The Strategy Unit.

Proposed Changes to Adult Mental Health Services in North West London

An Independent Review for the Mayor of London of the North West London ICB's Decision-Making Business Case Version 1.7

Phase 2 – January 2025

NHS
Midlands and Lancashire
Commissioning Support Unit

Introduction

This review builds on our Phase 1 Review and should be read in conjunction with it. Our task here has been to review the proposals in the Decision-Making Business Case (DMBC) prepared by NHS way London Integrated Care Board (ICB) in partnership with the Central and way London NHS Foundation Trust (CNWL) against all six of the Mayor's tests.

The essence of these proposals concerns the replacement of a proportion of the acute mental health inpatient beds in North West London with a range of community services including step-down beds; a Mental Health Crisis Assessment Service (MHCAS); enhanced services from voluntary, community and social enterprise (VCSE) partnerships, and; a community based crisis alternative service (the Coves) provided by Hestia on behalf of Central and North West London NHS Foundation Trust, offering non-clinical support to individuals experiencing a crisis or mental distress.

The DMBC seeks to regularise the position that has evolved since the temporary closure of 51 beds at the Gordon Hospital during COVID, due not least to concerns about infection control. This resulted in there being no mental health inpatient beds within the City of Westminster, although CNWL provides services on a bi-Borough basis jointly for the Royal Borough of Kensington and Chelsea. The most material change made to proposals between Pre-Consultation Business Case (PCBC) and DMBC stages is that the MHCAS would remain at the St Charles Centre rather than move to the Gordon Hospital.

As with our prior review of the PCBC, the purpose of this Phase 2 Review is to support the Mayor in taking a structured, evidenced and independent position on the proposed changes and to ensure they are in Londoners' best interests, ahead of the DMBC being formally considered by the ICB. It is again intended to be a constructive critical analysis of proposals. In cases where we take the view that improvements could be made as proposals move towards implementation, we seek to offer practical suggestions as to how this might be done. The approach we have taken in this review of DMBC proposals is twofold.

- For tests 1-4, we have primarily examined the ICB's responses to the Mayor's letter of 26 January 2024 and our associated Phase 1 Review of the PCBC, as contained within the DMBC and other evidence supplied to us by proposers. The Mayor's letter set out the areas in which he was looking for further assurance on the proposals and, in the main body of the review below, these areas appear in bold type.
- For tests 5-6, we have directly addressed our comments to the relevant sub-tests within the Mayor's framework.

Our findings here relate to Version 1.7 of the DMBC. We initially reviewed an earlier draft - Version 1.4 - and shared our emerging findings with proposers. The clarifications and further evidence they submitted in response to those emerging findings have also informed our present findings.

We are very grateful to colleagues at the ICB and within CNWL for the extremely helpful way they have supported the review process.

Key Findings

1. Health and Healthcare Inequalities

a) We had expressed concern that proposers have defined the **catchment population** considered in the IIA as being limited to the populations of the Royal Borough of Kensington and Chelsea and the City of Westminster to the exclusion of other users of services at the Gordon and St Charles. We welcome the clarification provided about the nature of the 26% of 2019/20 inpatients not recorded as coming from the two Boroughs. The impact of this exclusion may or may not be material, but it makes the process – including option appraisal and IIA - suboptimal. Ideally, there would have been a single analysis of what was expected to happen with all the displaced activity, for decision-makers and other stakeholders to assess in the round.

b) We welcome plans for a programme of work linked to the Patient and Carer Race Equality Framework to improve understanding of **ethnicity**, use of services, access and outcomes for service users from all ethnic backgrounds. Differential access by the Black population is noted and mitigations to address this are proposed. Whilst there are mitigation plans relating to improving engagement with community services, working with local community groups, and improving the discharge pathway, targets for improvement are not set out. We would expect to see some clear ambitions defined as part of the PCREF work, in addition to the monitoring referred to in the DMBC.

c) We welcome mitigations to the model in relation to five population groups that may experience an adverse impact from the proposed change: Black and Black African; carers; the homeless and rough sleepers; North Kensington; Pimlico South. We are not clear what involvement of people with lived experience there has been or will be around these mitigations and how groups continue to experience the effects of service change, so the Mayor's point about **continuing to work with people with lived experience** clearly remains significant.

d) We have not found evidence of **targets and metrics that would be used to track progress with reducing inequalities**. Proposers have advised that targets are being set through a wider and integrated approach to all mental health services. We accept this logic and explicit intent but the implication of those targets for these services should be made plain and enable monitoring.

e) In terms of those experiencing **homelessness**, we welcome the commitment by the ICB to commission a year-long audit of care to the homeless who are suffering from an acute mental illness in the two Boroughs and to prioritise addressing any capacity shortfalls that are identified as resulting specifically from the service change.

f) In terms of those with a **learning disability and/or autism**, we welcome the assurance around the reasonable adjustments available for those with mild to moderate needs (those with higher needs having a specialist provision) on general wards and in the community. How patients experience these adjustments or what other provision they may value was not addressed.

g) Whilst there are analyses of cumulative travel times and travel cost impact on vulnerable populations, the **travel cost impact assessment** still focuses on single journey impacts rather than on a course of treatment, as the Mayor had requested. The latter can more readily be undertaken than the DMBC suggests. The single journey approach tends to minimise the costs and/or savings that patients and their families/carers experience. Similarly, the opportunity to model the benefits of journeys avoided was missed (e.g. through comparing total travel cost/time before and after the change).

Key Findings

1. Health and Healthcare Inequalities

h) The approach taken to assessing the **relative travel impact of the options** in option appraisal and impact assessment makes it very difficult to get a sense of how each option, and especially now Option C2, would actually affect different population groups and communities. The analysis treats the Baseline, Option 1 and Option 2 as the same for travel purposes, and focuses on travel for inpatient care but, under Option 2, the aggregate position changes because there would be only 13 Gordon beds; and it also addresses a single Option 3 when the DMBC is clear that it proposes a shift from C1 to C2. Option C2 retains the MHCAS at St Charles so would have the maximum impact on patients and carers living closer to the Gordon.

i) The Mayor asked for **data on access routes and waiting times for vulnerable populations**, and that this should be used to develop plans to improve access to care for these groups, informed by co-producing plans with people experiencing inequalities in the current service. This point is broadly assessed within the DMBC and the associated IIA. We also note the commitments to co-production within the DMBC and the very helpful recommendations in the Consultation Engagement Report concerning ongoing engagement.

j) The ICB Mental Health Strategy does not address for each group **the specific needs of diverse population groups** and/or the mental health service demands likely to arise from them. What might be more useful is an analysis of the risk factors for SMI – drug misuse, crime rates, homelessness, levels of other mental health conditions, etc. - and an intersectional analysis of how overlapping vulnerabilities might compound inequalities and affect access. We welcome proposers' confirmation that, as they continue to develop plans to address the wider determinants of inequalities in mental health, they will be working on analyses of this nature.

2. Hospital Beds

a) We accept there is evidence of the likely **adequacy of the capacity proposed** to re-provide, through various services, lost inpatient capacity. We remain of the view that proposals could more clearly differentiate between population need (and the diversity of that need) and expressed demand (especially where this is necessarily constrained by current supply). In this context, it is challenging to fully assure the Mayor and other local stakeholders that the nature and scale of capacity proposed will be able to meet evolving population need.

b) We found there to be an insufficient emphasis in the DMBC with reference to local stakeholder concerns about **out of Borough, as opposed to out of area, placements.** The latter are described as the best indicator of under-capacity but this risks underestimating the significance to local people of the former. Where it is stated that there are zero out of area placements, this refers to the official definition of 'area' meaning the catchment of the person's local community mental health service. Some stakeholders focus on a different meaning where 'area' means Borough of residence which, whilst not the technical meaning, will have a more obvious resonance for local residents. The IIA reports that out of Borough admissions have increased by 20% between 2019/20 and 2023/24. We also note the absence of consideration about the potential impact of out of area placements from other areas.

Key Findings

3. Financial Investment and Savings

a) We believe that the DMBC sufficiently demonstrates the **affordability** of its proposals in both capital and revenue terms.

b) Although **funding levels for mental health services** are low in national terms, they are high relative to London peers. Given the Mayor's statutory duty to reduce health inequalities in London and his general duty to improve the wellbeing of all Londoners, he may wish to give further consideration to these funding gaps and their impact on Londoners, but this raises questions that go well beyond the scope of the DMBC proposals and this review.

c) Further detail could be provided on the funding planned for **voluntary and community sector organisations** and how this is expected to change in the medium term.

4. Social Care Impact

a) Significant work has been undertaken to understand the impact of proposals on social care services, especially in relation to **assessments by approved mental health professionals** (AMHP) that can recommend inpatient admission. Notwithstanding this work, the DMBC reports that it has not been possible to reconcile CNWL and Local Authority data and there remains a lack of agreement about the impact.

b) We welcome the **commitment to integrated planning** with Boroughs but note there are no plans for modelling the interaction between services to support this.

c) Whilst the DMBC reports that a work programme is being agreed to ensure a **shared understanding of access to services in the future**, the evident distance between the understanding of health and social care partners respectively must be a material concern (though clearly not confined to the scope of the present proposals and this review).

5. Clinical Support

a) We find there to be **broad clinical support** for increasing the availability and accessibility of community services alongside **significant concerns** about whether there will be enough inpatient capacity, and in the right places, and how some vulnerable groups will be impacted. The DMBC is careful in seeking to explicitly address these concerns.

b) DMBC documents give an impression of **stakeholders not sufficiently understanding each other**, so we support the observation made in the independent consultation report that "whatever decision may be taken, it would be helpful if a shared understanding could be reached about information received from different sources", given the report's finding that responses demonstrated "a high level of polarisation". Of the NHS Staff who agreed with the preferred option, the report notes comments about the need for increased investment in community mental health services to address wider determinants of health and provide flexible, holistic care, and concerns about the Gordon Hospital's suitability as an inpatient mental health care setting both for patients and staff. Of those who disagreed with the preferred option, comments concentrated on a perceived need for more psychiatric inpatient beds due to long waiting times, early discharges, and concerns about patient safety. They also expressed concerns about the move to community mental health services deskilling staff, creating additional barriers to care for certain patient groups, and increasing the acuity of admitted patients

Key Findings

5. Clinical Support

c) Some professionals, notably in the **police and social care**, have expressed concerns about the impact of these changes on demand for their services, and the DMBC seeks to address these concerns.

d) The DMBC provides evidence from the Royal College of Psychiatrists (London Division) which, although it takes no view on the specific proposals set out in consultation, does register concern about the adverse impact of the closure of the Gordon Hospital, especially on **vulnerable groups such as the homeless and rough sleepers**. The DMBC again seeks to address these concerns.

6. Patient and Public Engagement

a) There is **extensive evidence of significant consultation activities** over a sixteen-week period. Feedback is combined from a broad range of participants, including equalities and hard-to-reach groups. We commend the efforts put into engagement and consultation activities by the ICB and the Trust. We recognise that many stakeholders remain unpersuaded about the appropriateness of the proposed changes and that ongoing engagement by the ICB and CNWL will be required so that the way changes are implemented and services continue to evolve is experienced as genuine co-design which remains attentive to the diversity of population needs.

b) The quality and representativeness of the feedback are not fully addressed, and it is not clear whether the feedback from **equalities and hard-to-reach groups** was proportionate or detailed enough compared to other groups.

c) There is evidence of how the **consultation influenced proposals**, including

- withdrawing the proposal developed in response to previous stakeholder views to move MHCAS to the Gordon, following concerns about the safety of providing the MHCAS on a site without inpatient care because of the lack of backup on site in the evident of a serious incident
- providing more varied and culturally sensitive community spaces because Black service users reported high levels of dissatisfaction with inpatient admission and care, finding the experience to be re-traumatising.

d) We welcome the commitment in the DMBC to **working closely with system partners and service users and carers around the implementation of proposals**. We are mindful that the Grenfell community is within the scope of these proposals and note the generalisable People Power lessons from the health care response to the Grenfell Tower fire prepared by the King's Fund: "Grenfell shows in sharp relief what happens when minoritised voices are not heard by statutory services. It also shows a possible way forward. This research acknowledges what went wrong, but it also shows what can happen when services are willing to engage differently – and find a way to have honest, often uncomfortable and deeply challenging conversations about power, inequality and racism."

1. Health and Healthcare Inequalities

1. Health and Healthcare Inequalities

In this section we consider the key matters related to health and healthcare inequalities that the Mayor raised in his letter in response to the PCBC. We note at the outset our concern that proposers have defined the catchment population considered in the IIA as being limited to the populations of the Royal Borough of Kensington and Chelsea and the City of Westminster. Whilst c.80% of affected patients may come from these Boroughs (see discussion on slide 12), the approach taken is not wholly representative of the actual service users affected as we would have expected. This is a cause for concern as it becomes harder to assess the overall impact of the change, for good or ill.

Set out analysis of the factors that are causing inequalities within the current service.

The DMBC identifies (2.2.3) poverty and structural racism as being key determinants of inequalities relevant to all mental health services locally and there is also good evidence of learning from wider national experience. Two local issues are highlighted: that Mixed and Black ethnic groups have substantially higher admissions per 1,000 people than all other groups, and; that the Black ethnic group accounts for only 10-12% of referrals to community mental health hubs compared to 17-21% for inpatient services.

In response, CNWL has a programme of work linked to the Patient and Carer Race Equality Framework (PCREF) to improve understanding of ethnicity, use of services, access and outcomes for service users from all ethnic backgrounds through monitoring ethnicity data reporting, use of the Mental Health Act, use of restrictive interventions, delivery of physical health checks, access to community services, outcomes recorded (6.2.5). Further detail is provided below in relation to addressing structural racism. This monitoring should enable the Trust to take the appropriate remedial actions, and we welcome it.

Draw on analysis of current inequalities and the reasons behind them to shape the future model of care and to develop specific plans for reducing them, working closely with the groups experiencing these inequalities.

Analysis within the updated IIA identifies five population groups that may experience an adverse impact from the proposed change, and the DMBC sets out related mitigations (6.4.5). This covers the following population groups: Black and Black African; carers; the homeless and rough sleepers; North Kensington; Pimlico South. To be precise, these are mitigations to the proposed model, rather than considerations that have fundamentally shaped that model. Additionally, whilst the data analysis for specific groups was limited, data gathered from public consultation suggested other groups that might be adversely affected by the preferred option, including refugees and people with disabilities. In response to this, the DMBC:

- Reports (2.2.1) that 4-5% of the local population resided outside the UK one year earlier and notes that the “intersection of trauma, displacement, cultural adjustment, and systemic barriers can place a disproportionately larger burden on the mental health of refugees, migrants, and ethnic minorities underscoring the urgent need for accessible, culturally sensitive care that addresses refugees and migrant challenges”. Proposers state that the PCREF work is relevant to these issues, but we would also have liked to see some direct consideration of how the proposed model will address them.
- Clarifies (5.4.2) that there is an expected positive impact both for people with physical disabilities (resulting from the shift towards community provision and the closure of Gordon Hospital beds which lacked the ensuites necessary to provide privacy for disabled patients) and for people with a learning disability and/or autistic people (because those with severe needs are admitted to specialist wards outside the scope of these proposals, only c.10 people with mild to moderate needs are admitted to general wards each year and those wards have sensory kits and staff trained in using them, and the increased provision of community services both reduces exposure to challenging ward environment and enables staff to make reasonable adjustments with the support of a complex care forum to provide advice, where necessary).

1. Health and Healthcare Inequalities

The Mayor's point about continuing to work with people with lived experience clearly remains significant.

Set ambitious targets for reducing inequalities and describe the metrics that will be used to track progress on this.

We have not found evidence of targets and metrics that would be used to track progress with reducing inequalities. Indeed, the DMBC states (p.200) that it "does not attempt to do this as the nature of the inequalities identified as being relevant to this service change and the data available on them does not allow it."

Proposers have subsequently advised us that targets are being set through a wider and integrated approach to all mental health services (PCREF) and that they do not think that targets should be driven by a service change related only to the most acute end of their services.

We accept this logic and explicit intent, noting our expectation that the targets developed will detail the change expected in these services in question here. That is to say, whilst these services do not drive overall targets, the implication of those targets for these services should be made plain and enable monitoring.

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

a) People experiencing homelessness

The DMBC recognises that the PCBC provided limited information on homelessness in the affected population and notes that homelessness was raised as key theme by respondents to the consultation, including the Mayor. Proposers identify as a risk the reality that some people may be receiving treatment and support for an acute mental health condition while rough sleeping or in inappropriate accommodation. They note that, before the closure of Gordon beds, an average of five beds was occupied by people experiencing homelessness and state that they "have mobilised several services to meet the needs of those patients, but we do not yet have data to tell us how well those service is working to meet needs". The DMBC also identifies this population as one of the four most vulnerable population groups for this service.

The IIA (p.251) reports that:

- "Homeless people have co-occurring needs relating to substance misuse, neurodiversity, behaviour, and multiple health needs. There is an increased likelihood that patients would abscond and there is a need to further develop services (e.g. MHCAS) to work with this group
- Average length of stay and admissions for homeless people have decreased in NWL since the closure of the Gordon. However, analysis found that the number of admissions at St Charles had increased slightly since the closure of the Gordon wards. It was also unclear if this group has seen an increased uptake of community services within Kensington & Chelsea and Westminster."

It goes on to identify a set of challenges experienced by this population group in relation to this service, and potential mitigations. In response to this, the DMBC sets out a homelessness model (section 6.2.3). This includes a commitment by the ICB to commission a year-long audit of care to the homeless who are suffering from an acute mental illness in the two Boroughs. It further states that "The details of the audit should be agreed with key stakeholders and the aim will be to identify where there are shortfalls and to make specific, detailed proposals on addressing them. Should the audit determine that any of those shortfalls are specifically because of the reduction in inpatient provision (which would probably mean they are related to where the patients are living) the ICB will prioritise addressing those issues in its funding plans for the future."

1. Health and Healthcare Inequalities

b) People with a learning disability and/or autistic people

The DMBC states (section 5.4.2, p.30) that "All specialist provision for people with a learning disability with higher level needs is provided through the separate assessment and treatment units and not through services we are consulting on" but that those with a mild to moderate learning disability and/or autism are admitted to general mental health wards.

There is recognition that general wards can be challenging spaces for those with sensory needs, and states that the Trust has responded to this with sensory kits and sensory training for staff. The effectiveness of these measures for the relevant population is not stated. Proposers conclude that they "cannot identify any significant negative impacts for these groups compared to the general population" although it is not clear what engagement has been undertaken to support this view.

In relation to community provision for this population group, the DMBC states that "There is no reason to believe that the same benefits we believe all patients receive from being supported within the community rather than a restrictive bed do not apply to these groups". We have noted above the reasonable adjustments that are currently in place. It would still be valuable, however, to seek evidence of how people with a learning disability and/or autistic people actually experience community services and what further or alternate adjustments might be experienced as beneficial, especially given the increasing proportion of care provided in the community.

In a rapid evidence scan undertaken by The Strategy Unit in 2022, research around barriers and facilitators to access for autistic people found that, while reasonable adjustments were perceived as important in supporting healthcare access, these adjustments are seldom offered, with 69% of autistic adults in one study not offered adjustments in mental health services and, in another study of autistic young people aged 18-25, mental health services not being tailored to autism was also identified as a barrier to access.

Further unpublished analysis by The Strategy Unit for NHS England's Learning Disability and Autism Health Improvement Team, co-produced with people with lived experience, found that:

- people with learning disability and autistic people are high users of all physical and mental health services, both community and acute, with around 5 times the number of total care contacts per person per year than the rest of the population
- autistic patients have much higher levels of (general) outpatient appointments for adult mental health support (6x) than the rest of the population
- the average autistic patient without a learning disability has around four clinical or therapeutic contacts with specialist mental health services per year – roughly half the volume of contacts for patients with a learning disability
- compared to the rest of the population, a greater percentage of specialist mental health contacts for autistic patients are in outpatient clinics, wards, and resource centres and around 30% fewer are in the patients' own home, where the environment may be more suited.

1. Health and Healthcare Inequalities

Directly and robustly address structural racism with clear plans and targets.

Differential access by the Black population is noted and mitigations to address this are proposed. The main drive for tackling the underlying issues is intended to come through the PCREF, referenced above. Whilst there are mitigation plans relating to improving engagement with community services, working with local community groups, and improving the discharge pathway, targets for improvement are not set out. We would expect to see some clear ambitions defined as part of the PCREF work, in addition to the monitoring referred to in the DMBC (6.2.5). It is welcome, however, to see the identification of priorities for local areas that are being developed through local engagement with experts by experience and local community organisations, building on the EDI report developed with Buckinghamshire New University (DMBC p.179) and summarised in the graphic reproduced below.

State the expected impact of the changes on travel times and costs for patients, families and carers across a typical course of treatment, and identify any inequalities in these impacts across different population groups.

The DMBC states that "The analysis does not cover the costs of a typical course of treatment because they will vary substantially dependent on the mode of travel chosen and the particular circumstances of the relevant family members/carers (such as whether or not they use public transport with a travel card in which additional journeys add no cost)." This is a not uncommon challenge in travel impact analysis, and it can be addressed through the identification and application of a transparent set of assumptions. Although there are limitations to such analysis, it does also support a richer understanding of the impact of geographic service changes than a single journey model. We note, however, that the cost analysis linked to single journeys (p.189) found no disproportionate impact, beneficial or adverse, on deprived populations or those with protected characteristics. The DMBC also does not include a travel time analysis over a course of treatment but does consider changes in cumulative travel times for patients and total travel times for carers from minority and/or vulnerable populations.

1. Health and Healthcare Inequalities

For example, the DMBC states that "For people travelling by private car the impact is minimal with a maximum increase of £2.55 a journey". This ceases to appear minimal when seen as a return journey (£5.10) which, for a family member visiting, say, 3 times a week (£15.30) adds up to a maximum additional cost of over £60 for a 4-week inpatient stay. The impact for someone using public transport who does not already have a travelcard would be similar.

The analysis briefly acknowledges the impact that length of stay could have on family members, carers or advocates, especially from more deprived population groups and adds proposed mitigations (6.4.5). It also states that there is substantial benefit in the proposed change for service users who no longer need to be admitted at all, but that there is no robust way of accurately estimating this benefit, although the cumulative travel time analysis (IIA p. 231ff.) does factor this in. Our view is that comparing total travel time before and after the change (including new journeys to community locations) would have been a robust way to accurately estimate the benefit.

Our review also found a range of other issues relating to the travel impact analysis that, in our view, are not entirely resolved in the DMBC. These issues relate to the startpoints and endpoints of journeys and the aggregate impact of each option relative to shifting activity volumes.

a) Startpoints

- Calculations are from LSOAs within the defined catchment, but this appears to exclude c.20% of patients who live outside that catchment. This reflects the approach taken throughout the PCBC and DMBC, not only the IIA, and we found it to be problematic. We have received additional information from proposers, outside of the DMBC, which clarifies that 26% of 2019/20 inpatients came from outside the two Boroughs comprising –

    a) 11% from 19 different ICBs and with no single ICB accounting for more than 2.5% of the total patients at the two hospitals

    b) 10% from CNWL outer Boroughs of Brent, Harrow and Hillingdon whose bed requirements are now expected to be provided closer to home given the development of 14 additional beds in Brent prior to the public consultation concerning Gordon and St Charles beds

    c) 5% lacked an NHS number on their records so it was not possible to identify where they came from.

  We welcome this detail and agree that further IIA work would add little value at this stage. Our concern stemmed from the decision taken further back to have two distinct proposals (one relating to KCW capacity and another to Brent capacity) somehow addressing the consequences of the closure of Gordon beds. The impact may or may not be material, but it makes the process – including option appraisal and IIA - suboptimal. Ideally, there would have been a single analysis of what was expected to happen with all the displaced activity, for decision-makers and other stakeholders to assess in the round.

- Consideration could have been given to whether demand for services is customarily higher from certain LSOAs and reflecting this reality in the analysis - for example, by basing modelling on a real patient cohort. The analysis is LSOA-based but not weighted to reflect patterns of demand.
- As noted in our earlier review, the analysis does not appear to take account of admissions being from other a home address - for example, a criminal justice or education setting. The DMBC states that using the home address "is the best indication for how easy it is for an individual to remain embedded in their local community when admitted to an inpatient facility". We do not dispute this - and it is a valuable effect to consider - but it addresses a different question to how the change impacts patient journeys linked to initial admission.

1. Health and Healthcare Inequalities

b) Endpoints

- The analysis treats the Baseline, Option 1 and Option 2 as the same for travel purposes, and focuses on travel for inpatient care. We agree that the Baseline and Option 1 are essentially the same, with patients and carers travelling to 51 Gordon beds and 67 St Charles beds. Under Option 2, however, the aggregate position changes because there would be only 13 Gordon beds. Proposers have suggested to us that this negative impact would be counteracted by the service model meaning fewer people needed to travel at all. We do not question the potential outcome, rather the fact that this analysis was not part of the process of option appraisal and impact assessment.
- It also addresses a single Option 3 when the DMBC is clear that it proposes a shift from C1 to C2. By comparison with the options above, Option C1 includes 67 St Charles beds only but the MHCAS at the Gordon. Option C2 retains the MHCAS at St Charles so would have the maximum impact on patients and carers living closer to the Gordon.

We assume the picture is, in reality, more complex than this because of the range of alternative community services provided under different options, beyond MHCAS.

In terms of any inequalities in **travel time and/or cost impacts**:

- The travel time analysis (IIA p.230 ff) compares the modelled single journeys for patients and total impact for carers across groups with protected characteristics. This reports a reduction in cumulative travel times along with an increase in individual travel times for the reduced number of patients needing to travel to an inpatient facility. Subject to the limitations of the analysis described above, it found that
  - there are minimal impacts in Option 1 and 2 on the travel time to the closest unit for each of the population groups compared to the general population
  - the proposed service changes do not have a negative impact on the travel time for each protected population group in Option 3 compared to the general population
  - the total travel time for carers to hospital has decreased slightly for all minority and vulnerable populations since the closure of Gordon beds.
- The travel cost analysis compares the modelled single journeys across groups with protected characteristics for taxi journeys only. It found that, under Option 3, taxi costs are expected to increase by between £4.55 and £6.60, with the lower figure applying to ethnic minorities and the higher to women of child-bearing age. The average increase for the general population is £5.45.

The approach taken, however, makes it difficult to get a sense of how each option, and especially now Option C2, would affect different population groups and communities.

The Mayor also asked for **data on access routes and waiting times for vulnerable populations, and that this should be used to develop plans to improve access to care for these groups, informed by co-producing plans with people experiencing inequalities in the current service**. This point is broadly assessed within section 6.4 of the DMBC and the associated IIA. We also note the commitments to co-production within the DMBC and the very helpful recommendations in the Consultation Engagement Report concerning ongoing engagement.

1. Health and Healthcare Inequalities

Other observations

a. The demographic profile presented in the ICB Mental Health Strategy (Appendix 1) does not address for each group the specific needs of those groups and/or the mental health service demands likely to arise from them. What might be more useful is an analysis of the risk factors for SMI – drug misuse, crime rates, homelessness, levels of other mental health conditions, etc. - and an intersectional analysis of how overlapping vulnerabilities might compound inequalities and affect access.

   Proposers have told us that, as they continue to develop plans to address the wider determinants of inequalities in mental health, they will be working on analyses of this nature but they do not think they are of significance for the specific service changes in question. We welcome this confirmation and recognise that work such as this and the wider Mental Health Strategy would ideally have come before the present proposals.

b. Population distributions re: age, ethnicity, deprivation, etc. are addressed as percentages. In our view the absolute numbers are more relevant here because, without these, it is not possible to get a realistic sense of the scale of impact.

c. No rates of admissions for any population sub-group are presented, only simple counts, limiting the conclusions that can robustly be drawn. There are also no confidence intervals provided to indicate whether changes in access or impact are significant.

2. Hospital Beds

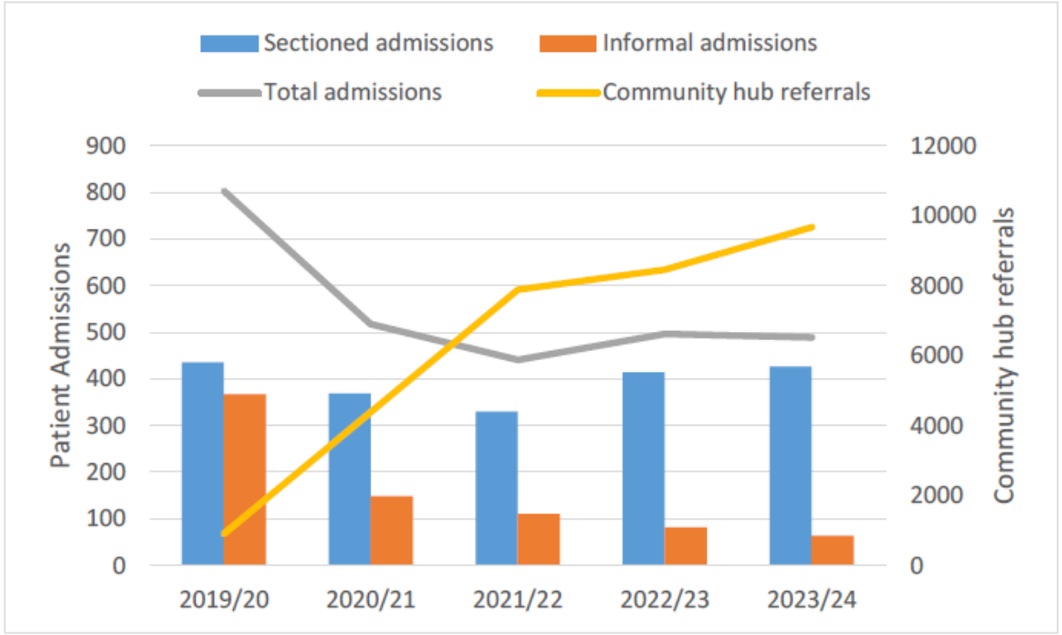
2. Hospital Beds

The Mayor asked proposers to put forward **robust demand and capacity modelling for the future service, based on a comprehensive assessment of mental health needs across North West London Integrated Care System**. In his letter he added that this should **include demand from outside the two boroughs in the catchment area and should be broken down by population group and types of mental health conditions**, in line with the recommendations set out in our previous review, to enable greater assurance that the modelling assumptions of 85% bed capacity and a 32-day average length of stay are realistic when tested against current performance.

Table 17 on p. 217f of the DMBC details the proposer's response to these requests.

The DMBC (Figure 7, p.46) provides data on the shifts in admission and referrals since 2019/20. This shows admissions by section remaining broadly stable, voluntary admissions reducing rapidly and community hub referrals increasing rapidly. What is not clear is whether this is more than a reflection of the change in supply, as opposed to population need. With bed supply constrained, we would expect admissions by section to have effective priority and for community referrals to be made where voluntary admission is not possible (as well as when it is the more appropriate disposition).

Benchmarking data is also provided (Table 3, p.47). This shows, for example, that inpatient beds and admissions per 100,000 resident population are relatively high across CNWL when compared nationally. What is not provided is any way of assessing the appropriate level of supply and activity relative to need. Bed occupancy rates are also shown as high (97%), against an assumption of 90% that underlies the bed provision proposed in the DMBC and the ICB mental health strategy. Admissions by section are very high when compared nationally which might be taken to reinforce the point about that this is due to constrained supply reducing local ability to make voluntary admissions.



DMBC Figure 7: The balance of inpatient and community provision in KCW

2. Hospital Beds

There is an implicit assumption throughout the DMBC that additional community referrals/activity and subsequent reductions in inpatient demand are the result of improvements to the community offer and access. The competing theory we have raised - to support assurance around planning assumptions - is that the rise in community activity is a result of the reduction in inpatient capacity.

Proposers hold that the addition of community-based capacity made as part of this service change is more than enough to meet the needs of patients who would previously have been admitted; that the reduction in voluntary admissions has not resulted in an increase in admissions under section, and; that the number of patients who are on community caseloads (or have been on them in the last 6 months) and then require an admission has reduced, both in absolute terms and proportionally, since the temporary service change was made. We accept this as evidence of the adequacy of the capacity exchanged (inpatient for community). The DMBC does not seek to address whether that capacity is adequate in the broader terms of population need or how that need might vary over time.

The DMBC also provides evidence that delays to admission from A&E are limited, with 6 patients a week waiting over 4 hours in a KCW Emergency Department because of difficulties accessing an acute mental health beds and with less than 30% of these waiting more than 12 hours. In terms of delays to admission from community settings, the greater number occur in Health Based Places of Safety. Whilst proposers accept that these delays are not at an acceptable level and that high levels of bed occupancy will be a contributing factor, they also set out how an additional 2-3 beds would relieve the pressure and that existing expansion plans exceed this number. This data provides greater assurance than was previously available.

The DMBC recognises that a key theme from stakeholder feedback is the view that the reduction to zero out of area placements does not itself demonstrate an adequate bed supply, as patients are still travelling out of their local borough. Indeed, it is clear (Figure 23, p.118) that out of Borough admissions remain significantly higher than before the temporary closure of Gordon bed capacity. The DMBC nevertheless emphasises the significance of zero out of area placements, describing them as the best indicator of under-capacity. Whilst we recognise that the DMBC has focused on the national definition of out of area placements and differentiates this from out of borough placements (e.g. p.4 footnote 2), our view is that this approach insufficiently recognises or addresses the concerns of local stakeholders, placing too much reliance on meeting a national target over the views and experience of the local population. The IIA, too, risks understating the position when it describes the increase in out of Borough admissions in KCW since the temporary closure of the Gordon wards as ‘slight’ when it is 20% (143 to 171). We also note the absence of consideration about the potential impact of out of area placement inflows from other areas.

We note that a wider range of data and information sources have been used and explored to assess both the likely impacts of the change on specific populations and to project future demand. We would also observe that:

a) There is still no accounting for the clinical composition/need of the patients in beds at any baseline period and the factors that may affect future demand from those groups e.g. changing incidence of eating disorders, personality disorders, prevalence of learning disability and/or autism, cost-of-living impacts, longer-term covid impacts. The DMBC argues that there is no merit to capacity planning in looking at a breakdown of the conditions making up demand because they fluctuate so much, but some consideration of these factors could support more robust long-term planning. Proposers advise that they are continuing to work on improving long term plan approaches and taking account of need in the most appropriate way, although it is not yet clear how they intend to do this.

2. Hospital Beds

b) The assumptions around efficiency gains seem to be predicated on there being a benchmarking gap that will be reduced. Plans have been advanced to reduce the gap (Appendix 15) and can, we are informed, be delivered within existing resources but what we have not seen is –

- an exploration of the reasons for variation, although proposers state that clinicians are clear that clinical presentations of need across the boroughs are very similar, and they cannot identify any evidence of differences in population need that is likely to have caused the benchmarking gap
- an assessment of the likelihood of the reductions being achieved, although proposers advise us that, should further investment be required to enhance delivery of the plan they expect the necessary resource to be available given that investment in community provision remains an ICB priority.

c) Capacity projections could be made more resilient if plans considered a range of (un)certainty in the bed model figures since point estimates are very unlikely to be 'right'. This is why the demand model for the New Hospitals programme takes a probability-based approach and produces a range of potential outcomes rather than a single point estimate. We understand that proposers need to plan on the basis of a defined capacity requirement but bed supply over the medium to long term will be more robust if uncertainties are explicitly acknowledged and related mitigation plans are in place. We note that some general mitigations are referenced.

d) Analysis in the DMBC uses proportions rather than absolute numbers to demonstrate need in different areas but we believe that absolute numbers are critical to the assessment of impacts.

e) None of the analysis is presented with confidence intervals to demonstrate any significant differences in metrics between sub-groups nor over time, yet assumptions are made about inequality without them.

f) Figure 12 (p.87) shows referrals rather than community contacts/treatment. It is not clear what the conversion rate/waiting list is like. This would usefully be shown alongside EUC attendances for MH trends. We accept that there are reporting process challenges with this.

g) We were not clear as to whether the reported length of stay figures relate to the whole detention spell or to constituent episodes since patients can and do have consecutive detention/care under multiple sections or extended stays under sections. Proposers have confirmed that figures are based on the whole detention spell.

h) Where admissions have declined, it is not made clear whether this results from there being higher acuity patients with longer length of stay, fewer patients, or some other reason.

We remain of the view that proposals could more clearly differentiate between population need (and the diversity of that need) and expressed demand (especially where this is necessarily constrained by current supply). In this context, it is challenging to fully assure the Mayor and other local stakeholders that the nature and scale of capacity proposed will be able to meet local need. Indeed, proposers are careful to be clear that their focus in the present proposals is on adequately reproviding lost inpatient capacity in alternative ways rather than ensuring population need in the round is appropriately met.

3. Financial Investment and Savings

3. Financial Investment and Savings

The Mayor expected the DMBC to demonstrate that **sufficient capital and revenue funding** has been secured for the future service, and against a background where both the DMBC and the wider ICS mental health strategy demonstrate how funding allocations meet population need and whether they do so in an equitable manner. He also looked for the DMBC to clarify the level and sustainability of funding planned for voluntary and community sector organisations.

a) Capital costs for the new preferred option (C2) with MHCAS remaining at the St Charles Hospital in a new location amount to £3.2m. This is £1.2m more than the PCBC preferred option (C1) and £0.2m more than the capital reported to be available at that point. The DMBC states the Trust's position on the availability of capital has been refreshed a year on, so it is now confident it can deliver the revised capital requirement.

b) Revenue costs of the new preferred option are reported as being an additional £0.17m p.a., lower than for all other options and including the cost of capital. This is not a material additional cost, and the Trust has plans, subject to future capital availability, to secure efficiencies of £1.46m p.a..

c) Overall funding allocations for mental health services in North West London remain significantly below national averages, although there has been a marginal improvement. In our previous review we noted that, according to the Royal College of Psychiatrists' Mental Health Watch, spending per person on mental health services in North West London was 14.3% lower than the average for England in 2021/22. More recent data shows that gap reducing to 13.9% based on planned spending for 2023/24. That gap from the national average, whilst material, is the smallest of all London ICBs – South West 15.0%, North Central 15.2%, South East 22.9%, North East 31.3%. The DMBC confirms that the ICB recognises the need to increase the level of investment in mental health services overall and its Medium Term Financial Strategy reports 20% underinvestment in mental health. The DMBC argues that this is partly because "the ICB receives significantly less per head of population (after weighting for need) than the national average (£1,887 allocation per needs weighted head of population against the national average of £1,946)", and also that the "only way to deliver significant extra funds to support mental health in the short to medium term would be to substantially reduce funding for our acute hospitals which would direct negative impacts on patient care, and we do not believe they would be supported by local people." In the ICB's new mental health strategy, increased funding into mental health, benchmarked with other areas nationally, is identified as a key enabler of the strategy. There is, however, no clear path to tackling the reported underinvestment. The strategy also proposes the allocation of resource based on need but it is not made clear how that need will be assessed.

d) In terms of the level and sustainability of funding for voluntary and community sector organisations, little detail is provided to understand this. The DMBC simply refers to "A number of contracts with Voluntary sector partners in Westminster to support delivery of the Community mental health hub offer to provide an earlier access to support".

We believe that the DMBC sufficiently demonstrates the affordability of its proposals in both capital and revenue terms.

Although funding levels for mental health services are low in national terms, they are high relative to London peers. Given the Mayor's statutory duty to reduce health inequalities in London and his general duty to improve the wellbeing of all Londoners, he may wish to give further consideration to these funding gaps and their impact on Londoners, but this raises questions that go well beyond the scope of the DMBC proposals and this review.

Further detail could be provided on the funding planned for voluntary and community sector organisations and how this is expected to change over the medium term.

4. Social Care Impact

4. Social Care Impact

The Mayor has asked for **a clear assessment of the expected impact of the changes on social care services and the extent to which local social care services agree with this assessment**. He has also encouraged close and continued engagement with social care, police, housing and other services throughout the development of proposals and the ICS mental health strategy, stating that this should include modelling the impact of interactions between local services on activity, demand, capacity and resourcing, as well as maximising opportunities for collaboration and integration.

a) **Impact on social care services**. The DMBC states that proposers have not found evidence that the changes made in 2019/20 have contributed to the increased burden on social care services and proposers argue that their plans to increase investment in community provision should benefit other community-based services - for example, where the NHS is funding step-down beds that are normally funded via the relevant Local Authority. The DMBC notes that social care colleagues report an additional burden linked to assessments by their approved mental health professionals (AMHP), due to the associated travel requirements and where repeat assessments are required, but that the Trust's data, however, does not support this view.

   Appendix 17 summarises in-depth work undertaken between partners from September 2024 to address their "different beliefs" about the trend and volumes of adult admissions to acute beds, which is to be welcomed. This found that, whilst there were valid reasons for discrepancies between the datasets where an assessment was recorded with a corresponding admission, "it is not possible to reconcile the two datasets". In response, CNWL and the Local Authorities has agreed further work including a routine and regular process of data sharing and working together to improve flow and capacity.

   As things stand, however, there remains a lack of agreement between health and social care partners about the impact of the changes.

b) **Engagement with wider services and modelling of interactions.** The DMBC states that the changes are not believed to have had an impact on the police service. Where the police report an impact relating to the transfer of a Health Based Place of Safety from the Gordon to St Charles, the DMBC notes that this occurred before the changes that are the subject of the present proposals. It further states that that the 'Right Care Right Place' operational changes made by the police have not had any significant impact on the Trust's services.

   In the independent report prepared for the two Local Authorities (Appendix 8), it states that "a senior MPS officer reported currently [2023] that their service was experiencing more calls for assistance from local Community Mental Health Services but that officers were also attending St Charles Hospital in response to reports of assaults upon staff and other patients" although it is not clear that this relates to the changes in question here.

   Going beyond the police service, the same report states that "There is a feeling among some of WCC's supported housing provision staff that their service is becoming the 'default' position for lack of in-patient beds or a 'sticking plaster' to address evident shortages of skilled clinical services, problems accessing clinical support, and the difficulties raised by premature discharge", and it asserts that the impact of inpatient changes do not appear to have been fully explored.

4. Social Care Impact

Given the general demand pressures faced by all services, it is challenging to associate any particular activity shift to the temporary changes in mental health services that the ICB is now seeking to make permanent. Whilst there has been in-depth work between NHS and local authority partners to better understand and address data discrepancies, we note that the ICB has also reported that it has experienced challenges in accessing social care data and has found substantial issues when seeking to reconcile its historic data with Local Authority data from earlier years. The DMBC also observes that the termination of a Section 75 arrangement with the Local Authorities has impacted ways of working with social care colleagues.

In addition to the historic data issues between CNWL and the Local Authorities, we have seen no evidence of the modelling of interactions between services, although proposers have advised us that there is integrated planning and delivery underway focussed on Borough-based action plans. This is likely to be a barrier to the opportunities for collaboration and integration which the Mayor would like to see optimised for the benefit of Londoners.

Whilst the DMBC reports that a work programme is being agreed to ensure a shared understanding of access to services in the future, the evident distance between the understanding of health and social care partners respectively must be a material concern (though clearly not confined to the scope of the present proposals and this review).

5. Clinical Support

5. Clinical Support

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
Proposals demonstrate widespread clinical engagement and support, including from frontline staff.	There have been significant attempts to engage with clinicians. We find there to be broad clinical support for increasing the availability and accessibility of community services but significant concerns about whether there will be enough inpatient capacity, and in the right places, and how some vulnerable groups will be impacted. The DMBC is careful in seeking to explicitly address these concerns. DMBC documents give an impression of stakeholders not sufficiently understanding each other, so we support the observation made in the independent consultation report that "whatever decision may be taken, it would be helpful if a shared understanding could be reached about information received from different sources, in particular: • Where different conclusions have been drawn • The reasons where datasets appear inconsistent with each other • The accuracy and reliability of data available • Where there are gaps and how insight can be gathered to fill these."
i. Include a demonstrable, robust clinical case for change, including an improvement in both quality of care and outcomes?	The fundamental case for change and the direction of travel towards increased community provision was made in the PCBC and supported by the London Clinical Senate.

5. Clinical Support

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
ii. ***Have the support of local primary and secondary care clinicians, including but not limited to those whose services/patients will be directly affected?***	The DMBC sets out that senior clinical oversight has been provided throughout with the Chief Medical Officer of CNWL chairing the Project Board, and day to day clinical leadership of the project provided by the Medical Director for Jameson Division and the Clinical Director for Westminster. It also notes that senior CNWL clinicians have written to the ICS Chief Executive to confirm their support for the proposals, and this is included as Appendix 14. The letter confirms their support for the revised proposals and commends them to the ICB "as the best configuration of services to support the population of Westminster and Kensington & Chelsea". The ICB's position is expected to be confirmed once it has formally considered the DMBC. The independent consultation report (Appendix 5) states that 190 questionnaire responses were received, of which 42 were NHS staff and 60% of them expressed support for the preferred option (i.e. C1 rather than the now preferred C2). This represents a higher proportion of positive support than from other groups (e.g. patients, carers, others). The report also notes that responses demonstrated "a high level of polarisation". Of the NHS Staff who agreed with the preferred option, the report notes comments about the need for increased investment in community mental health services to address wider determinants of health and provide flexible, holistic care, and concerns about the Gordon Hospital's suitability as an inpatient mental health care setting both for patients and staff. Of those who disagreed with the preferred option, comments concentrated on a perceived need for more psychiatric inpatient beds due to long waiting times, early discharges, and concerns about patient safety. They also expressed concerns about the move to community mental health services deskilling staff, creating additional barriers to care for certain patient groups, and increasing the acuity of admitted patients Two responses were received from GP practices which both strongly disagreed with the then preferred option. These expressed particular concern about the appropriateness of proposals for the homeless population in Westminster, delays in Mental Health Act assessments, and a lack of inpatient beds.

5. Clinical Support

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
iii. Have the support of pan-London clinical bodies – London-wide LMCs, London Clinical Senate?	As part of PCBC processes, proposals were formally reviewed by the London Clinical Senate which "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". We addressed the recommendations of the Clinical Senate and the responses to it made in the PCBC in our previous review. We note that proposers have continued to develop the MHCAS model and have developed mitigations in response to the IIA. We previously raised a question about surge capacity linked to recommendation 3 in the Clinical Senate review, and address this further, above, in relation to the hospital beds test. The Clinical Senate has not undertaken a further review.
iv. Have the support of local authority social care and other professionals?	Some professionals, notably in the police and social care, have expressed concerns about the impact of these changes on demand for their services, and the DMBC seeks to address these concerns (see Sections 5.6.5 & 6). The DMBC (Appendix 11) provides evidence from the Royal College of Psychiatrists (London Division) which, although it takes no view on the specific proposals set out in consultation, does register concern about the adverse impact of the closure of the Gordon Hospital, especially on vulnerable groups such as the homeless and rough sleepers. The DMBC seeks to address these concerns (see Section 7.5). We did not find evidence of explicit support for the proposals from local authority social care and other professionals for the proposals. Where specific concerns have been raised, we note that the DMBC directly responds to them.

6. Patient and Public Engagement

6. Patient and Public Engagement

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
Proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.	Extensive evidence of engagement is available. This is recorded in the: • Pre-Consultation Engagement Report (Appendix 2 of the PCBC) • Communication & Engagement Strategy (including Consultation Plan) (Appendix 8 of the PCBC) • Independent Consultation Evaluation Report (Appendix 5 of the DMBC). We note from the independent report and the DMBC that, in response to feedback, the consultation period was extended to 16 weeks (an unusually long duration), and the ICB sought to produce clearer information, arrange additional meetings, and provide events on particular sites. We commend the efforts put into engagement and consultation activities by the ICB and the Trust. We recognise that many stakeholders remain unpersuaded about the appropriateness of the proposed changes and that ongoing engagement by the ICB and CNWL will be required so that the way changes are implemented and services continue to evolve is experienced as genuine co-design which remains attentive to the diversity of population needs.
i. Did patients/the public/the local Healthwatch influence proposals before they were published for formal public consultation?	Extensive pre-consultation activities were undertaken, including through a citizen's advisory panel called The Voice Exchange, and this is detailed in the Pre-Consultation Engagement Report (Appendix 2 of the PCBC). This engagement provided support for reducing reliance on the most restrictive interventions and for working collaboratively and flexibly in the community. Section 1.5.4 of the PCBC presents a summary of how engagement shaped proposals, including: • Moving MHCAS to the Gordon because stakeholders wanted an option which included some admitting capacity in the south of Westminster. This change has been withdrawn in the final proposals, following further feedback in consultation. • The provision of more varied and culturally sensitive community spaces because Black service users reported high levels of dissatisfaction with inpatient admission and care, finding the experience to be re-traumatising. Similar concerns are repeated in the DMBC, where they have informed plans to establish a Black Service User Group to strengthen involvement as part of the CNWL Patient and Carer Race Equality Framework.
ii. Did patients/the public/the local Healthwatch advise on the consultation plan?	Healthwatch played an active role in pre-consultation engagement and consultation activities, although we did not find clear evidence of the role of Healthwatch or others in shaping consultation plans. The Consultation Evaluation Report states that "The ICB and Trust teams designed a comprehensive and proactive programme of communication and engagement to support the consultation. They sought feedback and advice from relevant colleagues in both Westminster City Council and the Royal Borough of Kensington and Chelsea Council".

6. Patient and Public Engagement

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
iii. Did proposals set out sufficient, easily understandable information about, and reasons for the proposals to enable an informed response?	There is evidence that some documents were overly complex or unclear but also that the proposers took action on this from the feedback they received.
iv. Was the formal consultation well-publicised throughout the geographical and other communities in which affected people live, work and spend their time?	Yes. This is evidenced in section 1 of the Consultation Evaluation Report. It was well-publicised using various channels such as social media, news media, printed publicity materials, door drops in key areas, emails to stakeholders, and promotional materials on the Trust's sites. The ICB worked in partnership with local authorities to distribute materials and promote participation. Low participation in the initial public meetings suggests that publicity may not have reached or engaged all relevant communities effectively. For instance, the additional meetings had to be arranged after feedback that the initial locations and timings were unsuitable, indicating gaps in the original outreach strategy.
v. Were local networks used to promote engagement?	Yes. This is evidenced in section 1 of the Consultation Evaluation Report. ICB and Trust teams engaged with local voluntary groups, community organizations, and other networks to encourage participation. Local groups helped host meetings, promote the consultation, and distribute consultation materials. Specific data on how many people from each network were reached or how representative their feedback was are not provided. Some local networks may not have had the capacity or reach to effectively engage all community members, particularly those from more marginalized groups.
vi. Was the formal public consultation open for a sufficient period of time?	Yes. The original plan was for 14 weeks which was extended after feedback to 16 weeks.
vii. Was the consultation available via a range of mediums including online and hard copy?	Yes. In addition, the DMBC describes the provision of: • Translated versions or access to interpreters for people for whom English is not a first language or who need a BSL signer. • Audio, large and Braille formats on request (not accessed). • A digital Easy-Read version of the consultation document via the consultation website (downloaded frequently). • Support on request to people with learning disabilities or difficulty in communicating (none received). We note that the greatest use appears to have been made of the most easily accessible consultation resources. So, although a range of support was made available in principle, in practice some resources came with barriers to access (i.e. the need to make a specific request). There is a risk that this approach may have inhibited the participation of some stakeholders.

6. Patient and Public Engagement

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
viii. Was it possible to comment verbally via telephone and face to face meetings, as well as in writing?	Yes.
ix. Were proactive steps taken to engage patients and the public, especially harder-to-reach groups and communities, and those particularly affected by proposals – both directly and through representative groups?	Yes. The identification of target groups and the activities provided to engage with them are detailed in Appendix 11.3 of the Consultation Evaluation Report (Appendix 5). That report also records that "The ICB, supported by the Trust, made significant efforts to ensure that everyone with an interest had the opportunity to give their views. This included reaching out through community and voluntary sector networks to hear the voices of service users and people most likely to be impacted, offering flexible and accessible approaches and actively seeking to engage groups facing exclusion and inequality, including those sharing protected characteristics." We would observe, however, that offering flexible participation options is not necessarily sufficient if particular groups do not feel adequately supported or represented.
x. Did the consultation yield widespread, detailed public/patient feedback, especially from equalities and hard to reach groups, and those particularly affected by the changes?	Yes. Feedback is combined from a broad range of participants, including equalities and hard-to-reach groups. Around 35,000 words of free text comments were submitted through the questionnaire, and a total of 120,000 words of feedback were considered. The quality and representativeness of this feedback are not fully addressed, and it is not clear whether the feedback from equalities and hard-to-reach groups was proportionate or detailed enough compared to other groups. The Consultation Evaluation Report notes that "In all, 580 individuals participated in online or in person meetings to discuss the consultation and a further 200 contributions were received through the questionnaire."
xi. Have the final proposals been demonstrably modified following patient/public feedback?	The DMBC reports that concerns were raised through the public consultation about the safety of providing the MHCAS on a site without inpatient care because of the lack of backup on site in the evident of a serious incident. It would be helpful to understand how extensive these concerns were and amongst which stakeholder groups. As a result of these concerns, however, final proposals co-locate MHCAS with inpatient services at the St Charles Centre (C2) rather than at the Gordon Hospital (C1). Other concerns raised are addressed by the DMBC, either to justify the existing proposal and/or to specify mitigations where there is a risk of adverse impact.

6. Patient and Public Engagement

Mayor's sub-tests	Strategy Unit Findings from our DMBC Review
xii. Do the final proposals set out plans for ongoing dialogue with patients and the public as detailed delivery plans are developed and service changes are implemented?	The DMBC commits to working closely with system partners and service users and carers around the implementation of proposals. Specific mention is made of: • A Task and Finish group to develop and implement the ways of working across organisations to deliver a more joined up pathway for the homeless population. • The role of both the Bi-Borough place-based partnership (with representation from all providers in the area including GPs and the voluntary sector) and experts by experience in informing and delivering plans. • A Bi-Borough wide bi-annual event, working with partners and led by St Mary Abbot's Rehabilitation and Training (SMART), to brings together all organisations working with people with mental health needs along with service users and carers to network, share information about services and hear feedback to support improvement. The intent is to engage this network throughout implementation and in support of evaluation. We welcome the plans for ongoing dialogue around the implementation of proposals, and we support the co-design recommendations set out in the independent consultation report (section 34, p.100) • Clear terms of reference focused on how solutions connect with key local services and support networks e.g. NHS acute care, housing, community-level partners etc. • Specific involvement of local agencies supporting people experiencing homelessness • An agreed scope limited to services for people with acute mental health needs – informed by broader community needs but not diverted by trying to solve all problems • A review of data to bottom out the differences of view around capacity – both of inpatient beds and community services • Appropriate engagement with communities and experts by experience, including structured involvement of service users and carers and strengthened engagement with people from Black and minority ethnic backgrounds. We are also mindful that the Grenfell community is within the scope of these proposals and note the generalisable People Power lessons from the health care response to the Grenfell Tower fire prepared by the King's Fund: "Grenfell shows in sharp relief what happens when minoritised voices are not heard by statutory services. It also shows a possible way forward. This research acknowledges what went wrong, but it also shows what can happen when services are willing to engage differently – and find a way to have honest, often uncomfortable and deeply challenging conversations about power, inequality and racism." (p.65)

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