thoughts
    - Access to placements and housing to support discharge
    - Predicting future demand
    - Detox rates

***Access to community support***

- Accessibility
    - Services should be accessible wherever you are
- Continuity of care
    - Community should complement in-patient care – before, during and after
    - Have the same person seeing you
- Cultural competence
    - Geared towards local needs
    - In practice, need joint delivery in community working with community leaders and groups
    - Context of local need is necessary to understand
    - Build trust with the local community, groups and leadership
    - Early identification of local needs of young people
    - Define 'community' – BAME is far too wide and not specific enough
- Admissions
    - Mental Health Act formal admissions need to be direct and not via Health-Based Place of Safety
- Communications
    - Digital support needed for people to find and support one another
    - Need good communication and information between different system parts e.g. between community teams and GPs to avoid people having to re-tell their stories
    - Safe handovers of care between hospital, GO, community
    - Community support needs to be responsive
- Integrated Network Teams (INTs)
    - Partnership with INTs
    - Explore potential for INTs to extend range of services across boroughs
- Staffing
    - CMHTs are stretched. Need team managers and Band 7 input
    - There aren't enough in-borough placements to meet needs
- Evidence
    - Need to show evidence of benefits of community interventions for families and residents

***Quality of inpatient facilities***

- Important elements include:
    - Compassion
    - Staff are looked after
    - Safety for patients – proximity can lead to potential flash points; patients should be listened to when incidents are reported
    - Staff should be committed to a social model of care
    - Care should be well resourced and include arts and access to psychological therapies

- Useful information for assessing service quality:
    - Resident feedback, e.g. Voice Exchange
    - Staff engagement and review
    - Feasibility studies, e.g. 'what is good enough?'
    - Consideration of a workforce skill mix covering inpatient and community services

***Promoting equality***

- What this means:
  - Culturally competent
  - Quality of social support available to people experiencing mental health crises, e.g. because of housing issues
  - To ensure access for people in disadvantaged groups, flexing provision
  - Need to ensure access to beds – currently unequal as no beds in south Westminster
  - Address barriers which prevent people reaching services
    - Impact of generational trauma of disadvantaged communities accessing health and social services, particularly mental health services
  - Social care/housing worries/better links following Sec 75 disaggregation
  - Bridge the BAME communities' access who have higher inpatient admissions, but not engaging with communities. Is there a bias in referrals?
  - Use the voluntary sector more to reach diverse communities
  - Equality is not about ensuring the same number of each ethnic group access a service – inequalities affect every aspect of a person's life. Over representations is a societal problem
- Further definition:
  - There is further definition of BAME groups required
    - Avoid vague and broad categories, e.g. Black/Black British/African
    - Identify the sub-groups
  - Equality seems sound in theory, but not in practice – especially with limited resources. Perhaps better to adopt a framework around 'equity'
  - What about people we don't know about/understand well (particularly transient populations)
  - Does the inpatient plan feel enough to support the most vulnerable patients?

- Information required/to be added for assessment
  - JSNA – Grenfell to be included
  - Qualitative and quantitative data from our communities
  - The voice and experience of people in these communities (prior to service use and after experience of use)
  - National benchmarks of use of MHS for place
  - Need to know fares to and from areas to inpatient settings, including taxi fares for family members
  - Need information about access and who currently gets left out of accessing services
  - Population health data – ethnicity, deprivation, SMI (whether admitted) and intersectionality between these
  - Assessment of the impact of Grenfell
  - There is a workstream '20234 on forwards in the Borough' – needs to be tied in

***Deliverability***

- Economies of scale make one site more viable, e.g. one on-call medical rota; having two sites could lead to delays in response if staff had to travel between sites
- Safe sites: consideration of the minimum number of staff needed on a site for 'resilience' and cross cover for incident responses such as restraint
- Affordability is not just about what is affordable to CNWL but should also consider what is affordable to the whole system. Closure of The Gordon has financial implications for

other parts of the system e.g. police, A&E and local authorities – and financial impacts must include these considerations

**Next steps**

The aim is that the same organisations and, if possible, the same individuals will have input at all three workshops. Workshop one looked at what good looks like in acute mental health care, workshop two, reported here, looked at possible scenarios for models of care and workshop 3, to be held on 18 May will look at proposed consultation options. A summary report, like this one, will be published for workshop 3.

It is anticipated that the final options for consultation will be announced in early June, and the options appraisal process will be reported fully when the PCBC is published.

In the meantime, this report along with the report from Workshop 1a and 1b is available and additional comments invited on the process and the topics covered.

## Appendix 3: Workshop 3 report

**Preparation for consultation on the future of acute mental health care for residents of Westminster, Kensington & Chelsea, and Brent**

**Background**

Following temporary closure of mental health wards in the Gordon Hospital in 2020, plans for consultation on the future of acute mental health care for residents of Westminster, Kensington & Chelsea, and Brent have been considered by the North West London Integrated Care Board (NWL ICB), which is the consulting body.

In developing plans, NHS commissioners are required to consider a full range of service change options that can improve outcomes and identify those which are viable and sustainable. These will be developed into options for formal consultation, which is expected to happen later this summer. The list of options must always include a "no change" configuration, so that it can be compared properly with whatever changes are proposed.

The development of these options is informed by detailed analysis which incorporates clinical evidence, views of service users and staff gathered during pre-consultation engagement, insights 0from other stakeholders, patients flow, financial and workforce considerations. The options will all be set out in a comprehensive Pre-Consultation Business Case (PCBC) document, with detailed assessment of each against the agreed criteria and objectives which will be agreed in advance of the appraisal, taking account of input from stakeholders.

Following agreement by the Board, the NWL ICB would submit the PCBC to NHS England, which is the body responsible for authorising public consultations to proceed.

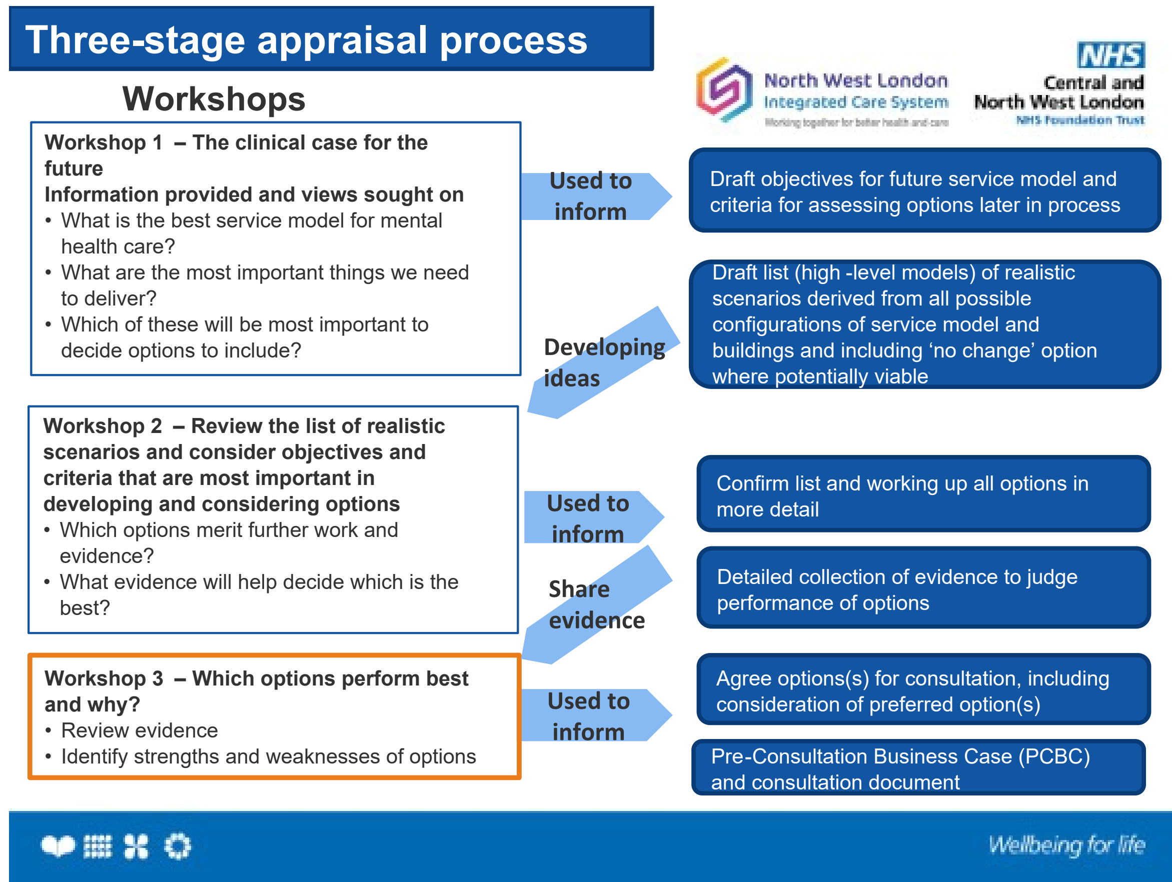


**Table1. The options appraisal process**

Appraisal is a structured process through which all a full range of possible service solutions are considered and evaluated - and a range of options put forward for public consultation, all of which must be realistic and viable. It is important that we do not offer for public consultation any options which we know to be undeliverable or unaffordable.

The appraisal process that we are using is summarised in the flow diagram at Table 1.

It is based on three workshops to which stakeholders bringing a broad range of relevant perspectives were invited (service users, clinicians, service managers, commissioners, statutory partners). Individuals worked together to discuss "what good looks like" and review realistic scenarios and criteria which are important when considering options to inform the process; from these discussions a final list of possible options was determined and presented in workshop 3.

It is important to emphasise that these workshops are not the only way – or the only opportunity – for services users and other stakeholders to give their views.

Two workshops (consistent in content) were held with stakeholders on 27/03/23 and 18/04/23 to identify what good looks like in the provision of acute mental health services. The outputs of those workshops supported the development of a set of scenarios for discussion in workshop 2, which was held on 25/04/23. The outputs from workshop 2 were used to identify which options merit further work and what evidence is needed to support them.

Workshop 3 was held on 18th May 2023 from 10.00 to 13.00 at 110 Rochester Row, London SW1 1JL.

Thirty three stakeholders participated in the workshop.

The aim of workshop 3 was to consider which options perform best and why. The two key tasks for this workshop were:

- To review data
- To identify the strengths and weaknesses of options

The workshop comprised three sessions:

- Plenary 1 was a presentation of data, including for gaps identified in previous workshops, followed by a question and answer session
- Plenary 2 was a presentation of viable options, including a new model developed after input from the previous workshops, followed by a question and answer session
- Breakout discussions considering the strengths and weaknesses of each option

Packs were available on the tables showing more detail on the data being shown in the presentations.

**Plenary session 1**

Presentations were given on data relating to:

- Change in activity profile
- Sufficiency of acute capacity
- Impact on waiting times for beds
- Whether pressure on beds leads to short length of stay or inappropriate early discharge
- Impacts on other public services
- What service users say about inpatient services
- Bi-borough services
- The impact of the temporary closure of the Gordon on travel times
- Service user demographic profile

Suggestions from participants on other data to consider:

- Travel times between sites for patients and professionals
- Qualitative data to support the quantitative data
- How many adult beds are taken up by young people transferring from CAMHS
- AMP data should be considered – including out of area admission data
- Data held by the police should be considered, including:
    - Travel times between sites for police
    - Amount of police time spent per patient when dealing with mental health issues
    - Admissions
    - Rough sleepers
- Where people who use a Single Point of Access are asked to go to, e.g. within borough or out of borough
- How long people wait in Health Based Places of Safety
- Assessments which are cancelled because of non-availability
- Kensington & Chelsea have data related to out of hours demand

The CNWL team welcomed the suggestions and said they would look into them all. They invited people to also send further suggestions, reports or other information.

Other comments:

- Step-down beds in crisis hostels are used by other boroughs
- If the Gordon closes the money should be ring-fenced for Westminster
- It was noted that the admissions data presented related to the pandemic period – and some queried the relevance of this as the Gordon was closed

**Plenary session 2**

Presentations were given on the development of options based on the outputs of Workshop 2:

- A review of the works which would be required at the Gordon to make the inpatient wards at the least safe and at best acceptable
- A review of the clinical models to consider what could be offered between inpatient and community to address key system pressures
- Consideration of ways to address the needs for a greater presence in south Westminster

Updates to the options were shown, including a new option putting an urgent care hub and community services into the Gordon, with the ability to take short term admissions.

The tests for affordability and deliverability were presented and the five remaining potential options were shown. These were:

| Option – summary of change | Detail |
| --- | --- |
| A1: Reopen 51 beds at Gordon – facilities "safe". (Return to 2019). | Highest acute bed base (118). Lowest community service provision.<br><br>Two site inpatient service (at St Charles and the Gordon). Facilities at Gordon meet "safe" standards only. |
| B1: Reopen c. 34 beds at Gordon – facilities "safe". | Lower acute bed base (67). Higher community service provision.<br><br>Two site inpatient service (bed split between St Charles and the Gordon). Facilities at Gordon meet "safe" standards only. |
| B2: Reopen c. 34 beds at Gordon – facilities "acceptable" | Lowe acute bed base (67). Higher community service provision.<br><br>Two site inpatient service (bed split between St Charles and the Gordon). Facilities at Gordon meet as many national standards for quality as possible. |
| B4: Maintain current 2023 service pattern | Lower acute bed base (67). Higher community service provision.<br><br>One site inpatient service at St Charles. Facilities meet all key national standards for quality. |

| C: Adapt Gordon for “urgent hub” in South Westminster for short-term admissions. | Lower acute bed base (67). Additional community service provision.<br><br>One site inpatient service at St Charles. Facilities meet all key national standards for quality<br><br>In addition, community and urgent care hub at the Gordon, with ability to take short term admissions |
|---|---|

Questions and comments following Plenary 2:

Question: Has there been additional investment for the current provision – since the closure of the Gordon? Is it possible to reopen the Gordon and continue with the current levels of community based care?

Answer: There had been additional investment, but the budget is finite, so difficult choices have to be made.

Staffing needs also constrain what is possible.

Question: What about other step-down beds in Westminster?

Answer: These are funded by other funding streams.

Question: Is there more budget available for CNWL for mental health since it is a top priority?

Answer: Not all the budget is ring-fenced. Mental health usage has been increasing and there is a long list of other top priorities advocated by other departments.

Question: Is there ‘other borough’ data for ‘other borough usage’?

Answer: Work is being done to look at outer boroughs. The models under discussion are viable for Kensington & Chelsea and Westminster residents.

Question: In Workshop 2 there was a challenge about the occupied bed days equation used. What is being done about that?

Answer: We are looking into this.

Comments:

- More information is needed on the cost options of different numbers of beds
- Option C was thought to be:
  - In line with the Long Term Plan and community care
  - Putting some resources into the Gordon

- Practical

**Breakout discussions**

Participants held facilitated discussions about the five options presented in Plenary 2, and for each option they were asked to consider:

- The strengths of the option
- The weaknesses of the option
- If the option were to go forward to the consultation process what would need to be considered for implementation
- Who would need to be consulted about the option

The following sections collate the comments and views about each option from the six breakout groups. The participants' views on who needed to be consulted were the same across all the options; this list is presented separately after the views on the options.

**Option A1:** Reopen 51 beds at Gordon – facilities "safe". (Return to 2019)

Highest acute bed base (118). Lowest community service provision.

Two site inpatient service (at St Charles and the Gordon). Facilities at Gordon meet "safe" standards only.

Strengths of option A1:

- Puts a facility back into south Westminster
- Increases the number of acute beds, which would reduce pressure on beds
- Reduction in waiting times in A&E for admission
- Safer for those at risk of suicide

Weaknesses of option A1:

- A backwards step in terms of direction of care with a return to more restrictive care and the loss of valuable community services
- Reduction of patient choice
- Likely to increase delays to transfers of care to community
- Number of step-down beds reduced
- It does not appear to create more capacity
- Affordability
- Recruitment of staff will be difficult

Considerations needed if option A1 is taken to the consultation process:

- The impact on length of stay for patients
- The impact on patients of fewer choices
- The ability to deliver the least restrictive choice
- Timings are undefined so far

- The standards of accommodation at the Gordon

**Option B1:** Reopen c. 34 beds at Gordon – facilities "safe".

Lower acute bed base (67). Higher community service provision.

Two site inpatient service (bed split between St Charles and the Gordon).

Facilities at Gordon meet "safe" standards only.

Strengths of option B1:

- Improves access for people in south Westminster
- Provides more community treatment than A1
- Reduces travel for patients in the south of Westminster

Weaknesses of option B1:

- Fewer acute beds
- Loss of capacity at St Charles
- Does not address capacity in the system
- Loss of step down options
- Cost and only sustainable in the short term
- Will not improve facilities such as bathrooms
- Safety and quality of provision on both sites likely to be degraded because staff resources would be spread too thinly
- Would take time to implement

Considerations needed if option B1 is taken to the consultation process:

- How does this option compare to the community service provision available prior to the Gordon's temporary closure?
- Need more information from local GPs
- How the voluntary sector would be involved

**Option B2:** Reopen c. 34 beds at Gordon – facilities "acceptable"

Lower acute bed base (67). Higher community service provision.

Two site inpatient service (bed split between St Charles and the Gordon).

Facilities at Gordon meet as many national standards for quality as possible.

Strengths of option B2:

- Convenience for people in south Westminster
- Wastes less money than option B1

Weaknesses of option B2:

- Inefficiency of having beds on two sites
- Loss of services
- Loss of beds overall, including step-down beds
- Staffing issues

Considerations needed if option B2 is taken to the consultation process:

- The impact on other services in terms of budget allocation
- The time frame for implementation
- Need more information from local GPs
- Role of voluntary sector

**Option B4:** Maintain current 2023 service pattern

Lower acute bed base (67). Higher community service provision.

One site inpatient service at St Charles.

Facilities meet all key national standards for quality.

Strengths of option B4:

- Patient choice – e.g. crisis house, MHCAS, step-down beds
- Less restrictive care
- Provision at St Charles is good, including outside space

Weaknesses of option B4:

- Lack of provision for people in south Westminster
- No direct access to services
- Navigating services
- Creates pressure on acute hospitals
- Too few acute beds

Considerations needed if option B4 is taken to the consultation process:

- Whether the need for acute beds is being met with this model
- Impact on areas where there are no services
- Consideration of the needs of 'hidden communities' whose needs are not being addressed
- The needs of homeless people
- Economies of scale for staffing
- The impact of mental health presentations at A&Es
- Is there scope for improvement at St Charles?

**Option C:** Adapt Gordon for "urgent hub" in South Westminster for short-term admissions.

Lower acute bed base (67). Additional community service provision.

One site inpatient service at St Charles.

Facilities meet all key national standards for quality

In addition, community and urgent care hub at the Gordon, with ability to take short term admissions

Strengths of option C:

- Puts facilities in south Westminster and services such as a walk in centre would be a valuable asset in the area
- Augmented services such as Clinical Decisions Unit
- St Charles' provision is preserved
- Preserves community provision
- Working with 3rd Sector

Weaknesses of option C:

- Insufficient inpatient beds
- Acute beds are short-term – still leaves Westminster with no long-term acute beds
- The separation of some services – including moving MHCAS from St Charles
- Wards with bays cannot take the most acute cases
- Relying too heavily on volunteers to deliver community based services
- Potential blockages to patient flow with low acute bed capacity
- Patients having to move from short term provision at the Gordon to St Charles if they need an inpatient bed
- Does not appear to address continuity of care
- Standalone unit could be unsafe for patients and staff
- Removes some services from St Charles

Considerations needed if option C is taken to the consultation process:

- How this would work for the police and s136
- The distribution of services between the two sites
- Is there sufficient capacity for inpatient beds
- More data is needed for this option
- How will the needs of people needing long-term admissions be met?
- Definition needed – e.g. what is meant by 'short-term beds', how the referral process works, how people could access services

- The impact on other boroughs of moving MHCAS to the Gordon – and whether this could lead to a reduction of provision for Westminster residents if patients from other boroughs are brought in
- Could the Gordon be ringfenced for Westminster patients?
- AMP data should be considered

**Who should be consulted?**

The following list is compiled from the table discussions. Stakeholders said that who should be consulted in the next stage was not dependent on which options are put forward.

- Acute hospitals and their staff (including liaison services) – St Mary's, St Thomas and UCLH were mentioned
- Carers
- Clinicians
- Community Mental Health Teams
- Community, including Grenfell, North Kensington
- GPs – especially those in areas such as Churchill Gardens and other local areas
- Home treatment teams
- Housing partners – Peabody and Octavia were mentioned
- Joint Homeless Team
- Local Authorities
- London Ambulance Service
- Other boroughs affected – e.g. Brent, Lambeth and Camden
- Outreach services
- Police
- Residents
- Service users
- Staff who previously worked at the Gordon
- Voluntary Sector – One Westminster and Red Cross were mentioned

**Next steps**

It is anticipated that the final options for consultation will be announced in early June, and the options appraisal process will be reported fully when the PCBC is published.

The next part of the process is consultation engagement based on:

- **Statutory Duty to Involve** – NHS Act 2006 (amended)
    - s14Z45 (ICBs), s242 (Trusts), s244/245 (Health Scrutiny)
    - B1762 Working in Partnership with People and Communities (NHSE, July 2022)
- **Equality Act 2010**
    - s149 public sector equality duty
    - Other obligations including duty to reduce inequality

- **The Government's five tests** (specifically: Strong public and patient engagement)

- **The London Mayor's six tests** for NHS service change (specifically test 6. Patient and public engagement)

- **Gunning Principles** for public service consultations:
    - Proposals are still at a formative stage
    - There is sufficient information to give 'intelligent consideration'
    - There is adequate time for consideration and response
    - 'Conscientious consideration' must be given to the consultation responses before a decision is made.

In the meantime, this report along with the reports from Workshops 1a, 1b and 2 are available and additional comments invited on the process and the topics covered.