NHSE Stage 2 Assurance Review – 5 Tests

Stage 2 assurance review - Requires clear evidence that the following five tests for service change have been satisfied in order to support the CCG to take any proposals forward to further engagement and/or public consultation:

Test 1 – Strong patient & public engagement

The business case summarises the engagement to date.
A full report on engagement is in appendices in the business case.
Any groups not involved in engagement will be part of the consultation.

Around 900 people have been involved in the stakeholder engagement including approximately 250 service users, carers or family members of service users. The table below lists engagement that has taken place:

Stakeholder / Audience
Launch of the Discovery phase – 9 September 2015
Service User workshops (café Visits) October 2015 – November 2015
Series of Internal and external facing co design workshops - March 2016 events
Staff workshops – summer 2016
Spring Transformation Events - May 2017
Staff drop-in sessions – Autumn 2017
Inpatient engagement questionnaire 1st December 2017 to 31st March 2018
Dialogue Groups: LGBTQ Group Afro-Caribbean Groups 2018 - 2019
Equality Delivery System (EDS) Review – Spring 2019
West Yorkshire Integrated Change System - May 2021 and ongoing
Inpatient staff conversations - October 2021
Staff listening events - September 2022
OPS Transformation Workshop – 10th October 2022
OPS MH Inpatient Transformation Stakeholder Event 15th December 2022
System discussions (LA / advocacy) Feb-Mar 2023
Ward staff conversations - March 2023
Staff Briefing - July 2023
OPS Inpatient Services Transformation Programme board – ongoing
Communication, equality, and involvement group (CEE)
SWYPFT OPS Steering Group
Partnership Boards and local stakeholder groups – ongoing throughout
Political and member engagement
Options Review Workshops 2022
Northern England Clinical Senate - from March 2022 to August 2022
Workshop / Events late 2022

Consistent with choice
This has been considered as part of the Quality Impact Assessment and assessed as neutral for choice. Choice is limited due to the nature of inpatient mental health. Choice would be offered where possible.
Clinical evidence base
There is a strong clinical evidence base for the model. The programme team have built the clinical requirements quality impact assessment and used it or options assessment. National and regional context has been considered. Acute Inpatient Mental Health Care for Adults and Older Adults Guidance (2023): • Care is personalised • Admissions are timely and purposeful • Hospital stays are therapeutic • Discharge is timely and effective • Care is joined up across the health and care system • Services actively identify and address inequalities • Services grow and develop the acute inpatient workforce in line with national workforce profiles. The West Yorkshire ICB strategy states that local hospitals will be supported by centres of excellence for services such as cancer, vascular (arteries and veins), stroke and **complex mental health**. The evidence gathered shows how having separate in-patient beds for the two functional and dementia (organic) groups has been consistently regarded as good practice. They allow the older people who need an inpatient stay to have the right care and support, whether they have dementia, depression, psychosis or any other need. Many of the standards for delivering separate specialist care were agreed several years ago. The joint commissioning panel (May 2013) for mental health guide advocates: • Where possible, separate ward space for functional and dementia (organic) disorders • Gender separation guidance for inpatient services being properly applied In Scotland, the Mental Welfare Commission has undertaken several research studies into the ward environments, including their 2020 report (Older people's functional mental health wards in hospitals - new report | Mental Welfare Commission for Scotland (mwcscot.org.uk)). They found that: “While it is appropriate that these wards can and do treat some patients who have both functional mental illness and dementia, the Commission is clear that mixing patients who are solely diagnosed with dementia with those who do not have that diagnosis is challenging, and does not meet the needs of either group”. The type of supervision and clinical intervention and workforce skills needed for the two groups may be quite different (Audit Commission, 2000 and 2002). This was reiterated in the document ‘Everybody’s Business’ (Care Services Improvement Partnership, 2005b).

The Health Education England (2017) Older People's Mental Health Competency Framework highlighted the need for skills and specialism based on patient group. On mixed needs wards, providing activities that would be stimulating and meet the needs of each person is cited as challenging.

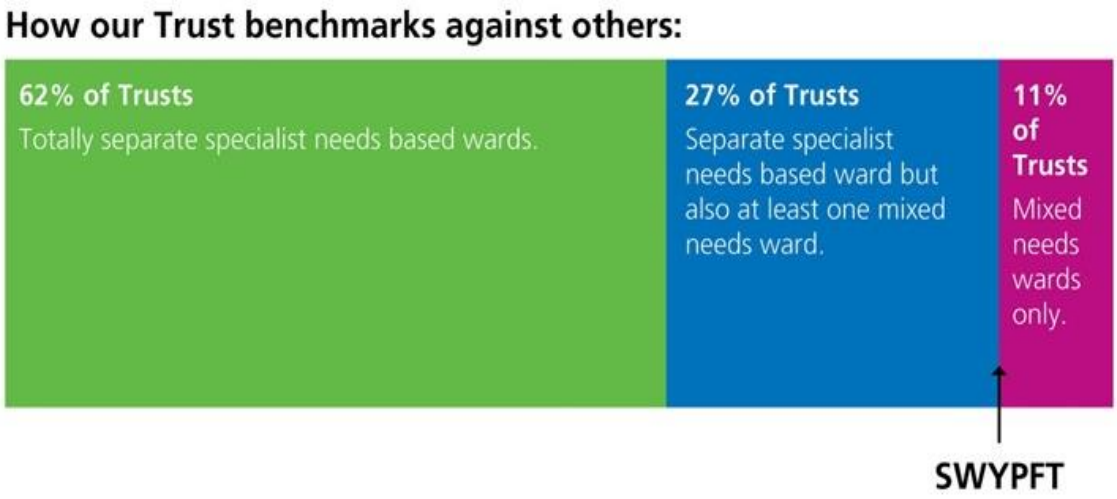
In terms of needs, training and skills, patients with severe dementia and distressed behaviours in secondary care have specific care needs (feeding, dressing, tailored care approaches, etc.) that require staff with specific dementia training, expertise, mentoring, and time to deliver care. The Royal College of Psychiatrists (2019) Standards for Older Adult Mental Health Services, sets minimum standards for dementia specific education and skills.

Through summer of 2022 the Trust engaged with the Northern Clinical Senate to review proposals. Clinical Senates are independent non-statutory advisory bodies established to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change and service reconfiguration are clinically sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

As part of this process, they did feedback on the clinical model. Their report references "National guidance and established practice across the UK seek to ensure that patients with dementia (organic) and functional conditions receive care specific to their needs in dedicated units".

The clinical senate fed back that it "strongly concurs that patients with functional and dementia (organic) disease should be cared for in separate distinct dedicated units".

A desktop review of what other providers publish as their models shows the following:



The programme has also considered what an appropriate, evidenced based workforce for the model should be.

Data shows that people with dementia have higher levels of acuity and dependency when admitted to the wards than people with functional needs. The programme team used the Mental Health Optimal Staffing Tool (MHOST), Planning for the mental health support workforce (hee.nhs.uk), which was developed with NHSI, Imperial College London and 26 different Trusts and is the most evidence-based tool available and is part of NHSE's chief nursing officer's safer staffing fellowship programme as a recommended staffing/acuity tool.

2 data collection exercises were undertaken following this methodology, one in December 2019 and a further one in July and August 2021. Additional clinical auditing was added to the 2021 exercise, to ensure more robust and consistent data collection.

The data also shows that in the current model the Trust often goes well above 100% fill rates and requires bank and agency.

The modelling has been used to establish the appropriate workforce levels for the model.

Consideration has been given to the support staff required to enable the right therapeutic environment, on both dementia and functional wards, using clinical and operational staff and best practice models to support design.

A report for the Scottish Government recommended the provision of specialist dementia hospital care in 2018 (Transforming Specialist Dementia Hospital Care, Alzheimer Scotland, 2018) for people with dementia who have an acute psychological presentation because of dementia or co-morbid mental health illness.

The report concluded that the modern specialist dementia unit should provide a centre of excellence to deliver quality treatment and care for the small number of people with dementia who will have a clinical need to be in hospital.

On a specialist dementia ward, there would also be a need to access a wider range of specialist practitioners in response to the specific requirements and wellbeing of each patient, including specialist consultants, such as a geriatrician for complex physical conditions and a cardiologist for heart and vascular health.

Additional allied health professional support would be important, including podiatry to help people stay mobile and independent, and arts therapies delivering highly specialist psychological therapies for difficulty in communication and expressing emotions verbally.

The NHS People Plan (NHSE 2020) is reflected in the SWYPT workforce strategy of making this a Great Place to Work with a focus on:

- Growing Our Workforce and Working Differently. Ethical international recruitment for nursing and medical roles, redesigning core workforce to offer more flexible working roles, local recruitment to reflect the demographics of our local communities' new clinical roles to develop potential and effective staff engagement.
- Looking After Our People. Civility and Respect Model implemented to reduce bulling and harassment, ensuring clear and progressive career pathways, established health and wellbeing programmes and revising managers and leadership development pathways.
- Inclusive and Compassionate. Race Forward to develop an action plan, effective and efficient deployment of staff through the rollout of Safe Care, supporting a speak up culture and engaging and listening to feedback and development and implementation of the Trust's Talent Management Plan.

Any future models will need to expand on the NHSE workforce plan recommendations for reform, by increasing the number of nursing associate roles and Advanced Clinical Practitioner roles. This will lead to alternative career progression pathways to attract and retain staff. Also exploring the potential of digital enhancements and working differently to support new roles and ways of working.

Using validated safer staffing tools such as MHOST or Safe Care would continue to reinforce safe/effective workloads and reassure staff that their voice counts.

Below is a summary of some of the benefits of changing to a needs-based, specialist, approach:

- Skilled staff able to better focus the right care and interventions based on the needs of the people on the ward and different needs can be met better. For example, functional admissions will often have some accompanying psychosis and carry a high level of risk.

- Having separate specialist wards for people with functional needs allow the quality of therapies to be improved, enables staff to have the right skills.

- Type of observation and input are different, meaning that we can get the right levels of workforce and supervision for both groups.

- Having functional and dementia / organic only units means that staff can dedicate their time to people with these needs. It means that they are not focussing disproportionately on the needs of people with dementia who often display the most behaviours that challenge.

- It will resolve issues where mixed needs wards can be counterproductive to the needs of patients, for example, invasion of privacy of functional patients by people with dementia or people with dementia surrounded by depressed patients.

- Having separate needs-based wards means that we can get the most out of the environment for the different groups, for example enhancing opportunities to create a dementia friendly environment on a specialist dementia only ward.

- Delivering improvements to inpatient pathways should help improve length of stay on the wards, which has increased overall in recent years, particularly for people with dementia, though work on forward pathways will also be needed to support improvements.

- Staff are able to focus on their preferred specialism, increasing their skills and knowledge and improving staff retention.

Potential issues could arise with the model, highlighted below:

- If there are issues with deciding on an admission to functional or - dementia wards due to uncertain diagnosis, then we will manage according to predominant presenting psychopathology. Feedback from services is that there may still be a small number of cases that are difficult to assess until the person is on a mental health inpatient ward due to comorbidity and a presentation that would make assessment in the community difficult. Clinical judgement would be required at time of admission and a transfer would be considered, if required, following assessment.

- Whilst staff will develop more specialist skills for supporting service users based on need, we've had feedback that there is a risk of deskilling more general skills across both needs group, which might still be required. This could be achieved through creating a set of competencies that are universal across both functional

and dementia/organic wards, in addition to any competencies that are needed for staff in those specialist wards alone. Time spent working across other wards areas, training and supervision would be used to achieve these competencies.

- Capacity to meet demand of different needs groups: The current model has flexibility in the numbers of people with functional and dementia/organic needs and male and female patients within the overall capacity. A needs-based model will create a ceiling for both needs group and could create extra challenges in managing male/female demand.

Support of GP commissioners

There is a joint programme board led by Kirklees ICB, with Calderdale and Wakefield ICB as partners.

The programme has engaged with GP commissioners as part of the programme and the GP commissioners have been part of options work in 2022. We've also specifically engaged with partnership boards for each place through the programme, keeping them updated with the development of the programme.

The programme board agreed to form a joint committee of the three places. The joint committee is responsible for making a single decision which is binding on all 3 places and has representatives from each of the 3 places. Membership broadly reflects the makeup of place committees, for example including non-executive representation.

The Joint ICB committee of Calderdale, Kirklees and Wakefield ICB took place on 1 December 2023. The Business case was supported and the committee was assured of the approach and rationale, the public consultation approved by the methods set out and the financial risks / planning was noted.

GP commissioner leads will also support the consultation public events in January 2023.

Hospital bed-based reduction

The preferred options from the options review exercise do not reflect a significant reduction in the bed base as there would be a total reduction of 2 beds from the current operating model. The data shows that the model can operate within these numbers. Although there are increasing numbers of older people, the West Yorkshire health system, in line with national data, has been successful in reducing demand, particularly for people with dementia, as community pathways improve.

The delivery of a specialist model and improved inpatient pathway, including a reduction from 30% of people that have more than 1 ward stay, supports a reduced LOS and the programme team are confident that we can deliver within proposed model numbers for the time period proposed of up to 10 years, factoring increasing populations of older people.

There is an option for a model with a reduction of 6 beds from the current operating model. This would take the operating model in West Yorkshire to 66 beds. Data and demand over time suggests that there is enough capacity to manage demand within these, though it would take demand levels closer to 100% and we would need to ensure that population growth didn't take the model above capacity. Whilst this currently is not the option that scored highest in the options appraisal it will form for part of the consultation due to affordability but still achieving many of the model requirements.

Investment has been made into the community services as part of the Transformation to support reduction in bed demand and it is an aspiration to continue to reduce demand and support more people at their home. For example, developments such as CLEAR training aim to support both carers and care staff to better enable understanding of dementia and behaviours from the perspective of each person. Improvements to prescribing in primary care, specialist mental health pharmacists, improved joined up and seamless care between mental and physical health will support continued improved ways of working.

To summarise, the programme team has been through a robust process of analysing demand for the services and capacity required. This has included consideration of:

- Population projections and increasing numbers of older people / people with dementia.
- Long terms admission trends reducing.
- Impact of reducing the number of moves between wards reducing length of stay.
- Demand for functional and dementia beds as well as male / female beds, with the need to have more functional than dementia beds.
- Daily bed use data to understand higher bed use limits of the different groups.
- Demand and capacity has been modelled based on low, medium and high demand scenarios.