The Strategy Unit.

Proposed Changes to Adult Mental Health Services in North West London

Independent Review for the Mayor of London of the Pre-Consultation Business Case

Phase 1 – January 2024

David Frith, Principal Consultant
Mark Thompson, Managing Consultant
Mahmoda Begum, Senior Consultant
Andrew Hood, Analytics Manager

NHS
Midlands and Lancashire
Commissioning Support Unit

Contents

Executive Summary

The pre-consultation proposals independently reviewed here concern potential changes to acute mental health services for adults aged 18-65 in North West London.

The scope of the review is determined by the Mayor of London's Six Tests for major service changes in NHS services in London. These tests are designed to enable the Mayor to take a structured, evidenced and independent position on proposed changes and to ensure they are in Londoners' best interests.

NHS North West London Integrated Care Board, in partnership with the Central and North West London NHS Foundation Trust, is proposing to reduce the number of adult mental health inpatient beds and increase the provision of community services, especially those designed to meet service user needs in times of acute crisis. These proposals mostly affect residents of the City of Westminster and the Royal Borough of Kensington and Chelsea. Inpatient beds at the Gordon Hospital, Westminster, have been temporarily closed since early in the COVID-19 pandemic due to concerns around infection control. In parallel, there has been a material extension of community services.

There is now a need to determine the future pattern of services and to resolve the current temporary position. Three options have been put forward for public consultation:

- **Option One.** This option is closest to the service that existed before the temporary closure of wards at the Gordon Hospital.
- **Option Two.** This option would re-open a reduced number of beds at the Gordon Hospital and scale back the alternative services that have been developed since 2020**.**
- **Option Three.** This option reflects the current position and would further extend the crisis provision developed since 2020. It is the proposers' preferred option.

Our review is based predominantly on the published consultation proposals and the underlying Pre-Consultation Business Case. It reflects, therefore, the status of proposals at a certain moment in time, whilst further work will have continued to be undertaken that we cannot fully reflect here.

We are grateful to colleagues in North West London for the open and positive approach they have taken to engaging with the review.

In the sections that follow we highlight where we believe the proposals already meet the Mayor's tests and where they could be enhanced to meet the tests more fully.

Our key findings are that:

On health and healthcare inequalities

- A broad range of analysis and engagement have been undertaken concerning the differential impact of the temporary closure of Gordon beds on groups with protected characteristics and other groups identified as vulnerable. A significant exception to this is the silence of proposals on the needs and experiences of people with a learning disability and/or autistic people, albeit they may represent a small proportion of relevant activity.
- We did not find evidence of work to understand the impacts and trends reported, nor was it evident that this work has informed the model of care or the changes proposed or led to specific plans for addressing inequalities.
- Impact assessment of the options focused on travel time and cost and should be extended to other potential impacts.
- There is significantly greater value that can be realised from the data presented and from other routinely available data, particularly in terms of drawing conclusions and specifying mitigations where there appear to be opportunities for addressing inequalities.
- Intersectional effects do not appear to be explicitly considered currently. We therefore endorse the recommendation in the IIA concerning the further analysis of this kind that should be undertaken.
- There should be a much clearer description and explanation of patterns evident in the data, including the relationships found between:
    - specific population groups, especially by ethnicity, gender and deprivation;
    - diagnoses made; and
    - differences in access to the various points of care, in service user experience, and in outcomes.
- Proposals critically lack the benefit of an overarching local mental health strategy and inequalities reduction plan that we would expect to inform their development. An overarching assessment of mental health needs in North West London is required that includes:
    - An epidemiological profile;
    - Comparison of access, experience and outcomes against suitable peers;
    - Analysis of differentials by demographic group and high-level conditions (e.g. psychoses, personality disorders, anxiety and depression, cognitive impairment, other);

- Exploration of intersectional dynamics and interactions with other services (e.g. social care, housing, criminal justice);
- Demand and capacity modelling that explicitly responds to the nuanced analysis of need.

- Proposals are based on existing demand, not on such a comprehensive assessment of need across North West London ICS. In particular:
  - The catchment population is defined as the Boroughs of Westminster and Kensington and Chelsea, but it is not clear from proposals where the totality of demand for the affected services currently comes from. This inhibits the ability to assess the extent to which proposals meet need or demand.
  - Service users are mostly considered as if they are a single group of mental health patients whereas consideration should be given to the demand relating to specific conditions and the discrete needs associated with those conditions.
- There is a lack of evidence that data on access routes and waiting times for vulnerable groups has been considered and used to inform action on where disadvantage may be being compounded.
- The potential cost impact of each option on service users, families, and carers should be an explicit consideration in final decision-making.

On hospital beds

- The changes proposed – reducing beds and increasing community provision – are in line with an established national direction of travel reinforced within the NHS Long Term Plan which promotes the provision of community services as an alternative to inpatient care.
- In these proposals, the resourcing for the additional community services that have been developed (and would be extended under the preferred option) is portrayed as a direct trade-off with inpatient capacity. Whilst there will inevitably be funding constraints for services, the lack of an overarching modelling of need means that the proposals, as currently described, risk appearing more resource-driven than needs-driven.
- For greater assurance, there should be more detailed modelling of need, demand, and capacity across North West London, broken down by population group and by an appropriate high-level grouping of mental health conditions (e.g. psychoses, personality disorders, anxiety and depression, cognitive impairment, other). This should make transparent the relative investment being made in services for different geographic populations and provide assurance on the capacity to manage peaks in demand across the ICS.

On financial investment and savings

- There are credible plans to deliver the preferred option, in both capital and revenue terms. Given the limited capital available to the Trust, other options put to the public in consultation appear not to be deliverable and this would normally result in their exclusion from the consultation process.
- Given that aspects of the service model continue to be developed, in an entirely appropriate way (e.g. MHCAS), further sensitivity testing of capacity assumptions would provide greater assurance, supported by high-level mitigation plans where capacity may be exceeded. The current work within the wider mental health strategy for the ICB should also provide assurance about future needs.
- The resourcing for the additional community services that have been developed (and would be extended under the preferred option) is portrayed as a direct trade-off with inpatient capacity for residents of the two Boroughs. This risks being misleading given that proposals for additional beds at Park Royal are being advanced (with a resource impact not disclosed in these proposals) and evidence that per-person funding for mental health in North West London has lagged behind the national level.

On social care impact

- There are credible arguments presented that there would not be a material impact on social care services. For assurance, formal assessment of this should be undertaken or explicit confirmation secured from social care services that they share this view.
- We would expect this to need further exploration and, if necessary, mitigation in the DMBC. This is especially the case where a reduction in inpatient capacity is proposed and with some reliance on efficiency assumptions, creating a risk of an unintended adverse financial impact for social care services, either from additional community demand pressures or from a shared responsibility to fund aftercare for those who have been detained under section as inpatients.

Background

The Mayor of London's Six Tests

The Mayor of London is committed to using his influence to champion, challenge, and collaborate with the NHS on behalf of Londoners. The Six Tests are a framework for assessing major health and care transformations in London. They enable the Mayor to take an evidence-based position on proposed changes to ensure that they are in Londoners' best interests.

The Six Tests cover:

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

The Mayor has decided to apply the tests in the case of proposed changes to Adult Mental Health Services in North West London. The tests are applied at two stages, linked to the publication by the proposing body of the pre-consultation business case (PCBC) and the subsequent decision-making business case (DMBC). At each stage, the Mayor writes a letter to proposers setting out his position on the proposals and any changes he would want to see. Mayoral letters are informed by an independent review that is based on published proposals and supporting documentation.

Proposed Changes to Adult Mental Health Services in North West London

There is a long-standing and ongoing direction of travel in NHS mental health services to provide a greater proportion of care in the community rather than in hospital settings. The additional resources for mental health services nationally, resulting from the Mental Health Investment Standard that commits the NHS to increase funding for mental health services faster than the growth of the overall NHS budget, have explicitly supported this direction of travel.

The NHS Long Term Plan (2019) states that mental health services "will be resourced to offer intensive home treatment as an alternative to an acute inpatient admission", as part of a commitment to 24/7 community-based mental health crisis response[1]. It also noted the work of the

[1] NHS Long Term Plan v1.2 August 2019 - Section 3.89 ff.

Crisp Commission (2016)[2] which recommended that local partners in each area should "undertake a service capacity assessment and improvement programme to ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home Treatment teams to meet the need for rapid access to high quality care". Building on the Commission's work, research that the Strategy Unit undertook in 2019[3] found that:

> "The vast majority of Royal College of Psychiatrists' members believe that the solution to pressure on inpatient beds lies in increasing the coverage and resilience of community services, but this will take time, and in many areas the pressures are reaching critical levels. Whilst there is some good evidence to suggest that early intervention and talking therapies might reduce pressure on inpatient beds, the evidence base for crisis resolution teams and primary care mental health services needs to be strengthened."

NHS North West London Integrated Care Board (ICB), in partnership with the Central and North West London NHS Foundation Trust (CNWL), is proposing to reduce the number of adult mental health inpatient beds and increase the provision of community services, especially those designed to meet service user needs in times of acute crisis. These proposals mostly affect residents of the City of Westminster and the Royal Borough of Kensington and Chelsea aged 18-65 with acute mental health needs, although it is evident that the facilities in these boroughs (the Gordon Hospital and the St Charles Centre for Health and Wellbeing, respectively) serve a wider population, too, especially from Brent.

The pre-COVID-19 position included 51 inpatient beds at the Gordon Hospital and 67 at St Charles, and it is reported that these provided 90% of the inpatient admissions for residents of the two boroughs.

- At the Gordon, 69% of admissions (61% of bed days) were from Westminster and 3% from Kensington and Chelsea (2% bed days);
- At St Charles, 22% of admissions (23% of bed days) were from Westminster and 55% from Kensington and Chelsea (52% bed days);
- Brent residents had more admissions to the Gordon than did residents of Kensington and Chelsea (20 vs. 13) but fewer bed days (374 vs. 428), and they also had 39 admissions to St Charles (utilising 1179 bed days).

There was also a range of community-based services including:

[2] policy-old-problems-new-solutions-caapc-report-england.pdf (rcpsych.ac.uk)
[3] Exploring Mental Health Inpatient Capacity | The Strategy Unit (strategyunitwm.nhs.uk)

- Talking Therapies;
- Kooth – digital therapies for younger adults (16-25) across North West London;
- Integrated Community Mental Health Hubs;
- a range of voluntary sector support:
- Age UK digital inclusion support for older people;
- a First Response Service offering 24/7 assessments in the community;
- a revised Crisis Resolution Home Treatment Team;
- British Red Cross providing support for people who are regular users of services, particularly A&E;
- new non-clinical support services for people in crisis, open in the evening 365 days a year, called the Coves.

The cost of staffing the Gordon Wards in 2019, adjusted for 2023/24 prices, is stated at £5.4m. Baseline costs for St Charles or for community services are not stated.

In response to reported infection control and staffing risks during the pandemic, inpatient wards at the Gordon Hospital were closed temporarily in 2020. The 51 affected beds remain closed, with the associated (and matching additional) funding supporting a range of targeted community services, including 8 beds in a new Mental Health Crisis Assessment Service (MHCAS), as well as increased staffing for the remaining inpatient units (8 WTE per ward).

The ICB is now proposing to regularise this temporary position and is consulting with the public on three options for change (see Figure 1 below). Option 1 broadly reflects the 2019 position, before the temporary closure, Option 2 is a variant of this with just 13 beds at the Gordon, and Option 3 reflects the current position but with the addition of further MHCAS beds.

The ICB has identified Option 3 as its preferred option and has stated that for reasons largely associated with quality of care (as well as capital funding constraints), Options 1 and 2 "cannot be recommended to the public as a good option". Option 2 responds to a recommendation of the Royal Borough of Kensington and Chelsea's Adult Social Care and Health Select Committee to include an option in which there remain inpatient beds at the Gordon. It is noted in the PCBC that "Both Local Authorities have confirmed that they plan to oppose the preferred option in the consultation and campaign for beds to be reopened in Westminster."

Option 1. 2019 model

This option is closest to the service that existed before temporary closure of wards at the Gordon Hospital.

It would comprise of 118 beds inpatient beds across two sites, St Charles (67 beds) and Gordon Hospital (51 beds). The Gordon Hospital facilities would meet "safe" standards, but not "desired" standards, due to the constraints of the building.

There would be less additional capacity created in Brent than in our preferred Option 3, so some of the beds at St Charles would still be used by Brent residents.

Community and crisis services developed since March 2020 would be cut, with these being reduced or stopped entirely.

Option 2. Partially transformed model

This option involves 80 beds across two sites: 67 at St Charles and 13 delivered as a single ward in the Gordon Hospital.

Community and crisis services would be reduced, including closure of the MHCAS service, with its staff moving to support inpatient care. Voluntary sector partnerships would remain in place and the Community Access Service (CAS) would continue.

There would be less additional capacity created in Brent than in our preferred Option 3, so some of the beds at St Charles would still be used by Brent residents.

Option 3. Transformed model – plus enhanced crisis assessment service

This option is closest to the current service, with 67 inpatient beds at St Charles (as now), supplemented by the MHCAS service expanded and relocated to the Gordon Hospital with capacity for 12 patients, including the capability for 4 patients to be admitted overnight.

Additional capacity in Brent would free up seven beds at St Charles.

This option retains the community and crisis services developed since the Gordon Hospital wards were closed, voluntary sector partnerships would remain in place and the Community Access Service (CAS) would continue.

Figure 1 - Options for change

Our Review

The Strategy Unit is an internal NHS consultancy, operating independently from NHS decision-making bodies, that provides leading research, analysis, and change from within the NHS. It exists to improve health outcomes and reduce health inequalities through:

- the application of critical thinking and structured analysis in high-quality processes, helping the health and care system to make better decisions, improve services, and achieve practical benefits for population health and wellbeing. Clients trust us to provide impartial advice, based on clear thinking and rigorous analysis; and
- our work as a partner to systems to support the development of local competencies and to be a catalyst for, and coordinator of, collaborative decision-making processes.

Its core tenet is that better evidence leads to better decisions and better outcomes. Unit specialisms span complex analytics, data science, evidence analysis, strategic change, evaluation, and policy research.

The review team for this work has established expertise and experience relating to the areas covered by the Mayor's six tests. For this first phase of our independent review, we have individually examined the PCBC, its technical appendices, and other information provided by both NHSE and other stakeholders or independently accessed, including:

- MHCAS service evaluation, April 2023;
- Bi-borough Healthwatch report on 'Community perspectives on the impact of the closure of acute mental health services at the Gordon Hospital', October 2023
- Bi-borough Health and Wellbeing Strategy 2023-24;
- Royal College of Psychiatrists 2022 local area report for NORTH WEST London;
- Ealing Save Our NHS response to adult mental health bed closures in Ealing, December 2022;
- Hammersmith and Fulham Save Our NHS summary of public meetings, September 2023;
- relevant Strategy Unit analyses.

We then compared and tested the lines of enquiry that each reviewer identified, and have summarised these in the following sections. Interim findings were also tested with the proposers.

We were asked to:

- summarise positive evidence towards the test being met
- highlight areas where there is a lack of evidence (for example, if a proposal did not appear to consider demographic change)
- highlight areas where there is evidence of lack (for example if a proposal stated that demographic growth had not been considered)
- highlight areas where stakeholders are proposing to do further work (for example if a proposal stated that the NHS was undertaking further equalities impact work during the period of public consultation)
- critically assess key assumptions on which proposals are based – including but not limited to financial, demographic, and supply/demand assumptions – and highlight any areas in need of further development and/or challenge.

In what follows we have sought to add value to the work of the proposers of this service change and, through this, to those who receive the services. We have taken a view on what may be of material impact.

Our review is intended to be a constructive critical analysis of proposals in the light of the six tests and aims both to highlight where the tests are met and where they might be met more fully. In cases where we take the view that improvements could be made, we seek to offer practical suggestions as to how this might be done. We recognise that the PCBC reflects a formative stage in the development of proposals and that some of the improvements we identify may already be planned for later stages of the work.

We are explicitly asked not to take a view on the relative merits of the options under consideration. The purpose is, instead, to ensure that any changes are in the best interests of Londoners.

Each subsequent chapter addresses one of the tests and its structure reflects the detailed questions posed within those tests. For this first phase relating to the PCBC, we are asked to focus exclusively on the first four tests. In the second phase relating to the DMBC, we will review final proposals against all six tests, including a review of the consultation process and the NHS's response to it.

Health and Healthcare Inequalities

Key Findings

- A broad range of analysis and engagement have been undertaken concerning the differential impact of the temporary closure of Gordon beds on groups with protected characteristics and other groups identified as vulnerable. A significant exception to this is the silence of proposals on the needs and experiences of people with a learning disability and/or autistic people, albeit they may represent a small proportion of relevant activity.
- We did not find evidence of work to understand the impacts and trends reported, nor was it evident that this work has informed the model of care or the changes proposed or led to specific plans for addressing inequalities.
- Impact assessment of the options focused on travel time and cost and should be extended to other potential impacts.
- There is significantly greater value that can be realised from the data presented and from other routinely available data, particularly in terms of drawing conclusions and specifying mitigations where there appear to be opportunities for addressing inequalities.
- Intersectional effects do not appear to be explicitly considered currently (e.g. where significant increases in ED attendances are noted for young adults and ethnic minorities, what is the interaction between these groups?). We therefore endorse the recommendation in the IIA concerning the further analysis of this kind that should be undertaken.
- There should be a much clearer description and explanation of patterns evident in the data, including the relationships found between:
    - specific population groups, especially by ethnicity, gender and deprivation (including those experiencing homelessness or rough sleeping);
    - diagnoses made; and
    - differences in access to the various points of care, in service user experience, and in outcomes.
- Proposals lack the benefit of an overarching local mental health strategy and inequalities reduction plan that we would expect to inform their development. There is data available in the local Joint Strategic Needs Assessment and in other routine data sets but these do not appear to have been drawn on in the absence of a strategy. An overarching assessment of mental health needs in North West London is required that includes:
    - An epidemiological profile;
    - Comparison of access, experience and outcomes against suitable peers;

- Analysis of differentials by demographic group and high-level conditions (e.g. psychoses, personality disorders, anxiety and depression, cognitive impairment, other);
- Exploration of intersectional dynamics and of interactions with other services (e.g. social care, housing, criminal justice);
- Demand and capacity modelling that explicitly responds to the nuanced analysis of need, both now and in the future.

- Proposals are based on existing demand, not on such a comprehensive assessment of need across North West London ICS. In particular:
  - The catchment population is defined as the Boroughs of Westminster and Kensington and Chelsea, but it is not clear from proposals where the totality of demand for the affected services currently comes from. This inhibits the ability to assess the extent to which proposals meet need or demand, and it becomes a material issue where a key element in the delivery of the preferred option is the establishment of 14 additional beds in Brent to create capacity at St Charles. Arguably, the proposal for those additional beds should be integrated within these proposals and the associated consultation. As it stands, both the proposals themselves and some of the recorded objections to them, risk being driven more by borough boundaries than by actual patient flows or distance from services.
  - Service users are mostly considered as if they are a single group of mental health patients whereas consideration should be given to the demand relating to specific conditions and the discrete needs associated with those conditions. Conditions can be grouped to aid analysis (see, for example, the categories used in the analysis in Figure 3 below), and data can be pooled over multiple years where cohorts are small. This would also enable a richer understanding of the relationship between diagnosis categories and ethnicity, gender, deprivation, etc, providing a strong basis for a plan to address any inequalities that are identified.
- There is a lack of evidence that data on access routes and waiting times for vulnerable groups has been fully considered and used to inform action on where disadvantage may be being compounded.
- The potential cost impact of each option on service users, families, and carers – especially from vulnerable or protected groups – should be an explicit consideration in final decision-making.

Detailed Analysis

TEST 1: The proposed changes have maximised the opportunities available to the health system to reduce health and healthcare inequalities, which have been set out transparently together with an evidenced plan for further action. The plans set out proposed action to prevent ill-health, including targeting action and resources to improve the healthy life expectancies of the most disadvantaged.

Do proposals:

Set out the current systemic health inequalities issues in their local population, including those driven by socio-economic deprivation and structural racism? Is the contribution of these inequalities to the Healthy Life Expectancy gap and other relevant measures of inequality considered?

This sub-test focuses on the extent to which proposals have considered the relevant underlying health inequalities faced by the local population ahead of any change.

The PCBC describes the key demographic features of the populations of Westminster and Kensington and Chelsea, and an appendix does the same for Brent. These summary descriptions cover factors such as population size, change and density; age; ethnicity; health condition prevalence; deprivation; and employment.

Proposals observe the differential prevalence of mental health conditions amongst the non-white population in the two boroughs where 36% of the population represents 45% of mental health service users, although the reasons for this are not explored.

Healthy life expectancy (HLE) for the boroughs is stated (except for Brent), but there is little exploration of the relationship between HLE and demographic and socio-economic factors.

Given the scope of the proposals, it is notable that there is, in particular, no exploration of the relationship between mental health and physical health. Previous analysis by the Strategy Unit of 2012/13 to 2014/15 linked national datasets[4] showed that, on average, North West London men and women who were in contact with mental health services had a life expectancy 17.5 and 14.7 years shorter, respectively, than the rest of the population (see Figure 2). Although this compared relatively well with similar health systems, it nevertheless highlights a significant health inequality associated with mental health that, in our view, warrants attention in any major change for mental (and, indeed, physical) health services.

[4] Making the Case for Integrating Mental and Physical Health Care - Full Report. | The Strategy Unit (strategyunitwm.nhs.uk) – see tab for North West London analysis

The analysis cited also summarises the evidence around effective mechanisms for addressing this life expectancy gap, including:

- psychiatric liaison services;
- collaborative care - intensive case management for caseloads of <20 people with severe mental illness (SMI) reduces hospitalisation;
- lifestyle interventions of longer duration, with frequent contact and multiple components.

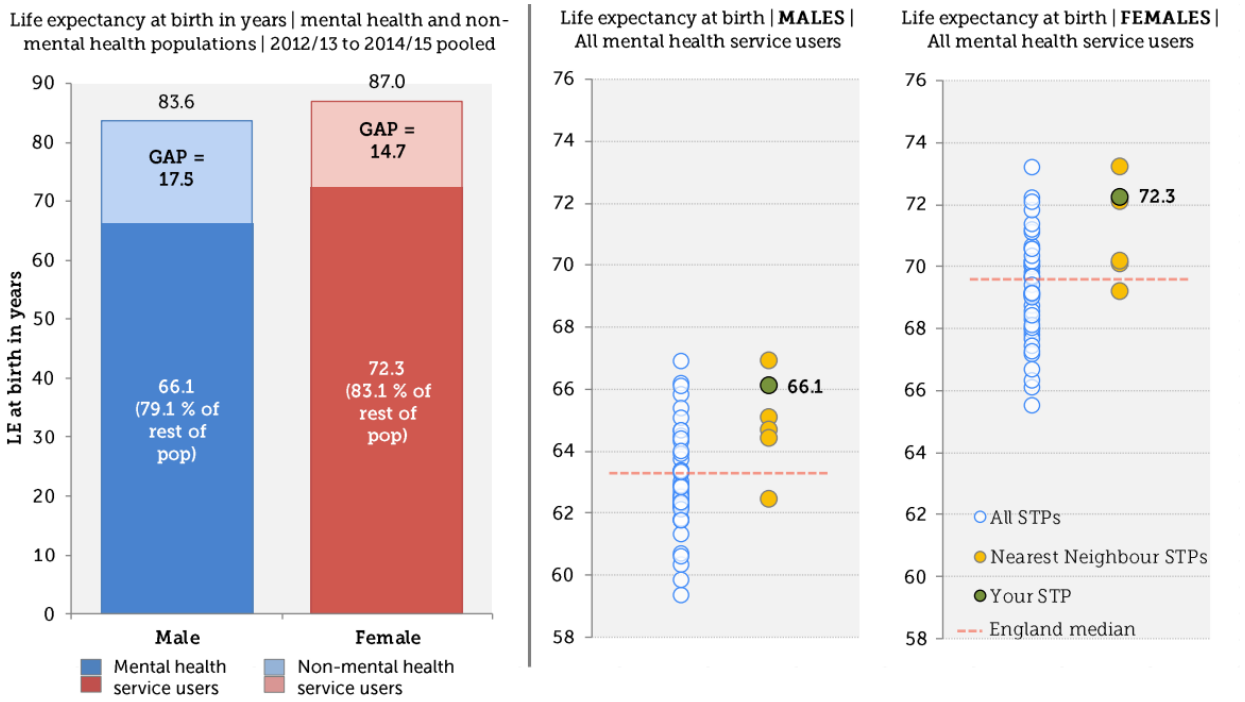


Figure 2 - Relative life expectancy in North West London of those in contact with mental health services compared with the rest of the population, benchmarked against all other health systems

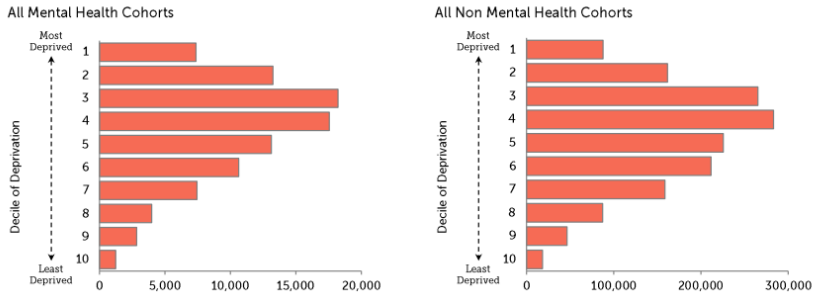
The same Strategy Unit analysis evidenced the relationship between deprivation and the prevalence of specific mental health conditions (see Figure 3) and also found that, after adjusting for the age-sex profile, mental health service users:

- attended A&E and received emergency hospital admission at 3 times the rate of other service users;
- accounted for 20% of all emergency admissions whilst making up just 5% of the population.

The apparent absence from these proposals of analysis that seeks to understand the relationship between demographic characteristics, socio-economic factors, specific mental health conditions and the utilisation of various public services severely constrains opportunities for ensuring that the design and configuration of future services is fully responsive to population need.

Deprivation profiles

	No. of People		% in most deprived quintile	% in least deprived quintile
All Mental Health Cohorts	96,638	5%	22%	4%
- Cognitive impairment including dementia	21,159	1%	17%	6%
- Psychoses	31,914	2%	26%	3%
- Personality disorders	3,933	0%	24%	3%
- Common and other mental health conditions	31,655	2%	21%	4%
- Mental health conditions, unassignable	7,977	0%	20%	5%
All Non Mental Health Cohorts	1,761,570	95%	16%	4%
- Physical health needs	795,207	43%	19%	5%
- Well population	966,363	52%	14%	4%
	1,858,208			



Within North West London STP 22% of mental health patients live in the most deprived quintile (two most deprived deciles combined).

For non-mental health patients this is lower with 16% of patients living within the most deprived quintile.

Of the individual cohorts, patients with psychoses are most likely to live in the most deprived quintile (26%) closely followed by the personality disorders cohort (24%).

Figure 3 - Prevalence of mental health conditions by deprivation quintile

Set out current systemic healthcare inequalities issues – in access, experience, and outcomes – in their local populations and healthcare services, including those driven by socio-economic deprivation and structural racism? Is the contribution of these inequalities to the Healthy Life Expectancy gap and other relevant measures of inequality considered?

This sub-test focuses on the extent to which proposals have examined the relevant inequities in healthcare experienced by the local population ahead of any change.

As noted above, proposals present a range of data on service activity, analysed by population group. These data should now be used to construct an intelligible overview of mental health needs in North West London. It is not possible to determine from the PCBC whether Londoners are getting the care appropriate to their needs or, where they are not, how the current proposals will contribute to them accessing the services they need, having a better experience of those services, and securing improved outcomes from them. This should be addressed within the DMBC

There is, in particular, no reference to the needs and experiences of people with a learning disability and/or autistic people. We are informed by proposers that:

- only a very small number of people with a learning disability or autistic people are admitted for inpatient care (43 in 2019/20 and 23 in 2022/23);
- there is a specific assessment and treatment unit for those admitted sensory kits on all wards, and targeted improvements are being made to the gardens at St Charles;

- CNWL is seeking to deliver a higher proportion of care for these groups in local communities, in line with the Transforming Care agenda[5].

We would suggest that the DMBC is more explicit about how proposals relate to these patient groups. NHS Digital's most recent monthly data[6] suggests that, in England, 8.4% of mental health inpatients are people with a learning disability or autistic people, compared with 3.6% (23/644) in the data provided to us by proposers. For additional context, the latest QOF prevalence data[7] indicates a prevalence of 0.40% in North West London (England 0.56%), so slightly lower inpatient volumes may be expected but perhaps not to the extent indicated in CNWL data. This may relate to London ICBs having some of the lowest ascertainment rates on their GP learning disability registers when compared to estimated prevalence.

The Equalities Impact Assessment includes demographic data on access to the wards and local community services. It states that this shows a relatively even split of age, gender, and ethnicity and that there is a lack of data relating to other protected characteristics. Where there is differential access, the PCBC does not generally explore associated contributory factors, the impact on HLE, or potential mitigations.

The clearest example of this, and of opportunities being missed to explore structural racism, is where there doesn't appear to have been a desire to understand why, since the closure of Gordon wards:

- the most significant increase in referrals has been for the Black, Asian and Mixed populations;
- Mental Health ED attendances in 2022/23 reduced for all ethnicities except for the Black, Mixed and Other populations in Westminster, and the Black population from Kensington and Chelsea; and
- the decrease in inpatient admissions for Black and Asian populations has been disproportionately small.

A valuable exception is the EDI report from 2021 that is appended to the PCBC and which explores the 'Disproportionate Representation of People of Black African and Caribbean Heritage in Crisis Pathways & under Mental Health Act'. This highlights concerns about racial profiling and stereotyping, and how black service users associate this with increased use of sections under the

[5] https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf
[6] Mental Health Services Monthly Statistics, Performance November 2023 - NHS Digital; https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-november-2023-mhsds-september-2023--october-2023
[7] Quality and Outcomes Framework, 2022-23 - NHS Digital

Mental Health Act; misdiagnosis (e.g. schizophrenia, associated with a lack of understanding of certain religious beliefs and an assumption of illegal drug use); and mistreatment in care. It notes that a "common thread in the focus group discussions was the sense of hopelessness and being misunderstood and misrepresented". Those engaged with reported a general lack of sensitivity and cultural awareness in NHS and police staff when communicating with and assessing black service users (especially from more senior staff who were felt to be less diverse), and that assumptions were commonly made of illegal drug use and increased aggression from black service users (with aggression in white service users inducing a more moderate response). From the evidence available it is not clear that the experiences of Black people described in the report have directly informed the model of care or the scale, nature, and configuration of services proposed in the PCBC.

The IIA examines activity and travel changes for groups with protected characteristics. This should be extended to assessing the appropriateness of the activity changes in terms of the size or discrete need of each population group. It highlights that inpatient admissions have reduced by 22% across the two boroughs since the temporary closure of Gordon beds but, whilst reporting the significant differential change by borough (14% Westminster; 32% Kensington and Chelsea), does not offer a view on the reasons for or appropriateness of the differential. Similarly, for the associated increase in community referrals (reported as 24% for Westminster and 5% for Kensington and Chelsea), it is not clear whether these changes are now more or less appropriate to need in each area.

Other examples of where there are opportunities to realise greater value from the data reported are to be found in the IIA where it is noted that:

- there is a larger reduction in male inpatient admissions but a greater increase in community access for females;
- the reduction in admissions for ethnic minority service users is close to the average but community referrals are below average, in a context where black service users say they prefer alternatives to inpatient care (because of the traumatic experience they report) and where Emergency Department presentations have increased by 32% for this group (compared with a 0.1% average for all groups);
- women of child-bearing age have experienced a slightly lower than average reduction in inpatient care but a disproportionate increase in community care;
- the 18-25 age group has experienced a greater than average reduction in inpatient admissions, a large increase in community referrals but also a 22% increase in Emergency Department presentations;
- three geographic population clusters in the two boroughs are identified as the most vulnerable (based on ethnicity, deprivation, and poor health outcomes).

Whilst the IIA is an ongoing process and there is potential for the further analysis and engagement that it proposes to shape final plans, the data available do not appear to have materially informed current plans. Proposals could be improved with some clarity on the extent to which the expressed demand from each population cohort at each point of care is appropriate to their needs.

Data are not provided about the homeless population or for gender reassignment or sexual orientation, although some broad demographics and service-related considerations are noted. While data gaps are common for these groups, there are sophisticated ways of assessing impact that could be explored in the next phase. These methods, such as synthetic estimation or micro-simulation, enable the results of research from one area (e.g. prevalence studies) to be applied to granular local data or the simulating of individual circumstances and behaviours. More simply, attempts can be made to bolster ethnicity recording, for example, by screening historic routine data for valid records at the individual level and then cross-referencing. The Healthwatch report we accessed[8] also provides an example of what can be done with qualitative data.

Consider their impact on the health and healthcare inequalities identified in their baseline analyses in a systematic, documented way?

This sub-test focuses on the extent to which proposals have considered how the options being explored may affect the health and healthcare inequalities to which the previous sub-tests point.

Much of the work referenced in the previous section is also relevant to this sub-test because the baseline position has already created impact as a result of the temporary change effected during COVID-19. There is some presentation of activity changes in mental health and A&E services since the temporary closure was effected. This could be added to with some interpretation of the significance of those changes and evidence of how proposers expect their preferred option to further affect these services, especially for more vulnerable groups.

Where there is work more directly relevant to the options under consideration, this is primarily focused on the impact of travel times and is addressed under the following sub-test.

We raise, above, the importance of considering the inter-relatedness of physical and mental health. In terms of the impact of these proposals, it might also be beneficial to assess the differential impact on the physical health of mental health service users of fewer inpatient stays and improved access to community-based services.

[8] Community perspectives on the impact of the closure of acute mental health services at the Gordon Hospital | Healthwatch Westminster

Ensure that services become more accessible to vulnerable groups, including those identified as experiencing the worst health and healthcare inequalities?

Here, accessibility is essentially equated with travel time and cost, and data are provided on differential rates of access to specific services (e.g. to inpatient care, A&E attendance, community services). There is an additional need, however, for evidence that data on access routes and waiting times for vulnerable groups have been considered and used to inform action on where disadvantage may be being compounded. Similarly, it should be clearly set out how the qualitative feedback that is available has directly informed the proposals. Particular opportunities for this are available in relation to people of Black African and Caribbean heritage and those experiencing homelessness or rough sleeping.

Travel time analysis considers the average travel time for the protected characteristic and deprived populations, for both driving at peak times and using public transport, compared with the general population. The proposal coherently argues that the increase in community provision and concomitant reduction in admissions results in a net reduction in travel time.

The analysis is used to support a narrative of travel time and costs varying little for vulnerable groups (including family and carers), compared with the general population, across all options. We would caveat that narrative with the following observations:

- Travel times are considered as either a single journey for an individual service user or a cumulative total for journeys by all service users in the two boroughs. This might be more intelligible to service users and the wider public if some additional analysis was undertaken that shows the impact of travel times and travel costs over a typical course of treatment, including how the treatment received would vary under each option. The current analysis treats options 1 (A1) and 2 (D) as equivalent to the 'business as usual' model but this does not allow for the different numbers of beds at the Gordon (51 vs 13) or the different types of bed (inpatient vs MHCAS, with 4 of the latter being overnight beds). For example, the wholesale transfer of the MHCAS service to the Gordon may create a situation in which service users who require escalation may have to travel twice, and little is said about expected MHCAS flows.
- Travel costs are considered for travel by car or by taxi, though strangely not by public transport. These are also based on single journeys alone. The impact for family and carers visiting inpatients could be especially significant here, and this could be tested through assumptions of frequency of visits over an average length of stay (and, again, allowing for the service model nuances under each option). The potential cost impact of each option on service users, families, and carers – especially from vulnerable or protected groups – is not currently informing public consultation but it should in our view be part of final decision-making.

- For the preferred option, it is stated that populations that have the greatest increase in travel time are situated close to the Gordon to the south of the catchment. It could be made more explicit that this includes one of the designated 'vulnerable populations' (Pimlico South) and that there could be a similar impact on the accessibility of the MHCAS, if it moves to the Gordon, for the two vulnerable populations identified in the north of the catchment. The untested impact on activity from outside the two boroughs is also material here.
- Proposers have taken care to identify three particularly vulnerable geographic population groupings and to consider the impact of proposals on those groups. This involves the application of a vulnerability index covering the "equally weighted average of the rank of the percentage of ethnic minorities, deprivation, and poor health outcomes". It would be helpful to have further explanation of why these factors were selected and others not.
- Modelled access impacts assume that 100% of service user journeys begin from their place of residence. In reality, only 1 in 5 admissions are from the home address so consideration should also be given to the flows from relevant hospitals and other agencies. Conceivably, this may reveal that journeys are supported (e.g. by ambulance transport) and so have a reduced impact on the service user (if not families and carers).
- Linked to the previous point, it is evident that there has been involvement from police, social care, and voluntary sector services in the development of plans and assessment of impacts but, perhaps because of its novelty, the impact of the new national agreement between health and policing partners on the care of those experiencing a mental health crisis, 'Right Care, Right Person'[9] that came into operation on 1st November 2023, is not evident in current proposals. This significant change to standard operating procedure between the police and the NHS, whilst not the responsibility of North West London ICB or CNWL directly, has potential knock-on effects on demand, accessibility, experience, and outcomes of the services covered by the present proposals that should be identified as a matter of priority, including any differential impact by gender, ethnicity or other protected characteristic.
- Research undertaken by Healthwatch[10] evidences an adverse impact from the temporary closure of Gordon beds on rough sleepers in Westminster that does not appear to be

[9] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person

[10] https://www.healthwatchwestminster.org.uk/sites/healthwatchwestminster.org.uk/files/Community%20perspectives%20on%20the%20impact%20of%20the%20closure%20of%20acute%20mental%20health%20services%20at%20the%20Gordon%20Hospital%20-%20Healthwatch%20Report.pdf

addressed in proposals. It states that staff from the CNWL Joint Homelessness Team attributed the reduction in their inpatient referrals to a lack of available beds rather than a reduction in the need for inpatient care. Whilst we cannot verify this view, it illustrates the importance of focusing on underlying need not just expressed demand.

Set out specific, measurable goals for narrowing health and healthcare inequalities and how health and healthcare equity is weighted in the options appraisal process? Are there plans to address information gaps on inequalities and population groups where such gaps exist?

We have not found evidence in the current iteration of proposals of detailed plans for reducing inequalities. Our finding echoes recommendation 6 of the Clinical Senate review that proposers should "Respond and plan mitigations to the full equalities impact assessment". We note the intent of proposers (PCBC, p.152) to engage further with relevant groups and to "co-design mitigations to any potential impact" which we would expect to see set out in the DMBC.

We are aware of the parallel development of a mental health strategy for North West London and it is commonly in such strategic documents that one would expect to find the goals for narrowing health and healthcare inequalities that are subsequently embodied in proposals and programmes for change. The lack of an up-to-date strategy with such goals makes it harder to assess the appropriateness of the plans set out in the PCBC. We understand, however, that the ICB has made a commitment not to make a final determination on these and similar proposals until work on the overarching strategy has been completed in early 2024, a commitment we would strongly endorse. Where there are challenges in the availability and/or the quality of relevant data, outside the control of the ICB and CNWL, there remain significant mitigations that should be fully explored. For example:

- Where there are issues with data from the height of the COVID-19 pandemic, a representative period from before or after that time could be used as a proxy;
- Where there is a lack of national data, a descriptive analysis could be undertaken of those admitted to a mental health inpatient bed in the ICS over, say, the preceding 5 years. This might include the reason for admission, the care received and demographic data.
- Where elements of the data are incomplete (e.g. diagnosis, ethnicity), it is still worthwhile analysing the data that is recorded, albeit with appropriate caveats.
- Where there are challenges in identifying some patient groups, Mental Health Clustering Tool[11] categories may provide some insights (1 in 5 patients has a valid cluster assigned).

[11] Annex_B4_Mental_health_clustering_booklet.pdf (publishing.service.gov.uk)

The options appraisal process appears to have been conducted by the programme team drawing on available data and qualitative feedback from stakeholders, rather than using a stakeholder panel to conduct the appraisal itself. In our experience this is unusual but not necessarily problematic. The scoring processes commonly used in such workshops can offer false certainty, and it is clear that options have evolved through stakeholder engagement. One of the criteria used explicitly addresses "Promoting equality – reducing inequalities in outcomes, access and experience" and appraisal against this criterion was informed by the Equalities Impact Assessment undertaken. There is, however, no weighting of the criteria used in the appraisal.

Set out plans to maximise the role of the NHS as an anchor institution by considering the following: widening access to quality employment and work, making local purchases for social benefit, using buildings and spaces to support communities, reducing environmental impact, and working with local partners to advance a collective 'anchor institutions' mission?

The nature and scale of current proposals would not be expected to give much scope for anchor initiatives, though perhaps there could have been reference to wider plans across the ICB and CNWL.

There is a potential social benefit from the close engagement of voluntary sector organisations on the pathway, though this will depend on the extent to which this support is funded and sustained.

Proposals also refer to the carbon impact of the preferred option, resulting from the use of more energy-efficient premises and from a reduced "number of journeys required by patients and their family and friends to access inpatient wards". It would be helpful to provide some quantification of those expected benefits. This could include an exploration of opportunities for reducing face-to-face contact where clinically appropriate. In relation to travel, it is not entirely clear that there would be a net reduction in travel-related carbon impact (that is, whether the decrease in travel relating to inpatient stays and visiting would or would not outweigh additional travel linked to community services, both by staff and service users).

Hospital Beds

Key Findings

The changes proposed – reducing beds and increasing community provision – are in line with an established national direction of travel reinforced within the NHS Long Term Plan which promotes the provision of community services as an alternative to inpatient care. The review by the London Clinical Senate "supported the plans for increased community provision as an alternative to inpatient beds, noting the plans are also consistent with current best practice opinion and guidance".

In these proposals, the resourcing for the additional community services that have been developed (and would be extended under the preferred option) is portrayed as a direct trade-off with inpatient capacity. Whilst there will inevitably be funding constraints for services, the lack of an overarching modelling of need means that the proposals, as currently described, risk appearing more resource-driven than needs-driven. No material demographic change is projected.

For greater assurance, there should be more detailed modelling of need, demand, and capacity, broken down by population group and by an appropriate high-level grouping of mental health conditions (e.g. psychoses, personality disorders, anxiety and depression, cognitive impairment, other). We are informed by proposers that there has been a move, locally, to services being led by patients' care needs rather than their diagnosis, and that the recording of diagnoses is now limited. It is not clear to us, however, how needs are robustly identified (and services planned and adapted) without some reliance on diagnostic data. Where there is evidence to support such an approach it could helpfully be described at the DMBC stage, alongside the specification and application of the care needs categorisation in modelling demand and capacity.

Without this detail, it is hard to be clear that a certain configuration of community services, aspects of which are novel, will adequately replace previously established inpatient services. Such modelling should explicitly situate the capacity requirements for the Gordon and St Charles within a wider analysis of mental health needs across North West London and make transparent the relative investment being made in services for different geographic populations. Whilst the PCBC seeks to address Clinical Senate recommendations concerning bed capacity (modelling approach, A&E impact, and surge capacity) there remains a reliance on capacity in other boroughs to manage peaks in demand and, since an overall demand and capacity picture is lacking, it is still not clear whether the capacity proposed would be adequate.

Detailed Analysis

TEST 2: Hospital beds. The proposed bed capacity will need to be independently scrutinised in relation to the latest demographic projections. Any plans that involve a proposed bed capacity that is less than

that implied by these projections should meet at least one of the following conditions (which are based on NHS England's 'common sense' conditions):

- *Demonstrate that sufficient alternative provision is being put in place alongside or ahead of the proposed changes, and that the additional workforce required will be there to deliver it. The alternative provision might involve:*
  - *changes in care pathways in hospital (e.g. the introduction of the South West London Elective Orthopaedic Centre [SWLEOC] model).*
  - *changes in care pathways outside of hospital (e.g. increased GP or community services).*
  - *adapting to new technologies and innovations that lead to improved care (such as virtual wards, video consultations) whilst ensuring that these meet other tests and fully support those experiencing digital exclusion.*
  - *changes in patient flows (e.g. patients going to another hospital/service).*
- *Show that specific new treatments and therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.*
- *Show, where a hospital has been using beds less efficiently than the national average, that the hospital has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First-Time programme).*

Do the proposals reflect the implications of the latest demographic projections? If not,

- **Is suitable alternative provision in place alongside or ahead of changes, with the required workforce?**
- **Are there new treatments and therapies which will reduce specific categories of admissions?**
- **Are there credible plans to improve bed use efficiency where currently less than the national average, without affecting patient care?**

Two out of three options under consideration involve a reduction in bed capacity. The demand and capacity modelling of bed use over 5 years included in the proposals, factors in ONS demographic projections. The impact of population change is likely to be highly marginal.

Where bed reductions would be made, varying levels of mental health community service provision are proposed as offering a more appropriate and more efficient model of care. In most cases, these services are already in place, following the temporary closure of beds at the Gordon, so the proposed change has effectively been tested in practice (although aspects of the model, including MHCAS, continue to evolve). Responding to Clinical Senate recommendations seeking further evidence for, and evaluation of, the MHCAS model, the PCBC states that "By increasing the number of spaces at the MHCAS we will be able to move approximately an additional 56 people a month

out of A&E, which will significantly reduce waits in ED. There is ongoing work to improve the flow into MHCAS to ensure people are diverted away from ED as early as possible". It is not made clear from current operational performance data whether the expected efficiencies are being achieved and, therefore, whether the balance of community and inpatient services proposed will be adequate. For example, proposals do not give a clear understanding of the waiting times for admission associated with current occupancy levels or the impact of waits on service users, carers, other services, or the wider community.

What we did not find was consideration of population trends or projections specific to the at-risk populations (e.g. ethnic groups, deprived groups, and those with adverse health outcomes), or expert views on potential changes to the current baselines of clinical need and presentation. Similarly, it is not made clear how the future bed base will be broken down in terms of secure levels, gender-specific accommodation, or environments suitable for those with a learning disability or autism, so there is a risk that future provision may not be appropriate to the specific shape of future demand.

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

The PCBC states that, in 2019/20, CNWL had 25.2 beds per 100,000 weighted population, above the national average of 19.9, and that it had the highest ratio of all the Trusts in the London region. There is a clear but unevidenced suggestion that fewer beds is better, and the ratios quoted are not linked to specific assessments of local needs.

We believe that decision-makers and other stakeholders would be able to be more assured of the proposed service change should a fuller analysis of need, demand, and supply be provided that is not unduly constrained by administrative boundaries, and that this should be completed before a final decision is made. We have undertaken a rapid analysis of inpatient demand at the Gordon and St Charles sites from 2018/19 to 2022/23 which reveals that, whilst the majority of demand is from the two boroughs, there are also material flows from other areas of North West London and beyond (see Figure 4).

The PCBC takes the reported absence of out-of-area placements as assurance that the already reduced bed capacity is adequate. The latest Royal College of Psychiatrists local area report for North West London states that "in the three months to June 2022, there were 2,180 inappropriate out of area placement days across North West London compared to 1,375 in the corresponding

period to June 2021. This is a 58.5% increase compared to a 12.1% decrease when looking at the same two periods in England overall."

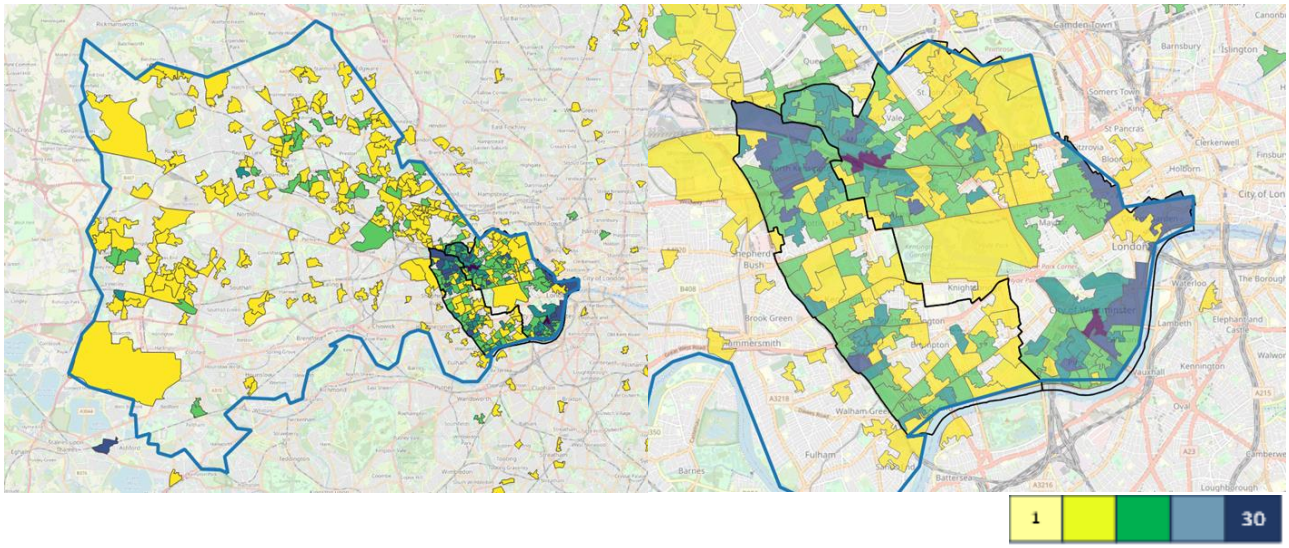


Figure 4 - Source of admissions to St Charles and the Gordon by LSOA 2018/19 - 2022/23

We cannot be clear how this reported position affects the services in question or how the options under consideration might impact the requirement for inappropriate out of area placements. But it is reinforced by data covering October 2022 to September 2023[12] that record CNWL as the sending provider for 50 out of area patients and 1,800 bed days. The PCBC (p.67) states that inappropriate placements "have now been reduced and maintained at zero during a challenging winter period where other providers were increasing the use of out of area beds", and proposers have subsequently advised us that these other data relate to a period early in the transformation process when bed pressures were much more challenging.

We entirely accept the proposers' reporting of zero inappropriate out of area placements over the recent period, as illustrated in Figure 5, but in the context of long-term service planning, there is a need to provide assurance that the bed capacity proposed will be resilient to normal variations in demand. Data from NHS Digital (Figure 6) illustrate a longer timeframe than the CNWL data and how there have previously been peaks and troughs in out of area placements by CNWL. The DMBC and/or the strategy in development should include a clearer setting out of ICS performance in terms of out of area placements, how these and other proposals may affect the future need for such placements, and how the proposed bed capacity would be resilient to normal variations in demand over an extended timeframe.

[12] https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services/september-2023

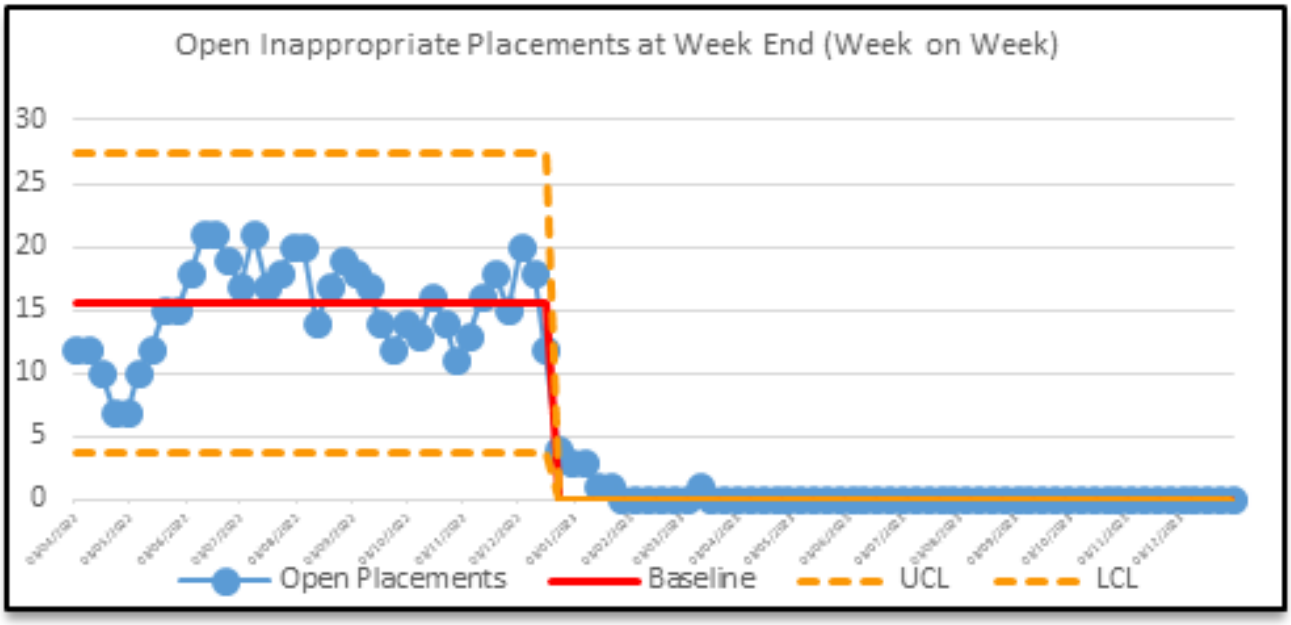
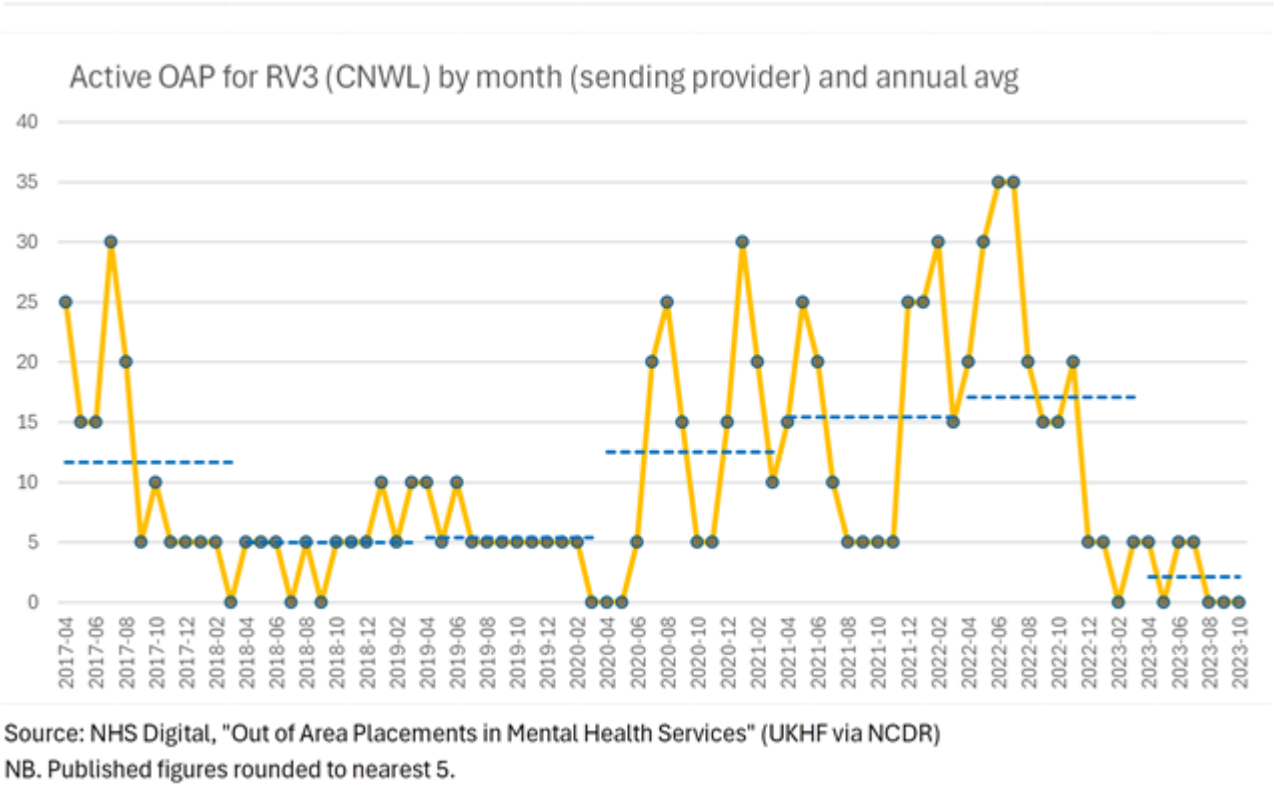


Figure 5 - CNWL data on inappropriate out of area placements



Source: NHS Digital, "Out of Area Placements in Mental Health Services" (UKHF via NCDR)
NB. Published figures rounded to nearest 5.

Figure 6 - Out of areas placements by CNWL, 2017-2023

We would also offer the following observations on the modelling we have reviewed. These should be considered for inclusion in DMBC work, where it is not already planned to do so. We note that there is a proposal for a North West London mental health strategy that will include "modelling demand and capacity of our adult mental health services – including community and inpatient

beds"[13], and it will be important that this reflects the nuanced understanding of population needs described in the inequalities section above.

- Proposals state that Westminster and Kensington and Chelsea admissions are higher than national levels, although the detail is not provided. It is also stated that, in 2022 (after the temporary closure of Gordon beds), CNWL had 17.8 beds per 100,000 weighted population against a national average of 17.3 beds. Again, there is a lack of information on whether or not this difference is appropriate and, indeed, what the proposers view as the necessary rate for their population. The 2019 JSNA summary report on Mental health and wellbeing in Kensington and Chelsea, and Westminster found that "Rates of depression recorded by GP practices in Kensington and Chelsea are above the London average, while rates in Westminster are below the London average. The recorded prevalence of serious mental illness is higher than the London average in both boroughs" (see Figure 7).

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**London**	**England**	**RBKC**	**WCC**
Depression incidence [a]	2017/18	1.2%	1.1%	1.2%	1.6%	1,994	2,636
Depression prevalence[a]	2017/18	8.5%	5.7%	7.1%	9.9%	14,341	13,562
Severe Mental Illness [a]	2017/18	1.5%	1.4%	1.1%	0.9%	3,851	3,215

Figure 7 - GP recorded incidence and prevalence

- PCBC modelling assumes 85% bed occupancy and an average length of stay (LOS) of 32 days. Trends in LOS are provided for sectioned patients (which proposers state make up the bulk of admissions) but occupancy trends are not stated. CNWL's November 2023 performance report[14] records that, at a whole Trust level, adult mental health bed occupancy was 97.4% (100.3% for the Division covering Kensington and Chelsea, Westminster, Brent, and Harrow) against a 95% target and a national average of 92%. The report records there had been no out-of-area admissions and an adult LOS of 32 days (36 for the relevant division) against a national average of 36 days. There is a challenge in getting to the level of the PCBC assumptions but, even assuming this to be feasible, it would be sensible to add sensitivity analyses to the current point estimates. In modelling the Strategy Unit undertook for the Royal College of Psychiatrists based on 2018/19 capacity (i.e. including the Gordon beds), North West London was projected to require an

[13] North West London Joint Health Overview Scrutiny Committee, 12 September 2023
[14] Board_Paper_Pack_08.11.23_PUBLIC.pdf (cnwl.nhs.uk)

additional 50+ beds to achieve 85% occupancy[15]. North West London was also reported to be above average (based on 2016/17 data) for spells, LOS, and bed day ratios (standardised for age, sex, and deprivation). This earlier analysis also found that:

- Whilst the number of admissions to mental health beds had declined rapidly since 2000, the number of admissions of patients with primary mental health diagnoses to general and acute hospital beds had increased. Since 2015/16, the number of mental health patients admitted to general and acute hospital beds exceeded the number of admissions to mental health beds.
- Pressures on psychiatric beds appeared to be forcing up admission thresholds, driving inappropriate use of out-of-area placements, and the use of general acute hospital beds for patients with mental health problems.

We are not assuming that these data are still valid, but they raise a question about the resilience of current proposals in the absence of a more comprehensive analysis within the PCBC or wider ICB needs assessment. Such an analysis might include:

- modelling for specific sub-groups of the population (i.e those at higher risk as opposed to the absolute demographic shift);
- incorporating views on changes in presentation and clinical need of admitted patients, and perhaps also some assessment of the longer-term impacts of COVID-19;
- breaking down the bed capacity requirements and forecasts by patient groups (e.g. Gender, LDA); and
- reviewing assumptions about LOS and out of area placements in light of changes that have occurred within and beyond the 2 boroughs, and benchmarking capacity plans with other areas (linked to SMI prevalence);
- undertaking an analysis of waits for inpatient admission in terms of who is affected, where they come from, why they are waiting, how long they are waiting, and the impact of the wait on their health outcomes; and
- considering the potential benefits, and associated capacity requirements, of voluntary admissions as a preventative measure (e.g. linked to social factors).

[15] https://www.strategyunitwm.nhs.uk/sites/default/files/2019-11/Exploring%20Mental%20Health%20Inpatient%20Capacity%20accross%20Sustainability%20and%20Transformation%20Partnerships%20in%20England%20-%20191030_1.pdf

Financial Investment and Savings

Key Findings

There are credible plans to deliver the preferred option, in both capital and revenue terms. Given what is said about the limited capital available to the Trust, other options put to the public in consultation appear not to be deliverable and this would normally result in their exclusion from the consultation process.

Given that aspects of the service model continue to be developed, in an entirely appropriate way (e.g. MHCAS), further sensitivity testing of capacity assumptions would provide greater assurance, supported by high-level mitigation plans where capacity may be exceeded. The current work within the wider mental health strategy for the ICB should also provide assurance about future needs.

As noted in relation to bed capacity above, the resourcing for the additional community services that have been developed (and would be extended under the preferred option) is portrayed as a direct trade-off with inpatient capacity for residents of the two Boroughs. This risks being misleading given that proposals for additional beds at Park Royal are being advanced (with a resource impact not disclosed in these proposals) and evidence that per-person funding for mental health in North West London has lagged behind the national level.

Detailed Analysis

TEST 3: Financial investment and savings. Sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from hospital to primary and community care and investing in prevention work. Proposals to close the projected funding gap, including planned efficiency savings, are credible.

Are plans to make efficiency savings sufficiently detailed and credible?

As noted above, modelling assumptions include bed occupancy and LOS levels that are not currently being achieved across CNWL. It is also assumed in proposals that historic LOS gains, following the closure of Gordon beds, will be sustained. Whilst this is feasible, trend analysis doesn't necessarily support that view, and further analysis should be considered This could include a longer-term view (trends in LOS reduction tend to be non-linear) and preferably with an external control comparison to check whether other similar areas/providers have seen similar reductions sustained. Attempts could also be made to isolate the effects of COVID-19 on LOS or to identify published evidence that supports the view that the gains are not a short-term effect biasing the data. Given the uncertainties here, it would be beneficial to use a range rather than a point estimate for key assumptions to reflect the confidence with which they can realistically be held.

Again, as noted above, proposals do not give a clear understanding of the waiting times for admission associated with current occupancy levels or the impact of waits on service users, carers, other services, or the wider community.

Achieving 85% bed occupancy is seen by proposers as providing resilience to peaks in demand but it is not clear how that occupancy level will be achieved and sustained.

There is an expectation of alleviating waits in A&E by raising the number of MHCAS beds to 12 with 4 overnight beds but this assumes even demand throughout the year with an average LOS. Further sensitivity testing would provide greater assurance.

Have plans secured capital and revenue investment to deliver in full, and are the sources of funding credible?

On revenue funding, the PCBC states that "All of the £5.4m funding released as a result of the temporary closure has been reinvested in these services and we have added £5.6m on top of this." This is a significant investment but, without a full needs analysis, it is not possible to be sure of the appropriateness of its scale and focus. This is especially so in a context where, according to the Royal College of Psychiatrists 2022 local area report for North West London[16], spending per person on mental health services was 14.3% lower than the average for England (see Figure 8). It should be noted, however, that these figures relate to all mental health spending across the whole of North West London not just acute adult services in the two Boroughs.

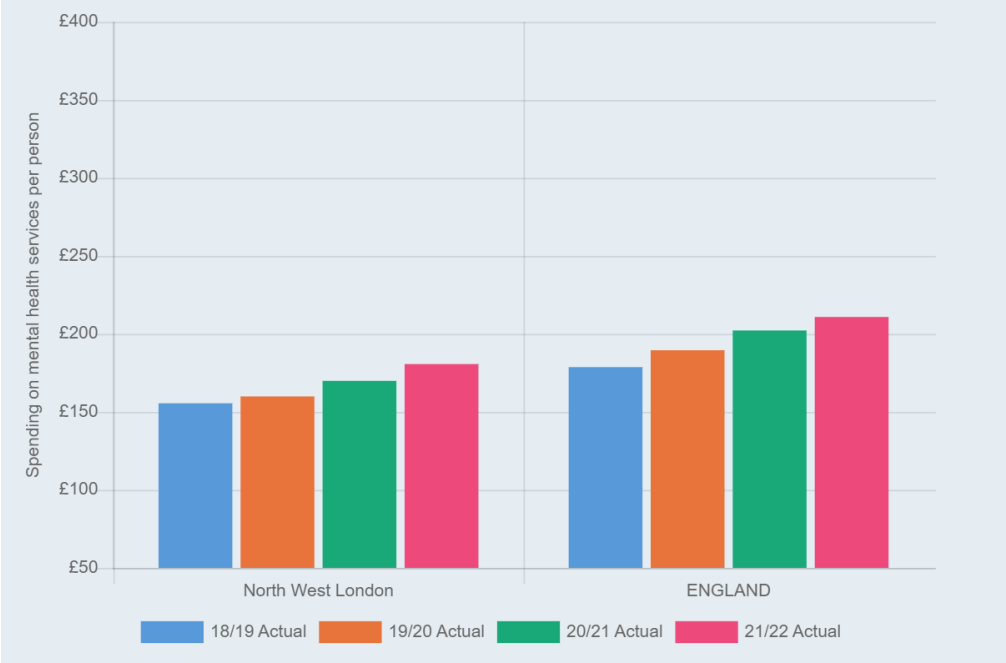


Figure 8 - Spending per person on mental health services

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

Either within DMBC proposals or in the ICS mental health strategy to be determined at the same point, there should be a clearer setting out both of population needs and how funding allocations respond to that need equitably.

Delivery of the preferred option 3 is projected to require £2m capital and have a net additional revenue impact of £0.11m. It is stated that the Trust has the required capital available.

Options 1 and 2 require £12m and £5m capital and have a net revenue impact of £2.13m and £1.16m, respectively, which would exceed what the Trust reportedly has available. It is also the case that capital resources, nationally, are highly constrained currently. Given that the adequacy of the proposed bed capacity relies on the transfer of Brent activity to 14 additional beds at the Park Royal Hospital, a question is begged about how the decision to allocate capital and revenue resources to that expansion is impacting the options available in Westminster and Kensington and Chelsea, especially when the present PCBC puts a resource constrain on options it deems feasible. It may be that the allocations made to each scheme are appropriate to local needs, but this is not made explicit for decision-makers or the local population. Consideration should be given to combining the two sets of proposals in a single decision-making business case.

The figures quoted above exclude the revenue costs and benefits of a potential additional capital investment of £2.2m. This would enable CNWL to refurbish the remaining vacant space at the Gordon (not required by MHCAS) so that other Trust services could be consolidated on the Gordon site and their current lease costs be saved. Our view is that this additional proposal is effectively not part of the current decision-making process because:

- CNWL is not currently able to confirm the availability of the additional capital, and;
- whilst the additional work would enable the Trust to realise further revenue savings, current proposals are not dependent on this (whereas they appear to be on the Brent proposals).

Do plans include increased investment in primary and community care, including moving resources from acute care where appropriate?

The essence of these proposals – with the exception of option 1 – is to maintain the shift to community care that took place following the temporary closure of the Gordon's acute mental health beds for adults. As already noted, this was accompanied by additional investment. The PCBC makes it clear that proposers see a direct trade-off between investment in inpatient and community services. That view might be queried both in principle (as it is in Healthwatch evidence) and given:

a) what we have already noted about North West London mental health spending lagging behind national levels historically, and;

b) the lack of information on concurrent mental health funding decisions in adjacent areas of the ICS (notably Brent).

The proposals deal with the care of serious mental illness such that wider primary and community services would not be expected to have a material role in the pathway.

The important role of voluntary and community sector organisations is emphasised in proposals, although the level and sustainability of funding are not clear.

Do plans include specific, increased investment in the prevention of ill health?

Plans for secondary prevention are central to these proposals, especially the preferred option, through focusing investment on community services, discharge support, and admission avoidance. The proposed mental health strategy and/or the DMBC should also set out plans for population-level primary prevention.

Social Care Impact

Key Findings

There are credible arguments presented that there would not be a material impact on social care services. For assurance, a formal assessment of this should be undertaken or explicit confirmation secured from social care services that they share this view.

We would expect this to need further exploration and, if necessary, mitigation in the DMBC. This is especially the case where a reduction in inpatient capacity is proposed and with some reliance on efficiency assumptions, creating a risk of an unintended adverse financial impact for social care services (either from additional community demand pressures or from a shared responsibility to fund aftercare for those who have been detained under section as inpatients).

Detailed Analysis

TEST 4: Social care impact. Proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing. Sufficient investment is available from Government to support the added burden on local authorities and primary care.

Do plans include a full and credible assessment of the financial impact on social and community care?

There is good evidence of engagement with local social care leaders, including through the option development workshops that led to the inclusion of overnight beds in the MHCAS. This is explicitly linked to a concern to prevent "undue pressures on other services (such as the police and social care staff)".

The impact of interactions between public services has not been modelled and, although it is more in the scope of the proposed strategy than this specific change, the development of integrated datasets across health, care and other services (e.g. police, housing) should be considered to enable more effective collaboration between services and the better use of public funds. The PCBC (p.109), in setting out the objectives of the proposed change, refers to "A holistic approach integrated with social care and enablers such as housing". Further detail should be provided on how this will be achieved. Local place-based partnerships across health and care, referenced in the Clinical Senate review (recommendation 7) but not otherwise in the PCBC, will likely have a valuable part to play in this.

Arguments are also made about the expected beneficial impact of the preferred option on social care services, including:

- CNWL directly funding step-down beds that otherwise tend to be funded by the Local Authority;

- fewer and shorter inpatient stays leading to a reduction in deconditioning and the associated social care support costs;
- additional CNWL investment into services such as Community Rehabilitation;
- funding for the work of voluntary and community sector organisations (albeit at an unspecified level); and
- the proximity of the proposed expanded MHCAS to key social care services such as local hostels and homelessness shelters.

Beyond this, however, we did not find in the proposals an explicit assessment of any financial impact on social care should the proposals be implemented, and this might be included in the DMBC. If there is evidence of an adverse impact from the temporary closure, we have not seen this in the published materials.

Does this assessment take account of future demographic changes, especially an ageing population?

Demographic changes have been accounted for in the bed demand model but we have not seen evidence of detailed modelling of potential social care impact with or without demographic projections.

Does this assessment take account of the impact of new social care provision and funding models set out in the adult social care green paper?

We did not find evidence that this impact had been considered. Whilst there may not be a direct impact on the services in question from recent developments in adult social care, we would again recommend that a shared understanding is developed of the dynamic interactions between mental health and social care services across the two Boroughs, in terms both of activity and resource implications.

Are there credible, funded, joint NHS/LA plans to meet any additional costs?

No such costs are identified in the proposals. It would be helpful to present evidence that no additional social care costs arise from these proposals. We assume that the consultation process is enabling social care leaders to evidence any alternative view.

There is a stated ambition to flex voluntary sector provision "as long as funding is available" but, clearly, no specific commitment at this stage.

Do plans fit with local health and wellbeing board strategies?

We did not find evidence in the PCBC that local HWB strategies had been considered during the development of proposals, although the proposer's active engagement with the relevant Joint Health Overview and Scrutiny Committee enables local stakeholders to identify any misalignment.

From a brief review of the 2023-24 bi-borough Health and Wellbeing Strategy, we found nothing directly relevant to these proposals except a focus on prevention and early intervention in mental health. We noted earlier that proposals can be seen as contributing to secondary prevention and, especially through MHCAS, early intervention, and that the developing ICB mental health strategy should address wider considerations.

The Strategy Unit

Email: strategy.unit@nhs.net

Web: www.strategyunitwm.nhs.uk

Twitter: @strategy_unit

Midlands and Lancashire
Commissioning Support Unit