South West Yorkshire Partnership NHS
NHS Foundation Trust

Older People's Transformation

Inpatient Model

Quality Impact Assessment

Date

13 Jul 2023

Quality Impact Assessment

Title of scheme: **QIA OPS Inpatient MH Transformation**	**Overall Quality Impact**	**Positive (improved)**	**Neutral (maintained)**	**Negative (reduced)**		
People involved in completing the QIA: **Ryan Hunter.** **Gemma Hinchcliffe, Valerie Aguirregoicoa, Siobhan Dorotiak –** review and support		**All options are positive overall, though have differing mitigations required.**				
Lead person: **Matthew Burns**						

Brief description of scheme – (*please embed business case or relevant proposal paper)*

This is a QIA of the proposed options to take to consultation from the OPS Transformation Business Case for changes to the older people's mental health inpatient estate across Calderdale, Kirklees and Wakefield.

The current model of care is set out below:

- In Calderdale, Beechdale is a 16 bedded, mixed gender and mixed needs, functional and dementia ward at the Dales in Halifax, which is located on the site of Halifax Royal Hospital.
- Ward 19 constitutes 2 x 15 bedded single gender wards, both mixed functional and dementia needs, on the site of Dewsbury and District Hospital and people from Calderdale will often stay on this site in the current model.
- Wakefield currently has 2 wards, Crofton on the Fieldhead site and the Poplars, at Hemsworth. Crofton is a 16 bed, mixed gender, mixed functional and dementia acute needs ward. The Poplars is a mixed gender ward for people with dementia. People accessing services at the Poplars generally transfer to the ward after an admission to Crofton. It has been operating as a 12 bedded ward for several years.

Challenges of the current model:

There is strong evidence that the needs of the people with dementia and functional needs are different, and they do not mix well together. As our inpatient ward offer remains mostly mixed, the Trust has been developing a proposed clinical model to transform services.

The SWYPFT older people's wards only admit people with dementia who have very complex and challenging behaviours and need a hospital stay after all attempts have been made to support them in their own own/care home. The model of mixing people with dementia with other needs does often have a negative impact to people on the wards.

The behaviour of people with dementia on the wards can have a negative impact to people who might have anxiety or psychosis. People can be frightened and they might not engage as well on the wards because of this. Staff spend considerable time supporting the people with the most challenging behaviours and this can be at the expense of delivering therapeutic support to others.

The current model also leads to a number of other challenges such as an isolated ward which, due to location, has issues admitting a high level of acuity and access to timely support when required.

The current system leads to many people moving between wards, which is has a negative impact on their wellbeing, impairs continuity of care, prevents best use of therapeutic interventions and leads to increased length of stay.

30% of people are admitted to a bed outside of their locality and 30% of people have more than one ward stay as part of their inpatient spell.

The current systems of care lead to many people having more than one stay. Operational and clinical staff have fed back that this can have a negative impact on people's wellbeing as it:

- Impairs continuity of care
- Prevents the development and utilisation of therapeutic relationships
- Hinders access by carers due to the geographical differences.
- Unnecessarily extends the Length of Stay
- Means there is an additional period of assessment while a new care team and the service user get to know each other
- Means an understanding of the wider multi professional team and their role in supporting care in the community has to be re-established.
- Means that relationships between the carer and the care team have to be re-established
- Leads to attitudes to risks being lowered while impact is re-evaluated
- Increases the risk due to the change of environment / change of staff, for example, can also lead to increased confusion when moving people. The changes can't always be mitigated and there can also be an impact on carers.

Features of the current system include:

- 4 of the 5 wards are mixed functional and dementia needs.
- Single sex accommodation guidance is met on all units expect Poplars in Wakefield. Currently, 3 out of 5 of the wards are mixed gender, which can make clinical management an issue, especially for those patients with organic diagnosis.
- Services are local to place but site isolation of Poplars ward leads to challenges in terms of access to acute general hospital. The isolation of the Poplars ward creates issues in terms of access to cover, support in an emergency, shared facilities and medical out of hours support.
- There are challenges with some of the ward environments, notably Beechdale.
- There are very different pathways and stays across the Trust, particularly for people with dementia. Most people with dementia from Wakefield have more than 1 ward stay and a typical stay of well over 100 days. In Calderdale, around 50% of people with dementia have had more than one ward stay, and the length of stay is over 100 days on average.

More information on the challenges can be found the business case.

The business case also sets out the required clinical model which have been mapped against the quality domains in this QIA.

3 options are being assessed in this QIA:

1a A dedicated central specialised dementia unit developed on Ward 19 with additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds.

1b A dedicated central specialised dementia unit developed on Ward 19 but with fewer beds being relocated to Crofton (6 in total), meaning that Crofton would operate a single 22 bedded mixed gender functional needs only ward.

2 Crofton being a 26-bed dementia unit (2 wards with 10 beds being relocated from Poplars), all other wards functional.

The Poplars site would not be in any of these proposed models, the service would be relocated and reconfigured in each option into the Fieldhead site and the wider model.

Quality Impact Assessment Tool

RATING	The assessment suggests that this the impact on quality is rated as follows
BLUE	Improves quality
GREEN	Neutral impact on quality
AMBER	Potential impact on quality. Requirement for mitigation and monitoring
RED	Likely impact on quality. Requires further work or substitution

The quality is assessed against the three options, where the impact is displayed under multiple options then it is thought to be applicable to all those options.

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
SAFE	Improvement in the environment in which service users are treated	Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs.	**IMPROVEMENT** ▪ The model takes on the evidenced based recommendation of separate wards for diagnosis - functional and dementia. ▪ This will improve socialisation, for example, dedicated socialisation for people with similar needs. ▪ There will be an appropriate environment for respective needs – i.e. dementia friendly and fit for purpose. ▪ The clinical senate strongly supported a model implemented based on needs: *"The review team strongly concurs that patients with functional and organic disease should be cared for in separate distinct and dedicated units."* Feedback from stakeholder workshop in December 2022 also supports this: *There would be real positives in separating the services out and having a specialist dementia ward and the staffing of it, you can get the correct staff training/skills in place.* Data shows a much lower number of falls on the Trusts only functional only ward. Both models would be expected to reduce the overall number of falls across the system. We have had feedback from staff that functional patients can isolate themselves to their bedrooms because they may find being with dementia patients in communal areas difficult. This can lead to reduced mobility and increased falls risk. Dementia patients are also much more likely to fall due to neurological changes, difficulty in using aids and adaptions and fluctuating cognition, making care planning difficult. **Potential differences across options:** The options appraisal process found the W19 environment to be the best option in terms of a dementia appropriate environment especially if a small number of en-suite could be added to that site, though the Crofton option would also		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			improve the current mixed environment (see table above). So, both options would improve quality compared to current model.		
	Promotes a safe approach to service user care and/or helps to prevent harm to service users	A model with the best specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation. e.g., dedicated socialisation for people with similar needs.	**IMPROVEMENT** A specialist environment would improve safety of both functional and organic patient groups by removing interactions between the patient groups that could increase risk. Royal college states main problem with joint functional and dementia wards is that some patients with dementia tend to interfere and invade the personal space of other people - there is an history of examples of this. Specialist wards would remove or reduce the impact this has on patient experience. Specialist wards would also allow for staff to increase their specialist skills in dementia or functional illnesses, such as the CAMS suicide prevention training or dementia specific assessment skills. Previous training in similar areas has been undertaken but maintain the skill across the staff groups has proved difficult when ward staff have to care for a wide variety of patients. All wards would be co located with other mental health wards in all models. As well as being co-located (or nearby) to acute hospitals. This would allow for a quicker response from on call doctors and other staff in clinical emergencies. This is not currently the case as Poplars ward is not aligned to any trust or acute hospital site. In all models Beechdale ward would be a unit for functional mental health.		
		Single Sex Accommodation	**IMPROVEMENT** Single sex accommodation guidance would be fully met in all these models. Currently we do not meet single sex accommodation guidelines on all wards.		**IMPROVEMENT BUT MITIGATIONS REQUIRED** Single sex accommodation guidance would be fully met in all of these models. There would be no option for a single gender ward for patient with functional illness. If a patient's symptoms make being on a mixed sex ward difficult this could lead to clinical management issues.

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
		Wards sizes in line with or close to best practice guidance of 15 beds	**IMPROVEMENT** Modelling (DH 2013) suggests 15 beds is an optimum size for clinical and therapeutic engagement. This option would have two 13 bed functional wards at Crofton, two 15 bed dementia wards at Ward 19 and one 16 bed functional ward at Beechdale.	**IMPROVEMENT** This option would have two 13 bed dementia wards at Crofton, two 15 bed functional wards at Ward 19 and one 16 bed functional ward at Beechdale.	**MITIGATIONS REQUIRED** This option would have two 15 bed dementia wards at ward 19, one 16 bed functional ward at Beechdale and would introduce a 22 bedded unit at Crofton ward, which is above the DoH recommendations of 15. There would need to be mitigations in place to minimise the impact this had on clinical and therapeutic engagements.
	Supports a risk management and safety systems	Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards.	**IMPROVEMENT** The current risk management of diagnostic groups differ, so the proposed model should help risk management strategies by separating the needs based groups and enabling more cohesive risk strategies to be designed. The clinical senate found in relation to options with a central dementia unit and service relocated from Poplars: ▪ Addresses the risks and issues associated with mixed wards. ▪ Mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward. Incidents of falls		
		Staffing to appropriate levels, in line with clinical need to support safety.	**IMPROVEMENT** It is an aspiration of a specialist model to improve demand for staffing across the models. There will be more than one registered nurse in all proposed staffing models. Currently there is a shortage of qualified members of staff, especially on a night shift where most of our wards have one registered nurse. This may also be having an impact on staff recruitment and retention. With new staffing models retention and recruitment could improve due to richer staffing models.		**NEUTRAL IMPACT** Similar to other proposed options but there is a concern that staff retention and recruitment may be affected by the 22 bedded ward at Fieldhead.
	Takes account of the duty of 'due regard'		Due regard has been fully considered (please refer to Equality Impact Assessment for detail).		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
	Impact on partner organisations and any aspects of shared risk	Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	**IMPROVEMENTS BUT MITIGATIONS REQUIRED** Currently social care is aligned to services in each area, however there are still patients that are admitted and discharged from wards that are not in the same LA as their usual residence. Social workers will work across place boundaries in these cases and this practice is assisted by ward teams, including discharge coordinators. Conversations have been held with partner stakeholders through the development of the model, including LA and VCSE. There will be some impact on the third sector, but these will be limited. For example, advocacy will adapt to whatever structure is implemented. Local authorities have told us that they will be able to adapt their working practices to a specialist model though we did hear some concerns about travel impact for staff that are often working into the wards to facilitate discharge. This was raised as more of a concern for staff potentially from the west side of the Trust footprint if travelling to a dementia unit in Wakefield. **Potential differences across options:** There will be an impact on the need for YAS with the Dewsbury dementia option being on the site of Dewsbury District Hospital, meaning that dementia patients, who are more likely to fall could, in most instances receive general hospital care on the same site but we believe this impact is very small. We don't believe that there is likely to be any significant negative impact on the local general acute hospitals as a result of the options. A reduction in falls would hopefully reduce the numbers of general hospital admissions Note, there is also the informal arrangement with DDH geriatrician and ACP resource supporting physical health. There could be the opportunity to make more formal arrangements over time which would help support more people with physical needs without requiring a general hospital admission. The Fieldhead site is close to Pinderfields with nurse consultation – could explore linking in over time. The general hospitals have fed back that they have no plans for changes to their offer that will impact on an option.		
EFFECTIVE	Supports staff in understanding their role in improving the service user experience	Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored	**IMPROVEMENT** The evidence gathered shows that the type of supervision, clinical intervention and workforce skills needed for the two groups may be quite different, evidenced in HEE older people's mental health competency framework which outlines different competencies for different specialisms. Psychology clinical leadership model, implemented on other specialist dementia wards, would be implemented on a specialist dementia ward.		

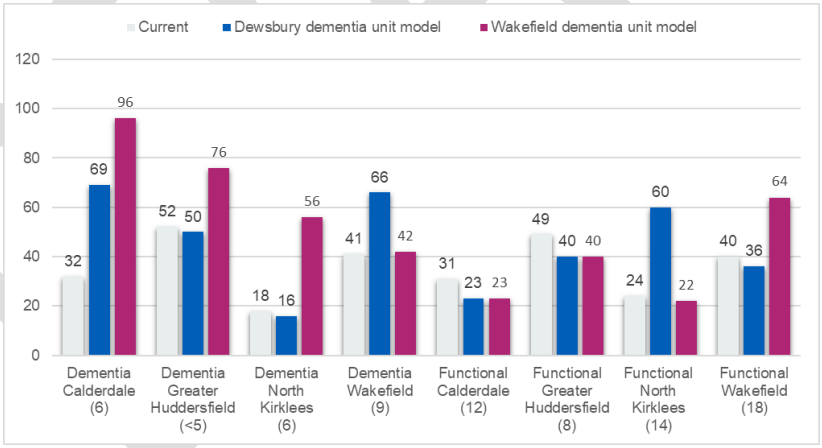
DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
		therapeutic care.	Staff will have a very well-defined remit of care in the proposed model. The various staff will have a clear understanding of expectations and appropriate / enhanced staffing levels should lead to a more sustainable service. Targeted approach to a singular client group rather than having to design activity for a number of clinical issues and activities. Current dilutes activity resource by having to do multiple things. Quote from the December 2022 event: *There would be real positives in separating the services out and having a specialist dementia ward and the staffing of it, you can get the correct staff training/skills in place.*		
	Reduces impact on variation in care provision.	Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge.	**IMPROVEMENT** Patients who need dementia beds will all access the same service, via a central unit. This will improve consistency of care. It is also envisioned that people who need functional mental health beds will have less ward stays as the clinical environment will be improved due to specialist wards. A set of standard operating procedures will be developed for functional and dementia beds to ensure consistency across the footprint to support enhancing quality of care and helping people recover.		
	Involves and engages service users, staff, public, people who use services and other stakeholders.	Stakeholders are involved in design and their input informs decision making.	**IMPROVEMENT** We have involved service users and staff in this model design, coproducing via a number of workshops and events (see business case for more evidence). We used the engagement to inform the options analysis criteria and options appraisal work. More information is in the business case. We plan to continue to involve and engage, via the formal consultation process where will listen and use feedback to inform the agreed model.		
	Promotes positive outcomes of care.	Will deliver positive outcomes of care and allow for implementation of evidence-based practice.	**IMPROVEMENT** The clinical senate fed back: *It is well recognised that patients with organic disease benefit from a therapeutic environment dedicated solely to their needs. The same is true for patients with functional disease. National guidance and established practice in most centres*		**IMPROVEMENT BUT WITH SOME MITIGATIONS REQUIRED:** As other options but a 22 bedded ward could have potential impacts on clinical and therapeutic engagement. The

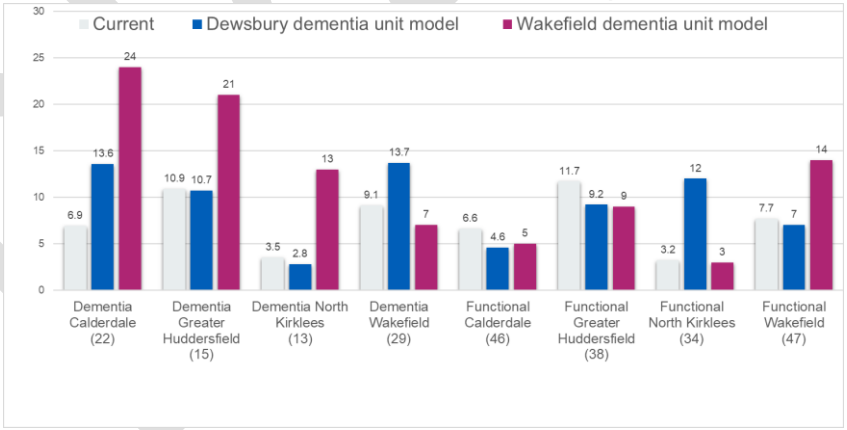
DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			has led to reconfiguration of services to achieve this. Maintaining mixed wards is thus not acceptable. The new model will provide a better environment through dedicated needs-based wards, tailored and appropriate therapeutic programmes. Specialist training will be provided to staff on the wards. Care would be more specialised to patients with functional/organic need to improve outcomes. This will be achieved not only by having a place that is specialised but also a group of staff, model of care and an environment that is specialised to organic/functional need.		impact of this on a 22 bedded ward is unknown but not thought to be optimal.
	Support services are aligned with pathways.	Clinical support staff teams and services, across pathways to work together to deliver safe, effective care	**NEUTRAL IMPACT** The model involves a shared bed base so will be bringing people together with shared objectives. A challenge will be in working across place boundaries so measures will need to be put in place to support staff working on a shared pathway across these geographic boundaries. For example, Kirklees Outreach Team (KOT) will need to reach more widely across wards. This will be covered in the standard operating procedures. The pathways in, out and through of the wards should improve as people will generally not be transferred from ward to ward as part of the pathway. Recent conversations with advocacy have confirmed that a revised model is likely to have a minimal impact on how they operate. The reducing restrictive practice team, pharmacy and other centralised clinical support teams would also be better aligned to wards. Additional work and training needs for staff that involved with coordinating the patient journey will be needed. Time spent shadowing services across localities to better understand their pathways and build relationships will be needed for discharge coordinators and ward managers. Coordinating the ward review schedule to align with localities will also allow for a reduction in wasted time and duplication for teams in-reaching into the wards.		

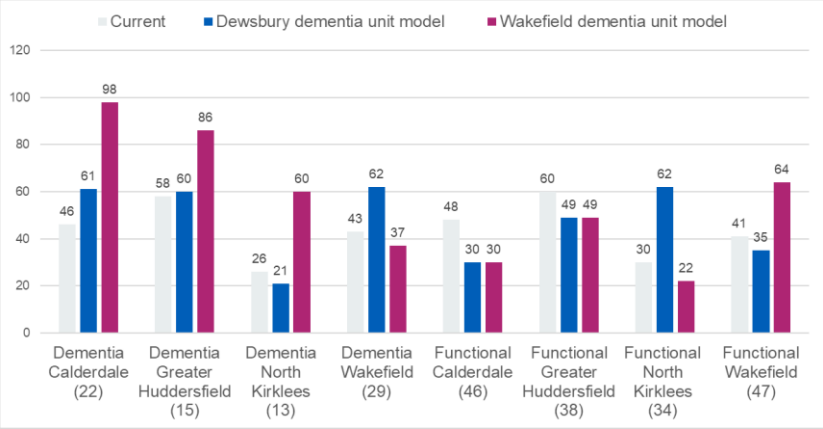
DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Further consideration is needed for speciality services that will in reach into our wards, such as diabetes nurses or end of life care. There are cross boundary issues that exist in the current model that could be amplified by any of the proposed options.		
		Non-clinical support staff teams and services, across pathways to work together to deliver safe, effective care	**IMPROVEMENT** Alignment with other trust sights would improve access to estates, domestic, catering and other non clinical services. Improved access would provide better cover at busy times and improved support in an emergency (such as flooding, or supply chain issues).		
	Impact on eliminating inefficiency and waste by design	Patients received the right care at the right time. Pathway delays a minimised as much as possible.	**IMPROVEMENT** In this model, most patients will stay on the ward they're admitted to until ready to discharge. Currently around 30% of patients have more than one ward stay. Less ward stays will allow staff to plan for discharge as soon as is clinically indicated. Patients will also have access to appropriate therapies and interventions in a timelier manner, as separate organic and functional wards will have specialist staff who can focus solely on their needs.		
CARING	Allows staff time to care for people.	Ward staff who have skills, knowledge and experience that aligns to the patient specialism on their ward.	**IMPROVEMENT** Separate functional and dementia wards would mean that appropriate staffing based on people's needs. As covered above from the clinical senate: It is well recognised that patients with organic disease benefit from a therapeutic environment dedicated solely to their needs. The same is true for patients with functional disease. National guidance and established practice in most centres has led to reconfiguration of services to achieve this. Maintaining mixed wards is thus not acceptable. As cited in our evidence: 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 on the wards. Having functional only units means that staff can dedicate their time to people with these needs. It means that they are not juggling needs of people with dementia who can often take a disproportionate amount of resource and support		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Separate need wards could lead to improvements in physical health care. A richer staffing model, with more overall staff and clinical specialists, like an extra ACP on the dementia unit, would give more time to care for some physical health issues and reduce transfers to acute hospitals.		
	Services that have been co-produced.	Improvement has been co-produced with patients and carers.	**IMPROVEMENT** Patients and carers will continue to give feedback through groups, friends and family feedback, complaints, compliments and serious incident reviews. This information is fed back to ward managers and quality leads. Involved service users and staff in this model design, coproducing via a number of workshops and events. We have used the feedback to inform the options development. The EIA focuses on the co-production that is required throughout service change, to reduce health inequalities and meet WRES and WDES standards.		
RESPON-SIVE	Improves the timeliness of any stage of the service user pathway.	Pathways that allow clinical interventions and discharge planning to happen as soon as clinically indicated.	**IMPROVEMENT** The dedicated function for each ward and improved therapeutic environment should reduce the time it takes to reduce levels of acuity, though work with local partners will also be required to ensure timely movement onto any further pathways. Feedback from partners is that working across place-based boundaries is not likely to have a negative impact on LOS, though at the December 2022 Event a potential impact of the changes was flagged and that it will be a challenge / barrier to discharge especially for dementia patients who do not live in the local area. Each area has a way of doing things e.g. social services and will need to be streamlined. So, while a single streamlined ward stay does have the potential to improve the timeliness and reduce length of stays, we will need to ensure that the correct systems are put in place to support improved timeliness. A detailed optional plan will be established to support this.		
	Supports delivery of service performance and the principle of Right Care,	Evidence that service users are in the most appropriate environment, receiving the most appropriate care	**IMPROVEMENT** The programme and changes will lead to various improvements in performance. Standard Operating Procedures should lead to more consistency in terms of service offered and could improve outcomes and Length of Stays, though there are some dependencies outside of this such as facilitated move on to the right accommodation.		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
	Right Place, Right Time	and for the most appropriate length of time.	Project team need to consider how they will measure service performance from a quality perspective.		
		That we have the right capacity in the system to meet the demand required, factoring in projected population increases.	**NEUTRAL IMPACT/MITIGATION REQUIRED** See Appendix 1 for information on current bed use. There is also a potential capacity caps in both functional and organic beds as well as male and female beds. See Appendix 2 for a detailed breakdown of bed surge testing. This option has 30 dementia beds and 42 functional beds in the trust. Compared to 2040 demand modelling this option appears to have capacity for both organic and functional beds. There is a potential for difficulty with surges of male dementia bed demand. Potential mitigations have been discussed with estates colleagues and there will be options to add some limited gender flex in the dementia beds at ward 19. We don't feel this will have an impact on 12 hour A+E waits and out of area placements as older people's admissions tend to be by a more managed process and it is likely that we would find mitigations to caps in functional/organic male/female before admit patients in non SWYPT beds.	**MITIGATION REQUIRED** This option has 26 dementia beds and 46 functional beds in the trust. Compared to 2040 demand modelling this option may be leave slightly low capacity for organic beds but be a little over capacity for functional beds. This option will allow for significant gender flex on both functional and organic beds with functional beds being able to be up to a 15/31 male female split and dementia beds be a 8/18 split.	**NEUTRAL IMPACT/MITIGATION REQUIRED** This option has 30 dementia beds and 38 functional beds in the trust. Compared to 2040 demand modelling this option may have lower capacity for functional beds but has the right capacity for organic beds. There is a potential for difficulty with surges of male dementia bed demand. Potential mitigations have been discussed with estates colleagues and there will be options to add some limited gender flex in the dementia beds at ward 19.

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
	Supports fair access and the principles of the Equality Delivery system	The service users, family and carers are able to access the service as needed.	**MITIGATION REQUIRED** Any centralisation of a service to create specialism is likely to involve additional travel impact for family and carers. It should not impact on the numbers of people requiring access to a bed. The current model has challenges, for example, Poplars isn't very accessible at present, even for people within the Wakefield locality and is used by other parts of the Trust as part of the joined-up bed base. All sites in proposed models have good access to other acute sites. A full Equality Impact Assessment is being undertaken which will consider any actions required to ensure the new system gives equal access to all. **Impact of different options:** The table below shows the public transport travel impact of people from the most deprived 20% areas (likely to impact on family and carers). The numbers in brackets show the average number of people per year from this population being admitted: 	

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Both options have a negative impact on people from the most deprived areas, with the Wakefield dementia option having a bigger impact. In feedback from the options scoring exercise in May 2023 members from Calderdale were concerned about the travel impact for patients with Dementia from Calderdale if the dementia ward was in Wakefield. Mitigations are considered in the business case and will be explored more in a consultation process.		
	Results in a more accessible service.	Service is accessible for families, carers and support services.	**MITIGATION REQUIRED** There will be some impact in terms of distance travelled to any specialist site for family and carers but the service users will be accessing better care and the model still delivers that care for all the people in the current model. Although current data shows 30 % of admissions are currently outside of people's locality meaning that there are challenges with access to the current model. Also challenges with accessibility to Poplars site, including staff challenges – for example medical cover. All sites in new function have good access to other acute sites. Travel impact analysis has been undertaken and options to support people who are impacted will be explored in a consultation before a final business case is completed. The table below shows the driving distance to each of the options (on average from each place):  The table below shows the public transport time (on average). More detailed travel impact analysis is in the business case:		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			 Issues with travel and access raised at December 2022 event but many potential mitigations also put forward and will be explored more in a consultation process, including: • Dedicate transport between each hospital and limit stops • Accommodate the use of assisted technologies to encourage virtual contact and avoid transport – i.e. to make contact in the week and a physical visit at the weekend. As a complimentary option • Shuttle buses – consider what is already available for these geographical areas. All agreed that where a service has been implemented, they do work well • Discharge teams are an important part of the ward to get people back into the community. Travel/discharge could be integrated from Hospital with a clear plan of structured support to minimise the travel impact on a certain percent of the population. Consider how to integrate services and think of ways to do this. • Consider using local transport systems in a better way • Integrated travel across boundaries when thinking about travel problems Visiting times could be more flexible, especially for those who are travelling out of area. Dementia specialist ward could have more flexible visiting time around mealtimes, to help with nutritional needs as appropriate. Based on having an agreed approach to support people this could potentially change to NEUTRAL IMPACT because we'd have mitigated against the impact. Equality impacts of travel, including areas of social deprivation are further explored in the EIA.		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
	Impact on choice agenda	Provide patient choice wherever possible	**NEUTRAL IMPACT** Choice is limited due to the nature of inpatient mental health. Choice would be offered where possible.		
WELL LED	Aligns with trust vision, values, and strategic objectives	Objectives of the project align with the trusts.	**IMPROVEMENT** The vision of the transformation sets out clear objectives that align to trust values – see project vision and objectives (shared with Service Users) in the business case. There is potential for improvement in the digital access to the wards,		
	Takes account of the needs of service users, staff, public and other stakeholders	The needs of stakeholders are reflected in the design of the service.	**IMPROVEMENT** A wide range of engagement has been held between 2015 and 2023 to ensure that these needs have been considered and factored into the design. Although much of the major public engagement was before 2020 a formal public consultation process will inform any future design of the options.		

Appendix 1

Our current ward beds allow us to have around 85% bed occupancy, which allows for surges in admissions and mostly avoids any delays in admission due to no beds being found in the trust. We have almost no out of area placements of our older adults inpatients.

Below is a table of our bed use over recent years:

Year	Total Available Beds Days	Occupied Bed Days Inc Leave	Occupancy Rate Inc Leave
2018	27010	22905	84.8%
2019	27010	23451	86.8%
2020	27084	22069	81.5%
2021	27010	24024	88.9%
2022	27010	23148	85.7%

This is split across condition and gender as follows:

	Female	Male
functional	59%	41%
organic	46%	54%
Grand Total	**55%**	**45%**

Populations projections from POPPI combines with the age profile of our patients allows us to project how many beds we may need in the future. The table below shows an increase of around 100 beds over the next 17 years, it is to be noted that previous population increases have not been realised in bed use. This may be because of improvements in care and support for mental health and improving lifestyle factors.

Condition	18-21	2025	2030	2035	2040
Dementia	93.2	105	112	125	131
Functional	202.6	217	239	259	267
Total	**296**	**322**	**351**	**384**	**398**

Demand modelling shows that we can expect to have the following occupied bed days (excluding leave) over the coming years. With a presumed reduction in length of stay and an increase in local population.

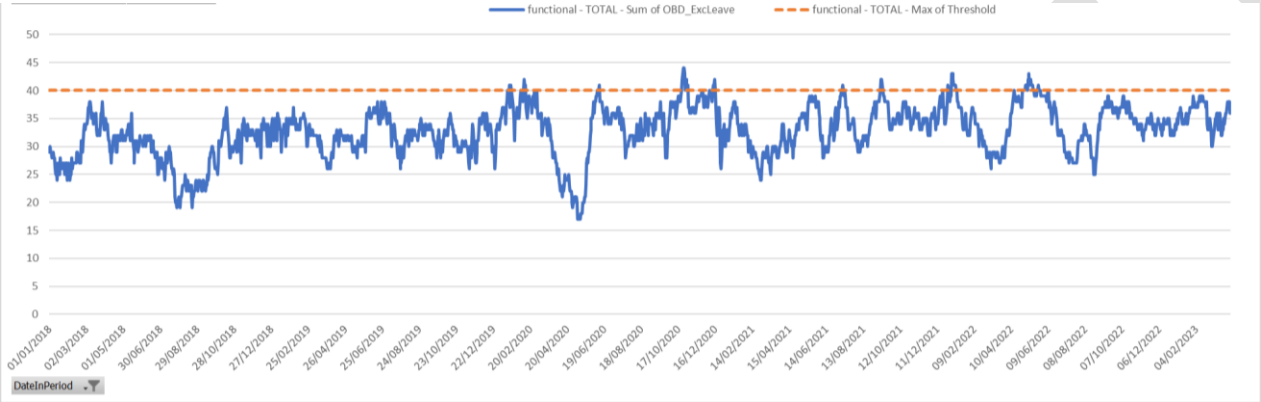
	2025	2030	2035	2040
Functional	32.7	36	39	40.2
Organic	23	27.4	27.4	28.7
Total	55.7	66.4	66.4	68.9

Appendix 2

Surge Testing

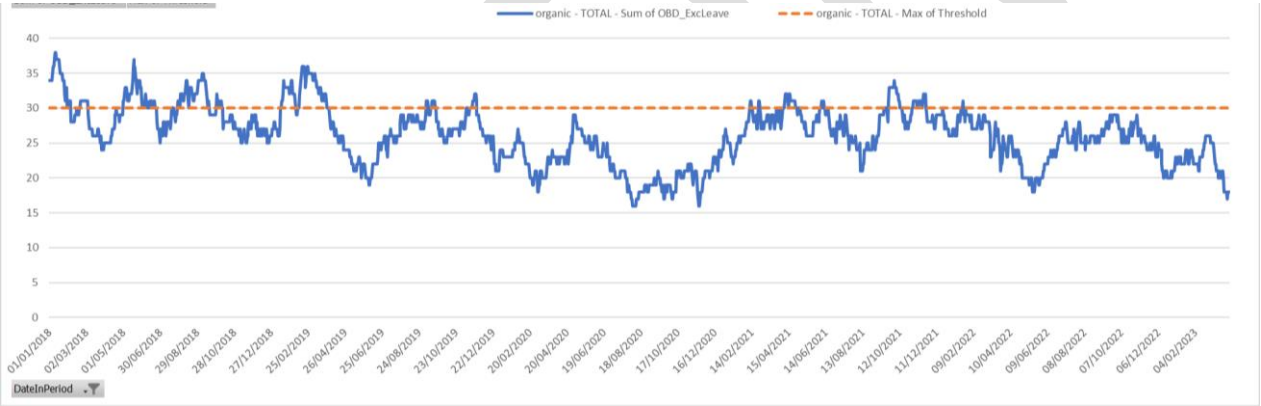
The table below shows the day-by-day bed use, by functional and dementia/organic needs of people from Calderdale, Kirklees and Wakefield from 2018 to 2023, including leave:

Overall functional bed use:



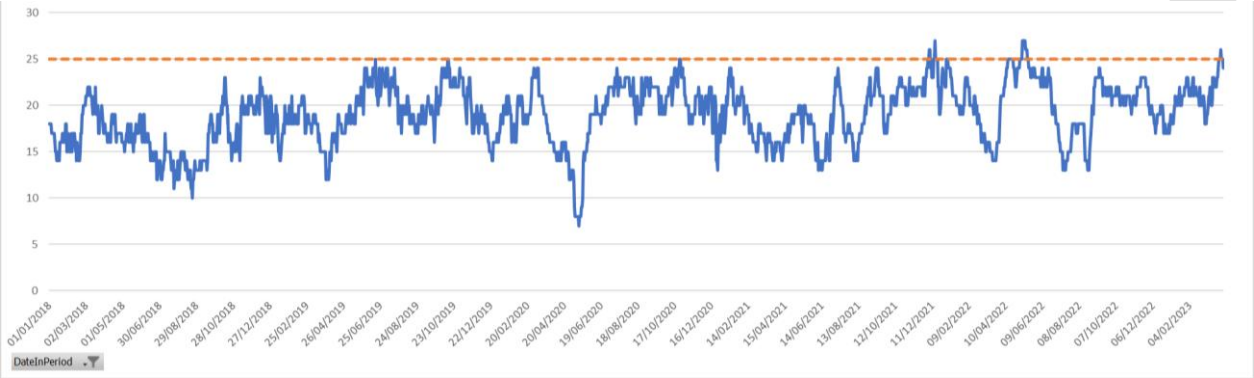
This shows that a model with around 40 beds overall should be enough for the vast majority of time.

The table below shows the overall dementia bed use:

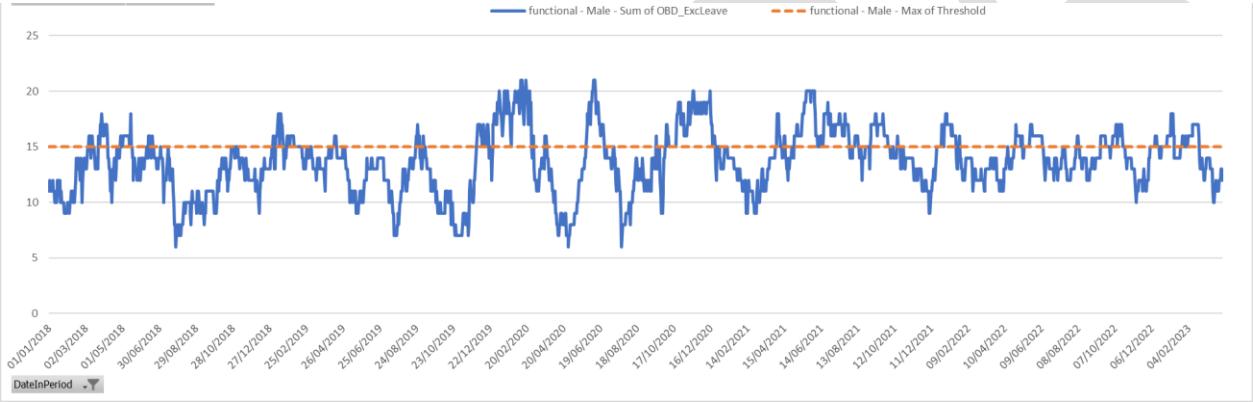


It shows that 30 beds is enough for the vast majority of time over the most recent 4 years, though there were several instances in 2018 and early 2019 where more than 30 beds were needed.

Functional female daily demand:

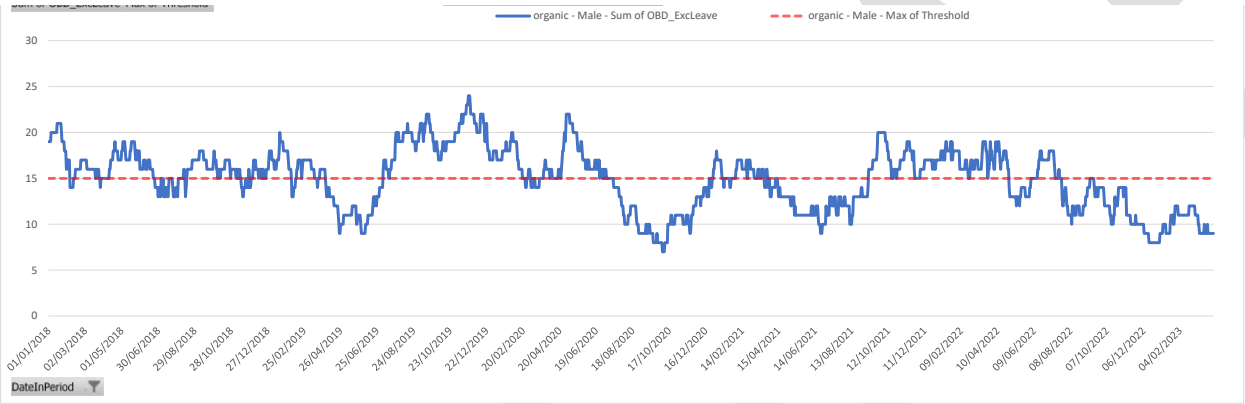


Functional male daily demand



Dementia Female:

Dementia Male:



Gender use:

- **Functional:** Whilst 40 beds is enough to meet overall demand for functional beds there appears to be an upper ceiling of around 25 female beds and 20 male beds in use.
- **Dementia:** Whilst 30 beds is enough to meet overall demand male use has often been above 15 but only rarely above 20. Female bed use has mostly been within 15 but has occasionally gone above.