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.

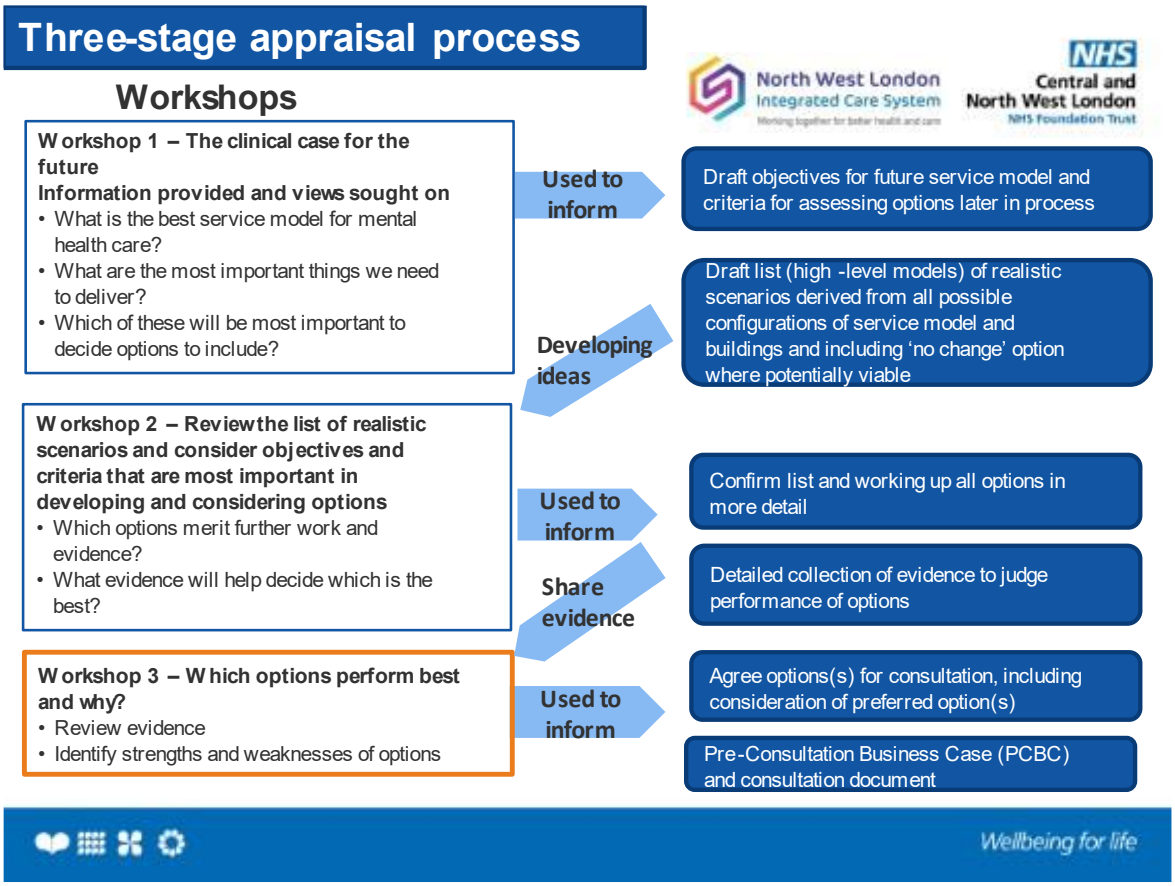

Table1. The options appraisal process

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. A report of the workshops can be found here https://www.cnwl.nhs.uk/gordon-hospital-get-involved/latest-news 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 18 May 2023 from 10am to 1pm 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. 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. 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. 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. 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. 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

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.

If you would like to comment on this report please add your comments here