SWYPFT OPS Inpatient Transformation Pre-Consultation Business Case

Version Control (major version changes):

Current version: 1.0

Major Version	Date	Reason	Name
0.1	20/02/23	Sharing first draft for programme board review and section update	Ryan Hunter
0.2	04.09.23	Structure and additions factoring feedback from various sources, options workshops and other 2023 activity, surge testing analysis, how the current model maps to vision, further revisions and summary impact assessment text	Ryan Hunter and Matthew Burns
0.3	12.09.23	Minor edits following feedback from programme board, including equality summary text, alignment of appendices	Ryan Hunter
0.4	24.10.23	Updates following NHSE assurance review.	Ryan Hunter
0.5	24.11.23	Minor amends following further feedback	Ryan Hunter
1.0	21.12.23	Updated following governance processes	Ryan Hunter

1 Foreword

South West Yorkshire Partnership NHS Foundation Trust and West Yorkshire Integrated Care Board are committed to working together to make sure that the people we care for have access to the right care and support, in the right place, and at the right time. This commitment is at the heart of our transformation programme for older people's mental health inpatient services.

Living with dementia, or a functional mental health need such as anxiety or depression, is often complex, and affects people in multiple ways; not only from a mental health perspective but physically and socially too. We know that being close to home is better for people's care and their wellbeing, and is also better for their families, carers and loved ones.

Over the last eight years we have made significant improvements to older people's mental health services in the community. The model provides a holistic approach which gives people access to a wide range of services and promotes early diagnosis and intervention.

Fantastic partnership working across providers in the community means that there are core central services with close links into GP practices and community physical health teams across Calderdale, Kirklees and Wakefield.

The substantial work we have done around the community model now means that most people are cared for as close to home as possible.

Our focus is now to look at how we can better support the small proportion of people who are acutely unwell, who present with complex needs and co-morbidities, and therefore need admission to an inpatient ward.

At the moment, most of our older people's mental health inpatient wards are mixed, which means people with dementia and people with functional mental health needs share the same ward space.

A person's experience of living with dementia or a functional mental health need is very individual. Each day may feel very different, and the care and support needed to best support a person should be tailored and personalised. Factors such as a person's environment, and specialist activities really matter in managing wellbeing and a person's condition.

It is so important that all our patients get the right care in a safe and supportive environment. We know that the clinical and personal needs of people living with dementia or a functional mental health need are different. Sharing a ward space often means that they do not get the appropriate specialist care that they should.

Creating separate wards for people with dementia, and people with functional mental health needs, will help us give the right type of care and support on all our older people's inpatient mental health wards. It means that people will be admitted to the right place, first time, which means they are less likely to need to move wards during their stay and can be discharged sooner.

Families, friends, carers and loved ones make a big difference to the wellbeing of patients on our older people's wards. We have heard strong feedback from them about how separate wards would work better. We are hopeful that these changes will give those who have a caring role for our inpatients a more positive experience when visiting their loved ones.

We know from all our work and engagement that continuing with our current model is not a viable clinical option for the older people who need our care and support. It is not in line with

best practice, does not meet the needs of either patient group nor does it address the challenges we face with some of our current estate.

Our business case explores the options for creating a specialist service which gives older people the most appropriate evidence based and best practice inpatient care to a high standard. We believe that a public consultation will best help us to understand what matters to people and help us make the right decision for patients, their carers, families and loved ones.

Professor Subha Thiyagesh,

Chief medical officer,

Consultant in psychiatry for older people and clinical lead for older people's transformation, South West Yorkshire Partnership NHS Foundation Trust

Vicky Dutchburn

Director of operational delivery and performance and senior responsible officer for older people's transformation, NHS West Yorkshire Integrated Care Board

2 Contents

3 Executive Summary

3.1.1 Foreword

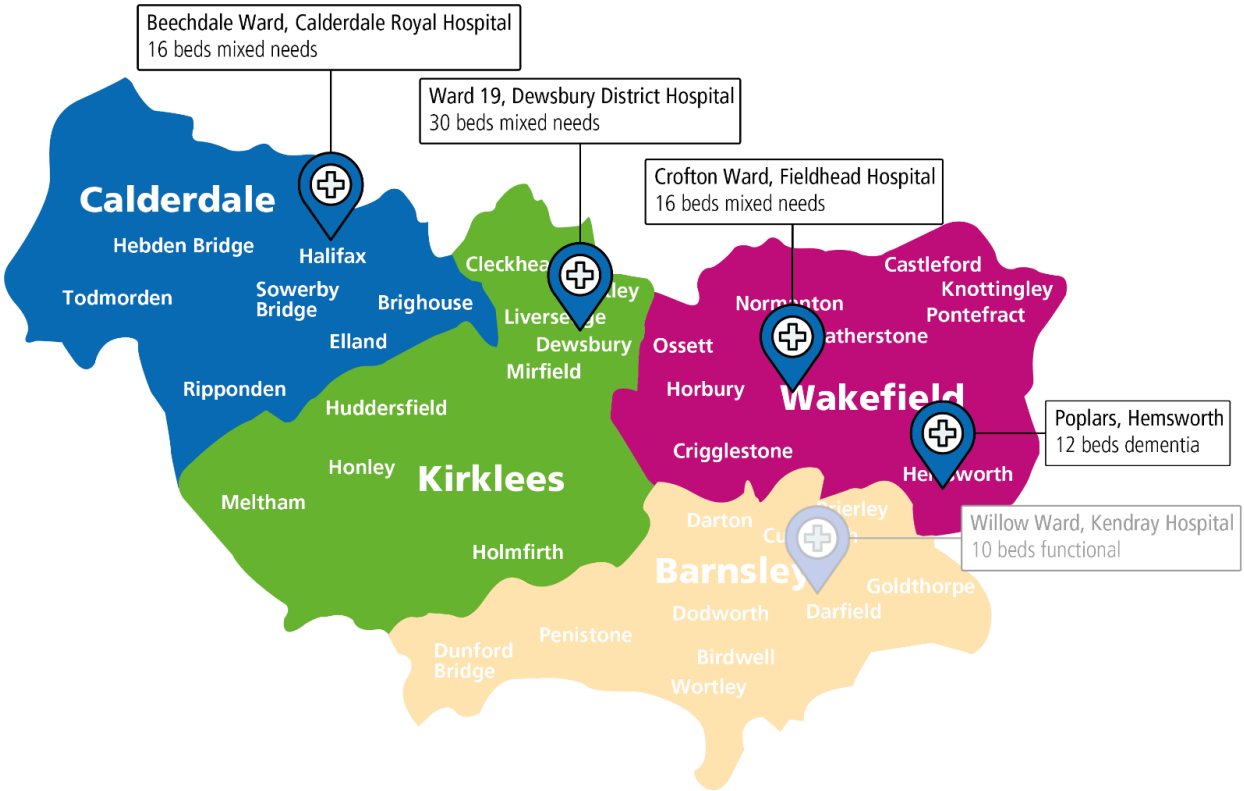
Professor Subha Thiyagesh, Chief medical officer and consultant in psychiatry for older people, South West Yorkshire Partnership NHS Foundation Trust, and Vicky Dutchburn, Director of operational delivery and performance, NHS West Yorkshire Integrated Care Board, outline the challenge to provide better care for older people that require an acute mental health inpatient admission. The current model doesn't enable the support or the service that people should receive because the wards currently care for people with dementia needs in the same environment as those that have other, functional, needs. People should get the right care in a safe and supporting environment and to do so we need to create separate specialist wards for people with dementia and people with other needs.

3.1.2 Introduction

This section describes the work that has been done in partnership between South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and the Integrated Care Board (ICB) to explore how to improve mental health services for older adults.

The work has been done together with system partners to focus on solutions that deliver a range of improvements across older people's inpatient services but predominantly seek to address challenges of a model that mixes patients of different needs across the wards.

The map of the current model:



3.1.3 Context and Current Service Model

This section describes the context that the service currently operates in and the people that the model caters for.

Community transformation improvements have been made already which include improvement across the following domains:

- Ensuring there are fit for purpose intensive community support services in all places.
- Appropriate specialist workforce across all services.
- Improved care home liaison services that reduce unnecessary admissions.
- Equitable psychological services for older people.
- Maximise productivity to support sustainability.

These changes have helped to enhance community offers and mean that only a very small proportion of people require inpatient admissions. Patients are admitted to older people's mental health wards because the symptoms of their dementia condition or other mental health or are no longer manageable in a community setting. There is usually a significant degree of risk involved to themselves or others and often patients are detained under the mental health act.

Commonly inpatient wards see:

Patients with depression and significant risk of self-harm, self-neglect, or suicide.	These are sometimes referred to as 'functional needs'
Patients experiencing hallucinations that have significantly impacted on their ability to live safely independently, or who pose a risk to others.	
Patients with a mood disorder (such as Bipolar), who may have a risk of suicide, neglect, vulnerability, or risky behaviour.	
Patients with dementia who are experiencing BPSD (behavioural and psychological symptoms of dementia), that have led to a risk to others, or who are unable to live safely in a community setting.	These are sometimes referred to as "organic needs"

Typically. there will be between 80-100 people with dementia admitted per year and between 150-200 people admitted with functional mental health needs across Calderdale, Kirklees and Wakefield.

Data also shows that there has been a reduction in admissions over 10 years, though lengths of stay have increased in this time period.

Population analysis shows an increasing number of older people and projections are for this population to grow, meaning that there will be more people with dementia and more older people with other mental health needs in years to come.

We also know that people from across the protected characteristics are key users of the service, that carers and family members are key stakeholders in the care of our service users and that a higher proportion of people from more deprived areas require services.

3.1.4 How the current model works

This section describes how the model operates and what the challenges are in the current system. Features of the current model are:

Mostly mixed needs wards of people with dementia sharing the ward with people that have acute functional mental health needs. This can create a challenging environment as the mix of patients doesn't work well from a clinical or therapeutic perspective and increases the risk of incidents.

Often people are moving between wards, which is detrimental to their wellbeing, impairs continuity of care, prevents best use of therapeutic interventions and leads to increased length of stay. 30% of people have more than one ward stay as part of their inpatient spell. 45% of people with dementia have more than 1 ward stay. 30% of people are admitted to a bed outside of their locality.

Admissions have been reducing but there has been an increase in the length of stay (LOS) over time, particularly for people with dementia.

Not all wards are aligned with other services, for example, an isolated ward in Wakefield, the Poplars, which due to location has issues admitting a high level of acuity and access to timely support when required. Following a 2022 visit, the CQC noted that the location of the Poplars away from any other of the trust's location meant that the staff team were isolated in terms of access to urgent support or cover for unplanned staffing issues. They also stated "We were concerned that the distance from The Poplars to other trust locations would impact on out of hours medic assessments".

Some ward environments are challenging. For example, Beechdale ward in Calderdale has narrow, twisting corridors that lead to 'dead ends' and the corridors do not allow the staff to have full line of sight of the whole ward and patients can find this hard to navigate.

The workforce model across the wards is inadequate for the level of care required. The wards regularly need to bring in bank and agency staff because there aren't enough ward staff to cater for the high levels of need.

3.1.5 Vision for the clinical model

This section sets out the national and regional context and explores what the best practice for older people's inpatient services should be to establish a vision for the model.

These include separate wards for diagnosis, functional and organic, delivering the specialism to meet needs; specialist ward environments; accessible services for service users, carers, family staff and partner organisations; improved pathways and fewer ward moves; reduced length of stays; the right level of workforce and skills; meeting the needs of people from the protected characteristics.

3.1.6 How the current inpatient model compares to what we need

This section maps the gap between the current model and the vision for our services. It summarises some of the key differences including the mixed nature of the wards, challenges

with environment and ability to deliver therapeutic interventions, locations, staffing, incident management, pathways and length of stays.

3.1.7 Benefits

This section sets out what benefits should be achieved and how they should be measured by making improvements to the inpatient system. These include improved clinical outcomes for service users, improved experiences for service users, carers and staff, reduced incidents and shorter lengths of stays.

3.1.8 Development of options

This section sets out the process of developing options. It covers the activity from an initial long list to shortlisting and finalising the options that will deliver the vision for the clinical model and therefore viable for a public consultation.

The **Patient, public, carer and wider stakeholder engagement** section describes how there's been a range of engagement with stakeholders through the programme. These have included major stakeholder events, focus groups, ward visits, meetings, presentations, and briefings. A range of stakeholders have been central to development of the programme, including clinicians, patient groups, the public, key partner stakeholders including local authorities, and political stakeholders. This has enabled the vision to be developed and then the options established to meet this vision, in a fully co-designed way with the key stakeholders impacted.

The section summarises some of the key themes we've heard from our service users and clinicians. It describes some of the issues that our service users and carers have found with the current model but also flags considerations required and the potential for travel impact of different models / potential options.

The staff feedback considers the strengths of different models of care and highlights some of the ongoing challenges of maintaining the current system.

The **developing options** section sets out how the programme team reached options that could be recommended for consultation.

There was a consensus view, supported by the clinical senate, that new, purpose built, opportunities would potentially offer the best long-term solutions but that these would not be deliverable in a 5-10 year period. Therefore, this is not a viable option in the medium-term scope of up to 10 years, but potentially an option that should be considered for the longer term.

Over recent years the programme has been through a detailed process that has been clinically led to consider and develop options for the inpatient model and that this process has factored in the views of stakeholders and the needs of the protected characteristics to support the options process.

A structured process took place of shortlisting from the long-list and the clinical senate supported this process. The programme team worked with a range of stakeholders to ensure that the options being considered appropriate for consultation were the right ones.

Options	Comments	Decision

No change to the current model	Not felt to be a viable / sustainable model but to remain in options work to provide baseline and benchmark.	Shortlisted
Ward 19 dementia unit, 6 extra beds at Crofton (The Poplars site is not in this model) which would be managed as a single ward, Beechdale functional	Clinically viable	Shortlisted
Ward 19 dementia unit, 2 extra beds at Crofton (functional), 1 extra at Beechdale Ward (functional). (The Poplars site is not in this model)	Clinically viable	Shortlisted
Ward 19 dementia unit, all others functional (including The Poplars site).	Not clinically viable	Not Shortlisted
Ward 19 dementia unit, 10 extra beds at Fieldhead, adjacent to Crofton ward for functional needs managed as 2 wards (The Poplars site not in this model). Beechdale functional.	Clinically viable	Shortlisted
16 dementia beds at Beechdale Ward, Ward 19 functional, Wakefield stays the same.	Not clinically viable	Not Shortlisted
East/West Split option – 20 bed functional at Ward 19, 16 functional beds/10 dementia beds at Crofton, 10 functional beds at The Poplars, 16 dementia beds at Beechdale.	Not clinically viable	Not Shortlisted
East/West split: 10 dementia beds being repurposed at Crofton, making the site 16 functional and 10 dementia, 16 dementia beds at Beechdale Ward, Ward 19 functional	Not clinically viable	Not Shortlisted
Crofton dementia unit, 26 beds (as 2 separate wards). All other wards functional (The Poplars site not in this model)	Clinically viable	Shortlisted

The programme undertook a detailed options review of the potentially clinically viable options, and the options were reviewed in 2023 with the most recent data and information to support this review. A shortlist of options that were potentially clinically viable to take to consultation was agreed based on the evidence.

3.1.9 Capital and Revenue implications

This section explores the value for money and affordability of the different options.

It describes the capital implications of the building work required for each of the options and describes how this is affordable within the current capital constraints of the provider Trust so long as this programme is prioritised. The cost of capital of ranges from £5.5M to £8.2M for the options.

The NHS WY ICB has confirmed prioritisation of this scheme from a system capital & estates perspective.

It covers the revenue implications of the different options and explains how a scoring criterion has been established for each of the options and a summary of the scores each option received for value for money.

This section of the business case also explores when the funding for the options in the model will be required and sets out a series of agreed principles of how the provider and commissioners will work together over the coming years to achieve funding for any agreed model.

3.1.10 Options to take to consultation

This section summarises the overall scoring and describes the options that are viable to take into formal consultation when clinical quality, value for money and affordability have all been taken into account.

The table below summarises the scoring of the different options that were shortlisted for further consideration. The text in red shows where an option did not meet the threshold required against a domain:

	Quality Domains				Total quality score	Value for Money	Total	Capital Required (£million)	Revenue (£million per annum)	Quality/ Equality Impacts
	Quality (clinical)	Access	Deliverability Sustainability	Strategy alignment						
Weight	30	20	10	10	70	30	100			
No change	12	8	2.5	4	26.5	21.6	48.1	-	£7.0 (budget) £8.1 (actual)	Only Poplars ward is a dementia only ward, all other wards are mixed dementia/functional. Concerns raised about environment for dementia at Beechdale not addressed. Will need to consider that Poplars will need to be replaced within the 10-year time frame of the programme because of site isolation.
W19 dementia unit, 6 extra beds at Crofton	15	8	4	5	32	25.2	57.2	£5.5	£8.2	Separate specialist wards are evidence based and recommended by clinical bodies to improve quality and patient experience. 22 bed ward at Crofton above national guidance Alignment with local partners, clinical and support services. Some increased travel distance/time for visitors.
W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale	18	6	2.5	4	32.5	22.8	53.3	-	-	Discounted option due to deliverability and issues with capacity in this model.
W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards)	21	14	6	8	49	20.4	69.4	£8.2	£9.1	Separate specialist wards are evidence based and recommended by clinical bodies to improve quality and patient experience. Alignment with local partners, clinical and support services. Some increased travel distance/time for visitors.
Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	44	20.4	64.4	£8.2	£9.3	Separate specialist wards are evidence based and recommended by clinical bodies to improve quality and patient experience. Alignment with local partners, clinical and support services. Some increased travel distance/time for visitors, Calderdale dementia with a larger travel impact.

The options appraisal process found the following options were potentially viable. These are:

A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield.

There are two ways that this could be done:

a) 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 Ward would operate as 2 wards across the 26 beds.
b) with additional functional bed capacity of 6 beds being relocated to Crofton Ward and an overall inpatient bed number of 68. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward.

And:

A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees.

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.

No change is not a clinically viable option.

3.1.11 Impact of options

This section describes the impact of each option in more detail. It focusses on the travel impact for patients, family and carers, the quality impact of each option, the equality impact, the impact from a sustainability perspective and what the options mean for each place.

The travel impact section describes the travel impact of differing options on family and carers visiting loved ones and the impact on staff. In all options, some people will need to travel further. Around 80 people per year will need to travel further if the dementia unit is in Dewsbury and around 100 people per year if the unit is in Wakefield. The average public transport time for someone traveling from Calderdale to Wakefield is around 100 minutes (compared to 60 minutes to Dewsbury).

Consideration will be given to this and how people can be supported with travel in the consultation process.

The quality impact assessment describes how each of the options has a net overall benefit but how these differ from option to option. The options all deliver clear clinical benefits across quality domains including safer, more effective, caring and responsive services but do require mitigations in terms of access for family and carers, access for organisations working across boundaries and flexible environments to cope with surges in demand.

In addition, the Dewsbury dementia option (b) with 68 overall beds requires further mitigations linked to the large ward and ensuring an appropriate therapeutic environment as well as mitigation to support managing mixed gender wards for all functional service users.

The equality impact assessment considers who is likely to be diagnosed with organic and functional conditions from local and national research and compares this to who our services

support from protected and other groups. The data, insight from our engagements, travel analysis and ward design is then used to determine who may be potentially impacted positively and negatively by the proposed options. The EIA will be used to assure that we are ready to go to consultation as we understand who we need to hear views from.

Key considerations include who is not using our services, compared to expected use and seeking views from these communities to understand how best to meet their needs in any new service design, ward design priorities, including gender specific environments and travel and transport implications for family and carers.

The impact section also explains how the model does deliver overall benefits in terms of sustainability, especially in terms of the benefits of bringing the Poplars ward into a new build environment co-located on the Fieldhead site. There will be extra travel created for family and carers and the use of technology to contact loved ones and green travel options should be considered as mitigations.

The place impact describes how the proposed options impact on each place, focussing on both clinical impacts and travel impacts of the options.

3.1.12 Assurance

This section describes how the programme has assured the model, including the work we've done with the clinical senate, activity to test the options and model, and consideration of the 5 NHSE tests.

The clinical senate were fully supportive of proposals and strongly agreed that patients with functional and dementia should be cared for in separate distinct dedicated units. The options they proposed as clinically viable are the ones that have been considered for shortlisting and formal consultation.

The section also described how the options have been tested in various forums and with a wide range of stakeholders and have included a focus on whether we've reached the right options and whether there are any others that can be considered.

It directly considers the feedback we've received to date from NHSE and the 5 tests, in particular the 5th test in relation to hospital bed reduction to which the modelling shows that each option does have capacity to support overall demand.

This section also describes the governance that the programme has been through in 2023 to reach approval to take the business case and options into public consultation.

This includes agreement from the Trust Board, the Joint Overview and Scrutiny Committee and the Joint Integrated Care Board Committee of Calderdale, Kirklees and Wakefield.

As well as this, the NHSE NE&Y Regional Director confirms that they are satisfied that sufficient assurances have been obtained at this stage to support the need for the proposals to move to the next phase of the change process.

The WY ICB has confirmed support of the programme and process.

3.1.13 Consultation and decision making

This section sets out the high-level process for the public consultation and how a final decision will be reached on a preferred model to implement.

It describes the key audiences for the consultation process and how the programme will ensure that it considers equality and diversity at each stage of the consultation process.

The report of findings from the consultation will be used to inform the development of the decision-making business case.

A high-level timeline of the consultation process and decision-making process is included with a description of how the programme will manage political and legal risks.

3.1.14 Implementing the proposals

This section gives a high-level timeline of the activities required to implement any preferred model following a decision on which option to take forward for implementation. It describes the further planning activity required through 2024/25 to enable the model for any preferred option to go live in 2025/26.

4 Full Business Case

5 Introduction

5.1 Background

From 2015 onwards, a programme has been taken forward between South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and partners to considering how to improve the provider Trust mental health services for older adults. Whilst the programme of work has led to changes and improvements across community pathways, there have yet to be any changes to the inpatient model, which we know does not align to best practice models of inpatient care, see section on how the current inpatient model compares to the vision. Therefore, a partnership programme approach between SWYPFT and Integrated Change Board (ICB) partners has been established to focus on improving services for inpatients. This phase of work is now underway after being impacted by the global coronavirus pandemic.

This business case explores the challenges of the current inpatient model, the vision for the right clinical model and the opportunities and options to achieve the right clinical model.

5.2 Aims and objectives of the Pre-Consultation Business Case

The pre consultation business case aims to:

- Identify governance and decision-making arrangements
- Outline the case for change, including review current best practice, evidence and learning from other areas
- Define the impact in terms of outcomes and benefits
- Highlights potential disbenefits and mitigations that should be put in place
- Outline how stakeholders, patients and the public have been involved and how their views have informed options
- Describes the number of people affected and the benefits to them
- Outline how the proposed service changes will promote equality and tackle health inequalities
- Explain how the proposed changes impact on local government services and the response of local government
- Show that options are affordable, clinically viable and deliverable by demonstrating evaluation of options against a clear set of criteria
- Demonstrate links to relevant national and local commissioning plans
- Include an analysis of travelling times and distances
- Demonstrate how the proposals meet the government's five tests
- Identify any clinical co-dependency issues, including any potential impact on the current or future commissioning or provision of specialised or other services; and
- Identify indicative implementation timelines.

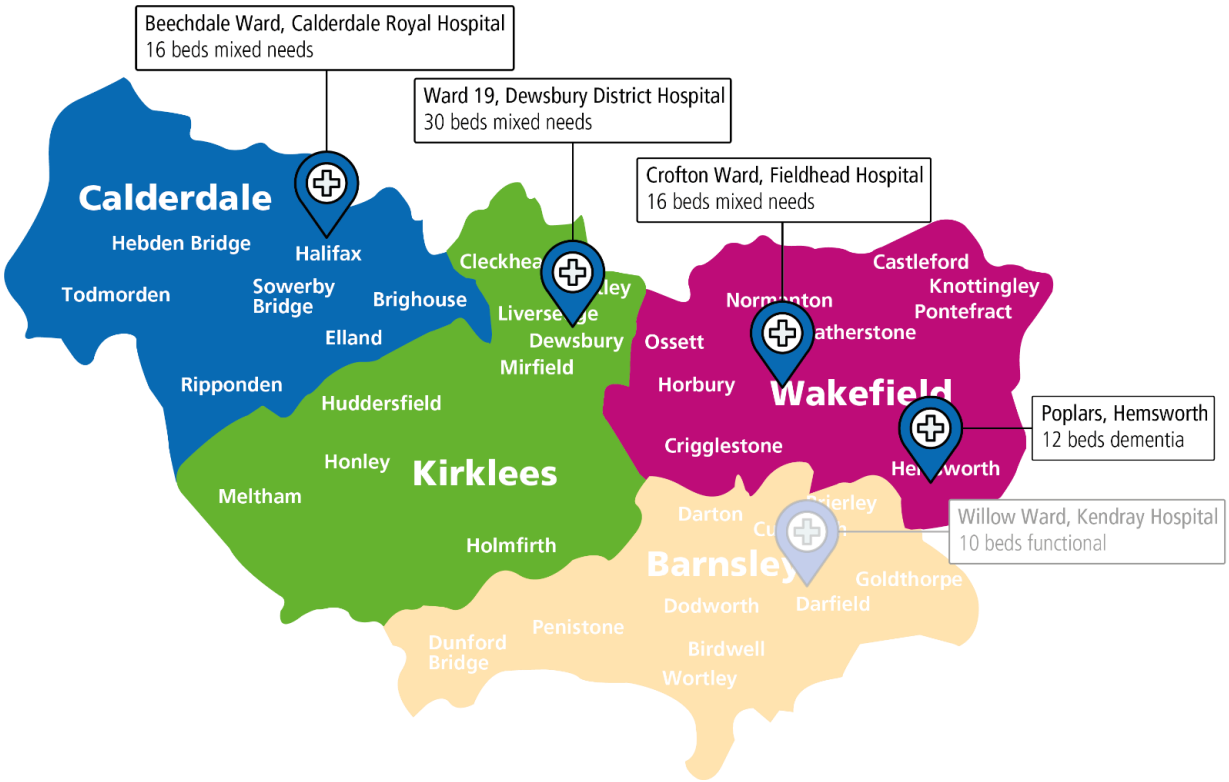
5.3 Scope of Business Case

The scope of the proposals in this business case are on the delivery of older people's inpatient mental health services across the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) footprint. It focusses specifically on the West Yorkshire part of the footprint (Calderdale, Kirklees and Wakefield districts) which would change service models if options for change are taken forward, provision of inpatient beds in Barnsley would not be affected.

The scope of this business case is limited to the inpatient model that SWYPFT delivers and not the wider system pathway. Interfaces with community services do need to be considered, in terms of how those services support demand and capacity for hospital stays and how those services need to operate to support the options being proposed. However, any wider community changes and transformation have been taken forward separately to this business case.

This document is a pre consultation business case and aims to show that options are viable enough to implement and therefore to take into a consultation process. A decision-making business case will be produced post consultation and propose a final option for implementation, having fully considered all feedback collected through the consultation.

The maps below show the current inpatient operating model and the sites that are in scope of the business case:



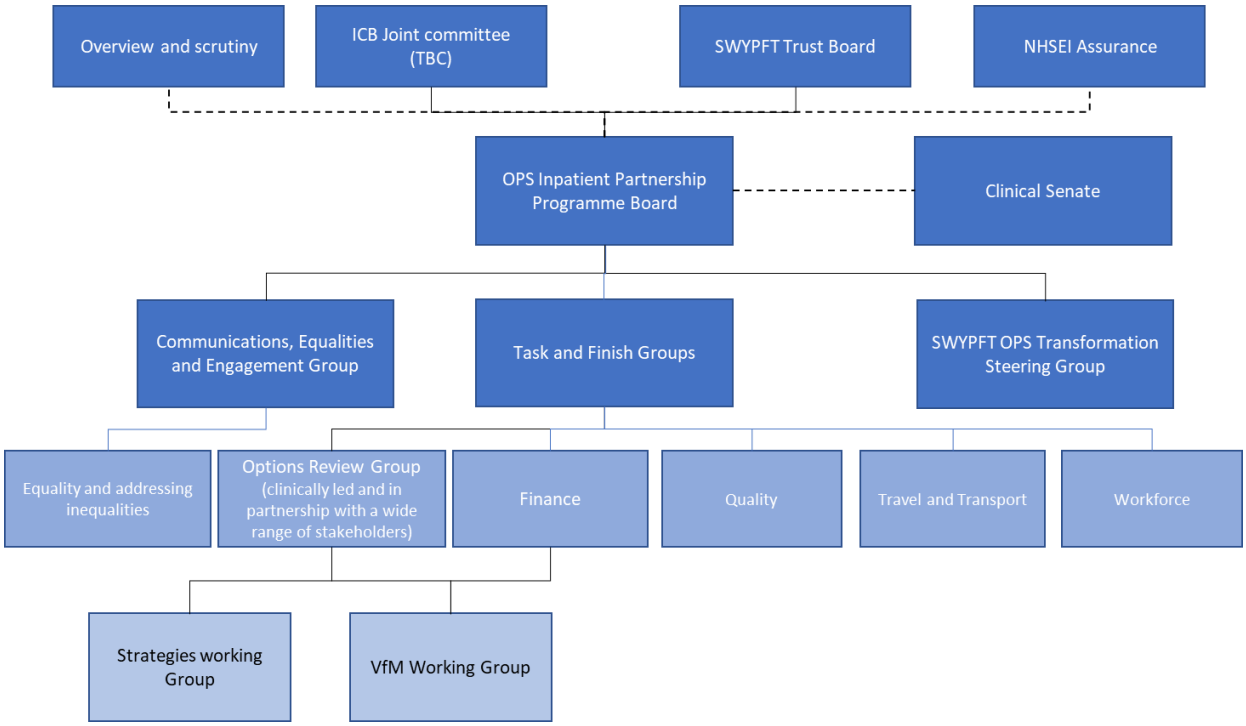
- In Calderdale, **Beechdale** is a 16 bedded, mixed gender and mixed needs, functional and dementia ward at the Dales in Halifax, which is located on the site of Halifax Royal Hospital.
- **Ward 19** constitutes 2 x 15 bedded single gender wards, both mixed functional and dementia needs, on the site 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.
- **Willow ward** on the Kendray site in Barnsley is the only exclusively functional only ward on the trust footprint and is a 10 bed, mixed gender ward.

In Barnsley there are no plans to change how the Willow Ward operates as Barnsley does not commission an inpatient unit for people with dementia. The number of people with dementia from Barnsley requiring an inpatient bed is small and so a spot purchase budget is in place should someone require an admission. Although Barnsley is an interested stakeholder, the impact on people from Barnsley is very limited.

There are 74 beds currently operating in the West Yorkshire model across Calderdale, Kirklees and Wakefield.

5.4 Governance Arrangements

Partnership governance arrangements are in place to oversee delivery of the programme and support system wide agreement on approaches. The model below summarises the governance:



5.4.1 ICB Approval – Joint Committee

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.

5.4.2 SWYPFT Trust Board

The SWYPFT Trust board is responsible for assurance of the proposals in the business case from a provider perspective.

5.4.3 Overview and Scrutiny (OSC)

The programme team worked closely with the scrutiny officers in each place to explore the possibility of joint scrutiny of the proposals. As a result, a joint health overview and scrutiny committee has been established to oversee the programme.

5.4.4 NHSE Assurance

NHS England assess and assure the business case and provide final approval (dependent on capital requirement).

5.4.5 Partnership Programme Board:

The Partnership Programme Board is responsible for holding to account the delivery of the programme. Its objectives and responsibilities include leading and directing the programme of work to define and deliver the business and clinical service change, reaching consensus agreement on preferred models and options, and making recommendations for local governance approval.

The programme board has an ICB chair who is also the Senior Responsible Officer for the programme. It is accountable to the SWYPFT Executive Management Team, ICB governing bodies, West Yorkshire Health and Care Partnership and will also report progress to and from NHS England in accordance with the NHS England Strategic/Major Change Assurance Process, see link for more information:

https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

The group membership includes senior and executive level clinical and operational leadership as well as finance, engagement, quality leads from across the partnership. It meets every 3 weeks.

5.4.6 Clinical Senate

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.

5.4.7 Communications Engagement and Equalities Group

The Communications Engagement and Equalities (CEE) Group has membership from across SWYPFT and ICB partners and is responsible for developing and overseeing the pre

consultation engagement plan and ensuring that the business model in development considers and addresses inequalities. It meets fortnightly.

5.4.8 SWYPFT Older People's Transformation Steering Group

The SWYPFT steering group has been responsible for giving an internal provider steer and supporting work to design and deliver options for service change. It has senior clinical and operational leadership as well as a range of leads from across specialist services. It meets every 3 weeks.

5.4.9 Options Review Groups

Partnership groups to assess viability of options have been established and held as required through 2022 and 2023 with membership including:

- SWYPFT
- ICB from each place
- Service managers from each local authority
- Both local acute Trusts
- Carer representation

The following professional leads have been part of options review activity:

- General Managers,
- Clinical and Medical leadership,
- GP representation
- Quality managers,
- Ward managers,
- Engagement and equality leads,
- Lead allied healthcare professionals,
- Social Care leadership,
- Estates and Finance leads,
- Dementia lead practitioner.

5.4.10 Other groups

Other groups have met as required, working on the principles of a partnership approach to take forward bespoke activity, across key programme areas.

6 Context and Current Service Model

6.1 Introduction to the Integrated Care Boards, SWYPFT and its services

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) is a specialist NHS foundation trust with a turnover of approximately £342m that provides community, mental health and learning disability services to 1.22m people across Barnsley, Calderdale, Kirklees and Wakefield. The Trust also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber.

SWYPFT services operate alongside the NHS West and South Yorkshire Integrated Care Boards (ICBs). These boards are statutory organisations made up of partners from across the NHS, local government and voluntary & community sectors. The ICBs work with partners in place to understand and meet the local health and care needs of people in each area and organise services appropriately in order to improve peoples' lives and address health inequalities. ICBs operate within a wider Integrated Care Partnership, which is a separate statutory organisation comprising the ICB and all local authorities within a geographic area, in this case West Yorkshire. The joint name for ICBs and ICPs operating within a geographic area is the "Integrated Care System".

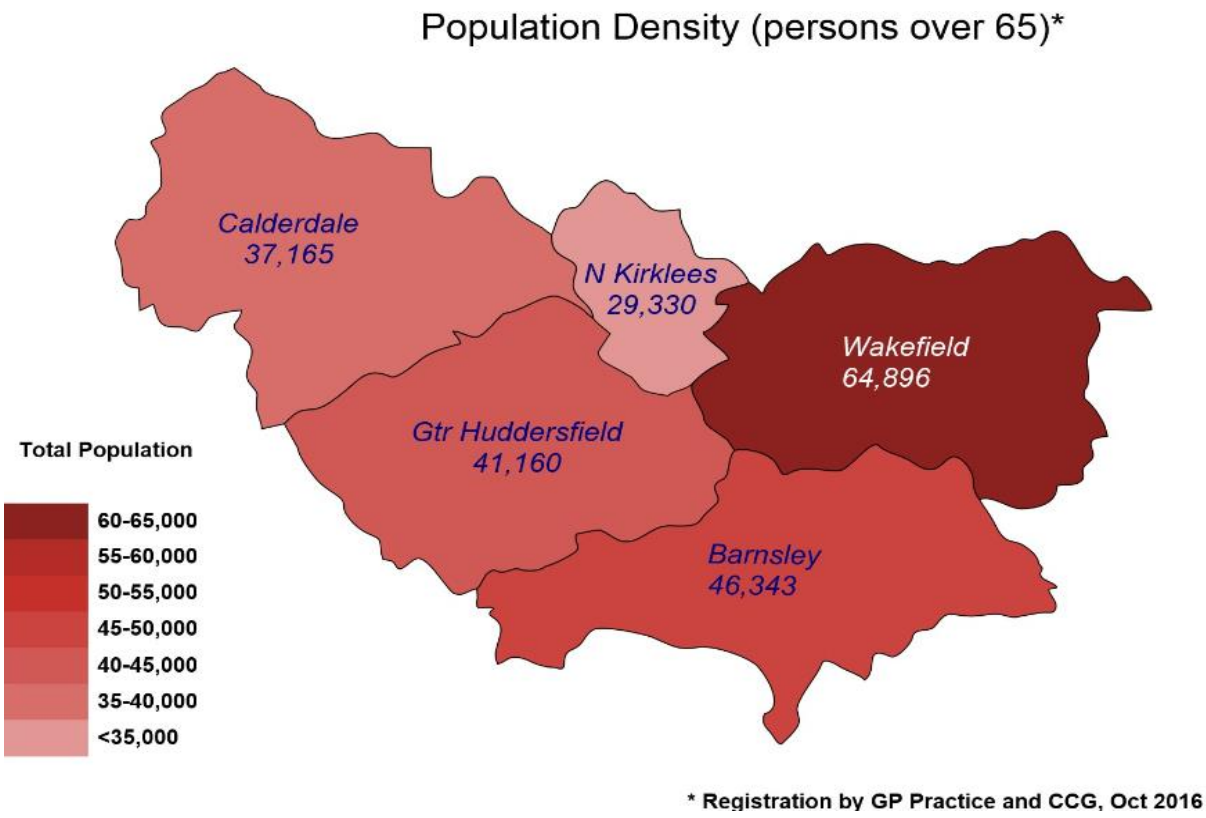
All SWYPFT services are focused on principles of recovery and co-production, working with the strengths of each person and those of their carers and wider community. The Trust provide services that promote health-producing communities and prevention through supported self-care, recovery focused approaches, peer support and community involvement, volunteering and supported employment.

The Trusts works in all villages, towns, and cities from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east and to Hoyland and the Dearne Valley to the south of Barnsley – and all points in between.

The SWYPFT daily mission is to help people reach their potential and live well in their communities. The Trust employs over 4,500 staff, in both clinical and non-clinical support services, who work hard daily to make a difference to the lives of service users, families and carers.

As part of this service model, the Trust delivers a range of community and inpatient mental health services for older people.

The map below shows the SWYPFT footprint and populations of people over 65 in each locality.



Kirklees, when considered as a whole (North Kirklees and Greater Huddersfield), has the highest over 65 population - 70,490.

It has approximately 10% more older people than Wakefield, 50% more than Barnsley and nearly double the Calderdale population.

Older people are disproportionately high users of health and care services including mental health. Dementia affects 944,000 people in the UK, which is 1 in 11 of people over 65 years old Prevalence and incidence - Dementia Statistics Hub The highest prevalence of depression in the population is found in those over 75 years (https://www.kingsfund.org.uk/publications/paying-price).

The majority of morbidity in older people is not dementia, but functional illness such as depression and psychosis. Suicide data also suggests that a suicide attempt in an older person is more likely to be successful and that men aged 75 years and above had the highest suicide rates (http://bjp.rcpsych.org/content/200/5/399).

More information on the population, the numbers of people that access our inpatient services and demographics and potential changes can be found further in this section.

6.2 Community Model and Improvements

As part of the **community** transformation programme for older people's services, an earlier phase of this programme's journey, initial set of requirements were established around best practice community models of care. These included age-appropriate specialist mental health services that are required to meet the needs of older people. We found that comprehensive

specialist mental health services for older people needed to be reconfigured and developed, to ensure all parts of the system provided:

- access to crisis home treatment
- care home liaison
- general hospital liaison
- early diagnosis and intervention
- access to psychological therapies
- ***an equitable distribution of resources*** within mental health services that takes account of an ageing population

Work on community models found a need to focus on the following areas:

- Ensuring there are fit for purpose intensive community support services in all areas
- Appropriate specialist workforce across all services
- Improved care home liaison services that reduce unnecessary admissions
- Equitable psychological services for older people
- Maximise productivity to support sustainability.

When we spoke with service users and carers about community transformation, people were generally positive about the community proposals and told us they prefer to be supported to have their care closer to home or in the home, for as long as possible. People were keen to ensure that our hours of service were appropriate, with extended hours available for people as needed. People were keen to ensure dementia awareness within a care home setting is built into a future model.

As a result of the work, a community model was established that operated as a framework to enable the community services to deliver transformation objectives. The model includes core central services with close links into GP practices & community physical health teams across each locality. These services support care being provided closer to home for those people accessing community services.

6.3 Community Pathways

Referrals to our services will be assessed by our Single Point of Access (SPA) team to determine which service best suits their needs. Often patients may need the input of more than one of our teams. The SPA team can assess any immediate risks within 4 hours if needed. If that referral is then passed onto our community teams it is triaged by a duty worker and then appointments/key workers are allocated as appropriate.

Our community offer varies slightly across the places that SWYPT covers but we offer:

- Crisis Teams: to assess and manage significant risks in the community through a variety of approaches such as: Medication review, medication management, advice and support, risk monitoring visits and use of local crisis beds.
- Community Mental Health Teams (CMHT): providing longer term input from a named nurse. A multidisciplinary approach is key to a CMHT service offer, with nurses, OTs, Psychiatrists, Psychologists and Support Workers, all working together to plan support, provide psychological interventions, review medications and manage risk.
- Memory Assessment Services: offer a comprehensive assessment of memory, which may result in a diagnosis of dementia and potentially medications, signposting and advice to help manage the condition.
- Care Home Liaison Services and practitioners– to offer support to paid care staff and to review and care plan for patients living in 24-hour care.

- Carer support including Admiral Nurses – support carers of people living with dementia, to help to understand the condition, manage behaviours that challenge and help navigate support.

6.4 Pathways with Partners

Our teams work alongside other health, social care and support services throughout the patient's journey. We share information (as appropriate), arrange joint assessments and make onward referrals.

When a patient needs a social care assessment discharge coordinators from the wards will refer to social service teams, these are either integrated with SWYPT teams or local authority based teams. We share our assessments of support needs and make collaborative decisions on discharge pathways with social workers in multi-disciplinary team (MDT) meetings.

When a patient's physical health needs are not manageable on our wards then we work alongside colleagues in local acute general hospitals. On some sites we have informal support arrangements with geriatricians working in co located acute hospitals. A patient could need transferring to an acute hospital bed. We will liaise with those wards, sharing risk assessments, medical histories, and current treatment. When a patient's mental health poses an increased risk on acute wards we will work alongside acute partners to manage that risk whilst they are an inpatient - in an acute hospital bed.

All patients that are detained under the mental health act, or do not have mental capacity and don't have an appropriate other person (attorney, carer etc) are offered a routine referral to advocacy services. Advocates are provided space on the ward to meet with patients that are referred, and they will also offer drop in engagement with other patients on the wards.

Care homes, that are identified as a place of discharge for our patients, are provided with information on a patient's risks and needs. They will then come to the ward to assess if they can meet the needs of the patient. Support following on from discharge is provided by the care home liaison team.

Discharge letters are sent to GP practices to inform them of our assessments, the changes in medications and the community support that is available to a patient post discharge.

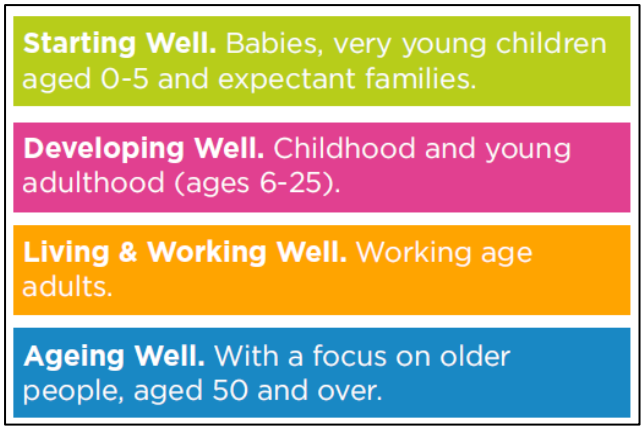
Care review meetings bring together all staff that are involved in a patient's care from community teams, inpatient teams, partner organisations, carers, and patients. This enables a collaborative, person-centred, decision-making process and promotes collaborative working. All our inpatients are registered for care programme approach.

A brief summary of strategies in place, community models of care and some of the developments that have been implemented include:

6.4.1 Calderdale:

The Calderdale Wellbeing strategy 2022-2027 has 4 core areas, with Ageing Well particularly aligning to this population. The charts below show the in-scope areas, the delivery aim and how Calderdale will deliver the strategy:

Core Areas:	What the strategy will deliver:	How the strategy will be delivered:



The goal of aging well is that older people have strong social networks and live in vibrant communities, including an aim of increasing in the percentage of older people who agreed or strongly agreed that they felt they belonged to their immediate neighbourhood.

It aims to develop and deliver community-based plans to achieve the four priority outcomes across the borough and in neighbourhoods.

SHARE, a community rehabilitation unit, is now open to all ages. This has been utilised by older people's services for those people who cannot maintain their safety at home but whose condition does not warrant an acute inpatient admission.

The SWYPFT core services in Calderdale are based in the Laura Mitchell and the Dales sites. Investment has taken place into a specific crisis team for older adults (Intensive Support Team Calderdale) as part of the community transformation programme. This team offers an extended hours 7 day a week service to support service users in their own residence and permanent 24-hour care. It became operational in September 2020. It is co-located at The Dales with the adult crisis team to support joint working.

The memory service has made improvements in diagnostic waiting times and has been accredited through the MSNAP process in 2022-23. It has diversified roles to include Advanced Nurse Practitioners to deliver more diagnostic appointments.

The model in Calderdale aligns with integrated care partnerships and the Neighbourhood/ Localities that are developed as part of the Calderdale Cares plans. It is hoped that the mental health community transformation will support further service integration and improved pathways.

6.4.2 Kirklees:

The Kirklees health and wellbeing strategy 2022 – 2027 sets out the place aims to achieve the 4 outcomes across the life course we will focus on 3 priorities, which are:

Mental Wellbeing:
Our ambition is that everyone in Kirklees achieves good mental wellbeing and has a good quality of life with purpose and fulfilment throughout their lives.

Healthy Places:
Our ambition is that the physical and social infrastructure and environment supports people of all ages who live, work or study in Kirklees to maximise their health opportunities and to make the healthy choice the easy choice.

Connected Care and Support
Our ambition is that organisations and professionals across the health and care system work together to ensure people are able to access the right care/support for their needs, when they need it, making the best use of all available resources.

The following describe some of the activity that local partners will do to support mental wellbeing:

- Understand your responsibility around suicide prevention; undertake training to help reduce stigma and know what you can do to help
- We will recognise people as experts in their own mental wellbeing, work in partnership with them and support them to self-care
- We will work together so mental ill-health and physical ill-health are viewed equally
- We will have good data, and use it and personal stories to understand people of all ages who live, work or study in Kirklees to inform evidence-based approaches to tackling mental wellbeing
- We will work together so support and services provided are easily accessible to meet the needs of those that require them the most and, where possible, are available in local communities.

The core SWYPFT services in Kirklees are based around the 2 ‘hubs’, Beckside Court in Batley and Folly Hall in Huddersfield.

The memory service has diversified roles to include Advanced Nurse Practitioners to deliver ‘one stop shop’ diagnostic appointments. It was accredited through the MSNAP process in 2021. The Admiral Nurse service has developed new roles in occupational therapy and works closely with the younger onset dementia team, CMHT and memory service to provide joint working for people with dementia and their carers.

Since the model was first established, Kirklees has moved from 5 to 9 Primary Care Networks (PCN’s). Work with PCN's as part of the mental health community transformation will support moving to fuller integration with the 9 PCN model. Kirklees already had an established older adult crisis team prior to the community transformation and this was used to model the practice and need in other localities. This team offers an extended hours 7-day service and works into people’s own home and care homes. The team is co-located with the adult crisis team to promote joint working.

6.4.3 Wakefield:

Wakefield District Health and Wellbeing Strategy 2022 – 2025 sets out its high-level vision and direction for health improvement for the Wakefield district:

It states that Mental ill-health is a concern for many people and suicide rates in the district are higher than the rest of the country, so we will invest time and money into helping people stay emotionally well, tackling the underlying causes of mental illness and supporting people who have mental health problems.

Amongst other objectives it states that we will ensure the whole health and care system works well together to help people live in good health for longer and reduce the need for people to be admitted to hospital.

Core SWYPFT services in Wakefield are designed around connecting care hubs in Wakefield and Pontefract, which is a joint NHS, local authority and Voluntary, community or social enterprise (VCSE) service.

There is integrated locality activity at the council hubs with scope to enhance integration with multi-providers on this site. The service aligns with new models of care including Connecting care and Frailty and older people's pathways.

The memory pathway has been aligned with the community mental health team to provide a core team model and smooth transfers of care for service users.

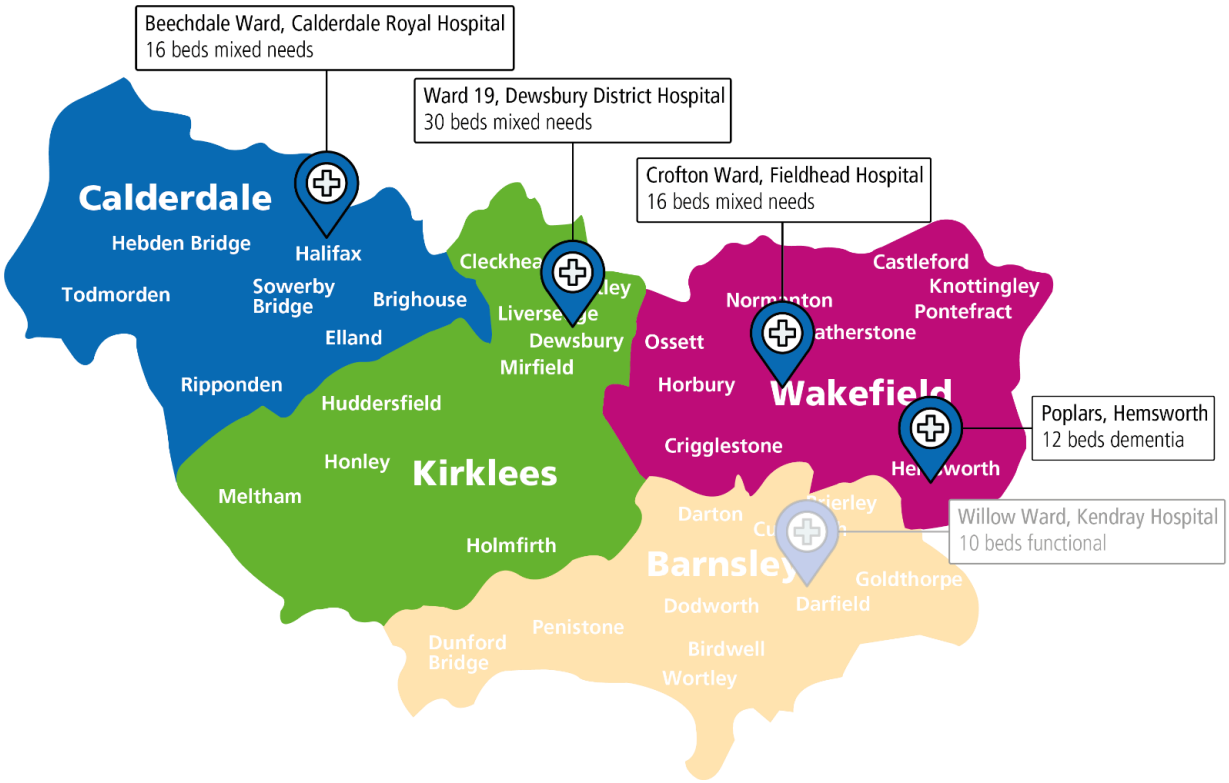
Community Teams and Intensive Support Services have further developed close working relationships to improve the care pathway. The care home liaison model is embedded within each element of the pathway. Primary Care Mental Health (MH) Practitioners are embedded in the Connecting Care Hubs and provide a seamless link between primary care and secondary mental health. Integrated activity in the connecting care hubs has developed on a locality level.

Primary Care MH Practitioners have close links with Locality Teams, District Nursing, MY Therapy and other providers in the connecting care hubs. This enables a timely and appropriate response to referrals. The Practitioners have also provided mental health consultation and training to colleagues within the connecting care hubs and GP colleagues.

The Trust is committed to continuing to evolve and support people through our community services as part of our mission to help people reach their potential and live well in their community. The data shows that these community models have been successful at reducing demand for hospital admissions, whilst older people's populations have been increasing.

6.5 The current inpatient operating system

Whilst the community models do aim to support most people at home, there is a continued need for access to inpatient care for a small number of people. The map below shows the current inpatient operating model:



6.6 Who the wards serve:

Patients are admitted to our older people's wards because the symptoms of their functional mental health or dementia condition are no longer manageable in a community setting. There is usually a significant degree of risk involved to themselves or others and often patients are detained under the mental health act.

Patient needs vary due to their condition, personal and social circumstances, as such there are a myriad of differing needs and risks when patients are admitted to our wards. However, commonly we see:

Patients with depression and significant risk of self-harm, self-neglect, or suicide.	These are sometimes referred to as 'functional needs'
Patients experiencing hallucinations that have significantly impacted on their ability to live safely independently, or who pose a risk to others.	

Patients with a mood disorder (such as Bipolar), who may have a risk of suicide, neglect, vulnerability, or risky behaviour.	
Patients with dementia who are experiencing BPSD (behavioural and psychological symptoms of dementia), that have led to a risk to others, or who are unable to live safely in a community setting.	These are sometimes referred to as “organic needs”

We would not admit patients who:

- Have a mental health condition that doesn’t pose a significant risk to themselves or others. These patients would be supported in the community with support from secondary mental health services if appropriate.
- Have increased support needs that are predominantly due to a physical health condition. These patients would be supported by appropriate physical health services and/or social care.
- Have significant cognitive decline due to late-stage dementia but do not pose a significant risk to themselves or others. These patients would receive a social needs assessment to support their changing needs.

Whilst patients are admitted on our wards they receive a thorough risk assessment, which leads to a care plan. This care plan will aim to reduce risks to a manageable level, but also not apply any restrictions on a patient that are unnecessary. Staff will also give 1 to 1 time, they may receive input from psychologists, OTs, Physios, and there will be a multidisciplinary review. In the review a psychiatrist considers medications with the aim of reducing risks or improving symptoms. We work with the patient, their family and advocacy services to ensure that the patient’s voice is central to the support we give.

When a patient’s symptoms have stabilised, we plan for discharge. We work alongside social services, community mental health teams, families, and carers, to plan a safe discharge. This can be back to a patient’s own home, with community mental health support and possible a care package from social care, or to supported living or a care home.

6.7 Recent use of and demand for inpatient stays

6.7.1 How many people access the services each year:

The table below shows the total number of people being admitted to inpatient services, from 2013 to 2022.

The data is based on any admission of any person aged 65 + across West Yorkshire (Calderdale, Kirklees, Wakefield) to SWYPFT beds:

	Functional	Dementia	Total
2013	238	161	399
2014	243	165	408
2015	224	149	373
2016	184	114	298
2017	165	115	280
2018	153	83	236

2019	175	82	257
2020	196	80	276
2021	184	91	275
2022	153	84	237
Total	1915	1124	3039

Total West Yorkshire admissions by place over the period:

Calderdale:

Calderdale	**functional**	**Dementia**	**Total**
2013	73	37	110
2014	61	41	102
2015	45	43	88
2016	46	32	78
2017	42	33	75
2018	45	20	65
2019	42	17	59
2020	60	22	82
2021	56	32	88
2022	33	27	60
Total	503	304	807

Kirklees:

Kirklees	**functional**	**Dementia**	**Total**
2013	91	62	153
2014	95	55	150
2015	96	42	138
2016	69	34	103
2017	64	40	104
2018	58	24	82
2019	89	30	119
2020	74	31	105
2021	78	24	102
2022	77	27	104
Total	791	369	1160

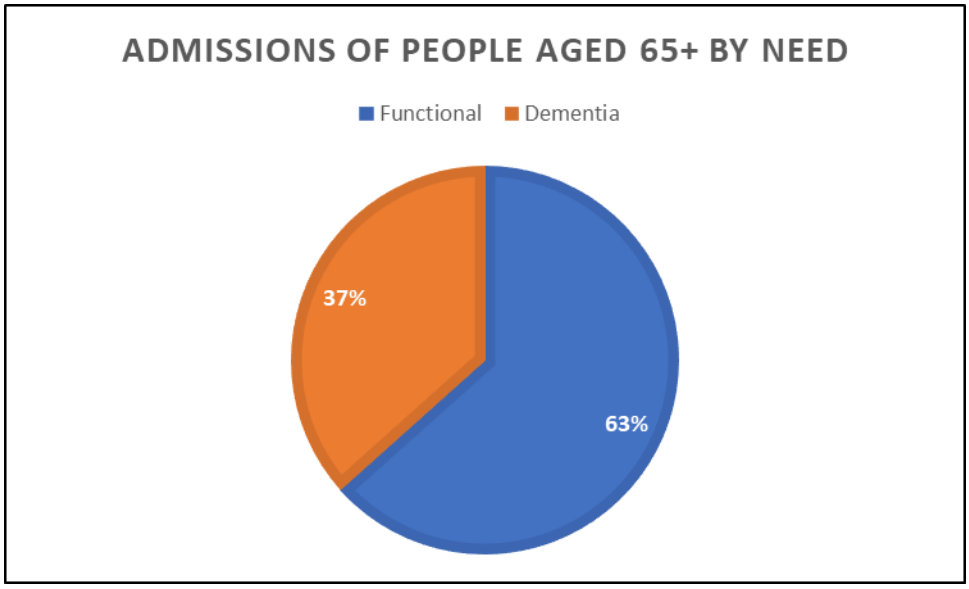
Wakefield:

Wakefield	**functional**	**Dementia**	**Total**
2013	74	62	136
2014	87	69	156
2015	83	64	147
2016	69	48	117
2017	59	42	101

2018	50	39	89
2019	44	35	79
2020	62	27	89
2021	50	35	85
2022	43	30	73
Total	621	451	1072

6.7.2 Functional and Dementia Mix

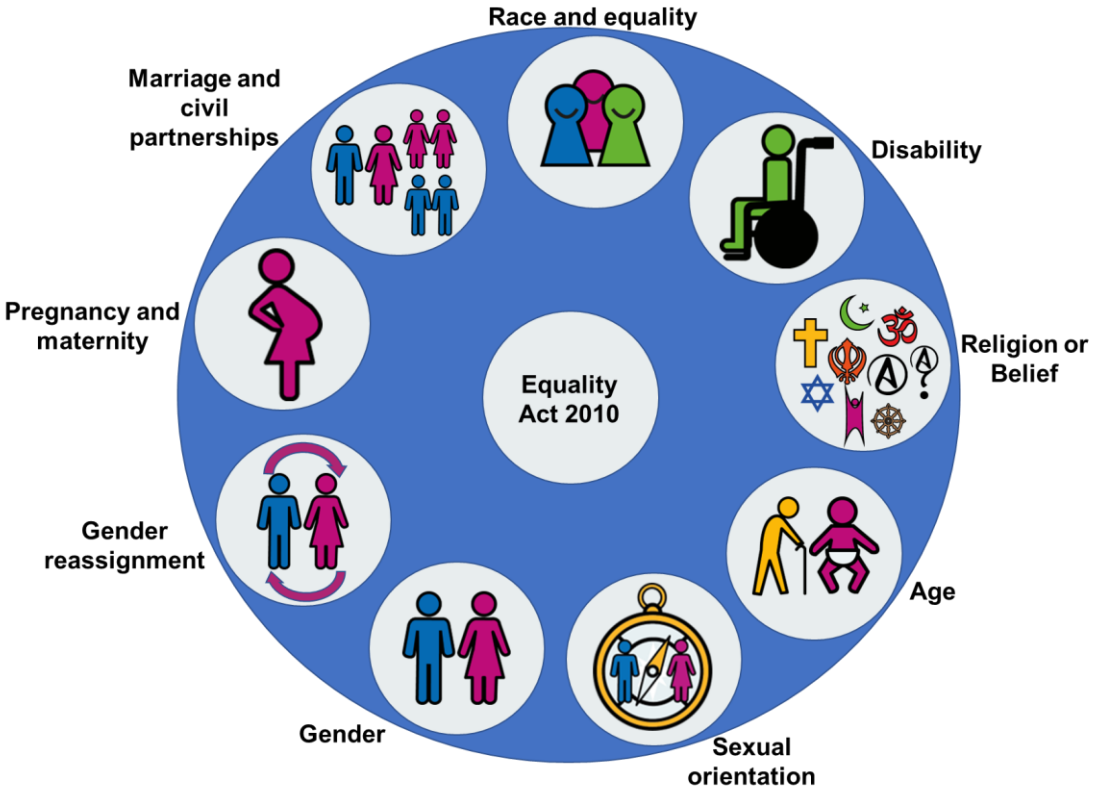
The chart below shows the totality of admissions of anyone aged 65+ from 2013 to 2021, split by functional and dementia needs from across Calderdale, Kirklees and Wakefield:



- 63% of the admissions are for functional needs, 37% are for dementia.

6.8 Who we provide services for from across the protected characteristics:

The diagram below shows the protected characteristics:

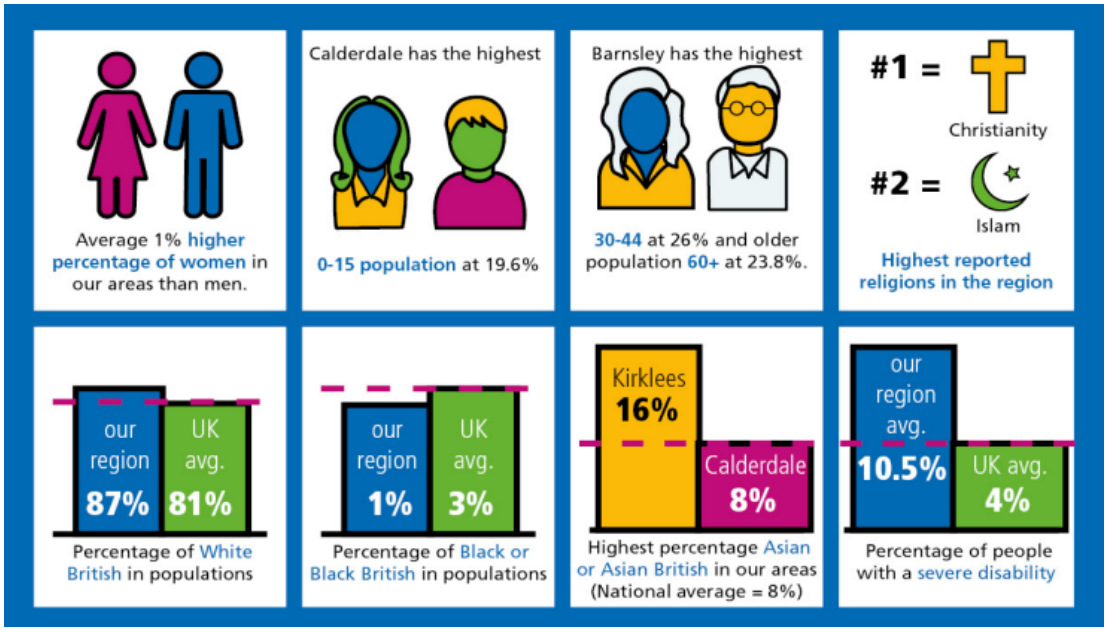


Carers are not one of the protected characteristics. However, ‘carers and representatives’ of individuals who use health services were specifically included in the legal duty to involve (s13Q of NHS Act 2006) as part of the 2022 Health & Social Care Act Changes, we recognise this as an additional consideration and therefore the impact for carers is part of equality impact considerations.

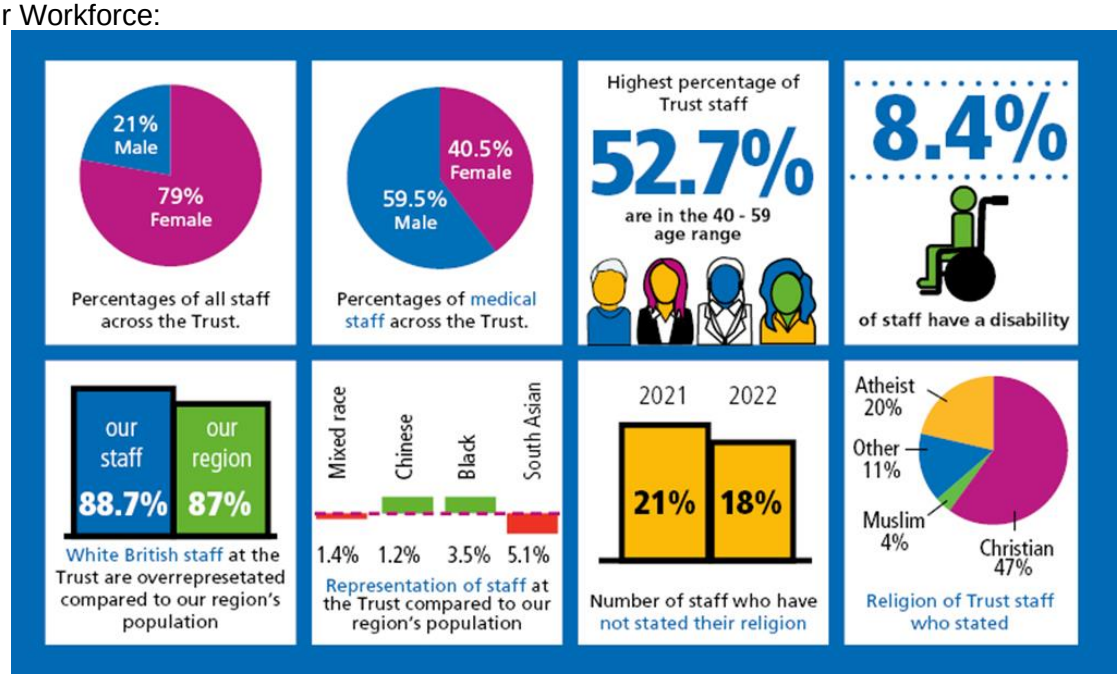
A desk top exercise to identify the specific impacts for each of the different protected groups based on national and local literature provided a baseline of insight.

The biggest identified single impact relates to travel and transport resulting in detailed analysis – with a particular focus on addressing inequality for the 20% most deprived postcodes and ethnicity.

Our population across the whole Trust (2011 Census data):



Our Workforce:



6.8.1 Carers, family and friends:

Nationally the statistics surrounding carers, family and friends is not fully understood but we do know that on average:

- 1 in 8 adults (around 6.5 million people) are carers.
- 6,000 people across the UK become a carer everyday.
- Approx. 260,000 unpaid carers, including young carers, living in West Yorkshire and Harrogate.
- 1 in 7 of our workforce currently balance work with their caring responsibilities, reaching to 1 in 5 in some sectors. The peak age for carers is between 45-64 years.
- 2.6 million people, to date, have given up work to care for a loved one (0.5 million within the past 2 years). A further 2 million have reduced their working hours.
- Carers save the economy £132 billion per year (average of £19,336 per carer).

- People providing high levels of care are twice as likely to be permanently sick or have a disability which can result in 'the carer becoming the client'.
- Carers experience multiple inequalities in both physical and mental health and they experience higher levels of social isolation.
- Women make up nearly 60% of carers.

6.8.2 Gender

- Women are more likely to make up the majority of patients in both functional mental health and dementia services across all services. This is in line with overall population of older men and women in the area.
- Women make up the majority of inpatients overall, though there is a slightly higher proportion of male dementia patients than female.
- The gender split for people with functional needs is 59% female and 41% male and 46%/54% for people with organic needs (admissions from 2013 – 2022):

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

More information on other protected characteristics is included in the EIA.

6.8.3 Deprivation

As well as understanding the population of people accessing services from across the protected characteristics, we know that services are required for people in the most deprived areas. Calderdale, Kirklees and Wakefield have the following proportion of people aged 60+ in the 20% most deprived areas:

- Calderdale: 22.9%
- Kirklees: 21.9%
- Wakefield: 30%

Source of data on 60+ population in most deprived areas: Mapping income deprivation at a local authority level - Office for National Statistics (ons.gov.uk)

The data below shows the number of spells and wards stays per year of the people from the 20% most deprived areas (average over 4 years from 2018 to 2022):

Need	Place	Spells	Ward Stays
Dementia	Calderdale	6	8
Dementia	Greater Huddersfield	<5	<5
Dementia	North Kirklees	6	7
Dementia	Wakefield	9	15
Functional	Calderdale	12	17
Functional	Greater Huddersfield	8	10
Functional	North Kirklees	14	16
Functional	Wakefield	18	24

The table below shows how inpatient stays align with the population over this time period and that they are broadly in line with deprivation for each place:

	Place and need	% spells from 20% most deprived areas	% 60+ population in 20% most deprived areas	Difference
Dementia	Calderdale	27.3%	22.9%	4.3%
Dementia	Kirklees	32.1%	21.9%	10.2%
Dementia	Wakefield	31.0%	30.0%	1.0%
Functional	Calderdale	26.1%	22.9%	3.2%
Functional	Kirklees	30.6%	21.9%	8.6%
Functional	Wakefield	38.3%	30.0%	8.3%

6.8.4 Who we cater for – acuity:

Data shows that people with dementia have higher levels of acuity and dependency when admitted to the wards than people with functional needs.

To evidence this, we have 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 process involved up to 3 leaders per ward to completing a daily scoring for a 2-week data collection period, using a set of descriptors that measure patient acuity and dependency on the ward.

Acuity and Dependency Level	Descriptor
Tier 1 – Low Dependency	Personal care can be managed by one staff, or patient is independent. Has cognitive impairment, but not at risk. Mental state is stable/predictable. General, hourly observations required. Vital signs are monitored twice-daily. Medically stable, requires rehabilitation only. No significant care-package changes required. Ready for discharge. Supportive family able to cope at home. Patient can contribute to care and care planning.
Tier 2 – Medium dependency	Patient is on general, hourly observations. Personal care can be managed by one staff. Early warning score trigger point reached, requiring escalation. Normal observation and therapeutic interventions. Mental state fluctuates. Care needs require regular re-evaluation. Increased multi-disciplinary team input. Patient has significant co-morbidity; e.g., an infection. Patient and family are participating in care/care planning.
Tier 3 – Medium-high dependency	Has significant mental and physical health problems, which fluctuate. Has co-morbidities, but physical health is stable. At risk, but safety can be maintained with moderately skilled interventions. Daily living activities are

	managed by two staff and rarely requires one-to-one care. Multiagency discharge, where there has been a change in circumstance/care or package, which is the ward-based nurse's/therapist's responsibility. Increased psychological/emotional and education support required by patient and/or family carers. Patient requires direct supervision and medication to ensure compliance, or has a complex drug regimen, including prolonged preparatory/administration/post-administration care.
Tier 4 – High dependency	Has significant on-going care needs, which can be met by two staff. Intermittent observations or one-to-one for part of the day. Significant co-morbidities with fluctuating physical health needs. At risk – has an unpredictable mental state or is likely to harm self or others. Skilled intervention required to maintain safety. Family/carers require increased psychological, educational and emotional support.
Tier 5 – Highest dependency	Patient requiring one-to-one care or constant supervision to maintain safety and care.

The following summarises the dementia profile:

Level	1	2	3	4	5
Proportion	7%	13%	27%	21%	32%

Functional profile:

Level	1	2	3	4	5
Proportion	26%	40%	17%	17%	0%

The modelling shows a clear difference in the level of acuity and dependency of the people with dementia to functional needs, with dementia needs being considerably higher.

6.8.5 How many beds we use:

The table below shows how many available bed days there are available in West Yorkshire (if used at 100%) and how many are used:

Year	Total Available Beds Days	OBD Inc Leave	Occupancy Rate Inc Leave	Ave Bed Use Inc Leave	OBD Exc Leave	Occupancy Rate Exc Leave	Ave Bed Use Excl Leave
2018	27010	22905	84.8%	62	21251	78.7%	58
2019	27010	23451	86.8%	64	21547	79.8%	59
2020	27084	22069	81.5%	60	20041	74.0%	54
2021	27010	24024	88.9%	65	22327	82.7%	61
2022	27010	23148	85.7%	63	21380	79.2%	58

The following table breaks the bed use down by ward of people from Calderdale, Kirklees and Wakefield:

Ward Name	Total Available Bed Days	OBD Inc Leave	Occupancy Rate inc leave	Ave Bed Use Incl Leave	OBD Exc Leave	Occupancy Rate Excl Leave	Ave Bed Use Excl Leave
Beechdale	29216	28792	98.5%	15.8	25866	88.5%	14.2
Crofton	29216	22265	76.2%	12.2	20259	69.3%	11.1
The Poplars	21912	16291	74.3%	8.9	16128	73.6%	8.8
Ward 19	54780	48249	88.1%	26.4	44293	80.9%	24.3
Willow Ward		1201		0.7	1121		0.6

Overall, typical bed usage of people from West Yorkshire is around 60 beds excluding leave and 65 including leave.

6.9 How demographic changes might impact on demand and bed use

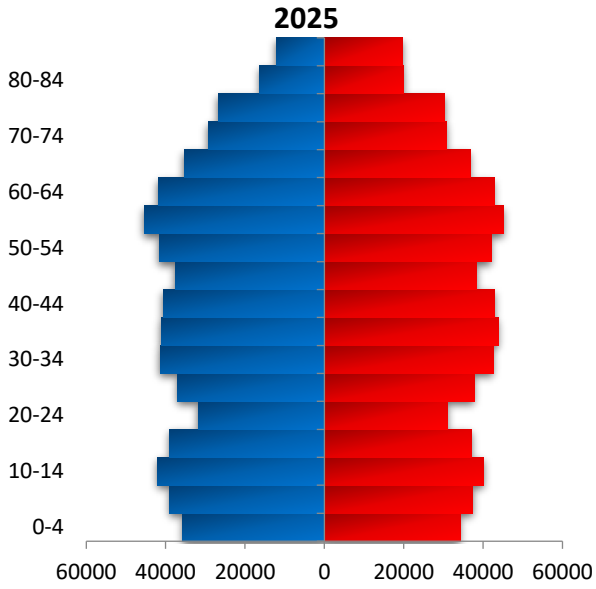
In the coming years, the number of older people in the UK population will increase significantly. By 2036 it is expected that 23.9% of the total population will be over 65 (http://ons.gov.uk) and over 5% of the population will be over 85 years of age. Mental Health issues and especially depression and dementia are becoming increasingly common amongst older people.

The information below shows the recent and projection of future population for older people in the SWYPFT footprint (all charts are based on an aggregated total of Barnsley, Calderdale, Kirklees and Wakefield).

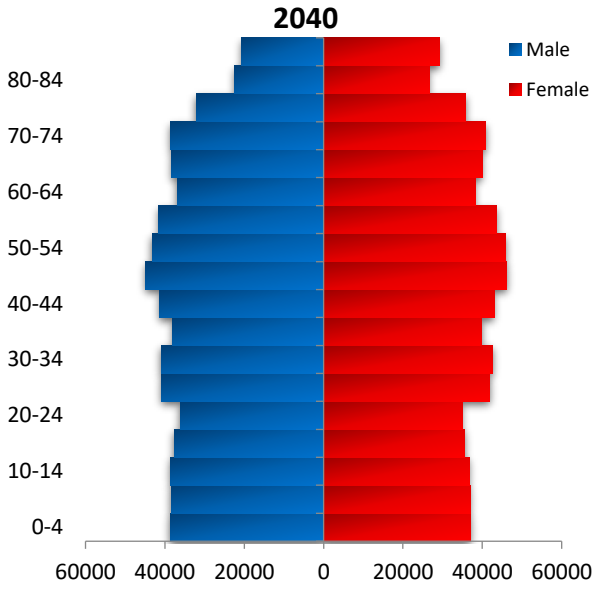
6.9.1 Population Trends with Projected Numbers

The population is forecast to increase by 5.9% between 2025 and 2040. The 65 and overs are expected to increase the most, by 26.0%.

Projected Population 2025

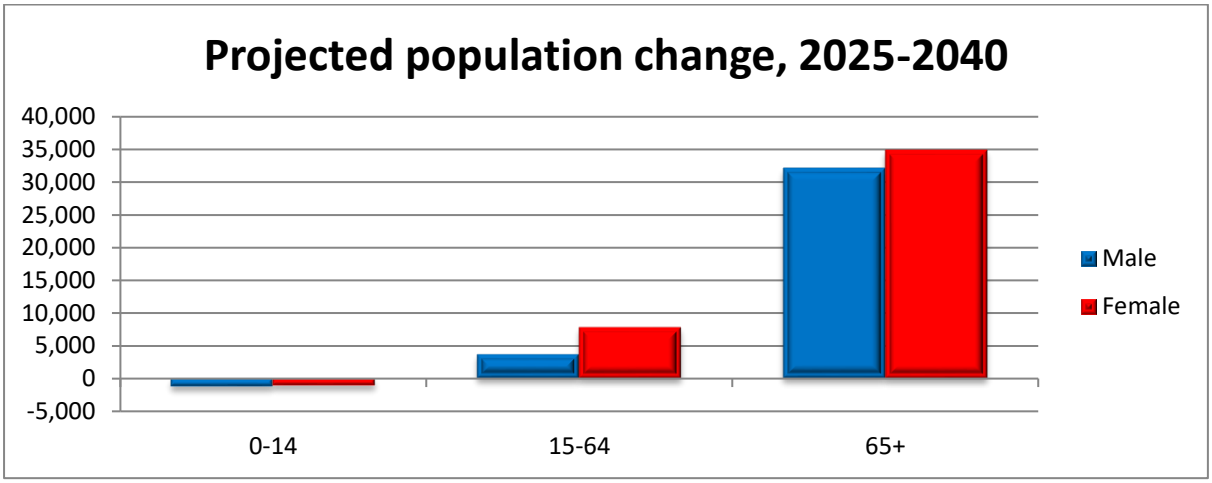


Projected Population 2040



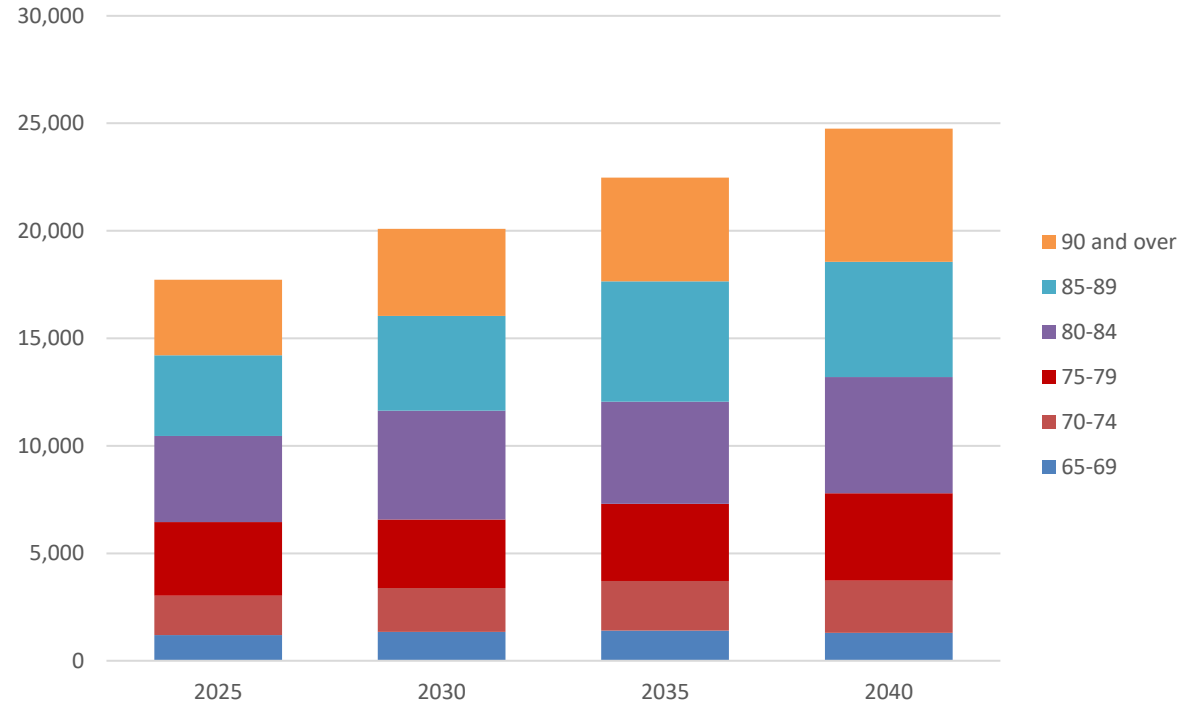
6.9.2 Projected population change 2025-2040

The table below shows how much each age group is forecast to increase/decrease between 2025 and 2040. The number of 0-14 year olds is expected to decrease between 2025 and 2040 (-1.0%), whereas 65+ is expected to grow at a much higher rate (+26.0%).



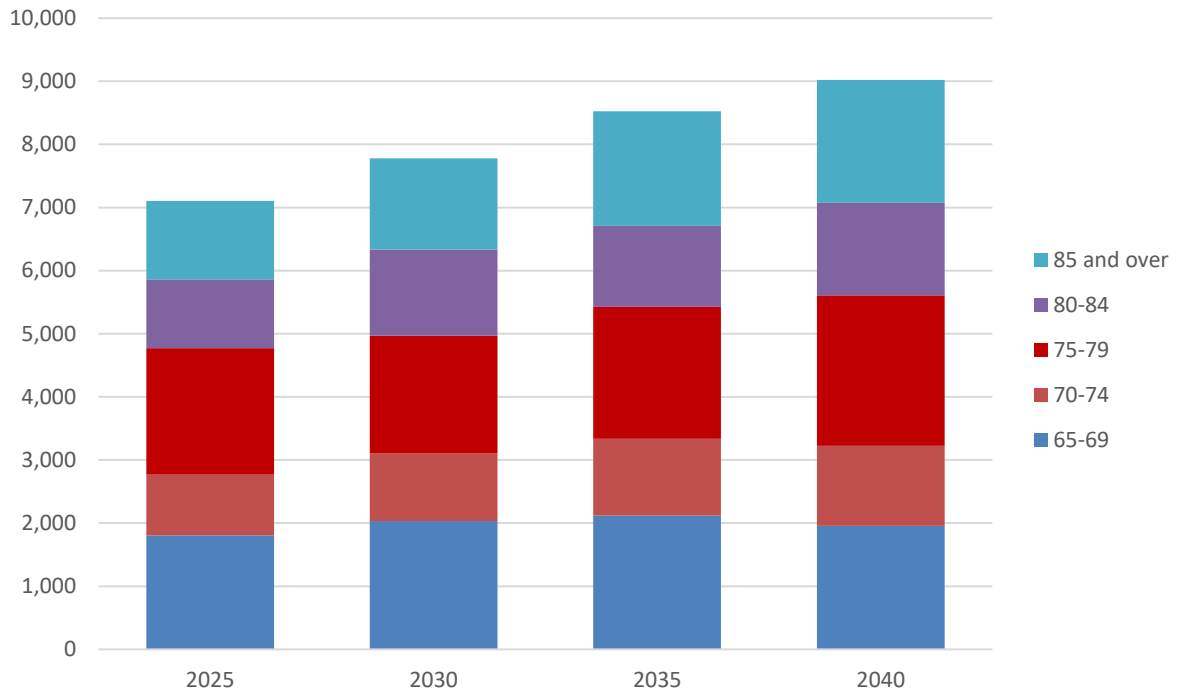
6.9.3 People aged 65 and over predicted to have dementia, by age, projected to 2040

The number of people aged '65 and over' who have dementia are projected to increase by 56.0% between 2020 and 2040. The number of people aged '90 and over' with dementia are predicted to increase by 90.5% (the highest increasing age group).



6.9.4 People aged 65 and over predicted to have severe depression, by age, projected to 2040

The number of people 'aged 65 and over' who have severe depression is expected to grow by 42.6% between 2020 and 2040. The '85 and over' age range is predicted to increase the most (with a forecast increase of 74.6%).



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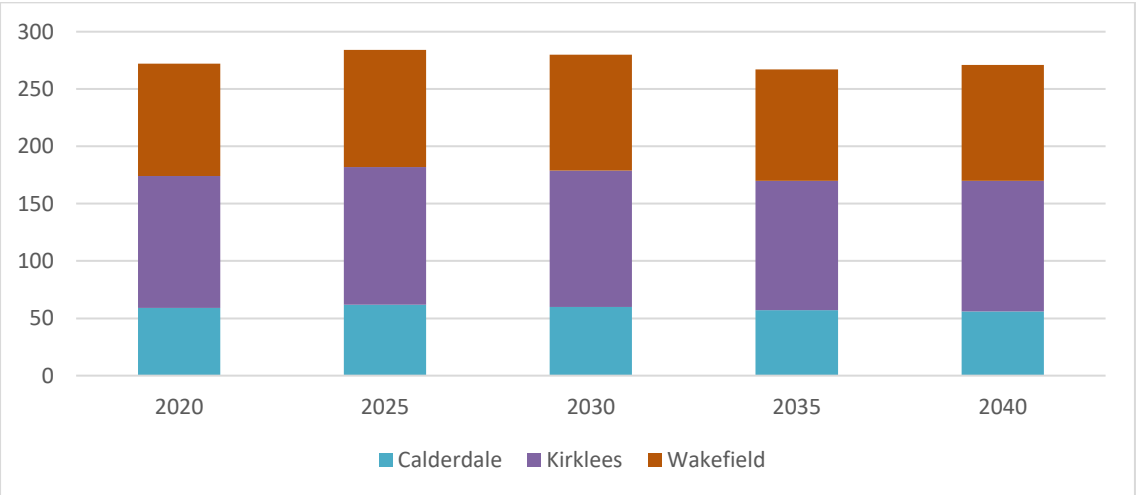
6.9.5 People aged 30-64 predicted to have early onset dementia, by gender, projected to 2040

Whilst numbers of people with dementia as a whole are expected to rise the number of people with a younger onset dementia are not projected to rise locally or nationally.



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6.10 Admissions based on age group to our wards

Our ward admissions are not spread equally across all age bands, due to changing clinical presentations with age. Population projections are also not equally spread across age bands e.g. dementia projections 2025-2040 for people age 90+ increasing 76% whereas people aged 65-69 only increasing 9%. With this in mind, it was useful to compare the current patient age profile and use this to model future projections for bed use rather than people living with dementia/functional mental health problems as a whole.

Functional Patients Admitted by Age	**% of admissions 2018-2021**
85+	9.2
80-84	10.3
75-79	16.0
70-74	29.9
65-69	34.6
total	100.0

Dementia Patients admitted by Age	**% of admissions 2018-2021**
90+	2.6
85-89	11.6
80-84	21.3
75-79	27.1
70-74	26.5
65-69	11.0
total	100.0

6.11 Factoring population changes in model:

The table below shows the current total admissions all SWYPFT older people's wards (all places by diagnosis):

			Actuals			
Condition	2018	2019	2020	2021	2022	Average
Alzheimer's & other Dementias (F00-09 & G30-32)	99	88	84	100	95	93.2
Psychotic Disorders (F20-29)	53	56	60	49	51	53.8
Mood Disorders (F30-39 & F40-48)	148	137	158	173	128	148.8
Total	**300**	**281**	**302**	**322**	**274**	**295.8**

Based on population projections, should nothing change, the table below shows how demand for admissions could increase over the coming years, which could equal towards 100 extra admissions in a 10-year period if nothing were done to manage demand:

	2018-22 Average	**Forecasts based on the Average**			
Condition		2025	2030	2035	2040
Alzheimer's & other Dementias (F00-09 & G30-32)	93.2	105	112	125	131
Psychotic Disorders (F20-29)	53.8	57	63	68	70
Mood Disorders (F30-39 & F40-48)	148.8	160	176	191	197
Total	**295.8**	**322**	**351**	**384**	**398**

Whilst population changes may have an impact on bed use the proposed changes will also have an impact on bed use. This is explored further in the capacity requirements section.

6.12 How the current model works

The following summarises how the services are delivered while people stay on the wards in terms of:

- Ward function
- Location and access
- Ward environment
- Admissions
- Pathways and moves
- Length of stay
- Incidents
- Workforce models
- Current travel

6.12.1 Calderdale

Ward function
In Calderdale, The Beechdale ward is a mixed-sex inpatient unit with 16 single rooms for older people with functional mental health conditions and for those with dementia.
Location and access
Beechdale ward is situated on the Calderdale Royal Hospital site in Halifax and co-located with 2 working age adult mental health wards. There is on-site access to the Emergency Department (ED) should any patient in the Beechdale ward become physically and acutely unwell and there is access to physicians with expertise in looking after older people. Electroconvulsive (ECT) therapy is available on site for people with functional needs. Patient advocacy is provided by Cloverleaf advocacy service. Referrals are automatically picked up by the team and the advocate visits the ward at least once per week. Social service referrals go to the Adult Social Care team who works closely with ward staff to assess patient's community care needs and find appropriate support and/or a residential placement.
Ward Environment
Beechdale ward has 2 bedrooms with en-suite, but the majority are not. There is little capacity to create any other space or additional rooms due to the ward footprint. The ward has narrow, twisting corridors that lead to 'dead ends' and the corridors do not allow the staff to have full line of sight of the whole ward and patients can find this hard to navigate. This leads to feedback that the Beechdale ward does not provide an appropriate environment for older people with dementia. It is more suitable for patients with a functional mental illness. This is due to the configuration of the ward that can cause confusion and upset among older people with dementia. Although there has been attempts to make the ward a dementia friendly environment there are still issues with navigation through environmental prompts, lighting and access to quiet space.

The environment does lead to increased use of other interventions e.g., medication, observation levels to manage the distress of the patients with dementia. The corridors do not allow the staff to have full line of sight of the whole ward which prevents them from being able to observe patients.

It has also been said by staff and patients that those with functional mental health needs do not always feel safe or able to relax on the shared ward areas, as there are often people with dementia who are distressed or invading their personal space. This can lead to functional patients staying in their bedrooms, becoming more socially isolated and physically inactive.

There is no seclusion or extra care area on the ward due to site constraints. There is a seclusion room on the wider site, with access via a waiting area open to the public, a lift and through a working aged adult ward.

Sometimes people with dementia with behaviours that challenge are transferred to Ward 19 in Dewsbury because of the issues with the Beechdale environment.

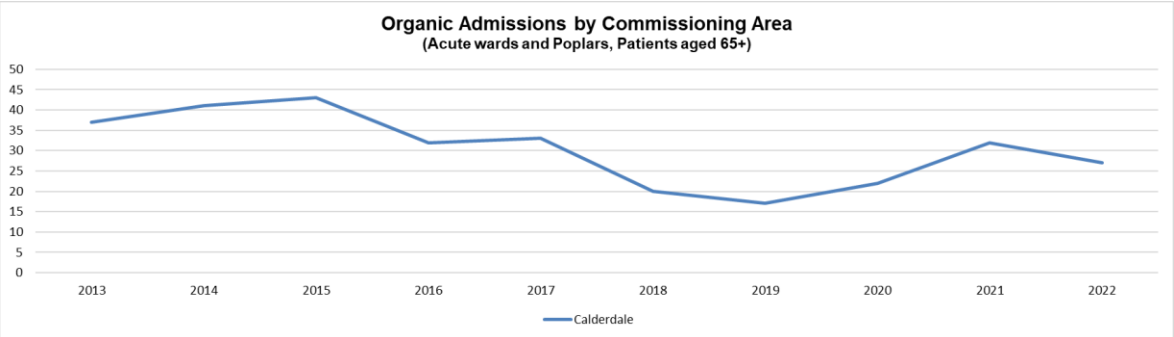
The bedroom corridors are designated by gender and there are separate lounges and communal bathroom for females. This meets single sex accommodation guidelines but there are potential issues with male and female patients with dementia being on the same ward, due to lack of inhibition or misinterpreting relationships, which are common symptoms of dementia.

In March 2023 we spoke with staff on the ward and feedback about the environment included:

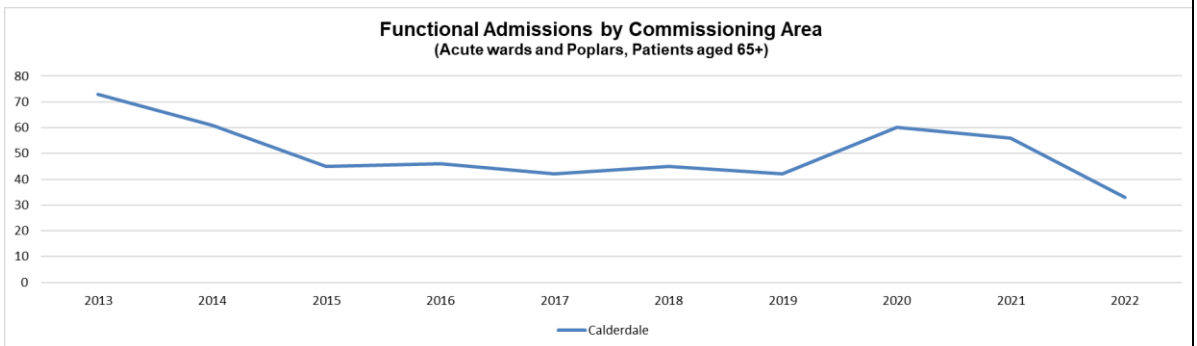
- There's no seclusion or extra care area here so it can feel unsafe to manage aggressive patients with dementia.
- There's no space for people with dementia to move about in here.
- It's difficult to provide stimulation for patients with dementia here.
- I run groups to help with pain, balance and exercise. There is not always space to do this on the wards so we do it in the corridors. Unfortunately, when there is a very confused patient these groups can get disrupted.

Admissions

Admissions of people from Calderdale with dementia (organic) have shown an overall downward trend, with an increase in recent years, in which between around 20 and 35 people per year have been admitted:



Functional admissions too have been on a downward trend though admissions have ranged between 30 and 60 people in recent years:



Pathway and moves

Often people are admitted outside of Calderdale due to demand and capacity and transferred back locally as part of their patient pathway to facilitate discharge. However, two ward stays does increase the length of the spell, and multiple moves are detrimental for the care of people with dementia (more impacts of multiple stays are summarised below).

As well as many people having 2 or more ward stays, there is also a high proportion of people from Calderdale who are already admitted outside of their local area.

Table showing number of ward stays for completed spells each year:

Calderdale	1	2+	Total
functional	**345**	**124**	**469**
2013/2014	68	12	80
2014/2015	36	18	54
2015/2016	39	11	50
2016/2017	28	12	40
2017/2018	31	12	43
2018/2019	30	16	46
2019/2020	32	12	44
2020/2021	44	17	61
2021/2022	37	14	51
organic	**170**	**111**	**281**
2013/2014	34	6	40
2014/2015	28	18	46
2015/2016	26	11	37
2016/2017	16	13	29
2017/2018	16	15	31
2018/2019	7	13	20
2019/2020	9	13	22
2020/2021	9	6	15
2021/2022	25	16	41
Grand Total	**515**	**235**	**750**

Admissions outside of local area from 2018-2021:

Barnsley Wards	Kirklees Wards	Wakefield Wards	Total
12	126	33	171

Length of Stay:

Dementia LOS for people in Calderdale is high and has averaged over 100 days in recent years, with a peak average LOS close to 160 days in 2019.

Functional LOS has ranged between 50 and 90 days from 2013 but has typically been around 70 days in recent years.

Incidents (2022) per bed

Overall incident rates and yellow or above rates were in line with the other mixed needs wards in 2022 and lower than the Poplars.

Fall and violence/aggression was also in line with the other mixed needs wards, though considerably higher than the functional only ward in Barnsley and much lower than the Poplars.

Workforce Models

The table below summarises the current rostered workforce on the Beechdale ward:

Ward	Days		Twilight	Nights	
	RN	HCA	RN	RN	HCA
Beechdale	2	2	1	1	2

As well as this rostered staffing, we do have a range of specialist resource that works into the ward including medical staffing, psychology, physiotherapy, and occupational therapy.

Staff fill rates varied from month to month but were on average around 125% on Beechdale through 2021/22. This means that throughout the period the staffing on the ward will have been, on average 25% above the rostered workforce. This does not include unfilled rostered which would mean that the desired workforce is even higher.

Current Travel

The table below shows the average public transport time from the patient's home address to the ward that they were discharged on (more detail can be found in the travel impact section).

Need	Place	Current average driving distance	Current public transport average travel (time mins)
Dementia	Calderdale	6.9	48
Functional	Calderdale	6.6	48

6.12.2 Kirklees

Ward function

Ward 19 and provides inpatient assessments and treatments for any form of mental health condition, both functional and dementia needs, for service users that are usually over the age of 65 years.

Ward 19 operates as 2 separate wards, a male and female ward.

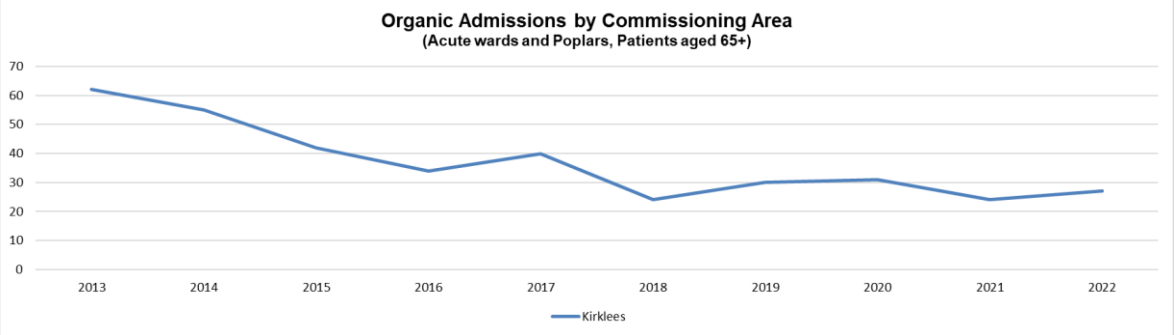
Location and Access
Ward 19 is located within the Priestly Unit and is co-located with a mental health ward for working age adults on the site of Dewsbury District Hospital There is on-site access to the Emergency Department (ED) should any patient in the unit become physically and acutely unwell and there is access to physicians with expertise in looking after older people. The is no access to ECT therapy at the Dewsbury site, meaning that people with functional needs that require this service need to travel to either Halifax or Wakefield to receive it. Patient advocacy is provided by Touchstone advocacy service. Referrals are automatically picked up by the team and the advocate visits the ward at least once per week. Social service referrals go to the Adult Social Care team who works closely with ward staff to assess patient's community care needs and find appropriate support and/or a residential placement.
Ward environment
Ward 19 is configured to provide 15 beds for male patients and 15 beds for female patients in separate areas of the ward with dedicated staffing for each area. The ward has considerable space for movement and wide corridors, with each ward having access to lounges, a dining room, an occupational therapies room and a garden conservatory. There is good courtyard space across the wards and an extra care area between the 2 wards. The ward does not currently have en-suite facilities and whilst there might be potential to undertake work to make some bedrooms en-suite, the current drainage system won't support the whole unit changing to en-suite. There are several features of Ward 19 that lend themselves to supporting people with dementia, for example, the space for movement and wide corridors, access to multiple lounges, a dining room, occupational therapies room and a garden conservatory. The clinical senate, when visiting, were impressed with the garden areas available for patients to enjoy the outdoors and to take part in gardening activities and acknowledged that while the ward space does not provide a circuitous pathway for patients with dementia but it does have large, wide corridors. The clinical senate did though feel that the environment in the ward appeared to be dark and sterile and it would benefit from being made brighter and with more stimulation and interesting décor for patients with dementia. Handrails and automatic lighting have been recently installed, which are essential to help reduce the amount of patient falls on the wards. A window has recently been created in the roof space of the central area for more natural light. The theme of handrails was also raised via a CQC visit in late 2022, https://api.cqc.org.uk/public/v1/reports/7ac7435c-4823-404d-9544-2c6349b312bf?20230315080038. It stated that Ward 19 did not have handrails fitted but the trust was in the process of carrying out some renovations which would include the fitting of anti-ligature handrails.

Some staff feedback on the environment from March 2023 includes:

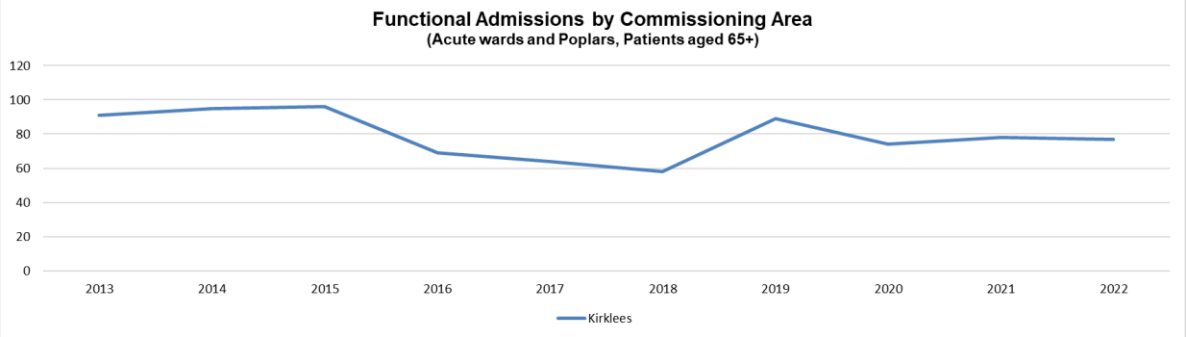
- Ward 19 has the space and the room to manage dementia need. More could be done to improve the environment such as sensory rooms.
- Dementia friendly wards need more space for patients to be able to get some quiet time. A low stimulus environment is needed. We've temporarily lost the use of a quiet lounge due to building works, you can really tell the difference in the patient's wellbeing, as they don't have access to that space.

Admissions

Kirklees dementia (organic) admissions have decreased over time, though have been at a steady rate between 20 and 30 in recent years:



Functional admissions have been more consistent and have been typically around 80 per year in recent years.



Pathway and moves

In recent years most people from Kirklees have been admitted to Ward 19 and have had only 1 ward stay, with length of stay being lower than in other parts of the Trust, particularly for people with dementia. This is supported by a well-established older adult crisis team, the Kirklees Outreach Team (KOT), that supports people in their own residence or in permanent 24hr care.

Table showing number of ward stays for completed spells each year:

Kirklees	1	2+	Total
functional	**608**	**99**	**707**
2013/2014	81	13	94

2014/2015	80	19	99
2015/2016	68	14	82
2016/2017	60	7	67
2017/2018	57	7	64
2018/2019	51	6	57
2019/2020	79	13	92
2020/2021	64	6	70
2021/2022	68	14	82
organic	**305**	**37**	**342**
2013/2014	55	12	67
2014/2015	50	4	54
2015/2016	36	3	39
2016/2017	35	3	38
2017/2018	28	3	31
2018/2019	26	5	31
2019/2020	26	4	30
2020/2021	28	0	28
2021/2022	21	3	24
Grand Total	**913**	**136**	**1049**

Admissions outside of local area from 2018-2021:

Barnsley Wards	Calderdale Wards	Wakefield Wards	Total
14	18	26	58

Length of Stay:

Kirklees dementia LOS has been in a range between high 50's and low 80's days over the last 10 years. It has been around 80 days in some recent years, though it has been as lows as 60 days in others (2020 and 2017).

Kirklees functional LOS has been similar to its dementia LOS and even higher in some years with an average LOS of around 90 days in 2018 and 2021.

Incidents (2022) per bed

Ward 19 records low overall incidents compared to the other OPS wards and has the lowest number of yellow and above incidents per bed (lower even than the functional only ward in Barnsley).

Its falls are slightly higher than the other mixed needs wards, considerably higher than the functional ward but lower than the Poplars.

Recorded violence and aggression on the ward is slightly lower than the other mixed needs wards, considerably higher than the functional ward but lower than the Poplars.

Workforce Models

The table below summarises the current rostered workforce across ward 19:

Ward	Days		Twilight	Nights	
	RN	HCA	RN	RN	HCA
Ward 19 F	2	2	1	1	2

Ward 19 M	2	2	1	1	2

As well as this rostered staffing, we do have a range of specialist resource that works into the ward including medical staffing, advance clinical practitioners, psychology, physiotherapy, and occupational therapy.

Whilst there are periods when fill rates go above 100%, Ward 19 has overall used an average of around 100% staffing through 2021/22. It has benefited from lower turnover rates in this period (11.9% on the female side and 0% on the male).

Current Travel

The table below shows the average public transport time from the patient's home address to the ward that they were discharged on (more detail can be found in the travel impact section).

Need	Place	Current average driving distance	Current public transport average travel (time mins)
Dementia	Greater Hudds	10.9	58
Dementia	North Kirklees	3.5	26
Functional	Greater Hudds	11.7	60
Functional	North Kirklees	3.2	30

6.12.3 Wakefield

Ward function

There are 2 older people's mental health wards in Wakefield, the Crofton ward and the Poplars unit.

The **Crofton ward**, is a mixed sex unit that provides inpatient assessment and treatment for people aged 65 and over who are experiencing functional mental health problems or people with dementia that are acutely unwell.

The Poplars ward is a mixed sex mental health unit for people who have been diagnosed with dementia, though not designed to deliver acute mental health care. Originally commissioned as 15 beds, the site has been operating with a maximum capacity of 12 beds for several years with capacity reduced to make space for a female lounge, clinical storage room and, more recently, a covid changing room. This is because of a change in the presentation of patients over time who now have more acute mental health needs.

Location and access

The **Crofton ward** is based on the Fieldhead Hospital site in Wakefield. As part of the Fieldhead site, there is access to support from across the ward base as this is co-located with several working aged adult wards.

The unit is located on an acute mental health site and emergency and specialist geriatric care is provided from the nearby, but not co-located, Pinderfields Hospital.

Electroconvulsive (ECT) therapy is available on site for people with functional needs.

There is scope to extend the ward environment into the space adjacent to the Crofton Ward that has previously been used as an inpatient ward but currently is office space.

The Poplars unit is located in Hemsworth, on the east side of the Wakefield district. The unit is located in the community amongst residential housing and is a dedicated dementia unit that provides care to patients from across the whole of Wakefield and some people from the wider SWYPFT footprint.

The nearest emergency department and access to specialist medical help is 20-30 minutes drive away, at Pinderfields hospital and the site is not co-located with any other services. This isolation could lead to delays in patients receiving medical input, especially out of hours. Similarly, from a nurse staffing perspective there is no onsite backup available as there would be when such a unit is co-located on a site with other interdependent services. Staff on all Trust sites use a 'PIN alarm system' which alerts other staff to a patient safety incident (such as aggression or a fall) or a medical emergency. At Poplars there is only the ward staff available to respond to this, on other sites staff from across wards will respond as well as a specialist crash team if there is a medical emergency.

This is particularly relevant when considering the complexity of the patients being cared for in the unit which requires more enhanced nurse staffing ratios. When acuity is high on the ward, it can be difficult to quickly bring the right workforce in as the site is physically and operationally isolated. Staff have no access to onsite support in the event of an incident placing a burden on staff on the shift. Staffing levels have to be artificially inflated in response to potential issues, which can be met by cross cover at other sites.

The location of the site also can negatively impact on recruitment of staff and could impede relatives from visiting. Non ward based bank staff are reluctant to work at the Poplars due to its distance from Wakefield, its isolation and resultant risks.

Feedback from medical staff highlights some of the challenges:

- Medical cover for Poplars is difficult. When a junior doctor is on call they are covering all the wards at Fieldhead, except the medium secure forensic ones. They might have 5 things that then need to attend over a night, if they have to go to Poplars it takes 2 hours to drive there, deal with the issue and drive back. In that time they could have done three jobs on the Fieldhead site. So jobs at Poplars get pushed to the back of the queue.

The CQC also visited the Poplars ward in late 2022 https://api.cqc.org.uk/public/v1/reports/7ac7435c-4823-404d-9544-2c6349b312bf?20230315080038. They noted that the location of The Poplars away from any other of the trust's location meant that the staff team were isolated in terms of access to urgent support or cover for unplanned staffing issues.

They also stated "We were concerned that the distance from The Poplars to other trust locations would impact on out of hours medic assessments".

For both Wakefield wards patient advocacy is provided by the Wakefield Advocacy Together Hub. Referrals are automatically picked up by the team and the advocate visits the ward at least once a week.

Social service referrals go to the Adult Social Care team who works closely with ward staff to assess patient's community care needs and find appropriate support and/or a residential placement.

Ward environment

The **Crofton ward**, does have en-suite facilities for all bedrooms. The clinical senate, when visiting, were impressed with the bright and airy environment, the layout and décor of the ward environment.

The ward does have more limited communal and outside space, compared with Ward 19 but better communal facilities than other older people's wards in the trust.

There is access to an extra care area on the ward. Seclusion rooms are not available on the unit but they are available in the unity centre, staff must take patients though a working age adult ward to access it.

The bedroom corridors are designated by gender and there are separate lounges and communal bathroom for females. This meets single sex accommodation guidelines but there are potential issues with male and female patients with dementia being on the same ward, due to lack of inhibition or misinterpreting relationships, which are common symptoms of dementia.

The ward contains an occupational therapy kitchen and activity room, physiotherapy room and a quiet lounge. There is an outside courtyard and second small outside seating area although this is relatively small.

Some feedback from staff includes:

- It's not a good mix, it's hard to run groups for the patients with dementia and the functional patients because they need different things. The patients with dementia can't concentrate on what is happening in the groups and can be disruptive for the other patients. Functional patients can be scared of what they see when a patient with dementia is distressed or shouting.
- We get a lot of patients with dementia at our office. They walk around the ward and end up here and sit with us. It's difficult to give patients with dementia things to occupy their time, it takes a lot of staff's time. It would be better if the ward was more designed for people with dementia. We could make some reminiscence areas or some sensory areas.
- The functional patients get scared by some of the patients they see, they don't understand why they are on the same ward.
- Patients with dementia and functional mental health problems do not mix well on the ward. When I have ward reviews with my patients with depression they often ask why they are on this ward. They say that they are not ready to be on a ward like this and that they don't think that they are like patients with dementia. There are times where having patients with dementia and functional leads to incidents.
- We don't keep patients with dementia here long, we transfer a lot to the Poplars. It would be more difficult if we weren't able to do that. Although if a patient has high needs we can't send them there. This means that we only have a few patients with dementia but they usually have high needs. One or two patients can take up a lot of the ward staff's time.

The configuration of **the Poplars unit** is well suited to its patient population and has a circular walkway. The clinical senate, when visiting, were impressed with the therapeutic

décor for the patients and the ward environment and the care provided at the ward is good. The site does not have access to a seclusion or extra care area.

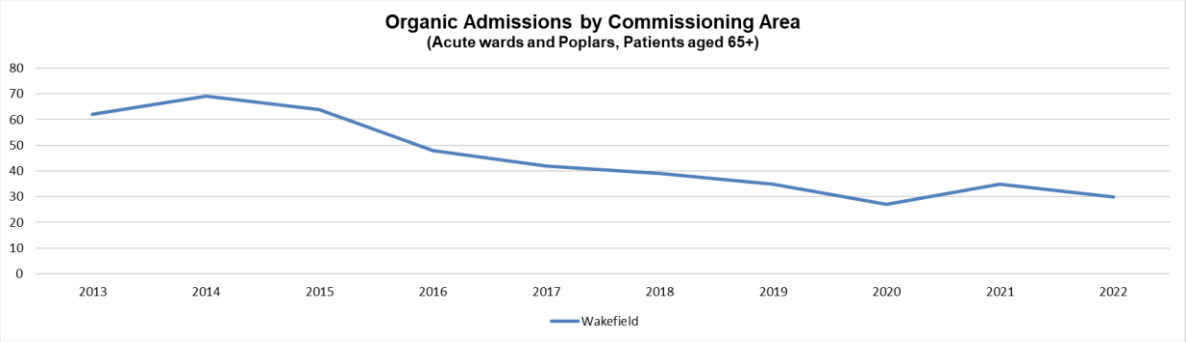
The unit is the oldest of all our older adult's inpatient wards and may need refurbishment.

The ward is separated into male and female bedroom areas, but there are potential issues with male and female patients with dementia being on the same ward, due to lack of inhibition or misinterpreting relationships, which are common symptoms of dementia.

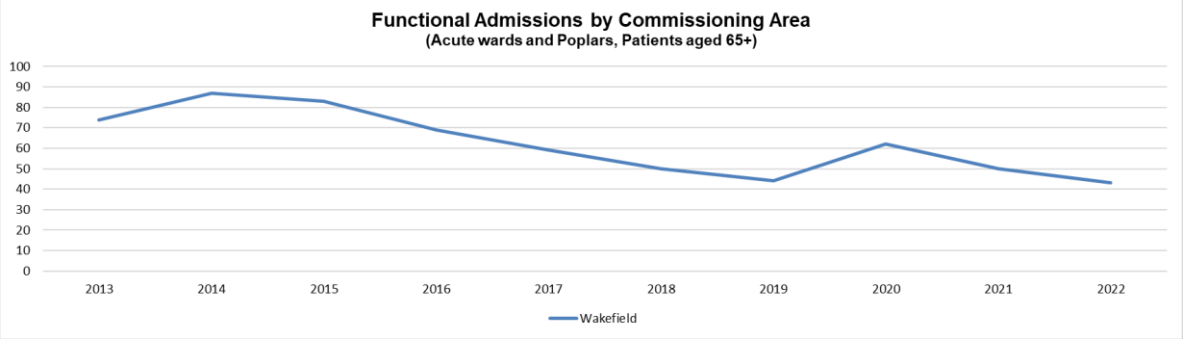
The CQC noted in their visit in late 2022 that female patients had to walk across a communal area used by male patients to reach a communal bathroom (they were always accompanied by a staff member when doing so).

Admissions

Both functional and dementia (organic) admission rates have reduced in Wakefield in recent years. Dementia admission rates now average around 30 per year:



Functional admission rates have ranged between 50 and 70 in recent years:



Pathway and moves

People with dementia in Wakefield are typically admitted to an acute hospital ward, such as Crofton ward, for a period of time before being stepped down to the Poplars ward. Two ward stays does increase the length of the spell and is detrimental for the care of people with dementia (more impacts of multiple stays are summarised in a section below).

The Poplars unit does not accept direct admissions due to the acuity and challenges highlighted above, though it does often have people with behaviours that challenge and high levels of dependency.

Most people with functional needs do only have one ward stay and overall LOS for functional needs is in line with other parts of the Trust.

Table showing number of ward stays for completed spells each year:

Wakefield	1	2+	Total
functional	**441**	**101**	**542**
2013/2014	57	11	68
2014/2015	54	13	67
2015/2016	61	11	72
2016/2017	59	9	68
2017/2018	46	12	58
2018/2019	37	16	53
2019/2020	35	12	47
2020/2021	52	8	60
2021/2022	40	9	49
organic	**153**	**262**	**415**
2013/2014	36	16	52
2014/2015	32	35	67
2015/2016	18	43	61
2016/2017	18	36	54
2017/2018	11	29	40
2018/2019	17	23	40
2019/2020	6	31	37
2020/2021	6	26	32
2021/2022	9	23	32
Grand Total	**594**	**363**	**957**

Admissions outside of local area from 2018-2021:

Barnsley Wards	Calderdale Wards	Kirklees Wards	Total
7	4	61	72

Length of Stay:

Average length of stay for people with dementia in Wakefield has consistently been above 100 days since 2015 and hit a peak of 140 days in 2019.

Functional LOS is in line with other parts of the Trust and has ranged between 50 and 80 days in recent years.

Incidents (2022) per bed

Poplars records the highest number of incidents overall of the older people's per bed, in terms of overall incidents, yellow and above incidents, falls, and cases of violence and aggression.

Workforce Models

The table below summarises the current rostered workforce across the Wakefield wards:

Ward	Days		Twilight	Nights	
	RN	HCA	RN	RN	HCA
Crofton	2	2		1	3

	Poplars	2	3		1	2

As well as this rostered staffing, we do have a range of specialist resource that works into the ward including medical staffing, advance clinical practitioners, psychology, physiotherapy, and occupational therapy.

The Wakefield wards do typically require more staff with both wards using an average of 160% fill rates through 2021/22.

Current Travel

The table below shows the average public transport time from the patient's home address to the ward that they were discharged on (more detail can be found in the travel impact section).

Need	Place	Current average driving distance	Current public transport average travel (time mins)
Dementia	Wakefield	9.1	43
Functional	Wakefield	7.7	41

In summary:

- 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 detail on current models is set out below:

6.13 Admission Pathways

Although the majority of patients won't need inpatient care, which is only used when risk is deemed to be significant and other options have been exhausted (in line with least restrictive practice), there are times when risks to self or others are too great to be managed in the community. When this is the case there are several referral pathways into our inpatient wards.

These are:

- Planned admissions through community mental health teams, these assessments receive a gatekeeping assessment from crisis teams to explore if it would be possible to maintain a patient's safety in the community and avoid an inpatient admission
- Detention under Mental Health Act following mental health crisis
- Admission via 136 suites, a place of safety used by the police

The Trust operates a shared bed base which means that people from each place can be admitted outside of their local area.

The table below shows the number of admissions outside of local area from 2018-2021:

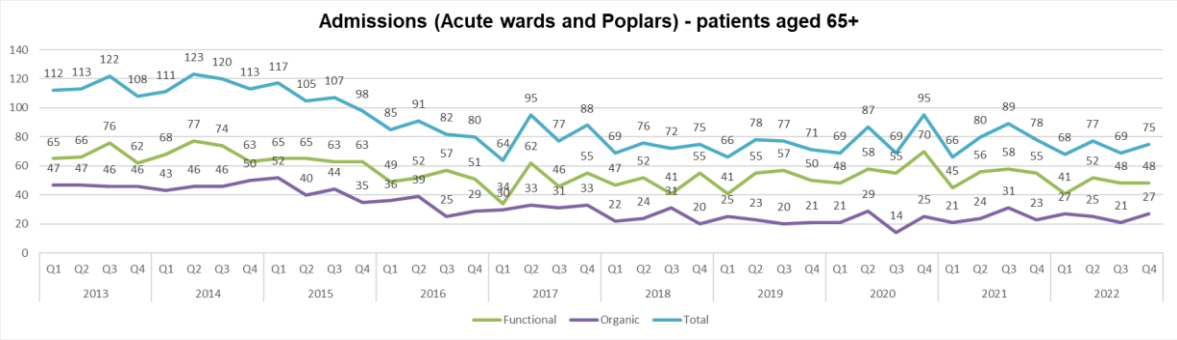
	Barnsley Wards	Calderdale Wards	Kirklees Wards	Wakefield Wards	Total
Calderdale	12		126	33	171
Kirklees	14	18		26	58
Wakefield	7	4	61		72
Total	33	22	187	59	301

Whilst, in a small proportion of cases the admission can be to another ward that is best suited to meet the service user needs, most of the admissions outside of a person's home locality are due to demand and capacity issues at that time.

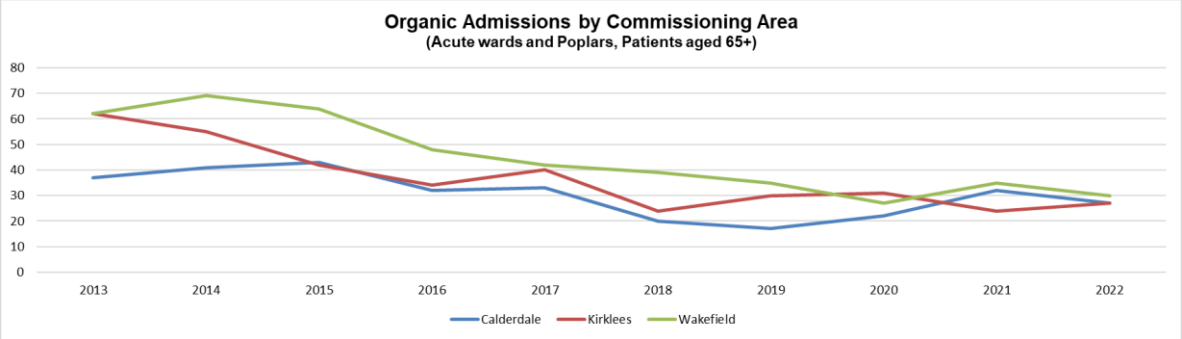
Approximately 70 people from Calderdale are admitted per year, 87 from Wakefield and 104 from Kirklees. From Calderdale, just under 50% of admissions are to that locality, Kirklees 85% and Wakefield 80% admissions to their own district.

Overall, about 30% of all admissions in the time period were outside of locality, with Calderdale having the highest proportion.

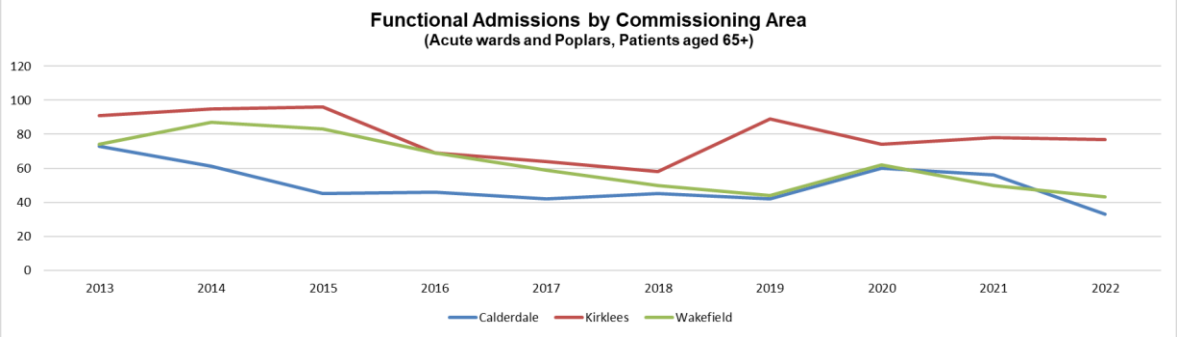
Data shows that over the past 10 years that there has been an overall downward trend in admissions, though rates have been more stable in the most recent 5 years.



The following chart shows the number of dementia (organic) admissions for each place over time:

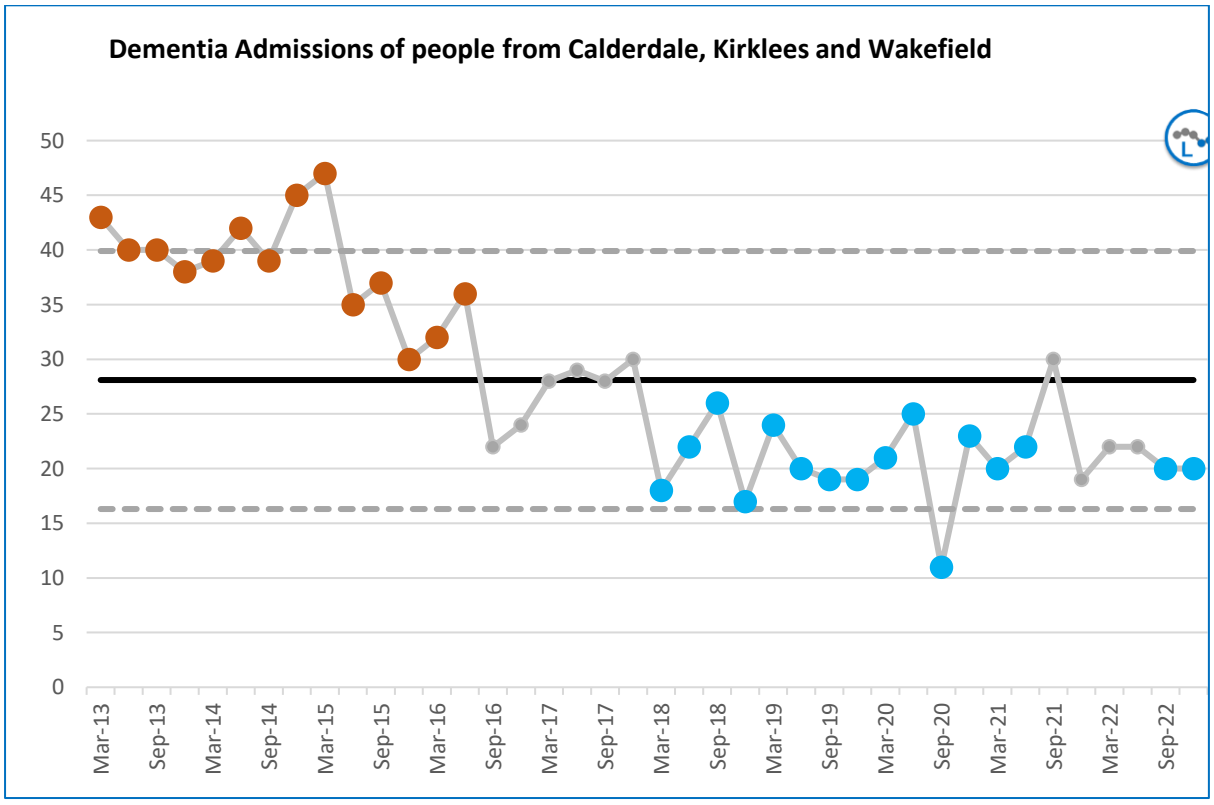


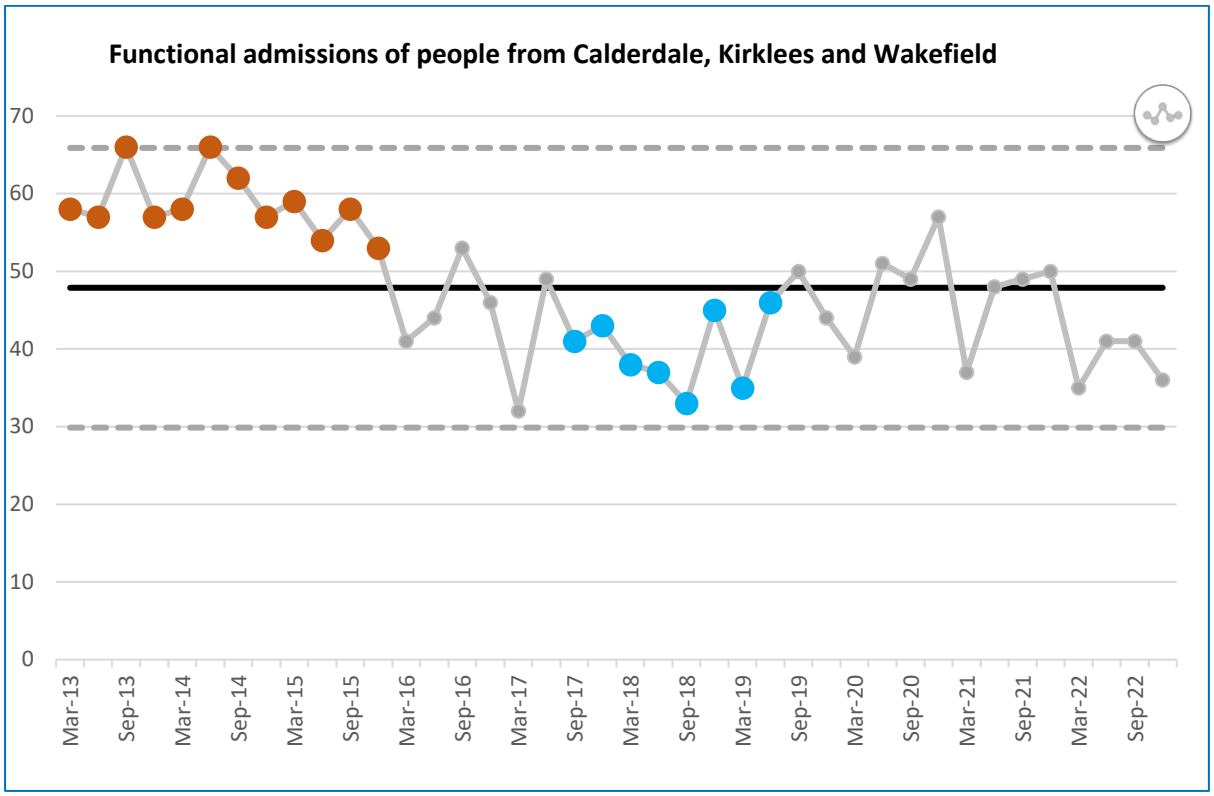
The table below shows the numbers of functional admissions by place:



Both functional and dementia admissions have declined in the most recent 10 years, with the sharpest decline being in the numbers of dementia admissions.

The following shows the admission rates when modelled using statistical process control from 2013 to 2022:





There has been a clear step change downwards in both functional and dementia admissions over the 10-year period. The change is clearer in dementia admissions, with some periods above the upper control limits in 2014/15 and more recently on or below the lower control limits.

6.14 Ward Stays

Whilst patients are on the wards the aim is to have one single ward stay and not to move people from ward to ward in different hospitals as a single stay. Whilst the Trust works hard to minimise the impact of moving patients between wards through comprehensive care planning and risk assessments, this is not always possible.

Potential benefits of a single stay are:

- Ensures continuity of care.
- Supports the development and utilisation of therapeutic relationships.
- Supports appropriate Length of Stay.
- Single period of assessment.
- Clear pathway and understanding of the wider multi professional team and their role in supporting care in the community.
- One relationship between the carer and the care team.
- Improves attitudes to risks.
- Reduces the risk due to the single environment / consistency of staff.

Potential risks of multiple ward stays are:

- 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.
- Especially disruptive to the treatment of a person living with dementia:
    - increased confusion.
    - increased disorientation.
    - staff not being able to interpret the person's needs appropriately.

6.14.1 What works well in the current pathways

- The last inspection by the CQC rated care as good. The Trust provides safe care, where risks are assessed, and care is planned as part of a multi-disciplinary team (MDT).
- There is capacity to meet the bed pressure demands.
- There is good local links with community teams and partner organisations on most of our sites.
- Teams meet regularly with local advocacy services to discuss issues and changes to provision on our wards.
- There is access to discharge coordinators who are able liaise with partner services, such as social services and care homes.
- Community Mental Health practitioners and the care home liaison team offer 72 hour follow up for all patients discharged from the wards to ensure there are no issues with a placement, medications etc.

6.14.2 What doesn't work well in the current pathways

- The length of stay is longer than the national average, particularly for people with dementia. There are many potential factors, but in part, due to lack of provision of appropriate placements following discharge.
- Many patients have more than one ward stay, this is partially due to the pathway for Poplars ward not allowing for most direct admissions to the unit (patient's often admitted to Crofton for a period of assessment first).
- We do not fully meet single sex accommodation guidelines which may limit where we can admit some patients.
- Poplars ward is not co-located with other mental health inpatient wards or an acute hospital. This leads to clinical risks which are currently being mitigated by overstaffing and not accepting admissions of patients with some risks to the Poplars.

6.14.3 Multiple stays

The tables below show the total number of completed spells and ward stays between the 2013/14 -2021/22 financial years:

CKW	1	2+	Total

functional	**1394**	**324**	**1718**
2013/2014	206	36	242
2014/2015	170	50	220
2015/2016	168	36	204
2016/2017	147	28	175
2017/2018	134	31	165
2018/2019	118	38	156
2019/2020	146	37	183
2020/2021	160	31	191
2021/2022	145	37	182
Dementia (organic)	**628**	**410**	**1038**
2013/2014	125	34	159
2014/2015	110	57	167
2015/2016	80	57	137
2016/2017	69	52	121
2017/2018	55	47	102
2018/2019	50	41	91
2019/2020	41	48	89
2020/2021	43	32	75
2021/2022	55	42	97
Grand Total	**2022**	**734**	**2756**

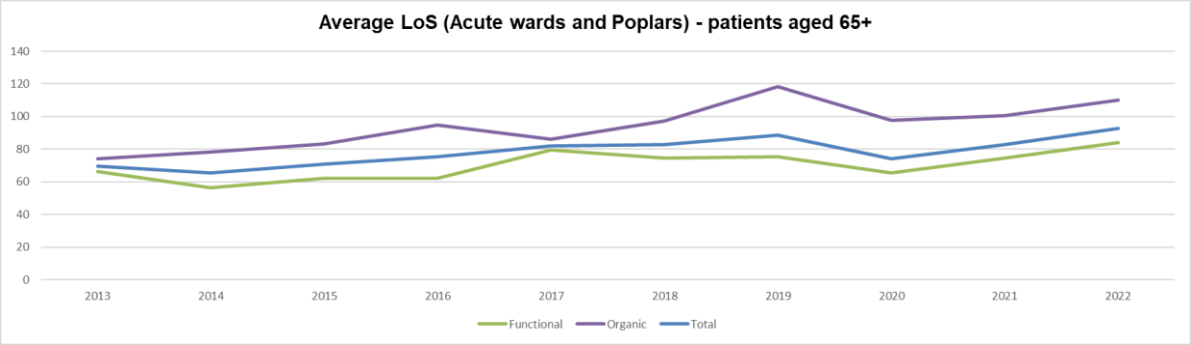
The table below shows the impact multiple stays has on the overall length of the stay, highlighting the length of the stays where people had just one ward stay compared to multiple stays:

	Functional (LOS)	Dementia (LOS)
1 stay	61	69
2 + stays	107	126

Whilst a small proportion of the 2+ stays will include transfers due to complexity, the majority are pathway issues.

6.15 Length of Stay overall

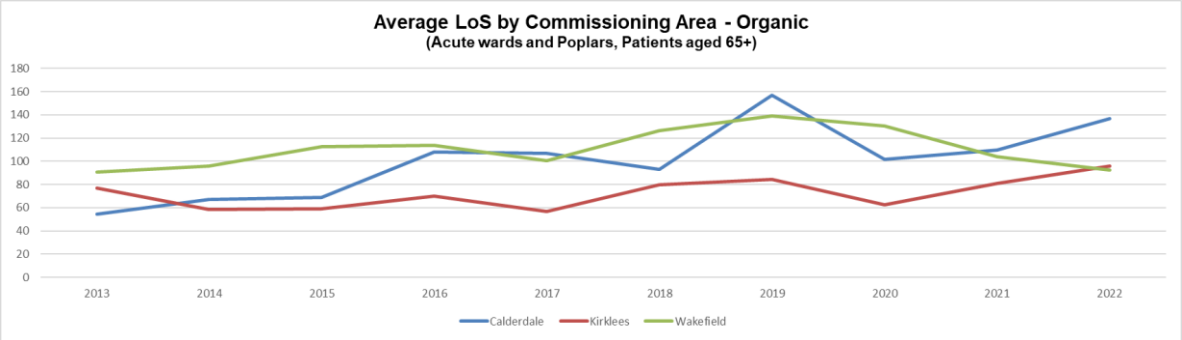
The average length of stay (LOS) has been increasing over time, with the greater increase being in dementia (organic) stays (average LOS increasing from around 80 days 2013-15 to over 100 days in recent years):



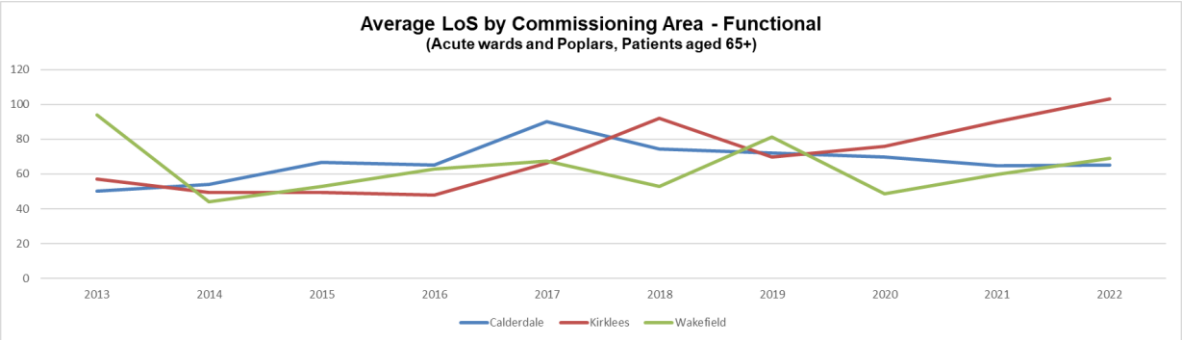
Place based breakdown:

The following charts show the breakdown of LOS across the different places:

The chart below shows the average LOS across each place for dementia (organic admissions):



Calderdale has seen the biggest increase in dementia (organic) Length of Stay, from around 60 days in 2013-14 to over 100 days in recent years. Wakefield organic LOS has also been over 100 days in recent years, though dipped just below in 2022. Kirklees has had the lowest organic LOS overall but had an upturn in 2022.



There is less clear difference and change in functional LOS place by place. Wakefield and Calderdale have much lower functional LOS compared to dementia (organic). In recent years the functional and organic LOS in Kirklees has been very similar – around 80 days, though Kirklees saw an increase in functional LOS in recent years.

6.16 Ward Environments

A summary of strengths and weaknesses of the wards in the current model is below.

The table below summarises the wards from a quality environment perspective:

	Pros	Cons	Comments
Crofton Ward, Fieldhead Hospital	Ensuite Large bathroom area with grab handles More modern feel Grab handles on corridors to reduce risk of falls Extra Care Area.	Not a lot of communal space Narrower corridors than W19 – feels more like an acute setting Limited access to outside space	While ensuite facilities are beneficial, people with dementia are more likely to need assistance in the bathroom. Increased communal space is required for people with dementia. On older people's wards there is a balance of risk between ligature safety and fall safety. Ligature safety is not as risky on Crofton Ward but more grab rails will be required for falls safety.
Ward 19, Dewsbury Hospital	More space for movement Wider corridors Courtyard space Extra care environment between the two wards Each ward has access to lounges, dining room, OT room, garden conservatory.	Work required to bring the ward to standard e.g., grab rails, toilet access No ensuite facilities Less ligature safety compared with Crofton Ward. Clinical senate found the ward dark and sterile.	Environmental standards and guidance have been considered Work is underway on the environment - hand rails and automatic lighting to be added which should help improve safety and make less dark/sterile Work can be done to make some bedrooms ensuite (the current drainage system won't support the whole unit changing to ensuite).
Beechdale		Poor line of sight. Narrow corridors. Lack of space for activities. Access issues to seclusion room, up a lift and though Elmdale ward.	Feedback that the weaknesses with the environment does mean that we are better able to manage people with functional needs on this site.
Poplars	Ward environment does work for people with dementia, for example, circular route.	No ensuite No extra care or seclusion area.	

The table below summarises the wards from an access perspective:

	Pros	Cons	Comments
Crofton Ward, Fieldhead Hospital	Close to general hospital site Access to Electroconvulsive Therapy (ECT) for functional needs Free parking.	Not collocated with general hospital.	Scope to provide up to 26 beds across 2 wards with capital investment at the site.
Ward 19, Dewsbury Hospital	More central Collocated with acute general hospital.	No direct access to ECT for functional needs Car parking charges – though space is generally available.	Provides up to 30 beds on one site, across 2 wards.
Beechdale	Collocated with acute general hospital so ambulance not needed for falls Access to ECT for functional needs.	Not central. Car Parking – very limited.	Scope limited to 16 beds on one ward. Consideration by CHFT to build multi-storey car park at site.
Poplars	Free parking	Isolation of site Approximately 30 minutes' drive from acute general hospital Difficulties accessing staff and resources when needs increase on the ward As a satellite unit there is no easy access to support in an emergency, such as a crash team response, a response team to pinpoint alarms, etc Does not accept direct admissions, people need to be transferred to the ward.	12 bedded ward.

6.17 Incidents

The table below shows the total number of incidents across all OPS wards in 2022. The incident data includes the Willow Ward in Barnsley to give a comparison to a functional only ward:

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)	**372**	**334**	**492**	**426**	**1624**
Beechdale Ward, The Dales Unit	58	80	92	57	287
Crofton Ward (OPS), Wakefield	85	71	101	81	338

Poplars Unit, Wakefield	115	70	135	178	498
Ward 19 (OPS)	79	86	138	81	384
Willow Ward – Barnsley (functional only)	35	27	26	29	117
Total	**372**	**334**	**492**	**426**	**1624**

Rates per bed:

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)					
Beechdale Ward, The Dales Unit	3.6	5.0	5.8	3.6	17.9
Crofton Ward (OPS), Wakefield	5.3	4.4	6.3	5.1	21.1
Poplars Unit, Wakefield	9.6	5.8	11.3	14.8	41.5
Ward 19 (OPS)	2.6	2.9	4.6	2.7	12.8
Willow Ward – Barnsley (functional only)	3.5	2.7	2.6	2.9	11.7
Total	**24.7**	**20.8**	**30.5**	**29.1**	**105.1**

Yellow and above risks:

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)	**101**	**84**	**109**	**91**	**385**
Beechdale Ward, The Dales Unit	13	10	21	12	56
Crofton Ward (OPS), Wakefield	25	21	25	16	87
Poplars Unit, Wakefield	36	27	36	40	139
Ward 19 (OPS)	16	14	21	15	66
Willow Ward – Barnsley (functional only)	11	12	6	8	37
Total	**101**	**84**	**109**	**91**	**385**

Rates per bed:

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)					
Beechdale Ward, The Dales Unit	0.8	0.6	1.3	0.8	3.5
Crofton Ward (OPS), Wakefield	1.6	1.3	1.6	1.0	5.4
Poplars Unit, Wakefield	3.0	2.3	3.0	3.3	11.6
Ward 19 (OPS)	0.5	0.5	0.7	0.5	2.2
Willow Ward – Barnsley (functional only)	1.1	1.2	0.6	0.8	3.7
Total	**7.0**	**5.9**	**7.2**	**6.4**	**26.4**

Slips, trips and falls (all risk categories):

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)	**111**	**76**	**144**	**128**	**459**
Beechdale Ward, The Dales Unit	19	21	23	19	82
Crofton Ward (OPS), Wakefield	18	9	22	20	69
Poplars Unit, Wakefield	26	10	40	58	134
Ward 19 (OPS)	44	35	56	20	155

Willow Ward – Barnsley (functional only)	4	1	3	11	19
Total	**111**	**76**	**144**	**128**	**459**

Rates per bed:

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)					
Beechdale Ward, The Dales Unit	1.2	1.3	1.4	1.2	5.1
Crofton Ward (OPS), Wakefield	1.1	0.6	1.4	1.3	4.3
Poplars Unit, Wakefield	2.2	0.8	3.3	4.8	11.2
Ward 19 (OPS)	1.5	1.2	1.9	0.7	5.2
Willow Ward – Barnsley (functional only)	0.4	0.1	0.3	1.1	1.9
Total	**6.3**	**4.0**	**8.3**	**9.0**	**27.7**

Violence and aggression (all incidents):

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)	**121**	**132**	**167**	**177**	**597**
Beechdale Ward, The Dales Unit	18	37	35	19	109
Crofton Ward (OPS), Wakefield	42	28	22	25	117
Poplars Unit, Wakefield	37	30	40	80	187
Ward 19 (OPS)	19	29	63	48	159
Willow Ward – Barnsley (functional only)	5	8	7	5	25
Grand Total	**121**	**132**	**167**	**177**	**597**

Rates per bed:

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inpatient Service (OPS)					
Beechdale Ward, The Dales Unit	1.1	2.3	2.2	1.2	6.8
Crofton Ward (OPS), Wakefield	2.6	1.8	1.4	1.6	7.3
Poplars Unit, Wakefield	3.1	2.5	3.3	6.7	15.6
Ward 19 (OPS)	0.6	1.0	2.1	1.6	5.3
Willow Ward – Barnsley (functional only)	0.5	0.8	0.7	0.5	2.5
Total	**8.0**	**8.3**	**9.7**	**11.5**	**37.5**

Overall, the data does tend to suggest a lower level of incidents and a lower proportion of violence/aggression and slips, trips and falls on the Willow Ward and although this is a 10-bed ward, compared with 12-16 across the others (Ward 19 has both wards included so is 30 beds), numbers do still appear to be lower based on proportion.

6.18 Existing Workforce

The table below summarises the current rostered workforce across the inpatient wards:

Ward	Days		Twilight	Nights	
	RN	HCA	RN	RN	HCA
Beechdale	2	2	1	1	2
Ward 19 F	2	2	1	1	2
Ward 19 M	2	2	1	1	2
Crofton	2	2		1	3
Poplars	2	3		1	2

As well as this rostered staffing, we do have a range of specialist resource that works into the ward including medical staffing, advance clinical practitioners, psychology, physiotherapy, and occupational therapy.

Fill rates show that most of the wards regularly run well above 100% staffing levels:

Ward	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Beechdale	121%	135%	117%	129%	136%	118%	108%	111%	121%	135%	133%	125%
Crofton	175%	146%	142%	148%	147%	185%	154%	153%	176%	158%	171%	164%
Poplars	142%	153%	140%	154%	155%	145%	142%	122%	153%	166%	169%	256%
Ward 19 F	93%	104%	95%	84%	85%	88%	88%	91%	99%	90%	91%	89%
Ward 19 M	100%	104%	93%	100%	97%	96%	101%	99%	110%	102%	104%	106%

The table below shows the current staffing levels across all wards against actual usage in 2022/23.

	Current Establishment	Actual Use
Registered Nurses	70.24	61.67
Healthcare Assistants	84.61	122.4
Total	154.85	184.07

6.18.1 Turnover rates:

Older Adult Wards Annual Turnover rates Oct 21- Sept 22:

Beechdale	23.80%
Crofton	22%
Poplars	22.60%
Ward 19 F	11.90%
Ward 19 M	0%

Willow	0%

50% of the older adult wards have a turnover rate in excess of the Trusts average rate of 12%.

Challenges that were identified in the work on the SWYPFT internal inpatient establishment review in early 2023 included:

- High proportion of newly qualified staff and lack of experienced staff to support and train - impacts on new starters experience.
- Reliant currently on international recruits, bank, and agency staff to cover vacancies and deficits – causes increase in support from current staff whilst providing care as well – impacts on new starters experience.
- Increased acuity resulting in use of additional staff above planned staffing levels.
- Establishment only set for 1 registered staff on a night. Can leave just a registered nurse from bank or agency on shift if unable to fill due to ward vacancies.
- Ongoing management of covid isolation for patients and associated increased Infection, Prevention and Control measures.
- Staff fatigue and wellbeing.
- Delayed discharges, length of stay and flow through the inpatient wards.
- Increased complexity of physical health care & polypharmacy.
- Increase of service users dying on the ward due to expected death due to End of Life – staff are then providing 1:1 care for these individuals and supporting families to be on the wards.

6.19 CQC Inspections

In June 2019, the Care Quality Commission (CQC) inspected SWYPFTs inpatient care for older people.

Our older adult inpatient wards are currently rated as Good by the CQC in 4 out of 5 domains, with a rating of Requires Improvement for safety.

The CQC were aware of our service transformation programme and the work with commissioners to explore development of a specialist dementia unit.

They saw evidence of good dementia care as part of their inspection but pointed out that this was inconsistent.

They noted that staff described the challenges of managing wards with mixed functional and organic patients.

The CQC has given our Trust the following action for improvement:

'The Trust should ensure that staff are supported to manage the mix of organic and functional patients and that dementia care is appropriate'.

The CQC also visited the Trust in late 2022, visiting ward 19 and the Poplars. They noted that the location of the Poplars away from any other of the trust's location meant that the

staff team were isolated in terms of access to urgent support or cover for unplanned staffing issues. They also stated “We were concerned that the distance from The Poplars to other trust locations would impact on out of hours medic assessments”.

6.20 Benchmarking Data

6.20.1 Summary of how we compare to others

The table below summarises how the Trust overall compares with the national averages (SWYPFT is MH032), Adult and Older People's Mental Health Benchmarking 2021/22:

Older Adult

Benchmarking Network

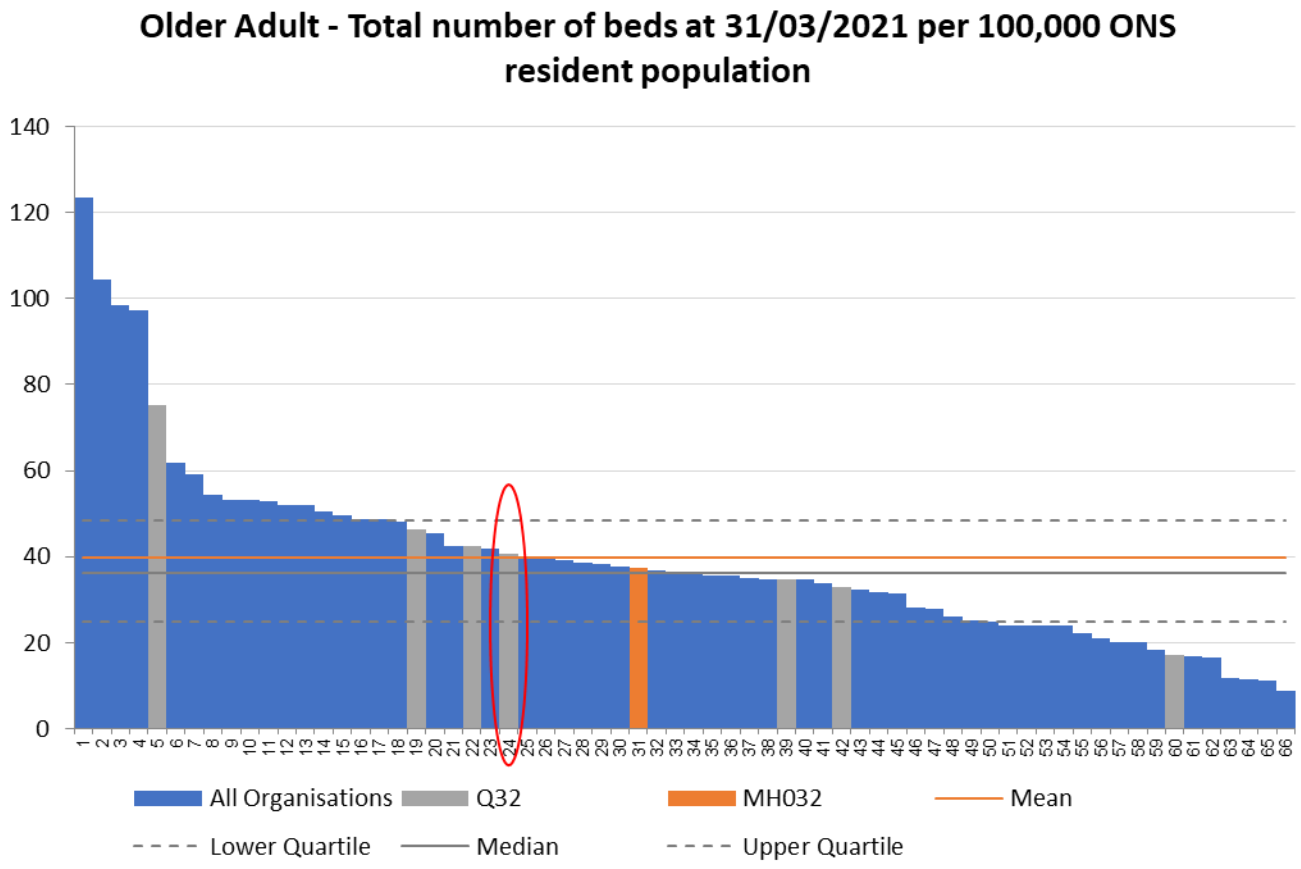
	MH032	Mean	Median	National Trend
Older adult beds per 100,000 resident population at 31st March 2022	37.0	42.4	34.8	
Older adult bed occupancy rates (excluding leave)	84%	85%	87%	
Older adult admissions per 100,000 resident population	144.4	162.0	133.8	
Older adult mean length of stay (excluding leave)	75.0	78.5	76.0	
Older adult delayed transfers of care	7%	10%	10%	
Older adult readmissions	6%	5%	4%	

The national trend for admissions is a reduction and LOS is an increase which in line with our trajectories.

The benchmarking report states that inpatient capacity for older adults is the smallest since the benchmarking project began, at a median of 34.8 per 100,000 resident population as at 31st March 2022. In context, the bed stock for older adults has decreased from a higher starting position in 2013/14 at 50.4 per 100,000 population (a 31% decrease between 2013/14 and 2021/22).

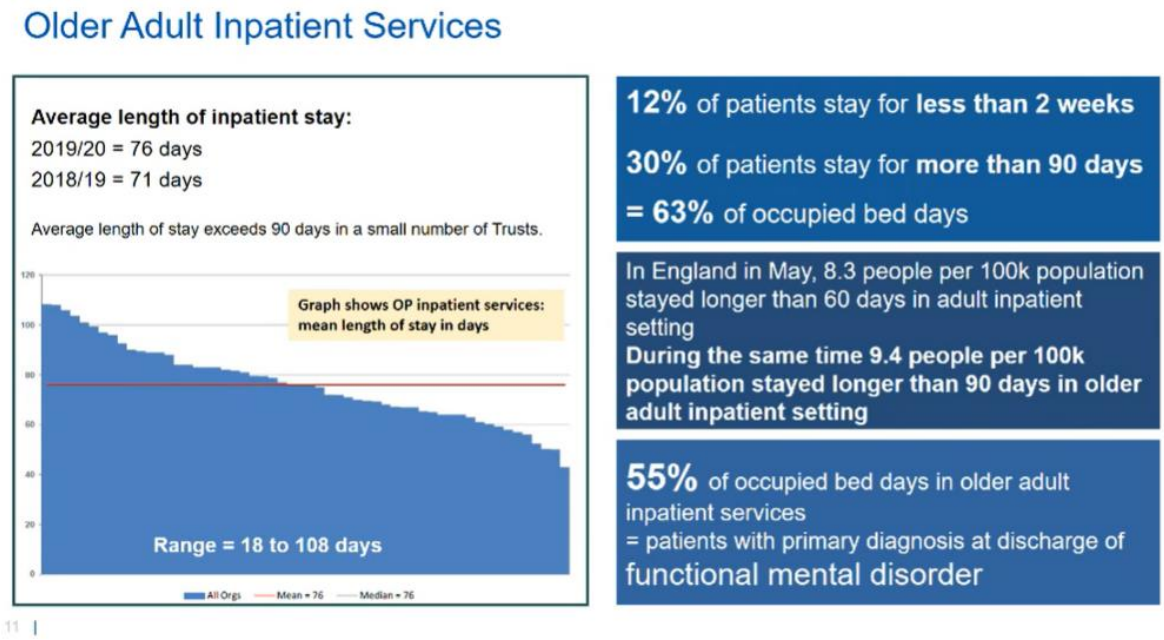
SWYPFT has not changed OPS bed base in this period, with 37 beds per 100,000 population, above the national median.

The orange bar in the table below shows the overall number of beds per 100,000 population for SWYPFT including Barnsley. The circled area shows the West Yorkshire population only (based on the Calderdale, Kirklees, Wakefield population and beds):



Across Calderdale, Kirklees and Wakefield there are approximately 41 beds per 100,000 population, well above the national median (red circle).

The national picture also shows that functional patients make up 55% of occupied bed days, dementia 45%:



Data shows that the average LOS of people from Calderdale, Kirklees and Wakefield in older people's beds has been increasing in recent years from 74 days in 2020, to 83 days in 2021 up to 93 days in 2022, which is now above the historic national averages for length of stay.

7 Vision for the clinical model

There is a strong evidence base to support the case to change to improve the current operating model and to deliver specialist needs based care. The programme team has taken a clinically led approach to establishing a vision and requirements for the inpatient model of care. This has been done via gathering a range of evidence including best practice guidance, understanding the national and regional context, learning from what others have done, listening to what staff, service users and other key stakeholders tell us that we should deliver, to shape the clinical model. A summary of this information is set out below.

7.1 Vision for the future

7.1.1 National Context

NHSE, in their document, Acute Inpatient Mental Health Care for Adults and Older Adults: guidance to support timely access to high quality therapeutic care, close to home and in the least restrictive setting possible (July 2023) have set out a vision for effective, good quality care in adult acute inpatient mental health services, which is based on these key principles:

- 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.

See NHS England » Acute inpatient mental health care for adults and older adults for more information.

NHSE commissioning guidance sets out where specialised and highly specialised services should be used. NHS commissioning » Highly specialised services (england.nhs.uk) sets out that where highly specialist services are required and that centres of excellence should be considered where there are no more than 500 patients' year. NHS commissioning » Specialised services (england.nhs.uk) describes the approach to specialist services, stating that "specialised services are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience."

7.2 West Yorkshire ICB

The West Yorkshire ICB has the 4 following aims:

- To reduce health inequalities
- Manage unwarranted variations in care
- Secure the wider benefits of investing in health and care

- Use our collective resources wisely

The West Yorkshire ICB strategy refresh Five Year Plan - Our vision (wypartnership.co.uk) states that if you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible and that access to care is equal for all. Local hospitals will be supported by **centres of excellence for services such as** cancer, vascular (arteries and veins), stroke and **complex mental health**. They will deliver world class care and push the boundaries of research and innovation.

7.3 SWYPFT Vision

The following sets out the SWYPFT vision, mission and values:

Our vision:

To provide outstanding physical, mental and social care in a modern health and care system

Our mission:

We help people reach their potential and live well in their community

Our values:

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

At the outset of the programme a vision for older people's services was established that aligns with the Trust vision, mission and values:

- Older People will have a more meaningful, healthy and independent life in their community
- Physical health, mental health and social care needs are met
- Collaborative, integrated and appropriate care in a safe and supportive environment
- Independence throughout the patient journey, including over admission and discharge
- Services are responsive, fit for people and accessible
- The needs of carers and families will be central to all that we do
- Services will be tailored, culturally aware and sensitive

To deliver these aspirations for older people's inpatient services the Trust also set out to improve quality of care and inpatient experience for people by moving away from having mixed needs ward and establishing specialist wards for people with dementia (organic) needs and with functional needs.

7.4 Evidence for a needs-based specialist model

7.4.1 Published evidence for needs-based model:

The evidence gathered in this section sets out 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 commission also found that where wards were mixed, nurses often described difficulties.

> "Challenge of meeting all individual needs for functional patients and dementia patients as needs can be complex."
>
> "When there is a higher percentage of patients with dementia this has a negative impact on patients with a functional illness."

Mental welfare Scotland also considered the patient mix on ward in their 2015 report Making progress: older adult functional assessment wards.

They reported that the majority of staff interviewed felt that having patients with dementia on the wards presented some issues. Most commonly, staff reported that patients with dementia required more nursing time, had more complex needs, and that the functional patients often found it difficult to understand or tolerate patients with dementia.

Wandering was a common problem described by staff, and they stated that patients often complain about this on the wards. Nursing staff are also aware that patients recognise that more time is spent with dementia patients, at the expense of time with other patients.

In the mental welfare Scotland report, patients also commented on their experience of being on the same ward as patients with severe dementia. Issues that can arise include dementia patients going into others' rooms or going through others' belongings. The following are comments from patients on a mixed ward:

> *"Having a mixed ward means that nurses have to spend a lot of time on personal care tasks for the dementia patients, and often apologise about not having enough time to talk with him. He also said that if he leaves his door open these patients will often come in and take things or move things around in his room."*

The report also referenced a female patient said that:

> *"The functional/dementia mix doesn't work. Staff time is spent physically caring for and monitoring dementia patients, with very little time left for functional patients."*

Their (2010) report 'Where Do I Go From Here?' also highlighted problems associated with mixed pathology wards. The main problem was that some patients with dementia tended to interfere and invade the personal space of other people.

People with severe depression, for example, may find that sharing their living space with other people with behavioural problems can make them feel worse and the effect on people with dementia of sharing a ward with people with severe depression may also be unhelpful.

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.

Specialist dementia units can support people with dementia to produce a behavioural support plan which will facilitate their move to a community-based setting, such as their home or a care home.

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. It noted that this would provide a highly skilled practice area and an attractive specialism for ambitious and talented practitioners to deliver therapeutic interventions.

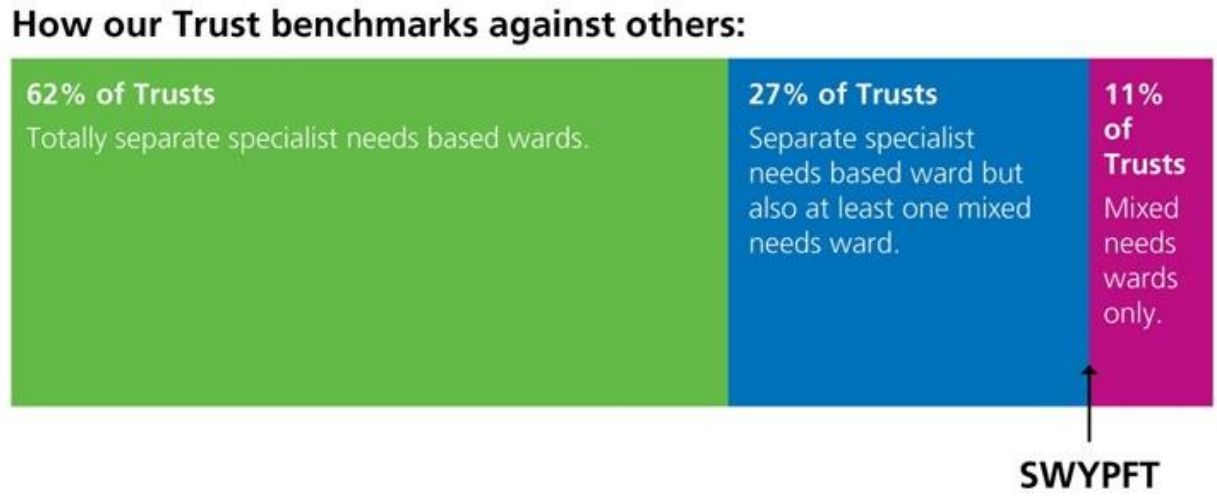
Through summer of 2022 the Trust engaged with the Northern Clinical Senate to review proposals. Clinical Senates are independent non-statutory advisory bodies established to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change 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".

7.4.2 Models implemented elsewhere:

Most providers now have separate specialist wards for dementia and other needs and the programme team have visited several other Trusts that have separate specialist units, considered their models and used learning to help us ensure that we design an effective and innovative workforce for our services. Most other Trusts have an operating model with separate specialist functional wards. A desktop review of what other providers publish as their models shows the following:



7.4.3 Why Places might not have separate provision:

Due to population and geographical spread of units it may be difficult to provide separate needs-based wards if activity levels and bed numbers are small in each place. Where this is the case, alternative approaches, for example, having only dementia wards and the elderly

with functional disorders being looked after within adult mental health wards, could be perceived to be more detrimental to patient care than having mixed needs older people's wards.

7.4.4 What people told us about a needs based model

Whilst there is access to specialist support services on the mixed needs, some of the real benefits of having the specialism are in relation to give the dedicated focus. The patients on a functional only ward would benefit from the specialist staff skills, dedicated time and focussed group work which are more difficult to establish on the mixed wards. The following is a case study of a person who had a functional admission to a mixed needs ward.

Ward: Ward 19 Dewsbury
Experience: Functional Service User staying on a mixed needs ward
Date: May 2021
• Struggled with boredom most of the time because he didn't have anyone to talk to. • Found it strange when just arriving, at his most unwell and then being sat in a dining area with people that lacked awareness. • For a period of time there was one person he could talk to with when they were discharged he was back to just being sat there without anything to motivate him and he struggled to do anything at all with his time. • However, the staff were great and he couldn't fault them, "nothing but praise" – they were "on a different level" to other nursing staff he had come across. • He had a lot of praise for the staff, they would take him for walks and the conversations he had then really helped him. However, he was also aware that the person going for a walk with him was one less on the ward. • When he was getting better he was noticing several incidents including one person being aggressive to a nurse, which he tried to intervene in. • He stated that a functional only ward would definitely be much better for him and that distance not a problem either for him. • Another patient that stayed on 2 wards (one functional only and one mixed) has fed back that their stay was much better on the functional only ward.

Our engagement with inpatients, family and carers also identified challenges across the current ward configuration. Direct feedback of challenges that were highlighted included:

- It was very upsetting and worrying for me coming in to contact with someone with dementia for the first time. I was worried all night hoping the person could not get into my room.
- I think the 'time element' of support currently is more geared to service users with dementia. We all need support.
- Dementia patients are more awkward and need extra care. Having specialist ward helps to aid recovery with patients with the same illness.
- Everybody in a similar position so can be catered to the person's needs. Sometimes helps to talk to and share with others who suffer similar things.
- Some patient behaviour can be challenging and upsetting.
- Be easier for staff if functional only. The ward would be calmer and better especially for dementia patients, who required more care and looking after.
- Seriously unwell patients need to be segregated from other patients for the benefit of both staff and other patients.

More information can be found in the engagement section.

7.4.5 Evidence of differing environmental requirements for older people's inpatient services

Modelling (DH 2013) suggests 15 beds is an optimum size for clinical and therapeutic engagement https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_03-01_Final.pdf

Work of NHS Scotland strongly supports purpose-built environments for people with dementia but also flags that in the absence of such a provision, it would be important to adapt the existing environment to provide features that respond to the experience of the illness as well as age-related impairments. It should provide an enhanced working environment for staff to deliver person-centred care and a welcoming and supportive environment for people visiting the unit, who may spend a large part of their time with their family member, supporting their care.

The information below summarises key features of an inpatient environment for older people's mental health services and what needs to be considered from both a dementia friendly and functional needs perspective. There are elements of a dementia friendly environment that we are able to provide on a mixed need ward and others where there are significant challenges in providing an environment that meets the needs of both patient groups.

In both dementia and functional need wards we ideally need:

- Built environment - An environment that maximises therapeutic potential through layout, design and key features.
- Sound - Absorbance from ceilings, floors, window covering and soft furnishings to support audible communication. Quiet ambience with noise minimised.
- Bedrooms - Individual en-suite facilities, room recognisable with easy visibility of bed and personal items on display.
- Outside space - Access to outside space during the day from communal areas.
- Good lines of sight – on wards where it is difficult to observe patients, because of the layout, there is a potential for increased risks. It also helps patients to navigate the ward, especially those with dementia.

In a dementia ward we ideally need:

- Corridors - All corridors lead to meaningful places, with endings avoided or made into an interesting feature for engagement and activity. This can be difficult on functional wards due to minimising ligature risk especially in areas that are difficult to observe like the end of a corridor.
- Signage - Clear signage to help wayfinding for everybody, with pictures and graphics in addition to words. Contrasting colours and 'landmarks' around the ward to help with perceptual difficulties.
- Meaningful occupation - Facilities that support engagement in occupation, activity and social stimulation. In a dementia friendly manner, a focus on maintaining personhood through reminiscence and tailoring facilities/activities to be accessible to those with cognitive difficulties.

- Safety - Environment to minimise risk of self-harm and injury. Increased focus on reduction of falls risk, handrails, bathroom grab rails and more likely to use hoisting equipment.

In a functional ward we ideally need:

- Meaningful occupation - Facilities that support engagement in occupation, activity and social stimulation.
- Safety - Environment to minimise risk of self-harm and injury, focused on not only reduction of falls but also the prevention of self-harm. There is increased possibility for supporting maintaining independence, such as the ability to make hot drinks for self, that may be prohibited on a mixed need ward.
- Therapeutic engagement – Facilities that support one-to-one or group therapy to aid recovery.

In addition, we are aware of the work that Stirling University (https://www.dementia.stir.ac.uk/) has done in relation to dementia environments and the Environment for ageing and dementia design assessment tool (EADDAT) which is something that would be incorporated into the detailed design of any specialist dementia ward.

7.4.6 Learning from other site environments

The project team made several visits to sites that have established specialist dementia units. The team visited an impressive purpose designed site for Older People, which operated a 16-bed dementia ward, adjoined to a 16-bed functional unit with a flex door and 4 flex beds in between the units to increase / decrease capacity as needed. The building had a circular corridor which allows people with dementia to walk around the whole ward. It has been designed to let in natural light.

Another Trust has a purpose-built environment with many features including circular route they call a ‘dementia pathway’ around the ward where people leave the ward itself and circle around the gardens and back into the building. This has reduced the numbers of people that gather around doors and reduces flashpoints. Staff will generally walk with the patients.

A third had a layout that modern and spacious and uses the ground floor of a 2-story building that was fully refurbished. It has wide corridors and figure of 8 design that could be fully walked around.

More information on site visits and learning from others can be found in **appendix 1.**

7.4.7 Summary of benefits of specialist needs based wards

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.

A summary benefits framework is established as part of the business case (see benefits management section).

7.5 Gender specific care for older people in mental health hospitals

Delivering same-sex accommodation (NHSE 2019) sets out principles and guidance for how wards should be configured, including having female only lounges and bathrooms, single gender sleeping accommodation and not having to pass through mixed gender areas to access those areas.

The Trust's sexual safety policy highlights the need to respond in an appropriate, timely and supportive manner to any sexual safety incidents/concerns. Whilst delivering same-sex accommodation may improve sexual safety on our wards, staff training in safeguarding, gender specific wards and support from specialist advisors on safeguarding will be required in the model of care to reduce incidents and improve outcomes following incidents/concerns.

Incident data and staff tell us that sexual safety concerns can be more common in people living with dementia. Reasons for this include a change in inhibitions, misunderstanding relationships and difficulty in understanding social interactions.

7.6 Location of wards and access

7.6.1 Co-location with acute general hospitals

There are benefits of being close to or even collocated with general acute hospitals. The mental health wards that are co-located can have on-site access to the Emergency Department should any patient in the ward become physically and acutely unwell and potentially have access to physicians with expertise in looking after older people.

Close geographical alignment also supports closer working between mental health and general acute hospitals. There are benefits of arranging access to geriatricians into the mental health wards to support managing people's physical needs when they become difficult to manage on a mental health ward. Conversely, we are better able to reach in and support people with acute mental health problems in a general inpatient stay. In addition, when patients need investigations, such as x ray, this process will reduce the time ward staff would have to escort the patient and potentially reduce patient distress.

The 2 local acute general hospitals are Mid Yorkshire NHS Trust (covering Wakefield and North Kirklees) and Calderdale and Huddersfield NHS Foundation Trust (CHFT).

Mid Yorkshire, in their strategy, reference aims for purpose-built facilities will be used to create centres of excellence and facilitate optimal clinical outcomes, patient safety and experience. They offer an acute care of the elderly unit at their Dewsbury and Wakefield sites.

CHFT have their general Elderly Care in Huddersfield Royal Infirmary. Fracture clinic is in Calderdale and the CHFT strategy includes exploring opportunities to transform services enabled by estate development.

7.6.2 Co-location with other acute Mental Health Services

There are benefits of co-locating the ward with other mental health services and wards. This allows for better access to cross cover and medical support should needs and demands on the wards change. Emergency response is also improved when there is alignment with other

mental health wards, such as a dedicated crash team or responding to safety incidents, for example, when a physical intervention or de-escalation is required.

7.6.3 Access to other services:

A range of other services input into the stay of people on older adult wards:

- Advocates should have access to the wards to meet with patients that are referred.
- Social care may be required and social care services are responsible for social care assessments.
- Care homes might also need access to the wards to assess whether they can meet the needs of the patient.
- Mental Health Community Teams may need access to facilitate discharge assessments and plan for post discharge support.

7.6.4 Patient Transport

For the majority of patient transport needs, the Trust uses private services, either taxi or secure transport. These facilitate all routine transfers between mental health wards or other places of care.

In any future model ambulance services will continue to be used to facilitate transfers to acute general hospitals, following a medical emergency, such as a significant fall. We do not use YAS patient transport services, but there may be times where other services use YAS patient transport to send patients to our mental health wards.

A future model of care that improves physical care on the wards and has close alignment between acute mental health and acute general hospitals will have a small but positive impact as it should reduce the numbers of patients that require a transfer and reduce the journey time when required.

7.6.5 Access for Families and Carers

Working in partnership with families and carers is core to good inpatient care. Currently family and carers are included in care planning, discharge planning and are involved with day-to-day care as appropriate. Involving carers and family in this way is essential to improve, patient, family and carer experience, reducing the need for restrictive physical interventions and improving outcomes.

Whilst family and carer involvement is widely used across our wards there are always areas for improvement or where we can work more creatively with families and carers. Any new model will need to continue and improve this practice. There should also be consideration on how to mitigate any impact that extra travel may have on working closely with families and carers, especially when they are assisting with care of a patient to reduce restrictive physical interventions or improve care outcomes.

7.7 Pathways

As covered, the majority of patients won’t need inpatient care, which is only used when risk is deemed to be significant and other options have been exhausted (in line with least restrictive practice), there are times when risks to self or others are too great to be managed in the community.

As part of the pathway, people should ideally have just one inpatient ward stay and not be moved from ward to ward in different hospitals as a single stay:

- Ensures continuity of care
- Supports the development and utilisation of therapeutic relationships
- Supports appropriate Length of Stay
- Single period of assessment
- Clear pathway and understanding of the wider multi professional team and their role in supporting care in the community.
- One relationship between the carer and the care team
- Improves attitudes to risks
- Reduces the risk due to the single environment / consistency of staff.

7.8 Workforce

7.8.1 Roles required across the wards:

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. It noted that this would provide a highly skilled practice area and an attractive specialism for ambitious and talented practitioners to deliver therapeutic interventions. It recommended that any unit should take students of each profession to make it an attractive career choice for the future workforce.

Specialist dementia units require a multi-disciplinary professional approach to provide day-to-day caring, therapeutic interventions, care, and treatment, and responses to acute and intensive psychological conditions. The intensity of experience is likely to continue for a relatively short period of time until the presentation changes.

The report recommended a workforce plan for a specialist dementia unit, which has been considered in proposed workforce plans.

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.

Patients may reach end-of-life in the specialist dementia care unit because of a co-morbid condition such as cancer or end stage dementia. Access to palliative care specialists would be key to managing pain and other distressing symptoms experienced at end-of-life.

Social stimulation and meaningful occupation would be required, so that people remain connected and engaged. This would include supporting continued involvement in the person's existing hobbies, interests and spiritual practices and may involve utilising connections with external agencies, voluntary organisations and community networks. It may include patients being supported to take part in activities outside of the hospital and community resources coming into the unit to provide social engagement.

The activities coordinator would work with the person and those closest to them to identify opportunities to link with supports within the community. The activities coordinator will also develop person-centred care planning for activities of interest delivered individually and as part of group work.

Many of these functions would also be relevant to the staffing model across functional wards and as such the supporting workforce model identify the level of resource required across both functional and organic wards.

Also, as part of the 2023 SWYPFT inpatient establishment review several new roles have been proposed workforce to help the inpatient services deliver the ambition of the Long-Term Plan: Therapeutic acute care ambition (2019). These roles are not included in the ward rosters, i.e. number of staff required on duty per shift for safer staffing requirements but they will be factored into decision making regarding the use of bank and agency staff to meet acuity demands, as they will be based at ward level and active members of the ward team.

The establishment review work in ongoing in 2023 and the resource required for these wards will align with this review. A summary of resource required on a 15-bed ward above rostered nursing and HCA capacity is:

Role	Function
Physiotherapy:	Physiotherapy resource across the trust has evolved in different ways across each Business Development Unit and as a result there is a mixed picture across the footprint. However, both functional and dementia service users in hospital beds require similar physio input with physiotherapy and assistant physio resource on the wards.
Occupational Therapy:	Dedicated occupational therapy and assistant resource will help manage behaviours that challenge, having robust activity coordination on the ward will support reduction of episodes of violence and aggression. It helps therapeutic engagement, active brain functioning by providing life work support (for example, portrait of a life) that will support people to stay calm and reduce anxieties
Psychology:	Each 15 bedded ward should have access to psychology resource, with the potential for the psychologist across a dementia ward could also take a leadership role, in line with learning from visits to other Trusts where a psychology leadership role was implemented in the model with a person-centred pathway, which supported timely recovery. There should also be a psychology assistant on each ward.
Medical workforce:	The medical workforce across the future structure should change and be made more consistent. The proposed model based on existing staffing would include access to some specialty doctor resource as well as a dedicated consultant and access to trainee doctors. The establishment review is looking to implement resources that will support the medical workforce (physician associate) and if approved / embedded the impact of these roles will be considered initially.

	Physician associates (PAs) are healthcare professionals with a generalist medical education who work alongside doctors providing medical care as an integral part of the multidisciplinary team. PAs work under the supervision of a doctor but can work autonomously with appropriate support. PA's are trained to work within a defined scope of practice and limits of competence to perform the following duties: • taking medical histories from patients • carrying out physical examinations • seeing patients with undifferentiated diagnoses • seeing patients with long-term chronic conditions • formulating differential diagnoses and management plans • carrying out diagnostic and therapeutic procedures • developing and delivering appropriate treatment and management plans • requesting and interpreting diagnostic studies • providing health promotion and disease prevention advice for patients.
Advanced Clinical Practitioner:	The model proposes an advanced clinical practitioner per ward to support physical health needs of patients and to provide training and support to other ward staff to improve their skills and knowledge.
Mental Health Social Worker	Access to social worker resource per ward to focus on carrying out needs assessment, pre-discharge and discharge planning and community care assessment, which could be Local Authority employed.
Discharge coordinator	Coordinating the discharge process across geographical boundrays and working alongside social services, care home and patient flow to maintain and improve discharge pathways.
Ward Manager	Providing operational leadership and management to the ward staff. Working alongside the Matron team and the management trio to make ongoing quality improvements to the ward.
Other roles:	Managers Assistant Speech and Language Therapy Dietician Admin – medical secretary, ward admin, reception Pharmacy Domestics Housekeeper

7.8.2 Required rostered levels for needs-based wards:

As part of our evidence gathering, we spoke with a number of wards about their models of care, including their staffing models. One Trust had a roster staffing model of 6/6/5 for a 15 bedded dementia ward but found they were overspending. Another ward had implemented a similar 6/5 staffing model for a 22 bedded ward but had found significant overspend. This led to remodelling the workforce to 9/8 and managing capacity, aiming to maintain numbers around 12 or fewer which would also give their staff capacity to support community services at times. A further Trust had implemented an 8/7 staffing model in each of their 2 x 15 bedded acute dementia wards. They had implemented a zoning system for staff and found the 8/7 staff resource worked well to manage demand.

Data from the MHOST exercises showed an overall high level of acuity of people on dementia wards than on functional wards:

Dementia level profile:

Level	1	2	3	4	5
Proportion	7%	13%	27%	21%	32%

Functional level profile:

Level	1	2	3	4	5
Proportion	26%	40%	17%	17%	0%

The modelling shows a clear difference in the level of acuity and dependency of the people with dementia to functional needs, with dementia needs being considerably higher.

7.8.3 Ward requirements:

The profile of service users on the wards does lead to approximately 30% of people on the ward requiring 1 to 1 care / constant supervision.

The evidence shows that there should be an ideal 9/8 rostered workforce for a ward with approximately 15 beds operating as a dementia only ward (with 3 registered nurses on the day shift and 2 at night), though an alternative option that would have 8/7 roster mix has been shown to work.

This will include a typical registered nurse levels of 3 on a day shift and 2 at night, whilst there would be 5 or 6 healthcare assistants at any time. With the alternative lower roster, in the day there should be 3 registered nurses and 5 health care assistants, at night there should be 2 registered nurses and 5 healthcare assistants. This may be viable but may increase the likelihood of requiring additional resourcing through bank and agency when acuity is high across the wards.

The functional wards should have a lower rostered workforce, modelled as 5/4 as they would have less people at level 4 and 5 dependencies.

Therefore, a proposed workforce of the following structure could be implemented:

Ward	Days		Mid	Twilight	Nights	
	RN	HCA	RN	RN	RN	HCA
Dementia 10 bed	3	4	-	-	2	4
Dementia 15 bed	3	5	-	-	2	5
Functional 10 bed	2	2	-	-	2	2
Functional 15 bed	2	3	-	-	2	2
Functional 20 bed	3	3	-	-	2	3

The Trust, in its workforce strategy sets out the aim to ensure that staff have time to care through the roll out Safe Care for inpatient services, which uses the MHOST methodology.

7.8.4 Workforce strategy

The NHS Long Term Workforce plan (NHSE 2023) sets out a robust and effective plan to ensure we have the right number of people, with the right skills and support in place to be able to deliver the kind of care people need. It focuses on three main areas:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
- **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

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.

As a short-term measure in any future model, it could also be necessary to continue ethical international recruitment for nursing and medical roles.

7.9 Capacity Requirements

7.9.1 Overall capacity to deliver demand:

The ONS POPPI data shows that actual numbers of people with dementia will increase for some years as we have more older people in society.

The service model of timely diagnosis, evidence-based treatments, and person-centred care planning through the lifespan of the person with dementia and their carer has proven effective.

A strong dementia care model across primary and secondary care reduces carer stress, improves quality of life, and reduces the need for acute inpatient admissions and placement in care homes. So, despite the increase in prevalence of dementia, the need for acute mental health inpatient care for people with dementia has fallen and may continue to fall.

Our data aligns with national trends of reducing dementia mental health admissions over time. Whilst nationally there has been an ongoing reduction in beds for older people's MH services, the SWYPFT bed numbers have remained the same, which in West Yorkshire alone are above the national average.

Another reason why we are not seeing the admissions rise with an increase in people living with dementia may be due to the age ranges of projected changed. The highest project increases in population are for those aged 90+ which makes up a very small proportion of our admissions. Whereas the lowest increase is in those people aged 65-69, who are more likely to be admitted to our wards.

Occupancy rates of people from West Yorkshire across the 74 operational beds has been at 80% excluding leave and 87% including leave.

The table below shows what occupancy rates would be if capacity changed:

Capacity	Occupancy Rate (Inc Leave)	Ave bed use inc leave	Occupancy Rate (Exc Leave)	Ave bed use excluding leave
74	85%	62.8	78%	58.0
72	87%	62.8	81%	58.0
70	90%	62.8	83%	58.0
68	92%	62.8	85%	58.0
66	95%	62.8	88%	58.0
65	97%	62.8	89%	58.0
62	101%	62.8	94%	58.0

The current 74 bed model in West Yorkshire has 78% occupancy (Calderdale, Kirklees, Wakefield people aged over 65) excluding leave and 85% including it. 74 beds is above the national average at 41 beds per 100,000 population.

If operating with 72 beds there would be on 81% occupancy rate excluding leave and 87% including leave, of people from Calderdale, Kirklees and Wakefield.

In summary the data does support an overall model in line with existing capacity and capacity of 68 beds would maintain occupancy at 85% excluding leave and allow capacity to increase if population demands do drive further increases.

Capacity of 66 or lower may be achievable but there may also need to be further activity/investment to reduce demand or to ensure that population changes are not feeding through to increased demand over time.
Also, consideration is required to use of beds from outside of West Yorkshire as part of the Barnsley spot purchase beds and the functional shared bed base. The functional demand has been managed with capacity in several recent years, but did exceed capacity in 2022, whilst a small number of dementia beds have been used on an ongoing basis.

7.9.2 Length of Stay Targets

Our most recent length of stay data shows an average length of stay of 93 days in 2022 this is above the national average of around 80 days (NHSE 20/21). As part of any proposed future models there is an ambition to reduce our overall length of stay. We believe that this is attainable for two reasons:

- Significantly reducing the number of different wards that our patients stay on will reduce the number of patients with more than one ward stay. Patients with more than one ward stay have a much higher overall length of stay.

	Mean Functional Length of Stay	Mean Dementia Length of Stay
1 stay	61	69
2 + stays	107	126

Based on data from 2013-22

- Providing specialist dementia and functional wards will make improvements in care, treatment and discharge planning for our patients. Staff will also be able to specialise in a patient group and improve clinical skills. We have also heard feedback about staff not being able to give as much therapeutic time as they would like to patients on mixed needs wards, which would change on any future models.

7.9.3 Demand and Capacity Modelling

The 3 tables below show the potential capacity required across the system with ‘low’, ‘medium’ and ‘high’ projections.

The low projections assume that the future increases in population and prevalence don’t come through into demand and that LOS in reduced (assuming a 10% LOS reduction of functional stays and 25% of dementia, down to 80 days on average).

The medium demand projections assume that LOS can be reduced but that the population increases do come through in terms of demand for admissions.

The high demand projections assume that LOS and admissions continue at current levels and the population increases come through.

Low Demand	2025	2030	2035	2040

Functional	30.5	30.5	30.5	30.5
Organic	20.4	20.4	20.4	20.4
Overall	51.0	51.0	51.0	51.0

Medium Demand	2025	2030	2035	2040
Functional	32.7	36.0	39.0	40.2
Organic	23.0	24.5	27.4	28.7
Overall	55.7	60.6	66.4	68.9

High Demand	2025	2030	2035	2040
Functional	36.5	40.2	43.5	44.9
Organic	30.6	32.7	36.5	38.2
Overall	67.1	72.8	80.0	83.1

The programme team believe that an appropriate approach is to plan for medium demand and then aim for the low demand model over time, noting the medium-term aspiration (up to 10 years) of the business case, see options development section for more information.

7.9.4 Gender mix

The table below shows the overall gender mix:

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

There are more females than male requiring access to functional beds and this ranged from 67/33% in Female/Male mix in 2017 to 49/51% in 2020.

The dementia gender mix has slightly more males and a range from 42/58% in 2019 and 2022 through to 50/50% in 2015 and 2016.

This highlights the benefits of designing gender flex into the system, particularly for functional needs.

7.9.5 Functional and dementia mix

Analysis of the West Yorkshire CCGs shows 65% of admissions are functional and 35% dementia.

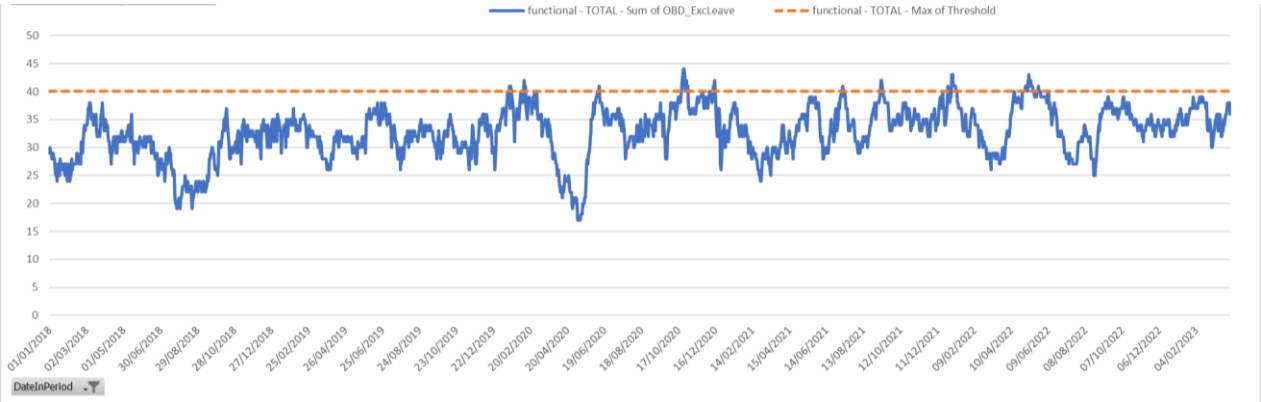
Dementia admissions have tended to have a longer length of stay which supports a range of 60%/40% to 55%/45% functional to dementia as a requirement across our services in West Yorkshire.

This is close also to the national picture of demand split across functional or dementia needs, reflecting our population demand.

7.9.6 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:

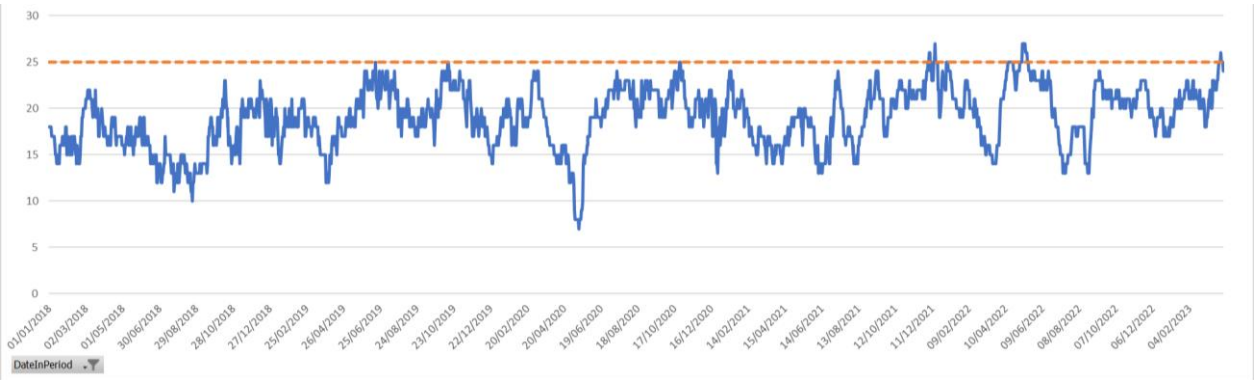


This shows that a model with around 40 beds overall should be enough for the vast majority of time.

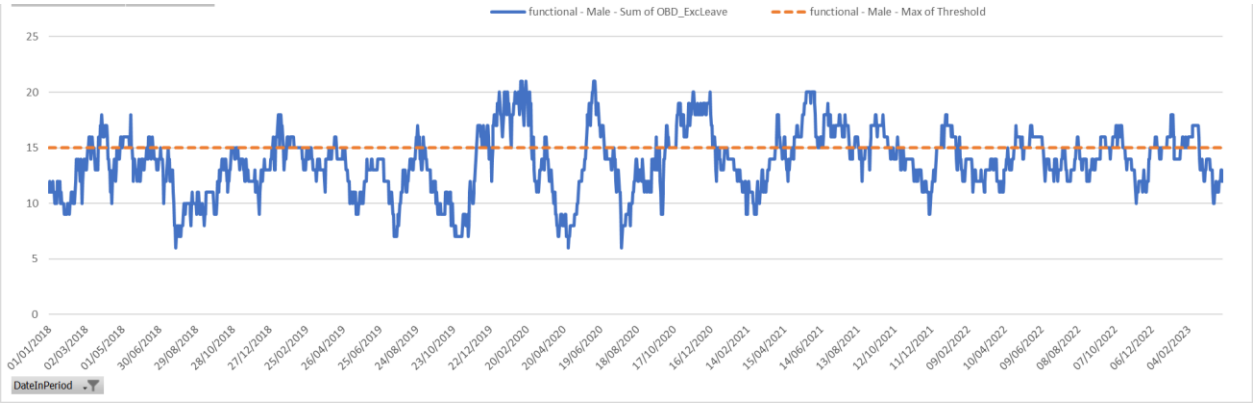
The table below shows the overall dementia bed use:

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:

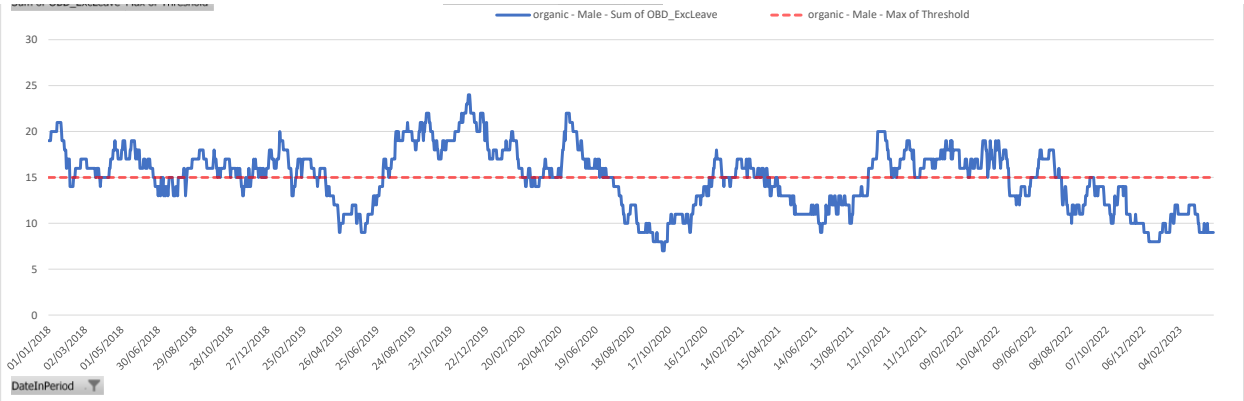


Functional male daily demand



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, though only rarely above 20. Female bed use has mostly been within 15 but has occasionally gone above.

7.10 Summary of findings of what people told us was important:

Below is a summary of the themes that people told us were important to them through our engagement exercises:

- Person centred
- Good quality information available at each stage, not all at once
- Telling a story once
- A service that meets all cultural and religious needs – particularly South Asian
- More support and focus on families and carers
- Improved access for carers so they can continue a caring role
- Better communication between GP and specialist service
- Quality of assessment
- Being kept informed at each stage of the process
- Quality of direct care and support
- Gender- Male/female privacy
- Continuity of care – seeing the same person
- A safe and supportive environment
- Physical and mental health needs are met
- Maintaining independence and good health throughout the patient journey including admission and discharge
- Consistency in medication
- Early intervention – help people understand the process to access services
- Services that are responsive and accessible
- Access to the right person to receive the right treatment in the most appropriate setting
- More support at the stage of diagnosis
- Minimise delays in care and ensuring the prompt action of staff
- Distance to travel and transport routes
- Good access to travel, transport and car parking
- Access to physical health care and other clinical support
- Access for carers which include flexible visiting times and facilities to enable a carer to stay.
- Good care coordination – one person overseeing the patient journey
- Safe, effective and well led outcomes
- Standard referral criteria
- Admiral nurses and nurse prescribing built into the model
- Specialist dementia wards were seen as a good idea
- More links with local health and social care providers
- Physical, mental and social care needs are met
- Focus on care closer to home where possible – community hubs and clinics
- Promoting an independent healthy, active lifestyle
- Supporting people at home
- Preventative approaches
- Involvement from the third sector
- Reimbursement of travel expenses if travelling further
- Explore the concept of funding a shuttle bus

More information on themes and engagement held can be found in the engagement section.

7.11 Services to meet the needs of the population:

We know that the services do cater for a range of people from across the protected characteristics and therefore some of the considerations include:

- **Gender** considerations include access to same sex clinician/staff, tailored activities.
- **Carer** considerations include:
    - Travel, particularly for older carers and those with other caring responsibilities.
    - Staff at all units.
    - Voluntary and other support organisations / community groups that signpost to and support patients around the service.
    - Visiting times and contact arrangements.
    - Estates facilities.
    - Involvement in care and discharge planning where appropriate.
- **Race and ethnicity considerations** include:
    - Addressing barriers of access – culturally appropriate environments, food and activities.
    - Faith and religious needs considered in built environments and through décor.
    - Reflective workforce, who are culturally and spiritually competent.
    - Access to an interpreter and translation materials.
    - Appropriate toilet facilities and consideration of bathing preferences.
- **Gender reassignment**
    - Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors.
    - Considering environments such as ward allocation, privacy, gender neutral facilities in line with trust policy and additional support through advocacy.
    - Considering how, for transgender people, how issues surrounding gendered wards can lead to poor experiences of care.

  Sexual orientation
    - Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe.
    - Visible symbols (such as the NHS Rainbow Badge, and/or use of badges and lanyards).

- **Religion or belief**
    - Access to faith and prayer rooms (including staff).
    - Ensuring parity of pastoral support for all faiths on inpatient wards.

- **Maternity and pregnancy**
    - Managing additional caring responsibilities.
    - Ensuring flexibility for visiting times.
    - Facilities are accommodating to visitors (for example parent access to changing facilities).
- **Disability**
    - Physical access to estates and built environments:
    - Parking bays.
    - Access to public transport.
    - Ease of access into buildings.
    - Visitor areas.
    - Accessible toilets.
    - Adult changing toilets.
    - Considering hidden disabilities.
    - Different types of seating and access:
    - Designated wheelchair seating areas.
    - Wider doorways and fewer heavy doors.
    - Automatic doors with ramps rather than stairs.

- Accessible lifts, signs and reception areas at visible heights.

7.12 Summary of what we need from an inpatient model:

Safe Approaches	Requirements
The right environment in which service users are treated A safe approach to service user care and / or helps to prevent harm to service users Supports a risk management and safety systems Impact on partner organisations and any aspects of shared risk	▪ Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs. ▪ A model with the best specialist ward environments to support people with design of the environment for gender needs and appropriate therapies and to support socialisation, for example, dedicated socialisation for people with similar needs. ▪ Wards sizes in line with or close to best practice guidance of 15 beds, ▪ Staffing to appropriate levels, in line with clinical need to support safety. ▪ Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards. ▪ Accessible services for partner organisations such as acute general hospitals, social care and advocacy.
Effective Approaches	**Requirements**
Staff understanding their role in improving the service user experience Consistency in care provision Positive outcomes of care Evidence-based practice Eliminating inefficiency and waste by design Staff teams and services, across pathways to work together to deliver safe, effective care	Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care. Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge. Length of stay being appropriate for the level of need. People having continuity of care in their pathway with one ward stay only until they are ready for discharge. Services that are accessible to staff teams, such as community services and other ward staff to work together.
Caring Approaches	**Requirements**
Allows staff time to care for people Co-production	The right staffing levels to support, including groupwork, based on people's needs. Staff, family and carers involved in design of care.
Responsive Approaches	**Requirements**
Delivery of strong service performance Promotes the principle of Right Care, Right Place, Right Time Timely service user pathway Fair access and the principles of the Equality Delivery system Access to services	Evidence that service users are in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time. That we have the right capacity in the system to meet the demand required, factoring in projected population increases. The service users, family and carers are able to access the service as needed. That people from across the protected groups are able to access services as needed and that services meet their needs. This includes travel needs for family and carers and environmental needs across the groups.

8 How the current inpatient model compares to the vision:

8.1.1 Separate wards for diagnosis - functional and dementia/organic, delivering the specialism to meet needs.

4 of the 5 wards are mixed functional and dementia needs with Poplars ward being the only specialist needs based ward across West Yorkshire.

8.1.2 A model with the best specialist ward environments to support people with design of the environment for gender needs and appropriate therapies and to support socialisation, for example, dedicated socialisation for people with similar needs.

Single sex accommodation guidance is met on all units except Poplars. 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.

Ability to have the right environment for therapies and socialisation is a challenge due to the mixed nature of the wards and configuration of some wards – for example the documented challenges with the layout of the Beechdale ward.

8.1.3 Wards sizes in line with or close to best practice guidance of 15 beds.

Ward sizes are in line with guidance in the current model:

Ward	Beds
Beechdale	16
Ward 19 F	15
Ward 19 M	15
Crofton	16
Poplars	12

8.1.4 Staffing to appropriate levels, in line with clinical need to support safety.

8.1.5 The right staffing levels to support, including groupwork, based on people's needs.

Staffing is regularly short of the required level and bank/agency staff are required when dependency levels increase on the wards.

There is a shortage of qualified members of staff, especially on a night shift where most of our wards have one registered nurse.

The staff levels mean that there can be a deficit of support for people on the wards with functional needs.

The current model also leads to wards regularly requiring bank and agency staff.

Staff have told us about the challenges of delivering groupwork on mixed needs wards.

The tables below identify the difference rostered in staffing between current establishment levels and those that would be required in a transformed model.

Current levels:

Ward	Days		Twilight	Nights	
	RN	HCA	RN	RN	HCA
Beechdale	2	2	1	1	2
Ward 19 F	2	2	1	1	2
Ward 19 M	2	2	1	1	2
Crofton	2	2		1	3
Poplars	2	3		1	2

Staffing required:

Ward	Days		Mid	Twilight	Nights	
	RN	HCA	RN	RN	RN	HCA
Dementia 10 bed	3	4	-	-	2	4
Dementia 15 bed	3	5	-	-	2	5
Functional 10 bed	2	2	-	-	2	2
Functional 15 bed	2	3	-	-	2	2
Functional 20 bed	3	3	-	-	2	3

8.1.6 Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards

Incidents, particularly falls and violence/aggression are much higher across the West Yorkshire wards than they are in the only functional ward.

Recorded incidents at the Poplars are much higher than across the other wards.

Some work can and is taking place regardless of transformation, but it is also expected that improved needs-based environment and specialist / well-resourced staffing will support further reduction of incidents.

We've had feedback that there is not always space to effectively deliver groupwork, for example, on Beechdale groupwork is often held in the corridors and when there is a very confused patient these groups can get disrupted.

8.1.7 Accessible services for partner organisations such as acute general hospitals, social care and advocacy

Services are local to place and we do have local access to social care and advocacy.

The site isolation of Poplars ward does though lead to challenges in terms of access to acute general hospitals.

The nearest emergency department and access to specialist medical help is 20-30 minutes drive away, at Pinderfields hospital and the site is not collocated with any other services. This isolation could lead to delays in patients receiving medical input, especially out of hours. Similarly, from a nurse staffing perspective there is no onsite backup available as there would be when such a unit is co-located on a site with other interdependent services. Staff on all our sites use a 'PIN alarm system' which alerts other staff to a patient safety incident (such as aggression or a fall) or a medical emergency. At Poplars there is only the ward staff

available to respond to this, on other sites staff from across wards will respond as well as a specialist crash team if there is a medical emergency.

This is particularly relevant when considering the complexity of the patients being cared for in the unit which requires more enhanced nurse staffing ratios. When acuity is high on the ward, it can be difficult to quickly bring the right workforce in as the site is physically and operationally isolated. Staff have no access to onsite support in the event of an incident placing a burden on staff on shift. Staffing levels have to be artificially inflated in response to potential issues, which can be met by cross cover at other sites.

The location of the site also can negatively impact on recruitment of staff and could impede relatives from visiting. Non ward based bank staff are reluctant to work at the Poplars due to its distance from Wakefield, and its isolation and resultant risks.

8.1.8 Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care.

Staff do have general older age skills but feedback that it is not always possible to reinforce training received due to the mix of patients on the wards.

8.1.9 Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge.

8.1.10 People having one ward stay only until they are ready for discharge.

8.1.11 Length of stay being appropriate for the level of need.

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 1 ward stay, and LOS differs from place to place and is higher where people have multiple ward stays.

70% have a single stay	**30% of people have more than 1 ward stay**

• Ensures continuity of care • Supports the development and utilisation of therapeutic relationships • Supports appropriate Length of Stay • Single period of assessment • Clear pathway and understanding of the wider multi professional team and their role in supporting care in the community. • A single relationship between the carer and the care team • Improves attitudes to risks • Reduces the risk due to the single environment / consistency of staff.	• 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 (as evidenced by people with dementia from Calderdale and Wakefield that often have 2 or more ward stays and have much longer stays). • 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.

Dementia LOS is well over 100 days overall and has been consistently so over recent years. In 2022 the length of stay of people from Calderdale, Kirklees and Wakefield in older people's inpatient services increased to 93 days.

8.1.12 Services that are accessible to staff teams, such as community services and other ward staff to work together.

Services are local to place but site isolation of Poplars ward does lead to challenges in terms of access to acute general hospital.

This is particularly relevant when considering the complexity of the patients being cared for in the unit which requires more enhanced nurse staffing ratios. When acuity is high on the ward, it can be difficult to quickly bring the right workforce in as the site is physically and operationally isolated. Staff have no access to onsite support in the event of an incident placing a burden on staff on shift. Staffing levels have to be artificially inflated in response to potential issues, which can be met by cross cover at other sites.

The CQC also visited the Poplars ward in late 2022 https://api.cqc.org.uk/public/v1/reports/7ac7435c-4823-404d-9544-2c6349b312bf?20230315080038. They noted that the location of The Poplars away from any other of the trust's location meant that the staff team were isolated in terms of access to urgent support or cover for unplanned staffing issues.

They also stated "We were concerned that the distance from The Poplars to other trust locations would impact on out of hours medic assessments".

8.1.13 Staff, family and carers involved in design of care.

Stakeholder involvement in the current service design has been limited. There has been no transformation programme in recent years which would have enabled stakeholder engagement.

Patients and carers do 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 and is used to inform smaller changes in practice.

8.1.14 Evidence that service users are in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time.

We cannot in confidence show that we deliver care in the most appropriate environment in the current model, though we do mitigate to make the care as good as possible given the system and environment constraints. The evidence shows that the mixed needs wards are not the right environment, exacerbated by some of the estates limitations, and this impacts on the care people receive, often people with functional needs when wards are managing people with dementia with behaviours that challenge. The systems we have are shown to increase the length of stay of patients on the wards.

8.1.15 That we have the right capacity in the system to meet the demand required, factoring in projected population increases.

The current model does support current and future demand.

8.1.16 The service users, family and carers are able to access the service as needed.

8.1.17 That people from across the protected groups are able to access services as needed.

Wards are local to place. However, around 30% of people have been admitted outside of their local place in recent years (data from 2018-21 below):

	Barnsley Wards	Calderdale Wards	Kirklees Wards	Wakefield Wards	Total
Calderdale	12		126	33	171
Kirklees	14	18		26	58
Wakefield	7	4	61		72
Total	33	22	187	59	301

There is a travel impact on families and carers that travel to visit patients that are admitted out of local area and data does show that there are higher proportions of people admitted from the 20% most deprived areas.

8.2 Summary of deficit between current model and best practice

Safe Approaches	Requirements	Current model
The right environment in which service users are treated A safe approach to service user care and /	▪ Separate wards for diagnosis - functional and organic/dementia, delivering the specialism to meet needs.	▪ 4 of the 5 wards are mixed needs ▪ Single sex accommodation guidance is met on all units except Poplars. Currently, 3 out of 5 of the wards are mixed gender, which can make clinical management an issue,

or helps to prevent harm to service users Supports a risk management and safety systems Impact on partner organisations and any aspects of shared risk	▪ A model with the best specialist ward environments to support people with design of the environment for gender needs and appropriate therapies and to support socialisation, for example, dedicated socialisation for people with similar needs. ▪ Wards sizes in line with or close to best practice guidance of 15 beds, ▪ Staffing to appropriate levels, in line with clinical need to support safety. ▪ Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards ▪ Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	especially for those patients with organic diagnosis. ▪ Ward sizes are in line with best practice. ▪ Ability to have the right environment for therapies and socialisation is a challenge due to the mixed nature of the wards and configuration of some wards – for example Beechdale. ▪ Staffing is regularly short of the required level and bank/agency staff are required when dependency levels increase on the wards. ▪ There is a shortage of qualified members of staff, especially on a night shift where most of our wards have one registered nurse. ▪ Incidents, particularly falls and violence/aggression are much higher across the West Yorkshire wards than they are in the only functional ward. ▪ Services are local to place but site isolation of Poplars ward does lead to challenges in terms of access to acute general hospital.
Effective Approaches	**Requirements**	
Staff understanding their role in improving the service user experience Consistency in care provision Positive outcomes of care Evidence-based practice Eliminating inefficiency and waste by design Staff teams and services, across pathways to work together to deliver safe, effective care	▪ Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care. ▪ Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge. ▪ Length of stay being appropriate for the level of need. ▪ People having continuity of care in their pathway with a single ward stay only until they are ready for discharge. ▪ Services that are accessible to staff teams, such as community services and other ward staff to work together.	▪ Staff do have general older age skills but feedback that it is not always possible to reinforce training received due to mix a of patients on the wards. ▪ Staff feedback that they are often unable to provide therapeutic interventions to functional patients when they have a patient with dementia who needs more support or supervision. ▪ 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 LOS differs from place to place and is higher where people have multiple ward stays. ▪ Wards are local but 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.
Caring Approaches	**Requirements**	
Allows staff time to care for people Co-production	▪ The right staffing levels to support, including groupwork, based on people's needs. ▪ Staff, family and carers involved in design of care.	▪ The current staffing models fall short of what is required, particularly to deliver a specialist needs based model of care.
Responsive Approaches	**Requirements**	
Delivery of strong service performance	▪ Evidence that service users are in the most appropriate environment, receiving the most	▪ The evidence shows that the mixed needs wards are not the most appropriate environment, exacerbated by some of the

Promotes the principle of Right Care, Right Place, Right Time Timely service user pathway Fair access and the principles of the Equality Delivery system Access to services	appropriate care and for the most appropriate length of time. ▪ The service users, family and carers are able to access the service as needed. ▪ That people from across the protected groups are able to access services as needed and that services meet their needs. This includes travel needs for family and carers and environmental needs across the groups.	estates limitations, and this impacts on the care people receive, often people with functional needs when wards are managing people with dementia with behaviours that challenge. The systems we have are shown to increase the length of stay of patients on the wards. ▪ The current models do have enough capacity to meet demand and the local model does support access for family and carers, though in recent years approximately 30% of admissions have been outside of the patient's home locality (though within the Trust boundaries).

9 Benefits

The vision for the clinical model set out the benefits that should be achieved across the older people inpatient services.

Overall, the main areas of benefit should be:

- Improved clinical outcomes for patients
- Improved experiences for patients and their carers
- Improved experiences for staff
- increased opportunities to maintain and enhance skills
- Supporting the delivery of sustainable services.

The following benefits framework has been established by the OPS Transformation Steering Group to meet these objectives and align with the domains in the QIA:

Domain	Benefit	Requirement	What to measure	Outcome
Safer	Improvement in the environment in which service users are treated. Promotes a safe approach to service user care and / or helps to prevent harm to service users Supports a risk management and safety systems Impact on partner organisations and any aspects of shared risk	Separate wards for diagnosis - functional and organic/dementia, delivering the specialism to meet needs. A model with the best ward environments to support people with design of the environment for gender needs and appropriate therapies and to support socialisation, for example, dedicated socialisation for people with similar needs. Staffing to appropriate levels, in line with clinical need, Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards Accessible services for partner organisations such as acute general hospitals, social care and advocacy	Length of stay Number of red or amber incidents recorded. Use of restraints. Violence and aggression Falls numbers To note: some numbers will be low so might need to review over longer period – quarterly.	Reduced LOS Reduced serious incidents Reduced falls Improved satisfaction (Friends and Family Test - FFT)

Domain	Benefit	Requirement	What to measure	Outcome
Improves effectiveness	Supports staff in understanding their role in improving the service user experience Reduce impact on variation in care provision Will deliver positive outcomes of care and allow for implementation of evidence-based practice Support staff teams and services, across pathways to work together to deliver safe, effective care Impact on eliminating inefficiency and waste by design Parity of esteem for physical and mental health.	Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care. Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge. Length of stay being appropriate for the level of need. People having a single ward stay only until they are ready for discharge. Services that are accessible to staff teams, such as community services and other ward staff to work together.	Learning needs analysis Staff retention rates LOS Outcome Measures* Incidents (in line with above) Effectiveness of and impact on services that interface with new model Transfer rate between OPS MH wards and General Acute wards * work is currently ongoing to define how outcome measures can be collected across inpatient stays.	Improved staff satisfaction Reduced vacancy rates Reduced turnover rates **Reduced LOS** Improved satisfaction Improved outcomes for people admitted Improved relationships and positive feedback from key internal and external stakeholders that support service delivery Reduced transfers
Caring	Allows staff time to care for people Enhances carers, family and friends experience of services	The right staffing levels to support, including groupwork, based on people's needs. Staff, family and carers involved in design of care.	Workforce levels on wards Care Hour per patient day Staff and SU satisfaction Improved referrer satisfaction Reduced complaints	Safe staffing levels achieved and care hours per patient day (e-roster), care hours per patient day. Improved staff and SU satisfaction FFT Adult Carer Quality of Life Questionnaire (ACQoL)

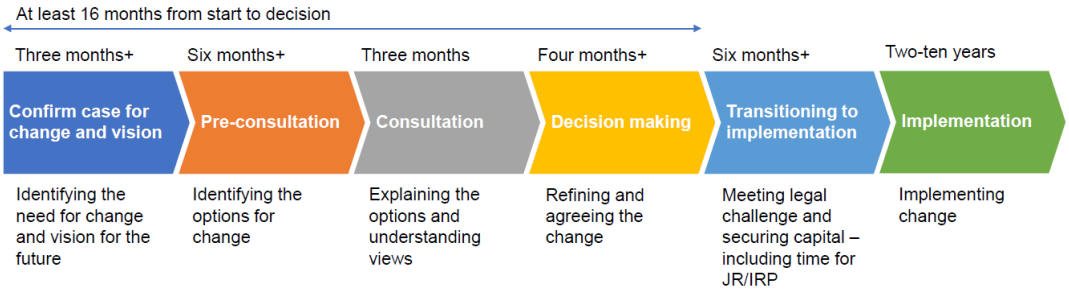
Domain	Benefit	Requirement	What to measure	Outcome
			Ensure that we have the appropriate levels of carer support factored into the new model. Ensure the new model delivers better outcomes for service users (see above on outcome measures)	Culture questionnaire
Responsive	Improves the timeliness of any stage of the service user pathway Supports delivery of service performance Promotes the principle of Right Care, Right Place, Right Time Supports fair access and the principles of the Equality Delivery system Results in a more accessible service	Evidence that service users are in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time. That we have the right capacity in the system to meet the demand required, factoring in projected population increases. The service users, family and carers are able to access the service as needed. That people from across the protected groups are able to access services as needed.	length of stay occupancy levels Access to the service across the protected characteristics. Access to the service for family and carers (see above).	Reduced LOS Reduced occupancy rates Positives feedback from family and carers (FFT) that service meets their needs Adult Carer Quality of Life Questionnaire (ACQoL)

10 Development of Options

10.1 Patient, public, carer and wider stakeholder engagement

Patient, public, carer and wider stakeholder engagement has been central to the development of the options and we have followed good practice approaches to ensure a range of stakeholders have informed the development of options.

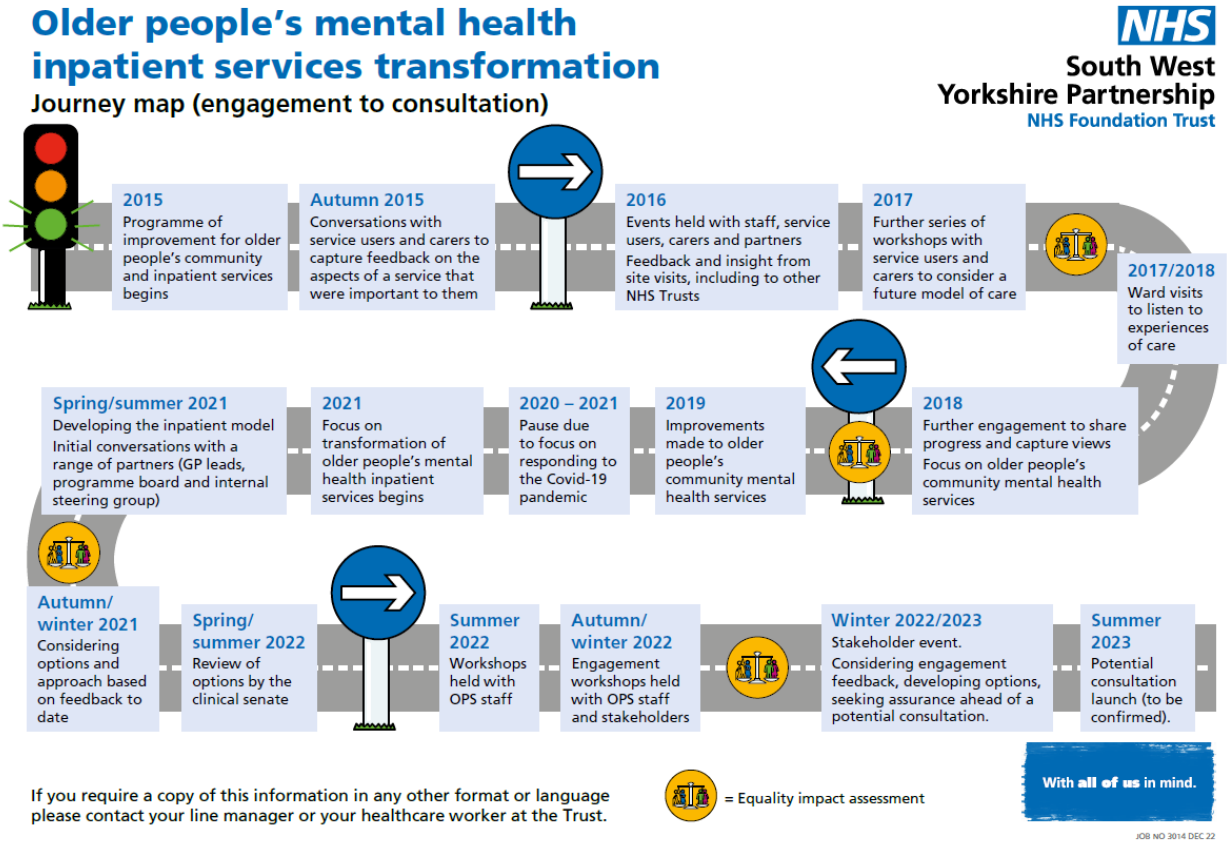
The model below shows the high-level process and timeframes.



Source: Connor Farrell.

For this programme, the timeframes have taken much longer with early thinking taking place from 2015 onwards. However, there has been 2 periods where work on the inpatient programme was paused. In 2019 work was paused on inpatient developments while changes and improvements were made to community models. Work commenced again in early 2020 but was paused further due to the Covid-19 pandemic and recommenced in 2021 before moving forward at a faster pace from 2022.

The diagram below shows the high-level timeline of the development of work across the programme:



The early work and engagement did inform the thinking and development of options and models. A high-level summary of early to more recent engagement is below:

Stakeholder / Audience	Purpose
Staff, service user, carer and wider public engagement	
Launch of the Discovery phase – 9 September 2015	Staff engagement discussions on the opportunities and challenges for the future transformation of Older Adults Services and developing early vision for services.
Service User workshops (café Visits) October 2015 – November 2015	Service users and carers at 10 sites were approached to give their views of what their experience was and make suggestions how services could be improved. The approach was informal using conversational questions.
Series of Internal and external facing co design workshops - March 2016 events	In March 2016, a series of SWYPFT wide workshops were held in Dewsbury with a mixed audience of staff, commissioners, partner organisations, service users and carers. These tested the high-level vision and emerging ideas about configuration of the service model.
Staff workshops – summer 2016	In summer 2016 several internal workshops were held with staff from across the Trust to consider potential models of care and in September 2016, an event was held with 30 SWYPFT staff to consider benefits and issues with the different configurations for both community and inpatient models. Following the workshops in 2016, smaller project groups were established and through 2017 a series of workshops were held with a range of staff to focus on workforce and skills required in each pathway. These included a range of team leads and professional leads.

Spring Transformation Events - May 2017	In May 2017 a series of workshops were held across the Trust footprint with a range of service users, carers, staff and partner organisations. Focus included community developments but also discussed inpatient challenges and opportunities.
Staff drop-in sessions – Autumn 2017	A series of staff drop-in sessions were held across the Trust throughout September and October 2017 with 36 staff members in attendance.
Inpatient engagement questionnaire 1st December 2017 to 31st March 2018	In late 2017 and early 2018 staff visited 6 OPS inpatient units to ask our existing inpatient service users and carers questions about the services. The questions were about the current level of care they were receiving and their thoughts on the possible changes including having separate wards for people with Organic (Dementia) and Functional needs.
Dialogue Groups: LGBTQ Group Afro-Caribbean Groups 2018 - 2019	In 2018-19 staff members met with several groups identified as gaps from our equalities monitoring collection. These included an Afro Caribbean dialogue group, an LGBTQ group and a South Asian focus group. The dialogue groups were mixed audiences of service users, carers and partners. The group shared thoughts on the current model and opportunity to have separate wards for people with Dementia/Organic and Functional needs within our Older Peoples Services and their thoughts on what was most important through a service user and carer journey.
Equality Delivery System (EDS) Review – Spring 2019	This took place to help review engagement taken to date across the programme and to support how we can improve performance for people from across the protected characteristics. The CCG established equality health panels representative of local communities, to support organisations to deliver on the requirements of equality and diversity systems. The Trust was asked to provide evidence around “Service Transformation and Engagement” and shared work done by this programme. The programme received a grade of “achieving” it’s goals.
2020	Pause for covid
West Yorkshire Integrated Change System - May 2021 and ongoing	Presented programme outline, shared ideas and tested whether any planned developments could or should interface with this programme to ensure linkages were in place. Presented our latest thinking to a range of - ICS stakeholders as part of a system wide event in October 2022.
Inpatient staff conversations - October 2021	In October 2021 conversations took place with a range of staff and managers from across the wards to test the principles of the options and establishing specialist units.
Staff listening events - September 2022	In September 2022, further staff listening events were held with a range of staff from across the wards to test latest thinking about the model development.
OPS Transformation Workshop – 10th October 2022	Delivered one digital workshop for Barnsley, Calderdale, Kirklees, and Wakefield and was initially targeted specifically at health and social care staff across the footprint. The workshop focused on the approach to the development of options and shared the options identified at this stage. In addition, all additional options that had been through the option appraisal process were shared for reference; this included the scores using the criteria. The presentation took attendees through the process, scoring of options to ensure that any thoughts or considerations could be captured. In addition to the options development approach, the feedback received from the approach to involve Clinical Senate was shared. Clinical Senate had received all the information prior to the workshop and had shared a view on the options through a report of findings, providing further insight into the viability of the current proposals. Health and social care staff were asked to consider the options development process, the proposed options and feedback from Clinical Senate and discuss and feedback on the following:

	• Your thoughts on the proposals? • Is there anything we should have/need to consider? • Any other comments?
OPS MH Inpatient Transformation Stakeholder Event 15th December 2022	In December 2022 a stakeholder event was held. The aim of the event was to listen to feedback from a wider group of partners, build on previous engagement, provide an opportunity for our key stakeholders and partners to contribute to the options for proposed models, and further inform our approach ahead of a potential consultation. At the event the Trust presented more detail on the work that has been done to date on the proposed models, including clinical considerations, engagement activity and equality.
System discussions (LA / advocacy) Feb-Mar 2023	Various conversations held with LA and advocacy colleagues to consider the implications of the potential options and whether / how they would impact on how their services needed to operate.
Ward staff conversations - March 2023	In March 2023 further conversations with 13 staff across the mixed wards was held to gain views on how the model works, to test whether views from previous engagement still held valid and to gather quotes to support the consultation process.
Staff Briefing - July 2023	In July 2023 a series of staff briefing sessions were held across the wards to inform staff of the latest activity and gain feedback,
Governance	
OPS Inpatient Services Transformation Programme board – ongoing	The OP Inpatient Services Transformation Programme Board is represented by members of the Calderdale, Kirklees and Wakefield ICB's and SWYT clinical, operational and corporate staff. The board meets every 3 weeks and regular updates are given on the development of the Older Peoples Inpatient services transformation.
Communication, equality, and involvement group (CEE)	Representation of specialists from each place, including ICB and with links to wider stakeholders including political representatives, Healthwatch and voluntary and community sector. The group helps shape, critique and oversee the engagement approach of the project. Meets fortnightly.
SWYPFT OPS Steering Group	An SWYPFT steering group for OPS with representation from the workforce, including clinical representation and staff side.
Partnership Boards and local stakeholder groups – ongoing throughout	Ongoing dialogue with partnership board level and other stakeholder groups in each place to update and test developing thinking, including: • Kirklees Local Authority Meeting – 30 January 2018 • Wakefield Frailty and Elderly Care Workshop – 9 March 2018 • Wakefield Local Authority meeting – 19 April 2018 • Calderdale Older People MH Transformation Presentation – 29 Jun 2018 • Clinical discussion with Wakefield stakeholders – 21 Aug 2018 • Calderdale -presentation of case for change – 7 December 2018 • OPMH meeting – Wakefield – 6 Jun 2019 • Kirklees Clinical Strategy Group – 7 Jul 2021 • Wakefield integrated care partnership – 27 Jul 2021 • Kirklees Partnership Board – 15 Sep 2021 • Calderdale CCG and GP lead – 16 Sep 2021 • Kirklees Partnership forum – 4 Aug 2022 • Calderdale Collaborative Community Programme Board – 8 September 2022 • Calderdale Clinical and Professional Forum – 8 September 2022 • Wakefield MH Alliance – 7 December 2022 • Kirklees MH Alliance – 9 January 2023 • Calderdale Dementia Steering Group – 12 January 2023

	• Calderdale iHub Meeting – 19 January 2023 • Wakefield Dementia and Older People's MH Strategy Group – 24 January 2023
Political and member engagement	Local political leaders have been briefed via scrutiny officers as development work has moved forward via briefing notes and ongoing dialogue with ICB leads. Political leads were part of the December 2022 workshop and in July 2023 an informal Joint Scrutiny committee was held to bring members up to speed, including any new members post local elections, and agree to establish more formal joint scrutiny processes.
Options Development	
Options Review Workshops 2022	A range of clinical and operational staff members from both provider and partner side met in April and November 2022 to review and appraise the options. In addition, The OPS SWYPFT steering group reviewed the scoring for the 'Deliverability and sustainability' criteria domains for all the options and fed into the following programme board.
Northern England Clinical Senate - from March 2022 to August 2022	The Northern England Clinical Senate review of proposals to change the existing configuration of the older adult inpatient wards to deliver specialist care for people with dementia and for those with functional mental health needs. The Senate formed an independent expert clinical panel from the North of England, Yorkshire and Humber and North West Clinical Senate Councils as well as some additional experts in older people's social work, occupational therapy and mental health nursing. The remit of the senate was to provide a review of the options and to comment on: 1. the viability, sustainability and appropriateness of the proposed models of care, and support those that are suitable for implementation 2. the extent to which the proposed models are likely to: a) Deliver improvements in the quality of care b) Impact on access to services c) Be sustainable for a period of 5-10 years d) Be in line with the drivers for change 3. the alignment of other interdependent services required to make the models effective and safe 4. the robustness of the quality and equality impact analysis associated with the proposed models and the appropriateness of any mitigations identified 5. whether they are any other options that might be workable and to provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made
Workshop / Events late 2022	These workshops were used to test the options and process to establish the options with a range of key stakeholders. Further detail included above.
Options Finalisation review workshop 9th May 2023	A wide group of stakeholders reviewed the previous scores against the agreed set of domains and tested whether they were still valid, using a range of data and supporting information.
Options work strand – alignment with strategies Jan – Jun 23	A group including ICB and SWYPFT considered the impact of the strategies criteria against each of the options and proposed scores into the subsequent programme board. Information was then reviewed and updated in May-June 2023.
Options subgroup: Value for Money May – Jun 23	A partnership subgroup established to assess value for money of the different options, included finance leads from both SWYPFT and ICB

The table below gives a high-level breakdown of the audience reached across the different events:

Event	SU	Carer / Family	Other					
			Staff	ICB/ CCG	Partner Org	3rd Sector	Other (inc. public)	Total
Service Users Workshops (10 café visits during Oct 2015)	150							**150**
Launch of discovery phase – Sep 2015			43					**43**
Dewsbury Workshops Mar 2016	3	4	98	4	12	8	4	**133**
Staff workshops summer 2016			82					**82**
Staff workshop Sep 2016			30					**30**
Spring Transformation Events 2017	15	9	71	4	26	27	28	**180**
Staff drop-in sessions Oct 2017			36					**36**
Inpatient visits (questionnaire)	35	18						**53**
Afro Caribbean Dialogue Group Spring 2018	2	2	2		4	1	2	**13**
LGBTQ Dialogue Group – Feb 2019	14							**14**
South Asian Elders Dialogue Group – Spring 2019		5					8	**13**
October Workshop 2022					50			**50**
December Stakeholder Event 2022			32	15	7	8	5	**67**
Local Authority/Social Care and Advocacy conversations Spring 2023			15		12			**27**
Total	**134**	**117**	**415**	**23**	**111**	**44**	**47**	**891**

10.2 Service User, Carer and Family Feedback:

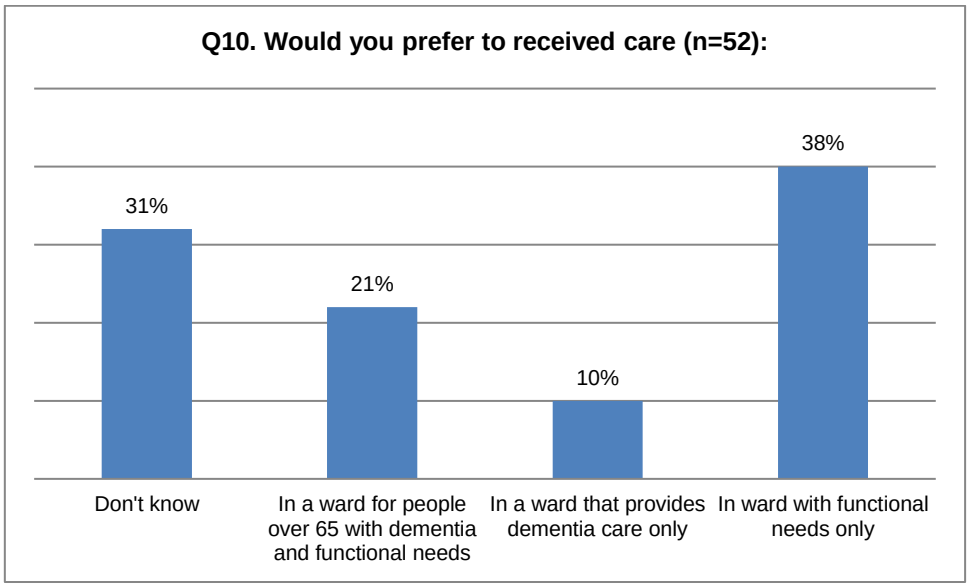
Across conversations with service users, family and carers, people saw benefits of having a separate needs-based model and thought a specialist dementia unit was a good idea and a move in the right direction.

The engagement with service users, carers and family has helped inform the development of the preferred clinical model of separate needs-based wards and has also highlighted other considerations that need to be factored into.

We have heard experiences from people that have stays on the wards whose care has been impacted by being on mixed needs wards.

As part of the programme of engagement we spoke with 53 people across the wards (67% service users and 33% family or carers) to gain a view of current experience, what works well and what challenges there are. Most people (73%) rated their current care and treatment from our services as 'Excellent or Good' and had lots of praise for the staff looking after them. In particular, people said our staff were very caring, hard-working and couldn't do enough for them.

Although, 11 people (21%) said they would not mind being in a mixed ward (dementia/organic and Functional needs) because they liked to have the mix of people on the ward, 25 people who had a preference said they would prefer to be on a specialised unit (48% compared to 21%, whilst 31% (16 didn't know):



Comments that supported separate needs-based wards included:

- It can upset patients if mixed.
- Specialist care would be better.
- It was very upsetting and worrying for me coming in to contact with someone with dementia for the first time. I was worried all night hoping the person could not get into my room.
- I think the 'time element' of support currently is more geared to service users with dementia. We all need support.
- Dementia patients are more awkward and need extra care. Having specialist ward helps to aid recovery with patients with the same illness.
- Everybody in a similar position so can be catered to the person's needs. Sometimes helps to talk to and share with others who suffer similar things.
- Some patient behaviour can be challenging and upsetting.
- Better calmer environment.
- Be easier for staff if functional only. The ward would be calmer and better especially for dementia patients, who required more care and looking after.
- Should be separate.

- Seriously unwell patients need to be segregated from other patients for the benefit of both staff and other patients.

Comments that supported mixed needs on wards included:

- There's more variety.
- Life is made up with all sorts. You can't be perfect.
- Mixed ward has a variety of people.
- Like a bit of the mix as that is what happens outside.
- I wouldn't like it just being one group of people.
- I like to mix with all people. No problem with anyone.

Of the 53 people we spoke with the following said they would prefer a gender specific ward:

- 14 didn’t know or mind
- 25 preferred a single sex specific ward
- 13 preferred a mixed ward but with separate sleeping areas
- 1 did not respond

The majority of people questioned also flagged issues about travelling further than they do now in a future model.

- Long way to go. Somewhere nearer home is better. Nice if on the doorstep.
- Hard for my daughter to visit.
- It would be difficult for my family to visit me further afield.
- I have travelled further for care and it was extremely difficult for my husband to visit.
- The staff are excellent. The distance from home too far. Grouping all 65 year plus together on one ward appalling.
- For me personally I am approaching 70 years of age and travelling further would make me feel extremely concerned.
- More convenient for my friends to visit me. If I am closer to home I am not worried about getting my personal belongings from home when needed.
- If the care is provided by specialist staff then I wouldn't mind the travelling
- I don't have transport and it costs me £38 for a return journey already.
- Don’t think it would help with my friends.
- Traveling and people to come and visit. I have had to go to Pinderfields twice whilst I have been here so hospital on the doorstep.
- Family maybe concerned about travelling further.

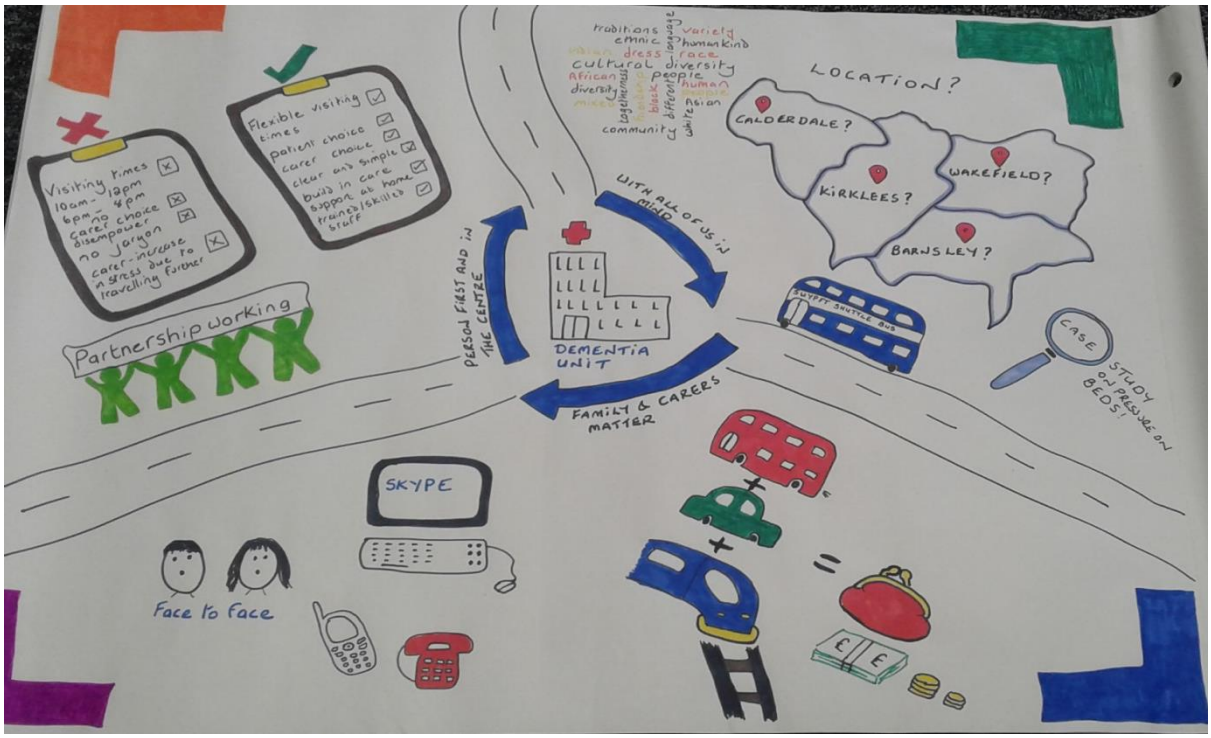
People were interested in the potential location of any specialised units. They raised that they might be further away from home and would need to travel further to the hospital than they would currently.

Below are some of the suggestions people made that the Trust could provide help/support with travelling:

- Reimburse the increase in bus/train fares and extra mileage.
- Explore concept of providing a shuttle bus to take Service users and carers to the unit.
- Flexible visiting times

People also shared their ideas on alternative ways to see their family members/loved ones in the unit instead of face-to-face contact/visiting, factoring in that everyone is not fully conversant and use technology and not to automatically replace any face-to-face contact/visiting with these methods.

Below is a graphical representation that highlights some of the issues and findings from the dialogue:



10.2.1 Summary of findings and what people told us was important:

Below is a summary of the themes that people told us were important to them through our engagement exercises:

- Person centred
- Good quality information available at each stage, not all at once
- Telling a story once
- A service that meets all cultural and religious needs – particularly South Asian
- More support and focus on families and carers
- Improved access for carers so they can continue a caring role
- Better communication between GP and specialist service
- Quality of assessment
- Being kept informed at each stage of the process
- Quality of direct care and support
- Gender- Male/female privacy
- Continuity of care – seeing the same person
- A safe and supportive environment
- Physical and mental health needs are met
- Maintaining independence and good health throughout the patient journey including admission and discharge
- Consistency in medication
- Early intervention – help people understand the process to access services
- Services that are responsive and accessible

- Access to the right person to receive the right treatment in the most appropriate setting
- More support at the stage of diagnosis
- Minimise delays in care and ensuring the prompt action of staff
- Distance to travel and transport routes
- Good access to travel, transport and car parking
- Access to physical health care and other clinical support
- Access for carers which include flexible visiting times and facilities to enable a carer to stay.
- Good care coordination – one person overseeing the patient journey
- Safe, effective and well led outcomes
- Standard referral criteria
- Admiral nurses and nurse prescribing built into the model
- Specialist dementia wards were seen as a good idea
- More links with local health and social care providers
- Physical, mental and social care needs are met
- Focus on care closer to home where possible – community hubs and clinics
- Promoting an independent healthy, active lifestyle
- Supporting people at home
- Preventative approaches
- Involvement from the third sector
- Reimbursement of travel expenses if travelling further
- Explore the concept of funding a shuttle bus

Generally, the people we've engaged with have been supportive of the principles of separate wards for people with Organic (Dementia) and Functional needs within our Older Peoples Services. However, some consideration needs to be given to carers/family members who have flagged that they may experience difficulties in travelling to the wards.

Some carers/family members will prefer flexibility to the visiting hours especially if coming from afar, with the option to visit during mealtimes. Carers/family feel this will offer better, quality time spent with their loved ones, for example, eating with or helping to feed their loved ones/family members.

This feedback has been used to shape the options for transformation both in their development and has been fed into the options review and scoring process.

10.3 Staff engagement – summary of findings

Staff engagement told us that there has been strong support for separate, needs based models. A specialist functional and dementia unit in each area would be a strong clinical model if demand made this viable. Options with a centralised dementia unit were considered viable, acknowledging distance for families and carers, the need for effective communication with local services and staffing requirements.

When exploring options to have specialism across place the following themes were raised by staff:

Strengths:

- Specialist care and specialist skills: Service Users receive better treatment due to the specialism of the unit and its staff. This could lead to reduced lengths of stay.

- Opportunity to create dementia friendly environments, allowing for service users to be managed with less medication in a less agitating environment.
- Specialist approach supports the provision of psychologically focussed treatments
- Splitting functional and organic inpatient services would achieve a more person centred, needs led service.
- Potential to reduce the number of incidents.
- Maintaining single sex units are more 'self-contained' but offer the potential for shared care communal areas.

Considerations

- Impact on the ability of family and friends to visit, could increase isolation and make it difficult to discharge service users when staff do not have full knowledge of their home locality.
- Predicted increase in the number of people with dementia over the next decade, which will impact on the demand for beds.
- Unit size and not being too big to meet the needs of its patients.
- Staff wellbeing on higher needs wards with more complexity and people with behaviours that challenge.
- Difficulties sometimes in separating a service user's primary need if they have both dementia and functional mental health issues.
- Service user may be placed in an area outside of their GP boundary raising issues around supporting any physical health needs.

How to make the models work

- Units needs to be located close to a general hospital and medical staff.
- Ensure single gender wards and having flexibility around male/female bed provision.
- Increase the scope of dementia treatments to reduce the length of stay.
- Ensure staff have the right specialist skills; including working with care homes and care home liaison
- Ensure the pathways into dementia and functional inpatient units are clear, simple and streamlined to place service user in the best place to meet their needs.
- Increase the resource available to support people in care homes and to educate care home staff to deal with crises that are currently triggering admission. Care homes being able to manage people with more complex needs by using psychosocial interventions rather than solely medication.
- Good relationships with social care partners to ensure that families are involved in care plan decisions.
- Set targets around the length of stay within the unit.
- Ensure best use of technology to support a flexible workforce and increase remote contact for both health interventions (e.g. telehealth) and family interaction.
- Consider options to include a seclusion area on wards rather than a dedicated PICU unit. This could be used as a normal bed if not needed.

In 2021 and 2022 we had further dialogue and held further staff listening events with a range of staff from across the wards. Below is a summary of their feedback:

Staff shared that it is well known that the mix of functional and organic patients doesn't work very well.

Feedback on patient experience about being on the wards:

- People with functional illness struggling sharing with those with dementia
- People want to leave mixed wards and more reluctant to go back in and selective of which ward they will go back into.
- Mixed wards are very difficult to manage. The age range and fitness levels are different e.g., those who are 65 on these wards alongside those who are frail e.g., 80+
- Feedback from staff who have experience on both wards: Dementia only ward and a functional only ward does work - needs of both patients are different. That we would benefit from a dementia specialist ward.

Considerations:

- Workforce - Staff were clear that staffing needs to increase if there are more beds and to also think of other posts e.g. discharge co-ordinators in all areas to support any changes.
- Ensuring similar community services are in place across the footprint.
- Carers travelling outside of local area - question around shuttle bus between sites or whether we could we use VCSE support.
- Ward environment - need to look at environment e.g. floorplans, doors, corridor width and length, space for storing equipment, dementia specific signs and facilities etc.

10.4 2023 Staff conversations to test relevancy

We believe that we've reached the right stakeholders to date and used their feedback gathered for design and development of the programme. It has informed criteria and development of options and has reached relevant stakeholders.

The overall engagement has reached all relevant stakeholders and will pick up any gaps in reach robustly through a public consultation. The current system remains the same as it was when service user engagement took place and the staff feedback, plus service user case studies that have been developed recently, show that the same issue remains, but this too will be tested thoroughly in public consultation.

Acknowledging that much of the engagement took place pre covid, in March 2023 further conversations with 13 staff across the mixed wards was held to gain views on how the current model works.

Whilst there was feedback that we do give great care and this does make a -difference there were many issues raised with the challenges of the current systems, a summary of comments is below:

10.4.1 Functional Needs not being addressed:

- Mixed wards don't work, dementia patients can be loud, aggressive and invade other patient's personal space. Because of this, functional patients can be scared and isolate themselves in their bedrooms.
- Looking after patients with dementia can take up a lot of ward staffs' time. This can stop you having time for 1 to 1 interventions with other patients.
- Functional patients can be upset when it is noisy at night, they need their rest and are often disturbed.

- Functional patients can find it difficult to come into a ward with dementia patients. I have heard ‘this isn’t the right place for me’ or ‘I’m not at the stage to be here’ many times before.
- Dementia patients take up a lot of time, which means that some planned interventions for other patients can’t go ahead.
- Mixed need wards are not good for functional patients. I’ve been a health care assistant for more than 20 years and it was better when we were in separate dementia/functional wards. There was much more time for 1 to 1s and activities. I can feel guilty that I haven’t had enough time to spend with functional patients.
- We can’t take patients off the ward easily anymore, we used to do this a lot.
- Dementia patients get most of our attention.
- Inpatient stays can deskill patients. Functional patients often do not like the noise or people with dementia getting in their personal space in the communal areas. This can lead to them spending a lot of time in their bedrooms and an increase in issues with balance and independent transfers.
- It’s difficult for people with significant depression to be with people with significant cognitive impairment. This can provide a barrier for people to get out and about.
- The reasons that people with dementia have to come into hospital can be very upsetting and challenging for people to see. If they are struggling with their own mental health this can have a negative impact.
- Both patients with dementia and functional mental health would benefit from being in a environment that focuses on their own needs.
- Patients with Organic mental health needs can have a negative impact on patients with functional mental health, they often don’t understand personal space.
- On a night it can get noisy, some patients are fearful. Especially those with reduced mobility who cannot get away from a patient in their personal space.
- When we have challenging care for people with dementia, functional patients can get left out.
- Functional patients might have a longer length of stay because we can’t prioritise their needs.
- Staff feel stressed when they haven’t had time to have a meaningful conversation with a patient with functional needs, as they have had to spend their time with a patient with dementia with behaviour that challenges.
- The functional patients get scared by some of the patients they see, they don’t understand why they are on the same ward.
- Patients with dementia and functional mental health problems do not mix well on the ward. When I have ward reviews with my patients with depression they often ask why they are on this ward. They say that they are not ready to be on a ward like this and that they don’t think that they are like patients with dementia. There are times where having patients with dementia and functional needs leads to incidents.

10.4.2 Dementia Environment and need:

- Ward is dementia friendly but could be better, some patients have difficulty opening the anti-ligature doors.
- Dementia care often includes palliative care, we provide good care but more specialist skills are needed.
- A dementia specialist unit should have more activities
- Both patients with dementia and functional mental health would benefit from being in a environment that focuses on their own needs.

- Ward 19 has the space and the room to manage dementia need. More could be done to improve the environment such as sensory rooms.
- Patients with dementia don't generally have a high suicide risk. A specialist dementia ward would allow us to change the environment to have things like memory boxes attached to the walls to help orientation. Currently this would be too much of a ligature risk.
- There's no space for people with dementia to move about in here (Beechdale Ward)
- It's difficult to provide stimulation for patients with dementia here (Beechdale Ward)
- Dementia friendly wards need more space for patients to be able to get some quiet time. A low stimulus environment is needed. We've temporarily lost the use of a quiet lounge due to building works, you can really tell the difference in the patients wellbeing, as they don't have access to that space.
- We get a lot of patients with dementia at our office. They walk around the ward and end up here and sit with us. It's difficult to give patients with dementia things to occupy their time, it takes a lot of staff's time. It would be better if the ward was more designed for people with dementia. We could make some reminiscence areas or some sensory areas.

10.4.3 Mixed activity challenges:

- Doing activities for functional and organic patients can be hard. We have lots of activities like quizzes but often dementia patients can't tolerate the noise of the questions/answers or they can't concentrate and will disrupt the session.
- Mixed wards can mean that there's friction between the patients when we do activities.
- It's hard to find group activities that are pitched at the right level for patients on a mixed need ward. Staff have to use generalist and flexible approaches, perhaps at the detriment to specialist skills in dementia or functional mental health.
- I run OTAGO groups to help with pain, balance and exercise. There is not always space to do this on the wards so we do it in the corridors. Unfortunately when there is a very confused patient these groups can get disrupted.
- We don't have enough OTs to run separate groups for people with dementia and those with functional mental health needs. We try and accommodate all patients but a few patients with dementia can become distressed and this makes it difficult to run the groups.
- It's not a good mix, it's hard to run groups for the patients with dementia and the functional patients because they need different things. The patients with dementia can't concentrate on what is happening in the groups and can be disruptive for the other patients. Functional patients can be scared of what they see when a patient with dementia is distressed or shouting.
- It is difficult to provide physiotherapy group sessions. The needs of patients with dementia are different to functional patients.

10.4.4 Challenges on mixed gender wards with people with dementia

- Being a mixed sex and mixed need ward is difficult. We sometimes have difficulty with dementia patients believing they are in an intimate relationship. Discussions about relationships and consent are hard as they may lack understanding. Care would be easier on a single sex ward.
- Dementia patients need separate male and female wards, we have just had to restrain someone because of issues with this.

10.4.5 Challenges moving people in the current system

- We try to transfer patients to be closer to home, but this meant that there is a new team and environment, for the patient it can be like starting from scratch. It can be frightening or disturbing to be in a new place.
- Patients with dementia should not move environments as they need a lot of time to adjust to their environment. Their only move should be at discharge!
- There are also lots of ambulance transfers to arrange between wards which costs a lot of money. I get asked to assess if someone is able to go in a wheelchair accessible taxi instead, I can sometimes feel pressure to say people can go in a taxi.
- Transferring between wards can be a trigger for aggression.

10.4.6 Travel Impact

- Families can get upset when a patient is far away from home.
- Travel impacts on families can be difficult, especially if they are having to travel after work.

10.5 Developing options – long or medium term

The evidence shows that the current models are not in line with quality expectations of an acute inpatient offer for older people.

Some of the opportunities to develop an appropriate solution for the challenges could involve development of new, bespoke, inpatient estate.

When long lists of options were developed, there has been agreement in principle that a new build (or new builds) would be the best option for a specialist model of care.

There is a consensus clinical view that a new build would achieve the best longer-term outcomes for people with dementia whilst enabling services for people with functional needs to be reconfigured into specialisms. It would enable a complete new design to create a highly specialist environment to minimise restrictive practice, promote independence and retention of skills as far as possible, whilst improving safety. It would also enable development of highly skilled teams and a shift from a medical model of care, to one which is asset based.

With this option, the right site and location would be of vital importance, ensuring any specialist dementia unit is as centrally located/accessible as possible and accessible for carers.

This would be a costly option from a capital perspective but also a sustainable one, providing a new Trust asset, and developing a reputation for excellence.

The benefits of establishing a new build environment for people with dementia in the model include:

- Specialist clinical and therapeutic environments
- Highly skilled teams
- Improved safety and clinical outcomes

As such we know that a purpose-built configuration would have the capability to score higher than any option using the existing estate.

However, current capital constraints and the integration older people's services across sites with other wards that have complex lease agreements creates challenges in the likelihood of delivering such a solution in the medium term. For example, any major development of estate in Calderdale and Kirklees is also tied into longer term aspirations for the inpatient estate and issues such as the PFI site in Calderdale (which we sub purchase from CHFT acute Trust) would need to be worked through.

As part of the options development work opportunities were identified to reconfigure largely within existing estate to deliver many of the key quality criteria of the programme. Criteria for the options therefore included that the models needed to be deliverable and sustainable for a period of 5-10 years, as we currently expect any new build solution to be at least 5 years, and much more likely to be 10 years before it could be established.

Feedback from the clinical senate in 2022 supported this:

- The clinical senate agreed that a new build offered the potential to offer the best long-term solution.

- Timescales needed would not deliver a short or medium-term solution to the way services are currently delivered.

Therefore, **a new build is not considered to be a viable option for this consultation process** but should remain an aspiration as a long-term solution.

The focus of the other options has been on the delivery of solutions that can meet the Trusts needs over the medium term.

10.6 Potential opportunities to work in partnership in the ICS

In May 2021, the programme team met with the ICS and partner Trusts with a specific focus on older adult beds.

The Trust presented ideas around developing a model based on changing the approach across current inpatient services from being largely mixed needs wards to being specialist wards based on diagnosis.

Opportunities including having a specialist dementia unit with other wards on the SWYPFT footprint being specialist functional units. These would deliver a solution that address challenges with the current clinical model in the medium term whilst a longer term, purpose built, environment would still be sought.

SWYPFT asked the group whether there were any developments that could support the model in the short-term or any developments that could assist in the longer term.

The group agreed that there wasn't any immediate need or requirement that would need to be considered as part of the work toward a medium-term solution for SWYPFT but that we should continue to engage, especially in relation to any longer term, new build requirements.

Further dialogue has taken place in 2022 (ICS workshop October 2022) and there is no change to this position.

West Yorkshire ICB has discussed the Older Peoples Mental transformation programme through the WY MHLDA Partnership Board, the WY Older Peoples Mental Health network and through the ICB Transformation Committee.

Other opportunities not progressed into options work:

Some early thinking included the potential to establish a Psychiatric Intensive Care Unit (PICU) for older people. However, feedback from other organisations is that the dementia ward operates as a high intensity ward. The workforce and staffing exercise highlighted that functional service users overall have a lower dependency level than people with dementia. As such, the dementia wards in the models have a workforce model designed to work with higher intensity service users and PICU is not often required for people with functional needs.

10.7 Determining a long list and shortlist of options for detailed evaluation

Early SWYPFT subject matter expert led thinking, up to 2018, was based on a modelled bed base of 62 beds in West Yorkshire and 72 beds in total, which would have represented an operational reduction of 12 beds.

The focus from 2020 onwards and for the subsequent detailed options appraisal in 2022, has been on delivering the appropriate operational model as closely in line with existing demand and capacity models and the change options ranged from 65 to 72 beds.

In 2020, a new longlist was established by SWYPFT steering group with clinical and operational subject matter experts. This work was not completed or fully tested due to the covid-19 pandemic. In 2022 the programme team used this long list and developed it further in a partnership approach to robustly test and ensure that the options were the correct and viable ones within the scope of the programme. The medium-term options in the long-list were designed around the existing estate and considered what options could be delivered within the constraints of the existing estates.

The clinical senate gave assurance of which of these options were clinically viable and which were not. As part of the assurance work with the clinical senate, this led to a further option being added to the list of potentially clinically viable options.

In late 2022 we tested the options development process and the options with 2 wide ranging groups of stakeholders. A full report on the workshop and event can be found on the SWYPFT website: Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust

In 2023 we convened a partnership stakeholder review group to test the options, ensuring we considered key data to test which options were appropriate to take forward into consultation. A full report can be found in appendix 2.

A key focus of all activities was to establish which ones were clinically viable but ongoing checking and testing that there weren't other options that could deliver the vision for the clinical model.

10.8 Assessment criteria

The SWYPFT Trust template for options appraisal was used for the options process. Specific detail was added to each section based on the quality requirements to deliver the vision for the model. Key feedback that we'd heard from service users, family and carers as well as key considerations highlighted in the quality and equality impact assessments were factored into.

As such, the options have been developed with the voice of staff and people who use services to ensure their voice and influence is part of the process *and* assessed using criteria that a wide range of stakeholders informed.

Criteria:

- Quality of Care
- Access to Care
- Deliverability and sustainability
- Co-dependencies with other strategies
- Value for Money

All measures of the domains were flagged as important but highlighted in bold below are some of the key criteria for each to help review groups focus on key differences between models. These were highlighted by clinical leadership on the programme, agreed by the OPS steering group and the Programme Board prior to the final review of options workshop.

10.8.1 Quality

This domain focusses on the key quality areas required to deliver a high quality, safe and effective service, informed by best practice, learning from others, feedback from service users, family and carers as well as key considerations highlighted in the equality impact assessment.

Domain - Quality	What we need to measure against	Measures	Supporting information
Clinical Quality and experience – service delivery	Delivery of the specialist clinical model	**Deliver improvements to clinical quality and safety whilst achieving standards.** Better experience for patients Better experience for staff More support for families and carers **Specialism to meet needs** Quality of assessment **Quality of direct care and support** Daily activities Asset based approach Highly Personalised care and support	Clinical Case of Business Case
Skills and staffing	A model that supports the right staff and skills	**Staff skills** **Staff recruitment** Access to appropriate non- nursing support	Clinical case
Quality Environment	A model with the best ward environments to support people.	**Gender- Male/female privacy** Ensuite facilities – both functional and dementia wards Other Private space A safe and supportive environment Physical and mental health needs are met Estate facilities to meet the needs of protected characteristics, for example, accessibility for people with disabilities, toilet and bathing, faith and religious needs (prayer rooms), gender neutral space	Analysis of wards findings from business case People with ward knowledge
Other		▪ Person centred ▪ Good quality information available at each stage, not all at once ▪ A service that meets all cultural and religious needs – particularly South Asian ▪ More support and focus on families and carers ▪ Better communication between GP and specialist service ▪ Being kept informed at each stage of the process ▪ Maintaining independence and good health throughout the patient journey including admission and discharge	These are themes relevant to quality of care but may apply to any model.

		▪ Consistency in medication	

10.8.2 Access

This domain focusses on the key access to the right care and support, informed by best practice, learning from others, feedback from service users, family and carers, partner organisations, as well as key considerations highlighted in the equality impact assessment.

Domain - Access	What we need to measure against	Measures	Supporting information
Pathway	Most seamless pathways and less moves.	Telling a story once **Continuity of care** – seeing the same person Minimise delays in care pathways once in receipt of care No requirement for step down/seamless service Reducing admissions**/Length of Stay** Good care coordination – one person overseeing the patient journey	Data showing ward moves in current model from business case. Summary of what changes in a future model with each option – to write.
Travel access for family and carers	Travel impact for family and carers, particularly from the most deprived areas.	**Travel, transport and car parking** Distance to travel and transport routes Access for carers which include flexible visiting times	Travel analysis and access to travel report system for any queries. Summary of other travel impacts if not covered by the travel system
Access for staff and support	**Access for staff, including partner organisations**	**Access to the right workforce (staffing levels)** Access to physical health care and other clinical support and advice to wards Access to the right person to receive the right treatment in the most appropriate setting Access to same sex clinician/staff, tailored activities More links with local health and social care providers Involvement from the third sector	Knowledge of impacts. Knowledge of alignment to general hospitals
Demand and capacity	Whether we have the right bed numbers to meet demand over time period of programme, including functional / organic and male / female split.	**Capacity to meet demand** Impact on capacity, particularly where current services running at different capacity Meeting organic/functional demand Demographic changes in the future 10% accuracy gap	Demand and capacity modelling from the business case, including: Total bed numbers Functional / dementia mix Gender mix

Other		Early intervention – help people understand the process to access services Services that are responsive and accessible More support at the stage of diagnosis Minimise delays in care and ensuring the prompt action of staff Reflective workforce, who are culturally and spiritually competent. Access to an interpreter and translation materials. Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors. Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe Ensuring parity of pastoral support for all faiths on inpatient wards	These are themes relevant to access of care but should apply to any model.

10.8.3 Sustainability

The main focus of this domain is deliverability and sustainability. Is the proposal sustainable for the expected timeframe of the programme (10 years)? Is the model deliverable in a timely way?

Domain - sustainability	What we need to measure against	Measures	Supporting information / comments
Sustainable for time period required	Whether the model can be sustained for 10 years.	**Delivers a robust system over a 5-10 year period, potentially as a medium term plan as part of vision for excellence.**	Demographics
Delivered as soon as possible	Whether the model can be delivered in a timely way.	**Minimises the time taken to deliver the proposed changes**	Estates capital plan information.
Cost effective	Cost effectiveness of the model	**Provides the most cost effective reconfiguration of services**	Any costs associated with reconfiguration.
Recruitment and retention	Whether the model supports recruitment and retaining staff.	Supports attraction and retention of staff, alleviating recruitment issues	Staffing model information from business case
Other		Safe, effective and well led outcomes Standard referral criteria Admiral nurses and nurse prescribing built into the model Specialist dementia wards were seen as a good idea (scored in access)	These are themes relevant to sustainability of care but may apply to any model or are being assessed elsewhere.

10.8.4 Strategies

This tests whether the programme aligns with national, regional and local strategic direction:

Domain - strategies	What we need to measure against	Measures	Supporting information / comments
Alignment with strategies	**Whether the model aligns with strategies.**	Demonstrates sufficient flexibility to align with and improve partnership working Aligns with national strategies Aligns with regional strategies Aligns with local strategies, including place and Trust strategies. Maximise resilience to wider system	Strategy summary document

10.8.5 Value for money

To test whether the options are affordable and represent value for money.

Domain – Value for Money	What we need to measure against	Measures	Supporting information / comments
Viability / Affordability	**Is the capital affordable?** **Is the revenue affordable?**	Supports sustainability of Trust financial position Provides the most positive net present value over 5-10 years, return on capital and other financial requirements Improves income/cost balance Sources of funding Reimbursement of travel expenses if travelling further Explore the concept of funding a shuttle bus	Costs of options Finance statement on viability
Use of resources		**Makes best use of resources** **Economies of scale**	Summary of potential economies
Capital investment		Minimises the need for capital Additional/specific: • Longer term value/building related issues • Medium term investment	If it can be delivered within capital budgets and investment in SWYPFT owned estate.

10.9 Weightings of options

The options have been score using the following approach. The 70% weighting ensures that quality domains are the most heavily weighted but do ensure that affordability and value of the options is fully factored in.

High level domain	Weight	Domain	Weight breakdown
Quality and Safety	70%	Quality of Care	30
		Access to Care	20
		Deliverability and Sustainability	10
		Strategic Alignment	10
Finance	30%	Value for Money	30
Total	100%	Total	100

The criteria process and options that were felt to be clinically viable would then be assessed against the other criteria. To be above the bar to progress, the option must score 4 or above for each quality and access criteria.

Agreed scoring for the quality domains are:

Score	Description	Summary	Viability
10	meets fully and exceeds	This gives us everything we'd expect from a model and more. A new build, for example, might allow an innovative environment that goes beyond some of our existing good practice models.	Viable
9	meets fully	This would fully meet requirements across all wards – for example, all wards would be en-suite, have good private space, strong male and female privacy etc.	Viable
8	meets the vast majority of requirements	This would meet the vast majority of requirements across all parts of the system. There might be some minor issues – for example meets single sex requirements but there is limited space for extra clinical activities – i.e. might be limited open space rooms.	Viable
7	meets the vast majority of requirements with additional work required	This could meet all but a small number of areas which could potentially be addressed over time without too much impact on the model – for example if not all bedrooms can be en-suite but that we can mitigate or wards with some space challenges, Single sex met, but needs management, etc.	Viable
6	meets most with more work required	Similar to above but there are more issues that require adjustments and management. For example, the overall environment is good, there are a few things that could be better across the system but we can still make it work safe and effectively	Viable
5	meets most but a key area not met	One of the key areas of delivery of the model can't be met. So this might be single sex accommodation can't be managed effectively everywhere or it might be delivery of the fully needs based model.	Viable but further considerations of how to improve the key area should be considered
4	meets some parts not others with key areas not met	This would be where a more than one key area can't be met. Viable but sub optimal.	Viable – but need to consider how to improve model
3	limited criteria met with several key areas not met or one significant risk	Where there are enough challenges that mean either the essence of a good service model can't be delivered or that something leads to a significant risk in the system.	Not currently viable – need to consider whether any changes could make the option viable

2	meets very few criteria well with many key areas not met / significant risks		Not viable
1	does not meet criteria		Not viable

Any option needs to be viable across all of the domains. If an option scores 3, not currently viable, in any of the domains the group should consider whether there are any mitigations that could make the option viable. If so, we may be able to score that option higher and define what is required to be put in place to make it so.

10.10 Options Reviewed

The table below sets out all of the medium-term options that have been considered through the process as options that could deliver the clinical model:

Option
Option 1- No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.
Option 2 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.
Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.
Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.
Option 5 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. 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. Beechdale would be 16 bed functional. The Poplars site would not be in this model.

Option 6 –Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.
Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.
Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in Dewsbury, in a separate ward area in the Crofton ward and in the Willow ward. The Poplars site would not be in this model.
Option 9 - Crofton dementia unit, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards with 46 functional beds in total (The Poplars site not in this model) – *this option was added following feedback from clinical senate.*

To note: option 2 does include an option with a 22 bedded ward. All other options where there are 26+ beds on a site are configured into separate wards.

10.11 Clinical senate review and feedback

In March 2022 SWYPFT and our commissioners approached the Northern England Clinical Senate to review proposals to change the existing configuration of the older adult inpatient wards to deliver specialist care for people with dementia and for those with functional mental health needs.
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.

Specifically, we asked the senate to review and comment on:

1. the viability, sustainability, and appropriateness of the proposed models of care, and support those that are suitable for implementation
2. the extent to which the proposed models are likely to:

a) Deliver improvements in the quality of care

b) Impact on access to services

c) Be sustainable for a period of 5-10 years

d) Be in line with the drivers for change

3. the alignment of other interdependent services required to make the models effective and safe
4. the robustness of the quality and equality impact analysis associated with the proposed models and the appropriateness of any mitigations identified
5. whether they are any other options that might be workable and to provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made

Information about the proposed models, with supporting evidence and travel impact assessments, were provided to the senate ahead of a virtual meeting to introduce the Senate panel to the programme.

In June 2022 some members of the Senate panel made site visits to the four current inpatient units that accommodate both patients with dementia and those with functional mental health illnesses, to gain an understanding of the geography of the areas being served, the precise location of the units, the proximity of other key interdependent services and to speak with staff members at each site. The full review session took place virtually via Microsoft Teams on 9th August 2022.

Summary of findings from the clinical senate include:

- The clinical senate were fully supportive of proposals, and "strongly concurs that patients with functional and organic disease should be cared for in separate distinct dedicated units".
- The Trust were "commended on the way in which they have developed options to significantly improve the care of older adults with both organic and functional mental health needs".
- "The clinical senate commends the immense amount of work done over the years and that the programme team has worked hard at the Older Person's Services programme".
- The review panel was "impressed by the commitment and enthusiasm shown by so many of the staff in all the current inpatient units".
- They also found that maintaining the current model is not a viable option.

Specific feedback on options:

Option 1

- Not a viable option
- Does not achieve the ambition to develop a central specialist dementia unit
- Maintains the mixed wards which negatively impact on patient experience and outcomes
- Patients with organic (dementia) disease, and those with functional needs, benefit from a therapeutic environment dedicated solely to their needs.
- National guidance and established practice has led to reconfiguration of services to achieve this.
- Maintaining mixed wards is therefore not acceptable.
- Maintains the clinical risks associated with current ways of working at The Poplars and Beechdale Ward.

Option 2

- A viable option
- Satisfies the ambition to develop a central specialist dementia unit
- Offers an opportunity to centralise and consolidate specialist skills and expertise.
- Addresses the risks and issues associated with mixed wards
- Mitigates clinical risks attached to the current ways of working at The Poplars and Beechdale Ward.

However, the panel noted that option 2 has 9 fewer beds than is currently the case and it heard that the SWYPFT team envisage a reduced length of stay in options that involve dedicated specialist units, thus reducing the need for as many beds.

The panel also noted that this option meant that the Crofton Unit would offer a 22 bedded ward environment which the SWYPFT team felt may be too large.

Option 3

As with Option 2 the Clinical Senate felt that Option 3 was viable on the grounds that:

- It satisfies the ambition to develop a central specialist dementia unit and offers an opportunity to centralise and consolidate specialist skills and expertise.
- It addresses the risks and issues associated with mixed wards
- It mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward.

The panel noted that option 3 has 3 fewer beds than option 2 and 12 fewer than the current situation. As with option 2, the SWYPFT team envisage a reduced length of stay in options that involve dedicated specialist units, thus reducing the need for as many beds.

Option 4

The Clinical Senate found that whilst Option 4 did create a dedicated specialised dementia unit and it did achieve dedicated inpatient units for patients with functional and dementia/organic illness, it was not felt to be a viable option given that:

- The Poplars unit is suboptimal for patients that have a higher level of acuity, associated with functional illness, given its remote location.
- The circuitousness of the Poplars unit means that it is not suitable for patients with a functional illness as this makes it difficult to observe patients.

Option 5

The Clinical Senate felt that Option 5 was a viable option, in line with Options 2 and 3 in that:

- It satisfies the ambition to develop a central specialist dementia unit with centralisation and consolidation of specialist skills and expertise
- It addresses the risks and issues associated with mixed wards
- It mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward.

Option 6

The Clinical Senate felt that Option 6 does not provide a viable solution to the clinical case for change because:

- It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise
- It maintains The Poplars and all of the described risks, not least its isolated location and lack of interdependent services
- It maintains a mixed ward at Crofton which is not best practice and is detrimental to patient experience and outcomes.

Option 7

Option 7 is not considered to be a viable option by the Clinical Senate:

- It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialised skill and expertise
- The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

- The Poplars is maintained as a functional unit which does not provide a satisfactory environment for patients due to the risks and issues with location, estate and lack of interdependent services

Option 8

The Clinical Senate finds that option 8 is not viable:

- It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise
- The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

Option 9

The panel suggested that a further option be considered if the requisite space were available to establish a dementia site at Fieldhead Hospital:

- The panel questioned whether the option for the central specialised dementia unit being sited at the Crofton Ward at Fieldhouse Hospital could be considered as an additional option. This is proposed given the unit's proximity to interdependent services and its optimal environment for patients with dementia. This then became option 9 in the long list of options.

See section on assurance of models for more feedback from the clinical senate.

Conclusions of the senate:

The viability, sustainability and appropriateness of the proposed models of care, and support those that are suitable for implementation

The Senate found from the long list that options 2, 3 and 4 were clinically viable, sustainable and most clinically appropriate.

2. the extent to which the proposed models are likely to:

e) Deliver improvements in the quality of care

f) Impact on access to services

g) Be sustainable for a period of 5-10 years

h) Be in line with the drivers for change

The Senate panel agreed that options 2,3 and 4 would deliver improvements in the quality of care and were in line with the drivers for change.

The panel received information relating to the travel impact assessments of options 2, 3 and 4 where it was evident that there would be some degree of impact and the programme team are advised to continue to consider mitigations for this.

Options 2, 3 and 4 appeared to be sustainable for a period of 5-10 years.

The senate also found that a solution involving new build facilities was clinically viable but not sustainable for 5-10 years as it would require a significant capital investment and the timescales associated with this are unclear.

3. *the alignment of other interdependent services required to make the models effective and safe*

The panel agreed that options 2, 3 and 4 addressed the requirement to have interdependent services in proximity to the older people's inpatient services. The Poplars presented the largest challenge in terms of isolated services and lack of onsite support for the staff and patients which is addressed by the options that potentially repurpose that unit.

4. the robustness of the quality and equality impact analysis associated with the proposed models and the appropriateness of any mitigations identified

It is understood that the quality and equality impact assessments have been undertaken however the Senate panel was not presented with the outputs of these to comment on. It is recommended that further work be undertaken in this area to ensure that any potential negative impacts associated with the options are known and mitigated for.

5. whether they are any other options that might be workable and to provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made.

The Senate panel acknowledged the scale of the programme and the challenges that are inherent within it. It was also acknowledged that no single solution is ideal and each will require a degree of compromise that will need to be managed. There is also a potential for investment to operationalise and optimise each environment.

The full report from the senate can found in appendix 3.

	Options	**Comments**	**Decision**
1	No change to the current model	Not felt to be a viable / sustainable model but to remain in options work to provide baseline and benchmark.	Shortlisted
2	Ward 19 dementia unit, 6 extra beds at Crofton (The Poplars site is not in this model) which would be managed as a single ward, Beechdale functional	Clinically viable	Shortlisted
3	Ward 19 dementia unit, 2 extra beds at Crofton (functional), 1 extra at Beechdale Ward (functional). (The Poplars site is not in this model)	Clinically viable	Shortlisted
4	Ward 19 dementia unit, all others functional (including The Poplars site).	Not clinically viable	Not Shortlisted

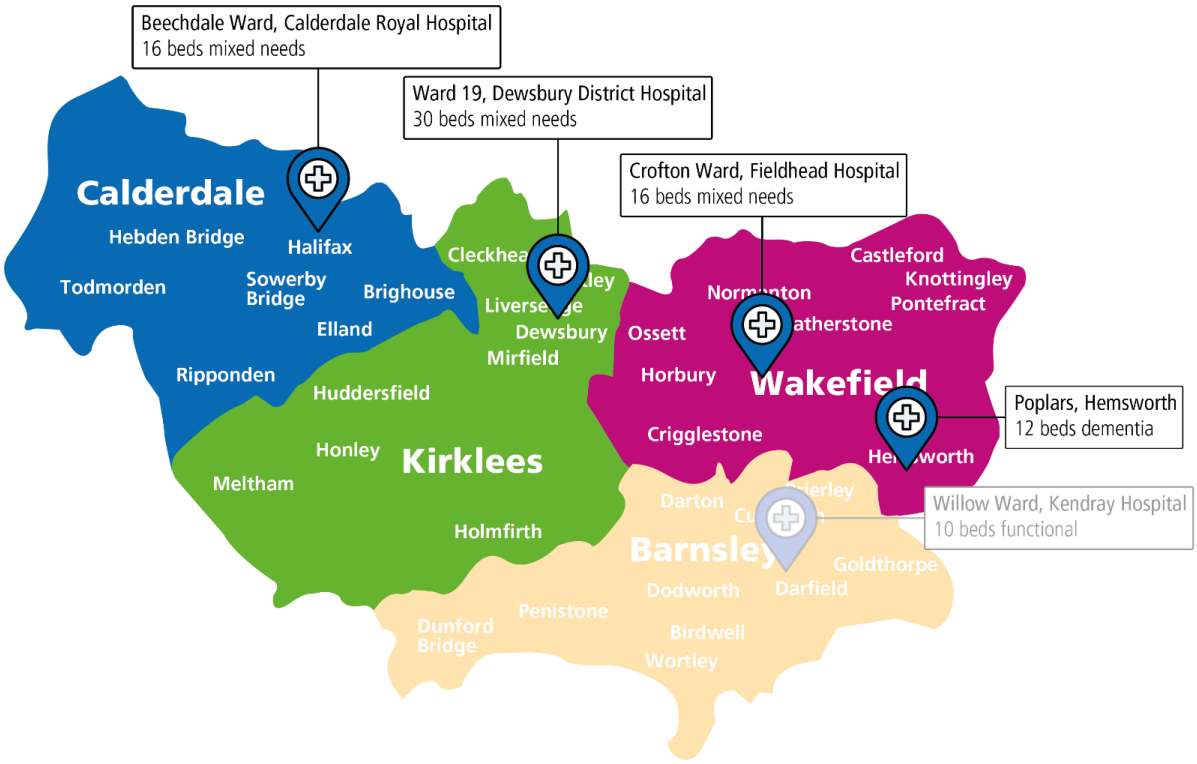
5	Ward 19 dementia unit, 10 extra beds at Fieldhead, adjacent to Crofton ward for functional needs managed as 2 wards (The Poplars site not in this model). Beechdale functional.	Clinically viable	Shortlisted
6	16 dementia beds at Beechdale Ward, Ward 19 functional, Wakefield stays the same.	Not clinically viable	Not Shortlisted
7	East/West Split option – 20 bed functional at Ward 19, 16 functional beds/10 dementia beds at Crofton, 10 functional beds at The Poplars, 16 dementia beds at Beechdale.	Not clinically viable	Not Shortlisted
8	East/West split: 10 dementia beds being repurposed at Crofton, making the site 16 functional and 10 dementia, 16 dementia beds at Beechdale Ward, Ward 19 functional	Not clinically viable	Not Shortlisted
9	Crofton dementia unit, 26 beds (as 2 separate wards). All other wards functional (The Poplars site not in this model)	Clinically viable	Shortlisted

10.11.1 Summary reasons for options not shortlisted:

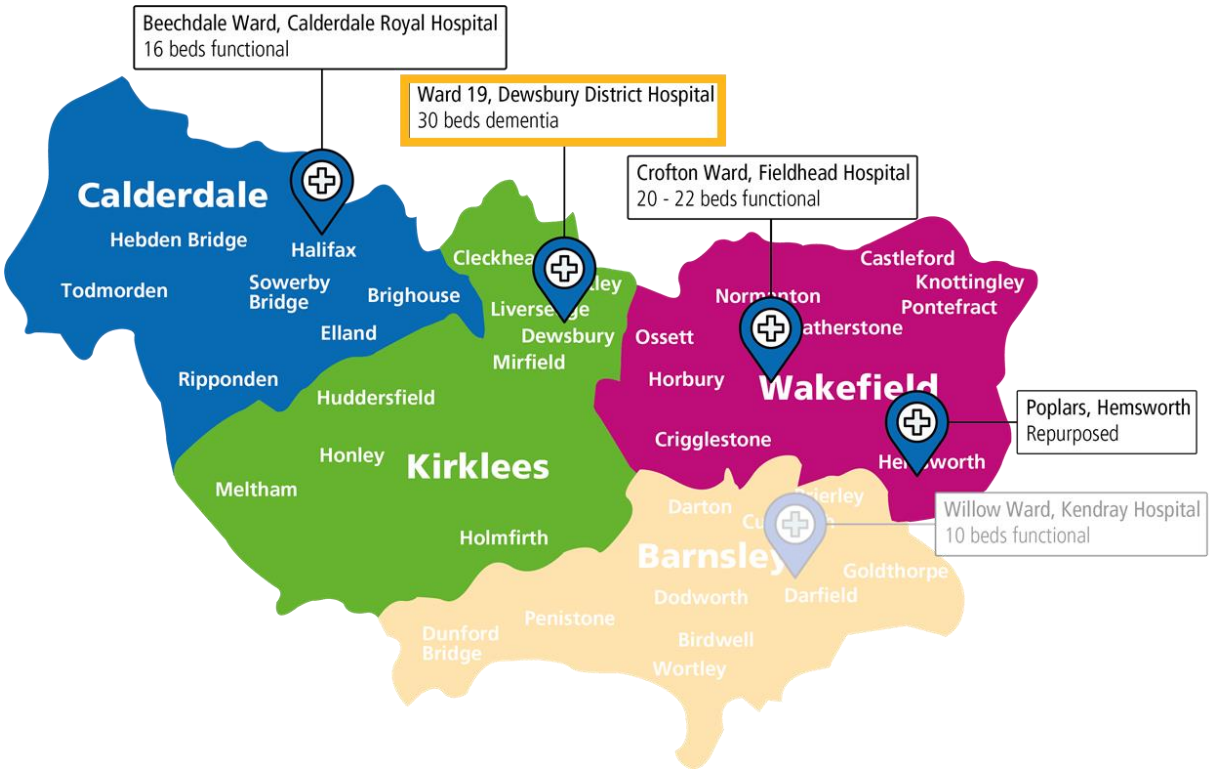
- Options including using Beechdale Ward as a dementia ward – challenges with the layout of the site mean it is not appropriate.
- Therefore, the options shortlisted in the proposed clinical model include Beechdale Ward, Calderdale Hospital to be used as functional only.
- Options which included retaining the use of The Poplars site in any form - challenges caused by the location of the site.
- To note: The clinical senate also identified and flagged these issues on their visits and agreed that options suggesting use of these sites in such a way are not viable.
- Inpatient services currently provided at The Poplars, Hemsworth will also be included in the proposed clinical model, but the estate will not be included.

10.11.2 Options still requiring consideration following the clinical senate review:

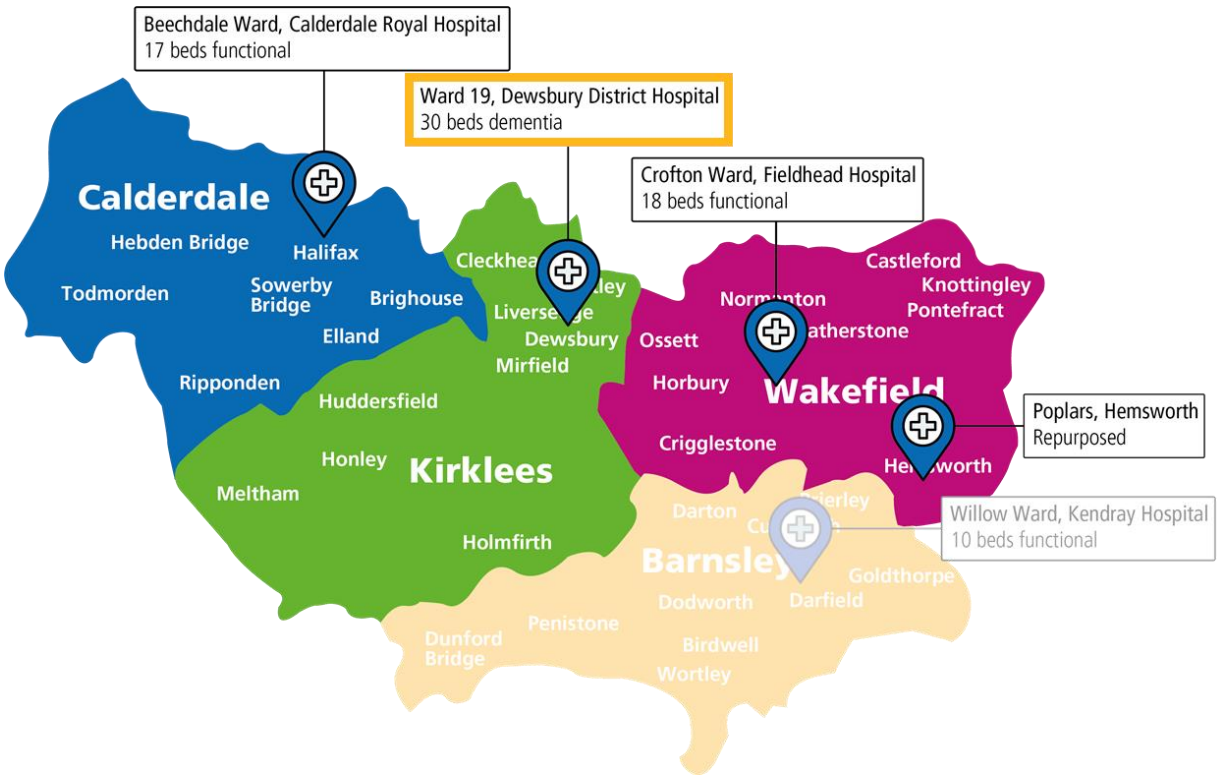
1. No change:



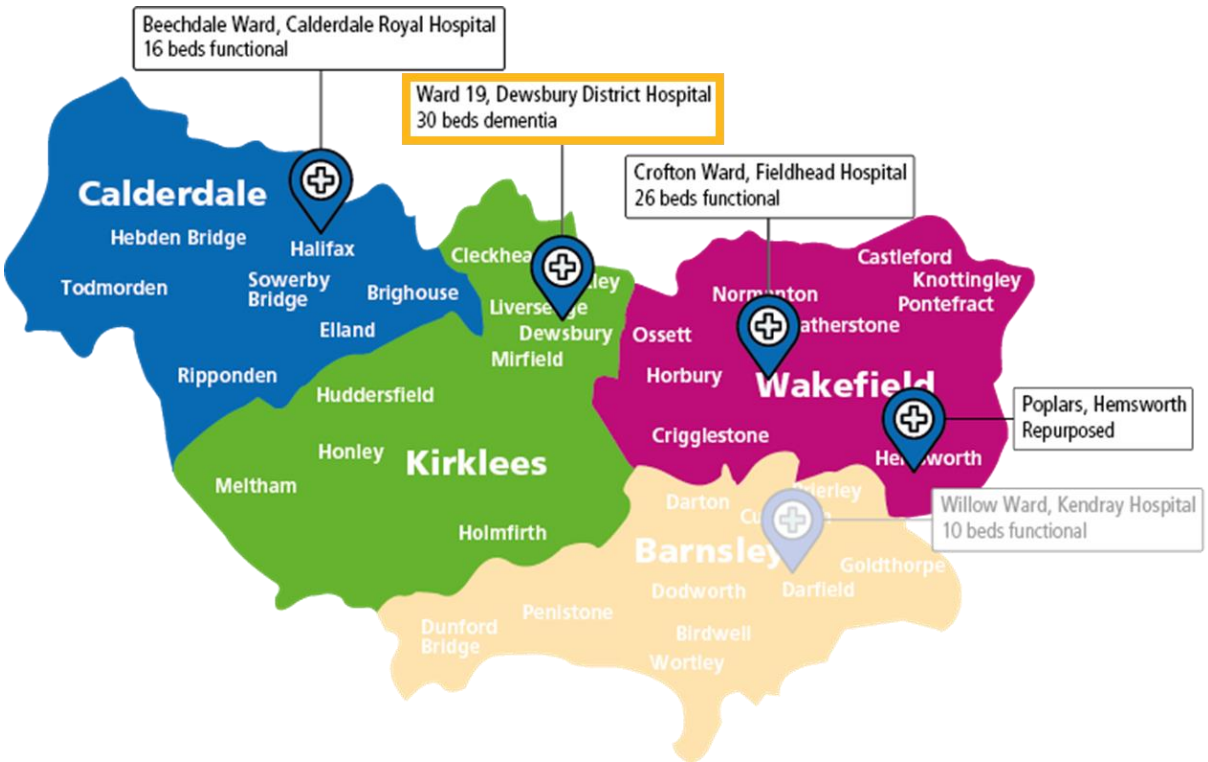
2. Central Specialist Unit in Dewsbury with 6 extra functional beds at Crofton:



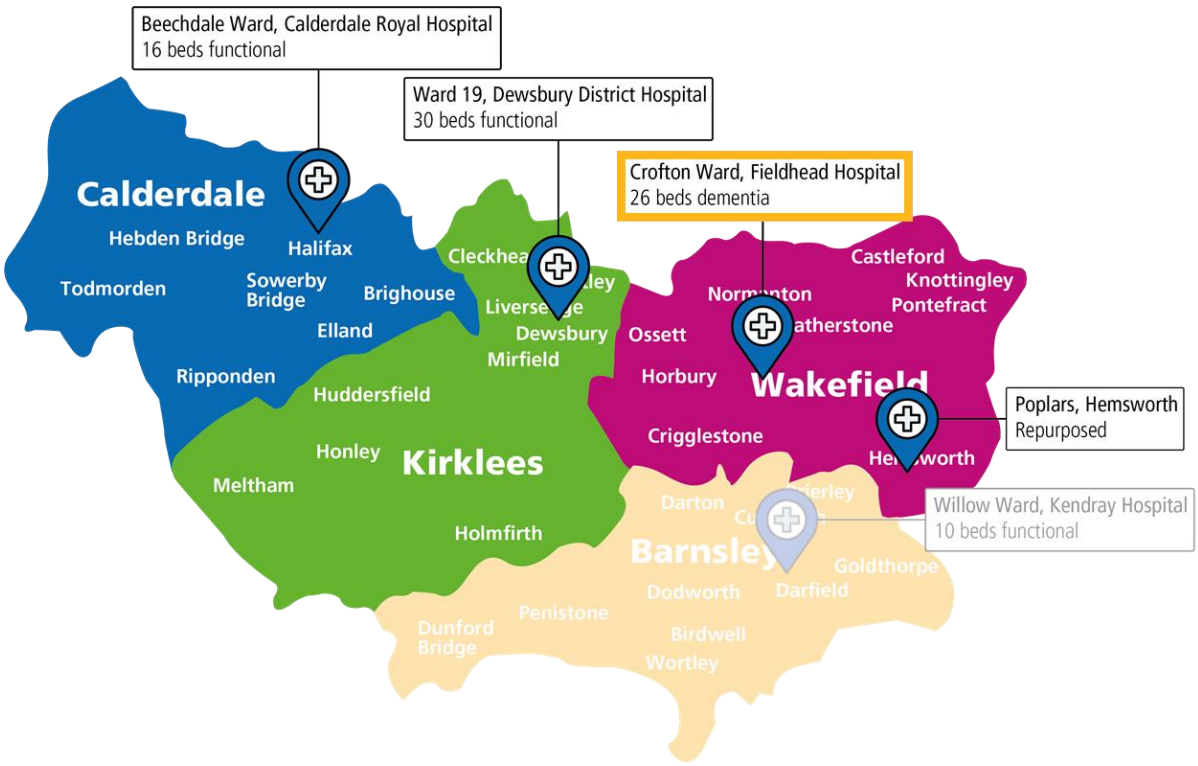
3. Central Specialist Unit in Dewsbury with Crofton having 2 extra beds and Beechdale 1 extra



5. Central Specialist Unit, with more functional beds (10 aligned to Crofton)



9. Specialist dementia unit in Wakefield, all other wards are functional.



To note: No change has been assessed as part of the process to provide a comparison to alternate options.

10.12 Options review scores

The tables below summarises the combined scoring that was established through 2022:

Option	Domain	Score	Rationale
1	Quality	4	No improvements, improvements need to be made due to the isolation of the Poplars site to remain safe and this is a significant risk – due to access to key staff to support safe model (medical on call, safe staffing levels). No specialism across acute wards in West Yorkshire. Achieved 'good' in CQC review (2019). Staff unable to dedicate training to one area of mental health. Ongoing issues with recruitment across the Trust 2 wards with completely separate gender needs, others have some separate gender areas. All meet male / female areas though partially met at Poplars - female patients have to walk across a communal area used by male patients to reach a female bathroom. Managing people with dementia on the Beechdale ward has been identified as an issue due to space restraints. In summary: able to deliver good services overall (CQC) despite some challenges across the wards.
	Access	4	Organic LOS has averaged over 100 days overall in recent years – well above national average. Functional LOS is around 70 days (in line with national averages). 45% of people with dementia have more than one ward stay. Local access for carers, family of services that need to input but issues accessing the right staff into Poplars. Does have capacity to meet demand. Overall some key areas not met (pathway / moves, Length of stay, access to staffing/support at Poplars).
	Sustainability and Deliverability	2/3	Concerns about whether the current model is sustainable as long as 5-10 years. In particular, ongoing challenges of Poplars site not sustainable for that duration. No time required. No cost – other than cost associated with establishment review. Unlikely to resolve any staffing issues. Overall - current model is not sustainable. This is because it has one significant risk which cannot easily get passed and the significant risk is that it is not sustainable.
	Alignment with strategies	4	Review of JSNA and ICB strategies in each place and found that there is nothing planned that would be detrimental to the delivery of the options in the proposed models. A benefit to option 1 is that it does support people in the local area, so aligns with the aspiration to support people as close to home as possible, though evidence shows that the current model exacerbates LOS in some places meaning that people are spending longer away from home. This option does not meet the underlying strategic objective of delivering care in the most appropriate in-patient needs-based environment and the Poplars ward does not align well with the acute hospital model. Overall, this option meets some parts of the requirements, but some key areas are not met.
2	Quality	4	Does remove the Poplars isolation issues – therefore improving safety. Potentially improving quality because of specialist wards delivers the clinical model.

Option	Domain	Score	Rationale
			Modelling (DH 2013) suggests 15 beds is an optimum size for clinical and therapeutic engagement. Therefore, this may have an impact on quality of care at the Crofton site where there would be a large ward. Specialist model will support specialist skills and training to support people on needs-based wards. Aim would be that recruitment would be more desirable to specialist wards, though there could be a negative impact on a large ward. Meets single sex accommodation guidance. Would be less communal area on the 22 bedded functional ward than would be ideal. Good environment for people with dementia on ward 19, for example, each ward has access to lounges, dining room, OT room, garden conservatory. Delivers an organic and functional split, the size of the proposed ward at Crofton is a barrier to scoring higher for both quality of care as the ward size is bigger than current good practice.
	Access	4	Very few people would move in this model, improving continuity of care. Poplars has longest LOS and LOS increased in current model due to moves. Therefore, this model should support reduced LOS. Travel would increase for family / carers. Several places where public transport journey times average 1 hour. Little impact on advocacy, some impact on partner and SWYPFT teams input across boundaries but workable. Robust workforce model 95% occupancy rates (including leave). In range for modelled numbers of functional / organic beds – though on the low side for functional. The option would be 6 beds lower than the current operating model though still within demand and capacity modelled numbers. Extra travel for family / carers for any specialist model.
	Sustainability and Deliverability	4	Anything moving across to Crofton will take up to 2 years. Will have right clinical mix but not the right ward size so could not sustain a ward size of 22 bed. Will attract staff to specialism but could have big ward on Crofton – previously suggested bigger wards lead to challenges so one offsetting the other.
	Alignment with strategies	4	Has specialist wards aligned to general hospital footprint. For each, it would involve displacement of people across geographical boundaries. Therefore, the new model would need to be factored into any considerations of the longer term SWYPFT estates strategy (in development) but should not have a major impact on delivery of any future changes (for example, people from Wakefield admitted to Dewsbury would need to be considered as part of the longer-term Calderdale and Kirklees estates opportunities). Cross boundary working required but we do believe that the models can align with and support partnership working. Option 2 had more than one key area not met, which was due to the ward size and impact this would have on system resilience, as well as the ward size not aligning with strategic aspirations for estate.
3	Quality	7	Does remove the Poplars isolation issues – therefore improving safety. Potentially improving quality because of specialist wards delivers the clinical model. Specialist model will support specialist skills and training to support people on needs-based wards. Aim would be that recruitment would be more desirable to specialist wards.

Option	Domain	Score	Rationale
			Meets single sex accommodation guidance. Good environment for people with dementia on ward 19, for example, each ward has access to lounges, dining room, OT room, garden conservatory. Overall it achieves the separation of needs and specialism without going over the accepted ward sizes, meaning that it meets the majority of requirements.
	Access	4	Very few people would move in this model, improving continuity of care. Poplars has longest LOS and LOS increased in current model due to moves. Therefore, this model should support reduced LOS. Travel would increase for family / carers. Several places where public transport journey times average 1 hour. Little impact on advocacy, some impact on partner and SWYPFT teams input across boundaries but workable. Robust workforce model 99% occupancy rates with this model and outside the range for functional / organic split (low on functional beds). Would mostly cater for gender split needs. Lower score for access primarily because this has fewer beds than has been modelled and represents 9 lower than current numbers.
	Sustainability and Deliverability	2	1 bedroom on Beechdale is not deliverable do not have the space – group agreed. 2 beds on Crofton site doesn't give us the number of beds we have modelled so not deliverable and couple of key risks. Difficult to achieve the space at the PFI site at Beechdale though the Crofton changes should take less time due to the smaller scope. Investing into the Beechdale PFI site to create one extra bedroom is not viewed as cost effective. Will attract staff to specialism.
	Alignment with strategies	3	Has specialist wards aligned to general hospital footprint. For each, it would involve displacement of people across geographical boundaries. Therefore, the new model would need to be factored into any considerations of the longer term SWYPFT estates strategy (in development) but should not have a major impact on delivery of any future changes (for example, people from Wakefield admitted to Dewsbury would need to be considered as part of the longer-term Calderdale and Kirklees estates opportunities). Cross boundary working required but we do believe that the models can align with and support partnership working. Option 3, due to the lower number of functional beds does not maximise resilience in the system and was felt to therefore carry one significant risk.
5	Quality	7	Does remove the Poplars isolation issues – therefore improving safety. Potentially improving quality because of specialist wards delivers the clinical model. Specialist model will support specialist skills and training to support people on needs-based wards. Aim would be that recruitment would be more desirable to specialist wards. Meets single sex accommodation guidance. Good environment for people with dementia on ward 19, for example, each ward has access to lounges, dining room, OT room, garden conservatory. Overall - achieves the separation and specialism; addresses issues with location of the Poplars site whilst maintaining largely the existing and required bed numbers.
	Access	7	Very few people would move in this model, improving continuity of care. Poplars has longest LOS and LOS increased in current model due to moves. Therefore, this model should support reduced LOS. Travel would increase for family / carers. Several places where public transport journey times average 1 hour.

Option	Domain	Score	Rationale
			Little impact on advocacy, some impact on partner and SWYPFT teams input across boundaries but workable. Robust workforce model 89.6% occupancy, within range for functional / dementia split and with some gender flex on functional side.
	Sustainability and Deliverability	5	Does deliver a sustainable system up to 10+ years. This option scores lower due to timeframes also becomes a risk if capital costs increase so will score lower on some elements but does score well with staffing side and will be investing in the estate we own. Scored as a 5 but need to monitor the capital and deliverability. If that becomes an issue it could reduce the score. Doesn't minimise time to deliver – estates work needed on Crofton. Does include an expensive capital but this invests in SWYPFT estate. Does also involve a rich workforce but this could prove cost effective over time. Will attract staff to specialism.
	Alignment with strategies	7	Has specialist wards aligned to general hospital footprint. For each, it would involve displacement of people across geographical boundaries. Therefore, the new model would need to be factored into any considerations of the longer term SWYPFT estates strategy (in development) but should not have a major impact on delivery of any future changes (for example, people from Wakefield admitted to Dewsbury would need to be considered as part of the longer-term Calderdale and Kirklees estates opportunities). Cross boundary working required but we do believe that the models can align with and support partnership working. It was felt therefore that options 5 and 9 both met the majority of requirements with some work needed – aligns with SWYPFT strategy to deliver safe care and continually improve care.
9	Quality	6	Does remove the Poplars isolation issues – therefore improving safety. Potentially improving quality because of specialist wards delivers the clinical model. Specialist model will support specialist skills and training to support people on needs-based wards. Aim would be that recruitment would be more desirable to specialist wards. Meets single sex accommodation guidance. Good environment for people with dementia on Crofton with ensuite but perhaps not as much communal and private space as ward 19. Functional services users at Ward 19 would not have the en-suite facilities. Pros and cons to where a dementia unit might this be. Elements of Crofton didn't quite work as well as a dementia unit, especially the use of space on the site.
	Access	6	Very few people would move in this model, improving continuity of care. Poplars has longest LOS and LOS increased in current model due to moves. Therefore, this model should support reduced LOS. Little impact on advocacy but some additional impact on services that would need to work across greater distances. Additional travel for carers and family, up to 100 minutes on average from some places. 89.6% occupancy, just outside range for dementia / functional split, low on dementia numbers. Lack of gender flex at W19 which would be functional in this model. Some issues in terms of functional / organic split and travel impact– though any scores might be revised if mitigations are put in place such as transport support for people.

Option	Domain	Score	Rationale
	Sustainability and Deliverability	5	Does deliver a sustainable system up to 10+ years. Doesn't minimise time to deliver – estates work needed on Crofton. Does include an expensive capital but this invests in SWYPFT estate. Does also involve a rich workforce but this could prove cost effective over time. Will attract staff to specialism. Overall, largely the same themes and challenges as option 5
	Alignment with strategies	7	Has specialist wards aligned to general hospital footprint. For each, it would involve displacement of people across geographical boundaries. Therefore, the new model would need to be factored into any considerations of the longer term SWYPFT estates strategy (in development) but should not have a major impact on delivery of any future changes (for example, people from Wakefield admitted to Dewsbury would need to be considered as part of the longer-term Calderdale and Kirklees estates opportunities). Cross boundary working required but we do believe that the models can align with and support partnership working. It was felt therefore that options 5 and 9 both met the majority of requirements with some work needed – aligns with SWYPFT strategy to deliver safe care and continually improve care.

10.13 Options Review Workshop – 2023

In May 2023 an options review workshop was held with the purpose of reviewing the options with a wide range of stakeholders, with the evidence that has been gathered and make sure they're the right ones to take into consultation.

It aimed to provide a check and balance for the options we've developed and scored and can update the case for change which we will use for consultation.

The event was attended by a range of stakeholders (33 people in total) across a range of organisations and disciplines.

Represented were:

- SWYPFT
- ICB from each place
- Service managers from each local authority
- Both local acute Trusts
- Carer representation

The following professional leads were in attendance:

- General Managers,
- Clinical and Medical leadership,
- Quality managers,
- Ward managers,
- Engagement and equality leads,
- Lead allied healthcare professionals,
- Social Care leadership,
- Estates and Finance leads (SWYPFT side),
- Dementia lead practitioner.

The following information was available to support the review:

- Clinical Case for change
- Clinical senate review
- Travel impact analysis
- Ward environment analysis
- Data on:
    - ward moves
    - length of stay
    - demand and capacity, including functional / dementia requirement and male / female requirements
- Proposed workforce
- Review of strategies

See appendix 2 for summary report from the workshop, including data available.

Following this, a separate subgroup was established with representation from each place (ICB) and SWYPFT with a remit to review the following strategies:

National:

- NHSE: Draft Acute Inpatient Mental Health Care for Adults and Older Adults: guidance to support timely access to high quality therapeutic care, close to home and in the least restrictive setting possible (October 2022)
- The Royal College of Psychiatrists (2019) Standards for Older Adult Mental Health Services
- NHSE service specifications: https://www.england.nhs.uk/commissioning/spec-services/highly-spec-services/
- NHS Confederation 2022/23 NHS priorities and operational planning guidance
- DH guidance on ward sizes: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_03-01_Final.pdf

Regional:

- West Yorkshire ICB Strategy: https://www.wypartnership.co.uk/application/files/6815/8451/9232/Better_Health_and_Wellbeing_for_Everyone.pd

Place:

- Calderdale Wellbeing Strategy 22/23
- Calderdale inclusive economy strategy
- Kirklees Health and Wellbeing Strategy 2022-27
- Kirklees Health and Care Plan 2023-28
- Wakefield District Health and Wellbeing Strategy 2022-25

Other:

- South West Yorkshire Partnership Trust Priorities 2022/23
- SWYPFT Social responsibility and sustainability strategy 2022-27
- Mid Yorkshire – Delivering MY Future 2023-28
- Mid Yorkshire Clinical Services Strategy 2023-28
- Calderdale and Huddersfield FT Five Year Strategic Plan 2023-28

The report which reviews the alignment of options with strategies can be found in appendix 4.

Number	Option	Quality Domain (4 breakout groups)				
		Previous score	Agreed Y/N	Alternate suggested score	Agreed score	Key discussion points
1	No Change	4	Y, Y, Y, Y		4	
2	W19 dementia unit, 6 extra beds at Crofton,	4	Y, N5, N5	5	5	Group agreed that this is a stronger option rather than do nothing overall, but did have one key area not met which relates to the larger ward.
3	W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale,	7	N6, N6, N5, N6	5	6	Group felt that adding more beds onto the Beechdale environment, within the existing space would have a negative impact on the environment
5	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards),	7	N6, Y, N8	6/8	7	One breakout room initially felt that this should score the same as option 9. Discussion that if W19 could be adapted to create a small number of en-suites for people most able with dementia this would differentiate the score further. One group did not score.
9	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	6	Y, Y, Y, Y	6	6	
Number	Option	Access Domain (3 breakout groups)				
		Previous score	Agreed Y/N	Alternate suggested score	Agreed score	Key discussion points
1	No Change	4	Y, Y, Y		4	
2	W19 dementia unit, 6 extra beds at Crofton,	4	Y, Y, Y		4	

3	W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale,	4	Y, N3, N3	3	3	Capacity issue and risk of sending people out of area was felt to be a significant risk by 2 groups and consensus reached to rescore.
5	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards),	7	Y, Y, Y		7	
9	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	6	N5, Y	5	6	One group didn't score, one group felt the travel impact and fewer dementia beds meant this should score lower, at 5, but consensus of 6 was reached.
Number	Option	Deliverability/Sustainability Domain (3 breakout groups)				
		Previous score	Agreed Y/N	Alternate suggested score	Agreed score	Key discussion points
1	No Change	2 or 3	Y2 or 3, Y2, Y3	2 or 3	2.5	All groups agreed this option was not viable for the required period of time with some minor differences on whether it scored 2 or 3 so agreement reached to score 2.5
2	W19 dementia unit, 6 extra beds at Crofton,	4	Y, Y, Y		4	
3	W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale,	2	Y2 or 3, Y2, Y3	2.5	2.5	One group suggested this should be same as no change and consensus on this was reached
5	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards),	5	Y, Y, N7	7	6	Ultimately, the overall group felt that both options 5 and 9 were viable and sustainable, with pros and cons to each - such as Priestley unit not being on SWYPFT estate (although confirmed that tenancy is secure) and the limit of 26 dementia beds at Wakefield if demand increases.
9	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	5	N6, Y, N6	6	6	Group felt that both options 5 and 9 were viable and sustainable

Number	Option	Co-Dependencies with other strategies (scored in a separate subgroup)				
		Previous score	Agreed Y/N	Alternate suggested score	Agreed score	Key discussion points
1	No Change	4	Y		4	Agreed that option 1 remains at 4 due to not delivering the key elements of a specialist model. Does support people in home locality but keeps people away from their community for longer. Option 2 does have one key area not met – the ward size which leads to a score of 5 but does meet other areas of strategies. Option 3 increases from score of 3 to 5 but still has concerns that links to resilience to enable support for people locally and SWYPFT priorities. Option 5 and 9 – increase score to 8 as they align well with the vast majority of local, regional and national strategies. Travel impact would be very limited (in terms of sustainability strategies).
2	W19 dementia unit, 6 extra beds at Crofton,	4	N	5	5	
3	W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale,	3	N	5	5	
5	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards),	7	Y		8	
9	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	7	Y		8	

11 Capital and Revenue implications

11.1.1 Capital Costs:

The main cost of capital in the proposals is for the relocation of the isolated site, the Poplars, to be co-located with other wards.

The table below gives a high-level summary of capital costs, as costed in 2023:

Option	Description	Total Capital Cost	Comments
2	Moving only 6 beds from Poplars site	£5.5M	Would involve 6 bed reduction in the overall operational model. Ward 19 would be the dementia unit in this option as 22 bed in Wakefield would be below dementia required capacity.
5 and 9	Model designed as part of an overall functional or dementia site	£8.2M	The 10-bed design would accommodate either of these proposed options, having a specialist dementia unit in Dewsbury or Wakefield.

The capital modelling in 2023 has led to an increase in the capital costs from an expected £3.0M for options 5 and 9.

The main costs above those factored into the previous costs have been identified as:

- Plant room – not previously costed in but now understood to be a likely requirement of any expansion due to the limits of the existing plant room. New Health Technical Memorandum (HTM) post COVID requirements makes the new plant a prerequisite of the technical design phase. The likely costs are in the range of £3-4M.
- New rules around contingency required.
- Additional space requirements, including relocation of medic offices.

There is a revenue implication for these models and the £8M+ capital options will add approximately £500K annual revenue costs.

Current planning assumptions are that capital costs will be spread across 2 financial years, 2024/25 and 25/26, with work being complete in spring or summer 2025.

More detailed summary of estates work can be found in appendix 5.

11.1.2 Workforce Modelling

The workforce section of the business case covers the workforce modelling process in more detail, which has been clinically led by the programme clinical lead resource, supported by the establishment review lead resource for skills mixing on the wards and reviewed by the service managers.

The table below references SWYPFT Trust establishment review activity took place in early 2023, using the same MHOST data as was used for transformation modelling, to identify gaps between the existing staffing and required staffing for the existing model.

Summary of staff across models:

	Current Establishment	Proposed (establishment review)	Actual Use	Option 2	Option 5	Option 9
RN	70.24	80.62	61.67	67.12	75.88	78.00
HCA	84.61	99.04	122.4	108.82	114.84	114.82
Total	154.85	179.66	184.07	175.94	190.72	192.82

Options 5 and 9 will require some additional staffing resources above existing levels and levels proposed in the establishment review. This is because it brings the people with the highest dependency levels into one place to deliver *specialist* dementia care whilst the remaining functional wards will still need to operate at similar safe levels to the existing mixed needs wards.

Whilst this model does increase the staffing above current levels of use, the clinically led team that focussed on the required workforce believe that this increases the likelihood of being able to manage within established levels of staff.

Transforming to a specialist model could also lead to less people in the dementia unit being on high level of observations, reducing very long stays and therefore reducing demand for dementia beds. However, economies based on these options can't be expected from day one, which is why a robust staffing model is initially needed for dementia specialist ward, though the Trust will also try to carefully phase to the new model if possible.

11.1.3 Additional staffing:

The staffing identified will ensure that a safe core workforce is in place. As well as this there may be some additional resource required to deliver a specialist model, for example, an extra Advanced Clinical Practitioner (ACP) at the specialist dementia unit site, consideration of extra speciality doctor resource, extra psychology assistant resource or extra support for occupational therapies. These are not currently costed into the model but will add extra benefits and will need to be considered separately.

11.1.4 Recruitment, training, and wider system impacts:

Staff recruitment would need to be phased in prior to the transformed model being fully implemented. The numbers required are relatively low in comparison to the overall staff base across SWYPFT and local partners. There is also the option to continue/expand the oversees recruitment programme that has been used in recent years by SWYPFT to fill vacancies for qualified nurses.

Although there could be some wider system impacts due to the transformation post being new and attractive, the increase in posts involved are low compared to current use. This is unlikely to have significant clinical or financial impact on the wider system.

11.1.5 Overall costs of the proposed option:

The table below is the most recent revision of the costed option.

Option	19 Male	19 Female	Beechdale	Crofton	Poplars	Willows	Revenue for Capital	Total
	£K	£K	£K	£K	£K	£K	£K	£K
a. 2022/23 budget	1,093	1,094	1,083	1,162	1,275	980		6,688
b. 2022/23 Actual	1,078	1,034	1,329	1,818	1,636	1,166		8,062
c. 2023/24 budget	1,168	1,175	1,146	1,214	1,352	968		7,023
1. No change (costed at current roster templates)	1,158	1,243	1,164	1,164	1,151	1,035		6,914
1a. uplift /safer staffing	1,342	1,350	1,308	1,429	1,528	1,017		7,975
2. W19 dementia unit, 4-6 extra beds at Crofton, Poplars not in this model *	1,963	1,963	1,233	1,724	0	1,008	324	8,215
5. W19 dementia unit, 10 extra beds at Crofton, Poplars not in this model **	1,963	1,963	1,233	2,430	0	1,008	486	9,082
9. Crofton being a 26-bed dementia unit, all other wards functional	1,178	1,251	1,233	4,123	0	1,008	486	9,279

The proposed options 5 and 9 in the table above represents just over £1M increase above the actual rostered staff revenue spent in 2022/23, though is over £2M above the budget levels.

11.1.6 VfM options scoring

On agreement of the methodology used, the group moved focus to options appraisal and the VFM, with key indicators highlighted in bold:

Domain – Value for Money	What we need to measure against	Measures	Supporting information / comments
Viability / Affordability	**Is the capital affordable?** **Is the revenue affordable?**	Supports sustainability of Trust financial position **Provides the most positive net present value over 5-10 years, return on capital and other financial requirements** Improves income/cost balance Sources of funding Reimbursement of travel expenses if travelling further Explore the concept of funding a shuttle bus	Costs of options Finance statement on viability
Use of resources		**Makes best use of resources** **Economies of scale**	Summary of potential economies
Capital investment		Minimises the need for capital Additional/specific: • Longer term value/building related issues • Medium term investment	If it can be delivered within capital budgets and investment in SWYPFT owned estate.

Each was appraised in line with these key criteria to achieve an overall score for VfM:

- Capital Affordability
- Revenue Affordability
- Best Use of resources
- Economies of Scale
- Capital investment

Finance leads agreed the following scoring:

Finance leads agreed the following scoring:

	Capital Affordability	Revenue Affordability	Best Use of resources	Economies of Scale	Capital investment	Total
Option 1	5	5	5	1	5	21
Option 2	0	5	5	3	5	18
Option 3	0	5	4	2	3	15
Option 5	0	4	4	2	5	16
Option 9	0	4	4	2	5	16

	Capital Affordability (£k)	Revenue Affordability (£k)	Best Use of resources (£k)
Option 1	0	8,062	96
Option 2	5,400	8,215	105
Option 3	3,100	8,001	107
Option 5	8,100	9,082	111
Option 9	8,100	9,279	113

	Capital Affordability	Revenue Affordability	Best Use of resources
Option 1	100%	99%	100%
Option 2	0%	97%	91%
Option 3	0%	100%	90%
Option 5	0%	88%	87%
Option 9	0%	86%	85%

The scores are split as:

- Capital affordability – lowest spend scores 5. Remaining calculated in relation to this.
- Revenue affordability – as above
- Best use of resources – based on bed day price (spend / beds). Lowest spend scores 5. Remaining calculated in relation to this.
- Economies of scale – option 1 scores as 1 as current staffing model utilising bank and agency. Option 2 would have more than others due larger ward and therefore can utilise some staffing economies of scale but minimal so rated as 3. Others scored as 2 as will look for substantive recruitment to reduce current premium payments and improve quality, safety etc.
- Capital Investment – based on investing in Trust estate (5) or other NHS provider properties (3). Would have scored 1 if non-NHS property and therefore no asset.

Weighting:

The scores about total 25 (up to 5 marks each across the 5 categories). When weighted to 30 are as follows:

	Total
Option 1	25.2
Option 2	21.6
Option 3	18.0
Option 5	19.2
Option 9	19.2

11.1.7 Financial engagement

Discussion on the **potential** financial elements has been undertaken via the programme board; there was a need to jointly develop the different service model options to enable indicative costings to be undertaken. This has considered both the revenue and capital consequences.

The discussions with stakeholders have confirmed the appropriateness of the costing process undertaken, the principles applied, the assumptions made (such as workforce modelling) and also confirmed the appropriateness of the overall financial scoring. The financial scoring has informed the overall option scoring and therefore provides a comprehensive position.

11.1.8 Timing

Current modelling assumptions are that a preferred model could be live from **2025 / 26**. It needs to be clear that this is an assumption and actual timing will be dependant on a number of factors which are dependent on the outcome of the public consultation including the agreement of a preferred option, decision to commence timelines, and triangulation with the capital programme scheduling.

Based on this, the system / commissioners will need to incorporate prioritise funding from that point. Recruitment plans, and part year effects, profiling etc, will be agreed with system partners once timescales are clarified.

11.1.9 Financial implications – revenue

Whilst the actual costs will depend on the preferred recommended options, confirming of final staffing models and agreed national pay rates, the financial modelling, used to inform the preferred options to take to consultation, highlight a current difference of £1.2m between current costs and the highest cost option. The difference to option 5 is £1.0m. The modelled financial gap for option 2 is £153K.

This is summarised in the table below and illustrates the mitigations that SWYPFT have included and the remaining funding gap:

Description / option	**Cost £k**	
Budgeted OPMH inpatient services 22 / 23	6,688	SWYPFT mitigation £1,374k
Actual Spend 22 / 23	8,062	
Option 2	8,215	Modelled financial gap £153k

Option 3	8,001	Modelled financial gap £ NIL
Option 5	9,082	Modelled financial gap £1,020k
Option 9	9,272	Modelled financial gap £1,210k

It is proposed that the additional cost would be apportioned between the three places (Kirklees, Calderdale and Wakefield using a methodology yet to be defined and agreed). For illustration purposes equal shares would equate to approximately £0.4m per place whilst population splits would be c. £261k (Calderdale), £489k (Kirklees) and £460k (Wakefield).

No additional non pay or overheads have been included within the financial modelling. These are not expected to significantly change from current costs incurred.

11.1.10 Financial implications – capital

The capital cost will be incorporated into the SWYPFT capital programme which has been developed in support of our long-term Estates strategy. This will utilise SWYPFT cash reserves. The main risks relate to ensuring that the Trust capital allocation is maintained at an appropriate and sustainable level and also the opportunity cost; doing this scheme will mean that another programme cannot be completed at the same time.

The Trust Estates strategy has formed the basis for prioritisation of schemes within the capital programme. The potential capital works identified within this document have formed part of this programme and have been repeatedly included in indicative medium term Trust capital plans which have been periodically shared with the ICB. Other schemes have been profiled around the indicative timing of this programme; based on current modelling this does not wholly utilise the capital allocation in any given year allowing other works to be completed alongside this.

The NHS WY ICB has confirmed prioritisation of this scheme from a system capital & estates perspective. This is on the basis that the forecast capital expenditure for the programme is £8.2m and will be spent across the 2024/25 and 2025/26 financial years. SWYPFT has confirmed that it will prioritise this programme from within its expected operational capital allocation.

Business case guidance around contingency and optimism bias have been factored into the costed models. For example, 15% optimism bias is factored in at a cost of £1.07M. However, the programme team remain conscious of price volatility. Cost uncertainty is recognised and we propose using the ProCure23 process for delivery in order to manage some of that volatility. As identified above the Trust does have the capacity to flex other capital scheme spend in year to mitigate against cost uncertainty.

11.1.11 Financial implications – opportunity cost

All parties recognise that there are limited resources within organisations, the overall system and that the financial position is becoming increasingly challenging (and is expected to increase further). As such prioritisation of investment (capital and revenue) will be required which in turn means that investment in other priorities will not be possible. At this stage those opportunities are not clearly articulated.

11.1.12 Financial implications – transition costs

There will be potentially be some transition resource required at time of go live and a period of up to 4 weeks where additional staffing is needed to manage the transition across sites. Based on previous experience of work at Fieldhead site this is an estimated £10-15K one off cost.

There may also be some staff relocation costs as a result of material changes to people's role and location. Data shows this could impact on 13 staff members from the Poplars site and the payment for excess journeys could cost up to £15K tapering down to £13K per annum for up to 4 years if all people are relocated to be based at Fieldhead. The actual cost could be lower if all staff do not relocate.

11.1.13 Financial implications – stranded costs

The impact on other organisations and partners has been considered as part of this programme especially as a number of the current services are provided in units leased from other local NHS Trusts. No other organisation is impacted or has any stranded costs as a result of the options. The Trust will follow the capital disposal process for the Poplars site should that be required following the public consultation, which involves the following:

- When a property is declared surplus to requirements, the Department of Health and NHS estates are informed and the property goes on the surplus register
- We would then ask if any public bodies want the property as a limited disposal and we are required to get a capital return which equates to the market value of the property.
- If no public body wants the property it is disposed of on the wider property market

Initial conversations have taken place with local partners about the future use of this site and how the site could be used as a local asset for health and care purposes. It is hoped that a solution to the use of the site can be found quickly. To note, this process would take place separately to the transformation programme.

11.1.14 Agreed principles

Final values will be confirmed post consultation and post final cost review and the programme will continue to engage with partners and ensure that this is undertaken on an agreed open book basis for both costing methodologies and the underlying service modelling.

Key principles that have been applied throughout include:

1. That SWYPFT will continue to contribute the difference in value of the total Commissioning budget 'v' total actual spend.

2. That the capital investment is within the SWYPFT capital allocation (noting the risk presented by any potential changes to ICB capital allocation methodologies) and that the Older People Mental Health inpatient programme is prioritised within the Trust Estates Strategy.

   This has been confirmed by the West Yorkshire ICB finance director, Jonathan Webb, who wrote "The NHS WY ICB can confirm prioritisation of this scheme from a system capital & estates perspective. This is on the basis that the forecast capital expenditure

for the programme is £8.2m and will be spent across the 2024/25 and 2025/26 financial years. SWYPFT has confirmed that it will prioritise this programme from within its expected operational capital allocation."

3. That the revenue costs will be phased, in agreement between system partners, with current modelled part year effect costs from 2025 / 26.

4. That we, as system partners, agree that if Mental Health Investment Standard funding continues we agree that in the Older Peoples transformation programme is initially prioritised to meet the revenue costs over the agreed period.

5. That SWYPFT and ICB will risk share any increases in costs that emerge as a direct result of the programme.

6. That if we agree to the above principles, SWYPFT will help manage any other business case / investment requests. (as Older Peoples Services (OPS) transformation will be the agreed priority (resulting in opportunity costs)).

7. That we discuss and confirm the above within West Yorkshire in terms of investment spend.

12 Options to take to consultation

12.1 Complete scoring matrix

The table below summarises the overall scoring across the domains when weighted:

		Quality Domains				Total quality score	Value for Money	Total
	Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	**70**	30	**100**
1	No change	12	8	2.5	4	**26.5**	25.2	**51.7**
2	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15	8	4	5	**32**	21.6	**53.6**
3	W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale, Poplars not in this model	18	6	2.5	4	**30.5**	18.0	**48.5**
5	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21	14	6	8	**49**	19.2	**68.2**
9	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	**44**	19.2	**63.2**

The fields highlighted in red show where an option did not meet the required threshold for the domain.

12.2 Proposed Options for Consultation

The options appraisal found the following options were potentially viable. These are summarised below:

A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield.

There are two ways that this could be done:

a) 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 Ward would operate as 2 wards across the 26 beds (option 5)
b) with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward (option 2)

And:

A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees.

This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beechdale would be functional wards (option 9)

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.

No change is not a clinically viable option.

On agreement of the business case, the programme will move forward with planning and delivery of a consultation phase.

To note: from this point on the options will be referenced as options 1a, 1b and 2 for impact analysis and consultation materials.

12.2.1 Mapping option numbers for consultation

From the longlist of options, options 2, 5 and 9 have been recommended to take forward into consultation.

It is agreed that to put into the public domain these need to be ordered in more straightforward numbering.

Options 2 and 5 have similar features in terms of the specialist dementia unit being at Dewsbury and specialist functional units elsewhere. These therefore will be presented as sub options of a Dewsbury specialist dementia unit option.

Proposed mapping of options:

New Option Reference	Description	Original Reference
1 a)	A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield 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 Ward would operate as 2 wards across the 26 beds.	**5**
1 b)	A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward.	**2**
2	A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees. This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beechdale would be functional wards.	**9**

13 Impact of options

The following section sets out the potential impacts of the differing options, considering:

- Travel and Transport
- Quality
- Equality
- Sustainability

13.1 Travel and transport

From the outset of the programme, one of the major themes we have heard from across a range of stakeholders is the impact on travel of any potential changes.

As such, the programme has undertaken a detailed transport analysis to understand what the likely impact is on people from different parts of the Trust footprint that may need to travel to visit a family member or a loved one.

Appendix 6 includes the more detail information that is summarised in this section including the methodology used and the approach to options that were discounted.

13.1.1 Travel impact – findings

Many people have stays outside of their locality and many also have more than one ward stay in the current model. However, delivery of a specialist model will have a further impact for any of the options.

The travel impact analysis focusses predominantly on:

- Driving distances
- Driving times
- Public transport times

With all of the options for proposed changes, there would be a positive impact for some people. This is because 30% of admissions to older people's beds are outside of the home locality and some of these people would almost certainly be admitted locally if a specialist functional or dementia ward is in their locality.

However, more family and carers will have further to travel if any specialist model is implemented. The negative impact is greater in the options where the dementia unit is in Wakefield compared to Dewsbury.

13.1.2 Impact on the overall population

The table below shows the average numbers of people per year in the analysis.

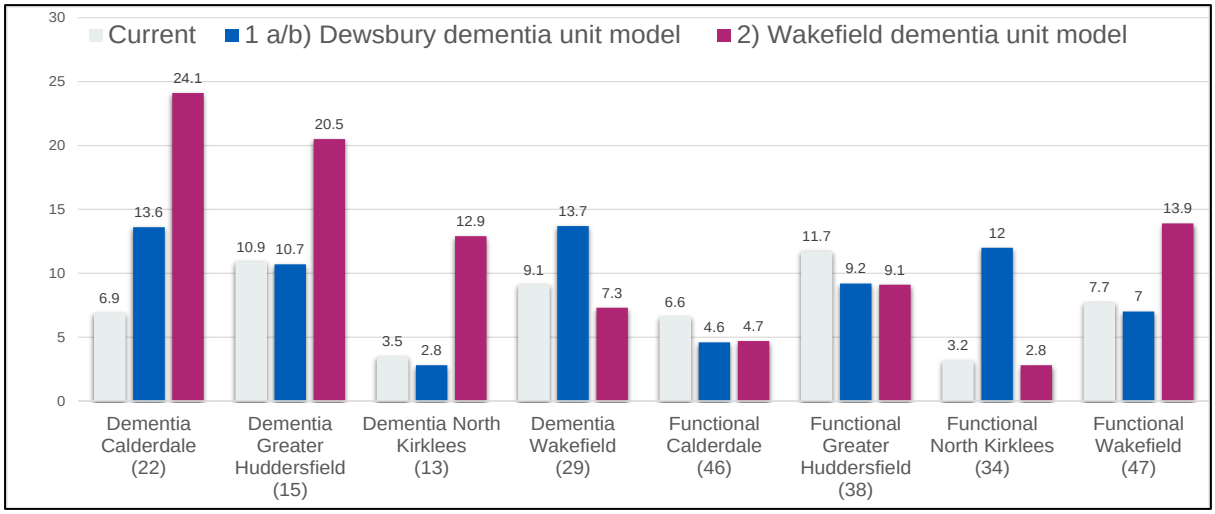
Need	Place and need	Spells
Dementia	Calderdale	22
Dementia	Greater Huddersfield	15
Dementia	North Kirklees	13
Dementia	Wakefield	29
Functional	Calderdale	46
Functional	Greater Huddersfield	38

Functional	North Kirklees	34
Functional	Wakefield	47

The charts below show the average journey distances and times for travel by car to the current and proposed models.

Driving Distance:

The following chart shows the average driving distance based on inpatient spells (discharge ward) with the number of people impacted per year in brackets:



In summary, if the dementia unit were in Dewsbury (option 1a and 1b):

- The longest average travel distances would be people with dementia from Wakefield (29 people per year) and Calderdale (22 people) with **14-mile** average journeys respectively.
- Functional admissions from North Kirklees (34 people) would also be an average of over 10 miles from home, as would dementia admissions from North Kirklees (13 people), though this would be a shorter average distance than the current model.

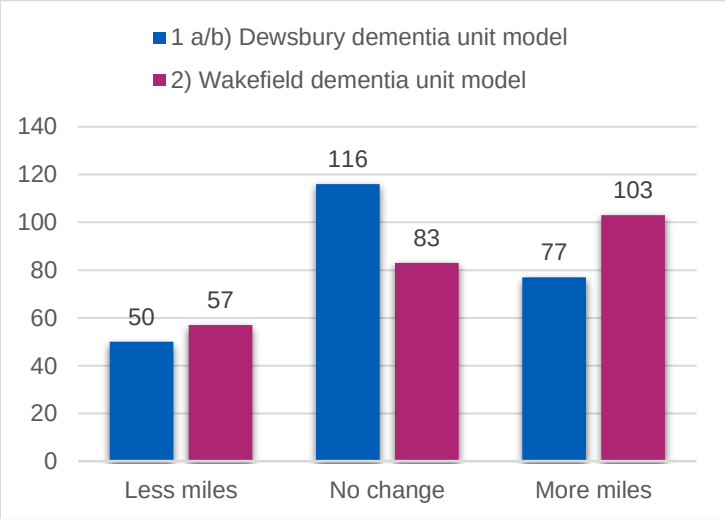
If the Dementia unit were in Wakefield (option 2):

- The longest average travel distances would be people with dementia from Calderdale (22 people per year) and Greater Huddersfield (15 people) with **24- and 21-mile** average journeys respectively.
- 46 Functional admissions from Wakefield would have an average 14-mile journey from their home and 13 dementia admissions from North Kirklees would average 13 miles.

In both models some people would have less distance to travel. Most notably, people with functional needs from Calderdale who are often admitted outside of the place.

13.1.3 Driving distance – mean change per year:

The chart below shows the numbers of people that would be positively or negatively impacted in terms of driving distance of each option:



Considering individual stays and based on the discharge ward, in a model with a dementia unit in Dewsbury (options 1 a/b):

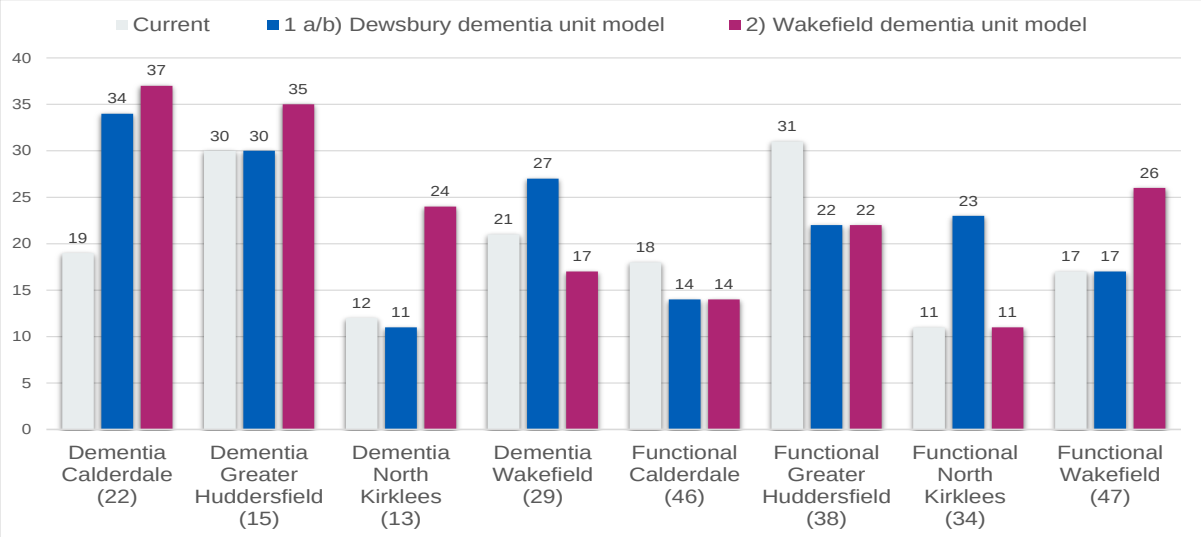
- 50 people would be closer home when discharged
- 116 people would be in the same place
- 77 would be discharged from a ward further away from their home.

Considering individual stays and based on the discharge ward, in a model with a dementia unit in Wakefield (option 2):

- 57 people would be closer home when discharged
- 83 people would be in the same place
- 103 would be discharged from a ward further away from their home.

13.1.4 Driving Travel Time Analysis

The table below shows the average driving time for each option:

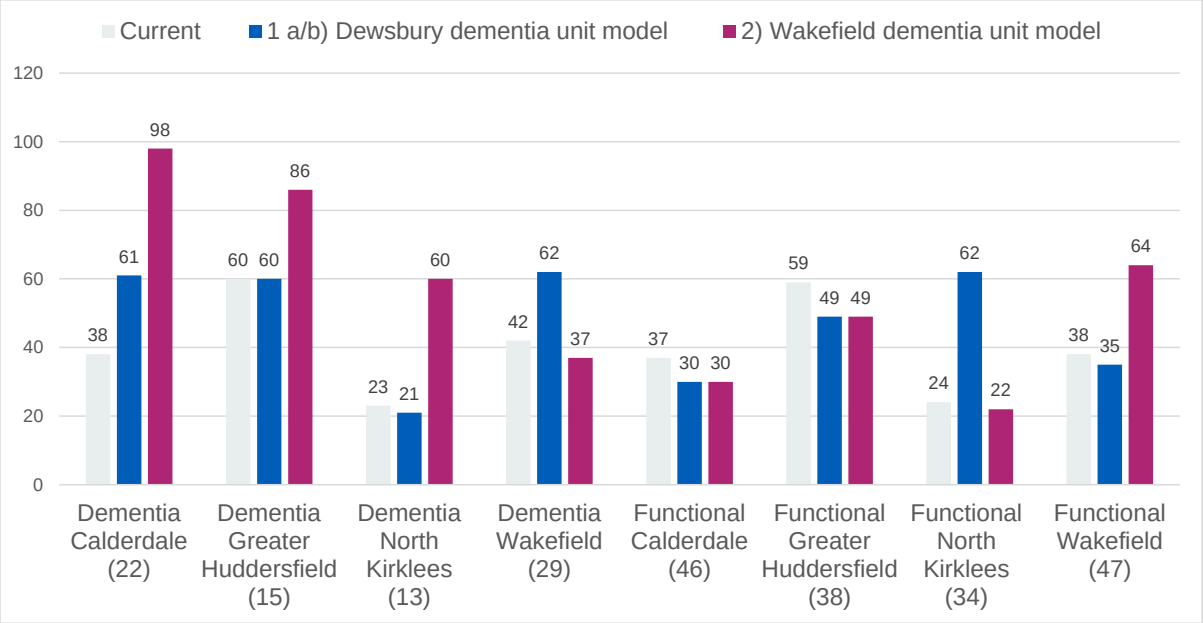


There are similar themes in terms of extra driving time, though the gap is narrower than driving distance. This is due to the motorway and dual carriageway access to Wakefield which isn't available when accessing central Dewsbury from the north or west.

13.1.5 Public Transport Times:

It is important to understand the impact from a public transport perspective, especially for family and carers who might need to use this service.

The data below shows the public transport times based on the proposed models, with the numbers of people impacted per year in brackets:



In both models there are 4 localities where the average public transport journey would be 1 hour plus.

The Wakefield dementia model would mean that people from Greater Huddersfield (15 people per year) and Calderdale (22 people) would be **86- and 98-minutes** journey away respectively.

Average public transport journeys of people in the current model take **60 minutes** for functional or organic admissions from Greater Huddersfield.

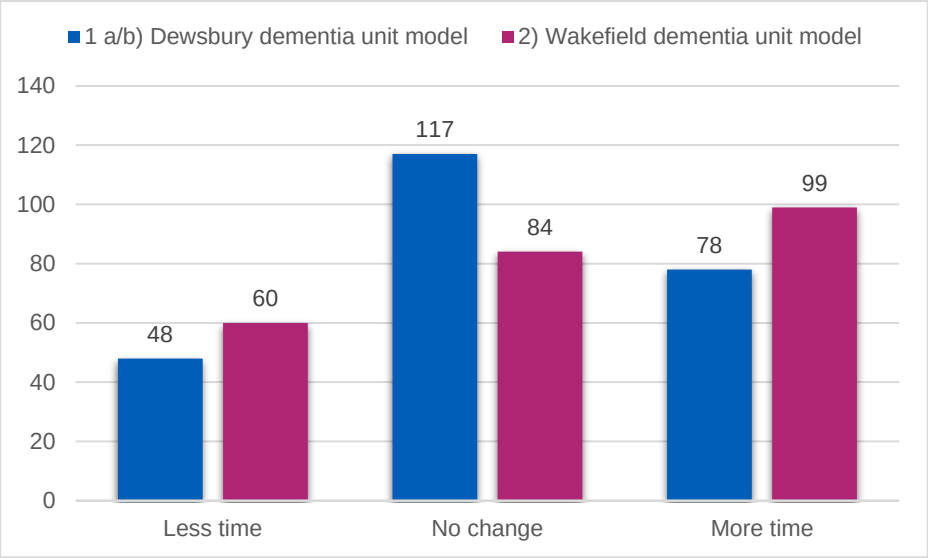
Places with long (approximately 1 hour or more) average public transport journeys in the current or future model are highlighted in the table below:

Need	Place	Current (time mins)	1 a/b) Dementia unit in Dewsbury (time mins)	2) Dementia unit in Wakefield (time mins)
Dementia	Calderdale	38	61	98
Dementia	Greater Hudds	60	60	86
Dementia	North Kirklees	23	21	60
Dementia	Wakefield	42	62	37
Functional	Calderdale	37	30	30
Functional	Greater Hudds	59	49	49
Functional	North Kirklees	24	62	22
Functional	Wakefield	38	35	64

The travel and transport appendix includes more detail on journeys from different places and what it might mean in terms of numbers of busses or trains and time required.

Public transport – summary of numbers of people that would have shorter or longer public transport journey:

Discharge ward:



Overall, there would be an average of around **80 people per year** that would have a longer journey with a dementia unit being in Dewsbury whilst around **100 people per year** would have a longer journey to Wakefield.

With both models, some people would have a shorter journey which reduces the net overall impact.

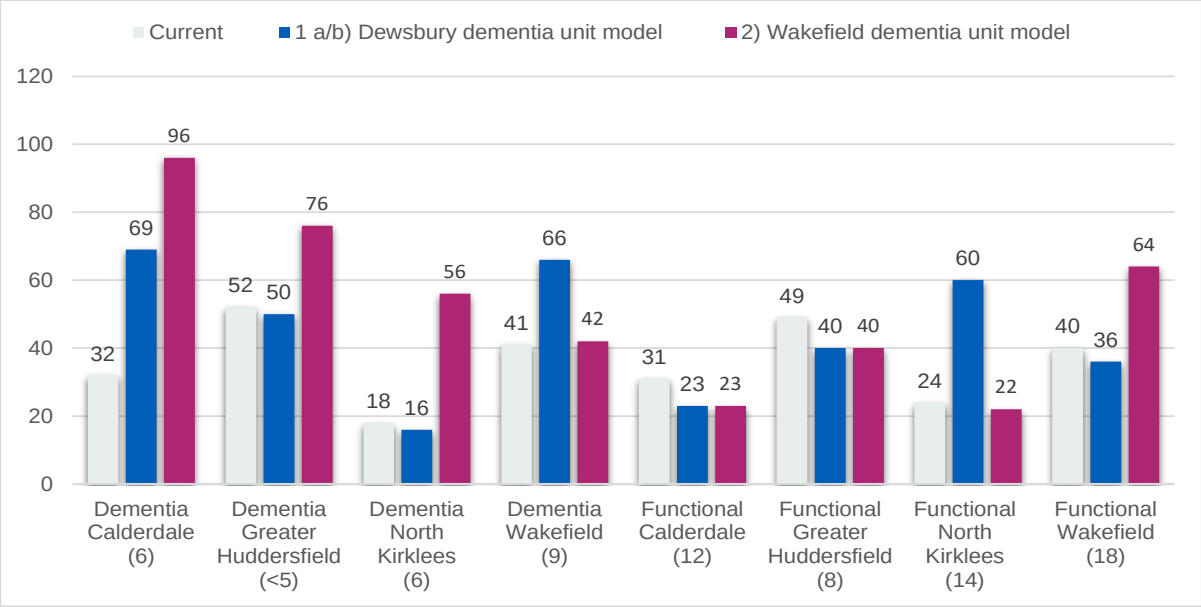
13.1.6 Analysis of impact on the 20% most deprived areas:

The data below shows the number of spells and wards stays per year of the people from the 20% most deprived areas:

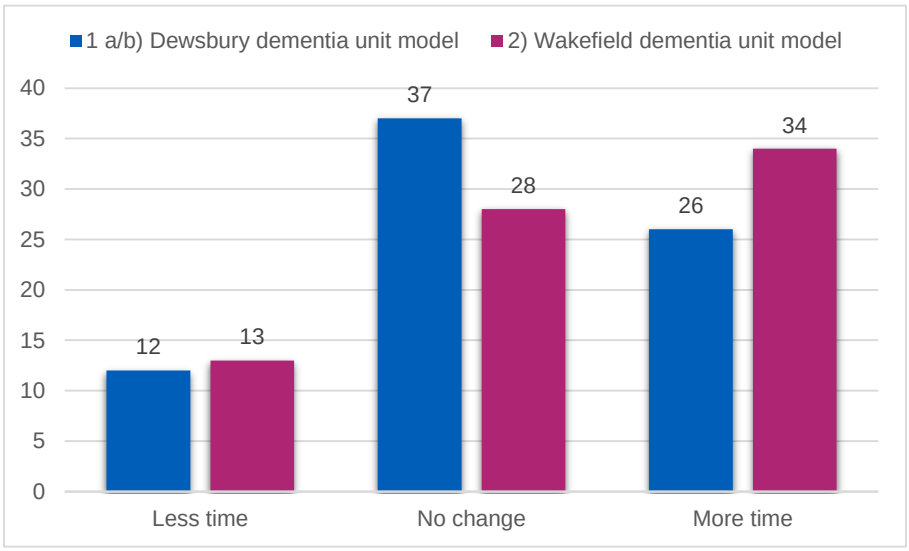
Need	Place and need	Spells
Dementia	Calderdale	6
Dementia	Greater Huddersfield	<5
Dementia	North Kirklees	6
Dementia	Wakefield	9
Functional	Calderdale	12
Functional	Greater Huddersfield	8
Functional	North Kirklees	14
Functional	Wakefield	18

The following focusses specifically on the public transport impact of people in the most deprived areas, who are more likely to require use of this mode of transport.

Inpatient spell (using discharge ward):



Public transport – numbers of people that are positively or negatively impacted per year:



Considerations:

The numbers are small but not inconsiderable and we know the negative impact could be high on the small numbers of people that struggle to visit their loved ones as people from the more deprived areas are more likely to be reliant on public transport.

In the option with dementia admissions to Wakefield (option 2), everyone from Calderdale and Kirklees with dementia will be admitted to Fieldhead Hospital. The public transport journey will be considerable, particularly for people from Calderdale and Greater Huddersfield (96 and 76 minutes respectively). Functional admissions from Wakefield will be into Dewsbury, which average over an hour for people from the most deprived areas.

With the dementia unit in Dewsbury (1 a/b) there are still several significant (one hour plus) average journeys for people travelling to a model with a dementia unit in, including people from Calderdale, Great Huddersfield and Wakefield, plus functional admissions from North Kirklees.

There are some considerable public transport times in the current model, regardless of any change. Greater Huddersfield does not have an inpatient facility so people from this area would have a long journey, as will the 30% of people who are admitted outside of their locality.

The appendix includes further breakdown of transport times and a high-level summary of impact by place.

13.1.7 Access for Black and minority ethnic (BAME) populations

We know also that people from black and minority ethnic groups are more likely to be from deprived areas. However, there are very few admissions and especially low numbers of dementia admissions for people from a BAME background. As there are very few spells for people with a BAME background per year the data has been suppressed.

13.1.8 Public Transport costs

Currently, (as of June 2023) people do not have to pay more than £2 for an adult single ticket or £4.50 for a Metro Card (MCard) day saver ticket for travel on any bus across West Yorkshire valid anytime. A weekender ticket costs £8.50 which can be bought on the bus for unlimited bus travel from 6pm on Fridays until midnight on Sundays on any bus, anywhere in West Yorkshire.

People travelling by bus and train would pay £10.10 off-peak and £15.60 peak for a bus and rail day saver ticket across the West Yorkshire area.

Off-Peak Countywide Bus and Train tickets cost £9.10 or £4.55 (concessionary)

People who have reached the state pension age and are a permanent resident of West Yorkshire will qualify for a Senior Pass. A Senior Pass provides:

- Free, off-peak bus travel throughout England.
- Half-fare, off-peak train travel throughout West Yorkshire, for West Yorkshire residents.

As well as this, there is currently a **free public transport option** that could support part of our population with a bus that runs across the Mid Yorkshire Hospital footprint, from Pontefract to Pinderfields in Wakefield and Dewsbury Hospital.

Taxi fares

Travelling by taxi may be another option for some people if they are unable to use public transport or they are unable to drive. Indicative costs are set out below as at June 2023: (link: Ossett to Dewsbury District Hospital (rome2rio.com)

From	Dewsbury Hospital	Fieldhead Hospital	Calderdale Royal
Ossett	£10 - £13	£14 - £17	£40 - £55
Hebden Bridge	£45 - £55	£70 - £90	£22 - £27
Huddersfield	£20 - £24	£45 – £60	£18 - £22
Pontefract	£35 - £45	£24 - £29	£75 - £95

13.1.9 Voluntary and Community Sector (VCSE) travel support

The VCSE can also offer an alternative transport option for people who need to access other forms of transport to visit their loved one in hospital.

Some local transport offers are in place, often delivered through VCSE organisations but often these might be place based and for example, focussed on patients themselves travelling to hospital rather than family or carers that need to visit their loved ones.

Age UK Transport services for the elderly and disabled | Age UK and Calderdale Community Transport Home (ctcalderdale.co.uk) offer older people support to arrange transport with a local provider, such as Dial-a-Bus or the Royal Voluntary Service however, there may be a small charge to cover the cost of petrol.

The Trust does also currently work with service users and carers/families to find and access appropriate transport support, including supporting them to find public transport options and transport support through the VCSE sector.

13.1.10 Use of technology

There is a chat pad offer on every ward in the Trust which uses ZOOM and has been rolled out as a result of covid-19. People staying on the wards can ask to use the system to connect with loved ones, family, friends and carers. It can also be used to contact an advocate.

13.1.11 Parking charges

The table below summarises the parking charges of each site (as of December 2022)

Location	Hospital	Costs
Calderdale	The Dales Calderdale Royal Hospital	30 mins (free) Up to 2hrs (£3.00) Up to 4hrs (£5.00) Up to 6hrs (£6.00) Up to 24hrs (£8.00)
Kirklees	Priestley Unit (Dewsbury and District Hospital)	Less than 20 mins (free) Up to 1hr (£2.00) 1-2hrs (£2.80) 2-4hrs (£5.00) 4- 24hrs (£6.90)
Wakefield	Fieldhead Hospital The Poplars	Free

13.1.12 Summary of travel Impact

Whilst changing models would lead to a positive impact in terms of transport for some people, all proposed change options models have a negative overall impact on travel.

With a dementia unit in Wakefield (option 2), overall, more people would have to travel further than if the dementia unit were in Dewsbury (options 1 a and b).

In options 1 a) and b) the Dewsbury (W19) dementia model, there are on average 80 people a year who have to travel further than now. In the Wakefield dementia model there would be around 100 people per year, though both would be offset by some people that would have shorter journeys.

Specifically, there is an additional negative impact for all people with dementia travelling from Calderdale. People from Calderdale who would rely on public transport if we had the specialist ward in Wakefield would face particularly long journeys of an average of **100 minutes**.

When considering the 20% most deprived areas, findings highlight:

- Around 25-35 people per year would have further to travel as a result of the changes.
- Around 6 people per year from Calderdale's most deprived areas will have an average **70-minute** public transport journey to Dewsbury (option 1 a and b) and 95 minutes to Wakefield (option 2).

13.1.13 Staff Travel Impact

Staff travel impact will be considered in more detail in the formal consultation process and further in any subsequent staff consultation process that might lead to changes in staff terms and conditions.

Current staff roles are based on generic job descriptions that could apply to both functional and dementia wards. Feedback from informal conversations with staff members suggests that there may be a small proportion of people that would wish to move wards if it changed function. This too will be explored further in consultation.

The Poplars service is proposed to be relocated in any of the shortlisted options. This means there will be a travel impact on the 29 substantive staff (in post in July 2023) that are based on the Poplars wards.

Data based on the home addresses of staff show that on average the Poplars ward is 0.8 miles closer than Fieldhead Hospital from people's home address. 9 staff members would have 7 miles + further to travel to Fieldhead and would be entitled to excess travel support for 4 years. Fewer than 5 people would be between 4-7 miles further and would receive support for 18 months.

This assumes that most staff would wish to relocate to the Fieldhead site regardless of the option eventually taken forward for implementation. The average distance from home to Dewsbury, for example, is further overall than to Fieldhead though it is similar or shorter distance to Dewsbury for around 40% of the staff. So, depending on eventual preferred option and staff preference there could be opportunities for some staff to choose to relocate to Wakefield and others to Dewsbury.

13.1.14 Travel themes and potential mitigations

The table below summarises the themes and potential solutions that were raised in relation to travel impact across the model at the December 2022 workshop:

Themes:	*Possible solutions for travel and transport:*

• The impact of travel for both patients and their carers. • Car parking at Dewsbury and how much consultation has been carried out on patient/carers transport times. • Age of people that need to travel. • Long and complex public transport journeys from parts of the Trust footprint. • Unreliability of public transport. • Needs of differing BAME groups including language and cultural needs. • Impact on services required to support changes across new boundaries (LA, pharmacy). • Implications for people that still need to access the service from Barnsley. • Choice and potential access to beds in another Trust if that is closer. • Supporting people back home when they're admitted outside of their local area.	• Reimbursement of travel costs. • Community transport solutions • Door to door transport solutions • Guidance and help for people finding their way to a new unit. • Buddy systems • Taxi support • Using technology for some virtual contact • Shuttle busses • Integrated discharge from hospital • Using local transport systems in the most appropriate way • Admitting to a neighbouring Trust if closer / more accessible.

As part of the consultation process we want to engage with service users, carers and family to explore what offers are needed to support people to travel to visit and support their family and loved ones. Whilst we would continue to offer the current support to people, options for additional support include:

- Considering a range of potential financial support options
- Working with the VCSE to find transport support options
- Guidance and support for people
- Buddy systems
- Use of technology
- Further exploration of public transport opportunities including shuttle busses
- Exploring a combination of approaches.

Feedback on these will help shape potential solutions and mitigate the impact of any extra travel for any option that we agree to take forward.

13.2 Quality Impact

The quality impact assessment (QIA) is a continuous process to ensure that possible or actual service developments and cost improvement programmes are assessed, the potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way.

South West Yorkshire Partnership Foundation Trust defines quality as the achievement and/or surpassing of best practice standards and there are three key components as follows:

- Safety: The first dimension of Quality must be that we do no harm to people. This means ensuring that the services we provide are safe and that people should not fear harm. We must learn from our mistakes and avoid all errors wherever possible.
- Person Centred: Our services should be provided in a personal way with dignity and respect with the person first and in the centre. This means we need to listen to what people say about what they require and respond appropriately.
- Efficient and Effective: Our services must demonstrate value for money and understand the benefits of the interventions that we undertake to achieve the outcomes that people are asking for. The outcomes need to be real for people who receive our services and for their families.

The quality impact assessment tool has the following ratings and uses prompts against CQC 5 key domains:

RATING	The assessment suggests that 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 QIA has been established from 2018 and updated as additional information has been collected, most recently updated with feedback from the clinical senate and workshops and events in 2022. The table below summarises the assessment:

DOMAIN	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	Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs.	**IMPROVEMENT** ▪ This model delivers separate wards for functional and organic needs. ▪ This is evidence based and recommended by stakeholders and clinical bodies. ▪ It would allow for improvements in environment, specialist staff skills and improve patient experience.		
	The best specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation.	**IMPROVEMENT** ▪ Royal College of Psychiatry highlight the risks that dementia patients can often impact on the therapies of other people by not recognising personal space. ▪ An environment for each specialist group could be modified to better meet the needs of that group e.g., reminiscence areas for dementia.		

DOMAIN	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
		▪ Staff feedback is that space restrictions compound these issues as often it is difficult to get space for therapies that meet the need of only one group.		
	Single Sex Accommodation	**IMPROVEMENT** ▪ Single sex accommodation guidance would be fully met in all these models.		**IMPROVEMENT BUT MITIGATIONS REQUIRED** ▪ Guidance would be fully met but no option for a single gender ward for patients with functional illness.
	Wards sizes close to best practice guidance of 15 beds	**IMPROVEMENT** ▪ Ward sizes between 12-16 beds	**IMPROVEMENT** ▪ Ward sizes between 12-16 beds	**MITIGATIONS REQUIRED** ▪ Ward sizes between 15-22 beds
	Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety.	**IMPROVEMENT** ▪ 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.		
	Staffing to appropriate levels, in line with clinical need to support safety.	**IMPROVEMENT** ▪ Specialist model could improve recruitment and retention of staff. ▪ More staff in model, especially on dementia specialist unit and more qualified nurses on each shift.		**NEUTRAL IMPACT BUT MITIGATIONS REQUIRED** ▪ Similar to other proposed options. ▪ Concern that staff retention and recruitment may be affected by the 22 bedded ward
	Due regard has been fully considered (please refer to Equality Impact Assessment for detail).			
	Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	**IMPROVEMENTS BUT MITIGATIONS REQUIRED** ▪ Specialisation of wards would mean that more patients are likely to be admitted and discharged from wards that are not in the same LA area as their usual residence, although this happens already on our wards to a lesser degree. ▪ Discussions with LA and VCSE partners have not highlighted any major issues with working across boundaries. ▪ General Hospitals have fed back that there are no current plans to change their provision. ▪ Transportation between mental health wards, acute general hospitals and other places of care will remain largely the same but journey times for ambulances/private transport providers will be shorter overall.		
EFFECTIVE	Staff skilled and delivering specialist support based on evidence based best practice and tailored therapeutic care.	**IMPROVEMENT** ▪ Psychology clinical leadership model would be implemented on specialist dementia ward. ▪ The type of supervision, clinical intervention and workforce skills needed for the two groups are quite different. ▪ Targeted approach to a singular client group rather than having to design activity for a number of clinical issues and activities.		
	Same care offer and pathway, ability to quickly stabilise people and facilitate timely discharge.	**IMPROVEMENT** ▪ Patients who need dementia beds will all access the same service, via a single unit. This will improve consistency of care. ▪ Functional pathways will be improved by having specialist functional wards.		
	Stakeholders are involved in design and their input informs decision making.	**IMPROVEMENT** ▪ Will continue to involve and engage via formal consultation process where will listen and use feedback to inform the agreed model. ▪ We have involved service users and staff in this model design		
	Will deliver positive outcomes of care and allow for implementation of evidence-based practice.	**IMPROVEMENT** ▪ 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.		**IMPROVEMENT BUT WITH SOME MITIGATIONS REQUIRED:** ▪ As other options but a 22 bedded ward could have potential impacts on clinical and therapeutic engagement.

DOMAIN	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
	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. ▪ The pathways through the wards should improve as people will generally not be transferred from ward to ward. ▪ The reducing restrictive practice team, pharmacy and other centralised clinical support teams would also be better aligned to wards. ▪ 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.		
	Non-clinical support staff teams and services, across pathways.	**IMPROVEMENT** ▪ Alignment with other trust sites would improve access to estates, domestic, catering and other non clinical services. ▪ Improved access would provide better cover at busy times or in an emergency (such as flooding, or supply chain issues).		
	Patients received the right care at the right time. Pathway delays a minimised as much as possible.	**IMPROVEMENT** ▪ Most patients will stay on the ward they're admitted to until ready to discharge. ▪ 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	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. ▪ Having functional only units means that staff can dedicate their time to people with these needs. ▪ Separate need wards could lead to improvements in physical health care. ▪ Patients with organic disease benefit from a therapeutic environment dedicated solely to their needs.		
	Improvement has been co-produced with patients and carers.	**IMPROVEMENT** ▪ Involved service users and staff in this model design, coproducing via workshops and events. ▪ We have used the feedback to inform the options development.		
RESPON-SIVE	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 will reduce the time it takes to reduce levels of acuity. ▪ 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.		
	Service users in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time.	**IMPROVEMENT** ▪ The programme and changes will lead to various improvements in performance. ▪ 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** ▪ Capacity caps created. ▪ This option appears to have capacity for both organic and functional beds. ▪ Potential challenge of demand surges for male dementia beds. ▪ Mitigations include gender flex areas on ward 19.	**MITIGATION REQUIRED** ▪ Capacity caps created. ▪ This option will mean 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.	**NEUTRAL IMPACT/MITIGATION REQUIRED** ▪ Capacity caps created. ▪ This option may have lower capacity for functional beds but has the right capacity for organic beds. ▪ As 1A, potential challenge of demand surges for male dementia beds and same consideration for gender flex mitigation required.

DOMAIN	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
	The service users, family and carers are able to access the service as needed.	**MITIGATION REQUIRED** ▪ All options involve additional travel impact for family and carers. ▪ All sites in proposed models have good access to other acute sites. ▪ The full Equality Impact Assessment considers any actions required to ensure the new system gives equal access to all. ▪ Mitigations are considered in the business case and will be explored more in a consultation process. ▪ 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.		
	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. ▪ 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. ▪ Equality impacts of travel, including areas of social deprivation are further explored in the EIA.		
	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	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.		
	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.		

For each of the amber ratings we are currently exploring the appropriate mitigations which would negate any negative impact and mean that the overall impact could be neutral or positive, for example, travel support options for carers and family members.

A summary of recommended mitigations are:

All options

- Remodel some ways of working with partner organisations to flex to the new geographic model
- Consider the most appropriate ways to support additional travel for family and carers, particularly those across the protected characteristics.
- Consider how to manage capacity limitations created by each option including:
    - Creation of additional gender flex on the dementia site for options 1A and 1B.
    - Consideration of how to manage the lower overall capacity of functional beds in option 1B
    - Consideration of how to manage the lower overall capacity of dementia beds in option 2.

In addition, there are further specific mitigations required to option 1B. These include:

- Consideration of how to manage functional gender needs as there would be no functional single gender wards in this model.
- Consideration of how to effectively manage the 22 bedded ward in this model and ensure there's not a negative impact on the clinical and therapeutic environment.

The QIA will be updated following further feedback via a consultation process. The full QIA can be found in appendix 7.

13.3 Equality Impact

The equality impact assessment considers who is likely to be diagnosed with organic and functional conditions from local and national research and compares this to who our services support from protected and other groups. The data, insight from our engagements, travel analysis and ward design is then used to determine who may be potentially impacted positively and negatively by the proposed options. The EIA will be used to assure that we are ready to go to consultation as we understand who we need to hear views from.

Following the consultation the EIA will be updated to detail the feedback from equality and other groups to understand what they believe the impacts could be. The EIA will then collate the data, insight and intelligence to identify the mitigations and actions that could be implemented to reduce any potential negative impacts and maximise the positive opportunities to shape services to meet diverse community needs. This will influence the final decision on the chosen option.

Following a comprehensive literature review and Equality Impact Assessment, the impacts and mitigations of the proposed options are as follows:

Options	**Impact**
Option 1a: A dedicated central specialised dementia unit in North Kirklees developed on Ward 19 with additional functional bed capacity adjoined to the existing Wakefield 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. The Wakefield Poplars site would not be in this model.	• Higher capacity for people with dementia who need inpatient support • No ensuite facilities for dementia patients – shared bathing and toilets only • Longer stays for dementia patients may mean visitors paying for parking. • The specialist dementia unit would be geographically central to Calderdale and Wakefield • Single sex ward standards met. • Dewsbury dementia ward and Wakefield functional wards would be single gender, Beechdale in Calderdale would remain mixed gender. • Functional patients' visitors will have to pay for parking in Calderdale. • Proximity to acute general hospital care for functional patients would be co-terminus in Calderdale and via the nearby Pinderfields hospital in Wakefield. • Proximity to acute general hospital care for dementia patients would be co-terminus at the Dewsbury District Hospital site, which would benefit carers, families, loved ones. • Dementia and functional services are currently under represented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food, and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer.

Options	Impact
Option 1b:	• Higher capacity for people with dementia who need inpatient support • No ensuite facilities for dementia patients – shared bathing facilities and toilets only • Longer stays for dementia patients may mean visitors paying for parking. • The specialist dementia unit would be geographically central to Calderdale and Wakefield • Single sex ward standards met. • Dewsbury dementia ward would be single gender, Beechdale in Calderdale and Wakefield would remain mixed gender. • Functional patients' visitors will have to pay for parking in Calderdale. • Proximity to acute general hospital care for functional patients would be co-terminus in Calderdale and via the nearby Pinderfields hospital in Wakefield. • Proximity to acute general hospital care for dementia patients would be co-terminus at the Dewsbury District Hospital site, which would benefit carers, families, loved ones. • Dementia and functional services are currently under represented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food, and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer.
Option 2: Crofton ward in Wakefield, as the dedicated central specialised dementia unit. This would operate as 2 wards with 26 beds in total. Ward 19 in North Kirklees and Beechdale ward in Calderdale would be functional only wards. The Poplars site would not be in this model.	• Higher capacity for people who use services with functional needs, lower dementia capacity. • No en-suite facilities for functional patients on ward 19 – shared bathing and toilets only. Only 2 functional e/s in the whole system at Beechdale. • The specialist dementia unit would be on the east side of the Trust footprint. • Dementia patients would have a single sex ward. • Functional ward would be mixed sex in Calderdale. • Functional patients' visitors will have to pay for parking in Calderdale and Kirklees. • Proximity to acute care for functional patients would be co-terminus. • Proximity to acute care for dementia patients could be either Mid York's which would benefit carers, families, loved ones. • Dementia and functional services are currently underrepresented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food and cultural activities (cooking) and faith rooms.

Options	Impact
	We need the voice and views of this population to help shape the offer. • Greater impact on travel, transport and parking for all localities including 20% most deprived populations.

Protected Group	Option	Mitigations and further insight required
Age • Impact on those under the age of 65 who require care, consideration of activities/environment. • A diverse range of age-appropriate communications in alternative formats • Digital should not the sole means of information /communication/contact • Estates and environment design enable independence and safe and easy access for older people/frailty. • Consideration for sensory impairment – sight and hearing using adaptions to environment/ signage/loop system/large print information	**Option 1a**	• Determine if the options to have no ensuite option for dementia patients has an age implication through consultation.
	Option 1b	• Determine if the options to have no ensuite option for dementia patients has an age implication through consultation.
	Option 2	
	All options	• Identify through consultation any specific age impacts of both options. • Identify visiting times that support working age adults and young people of school age/ students. • There may be opportunity to add several ensuites to Ward 19 in Dewsbury, Kirklees via minor capital works, which would benefit both options.
Gender • Access to same sex clinician/staff, • Tailored activities • Considerations for people who identify as non-binary	**Option 1a**	• Consider how gender specific environments could be supported for functional care for Calderdale residents who may request this option.
	Option 1b	• Consider how gender specific environments could be supported for functional care for Calderdale and Wakefield residents who may request this option.
	Option 2	• Consider how gender specific environments could be supported for functional care for Calderdale residents who may request this option.
	All options	• Attract and ensure a gender mix of staff
Carer • Travel, particularly for older carers and those with other caring responsibilities. • Staff at all units identify and support carers. • Voluntary and other support organisations / community groups that signpost to and support patients around the service. • Visiting times and contact arrangements • Estates facilities for carers	**Option 1a**	• Calderdale carers are the most impacted by parking charges – having to pay to see both dementia and functional patients – identify options to mitigate costs in line with carers coming from Kirklees and Wakefield. • Identify the option to use the Pinderfields/ Pontefract Mid Yorkshire shuttle bus for Wakefield Carers visiting relatives in a functional ward in Dewsbury.
	Option 1b	• Calderdale carers are the most impacted by parking charges – having to pay to see both dementia and functional patients – identify options to mitigate costs in line with carers coming from Kirklees and Wakefield. • Identify the option to use the Pinderfields/ Pontefract Mid Yorkshire shuttle bus for Wakefield Carers visiting relatives in a functional ward in Dewsbury.
	Option 2	• Calderdale carers will have to travel the furthest to visit a patient with dementia – ensure a plan is in place to support the carer with flexible visiting times and access to refreshments and lounge/ waiting areas.
	All options	• Identify visiting times that support carers to visit. • Promote the use of the 'Chatpad' to support contact for carers using a digital device. • Ensure every carer is identified and receives a carers passport. This will help ensure the specific needs of carers are supported.

Race and ethnicity • Addressing barriers of access – culturally appropriate environments, food and activities. • Faith and religious needs considered in built environments and through décor. • Reflective workforce, who are culturally and spiritually competent. • Access to an interpreter and translation materials. • Appropriate toilet facilities and consideration of bathing preferences.	**Option 1a**	• Calderdale patients who for cultural reasons may request a male or female only ward should have their needs considered but will have to travel further for both functional and dementia care. • Having Kirklees as the dementia specialist ward may mean that more considerations to cultural bathing and toileting considerations are needed.
	Option 1b	• All functional patients who for cultural reasons may request a male or female ward will have to be considered on an individual basis as all wards are mixed gender. Wakefield may be able to cohort patients. This means Calderdale patients will have further to travel. • Having Kirklees as the dementia specialist ward may mean that more considerations to cultural bathing and toileting considerations are needed.
	Option 2	• Having Kirklees as a functional ward may mean that more considerations to cultural bathing and toileting considerations are needed. • Calderdale patients who for cultural reasons may request a male or female only ward should have their needs considered, but will have to travel further for both functional and dementia care
	All options	• To maintain and improve the diversity of the workforce in all care settings. • Ensure that the environments reflect the diversity of the 'Trust wide' population rather than the 'place' population.
Gender reassignment • Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors. • Considering environments such as ward allocation, privacy, gender neutral facilities in line with trust policy and additional support through advocacy. • Considering how, for transgender people, how issues surrounding gendered wards can lead to poor experiences of care.	**Option 1a**	• Option to cohort patient needs to be considered in Kirklees for dementia patients and Wakefield for functional patients.
	Option 1b	• Option to cohort patient needs to be considered in Kirklees for dementia patients and Wakefield for functional patients.
	Option 2	• Option to cohort patient needs to be considered in Kirklees for functional patients and Wakefield for dementia patients.
	All options	• Advocacy for transgender patients' needs to be identified. • Need to ensure that the policy for transgender patients forms part of the proposals for service redesign. • Ward allocation would need to consider transgender patients.
Sexual orientation • Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe • Visible symbols (such as the NHS Rainbow Badge, and/or use of badges and lanyards)	**Option 1a**	
	Option 1b	
	Option 2	
	All options	• Maintain Trust wide visibility, staff development and person-centred care planning. • Improve visible symbols of support across all locations
Religion or belief • Access to faith and prayer rooms (including staff) • Ensuring parity of pastoral support for all faiths on inpatient wards	**Option 1a**	
	Option 1b	
	Option 2	
	All options	• Ensure all estates have adequate access and availability of prayer rooms and appropriate pastoral and spiritual support.

Maternity and pregnancy • Managing additional caring responsibilities • Ensuring flexibility for visiting times. • Facilities are accommodating to visitors (for example parent access to changing facilities).	**Option 1a**	
	Option 1b	
	Option 2	
	All options	• Need to understand through consultation the impact of travel and transport/ visiting for parents/ expectant parents. • Ensure all sites have the provision for baby changing and feeding. • Identify options for parking which include parent and child spaces. • Identify visiting times that support parenting responsibilities. • Ensure visiting environments are suitable and can cater for parents/children and expectant parents.

Disability
• Physical access to estates and built environments:
  • Parking bays
  • Access to public transport
  • Ease of access into buildings
  • Visitor areas
  • Accessible toilets
  • Adult changing toilets
• Considering hidden disabilities
• Different types of seating and access:
  • Designated wheelchair seating areas
  • Wider doorways and fewer heavy doors
  • Automatic doors with ramps rather than stairs
• Accessible lifts, signs and reception areas at visible heights
	Option 1a	• Consider the impact of no ensuite facilities for dementia patients in Kirklees as part of the consultation

	Option 1b	• Consider the impact of no ensuite facilities for dementia patients in Kirklees as part of the consultation
	Option 2	• Consider the impact of no ensuite facilities for functional patients in Kirklees as part of the consultation .
	Both options	• Estates and environment can be improved to meet specific needs of patients. • Use the consultation as an opportunity to look at access to accessible car parking. • Consideration for additional travel and access to suitable transport/ location of public transport.

The recommendations following from the EIA are as follows:

- Ensure the consultation reaches the identified audience impacted and can evidence the sample group is reflective of each protected group.
- Ensure the consultation responses are analysed by each protected group and any differential impact is highlighted, considered, and conscientiously considered with impacts mitigated and/or addressed.
- That the questions that are asked in consultation can ensure that responses inform the mitigations.
- That single sex accommodation is considered in future estates planning for both dementia and functional patients. This highlights the benefits of designing gender flex into the system, particularly for functional needs.
- That solutions for travel, transport and parking address the geographical impacts for populations, particularly those from the 20% most deprived postcodes.

More detailed information can be found in the EIA.

13.4 Sustainability Impact

We are fully aware that it is important to consider the possible sustainability impacts which could result from the proposed options for organisational change. Our Trust is taking a strategic approach to the environment supported by our Social Responsibility and Sustainability (SRS) strategy, our Trust Green Plan and the Estates strategy.

The NHS and government are signed up to the goal of being carbon neutral by 2040 in terms of directly controlled emissions which does cover the estate. There is an interim target for a reduction in emissions by 80% by 2028-32. SWYPFT has performed well in terms of this target to date. This has been achieved through both investment in estate and reduction in overall estate footprint.

The next stage of the reduction will require a more targeted approach to reducing carbon through reduction in use and elimination of heating from fossil fuels and continuing to use electricity exclusively supplied from renewable sources.

As part of our overall approach we will closely monitor our environmental impact and make every effort to take opportunities to reduce carbon emission and promote a sustainable approach wherever possible, so it becomes embedded in the fabric of the organisation. The commitment to this at board level and throughout the Trust, can be illustrated by the adoption of social responsibility and sustainability as one of our 3 named golden thread priority areas of focus for 2023 -24.

The Trust sustainability strategy 3 key areas are:

1. Reducing our environmental impact – We will strive to reduce our carbon footprint, energy consumption and waste generation across our estate. We will also work towards sustainable procurement and travel and promote biodiversity and green spaces.
2. Promoting social responsibility – We will work towards enhancing the health and wellbeing of our staff, patients, and local communities. We will also strive to promote diversity, inclusion, and equality, and support local economic development.
3. Embedding sustainability in our operations – We will integrate sustainability principles into our decision-making processes and ensure that sustainability is a key consideration in all our operations.

As part of the commitment to this strategy, SWYPFT is developing a new estates strategy that reflects the sustainability goals. The strategy focusses on reducing the environmental impact, including:

- Improving the energy efficiency of our buildings and equipment
- Reducing waste generation through better waste management practices
- Ensuring that all new buildings and refurbishments meet sustainability standards.

Delivery of estate to support the preferred option from the outcome of the consultation is a key objective of the Estates strategy.

Utilising the recommended sustainability impact assessment provided by West Yorkshire ICB sustainability lead, there has been scrutiny of on the potential impact of the options for this transformation, and it was found that in the long term there will be a positive change in the way we use our buildings, I.T. and pharmacy.

Work is also already well underway to reduce waste created by the Trust via initiatives such as the setting up of the Waste and Repurposing group and the specific targeting of food waste where we have already seen good progress. To use this as an opportunity for positive improvement, we will be looking at areas such as improving menus choices to patients including a supported increase in healthier locally sourced foods. This has the potential to both improve health and well-being and reduce overall carbon emissions through a decrease in high carbon foods as well as reductions in carbon emissions from buying locally sourced products wherever possible.

Another listed measure for the SRS strategy is the focus on improved medication reviews. Following a structured approach from the pharmacy team. The Trust is already seeing improvements in the form of an increase in the number of medications reviews by pharmacists which has led to a reduction in over-prescribed medicines which will have a positive impact for all inpatient services including the older people's wards.

It is recognised that for relatively small numbers of service users, families and carers, there will be changes to current travel and transport arrangements with limited numbers of people finding they will need to travel further. We will however be making every effort to mitigate effects by actively developing the aims of the SRS strategy, Green Plan and Estates strategy.

This will include working with local partners to develop and implement active travel plans, introducing extensive low energy lighting in all Trust areas, and increasing the use of renewable energy through exploring sources such as solar energy and geothermal energy from mines.

There will be a travel and transport impact as follows:

- Option 1 (a and b): approximately 27 people per year admitted further away from home (net increase)
- Option 2: Approximately 46 people year admitted further away from home (net increase)

The impact will be as a result of people needing to travel further to visit family and loved ones.

Below is a summary of the impacts of the transformation:

- Buildings – positive
- Technology – positive
- Transport – negative
- Pharmaceuticals – positive
- Waste – positive

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative (Click on box to see prompts)	Positive Impact	Neutral Impact	Negative Impact
Technology	☑	☐	☐
Pharmaceuticals	☑	☐	☐
Transport	☐	☐	☑
Supply/Purchasing	☐	☑	☐
Waste	☑	☐	☐
Green economy	☐	☑	☐
Climate Change*	☐	☑	☐
Air Qualty	☐	☑	☐
Housing	☐	☑	☐
Green economy	☐	☑	☐
Building: retrofit	☑	☐	☐
Buildings: new	☐	☑	☐
Energy (inc heat)	☐	☑	☐
Green clinical pathways	☐	☐	☐
Green social prescribing	☐	☑	☐
Green social care	☐	☐	☐
Green space	☐	☑	☐
Other (please state below):			
Climate Change	☐	☑	☐

More details can be found in appendix 8. You can read more about the aims and commitments by accessing the Social Responsibility strategy, Trust Green Plan and Estates strategy by following these links: https://www.southwestyorkshire.nhs.uk/about-us-2/performance/social-responsibility-and-sustainability-strategy/

13.5 Place Impact

Calderdale

Current Challenges:

There are numerous challenges with the Beechdale ward which mean that managing the mix of people with dementia and functional needs does regularly have a negative impact on the experience of the stay. All places have the challenges of managing the mixed needs but these are increased in Calderdale because of ward environment.

The data reviewed in the business case also shows that in recent years around 40 people from Calderdale have been admitted outside of their local area, though the recent implementation of an intensive support team (IST) is having a positive impact on admission rates and therefore reducing the number of people admitted outside of Calderdale.

People from Calderdale are having long stays, particularly people with dementia.

Impacts:

All options mean that Beechdale would become a functional only ward and whilst the environment wouldn't change, feedback is that it would be much better to only manage people with functional needs on the ward.

We would expect most people with functional needs to be admitted to the Beechdale ward and these make up around 60% of the bed use. This means that around 60% of people from Calderdale would still be admitted locally. That environment would be the same as it is now, and whilst issues such as line of sight in the ward cannot be fixed, the patient group will benefit considerably by the specialism of functional only.

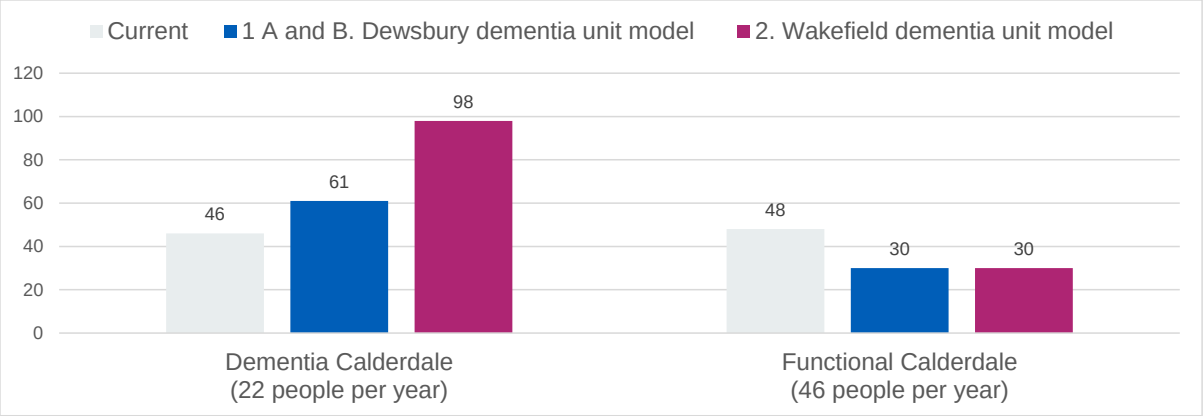
Around 40% of people requiring an inpatient stay from Calderdale will do so because of dementia and they will be admitted elsewhere in the proposals.

In options 1a and b, around 20 people per year with dementia will stay in Dewsbury and in option 2, those people would stay in Wakefield.

Because of the current people travelling outside of the locality, the overall travel impact of people in Calderdale is more limited.

The charts below show the travel time impact based on average public transport journeys for both dementia and functional admissions.

To note: the charts show the average public transport time of journey in minutes, the white bar being the current time, the blue bar being the average time expected for options 1a and b, and the purple bar being the expected journey time for option 2.



A key difference between options is the extra travel time required for people with dementia, who will have a longer journey to Wakefield.

For any option there will be limited impact on advocacy but it will mean that SWYPFT teams and local partners will need to adjust their ways of working to facilitate and support discharge across place based boundaries. Social care, for example, is more likely to be involved in facilitating discharge of people with dementia. So, similarly to service users, there will be extra travel impact for staff, with this being greater with option 2.

In any option, service users will gain all of the benefits identified in the quality impact assessment including the right staffing levels, skills and therapeutic environment to meet their needs and this will be a significant improvement on the offer that people have any mixed needs environment and especially on Beechdale.

Everyone would benefit from having just one inpatient stay in the new model and not being moved wards in their stay. This, with a well-resourced specialist focussed model should support reducing lengths of stays on the wards.

Kirklees

Current Challenges:

As with all places, people from Kirklees will face the challenges associated with the mixed needs wards. Kirklees has a small but not insignificant number of people that are admitted outside of the locality or move as part of their inpatient stay. Length of stay (LOS) has been increasing in recent years and Kirklees has had the highest functional LOS each year from 2020 onwards.

Impacts:

All people from Kirklees will benefit from the establishment of the specialist model. In any option service users will gain all of the benefits identified in the quality impact assessment including the right staffing levels, skills and therapeutic environment to meet their needs and this will be a significant improvement on the offer that people have in any mixed needs environment.

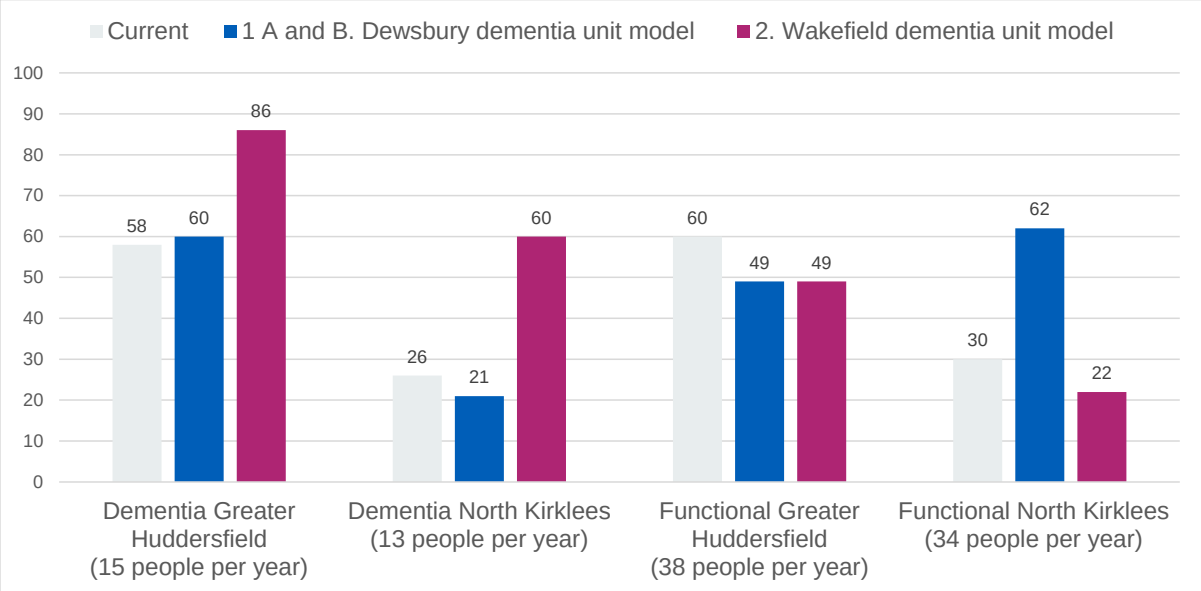
In option 1a and b functional service users will be admitted outside of Kirklees. People from North Kirklees would likely be admitted to Wakefield which would be further away than Dewsbury in the current model. People from Greater Huddersfield would be admitted to Calderdale, which, on average is a similar distance from Dewsbury where people are likely to be admitted in the current model. Because both options include more functional beds in Wakefield than Calderdale, it is possible that some people will require admissions into Wakefield.

People with dementia will be admitted locally.

The charts below show the public transport impact. It assumes that people from Greater Huddersfield are admitted to Calderdale and shows the biggest impact is on the functional stays from North Kirklees, which impact around 35 people per year who would have around an hour public transport journey to Wakefield:

In option 2, people with functional needs will be admitted locally but people with dementia will be admitted to Wakefield. This means that approximately 16 people per year from Greater Huddersfield would have an 85 minute journey on average, whilst around 15 people per year from North Kirklees would have an hour journey.

To note: the charts show the average public transport time of journey in minutes, the white bar being the current time, the blue bar being the average time expected for options 1a and b, and the purple bar being the expected journey time for option 2.



For any option there will be limited impact on advocacy but it will mean that SWYPFT teams and local partners will need to adjust their ways of working to facilitate and support discharge across place based boundaries. Social care, for example, is more likely to be involved in facilitating discharge of people with dementia. So, there might be slightly greater impact of social care working across to Wakefield rather than into North Kirklees.

Everyone would benefit from having just one inpatient stay in the new model and not being moved wards in their stay, which will also support reduced lengths of stay.

Wakefield

Current Challenges:

As with all places, people from Wakefield will face the challenges associated with the mixed needs ward at Crofton but because of the Poplars ward for people with dementia, the Wakefield system does face a slightly different set of challenges.

Due to the isolation of the Poplars ward it cannot accept direct admissions and cannot accept admissions of people that are acutely unwell.

This means that the most unwell people with dementia in Wakefield are likely to be on the Crofton ward, mixing with the people with functional needs. When people with dementia become less acutely unwell, but still unwell, they will be transferred to the Poplars ward. We know that moving people unnecessarily isn't good for people with dementia.

At Poplars the Trust is then managing the ongoing risks of the site isolation, including challenges of nursing and medical cover and distance from the acute general hospital. As a result, we know the site finds it difficult to manage -high volumes of people or when acuity increases.

Over recent years the LOS of people with dementia has typically been higher than anywhere else on the Trust footprint.

Impacts:

All people from Wakefield will benefit from the establishment of the specialist model. In any option service users will gain all of the benefits identified in the quality impact assessment including the right staffing levels, skills and therapeutic environment to meet their needs and this will be a significant improvement on the offer that people have in any mixed needs environment.

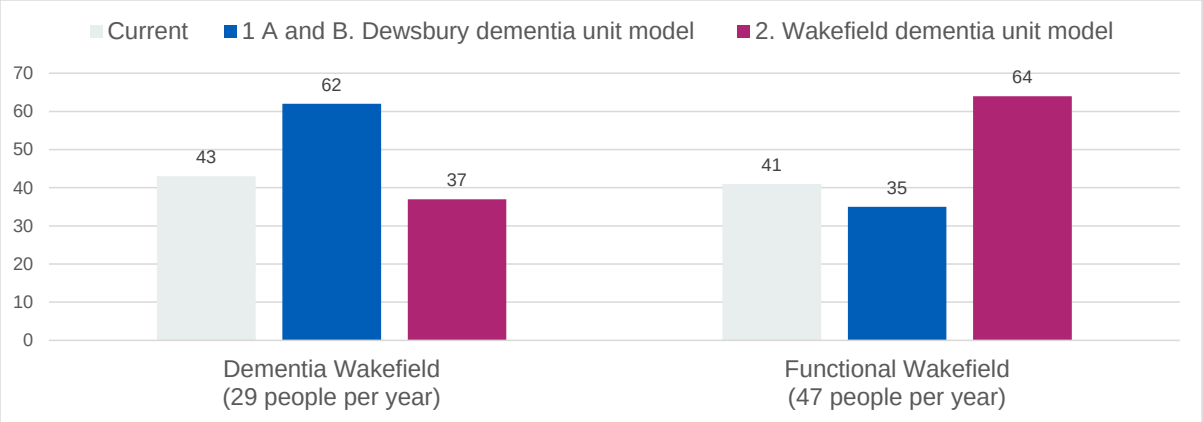
People with dementia will only have one ward stay and this will be on a better environment, aligned to other mental health inpatient wards and closely aligned with acute general hospital.

There will be a travel impact of both options, with either people with functional needs or dementia being admitted to Dewsbury, depending on which option is preferred.

Travel impact of options 1a and b, around 30 people per year would have a greater journey to Dewsbury.

Travel impact of option 2 around 50 people per year with functional needs would have greater journeys to Dewsbury.

To note: the charts show the average public transport time of journey in minutes, the white bar being the current time, the blue bar being the average time expected for options 1a and b, and the purple bar being the expected journey time for option 2.



For any option there will be limited impact on advocacy but it will mean that SWYPFT teams and local partners will need to adjust their ways of working to facilitate and support discharge across place based boundaries.

13.6 Summary options matrices including mitigations from impact assessments:

	Quality Domains				Total quality score	Value for Money	Total	Capital Required (£million)	Revenue (£million per annum)	Quality/ Equality Impacts
	Quality (clinical)	Access	Deliverability Sustainability	Strategy alignment						
Weight	30	20	10	10	70	30	100			
No change	12	8	2.5	4	26.5	21.6	48.1	£8.8 (moving poplars ward only)	£7.0 (budget) £8.1 (actual)	Only Poplars ward is a specialist ward, all other wards are mixed dementia/functional. Concerns raised about environment for dementia at Beechdale not addressed. Alignment with local partners, clinical and support services only possible if Poplars ward is moved to Crofton.
W19 dementia unit, 6 extra beds at Crofton	15	8	4	5	32	25.2	57.2	£5.5	£8.2	Separate specialist wards are evidence based and recommended by clinical bodies to improve quality and patient experience. 22 bed ward at Crofton above national guidance Alignment with local partners, clinical and support services. Some increased travel distance/time for visitors.
W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale	18	6	2.5	4	32.5	22.8	53.3	-	-	Discounted option due to deliverability and issues with capacity in this model.
W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards)	21	14	6	8	49	20.4	69.4	£8.1	£9.1	Separate specialist wards are evidence based and recommended by clinical bodies to improve quality and patient experience. Alignment with local partners, clinical and support services. Some increased travel distance/time for visitors.
Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	44	20.4	64.4	£8.1	£9.3	Separate specialist wards are evidence based and recommended by clinical bodies to improve quality and patient experience. Alignment with local partners, clinical and support services. Some increased travel distance/time for visitors, Calderdale dementia with a larger travel impact.

Option	Travel and Transport	Quality Impact	Equality Impacts	Sustainability Impacts
1 a)	All options: Reimbursement of travel costs. Community transport solutions Door to door transport solutions Guidance and help for people finding their way to a new unit. Buddy systems Taxi support Using technology for some virtual contact Shuttle busses Integrated discharge from hospital Using local transport systems in the most appropriate way Admitting to a neighbouring Trust if closer / more accessible.	Remodel some ways of working with partner organisations to flex to the new geographic model Lack of gender flex – consider creation of additional gender flex on the dementia site	Higher capacity for people with dementia who need inpatient support. No ensuite facilities for dementia patients – shared bathing and toilets only Single sex ward standards met. Ward 19 and Crofton single sex; Beechdale remains mixed sex. Consider travel solutions, particularly for people in the 20% most deprived postcodes.	All Options: Use of technology to support video calls and reduce travel impact. Green travel opportunities.
1 b)		Remodel some ways of working with partner organisations to flex to the new geographic model Lack of gender flex – consider creation of additional gender flex on the dementia site Consideration of how to manage the lower overall capacity of functional beds Consideration of how to manage functional gender needs as there would be no functional single gender wards in this model. Consideration of how to effectively manage the 22 bedded ward in this model and ensure there's not a negative impact on the clinical and therapeutic environment	Higher capacity for people with dementia who need inpatient support, lower functional capacity. No ensuite facilities for dementia patients – shared bathing facilities and toilets only Single sex ward standards met., though Beechdale in Calderdale and Crofton in Wakefield would remain mixed gender. Consider travel solutions, particularly for people in the 20% most deprived postcodes.	
2		Remodel some ways of working with partner organisations to flex to the new geographic model Lower capacity of dementia beds - consideration of how to manage the lower overall capacity of dementia beds	Higher capacity for people who use services with functional needs, lower dementia capacity. No en-suite facilities for functional patients on ward 19 – shared bathing and toilets only. Only 2 functional e/s in the whole system at Beechdale. The specialist dementia unit would be on the east side of the Trust footprint. Consider travel solutions, particularly for people in the 20% most deprived postcodes. Dementia patients would have a single sex ward. Functional ward would be mixed sex in Calderdale.	

14 Assurance

14.1 Summary feedback from clinical senate

As covered in the options section, in summer 2022 the programme worked with the clinical senate to review the long-list of options and test which ones were clinically viable. 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. The senate found the following:

- The clinical senate were fully supportive of proposals, and “strongly concurs that patients with functional and organic disease should be cared for in separate distinct dedicated units”.
- The Trust were “commended on the way in which they have developed options to significantly improve the care of older adults with both organic and functional mental health needs”.
- “The clinical senate commends the immense amount of work done over the years and that the programme team has worked hard at the Older Person’s Services programme”.
- The review panel was “impressed by the commitment and enthusiasm shown by so many of the staff in all the current inpatient units”.
- They also found that maintaining the current model is not a viable option.

The options that we now plan to take to consultation are the options that were recommended by the senate, with their recommendation to explore an option with Crofton ward as a dementia unit.

14.2 Testing the options

In October 2022 a workshop was held with a range of partners for Barnsley, Calderdale, Kirklees, and Wakefield. The workshop was initially targeted specifically at health and social care staff across the Trust footprint.

The workshop, held on Microsoft Teams, was attended by 50 health and social care staff from Barnsley, Calderdale, Kirklees, and Wakefield.

The workshop focused on the steps we took and the information we considered when developing the options. We also presented feedback from the clinical senate who provided insight on viability of each option. All options that had been considered were presented during the workshop, alongside how we scored and appraised each model.

Staff were asked to consider the process we took, the options presented and the feedback from the clinical senate. Following a presentation, staff were divided into six breakout rooms to discuss and feedback on three questions:

- Your thoughts on the proposals?
- Is there anything we should have/need to consider?

- Any other comments?

Following the discussion and feedback, we identified the following key themes:

Theme 1: Consider the travel impact of all options, factoring in cost-of-living challenges and using travel impact analysis which should include travel by car and public transport.

Theme 2: Ensure we address inequalities identified through the equality impact assessment in the development of options. This includes the impact on people who use services staff and carers.

Theme 3: Consider flow and length of stay by considering potential solutions which enable a reduced length of stay and consider other developments which could support this ambition, such as step-down facilities.

Theme 4: Consider the impact on staff of the potential changes and ensure that staff are fully engaged in the process and are consulted on the changes. It is important that staff feel involved in the process and can deliver the proposed approach solving any current staffing pressures.

Theme 5: Consider the additional option to centralise specialist services in Wakefield - Following feedback from clinical senate and discussions which took place at the workshop it is evident that the Trust need to option appraise centralising specialist services on the Wakefield site.

Theme 6: Describe what the Trust mean by re-purposing Poplars in the proposed options so that we are able to articulate this clearly to key stakeholders and the public.

Theme 7: The length of time since engagement should be considered and the Trust need to make sure that any gaps in information or target audience is picked up in consultation.

A full summary of feedback from the workshop can be found on the Trust Website: Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust

In December 2022 a wider event was held. The aim of the event was to listen to feedback from a wider group of partners, build on previous engagement, provide an opportunity for our key stakeholders and partners to contribute to the options for proposed models, and further inform our approach ahead of a potential consultation.

At the event we presented more detail on the work that has been done to date on the proposed models, including clinical considerations, engagement activity and equality. The workshop was attended, in total, by 67 people. There were 2 breakout discussions and people were divided into 6 smaller mixed groups, each group had a facilitator and scribe

Themes

Theme 1: Clinical Model - General agreement across several group discussions that a change is needed. Separating the services out and having a specialist dementia ward and the staffing was seen as positive dependent on the correct staff numbers with the right training and skill being in place. The change would provide better outcomes for patients and doing nothing was not seen as an option.

Theme 2: Use of estates – Several groups discussed the inpatient estate and there was a general view that Ward 19 would work better as a dementia ward in the model than Crofton. Overall, the ward environment of Ward 19 lends itself more to being a site for dementia due to design, layout and use of space. More work would be required on the site to further improve the environment, though some improvement activity is already taking place. Need to consider spaces for families particularly for patients nearing end of life.

Theme 3: Bed numbers and ward sizes - The number of beds and ward sizes within the proposed model and how capacity will be managed. Ensuring the model is still fit for purpose in 10 years, given the predicted population increase.

Theme 4: The Poplars – Most people felt Poplars should not be part of the proposed acute model but could be used in other ways to support people. The future use of the Poplars site needed to be clearly articulated as there are several identified potential uses.

Theme 5: Barnsley patients – how Barnsley patients would be accommodated in the model, given that some patients are currently admitted to West Yorkshire, needs to be described. Also, to clearly articulate why there is no impact for Barnsley public in the consultation.

Theme 6: Alignment with other services – Need to ensure that the proposed options align with the wider systems including both SWYPFT teams and partner organisations that will need to work in new ways and across boundaries to support a different model.

Theme 7: Workforce – Need to consider the workforce implications for all proposed options including staffing to the right levels, roles, staff specialist skills for each group but not losing overall old age specialism. The workforce model needs to be clearly articulated for each option to ensure that the workforce implications can be considered fully.

Theme 8: Travel, transport, and parking - The impact of travel, transport and parking for both patients, carers, families, loved ones and staff should be considered. This includes transport times and aligning with visiting, the age of people travelling (including access) and the frequency and reliability of transport networks. Transport during discharge should also be considered if the patient is out of their local area.

A full summary of feedback from the event can be found on the Trust Website: Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust

The **options review workshop and follow up activity in 2023** further tested the options and did so in a clinically led way that was also supported by a range of stakeholders. This work took place with the purpose of reviewing the options with a wide range of stakeholders, with the evidence that has been gathered and make sure they're the right ones to take into consultation.

It aimed to provide a check and balance for the options we've developed and scored and can update the case for change which we will use for consultation.

The review workshop was attended by a range of stakeholders (33 people in total) across a range of organisations and disciplines.

The outputs from the work were the final recommended options to take to consultation and also the assurance that within the scope and constraints of the programme that the most appropriate options are the ones that are being taken into the public consultation.

14.3 SWYPFT Trust Board

At Trust Board of 31st October 2023, it was RESOLVED to AGREE to progress the business case for use in a formal public consultation and to endorse the financial planning to achieve the options proposed.

14.4 Joint Health Overview and Scrutiny

The Joint Health Overview and Scrutiny Committee met on 27 November 2023 and reviewed the process to reach the shortlist of options and the plan for consultation. They supported the continuation into public consultation and have since reviewed the draft consultation document and other material.

We have agreed to provide monthly updates to the committee through the consultation process and agreed that committee members form part of the midpoint review.

14.5 ICB Joint Committee

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.

14.6 NHSE Assurance

A letter has been received from NHSE on Tuesday 5 December 2023, in which the NHSE NE&Y Regional Director confirms that they are satisfied that sufficient assurances have been obtained at this stage to support the need for the proposals to move to the next phase of the change process.

The letter states that a clear case for change has been demonstrated by the programme team and NHSE recognises the clinical quality and experience challenges posed by the mixed-needs nature of the current five older people's inpatient wards. It is evident that the Trust is fast becoming an outlier in maintaining this model and the system has demonstrated that the proposals stand to enhance staff specialist skills and improved ward environments for patients, likely to lead to less pharmaceutical intervention, fewer ward transfers and shorter lengths of stay.

The programme has demonstrated:

- A strong partnership approach to the development of the proposals with support across both provider and commissioner organisations;
- Clinical support for the proposed care model from the Northern Clinical Senate which advocates a model that separates out functional and organic care;
- Consideration of the views of the Yorkshire and the Humber Clinical Network for Mental Health and reflection of the network's feedback in the change proposals and process;
- Significant work to harness the lived experience of service users and carers, as well as the views of staff and wider stakeholders, which has informed both the proposals and the criteria against which these have been assessed, with more recent involvement activity undertaken to sense-check the relevancy of previous feedback whilst being mindful of maintaining a trauma-informed approach;

- Capacity and demand modelling that has considered relevant best and worst case scenarios, with tolerances built in accordingly, and enhancements to community mental health services (as part of the first phase of the mental health service review) and work with Primary Care Network integration underway to further support reduced admissions and length of stay and substantiate the small potential bed reduction;
- Learning from other Trust inpatient clinical models and configurations has been harnessed as part of the service review process;
- Due regard has been paid to statutory responsibilities with an iterative equality impact assessment in place that encompasses health inequalities and is aligned to engagement and consultation planning; a sustainability impact assessment and a travel and transport impact assessment;
- A consultation plan which sets out a clear understanding of stakeholders and aligned communications and consultation approaches;

Evidence supplied suggests that the best practice service change checks and the following five tests for service change3 (where applicable) have been proportionately satisfied, given available information at this stage of the change process:

- Test 1 – Strong patient & public engagement
- Test 2 – Consistent with choice
- Test 3 – Clinical evidence base
- Test 4 – Support of GP commissioners
- Test 5 – Hospital bed-based reduction

This is subject to certain conditions being met, including receiving written support for proposals from the system MHLD&A provider collaborative and system MH&LDA programme board; including evidence of system prioritisation for the capital expenditure, given other potentially competing MH capital programmes within WY, together with an impact assessment on other mental health priorities requiring funding from the system CDEL allocation.

Other caveats included information being used in the consultation document, consideration of political and legal risks aligned to decision making timeline and incorporating independent support in the review of findings of a public, which have been considered by the programme board and addressed as appropriate.

The letter is appendix 9.

A summary of how the programme has met the 5 tests can be found in appendix 10.

14.7 ICB System Prioritisation

In December 2023 the West Yorkshire ICB issued a letter setting out their support for the programme.

It set out that West Yorkshire ICB has discussed the Older Peoples Mental transformation programme through the WY MHLDA Partnership Board, the WY Older Peoples Mental Health network and through the ICB Transformation Committee. As part of these West Yorkshire discussions, the formal governance routes have been agreed, in line with the West Yorkshire Integrated Care Board Constitution which is supported by a Governance Handbook (adopted by the WYICB Board on 1 July 2022).

Also, that the West Yorkshire ICB is entirely supportive of the process being undertaken, the governance in place and the systems commitment to strategically prioritise both capital and revenue expenditures, across the affected places that will drive meaningful improvements that positively impact the lives of those accessing older peoples' mental health care services.

This letter can be found in appendix 11.

15 Consultation and decision making

A draft consultation plan now exists which describes the process for which we will consult on changes to older people's mental health inpatient services. It describes the options and scope of the consultation including the approach we will take to deliver the consultation process. It also describes the scope of the communication collateral and the process for ensuring due regard to equality is demonstrated throughout the process.

The key audiences and communities for this consultation will be:

- All older people who are currently using mental health services in Calderdale, Kirklees, and Wakefield
- Families, relatives, and carers of people who are currently using older people mental health services
- Voluntary and community groups representing, supporting or advocating for older people, carers and families
- Staff working in older people mental health services from all health and social care sectors including hospital, community, and primary care
- Key NHS partners and stakeholders with a stake or interest in older people services
- People who are identified as future service users

As part of our equality duty, we will ensure we consider equality and diversity at each stage in the consultation process. What this means in practice is that this we will consider equality in the development of our plan to ensure we reach people identified in the target audience using an equality impact assessment. We will ensure that we have a representative view which reflects the communities we serve so that we can make fair and informed decisions for everyone.

We will use the following principles which set out our partnership approach to consulting people:

- We will use what we already know as a starting point.
- The consultation will be supported by **clear information** and opportunities for **communication,** so people feel informed and able to participate.
- We will ensure that we consult the right people at the right time in the **development and design** of services.
- We will ensure we are fully **inclusive** in our consultation approach.
- We will be **honest and transparent in our approach** which will include being honest about what people can and can't influence and the reasons why.
- For the things people can influence we will provide **a genuine opportunity for consultation.** This will include providing the right conditions for people to get involved.

- The views gathered will be properly **documented** so people can see the information they have provided and feel confident that it is gathered in such a way that it can inform a decision on future services.
- We will thank people for their contribution and **provide feedback** on our next steps.
- That we keep people **informed and in the loop** by providing a communication platform which everyone can access.

The aim of our communications approach is to provide clear and timely information to our wide range of stakeholders, helping to build awareness, understanding, and encourage engagement at every stage of the consultation process.

Our communication objectives are to:

- Be respectful, honest, open and transparent.
- Work with our partners and stakeholders to ensure a broad and relevant reach across our geographical locations, particularly amongst those groups who are typically under-represented.
- Produce clear, concise, and accessible information available in a range of formats.
- Proactively inform, involve and engage our stakeholders at each stage.
- Inform, engage and support our staff through each stage, and encourage them to give feedback.
- Make appropriate connection to other transformation work which may be happening in other health and social care organisations.
- Make it easy for people to give their views.
- Keep people informed and up to date, in a timely manner, on the progress and outcome of the consultation.

The consultation plan sets out in further detail our communication outputs to support the delivery of the consultation; how we will involve our staff and stakeholders in the development of our communications to ensure they are clear, cohesive and accessible; the feedback channels we will use to make it easy for people to give their feedback; our communication channels; media protocol and evaluation methods.

All responses to the consultation will be equality monitored to assess how representative the views are which have been gathered during the consultation process. Following the consultation all the feedback generated including equality monitoring will be analysed and a report of findings will be developed.

The report of findings will be used to inform the development of the decision-making business case.

We have fully considered and taken into account the pre-election guidance and criteria for running a public consultation. The programme team will work with overview and scrutiny to ensure that consultation is launched and runs in accordance with required pre-election timing. We'll ensure that any newly elected members are fully briefed post-election as part of the decision-making process.

The table below sets out the consultation and decision-making timeline:

Process	Action	Timeline
Prepare for formal consultation process	Preparation and planning for Consultation including a review of engagement and EIA documents and stakeholder mapping	Completed by end November 2023
	Develop a draft consultation plan, including consultation mandate, document and survey which articulates the proposals to be formally consulted on	
	Share draft consultation plan and collateral with the NHS West Yorkshire ICB and NHSE for comment and assurance	
	Following NHS West Yorkshire ICB/NHSE approval share the consultation plan and collateral with the Overview and Scrutiny Committee for any final comments and considerations	
Preparing for launch	Develop collateral required to deliver formal consultation	December 2023
Consultation Launch and delivery	Website updated with consultation materials, consultation in the public domain	Friday 5 January 2024
	Consultation (12 weeks) – will include clinical support to front conversations with resources to support/ social media and media publicity maintained throughout	5 January – 29 March 2024
Consultation assurance	Mid-point review of reach – approach adjusted if required The membership of the midpoint review is as follows: • Independent chair – Huddersfield University/ CSU • ICB Equality lead • ICB Communication leads • ICB Engagement leads • Healthwatch in each place • Local councillor from each place • SWYPFT governor and elected members in each place	6 weeks into consultation
Post consultation	Report of findings on consultation including equality section. EIA updated	19 April 24

	Report of findings and EIA shared with NHS West Yorkshire ICB Briefing and report findings to OSC for comment and assurance	3 May 24 ASAP in mid-May following elections
Deliberation	Internal deliberation of the findings from consultation and EIA – including feedback from NHS West Yorkshire ICB and OSC	June 2024
Decision	Business case updated for decision.	July 2024

Scrutiny officers have informed the programme team that there is a small number of scrutiny members that are due for re-election in May 2024 but that the **overall risk to the process is low.**

The timeline above allows time to brief scrutiny members post-election with findings from the consultation prior to deliberations and decision taking.

The timeline above would work with a general election at the same time as local elections. The plan also allows enough time after local elections to take a decision, should the general election be in Autumn 2024 (or afterwards).

The plan will need to flex should a general election happen at any other time.

The programme team will continue to monitor risks in relation to local and national elections and legal risks.

A copy of the full consultation plan can be found as appendix 12.

16 Implementing the proposals

A high-level timeline and actions required for implementing a new model is set out below, which will be planned in more detail as the decision-making business case is being established.

Process	Action	Timeline	
Post consultation	Start detailed planning of the agreed option(s)	Summer 2024	12 months
Start Estates work	• Planning permission for work at Crofton (as required on any proposed option) and detailed estates project plan. • The designated Dementia ward – moving toward creating a dementia friendly environment. • Extra beds at Crofton Fieldhead • Start process for closure of service at Poplars	Early 2024 Summer 2024 Start work late 2024/25 financial year and finish work early 25/26	
Start consultation process for staff impacted in Wakefield	• Start to plan staff consultation process. • Hold staff consultation process (ASAP after decision)	Summer 2024 Late summer / Autumn 2024	6 months
Start recruitment	• Develop plan for International and student recruitment • Commence recruitment • Gradual increasing of dedicated workforce on specialist dementia site • Staff induction / training	Summer 2024 Winter- Spring 2024 / 25 Winter 2024/25 to Spring 2025	12 months
Initial phase (pre completion of building work)	• Some gradual realignment of admissions (based on safe staffing levels on each ward) • Undertake learning needs analysis for staff • managed gradual reduction in Poplar's patient numbers by: ○ considering where each patient is on their individual journey stay on current ward or if appropriate move to dementia ward or Poplars– staff to actively work with community teams to discharge people ○ considering short term use of Barnsley spot purchase budget for Out of area dementia patients ○ agreeing a day to cease new admissions to Poplars ward ○ targeted activity to discharge people from Poplars before move to new site	Early 2025 onwards	6 months
Phase 2 move to new site	• All admissions go to relevant ward • Continuing review to ensure safe staffing and appropriate mix on ward	Summer 2025	

	• Staff and any remaining patients in Poplars move (decision made on whether people move to dementia ward or to the new Crofton ward) • Induct staff onto the new ward • Implement training/learning needs analysis		

17 List of Appendices

1. Site Visits and Learning from others
2. Options Review Workshop
3. Clinical Senate Report
4. Alignment with strategies
5. Estates Capital and Building work
6. Detailed Travel and Transport Impact
7. Quality Impact Assessment
8. Sustainability Impact Assessment
9. Letter Outcome of NHSE stage 2 service change assurance review
10. NHSE Stage 2 Assurance Review – 5 Tests
11. WY ICB Final Supporting Statement for CKW OPMH programme
12. OPS Transformation Consultation Plan
13. Glossary
14. References

Further information on engagement through the programme, including the EIA, is or will be published via the following link:

Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust