healthwatch Kensington and Chelsea

healthwatch Westminster

Comment on North West London's acute mental health consultation and scrutiny process – Healthwatch Westminster and Healthwatch Kensington & Chelsea

About Healthwatch

The role of Healthwatch is to listen to the perspectives and experiences of patients and residents, and feed those views back to key stakeholders and those who have the power to make change happen. We are independent and aim only to represent the views and interests of the communities that we work with. There are local Healthwatch across the country, and there is one Healthwatch in every borough of London.

Healthwatch Westminster and Healthwatch Kensington & Chelsea partnered on this project to explore acute mental health services and needs in the bi-borough in light of concerns brought to us by community groups and residents across our two boroughs.

Overview of our findings

In October 2023, our teams published a report based on feedback and concerns shared with us about acute mental health services in the bi-borough since the closure of in-patient mental health beds at the Gordon Hospital in 2020.

This report was intended to supplement the ongoing discussions and public consultation. From June to September 2023, we spoke with over 100 people from people of diverse backgrounds and experiences, including representatives of healthcare services, charities, community organisations and residents' associations, as well as community members and patients with lived experience of acute mental illness.

Our key findings related to:

- patients' experiences of long waits and disjointed care
- effects and pressure on mental health services at St Charles Hospital
- impact on vulnerable groups, especially people who are rough sleeping
- concerns about the Gordon Hospital building and infrastructure
- feedback on the CNWL pre-consultation process

Comment on the proposed options

Option 1, or the 2019 model, is the most in line with the community's preference for local care. The following quote captures a key concern shared by many people we spoke to: "We cannot have an area the size of Westminster with no acute mental health facilities. We have sufficient people in the borough, with severe enough mental health needs, to warrant our own service."

We also heard feedback about patients being admitted into mental health wards that are far from their homes and family members and friends, which has caused a lot of isolation and at times exacerbated mental health challenges. Some community organisations and healthcare staff echoed these findings, stating that there have been significant disjoints in the care and support that they are able to provide patients or clients who are being sent out of borough.

This indicates that many would prefer acute in-patient services to be provided directly within Westminster. Option 1 also addresses some of the concerns that were raised about the pressure other services are being put under: "Staff and clients at St Charles Hospital are completely overwhelmed by the unprecedented numbers of people that present in distress. For the over 10 years I have been here, I have never seen wards where people are so distressed in such numbers."

Organisations we spoke to who work with rough sleepers also expressed a preference for local, acute mental health in-patient services: "The Gordon Hospital was the closest hospital to us, and it allowed us to do the forward planning for discharge. […] At the Gordon, we knew the staff, they would communicate with us about the discharge plans, we would take more positive risks. Whereas if it's a hospital that we don't work with or who don't really understand what homelessness services do, it's very hard to make a discharge plan that is conducive to that person's recovery."

However, the people we spoke to also felt that there cannot be an 'either/or' approach to providing acute in-patient services and community mental health services – preventative and community-based interventions are also required. *If option 1 is chosen, we would want further information about how those currently supported in the community would access care.*

Option 2, or the partially-transformed model, addresses some of the concerns about local care as raised above. However there is a question outstanding over whether the capacity would be sufficient to reduce pressure on other services, particularly St Charles.

Option two does raise some concerns due to the intended closure of the MHCAS service. *If this option is chosen, we would like to see further information about how patients currently using the MHCAS service will be supported. We also have questions around eligibility for MHCAS services, particularly for people with autism. Feedback provided by service users indicates that some people have not been able to access this service, and we would like to understand what alternative provision is in place.*

Option 3, the trust's preferred option, doesn't address many of the concerns we've heard about the need for local, in borough in-patient services and the risk of closures putting pressure on other services. Although the opening of additional beds in Brent will help to free up space for more local patients, it isn't clear that this will be sufficient.

Throughout our engagement, we found a high level of support for the community mental health services provided. However, these were seen as complementary to acute in-patient services, not as an appropriate alternative. The consensus was that, while preventive and community-based interventions are valuable, they do not make up for a lack of acute mental health beds and are not sufficient to meet Westminster's urgent and unique mental health needs. The below quotes extracted from our report demonstrate this view, and come from a range of different perspectives.

Two specialists in housing and homelessness shared with us:
"I think that access to actual counselling and talking therapies is rarely seen from the Trust. South London are doing psychotherapy in hospitals for homeless people. But in terms of local provision that is accessible to homeless people or the general public, I'm not sure who is getting psychotherapy through the NHS right now."

"I think [community services] have a much more therapeutic way of working with people and as preventive measure, that makes total sense by trying to meet people before they get so unwell. But, we have so many people who are already so unwell and the deficit there is what's glaring at the moment. So, I think we'll very much support therapeutic communities close to recovery houses and less sort of restrictive ways of working with people when it's appropriate, but it doesn't cover the same needs as a mental health unit would. I don't think anyone would compare the two with regards to how they actually serve the wider community."

A resident similarly expressed fears that community-based alternatives are not prepared or trained to respond to acute mental health cases: "What they're

calling local services are not local – it’s certainly not appropriate, because someone who is suicidal doesn’t go to a volunteer.”

We also spoke with some members of the CNWL Joint Homelessness Team, who felt that there should be targeted services for homeless mental health. One staff member shared: “We don’t have that many homeless mental health supported housing, and the threshold to get into that is extremely high. I think we need more investment in mental health supported housing and rehab placements. I think having a place like Westminster with the pressure that it’s under, I would obviously support an in-patient mental health unit, recovery houses, [which] are less restrictive and more approachable and flexible options but in terms of not having the basics covered, it seems high in the sky at the moment. I think there is a crisis in basic acute mental health provision so [what I think is needed are] hospital wards, rehab facilities, and housing.”

If the trust choose the transformed or partially transformed model, we would like to see detail of how they will ensure the most vulnerable members of our community are not negatively impacted. We would like assurance on how they will ensure continuity of care for those who are treated outside their home borough.

Summary

Throughout our engagement, we have heard a diverse range of perspectives which do not reach a unified consensus on the suitability of different options. We are not lending our support to any particular option, and appreciate the challenges that the trust is facing in balancing the different needs of patients alongside financial constraints.

However, we request that consideration is given to the comments shared above – and that as the trust move forward with their decision, they are clear and transparent in sharing information about which patient groups will be affected and how they intend to mitigate any potential negative impact. We also echo a number of recommendations from the Inner West London Mental Health Services Joint Health Overview and Scrutiny Committee, including:

- That there should be more in-depth analysis provided on the impact of proposals across the groups disproportionately admitted into mental health inpatient care.

- That the Mental Health Crisis Assessment Service model is further developed in advance of any decision being made, in consultation with

and using a co-production approach that involves partner organisations, stakeholders and the local community.

- That the proposal should be flexible to take into account the unique location of the local authorities and the challenges around beds and occupancy to specifically address the homeless population and high levels of visitors.

Finally, we ask that the health system is transparent about how they have arrived at the decision - evidencing that they have listened to a range of feedback from diverse community members, patients and staff, and that these diverse perspectives have been meaningfully integrated into the decision-making process.