The Gordon Hospital

Options and ambitions

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(picture Google Maps)

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

The Gordon Hospital – options and ambitions

Summary

This independent report considers the future of the Gordon Hospital following its sudden temporary closure as a mental health acute in-patient service in March 2020 at the start of the Covid-19 pandemic. It is based on documentary analysis and conversations with a range of people passionate about good mental health.

It presents a history of the hospital as a local resource for the population of South Westminster, an area with some specific needs arising from the mobility of its local populations some of whom have poor health needing care and treatment, sometimes in an emergency. For many decades the Hospital has been a local asset, providing care close to home. It has potential as a significant 'anchor institution'.

The report acknowledges the stressors in mental health services and under-investments in this service. While community services and public health initiatives help reduce crises and severe distress, it is widely acknowledged that a spectrum of services will be necessary including in-patient services that are therapeutic and recovery focused.

Currently most stays in local mental health in-patient services are arranged under the Mental Health Act 1983. This reflects severity and urgency of need, possibly expected to increase with rising levels of mental health problems in our community. Investments in community-based services are much needed generally and in-patient services need to work in partnership with other services. The Gordon Hospital was reported to do this well by those who helped contribute to this report. Its local presence in South Westminster was said to facilitate good working relationships, especially for people with experiences of homelessness.

Almost all services have room for improvement, however the evidence from the individuals who contributed to this report is that the Gordon Hospital was respected for the quality of its care. Staffing and availability of local amenities were positively reported. The hospital site's proximity to other services, such as housing, police and other mental health community provision, was said to assist in continuity of care, good inter-agency relationships, and the making of careful arrangements that are needed when people move back home – alone or back to their families.

The proposed options presented for the future of the Gordon Hospital need to meet certain tests set for major change to local NHS provision such as the closure of a hospital's in-patient facilities. Changing the function of the Gordon Hospital to one of providing short-term 'crisis' places for people in great distress arising from their mental health problems with the possibility of some four 'overnight beds' may not make the most of the huge potential of the hospital to provide care close to home that is legally authorised, therapeutically orientated and providing the optimal route to recovery.

Contents

1 Aims and Objectives

The aim of this report is to provide information and analysis for Westminster City Council (WCC) and Royal Borough of Kensington and Chelsea (RBKC) in the context of the consultation on plans to permanently close the acute in-patient beds at Gordon Hospital as announced in October 2023 by NHS Central and North West London (CNWL) Trust, the current provider of secondary and tertiary specialist mental health services in this part of London. This report was commissioned as an independent overview by the Directors of Adult Services in WCC and RKBC to inform debate within the Councils and their partners. It draws on a wide range of evidence from a range of documents but also from professionals, regulators, and policymakers and other local people, including elected Councillors. During the course of writing the report in Summer- Autumn 2023 a variety of options was being canvassed. By October 2023 these had coalesced into three options with North West London (NWL) Integrated Care Board (ICB) declaring its preferred option (described in the consultation document as Option 3) would be to:

- Expand the mental health crisis assessment (MHCAS) service (previously piloted at St Charles Centre for Health and Wellbeing) and move it to the Gordon Hospital, with capacity for 12 patients, including the capability for four patients to be admitted at night.
- Keep the existing 67 inpatient beds at St Charles. Additional new bed capacity in Brent would 'free up' seven beds at St Charles which would expand its ability to take patients from Westminster and RBKC.
- Retaining the community and crisis services developed since the Gordon Hospital in-patient wards were closed. Voluntary sector funded partnership services would remain and the Community Access Service (CAS) among other services would continue. (CNWL 2023a, 24 October)

This present report is divided into 7 sections.

Section 2 starts with an account of the Gordon Hospital over the many years that it has been part of the fabric of support for people in need in Westminster. This history includes the decades prior to the founding of the National Health Service (NHS). It shows the potential for a new vision of the hospital as a local asset and an anchor institution, linking it more closely to wider community resources. This would acknowledge its role in the spectrum of support available to local people in great distress attributable to a mental health illness. It would have implications for other local in-patient provision in RBKC potentially enabling it to regain more local connections.

Section 3 draws attention to the question of how many in-patient mental health beds are needed in a locality and where they should be. Unsurprisingly there are no precise estimates here although there is a consensus that, within a spectrum of services ranging from public health prevention to long-stay care, there will be needs for some in-patient provision of care and treatment for people in the greatest distress. This will encompass timely, legally authorised detention for assessment and therapeutic treatment under the Mental Health Act 1983.

In Section 4 the focus is on the Gordon Hospital estate and its activities prior to closure of its in-patient accommodation. Further mention here is made of its role as a community asset

and potentially as a local 'anchor institution' in line with wider ambitions for care of all types to be provided close to home and communities. While in-patient accommodation is not needed by most people, it is needed by some, and its scarcity can inhibit recovery or lead to serious harm. The unique position of WCC in respect of people with experiences of homelessness within England is addressed here, although there are also some homeless and vulnerably housed people in RBKC. The implications of the closure of the Gordon's in-patient acute beds for other public services are covered.

Section 5 explores the quality of in-patient care and treatment at the Gordon Hospital prior to 2020 and provides evidence about staffing. Points are made in this section about the current pressures on services where people are waiting for an in-patient bed in non-therapeutic settings, risking their ability to recover or feel more stable.

Section 6 directly addresses the possible permanent closure of Gordon Hospital's in-patient beds and the options being canvassed in October 2023 by CNWL (CNWL 2023a). The pressing need to rebuild trusted partnerships in this service area is also addressed.

2 What is the Gordon Hospital?

Gordon Hospital was founded in 1884 as a specialist voluntary hospital for the medical and surgical care of poor patients with rectal disease. Initially called the Western Hospital for Fistula, Piles and Other Diseases of the Rectum it was housed in a small house at 278 Vauxhall Bridge Road, in the same road as its present site. It opened with seven beds. In 1894 it took over a neighbouring building at 276 Vauxhall Bridge Road expanding to 10 beds.

As part of national commemorations of the life of Major-General Gordon (1833-1885), the Hospital was renamed the Gordon Hospital for Fistula, Piles and other Diseases of the Rectum (1886 - 1910).

In 1899 the Hospital moved to a purpose-built four storey site with 25 beds on the same street to 126 Vauxhall Bridge Road. Acquiring electric light in 1910, it was renamed the Gordon Hospital for Rectal Diseases (1911 - 1938). In 1928 an Out-Patients Department opened, with its entrance in Bloomberg Street.

By the 1930s the Hospital had acquired an international reputation for the treatment of rectal disease. International specialists came to study the Hospital's pioneering treatment of cancer of the rectum. In 1930 a large colonic lavage unit was installed in the basement. Between 1935 - 1937 the Hospital was extended and the old building demolished and rebuilt. This was mostly funded by John Arthur Dewar (1891-1954), the wealthy Managing Director of John Dewar & Sons Distillers and racehorse owner, who became President of the Hospital in 1933. Two new blocks had been funded by his previous gifts of £80,000 and his donation of an additional £50,000 funded the reconstruction. The newly equipped Hospital had 100 patient beds and rooms for 50 nurses (https://ezitis.myzen.co.uk/gordon.html) .

In 1939 it was renamed the Gordon Hospital for Diseases of the Rectum and Colon in 1939, with capacity of 102 beds. By 1941 it was simply being called the Gordon Hospital but was closed at the start of the Second World War with activities relocated under Sector VII (St George's Hospital, Westminster Hospital) (https://ezitis.myzen.co.uk/briefhistoryems.html) of the Emergency Hospitals Scheme for London.

The Gordon Hospital reopened in 1947 as a mental health hospital, even though in 1949 a specialist (proctology) meeting of the Royal Society of Medicine was held there on the subject of

Hirschsprung's Disease (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2184782/pdf/procrsmed00515-0021.pdf). When the Hospital joined the NHS in 1948, it merged with the Westminster Hospital and was classified as an acute hospital. In 1960 the urological beds on the ground floor of All Saint's Hospital (located at nearby 49-51 Vauxhall Bridge Road from its foundation in 1911 until it moved in 1932) were transferred to the Gordon Hospital, which was also a member of the Westminster Hospital group.

While its location has not changed since 1899, and indeed it is now part of a Conservation area, the Hospital has been run by several NHS administrative bodies, including London's Regional Hospital Board (Teaching) (1948-74) with a Westminster Hospital Management Committee (1948-74); then the North West Thames Regional Health Authority (1974-82) under its District Health Authority (1974-82) South (Teaching); and then Riverside District Health Authority (1982-99). (14 district health authorities were formed in the North West Thames Region in 1982, replacing 7 Area Health Authorities.) In 1999 it became part of the Brent, Kensington, and Chelsea and Westminster NHS Trust, an amalgamation of various NHS Mental Health Trusts.

The Hospital was then managed by the Central and North West London NHS Trust (CNWL), which was formed in May 2002, becoming one of the largest specialist mental health NHS Trusts in England. In 2007 the Trust became a Foundation Trust. In 2006 its capacity stood at 135 beds in dormitory style accommodation. During the period 2008-09 the Hospital was put under Special Measures indicative of concerns about its functioning. In 2012 its PICU (Psychiatric Intensive Care Unit) (Belgrave Ward), with capacity for 12 male patients, was closed by CNWL (Westminster City Council 2012). By January 2015 CNWL had restructured its service lines into three divisions with borough or service line structures underneath. A Westminster Borough structure was established for adult and older adult mental health services (other services such as CAMHS (Child and Adolescent Mental Health Services), Forensics, Addictions, Inpatient Rehabilitation and Improving Access to Psychological Therapies (IAPT) remained as service lines in other divisions) (CNWL 2015 page 1).

By 2019 (The North West London Health and Care Partnership 2019) the Gordon Hospital was also providing two beds as part of North West London's Health Based Place of Safety (HBPoS) provision of accommodation to which police and ambulance services were able to take people who under Section 136 of the Mental Health Act 1983. When this resource was at the Gordon Hospital site it was also made use for people from south of the River Thames owing to its proximity to the river. Currently (Spring 2024) HBPoS provision is co-ordinated by North and South London Hubs, including four refurbished suites at St Charles Hospital. A total of 480 Section 136 applications were made in the area covering Westminster, Kensington and Chelsea, and Hammersmith and Fulham in 2021, reflective of a rising trend in numbers across London (London Assembly 2022).

The Gordon functioned until March 2020 as an acute adult mental health hospital when it was registered with CQC as having capacity for 51 in-patient beds. Most of its patients were from the WCC and RBKC areas, with approximately 5% (one or two) from Brent. Its beds were temporarily closed by CNWL on 27 March 2020, the day after Covid-19 lockdown measures came legally into force in the UK. On 24 March 2020 as national lockdown was being announced CNWL reported that it had '*currently 23 patients at the Gordon and we have 65 empty beds at other CNWL sites'* (CNWL 2020a) and that the hospital would close on 27 March 2020 (see section 6 for more detail). The Level 4 emergency at the time owing to the pandemic has been given by CNWL as its reason why this closure took place without system engagement.

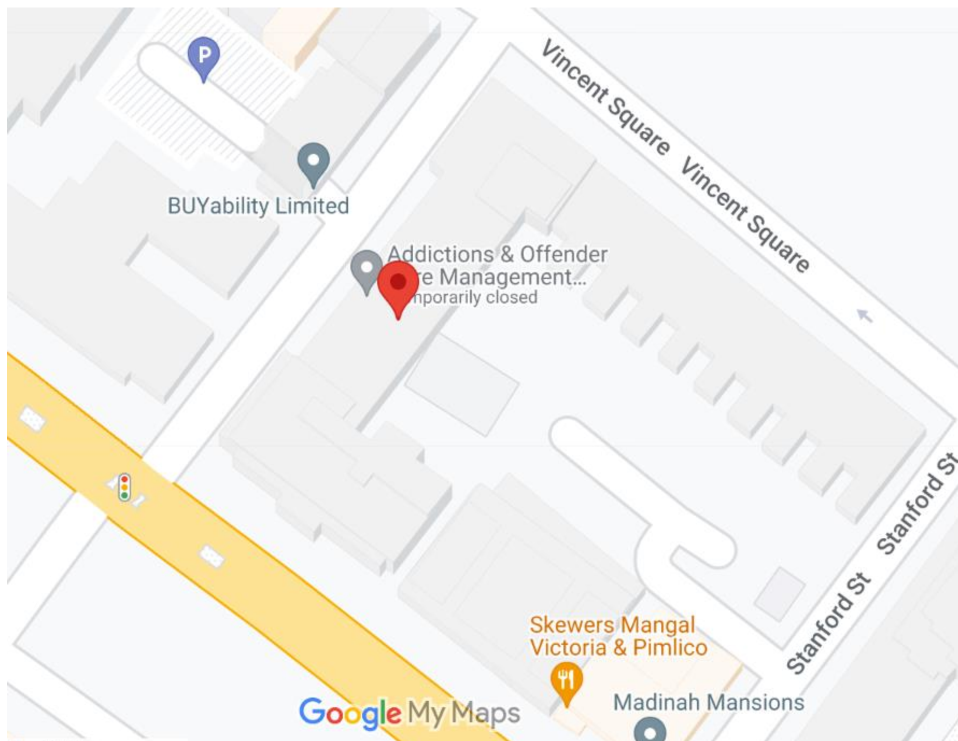
However, as the Care Quality Commission (CQC) (2019) noted in its inspection report, the Hospital was then working within the larger capacity of 51 beds. Several consulted during the writing of this

report were not aware of any engagement with system partners discussions around the decline in numbers of inpatients at the Gordon prior to March 2020 and the impact that this was having on local councils, the police and voluntary services in particular.

At the time of ward closure, the hospital contained three mixed sex wards: Vincent, Ebury and Gerrard, the first two taking the names of local residential squares. Authorised to take 18, 19 and 20 in-patients in each respectively, in 2019 the Hospital was operating with 17 beds in each ward (CQC 2019, page 43). However, by March 2020 actual patient numbers appeared to have reduced incrementally and had reached just 23 overall.

It should be noted that while the in-patient wards were closed, presently (May 2024) the hospital building remains in use as CNWL offices including being open at the weekend with a staffed reception area. At a workshop held by CNWL on April 2023 the hospital was reported to be the CNWL office base for some therapies, the Single Point of Access (SPA), Central Flow Hub, divisional staff (e.g. Transformation, Finance, Performance, etc), and the vaccination centre. Some care is also reported to be provided at the building. **Mentions in this report of the hospital closure refer to the closure of the three in-patient wards not the building and its service base. It should also be noted that these are 'adult' wards, not wards for older people or children and young people.**

The picture below gives an indication of the footprint of the Gordon Hospital in mid-2023 from Google maps in which the Offender and Addictions Case Management service is given as the service running from the building. As can be seen there is vehicle access from Stamford Street. Vincent Square contains a large private school playing field.



Many working in WCC and other services consulted for the purposes of this report specifically wished to emphasise their pride in the Gordon Hospital legacy and their desire to see it maintained as part of local provision for people in great need or distress. They viewed it as an asset in the community, adaptable and a scarce valued resource. One patient advocacy group provided the illustrative real example of a person who had been severely unwell but who had been sent out of the locality for mental health treatment. This move disconnected him from community services, added to the negative experience of being compulsorily detained, and delayed his recovery. It should be noted that, neither those consulted for this report nor CNWL or the ICB, has envisaged or proposed the closure of the building but were referring to its change of use to a base for services other than one containing both community services and inpatient care.

It may well be that there is potential for the Hospital to be more of an 'anchor institution' locally. Could WCC declare its ambition for the Hospital to be such, expanding on the definition: '*An anchor institution is an institution that – alongside its main function – plays a significant and recognised role in a locality, by making a strategic contribution to the local economy'* (Mid and South Essex NHS Trust n/d)? Would this complement the new locally focussed role of the NHS Integrated Care System (ICS)? Might RBKC be also enabled to help develop a vision of St Charles as a local anchor institution in its locality, if it were not accepting patients without local links, with the added value to its own residents that this could bring?

Concern about the proposed closure of the in-patient beds may attract more local people to become involved in the spectrum of mental health services in their localities, making a reality of the recommendation *'I am confident that the services I may use have been designed in partnership with people who have relevant lived experience'* (NHS England 2016). Both WCC and RBKC may be able to further assist local support and volunteering in mental wellbeing efforts that could support services at the Gordon.

More widely, and beyond this present consultation, there may be scope for WCC and RBKC to assist in the development of a better whole system approach, for example, setting out ambitions for good care for older people and a small number of young people in severe mental distress and for people being funded by WCC and RBKC in service settings far from home. They too are Westminster/RBKC residents and provision for this group could be scrutinised. WCC and RBKC public health services are engaged in work to promote good mental well-being and would need to help lead these developments.

Such efforts would need greater optimism than that currently evident among many contributing to this report. There would seem some pessimism that demand is inexhaustible and sometimes 'overwhelming' (as expressed by a patient advocacy group) and, among some CNWL staff a sense that even if there were to be once again 51 or more beds at the Gordon this would make no real difference to demand and waiting lists. Others have a more nuanced view, recognising that the very unusual move to assessment or treatment in a mental health hospital is not generally pleasant, but better, safer, and possibly increasing the likelihood of recovery than the alternatives.

3 How many mental health beds are needed and where should they be?

The question '*is there a 'right' number of mental health beds nationally, regionally or locally*?' has no easy answer. A Delphi or consultation panel comprising 65 experts (42% women, 54% based in low-

and middle-income countries) from 40 countries in the six regions of the World Health Organization considered 60 psychiatric beds per 100 000 population optimal, with 30 the minimum, whilst 25–30 was regarded as a mild, 15–25 as a moderate, and less than 15 as a severe shortage (Mundt et al 2022). However, the UK experience is the system that needs to be considered as a whole, with a spectrum of services ranging from what in the UK are forensic services, in-patient provision, community services, to preventative public health. And of course, 'demand' and the 'concept' of mental illness and wellbeing are further influencers and uncertainties. Whatever may be the 'right' number there is policy consensus that in-patient provision must be part of the spectrum of mental health care in England (NHS England 2019; 2023a), this being now the key location for those accommodated compulsorily for assessment and/or treatment through legal provisions of the Mental Health Act 1983. Showing the rising costs, the 'cost' of a mental health bed day in London (according to a national survey of providers, Care Quality Commission 2014) some 10 years ago was £459; in 2021 the East London Foundation Trust (ELFT) (2021) reported it within ELFT to be £446 per day. By 2022/23 this was continuing to rise, the NHS National Cost Collection from 2022/23 estimated the average cost of delivery of an inpatient bed day as being £656 in North West London.

There are declining numbers of 'psychiatric' beds in the UK. Statistica UK (2023) reports the number of such beds was nearly 55,000 in the year 2000 with a steady decline to less than 25,000 since then. The Strategy Unit (2019) noted that the decrease in mental health in-patient bed places has substantially increased the acuity or severity of the clinical needs of people admitted to such units:

> The thresholds for admission to a mental health bed have increased; the level of mental ill health of people admitted to hospital in 2018 was higher on average than individuals admitted in 2013. Furthermore, patients discharged in 2018, although deemed clinically fit for discharge, were on average less well than patients leaving hospital in 2013. (page 6)

As with a small number of other English areas, North Central London's mental health bed occupancy rates regularly or routinely exceeded 95% before the pandemic (Strategy Unit 2019, page 7) and are likely to be similar. The foreword to this Strategy Unit report, commissioned by the Royal College of Psychiatrists (RCP), highlighted that it is the RCP's:

> … ambition that a psychiatric bed is readily and locally available for anyone who is acutely ill and in need of inpatient care. It is unacceptable for anyone under these circumstances to experience a lengthy stay in the emergency department, to be sent away from their local area to receive the care they need, or to be admitted to a general and acute bed where there is a relative lack of dedicated mental health nursing and psychiatric expertise. It is also a matter of equality. It would never be deemed acceptable for someone requiring acute coronary care to be admitted to a psychiatric ward. (page 6)

Such sentiments reflect policy guidance from NHS England (2022) which states:

> It is vital that every person who needs acute inpatient mental health care receives timely access to high quality, therapeutic inpatient care, close to home and in the least restrictive setting possible.

Several of those spoken to for the purposes of this review held the view that the closure of the Gordon Hospital's acute in-patient beds has exacerbated pressures on other services. At St Mary's Hospital in Paddington, for example, a 'massive increase' in people with severe mental health problems was reported by staff working in its Emergency Department (September 2023), to the extent that it is 'off the scale'. This was thought particularly so in the rise of numbers where the Metropolitan Police Service (MPS) has had to be called upon for assistance, which they reported to

be typically involving injuries B8. St Mary's has made internal changes to its systems, following the development of the Lighthouse Service (a mental health assessment centre providing patients who require emergency care for their mental health with an immediate therapeutic environment where they can be seen by professionals). This joint service between CNWL and Imperial College Healthcare NHS Trust opened in August 2023. Some of the staff at St Mary's who offered their views expressed regret at the loss of Section 136 provision at the Gordon in 2019. They estimated that there were generally 10 patients in the Emergency Department at St Mary's at any one time, waiting for Section 2 or Section 136 assessments under the Mental Health Act 1983. The impact of this on their services to other patients is likely to be severe. However, according to CNWL, while there has been no increase in attendance by WCC and RBKC residents to acute hospitals, as is generally sadly well known, waiting time in A&E (Emergency Departments) is increasing nationally and locally. Such attendance may be that of young people who are not currently impacted by the Gordon in-patient closures as this provision was for adults. Nonetheless, several of those interviewed said they would like confirmation of these claims so that they can address the discrepancies from many of the reports they receive from the frontline of services with these figures. Greater transparency would be welcome to the councils and perhaps this could be addressed in other subjects of mutual concern in the future?

Locally, MPS officers contributing to this report have been attending pre-consultation meetings about the proposed closure of the in-patient beds at the Gordon Hospital to express their specific concerns (as in September 2023) at the lack of in-patient beds in Westminster which for them also encompassed the closure of Health Based Place of Safety (HBPoS) provision. The closure of these beds has placed extra pressure on the local MPS according to one officer who contributed to this report who thought it rare in their experience to be able to find a space for someone in substantial distress in a HBPoS setting when needed. This officer drew attention to the difficulties of travelling to and from St Charles Hospital as it takes up considerable amounts of Police Officers' time (average 2-3 hours; sometimes necessitating 4-8 officers) with some people in distressed situations. When a person is in hospital, this officer's experience was that Police Officers are often unable generally to talk directly to patients if needed for interview because of the distances involved.

The views of several of those spoken to for the purposes of this report the length of stay for some patients is too brief as they are too frequently encountering people who have been prematurely discharged when a Police presence has been called upon to manage difficult circumstances. They considered that people who are seriously unwell on the streets often give rise to public safety concerns for their own and /or others' safety.

Speaking of the current context (late 2023), a senior MPS officer reported currently 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. They had been made aware of substantial amounts of damage to mental health services and other NHS premises owing to distressed behaviour that is hard to manage. Officers expressed their views that NHS staff are managing very high levels of risk, without adequate support, for example, they consider that there are only limited security staff, with even lower provision at night, even in major hospitals such as St Mary's. Calling on the Police for assistance is an indication of the severity of situations for everyone but many incidents of violence and damage are said to be not reported to the Police exacerbating the risks of continued violence. Operation Cavell, designed to improve the safety of NHS staff (Mayor of London 2021), is reported to have not been able to embed in the local area owing to such pressures (and was postponed to November 2023). While there are four HBPoS places at St Charles, these are reported to be often full necessitating patients being

moved further afield to Hillingdon or Park Royal, taking further time away from local policing. The MPS officer observed that when patients had been accommodated in other parts of England this made it very difficult for them to maintain local links. While the closure of the HBPoS was not within the present consultation over the Gordon Hospital for some people the two are inter-connected.

The advantages of **care close to home** have also been articulated by the British Medical Association (BMA) (2023):

> Sending patients out of area for inpatient mental health care is both worse for health outcomes and costly for the NHS. Ease of access for family and friends is an important part of a patient's recovery, and, especially for someone experiencing mental distress, being removed from their support system can hinder recovery. This, in turn, can lead to delayed discharge, and reduced capacity for others also requiring help. Unfortunately, this type of placement is sometimes the last option for doctors and patients for whom a local bed cannot be found (the criteria in place which defines this type of placement as 'inappropriate').

Such ambitions may explain CNWL's decisions to increase its in-patient provision in Brent where it considers there is greater local need for beds. While not disputing the high levels of need in Brent, this indicates that there is no moratorium on increasing or sustaining or even increasing in-patient services in some areas. There has been mention of plans to link in-patient wards in St Charles Hospital by borough (a Westminster ward, a K&C ward and so on), although this would not provide additional in-patient resource to address service pressures however, CNWL has confirmed that borough dedicated wards are not planned as they had previously proved unsuccessful.

More precisely, CNWL has recognised that 2% of local residents who need to use mental health services will require the specialisms of an in-patient service. While it estimates that, on average, an in-patient bed costs the Trust the same money as caring for 44 people in the community such calculations are very generalised. Community services are, of course, not a precise equivalent comparator, and cost-effectiveness comparisons of interventions are in their infancy, especially where prevention and public health interventions are concerned. It should be noted that the Joint Strategic Needs Assessment (2019) for WCC and RBKC noted that ***'The recorded prevalence of serious mental illness is higher than the London average in both boroughs'*** **(page 6).** As mentioned later in this report, '*local residents'* in WCC and RBKC areas do not include those individuals who move to this area with severe mental illness and may not be registered with local services or may develop such conditions after this move.

The sufficiency of in-patient care matters to individuals and their families, as well as people in support roles such as housing staff, community services, acute hospitals, and so on. One way of establishing if the current whole system is working is to assess delays arising from problems in finding a bed, sometimes any bed. Some evidence of such delays comes from an analysis of an audit conducted over the period week ending 16th-20th March 2023 by an Approved Mental Health Professional (AMHP) lead in RBKC. This collected data on any delays in the undertaking of a Mental Health Act assessment by an AMHP (almost always a social worker) working in the Emergency Duty Team (EDT) and in the finding of a bed space when a legally based decision is that this is warranted for assessment and/or treatment (for example, for treatment or assessment under the Mental Health Act 1983). The EDT-related delays covering the period of this audit added up to about 53 hours in all, 42 of which were probably accounted for by one very intense series of referrals in the early hours of a Saturday morning, which could only be approached in order of priority and in one case not for nearly 15 hours beyond the four hours prescribed. Lack of Section 12 doctors (approved under this section of the Mental Health Act on completion of training) in the early hours, or their

own views about when an assessment would be medically optimal, were also judged significant factors in these delays.

Two out of nine patients referred in that time were ‘out of area’ patients brought earlier to the St Charles Mental Health Crisis Assessment Service (MHCAS): assessing one of them for discharge delayed another assessment while the other patient was still waiting at the end of the audit period on 20 March 2023.

On the other hand, counting the hours from the same point, EDT referral, when bed-finding should commence, the process appears to have accumulated about 625 hours of bed delays over the same period with the same patient group, not counting one patient with very complex needs in the MHCAS whose situation took six and a half days to resolve, or an overseas visitor who waited about seven days from their first Mental Health Act assessment (during this period) to be admitted to a ward in the North-East of England, or an older patient who waited nearly four days in the MHCAS after their first MHA assessment in Ealing, before they were referred to the EDT. At the end of the audit period, five patients were still waiting for beds, one of them after more than two days.

Looking at the two measures, the average EDT bed-delay per patient, counting all referrals, was 1.65 hours. However, the average bed delay per patient, counting all referrals was 19.5 hours (not including delays for MHCAS assessment from people out of borough or those five patients still waiting at the close of the audit). It is not just the delay that matters of course but what happens to people who are experiencing this and others affected as a consequence. The outcomes of delays in these liminal spaces for individuals is not known but their human rights may not be recognised as they would in a setting where there is clear legal authority and specific rights. Such settings include A&E or Emergency Departments, MHCASs, Health Based Place of Safety settings (HBPoS), and others.

By default or design these ‘holding settings’ seem now a regrettable but essential element in an overall strategy for managing bed capacity. This is a view held by some professionals. While any audit period may be atypical – in the extent of delays one direction or other, this data raises concerns, and WCC and RBKC would welcome further analysis and discussion on this subject as started in the pre-consultation phase of the proposals for the acute in-patient services at the Gordon Hospital. As noted above, wider discussions could also include what is happening to older patients, in line with civic commitments and public duties to equalities. As part of the Mayor’s six tests for hospital closure (see below Section 6) such data could be very useful in pointing to current demands. And, as noted below, the Integrated Care System (ICS) may be interested in such data especially the uncertainty of MHCAS provision to mitigate demand for in-patient beds and the complexities of this provision legally for people’s human rights.

On 24 July 2023 the new NHS North West London Integrated Care System (ICS) announced that, in collaboration with local authorities and partners responsible for the delivery and planning of health and social care services, it was working together to refresh the local Mental Health Strategy (NW London ICB 2023), stating:

> We are taking a phased approach that will start with reviewing progress against previous and existing strategies with a focus on adult mental health.

This ICS commitment makes any permanent decision about the future of the Gordon Hospital rather premature. WWC and RBKC public health experts have drawn attention to post-pandemic contexts such as greater numbers of asylum seekers/refugees, many from the Sudan and Afghanistan, who are newly coming to the attention of services and increasing demand. Moreover, current delays and the

lack of provision in WCC and RBKC indicate how the investments in CNWL community services need also to be complemented by local in-patient provision for some people.

One point of relevance here is the concept of **out of area** in relation to a large provider such as CNWL which has contracts with London's Integrated Care System (ICS) but also with ICSs situated beyond London and relationships with a wide number of local councils consequently. Out of area in-patient beds entail different geographies for CNWL compared to WCC and RBKC. Thus, out of area for CNWL may not mean **care close to home** for WCC or RBKC individuals, permanent residents or otherwise. This is reflected in a letter to RBKC (CNWL 2023b page 2) where it is stated:

> We currently have no inappropriate out of area placements (inpatient admissions for residents of CNWL boroughs to beds not provided by CNWL).

As noted, CNWL covers a wide area of London and beyond. However, CNWL also uses the DHSC (2016) definition of 'out of area' which is much narrower, referring to provision beyond the usual local network of services. In early 2024 CNWL had not needed to send any patient out of area for care, using the DHSC definition, for over a year. This is not always realised by many mental health stakeholders contributing to this report, including some people using services who often refer to out of area placements and difficulties of access and maintenance of local links perhaps because they have strong memories of cases where this was not the case, albeit some time previously. For councils listening to the resident voice and that of their own staff this suggests a need for accurate information, so they can communicate and share such changes. Of course, for people with long-engagement with mental health services, a year represents only a part of their experience.

In the same letter (CNWL 2023b) mention is made of the 'effectiveness' of CNWL's Mental Health Crisis Assessment Service (MHCAS) based at St Charles Hospital that opened in November 2022. This reflects, but was not attributable to, national NHS investments as part of the *NHS Five Year Forward View* (NHS England 2019) and the earlier Mental Health Review as part of the *Five Year Forward View for Mental Health* (NHS England 2016). The MHCAS is described as one part of added resources to help the NHS provide the full spectrum of care and treatment needed for people living with mental health problems and is open to people from other CNWL boroughs such as Harrow (London Borough of Harrow 2023).

The notion of 'care close to home' may be relevant to the Gordon Hospital more than 'out of area placements'. Broadening this to care close to community links would help stress the importance of family and neighbourhood. WCC or RBKC may wish to collate data or other evidence here. This could be linked to the localism theme of being **an asset** to the Westminster locality. WWC and RBKC might also like to support the ***vision of in-patient care*** as aspired to in the statement:

> For people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. Purposeful, patient-orientated and recovery-focused care is the goal from the outset. (NHS England, 2019 chapter 3, para 102)

One point relevant to numbers and locations of in-patient mental health provision concerns the largely unknown amount and type of private provision (privately paid not NHS commissioned) which is beyond the scope of the present consultation but of interest to the councils. The provider of mental health beds is not just the NHS. According to national figures reported in *The Guardian* (Campbell 2022):

> While private sector beds increased from 9,291 in 2010 to 10,123 in 2021, the number of mental health beds in the NHS dropped from 23,447 to 17,610 – a fall of 5,837.

The CQC (2018) provided a national overview of private mental health rehabilitation in-patient provision for people with complex psychosis whose needs cannot be met by general adult mental health services. It noted that large numbers were not being cared for in their home locality.

WCC and RBKC have not sought to consider the extent and usage of local private provision for this report but would perhaps be interested in ensuring that this is used effectively, operates as local assets, and is high quality. We suggest the ICS takes this into account in its review. WCC is one of a small number of local authorities in England providing social care residential provision for some of its citizens who are living with dementia and employs staff to liaise with private and voluntary sector care home providers. This is an example of WCC's commitment to good local services for local people, enabling them to retain local connections and encourage rehabilitation.

The context of under-investment in NHS overall was exposed by the recent pandemic where there was almost no spare capacity to absorb the increased demands. Local councils too have experienced severe budget reductions over the past years too. Service pressures are a result and joint efforts to address them are needed.

4 The Gordon Hospital in-patient provision and wider estate

As noted above in relation to the Gordon Hospital, reductions in bed numbers were already being implemented by CNWL prior to the pandemic to improve safety on the wards (CNWL 2023b), indeed a substantial loss of in-patient beds had occurred with the closure of the Paterson Unit at St Mary's in or about 2007 when some of this 60 beds provision moved to St Charles but other beds were never replaced. Commenting on the Gordon Hospital, the CQC (2019) observed in its inspection report of June 2019 that:

> The trust was committed to improving its premises to enhance patient safety. This involved eliminating dormitories and creating ensuite bathrooms. To facilitate this programme, the trust had already commenced a reduction of beds to improve safety.

This became a national imperative in late 2020 with the Department of Health and Social Care (DHSC) providing specific finance to to remove dormitory provision (DHSC 2020).

In terms of the wider local environment the Gordon Hospital is located near multiple public transport services, very near to bus stops, and has an accessible visitors' entrance. It is close to local shops, markets and activities such as the local Sports Centre, post office, free art gallery, a day centre for people aged over 50s, day services for people with experiences of homelessness (provided by St Mungo's, The Passage, and Anchor), WCC offices, faith and community group services, and a range of supported accommodation (WCC commissions some 450 units of such accommodation annually). These provided local activities for in-patients who were at the Gordon Hospital voluntarily and others with escorts (and for staff) and later in their recovery. The hospital reception area appears to have been refurbished and is bright and welcoming, with an accessible (for wheelchairs and for people with mobility problems) ramp entrance for visitors (CNWL wishes it to be noted that all its sites are accessible) . One side of the building looks over a quiet tree-lined large London green square. There is no garden provision on the Hospital site but there are several public spaces around Victoria and Pimlico potentially enabling 'green' walking sessions as recommended, if risk assessments support this, by the Royal College of Psychiatrists (RCP) (2022, recommendation 6.1.12).

A lack of outside space for patients was raised by CNWL in its July 2023 letter to Kensington & Chelsea (CNWL, 2023c) as part of the rationale for not refurbishing the Gordon Hospital. Access to outside space is recommended by the RCP (2022, recommendation 6.1.11, 'Patients have access to

safe outdoor space every day'). However, as the above paragraph notes, there are other imperatives such as continuing to avoid out of area placements and enabling family contact through multiple accessible public transport and social options. These are extensive in the Gordon Hospital neighbourhood but considered by those contributing to this report to be far less so around St Charles Hospital. The roof garden space offers another resource which was noted as an advantage by professionals familiar with the Gordon. Professionals observed that the Gordon Hospital locality, with its nearby cafes, shops, markets and community centres, was often made use of by in-patients on escorted or permitted leave (termed Section 17 leave) and others who were staying voluntarily. It is interesting to note this example of lack of outdoor space is frequently given by CNWL (for example in CNWL's 2023c letter to Cllr Knight dated 3 August 2023 from CNWL, included as part of Appendix 13 of CNWL 2023a) as a reason for not having in-patient beds on the Gordon site:

> None of these options will fully meet a standard of "high quality modernised inpatient services," because the physical constraints of the building and its location mean it is impossible to provide high quality modern inpatient services that comply with the Royal College of Psychiatrist's essential, expected and desirable standards – for example, good, safe unlimited access to outdoor space.

Those contributing to this report thought it would be timely to explore the potential for any refurbishment of the Gordon Hospital to make the most of its footprint, in partnership with its neighbours and were not aware that CNWL had evidently done this already and does not intend to do so again. WCC would be pleased to facilitate such engagement. In the views of some councillors, the outside space at St Charles Hospital is limited with only one ward having outside space, others have areas open to the elements but enclosed by metal mesh, although refurbishment is planned. Although these councillors had visited St Charles they were not aware that all wards also have access to a large herb garden in the centre of the site which is used for therapeutic gardening activities as claimed by CNWL.

South Westminster Community Mental Health Hub, based at nearby 190 Vauxhall Bridge Road, provides an office base for various health care professionals with specialist skills in working with people who have mental health needs and are living at home. The service provides integrated (meaning shared services between CNWL and WCC), recovery focused health and social care to WCC residents. At the same address presently are the Intermediate Mental Health & Physical Care Team for Older People and the Westminster Talking Therapies service. The proximity of this Hub would appear to be an advantage to patients and staff in terms of continuity of care and relationship building, even though WCC and RBKC are not going to be working any more under the shared services agreement over integrated provision of mental health and social care services (referred to as Section 75 NHS Act 2006 services). A similar CNWL hub is close to St Charles Hospital for RBKC and North Westminster patients.

In respect of the Gordon Hospital building, the CQC had commented on parts of this specifically in its overall inspection of CNWL (this took place 16 January – 2 April 2019) as then not fit for purpose in some respects but observed that its concerns had been addressed:

> While most wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose, a few were not. Bedrooms on two wards at the Gordon Hospital were too small for safe use by patients in distress. Also at the Gordon Hospital, rooms designed to offer flexible accommodation for male or female patients were breaching guidance to eliminate mixed gender accommodation. … By the end of the inspection the trust had addressed all these matters and where needed taken rooms out of use. (page 8)

In the CQC's main report other estate matters were identified as needing to be addressed:

> The trust should ensure that patients' privacy and dignity is maintained at the Gordon Hospital (clear windows overlooking private dwelling). (page 17)

It noted that improvements and new leadership had been put in place on its return visit to the Gordon on 25 March 2019.

Other matters of concern to the CQC throughout CNWL's other in-patient mental health wards were a lack of call bells, meaning patients were unable to call for urgent assistance from staff (this was the case in all but one CNWL mental health unit outside London and not specific to the Gordon) (page 46). This omission would seem relatively easy to address.

Overall, the proximity of local transport/facilities of the Gordon site needs to feature in any report on the needs of WCC residents (service users and families). Likewise, transport links and local facilities are often important to staff and evident in staff wellbeing, recruitment and retention. There is room to explore the potential linkages of local community based CNWL services with the Gordon Hospital in terms of it developing anew as an 'anchor institution'.

As covered in Appendix 4 of CNWL's consultation support materials, unsurprisingly there would appear no other suitable building in WCC area presently able to offer 51+ mental health in-patient beds for a ten-year lease period (CNWL 2023a), including extra provision at St Charles. This illustrates the resource provided by the Gordon site and its excellent location.

A brief note on provisions at **St Charles Hospital** (also run by CNWL) may be appropriate here since this is where patients of the Gordon Hospital were transferred on its closure of the in-patient beds (see above) (and indeed when St Mary's mental health provision at the Paterson Unit at St Mary's Hospital was closed in 2007, with the loss of 60 dormitory-style beds, some of which moved to St Charles). Situated in North Kensington, and a former Poor Law Infirmary, St Charles is the nearest mental health facility to the Gordon Hospital and currently (Spring 2024) the most local to Westminster. St Charles is often described as a Mental Health Unit (registered as a Mental Health Centre) (details of its limited parking (greater than that at the Gordon) and travel accessibility are contained on https://www.accessable.co.uk/venues/st-charles-hospital-mental-health-centre). While for some WCC residents St Charles Hospital is not far away for many it is a considerable distance, particularly for South Westminster residents (and for WCC and other staff) many of whom are not car owners. The travel time by public transport from the Gordon Hospital to St Charles is around one hour which includes walking time of approximately 15 minutes.

Such matters have relevance to inequalities such as the high number of adults experiencing mental health distress that need to move from Westminster to other areas if in-patient support is needed:

> … across the CNWL system, Westminster had the highest proportion of mental health admissions within the 50-64 years cohort, at 87.7 per 100,000. This higher risk of acute mental health among older people warrants further analysis, to understand how the current acute mental health provision does and doesn't meet the needs of older people in Westminster. (Healthwatch 2023a)

At the time of the CQC inspection of CNWL in 2019 (CQC page 43), the facilities at St Charles, excluding its older people's mental health wards, were:

- Amazon Ward – 17 beds, for both men and women
- Danube Ward – 16 beds, for both men and women

- Thames Ward – 17 beds, for both men and women
- Ganges Ward – 17 beds, for both men and women
- Shannon Ward – 12 beds, a Psychiatric Intensive Care Unit (PICU) for women taking referrals from other parts of England when places available
- Nile Ward – 14 beds, a PICU for men (see Rahman et al 2021 for a description of the ward environment)

The Lounge or four bedded suite of rooms at the HBPoS at St Charles Hospital is covered elsewhere in this report. Numbers being referred to these services are not known. More widely, according to CNWL (CNWL 2023b) in RBKC, an average of 44 people a month were admitted to in-patient services in 2019/20 (pre-Covid and pre-Gordon in-patient bed closure). This number fell to 30 people a month in 2022/23. What matters of course is not just admissions but outcomes in terms of recovery or decreased distress, with length of stay on a ward an indication of this but not the only outcome.

In April 2023, Healthwatch Westminster (2023b) reported on its 'Enter and View' visits to the four acute mental health wards at St Charles Hospital Mental Health Unit. Since this visit aimed to learn more about patient experiences of care, and their knowledge of mental health advocacy and the complaints system, it is reported in more detail below in Section 5.

5 Quality of care and treatment at the Gordon Hospital

The views of patients are important for any health service. The NHS national system of Patient-Led Assessments of the Care Environment (PLACE) run by NHS Digital is an annual assessment of the service environment. The CQC judged the Gordon Hospital as doing well (scoring 94.4%) in the 2018 process. St Charles' score at the same year was 93.7% (CQC 2019 page 70). (Note, the PLACE system processes changed in 2019.) PLACE scores for CNWL in 2019 overall were much higher than the national NHS average (CNWL 2020b).

The location and expertise of staff at the Gordon Hospital were considered as substantial by housing specialists within WCC with responsibilities for people with experiences of homelessness who offered their observations for this report. Westminster has the highest rough sleeping population in England. Indeed, despite various initiatives by the government, in March 2023 the bi-monthly Westminster Street Count found a sharp increase in the proportion of European Economic Area (EEA) nationals 'bedded down' in the area (mainly around Victoria), with a substantial growth from 64 in January 2023 to 116 in March 2023; a trend that is consistent with seasonal patterns of rough sleeping in Westminster. Many individuals with No Recourse to Public Funds (NRPF) are brought to the attention of local services in this locality, some of whom have mental illnesses, some of which are associated with drug and alcohol dependencies.

Particular concern (around end 2023) was expressed about changes in policing policy nationally, often referred to as *Right Care Right Person*. Although Police officers will continue to respond to in cases where a real and immediate risk exists to the life of a person, or a risk of serious harm during a mental health crisis, they will not respond to welfare concerns or other less than serious problems. They will still use their power to detain a person under the Mental Health Act's Section 136 to take them to a place of safety (as noted above, currently St Charles has the local Health Based Place of Safety (HBPOS) provision because the Gordon's closed in 2019). As reported in the *British Medical Journal* (Heyhurst and Sparkes 2023) the *Right Care Right Person* initiative has been implemented to resolve a situation that takes Police Officers away from other pressing duties:

> Currently, police in London report spending an average of 8.5 hours with patients brought to a health based place of safety, usually a "136 suite" within a psychiatric hospital, and 14.2 hours if the person is taken to an emergency department. People are usually taken to an emergency department because the 136 suite is occupied … Some emergency departments allow police to leave a patient under section 136 in their care, but many are unable to release police because of a lack of trained security staff who can respond in an emergency. Patients often have prolonged waits for assessment by approved mental health professionals and doctors with the training required under section 12 of the Mental Health Act. Approved professionals are overstretched; out of hours, section 12 doctors are not commissioned in the same way as other doctors who work on a rota. Doctors make themselves available as they wish, which leaves some periods without cover.

Such changes will require more from community and hospital NHS and other staff working with people who may suddenly deteriorate or enter a crisis. At the time of finalising this report, handover times at the CNWL HBPoS were reported by CNWL to be currently under one hour on average.

While it is important to enable Police Officers to undertake the jobs they are trained for and effective in doing, the impact of this major change will need to be addressed. The experiences of local mental health social work practitioners contributing to this report are that smaller local facilities such as the Gordon help build up and retain good relationships. They foster continuity of care and calm environments that decrease distress, as described elsewhere in this report, and mean less use of Section 136 procedures for patients who are known to its professionals. WCC is always concerned at the impact of such changes in the MPS on local residents who benefit from good or at least non-confrontational relationships with the Police and are known to them, such as rough sleepers and those living in hostels or supported accommodation. These are people with whom the Gordon Hospital staff had extensive expertise, able to extend this to the growing population of men in their 40s who we reported to be attending for crisis help often with early adverse childhood experiences or under-recognised autism according to WCC housing staff contributing to this report. These staff described the Gordon as having been a very strong anchor for diverse rough sleeping populations with complex needs (some of whom are in local supported accommodation in South Westminster). While this is not a large group numerically it is important that all services have such local expertise and can draw on other helping services such as the rich network of homeless and addictions agencies in the vicinity of Victoria. Sending such patients to out of borough in-patient wards jeopardises this continuity of care and chances of recovery. As noted in other sections of this report, WCC and RBKC are keen to make a reality of 'place based' care and support and this is supported by the Police locally who contributed to this report. WCC has made substantial efforts to commission its supported housing accommodation in line with Community Mental Health Team (CMHT) and GP services.

The care extended to local residents is vitally important to WCC and RBKC. However, as an inner-city area with high population mobility, this introduces the question of whether it is appropriate for CNWL to see **out of area placements** as more suitable for people who seem to lack local connections (not meaning here specialist services such as mother and baby units). In WCC and RBKC this is not an easy division to make – local or not local – some people move to inner London for what might be temporary purposes, others are transitory, others are without recourse to public funds. For a variety of reasons some may come to the attention of services in substantial crisis. WCC and RBKC have been proactive with voluntary and faith groups in responding to this need, taking an integrated person-centred approach. For some the aim will be to stabilise a person so that they can return home. To help this happen, good networks involving different agencies need to build trusted support. Moving a

person out of area breaks this chain. One example given was that of a person who was moved but still needed expert immigration advice that was available in WCC area. Staff felt that the momentum of this person's recovery was disrupted by the move. For them the Gordon had made a reality of 'place based approach' to care. They reported that complex mental health and other needs were rising among people who are vulnerably housed with pressures on hostels and supported accommodation becoming more difficult to manage if a person was very unwell. Likewise, people who are rough sleeping were thought by specialist staff contributing to this report currently to be at greater risk of turning up to services in crisis or to need help, sometimes not voluntarily, if their problems were becoming deeply entrenched. For those on a pathway to recovery in supported housing, if they were becoming very unwell there were reports that they might be left there while an in-patient bed was being sought, sometimes for weeks, placing huge pressure on the staff and other tenants.

Engagement of local professionals including local housing providers and local police station staff, undertaking multi-agency work to support people with severe mental health needs, and who know individuals well seems to be key in making good decisions and many of those spoken to provided examples of this evidently operating at the Gordon when the in-patient wards were fully running. Illustrative of this, one housing officer commented there was much use of first names between staff from different agencies in communications around the Gordon, and that people working in supported accommodation services were able to visit patients on the ward, maintain connections and make a reality of a recovery pathway. One MPS officer estimated they had been attending three meetings a week at the Gordon when the in-patient service was open so had been able to sustain relationships and hear of any imminent concerns from patients or other staff.

The discussions so far about the Gordon Hospital's in-patient provision and more generally do not seem to reflect the potential to rebuild a service that is so integral to local help. While this may apply to all local residents, this applies particularly to people with homelessness experiences or those with high usage of services. These include people with combinations of complex physical and mental health and care needs, including addictions and trauma-related circumstances, whom the police and ambulance services are needed if a crisis develops. Being small sized was attributed as giving the Gordon Hospital's in-patient provision the advantages of flexibility in meeting local needs more effectively in the views of several council and MPS officers. They spoke of it having a reputation for being quick to respond effectively to new imperatives; one that is hard to earn. Contrary to what some in senior roles in CNWL have alleged, the local Approved Mental Health Professionals (mostly social workers) spoken to for the purposes of this report do not agree that they are 'quick' to move to Mental Health Act assessments for such individual and, of course, an assessment does not necessarily lead to a recommendation for compulsory assessment or treatment.

The CQC (2019b) inspection evidence appendix provides some quantitative data about aspects of care and treatment that relate to its key lines of enquiry in mental health units where many patients are not there voluntarily but are being cared for on the grounds of their safety and urgent needs for care (some of whom have histories of homelessness as mentioned above). These include reports on the numbers of patients who were placed in seclusion if judged to be at severe risk of harm or of causing harm which were very few at the Gordon (none in Ebury and Vincent wards) (page 47). In terms of the use of restraints, again indicative of the high levels of distress among people who are in-patients, the numbers of such incidents over the period 1 October 2017 and 30 September 2018 were 32 on Vincent, 52 on Ebury and 39 on Gerrard. However, the CQC noted that it was difficult to avoid 'prone' restraints because of space problems on the wards; The CQC observed that the minutes of the bed management meeting in December 2018 had recognised this and the patient

safety team would be advising staff about resuscitation and restraint in the escalation rooms. As is the case nationally, CNWL has regarded prone restraints as unsafe and introduced Safety Pods in 2021 (equipment to support safe patient care when de-escalation and restraint is being considered) to increase the safety of restraint where necessary (CNWL 2021a; see also Bleetman and Lifshitz (2022) on their clinical effectiveness).

The CQC also examined case notes and records which are further indications of quality of care. It found that, while most were appropriate, some care plans lacked detail, were not recovery orientated, and not sufficiently reviewed (page 59). Most care plans also did not contain patients' views (page 71) and some patient observations were '*tick box exercises*'. On Ebury ward, the *ad hoc* nature of ward rounds made it difficult for team members to attend (page 63). Some legal requirements under the Mental Health Act had not been completed (page 63). Some risk assessments were out of date (page 45). The CQC (2019) reported that the main concerns about care at the Gordon Hospital raised by the manager of the local advocacy service were problems with leave and communications (page 69), however we could not find more on this subject.

CNWL has stated that these problems were addressed at several levels. Going forward, both WCC and RBKC would be happy to work with the Trust in quality improvement. Of course, questions about practice need attention whatever the location.

References to an 'incident' at the Gordon were mentioned by the CQC nearly a decade ago. To put this in a wider context, when a patient, detained under the Mental Health Act 1983, leaves the hospital grounds without the permission of their Responsible Clinician this presents risks (often referred to as being Absent Without Leave – AWOL). According to CNWL, in 2015 the Gordon Hospital Management Team had worked effectively with the local Metropolitan Police (Westminster and Belgravia) to consider the physical Hospital environment in response to AWOL risks (CNWL 2015). Work undertaken included the removal of push buttons on main doors to the ward; increased strength of locks, replacement of break glass fire points (these opened doors that exited the ward and were misused by some patients) with turn-key points, increased staffing and installation of internal doors to improve security. This effective local inter-agency working at the time led to a significant decline in the number of AWOLs (CNWL 2015 page 5).

The later CQC (2019) inspection made some criticisms of safety at the Gordon Hospital noting that policies were not always being followed (page 32), such as the policy relating to escalation room usage and found in its follow up visit that escalation rooms were still not in use (page 33). It observed that national policy of eliminating mixed accommodation was still not being complied with on Gerrard and Vincent wards but noted in its return or follow up visit that the use of 'flexible bedrooms' had been discontinued. There were gaps in the records of equipment checks (page 35) and some items were broken or missing. Bedrooms on two wards at the Gordon Hospital were too small for safe use by patients in distress (CQC 2019 page 8).

There are a few references to an incident that occurred at the Gordon in 2019 after the CQC's first visit. According to the CQC (2019 page 15) report this was a 'serious incident' where a patient attacked a member of staff. The Trust was reported to have voluntarily closed the Gordon to in-patient admissions while investigating this incident. The length of time of this closure is not reported by CQC but it noted:

> The site where there were the most concerns was at the Gordon Hospital where there had been a serious safeguarding incident. The trust was aware that this service needed additional leadership support and had put this into place. (CQC inspection report 2019 page 44).

An incident mentioned in the CQC report (page 45) concerned a patient who had been on leave and returned to the Hospital with a prohibited item. The CQC noted that there had been an immediate investigation and that 'lessons learned' about processes such as searching had been shared. It is not clear if these were the same incident. Such incidents highlight the severity of distress among many people legally detained on in-patient wards, potentially affecting the safety of both patients and staff, but also the risks facing community services who may be unable to conduct searches or adopt other risk management approaches.

Other safety considerations relate to the risk of crime and indicate how learning can and did take place when local agencies, including the in-patient service at the Gordon Hospital, worked together. In 2015 the Gordon Hospital was generating high numbers of calls to its nearby Belgravia Police Station. Working with the police and CNWL's Health and Safety Team the Gordon Hospital Management Team held patient forums and staff meetings to develop ways to manage such incidents. Through this work and through regular meetings with local police officers the Hospital staff reduced their calls to the Police. In June 2015 the local police reported a complete absence of MOPAC 7 crimes (Violence with injury, robbery, theft from people, criminal damage, burglary, theft of motor vehicles and theft from motor vehicles) and violent crime related to the hospital (CNWL 2015 page 6).

There are many indications from those spoken to for the purposes of this report that the Gordon Hospital was performing well and that CNWL was mostly managing it effectively – while there were problems, these were being addressed with involvement of local agencies where needed. The re-opening of any in-patient facility or accommodation would need to address future safety requirements but the positive experience of local agency partnerships is likely to stand this in good stead.

The level of safety incidents and avoidable harms is often high in mental health services (and examples of them at St Charles reflect a similar pattern, for instance, a Regulation 28 Report to prevent future deaths was issued in 2022 in respect of St Charles, CNWL 2022a). In-patient provision can manage these expertly in ways that other services often cannot and with legal safeguards that are not available to many other providers thus upholding individual human rights as well as public safety. The point made by CNWL (2023d) that there are substantial security issues to address does not seem to have been clarified to any extent and was not evident in responses collated by the ICB in the appendices supporting its option appraisal (CNWL 2023a).

Turning to a further related subject, while the ward or hospital environment matters, mental health care and treatment for people in great distress or at substantial risk of harm rely for their effectiveness on **staff** skills, values and attitudes. Therefore, this section focuses on staffing at the Gordon in-patient services **before its closure.** For example, the CQC (2019) addresses the subject of medical cover and expressed some concern at lack of medical cover on Vincent ward (page 43). The CQC advised:

> The trust should continue their recruitment processes to ensure adequate medical cover at the Gordon Hospital. (page 17)

In relation to other staff employed to work in the in-patient units, such as nurses, the CQC considered the Gordon staffing to substantially reflect the staffing profile at CNWL's St Charles Hospital and the Trust's other provision (page 37). It noted that only 4 of the 11 nurses on Vincent ward were on permanent contracts. It was positive in observing that the Gordon was not using external agency staff to cover vacancies but its own bank staff, with staff commonly working extra

hours to ensure staff were present. While bank staff use could cause problems, such as permanent staff having to cancel leave or training to work extra hours, it is evident that staff were willing to contribute to the service and continuity of care was somewhat protected as far as it could be in the context of staff shortages which is of course never a satisfactory state of affairs in any service.

The CQC found that Gordon Hospital staff were not leaving the Trust's employment any more often than elsewhere (page 41), noting that leaving rates were 18% on Vincent ward, 7% at Ebury and 4% at Gerrard. Similarly, sickness rates were not higher than expected, standing at 8.9% at Vincent, 3.8% at Ebury and 7.4% on Gerrard wards (the average sickness for permanent staff over the past year).

Overall feedback given to the CQC was that the hospital staff were **kind, respectful and caring** (page 69). Even with the high turnover of patients, staff were seen to take time to get to know patients. Such views reflected the opinions collected in 2021 by Healthwatch Central West London in its CNWL-commissioned VOICE Exchange project although there were greater emphases on deficiencies at times in compassion and empathy:

> Continuity and consistency during every stage of an experience is key to supporting people, especially when admitted to an inpatient ward (Healthwatch Central West London 2021 page 5).

VOICE Exchange participants expressed some concerns about staff welfare generally. Indications of good staff management, as measured by the completion of annual appraisals at the Gordon, were reported to vary by the CQC, standing at 44% in Vincent, 100% in Ebury and 89% in Gerrard wards.

CNWL has supported its Healthcare Assistants to develop as qualified nurses through its Nursing Associate programme with 30 graduating in 2023. These are valued investments in local people and encouraging of people with non-traditional education experiences to join professions working locally. WCC and RBKC could help any new provision at the Gordon and the existing provision at St Charles offer access to such career developments and could link up Further Education provision to such initiatives. As noted, WWC councillors have expressed concern about the impact of loss of local jobs owing to the closure of the Hospital's in-patient beds and to this should also be added risks of diminished job opportunities and career development (City of Westminster 2022).

A core element of in-patient care is access to medical expertise, in addition to the nurses and therapists as well as the support staff and any peer workers (experts by experience holding paid support roles). Prior to the CQC inspection, a review of CNWL provision for its psychiatry and general psychiatry medical trainees was undertaken following the findings of the 2018 General Medical Council (GMC) National Training Survey that had identified trainees' concerns about their training on these subjects. A team from Health Education England (HEE) (2018) identified three areas of serious concern. These were passed to the Trust's management team within 24 hours for urgent action and CNWL notes that the situation was under enhanced monitoring by HEE up until March 2020 when the wards closed E22. Several areas mentioned by HEE covered all CNWL provision for its trainees in this speciality, but specific to the Gordon Hospital they included concerns relating to:

> Patient and staff safety at the Section 136 units at The Gordon Hospital and the Park Royal Centre for Mental Health required urgent review. HEE was aware that the new Section 136 suites at the St Charles Hospital had been completed but only one was operational at the time of the review. (page 2)

Section 136 provision is covered below. CNWL has not reported to WCC or RBKC any continuing problems with trainees' experiences relevant to the care of local residents.

Staffing at the Gordon Hospital in-patient wards was therefore not a major problem compared to other CNWL services as far as WCC and RBKC have been made aware and was not cited by CNWL as the main reason for temporary closure of the wards in March 2020 although CNWL has noted that cross cover of staff in fewer wards while staff were absent from work with Covid-19 was a reason for closure The use of bank rather than agency nursing staff provided patients with better continuity of care than the use of agency workers, though of course bank working can place stresses on staff. For WCC staff this enhanced inter-agency working and communications. Excellent transport by train, tube and bus links presumably help staffing. WCC provides substantial support for key worker housing and this may be a further attraction. A major adult education services is close to the Gordon Hospital, opening up a range of courses to staff beyond that of CNWL and the NHS. A large sports centre is currently very close providing a further resource for staff taking a break or after work (with possible plans for re-development of the site) G35. The Hospital provided '**good work**' opportunities within the NHS to local residents in support roles, facilities, catering and domestic work on the in-patient wards. While St Charles Hospital is in an urban location its transport links are not as multiple and varied as those of the Gordon Hospital site.

The provision of clinical expertise at the Gordon would need to be addressed in any refurbishment. Councils may be well placed to help support the professional development of such staff through multi-disciplinary, shared, continuing professional development. They could engage with CNWL about investment in roles such as Approved Clinicians and Responsible Clinicians which can be taken on by social workers as well as other professionals to improve relevant staffing pressures. So far, other professionals have not been engaged in such developments other than one nurse at St Charles becoming an Approved Clinician so there seems more potential here.

As noted at the start of this report the closure of the three wards containing the acute in-patient beds is of interest but the hospital building in terms of patient bed capacity itself used to be larger than these wards. The Section 136 Suite at the Gordon Hospital was intended to provide a local place of safety for people requiring assessment under Sections 135 and 136 of the Mental Health Act 1983 (CNWL 2015). Following concerns from the Royal College of Psychiatrists (2013) that this did not meet the requirement under the Code of Practice for the Act or Guidance, the CQC (2014) also highlighted this as needing improvement. Evidently CNWL had already identified this on its annual estates work programme and had allocated capital funds to improve the suite. The Gordon Hospital Management Team and estates colleagues worked with the Metropolitan Police and British Transport Police on the design plans to ensure the space created would work for both CNWL and the two police services. The refurbished suite conformed to the recommendations of the Code of Practice and the Royal College of Psychiatry guidance. This includes a separate entrance into the suite (from Vincent Square) (still in existence), one of the two assessment rooms having an *en suite* toilet for people who require assistance, CCTV cover, two doors into each assessment room and an improved waiting area for friend and relatives. The CQC (2015) had noted other safety concerns in CNWL's Place of Safety provision which were addressed rapidly.

This tale of refurbishment and improved provision was welcome to those contributing to the report although as noted, the Section 136 provision was moved to St Charles in 2019. It demonstrated to them the ability to adapt and improve the building's physical features and CNWL's previous valued investment in the site and adjacent offices. For CNWL the problem remains that the building cannot be adapted, while changes may be made internally (with possible disruption to neighbours) it feels it would not be able to make any changes to the outside of the building (discussions with Westminster City Council over this might be helpful here).

The South Westminster Home Treatment Team (HTT) was reconfigured as CNWL's Westminster Home Treatment Rapid Response Team and is based in offices at the Gordon Hospital. The role of this HTT team is to try to avoid admission to a mental health inpatient ward by providing intensive support to people in acute mental crisis in their homes on referral from other staff in CNWL. The CNWL Crisis House (5 beds) in Paddington was under the responsibility of this HTT but, as noted, closed in October 2023 (a further 6 bed CNWL crisis house is in Hillingdon but only accepts referrals of people from that area).

6 The closure of Gordon Hospital's acute in-patient beds

In March 2020, the three in-patient wards at the Gordon Hospital were temporarily closed in what CNWL described as part of its COVID-19 response primarily due to serious concerns regarding infection control in the building (an example of the difficulty was lack of *en-suite* bathrooms), along with a need for rapid flexibility of service provision to support mental health care during the pandemic. The enhanced vulnerability of patients to the virus when staying at the Gordon owing to them being in confined spaces was also given as a reason by the Trust (CNWL 2022b). In the context of the level 4 emergency status caused by COVID-19 and its impact, CNWL stated it had been necessary to make the closure of beds decision rapidly and so it was not able to fully consult with local partners as would be normal practice (CNWL 2021b). The Hospital functioned as a vaccination site during the pandemic (CNWL 2022b).

What happened when the in-patient service shut in 2020? According to CNWL (CNWL 2022c) from1 April 2020 until 2022, 931 in-patient admissions of Westminster residents took place with most (61%) going to St Charles. Over the last 12 months admissions to acute adult inpatient beds were approximately 7 per week in January 2022, compared to 9 per week in November 2021 and 10 per week in September 2021. Most (90%) Westminster admissions were to the North West London (NWL) system, as was the case pre-Gordon acute in-patient bed closure (leaving 10% out of North West London area).

Use of any beds outside CNWL area was managed via block contracted beds. Since January 2021, most Westminster patients (75%) requiring this type of bed have been placed within that block contract at considerable distance from WCC (located in Milton Keynes, Hertfordshire, and Surrey). Such use of beds outside CNWL (Out of Area Placements or OOAs) is described as a last resort (9%), with priority given to patients with fewer connections to Westminster for these beds (e.g. foreign nationals). NHS England also arranged contracts for beds in Enfield although these were not in the end used by CNWL.

CNWL reported a continued reduced Length of Stay among patients of its mental health bed provision during the pandemic, with an average of 29 days for the period Nov-Dec 2021, compared to 36 days for 2019-2020 financial year. This was a further reduction from the average in November 2021, when the average Length of Stay was 33 days and September 2021 when the average was 35 days. More recently, there have been small in-month peaks in Length of Stay. Since the start of June 2021, 70 'long-stayers' (with an acute or PICU admission of over 60 days) have been discharged and more details of this were supplied by CNWL in its pre-consultation business case of 2023.

Analysis by CNWL2021b), addressed the protected characteristics thought most likely to be systematically impacted by the closure of the Gordon Hospital's acute in-patient beds: namely race/ethnicity and gender. They found no disproportionate negative impact to these groups in respect of Out of Area placements and readmissions (page 4). They noted the percentage of admitted Westminster patients who identify as male had reduced to 58% in 2020 (it is not clear what

are the actual numbers). However, during what proved to be a temporary release from many pandemic restrictions in August -September 2020, demand for acute mental health beds grew across London. To meet this heightened demand for beds at the time CNWL accessed some private provision (as Extra Contractual Referrals), stating:

> We know this is not ideal and occasionally we have had to place patients further away than we would have wished, but at the time our concern has been safety and care (CNWL 2021b page 5).

At other times, about 70% of Westminster residents needing in-patient mental health care were admitted to St Charles Hospital (see below). Beyond that between 5 to 10 patients were admitted over the last months of 2020 to outer borough beds (page 5). CNWL's (2021b) report is a strong indication that by the end of 2020 CNWL was not considering the closure of the Gordon Hospital's in-patient acute beds as temporary but a route to consolidating in-patient care at St Charles:

> If admission is needed, it will be purposeful and in a therapeutic environment with dedicated identified beds within the NWL system for KCW patients, including building on existing bi-borough co-location of beds at St Charles. Long-term, we want this consolidation to be within modernised facilities that enhance the delivery of high-quality treatment. (CNWL 2021b page 7)

As part of its general consultation work on mental health in 2022, CNWL commissioned the local Healthwatch to run a series of conversations with various individuals and groups (numbering 84 people in total). This Healthwatch report includes a small number of mentions of the closure of the Gordon Hospital's in-patient beds, but it is not clear if these were from former patients. The subject of its closure was also raised at two information days held for members of the local Citizens' Panel (each member had direct experience of inpatient care within the past three years) and a Deliberation Group that received minutes of the meetings of the Citizens' Panel and set them in a wider context (Healthwatch Central North West London 2022, page 7).

By 2023 the Hospital's in-patient beds remained closed, leading to more questions about CNWL's apparent change of policy from a temporary closure to permanent one. In addition to matters raised at local council level in both WCC and (RBKC (see below), an article in the *Health Service Journal's* section London Eye (Clover 2023) queried this change:

> One mental health trust seems to be keeping a 51-bed inpatient facility closed, in order to abide by social distancing rules which everyone has stopped bothering with. Central and North West London Foundation Trust has asked London Eye to be clear that is not to do with the potential commercial value of the land in Pimlico. The Gordon Hospital was assessed as having a "residual value" of between £18m and £22m by the trust's estates team in 2021, the trust confirmed…
>
> No one thinks the Gordon was ideal — like much MH estate it was designed for something else — but it seems bizarre to close NHS facilities which are in such demand…
>
> The trust plans to consult on the future of the facility in the summer. But given its confirmation that staff were "permanently redeployed into other services" and that "we have concentrated on improving service quality and community services rather than just accepting inadequate facilities" – you have to wonder what the options put to the public will be.

CNWL presented 4 papers to Westminster City Council's (WCC) Policy and Scrutiny Committee – in October 2020, April 2021, June 2021, and September 2021. It has been continuing discussions and meetings across 2022-24.

The paper presented in September 2021 (CNWL 2021c) was described as part of a pre-consultation period. It set out the national policy context and outlined growth in community-based provision. (A separate paper presented to WCC summarises CNWL's community provision and is not repeated here, CNWL 2021d.) Statistics were provided on 'key metrics' and the development of **community mental health services** as being promoted and funded by NHS England. Such community provision is described as enabling greater prevention of needs escalating to very severe levels and also as providing an alternative to in-patient services both as admission avoidance and as part of earlier discharge from hospital so avoiding delay when a person is clinically fit to be discharged safely. These initiatives involve several different developments; some related to mental health, others related to people with physical and mental health needs including those that are social in origin or impact. Some are North Westminster specific.

For example, mention was made by CNWL of the development of a service for people described as **High Intensity Users (HIU)**, frequently defined as minimum 5 times per year–- attenders at local acute hospital A&E departments (CNWL 2021b). The Westminster High Intensity Care Hub (WHICH) is described as a population health approach to providing support and guidance to High Intensity Users of NHS emergency services. Initially running as a 12-month pilot aiming to reduce frequency of attendances in the RBKC & North Westminster, this is presently a two-year project providing 'community alternatives' to A&E, by working with Community Champions and Wellbeing Coaches (WBC) in North Westminster (Westminster High Intensity User Hub 2023). In April 2021 CNWL also contracted with British Red Cross to include those patients considered to be a HIU risk or of unmet needs if support is not provided quickly (CNWL 2021c). This was reported to be a pilot programme of the RightCare approach with CNWL describing the rationale for this pilot thus:

> We know that frequent attendances can be an indication of unmet social needs. The team, therefore, take on a social prescribing, non-stigmatising approach, working closely with the individual and people involved in their care in ways that traditional services may not be able to. (page 8)

However, while this pilot is longer running as it did previously according to some staff at St Mary's the overall HIU service (covering all adults and patient groups) is still currently operating through the British Red Cross and has had a positive evaluation (Chisambi et al 2021). Hospital staff noted that funding for one of their staff members to work in the Emergency Department had regrettably been cut. Moreover, the Turning Point (alcohol) service, which is not provided by CNWL, at St Mary's is only for patients from Charing Cross Hospital and does not provide a weekend service.

Separately, and of course probably related to shorter Length of Stay, 47 people were discharged from inpatient provision over the first year or so to CNWL's new **Step Down service (and presumably the 5 bed pilot Crisis Recovery House** – see below). CNWL noted:

> This shows positive work against the principles of least restrictive setting and care in the community, but also the need to work collaboratively to ensure timely access to placements for complex needs.

In March 2022, CNWL opened a pilot Crisis Recovery House in North Westminster (Paddington) to provide 24/7 supported accommodation (support worker on site 24/7 provided by a for-profit agency, LifeCome Care run by Lifecome Limited, a domiciliary care agency mainly working in the

Borough of Lambeth) and support workers employed by the voluntary sector organisation Hestia) for five patients without a home to go to. The House was run under CNWL's Home Treatment Team (HTT) who provided clinical and service management, similar to its other Step Down provision (see below). It provided temporary (maximum 12 weeks stay) alternatives to in-patient care in RBKC and WCC, offering a bridge between hospital and (a yet to be arranged) home. This Crisis Recovery House was part of CNWL's Community Access Service –at one time encompassing three separate services:

> - The Crisis Recovery House, a pilot managed by the HTT that only accepted referrals from acute inpatient services. Its exclusion criteria included patients needing a forensic placement; having complex physical health, mobility or drug and alcohol issues; or who already had a tenancy (CNWL 2022c). It was described as a 12-month pilot but its closure announced in October 2023 was evidently to the surprise of some in WCC.
>
> - The Community Access Service, ward staff who help address social barriers to discharge from the point of someone's admission to an in-patient service.
>
> - Step Down, accommodation to support discharge of people who are clinically ready for discharge but have housing problems – such as needing access to supported housing and accommodation needing a deep clean. There are currently seven NHS Step-Down accommodations across the North West London boroughs including Brent, Harrow, Hillingdon, Westminster and areas of Battersea.

Prior to the closure of the North Westminster Crisis Recovery House, in January 2022 CNWL had mentioned:

> … exploring options for a new crisis house in Westminster and additional services in the South of the borough to support a providing care closer to home and a holistic community-based offer for residents, which will be developed through ongoing engagement with the Westminster Partnership Forum. (CNWL 2022c).

This had been raised in discussions with WCC in January 2022 (CNWL 2022c), but according to WCC and other staff there is, at the time of writing, no plan for a Crisis House in South Westminster which CNWL ascribed to unable to find a building that could house this (and being the reason why the pilot Paddington location was chosen). Some WCC staff familiar with this provision commented that such provision had not been generally working effectively with other services, for example, WCC was not regularly informed when people left the Crisis House or the on-going CNWL Step Down service, and the closure of the Crisis House, without apparent system engagement, appeared to them to confirm this position. There was a view among some of those consulted for this report that the closure of this facility was due to financial problems and regret that there did not appear to have been communication about this decision.

It should be noted that in Westminster there is Step Down provision funded by WCC that is part of mental health clusters or hubs in localities. These council funded hubs provide support if needed and generally are staffed by key workers who take part in regular meetings to assist recovery although they are not mental health clinicians. However, service effectiveness is sometimes threatened by what some of their staff describe as premature discharge from hospital, and a lack of engagement by CNWL ward staff about discharge decisions and no involvement in care planning (Section 117 plans). Premature discharge may mean treatment is not optimal and can lead to a long series of multiple unplanned admissions, with staff speaking of some incidents of restraint, notwithstanding the recent provisions in the Mental Health Units (Use of Force Act) 2018, also known as 'Seni's Law', which came into force at the end of March 2022. In addition to WCC's extensive supported housing for

people with mental health problems (about half of whom have rough sleeping experiences), WCC's refugee/asylum seekers' services pathway also needs mental health support. 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. WCC staff report trying to work collaboratively over such problems such as premature discharge rather than resorting to raising safeguarding concerns.

Other stress points are in local hostels, some of whose staff also say they also are not always consulted about discharges and who feel that the closure of the Gordon's in-patient acute beds continues to have a negative impact on their work and the welfare of their residents. There is well developed hostel provision in WCC and RBKC, mainly provided by experienced voluntary sector agencies, but they too are under pressure and many voluntary sector groups, like MIND, say that they wish to focus more on prevention of mental ill health and distress.

CNWL funds the voluntary sector organisation Hestia (a mental health/domestic abuse charity) to provide a 365 day drop-in service (open 2-10pm) in Paddington, **the KCW Cove,** which residents of both boroughs can visit if they are experiencing a mental health crisis (https://www.hestia.org/kensington-chelsea-and-westminster-crisis-cove). This service offers **non-clinical** services in the form of 'support, signposting, practical advice and coping techniques (CNWL 2021c), to people experiencing a crisis or mental distress, following assessment by CNWL staff. WCC has not seen details of the service's outcomes or any evaluation but observes that this welcome provision is helpfully part of community services.

As noted above, the **South Westminster Community Mental Health Hub** is located on the same road as the Gordon Hospital. This brings together a together a range of healthcare professionals who have specialist skills in working with people who have mental health problems to support people in their own homes or in other settings (operating five days a week). This is similar to North Westminster Community Mental Health Hub which is based in the North Westminster area close to St Charles Hospital.

Overall, NHS Step Down and Crisis House services can help in reducing delayed discharge from hospital and offering support post-discharge but the decision-making around the closure of the pilot Crisis Recovery House in North Westminster could be shared to explore evidence of its cost-effectiveness, and its system wide implications. What were the implications of the exclusion criteria and time limits for the Crisis Recovery House, what were the care outcomes for the service, and how stable/effective were the staffing arrangements? Could WCC and other stakeholders have been better informed about CNWL thinking and plans?

The implications of decreased Length of Stay in hospitals or alternatively delayed admissions may be increasing the acuity of the small number of people needing inpatient care and treatment. There could be more discussion about these factors. Local professionals have expressed their substantial concerns about premature discharge as a result of bed pressures and this risk needs to be addressed. One patient advocacy group that provides some community services regretted the lack of engagement from CNWL over matters such as discharge planning giving rise to some 'out of the blue' discharges late on a Friday and the ways in which local people who were moved to hospitals away from Westminster quickly lost touch with their supported housing provider. In their experience, the MHCAS could be chaotic and traumatising for some people, although they recognised experiences of it varied.

Both the Crisis House in Paddington (until its closure) and the Cove were staffed by non-professionals with CNWL providing specialist support. They do not appear to have been working with people who are currently or potentially subject to compulsory assessment and treatment under the Mental Health Act 1983 or to Community Treatment Orders, for example. While potentially a valued part of the spectrum of mental health services such provision lacks the legal authority central to in-patient care and treatment which offers safeguards as well as safety for individuals and the wider public. It may be helpful to hear more of the regulation and oversight of these services run and staffed by voluntary sector and private providers. It was interesting to see the Cove described as (CNWL 2023a Appendix 16, page 16) as 'a non-medicalised crisis alternative' in its list of 'key' interventions to reduce admissions. It is evidence that the alternatives are only for those people who are able to receive care in a less restrictive setting and are intended to only admit people when this is the most appropriate option for care.

CNWL (2023a, Appendix 7) also mentions its plans to develop a further new community hub – Hope in the Community - in partnership with voluntary and community sector in Westminster. '*The hub will have open access for all with a focus on equalities groups including homeless people'* (para 8.2) as a means to address possible inequalities arising from the proposed changes. It is not clear how far these plans included local councils or fit with other system wide provision for people who are homeless or others. Drawing on the website information for this 'hub' this will be a non-clinical resource for about a three-month period, run by CNWL in a non-clinical part of the Gordon Hospital premises:

> From February 2024, this non-clinical haven will offer non-profit organisations a free space to host services, activities, and groups, revolving around the pillars of learning, social prescribing, and community support. The space is designed for groups and organisations to make short bookings (approx. 2-4 hours) with slots available on a rotating basis. The space is able to accommodate 30 seated attendees and will operate from February 2024 to May 2024, Monday to Saturday, with three available slots per day (morning, afternoon and evening). (Chasing the Stigma 2024)

One example of this is the weekly coffee morning promoting all aspects of health and wellbeing that recently started on Tuesday mornings (from 12 March 2024) at the Gordon Hospital and is run by the Abbey Centre, a local community centre. The councils look forward to hearing of such developments and any evaluation.

From a **patient perspective,** Healthwatch Kensington & Chelsea's and Healthwatch Westminster's (2023b) visits to St Charles Hospital in April 2023 also attempted to explore how the closure of the mental health inpatient wards at the Gordon Hospital had affected patients receiving visitors, among other lines of enquiry at the St Charles' service. It was able to hear from three relatives who reported difficulties visiting but only one was from Westminster, another from Brent and a further one from outside London (page 10). What was of greater interest to WCC and RBKC was Healthwatch members' views on patients being moved within CNWL services which could be far from home and local connections:

> We are aware that if the acute wards are full at St Charles, patients will be allocated a bed where there is a space across the whole of CNWL. We felt that in order to really understand what impact of the closure of the Gordon Hospital is, there needs to be an audit across all the wards in CNWL (Healthwatch 2023b).

This Healthwatch report presents a series of other observations related to St Charles including its views that staff numbers were 'in crisis' (page 6) and that cleanliness, attention to repairs, provision and quality of activities, communications with patients, and staff attitudes could all be improved.

Concern was also expressed by council and other staff about current pressures on the **Mental Health Crisis Assessment Service (MHCAS)** at St Charles, some of which they viewed as related to the closure of Gordon Hospital's in-patient beds although the MHCAS was open when the Gordon was already closed so such pressures would not seem directly attributable to the closure. This provision at St Charles Hospital seems to some professionals to operate as a 'grey area' in which the legality of patients' position is unclear, there is limited therapeutic input and time in this setting is far longer than optimal. For example, the use of **Assessment Lounges** (as mentioned by CNWL 2021c) or Bed Management Lounges is considered by some as a grey area legally. This type of provision has been developing in parts of England for people who may be distressed in A&E but do not appear to be physically unwell. It was described by CNWL (2021c) as:

> Currently a pilot, this service area provides an alternative assessment space for informal patients presenting with mental health crises who might require a bed, in order to reduce the demand on the capacity of acute trust EDs. This ensures all potential admissions to acute inpatient beds meet the threshold of there being no realistic alternative, with admission preventing an imminent risk to self or others. (page 4)

Findings from the evaluation of this pilot are sadly not in the public domain and have not been shared with the councils although CNWL has reported that it has shared them with the ICS. Offering patients reclining chairs or mattresses in the presence of staff who are on duty round the clock, in separate rooms, individuals are not legally being detained or admitted to hospital. For some people this may be temporary and indeed the time in the Lounge may be a welcome time for some recovery, but for others they are an indeterminate waiting area for assessments followed by lawful admission in the case of people who refuse assessment or treatment via an in-patient admission. In other contexts, the impact on hospitals who take on work following a nearby hospital closure is described as 'speed up' behaviour:

> When faced with increased demand due to such closure, remaining hospitals in the market tend to respond by a "speed-up" behavior: they increase their service speed and spend less time per patient (on average), instead of accommodating the additional demand by reducing their bed idle times. Speed-up behavior can harm care quality, as it entails cutting some necessary and value-added care steps. (Saghafian, Song and Raja 2022)

CNWL has reported that it does not intend this provision to be in the form of armchairs should it move, as it would like, to the Gordon Hospital site following consultation. This does not address the legal uncertainties referred to above and for individuals the situation could be particularly confusing. In terms of staffing, CNWL has noted that staffing levels would be similar to that of an in-patient ward. While there are beds in St Charles Hospital, the MHCAS has been designed as an alternative to A&E not a waiting area.

This present report touches upon the background to the closure of the acute in-patient beds at the Gordon Hospital but notes that Healthwatch does not suggest that the service at St Charles Hospital is superior in quality to that of the previous Gordon in-patient service (Healthwatch 2023a). There is wide understand of the resource pressures on mental health services, many of which are long-standing, and CNWL's attempts at quality improvement and wider services in the community. There is no need for unnecessary comparisons of quality but honest discussions can assist about the

difficulties of providing local in-patient care to high standards within challenging contexts. **Of particular concern to many who contributed to this report is the role being played by the MHCAS initiatives and the use of Assessment Lounges as a 'holding bay' in which the impact of lack of beds is submerged. There could be greater clarity on the usage and development of these. Is the one-year pilot mentioned in 2021 continuing? All agencies need to be involved in such debates and decisions, including raising the risks of premature discharge as noted above.** At the time of the final draft of this report, CNWL reports that the 'conversion rate' of admission to an inpatient service from the MHCAS is 19% which, for CNWL, indicates strongly that most people are staying there to later move on to receive treatment and care in the community rather than being held there while waiting for a bed.

Also recently, as part of CNWL's Preparation for Consultation over its announced plans to permanently close the Gordon Hospital for in-patient acute services, CNWL's ran six workshops during which its emerging options appraisal care model (as in 18 April 2023) was presented. By 21 September 2023 this had been further revised (see below, CNWL 2023e) as essentially:

A Keep open wards at St Charles and Gordon Hospitals and close community services

B Confirm the move to St Charles of all Gordon Hospital in-patient beds

C Move the MHCAS to the Gordon and have 4 assessment beds

D Keep 12 beds open at the Gordon.

By October 2023 these Options had been reduced to three, as noted above (CNWL 2023a).

It may be helpful to set out possible principles to inform thinking behind any response to these options:

- The quality of mental health care should be good enough for ourselves and those we love.
- Mental illness should have parity with physical ill health.
- In-patient care and treatment are best for assisting recovery for some people at some times but a broad range of least restrictive care options, care close to home, and services that are linked with each other should underpin this.
- In-patient care is a necessary part of a spectrum of treatment, care, support and prevention that involves wider society, families, friends and communities. Local authorities have a key role in all aspects of mental wellbeing.
- It is widely acknowledged that mental health services have sometimes been coercive, poor quality, discriminatory, and stigmatising. They have often been poorly resourced and not treated their own staff well, or patients' families and carers, or people of all ages. A human rights approach, respectful of all stakeholders, will help keep individuals at the heart of a shared vision for good mental health.

With these in mind, there has been a huge reduction of in-patient services in the WCC area over the years, with closures of St Mary's provision and the Gordon Hospital's beds, and substantial growth in local council, voluntary sector provision, and joined up work with all parts of the NHS on community services in WCC and RBKC areas. While the increase in primary care capacity has not been calculated to the best of the councils' knowledge, CNWL has increased its secondary care community and community-based crisis services.

However, the huge real estate investment of Gordon Hospital is a substantial resource and there are few such buildings in which in-patient services could be provided in the locality. The building is in an area of great and rising need. It has every chance of being the local asset or anchor institution so much desired by place-based working both as a community resource but also if needed for other purposes. It would appear well set to make a reality of care for people voluntarily or otherwise staying in an in-patient service being close to home and working with other local services that are expert in supporting vulnerable people. Refurbishment to some degree could be possible and desirable. The impact on St Charles Hospital of providing -in-patient acute services to Westminster as well as RBKC residents could be to compound its present major pressures and safety risks leaving it less able to act as a local resource.

In respect of inequalities and inequities, mental health provision has been strongly criticised at national levels for lack of quality in numerous respects. These include problems with access and treatment but also on the lack of priority given to addressing the links between deprivation and ill-health. Particular problems have been identified in respect of services to people with lived experience of homelessness, people from many minority ethnic groups, and people experiencing socio-economic deprivation. CNWL's (2023a Appendix 7) presents an Equality Impact Assessment.

Within Appendix 7 lies mention of a report commissioned by CNWL (Rioga et al 2021) which is included in the CNWL consultation (CNWL 2023a) as Appendix 10. This report only covers the qualitative component of a mixed methods service evaluation (interviews and focus groups with patients and carers) and the full evaluation is not available publicly. This report identifies themes common to other studies that involvement with mental health services is often precipitated by crisis, that fear and mistrust underpin some reluctance to access services earlier, and that in-patient services can be experienced as punitive and unsafe. Other studies comparing Black Caribbean populations with White British counterparts with experience of admission to mental health services (in this instance severe psychosis) have similarly found:

> Against a background of entrenched social and economic disempowerment, services were experienced as disempowering by many black Caribbean people, compounding and perpetuating a sense of alienation. (Lawrence et al 2021)

It is not clear that locating a MHCAS solely at the Gordon would address this position; with the uncertainty of the provision, its possibility of beds or not, and possible additional moves to St Charles, if longer assessment or treatment is proposed. For families this would not appear particularly supportive in enabling them also to build relationships with staff.

CNWL's preferred option (CNWL 2023a) proposes moving the MHCAS to the Gordon Hospital and having 4 assessment beds for possible overnight stays, with the refurbishment that this would require as well as new continued staffing. As noted above, there are difficulties in the 'grey' area of the law here but importantly there are questions about the implications for continuity of care, the patient pathway, and what can be provided therapeutically in this uncertainty. In October 2023, CNWL's three senior medical practitioners stated in their case for choosing Option 3:

> There will continue to be a need to provide inpatient services for those people with the most acute needs, and we will always endeavour to ensure that these are provided in a timely manner, as close to a person's home as possible (CNWL 2023a Appendix 15).

However, this essentially refers to keeping St Charles as the in-patient option, which is not as 'close as possible' to the homes of WCC residents. Indeed, some RBKC residents could be taken to the Gordon for any MHCAS temporary stay and thereafter to St Charles, as currently (early 2024) 20% of

people in the MHCAS resource are then moved to in-patient provision. Having temporary provision at the Gordon would not provide in-patient care and treatment other than in an emergency. This letter mentioned that local council staff had been consulted about the proposed consultation but did not report their views. From the conversations held as part of this report several local council staff do not support the closure or MHCAS move.

As other clinical (medical consultant) opinion collated by CNWL found (CNWL 2023a) there is concern about people with homelessness' experiences in the Westminster area and a sense that they were committed to addressing this important need as well as other inequalities particularly those affecting 'invisible' women. The implications of this collation of views, undertaken by their employer (CNWL 2023a Appendix 14), are that there are reservations about the proposed final options.

Overall, re-engineering of the Gordon Hospital in-patient wards as an emergency MHCAS would not maintain provision in an under-served area of substantial inequalities, and overlooks the potential to provide more linked up services with other NHS provision in primary care, supported housing, and social care, and the voluntary, community and faith services that are active in the locality. The MHCAS service might provide compassionate, respectful, dignified care for those in greatest distress but we lack evidence of this, since any stay there would be temporary by necessity, entail substantial uncertainties, and not close to home for RBKC residents.

Those interviewed from WCC and RBKC had wished to shape ideas more fully at pre-consultation stage. Staff and local councillors took part in the CNWL pre-consultation workshops but would have welcomed greater, earlier engagement in developing the agenda and options and of scrutinising the detail behind the options. Many regret the initial lack of consultation or information at the original closure; and contrast this to their recollections of substantial engagement between themselves and many other agencies, including NHS primary care, at the height of the pandemic.

NHS England's 'Planning and delivering service change for service users' outlines good practice guidance on the development of proposals for major service changes and reconfigurations (NHS England 2018). Additionally, the Mayor of London (2023) has released a framework for major hospital reconfigurations containing a series of six tests. Thus, there are the Secretary of State's four tests; NHS England's service change guidance, and the Mayor of London's six tests to consider during the process of consultation.

The Secretary of State's four tests

All service change should be assured against the government's four tests:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear, clinical evidence base.
- Support for proposals from clinical commissioners.

At the time of this report's final drafting, it would seem that CNWL is far from having the necessary evidence to meet these tests which was, of course, the purpose of the planned consultation.

NHS England's (2018) Guidance

Specifically (see page 8 and others), where there are plans to significantly to reduce hospital bed numbers these should meet NHS England's test for proposed bed closures and commissioners (here the NWL ICB) should be able to evidence that they can meet one of the following three conditions:

> A: Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or
>
> B: Show that specific new treatments or therapies will reduce specific categories of admissions; or
>
> C: Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example, in line with the Getting it Right First Time programme)

Condition A remains to be met since alternative provision is small in size and evaluations have not been provided in several instances. Several initiatives have described themselves as pilots and some, such as the Paddington Crisis House, as mentioned above, have been closed. Reductions of admissions is inevitably affected by what beds are available. Evidence from AMPH audits and several mentions of premature discharge from in-patient services testify to the uncertainty of admission reductions. While CNWL has set out its description of input from WCC and RBKC stakeholders, as noted above, some of the content of this input is not conveyed on the topics of admission avoidance such as the views of some staff working with homeless people or in supported housing services reported above. Condition C relates to the situation of the Gordon Hospital up to March 2020. There would seem substantial interest and goodwill in improving some of the relatively minor matters identified by the CQC and Healthwatch as covered above and to consider meaningful performance metrics. As noted, local homelessness pressures in the Gordon Hospital area are deeply entrenched and so ‘performance’ needs to reflect this. CNWL reference to “extremely difficult security issues with the building” (as reported by CNWL 2023a) have not been referred to in consultation meetings; if the ICB’s preferred option is chosen this will of course require security measures for a 24/7 service in which people in great distress are being supported.

From the councils’ view the situation might appear to be a long way off from the ambition of NWL ICB to comprehensively address the requirements of mental health provision including in-patient services. Clarity of the process of raising concerns with the ICB would be of major interest to the councils.

The Mayor’s six tests

The proposed closure of Gordon Hospital’s in-patient beds seems eligible for assessment under the Mayor of London’s (2023) tests for ensuring that major changes are in the best interests of all Londoners. The test related to hospital beds (number 2) states:

> The proposed bed capacity will need to be independently scrutinised in relation to the latest demographic projections. Any plans which involve a proposed bed capacity that is less than that implied by these projections should meet at least one of the following 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.
> - Show that specific new treatments and therapies 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.

A further Mayoral test (number 4) is that:

> 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 may be needed from Government to support the added burden on local authorities and primary care.

Some of those contributing to this report raised the point that the local councils felt some disappointment at not being involved in the detail of CNWL's demographic and clinical projections and regretted that these did not appear to have drawn on their public health and other expertise to ensure these are as accurate, comprehensive and sensitive in their predictions as possible, for example including people with multiple long-term conditions and/or unsettled ways of life. CNWL had commissioned external organisations to independently look at population growth which they concluded to be flat and shared this at the workshops it organised on the subject of plans for the Gordon Hospital and included it in its business case pre-consultation. The system wide financial impacts of the Gordon Hospital closure of its in-patient beds (Mayoral test 4) do not appear to have been addressed and can only be so in partnership. As noted above, the pressure on local council supported housing services of in-patient changes do not appear to have been fully explored.

There would seem to be much support for the ambitions of the Royal College of Psychiatrists and others to minimise the use of Out of Area mental health provision but this needs to be through a focus on local provision and context – care close to home and as part of a service that is well linked to other statutory services such as those of local councils, police, housing sectors, other parts of the NHS, as well as voluntary, community and faith sector and business communities (expanding on Mayoral test 4). Government policy, as published under its Major Conditions Strategy (DHSC 2023), includes now mental health, indicating the importance of local primary care medical services for in-patients before and after any hospital stay:

> Data shows that people living with SMI (severe mental illness) statistically have a higher prevalence of physical health conditions, often develop multimorbidity at a younger age and die on average 15 to 20 years earlier than the general population, with two-thirds of those deaths from preventable physical illnesses (DHSC 2023a, Annex A).

Alternatives to local provision of in-patient services can be expensive, disrupt local links and of mixed quality. WCC and RBKC have expressed their commitment to local provision of services for those in greatest distress from their mental health problems to aid their recovery and to support family carers. These could build on the history of the Gordon as a community asset and act more as a springboard for local communities, including carers, to provide support. Both local councils have expressed their wish to work with CNWL or any other provider of their residents' mental secondary mental health services to ensure that a refurbished Gordon Hospital has such an ethos. This would continue its many decades as a local resource for those facing severely distressing health problems and so provide the highest possible chances of recovery and rehabilitation.

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