Older People's Inpatient Transformation Programme
Decision Making Business Case

October 2024

In partnership with:
South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

1 Executive Summary

1.1 The need for change and the aims of the report

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides community, mental health and learning disability services to 1.22m people across Barnsley, Calderdale, Kirklees and Wakefield. These include mental health services for older people. Following improvements to community services the focus of this programme is on making changes and improvements to the inpatient service.

There is a compelling need to change this part of the system:

- 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.
- 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.
- In the current model services are run from an isolated site in the Wakefield district, which means risks need to be mitigated on an ongoing basis to keep the service safe.

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.

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. Most other Trusts already work in this way.

An additional benefit of a transformed service is that all options align hospital wards to other acute mental health hospital sites and reduce the risks of the isolated site.

Our pre-consultation business case explored multiple options for creating a specialist service which gives older people the most appropriate evidence based and best practice inpatient care to a high standard.

The scope of the programme is the wards in Calderdale, Kirklees and Wakefield as Barnsley operates the only exclusive functional ward on the Trust footprint and does not commission dementia beds – so the system in Barnsley will not change.

To aid the decision-making process, this decision-making report aims to do the following:

- Provide an overview of programme progress to date.

- Clearly articulate the background and case for change of the programme.
- Outline the options for change including changes made in light of patient, public and staff feedback via the formal public consultation process.
- Provide key additional assurances for the decision-making process from consultation deliberations, where required; and provide system and finance assurances.
- Summarise the review of each option to inform decision-making, with recommendations.

This executive summary provides an overview of the progress, more detail can be found in the main report including links to published reports.

1.2 Engagement and consultation

Engagement and consultation took place over three phases, the first being the broader engagement phase, followed by pre-consultation engagement and then formal public consultation. Each stage of the process was supported by an equality impact assessment (EIA).

The initial engagement took place over several years in each of our local places of Barnsley, Calderdale, Kirklees and Wakefield, where we spoke to a range of stakeholders, staff, public and voluntary and community sector representatives. Through conversations it was identified that the transformation of inpatient services would only be possible if the initial focus was on improvements to community services to support care closer to home.

This initial engagement focussed on challenges with the current model, helped inform early options development and collect patient, family and carer experiences of people accessing our wards which would be the next stage of transformation. Progress on this work was further paused during the pandemic.

Following the pandemic, the pre-consultation engagement phase was once again mobilised, using what we already had gathered, with a clear focus on stakeholder engagement to help identify and support the development of viable mental health inpatient service options for older people. At this stage, it was identified that any developments would only impact people form Calderdale, Kirklees and Wakefield only. Barnsley remained informed but out of scope.

The options were developed in a clinically led way, using a quality impact assessment and all insight from the engagement stage to inform the criteria. All options were reviewed through several stages and in partnership approaches.

A plan was developed to deliver a public consultation period for the programme, which ran for 12 weeks, from 5th January to 29th March 2024. This was to ensure there was adequate time for the proposals and issues to be considered and responded to, as per Gunning Principle that “adequate time must be given for consideration and response”. The approach to consultation was co-designed with expert advice from leads across each of our places and tested through scrutiny to ensure the approach could reach the intended audience using a variety of approaches, including groups identified in the EIA.

As the proposals were complex, the consultation material ensured that information was accessible, easy to read and understand used a range of formats and approaches. This ensured sufficient reasons were put forward for the proposal “to allow for intelligent consideration and response” which is one of the four Gunning Principles tests.

Following the consultation, all of the public feedback was independently analysed and published in a report of findings in July 2024.

The report of findings and EIA were both considered during summer 2024 as part of a deliberation process. This included sharing the information with Joint Health Overview and Scrutiny Committee (JHOSC), Healthwatch, Integrated Care Board for West Yorkshire and NHS England. A stakeholder event in August 2024 which focussed on the findings, concluded the consultation process.

1.3 Summary of the options

Clinically-led design teams developed potential options for change as part of the programme, informed by the engagement with patients, family, carers, and other stakeholders, and overseen by clinical and non-clinical leaders from Integrated Care Boards, and the Foundation Trust. A long list of multiple options was developed and assessed against 5 criteria (quality of care, access to care, deliverability and sustainability, co-dependencies with other strategies, value for money) which resulted in a small number of potentially viable options to take to consultation.

The options were reviewed by a Clinical Senate, tested via public workshops through 2022 and finalised in a stakeholder workshop in May 2023.

The options agreed to take to consultation were:

1. 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 single gender wards across the 26 beds.
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.

And:

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.

1.4 Consultation findings

In total, we received 1,697 responses to the consultation, comprising of 1,554 survey responses, 21 advocacy organisation-led involvement survey responses, 6 correspondence, 110 pieces of feedback from event participants, and 6 pieces of feedback from social media channels. The demographic profile of respondents was reflective of the combined total population of Calderdale, Kirklees and Wakefield.

People were asked a series of questions in relation to the care of patients as well as value for money of the options. When comparing the level of agreement with each statement across the 3 options. The table below shows agreement with all 4 statements is highest for option 1a, and lowest for option 1b.

Comparing the level of agreement to each option

-	Strongly agree / agree	Not sure	Disagree / strongly disagree	*Base*
Improve care for people living with dementia				
Option 1a	82%	11%	8%	*1160*
Option 1b	58%	18%	24%	*1149*
Option 2	75%	12%	13%	*1138*
Improve care for people living with a functional mental health need				
Option 1a	80%	13%	7%	*1158*
Option 1b	56%	19%	25%	*1149*
Option 2	75%	14%	11%	*1136*
Offer the right care for patients with mental health needs				
Option 1a	79%	14%	7%	*1156*
Option 1b	51%	24%	25%	*1145*
Option 2	70%	18%	12%	*1138*
Services offer value for money				
Option 1a	65%	26%	8%	*1153*
Option 1b	46%	32%	23%	*1142*
Option 2	61%	26%	14%	*1133*

All places have the same overall ranking, though with different profiles – for example, the gap is narrower between the 3 options in Calderdale than elsewhere.

When considering the feedback by the different equality characteristics, the levels of agreement across most groups is highest for option 1a, followed by option 2 and 1b.

In summary, the consultation feedback shows the most important factors and key considerations are:

- the provision of single-gender wards with high levels of disagreement in response to mixed-gender wards
- the location of services and the potential impact this could have on the ability of patients and carers to travel
- the impact on carers, family members and visitors to support patients
- the staffing requirements for these revised services

- the quality of care provided to patients – with respondents highlighting the need for care to be provided closer to home and in a safe, supportive environment.

Of the 3 proposed options, **the highest levels of agreement are in response to option 1a** and lowest levels of agreement are in response to option 1b among participants for improving care for people living with dementia and functional mental health needs.

1.5 Deliberations on the findings from formal consultation

The Joint Health and Overview Scrutiny Committee (JHOSC) concluded that the consultation report of findings had reflected the key themes. They stated that the report "demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation".

The Committee also flagged importance of travel and transport in considerations, welcoming "the emphasis placed on transport, travel and parking, and notes the commitment to consider the implications on those people impacted by the proposed options".

The Joint Integrated Care Board (ICB) committee confirmed their view that the "key themes, identified and considered in the report, fully reflect those areas the joint sub-committee expected to be included based on the consultation scope and plan."

A stakeholder workshop on 23 August 2024, demonstrated support that the findings and feedback were both comprehensive and thorough. There was also positive feedback that travel and transport had been identified early and enthusiasm to ensure that solutions are found.

1.6 Post consultation option evaluation

A further process to evaluate all the proposed options followed the deliberation of consultation findings. The five evaluation categories were the same categories used to identify options prior to formal consultation. The final evaluation took place using a partnership approach.

The criteria are outlined below:

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

As well as the consultation findings, updated impact assessments for Equality and Sustainability were used alongside the quality impact assessment to support the options review. The findings from this approach were:

Quality: Following the review, it was found that **Option 1a** is the strongest option from a quality, and equality, perspective. **Option 1b** received negative feedback in relation to the

lack of single gender wards for functional needs. Following consideration, this led to option 1a quality score increasing, whilst option 1b was reduced and option 2 did not change.

Access: Option 2 would lead to a greater access impact in terms of travel and has a lower number of dementia beds. These items were considered in the previous options appraisal and therefore access scores did not change.

Following review, the assessment and scores for deliverability and sustainability, co-dependencies with other strategies, and Value for Money did not change.

The table below shows the weighted scores of options following the review of findings:

		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**
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21 **rescored to 24**	14	6	8	**49**	19.2	**72.2**
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15 **rescored to 12**	8	4	5	**32**	21.6	**50.6**
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18 **no change**	12	6	8	**44**	19.2	63.2

Based on the updated findings of the consultation and impact assessments, the overall ranking hasn't changed but some scores have. Out of a weighted total of 100, the 3 options now scored as follows:

- Option 1A: 72.2
- Option 1B: 50.6
- Option 2: 63.2

Though some scores to the options appraisal were changed as a result of consultation, the findings supported the previous analysis and options appraisal that has taken place, **with option 1A ranking highest** and being the most appropriate option to take forward to implementation.

1.7 System prioritisation

The programme has been prioritised from both a system and a capital perspective.

The West Yorkshire Mental Health and Learning Disabilities Partnership has endorsed the priority of the programme, stating that it is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme.

The recommended option has been fully costed and the capital forecast factors in inflation and optimism bias.

South West Yorkshire Partnership Foundation Trust (SWYPFT) has confirmed that the OPS inpatient transformation scheme is their capital priority as identified in their Trust Estate Strategy. Based upon current agreed capital allocation methodology this is contained within the SWYPFT allocation. The capital programme is scheduled to accommodate this scheme without creating additional estates risks. The Trust will be using its own cash reserves and therefore does not require cash support from the ICB.

Jonathan Webb finance director for West Yorkshire ICB has confirmed system finance support for the programme, stating that “the agreed methodology for capital allocation would need to change from the current model to have a direct impact on other Trusts. During 2024/25, the WY infrastructure plan has been developed and agreed, with this programme identified as a priority.

In late 2023, the NHS WY ICB confirmed prioritisation of this scheme from a system capital & estates perspective. This was 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.

In 2024, wider system challenges have emerged. However, based on proposed costs remaining as planned, it is our expectation that SWYPFT will receive the capital allocation they require to deliver the programme, factoring in their prioritisation of the programme and plans to spread costs across financial years.

The ICB is committed to delivering MHIS in line with NHSE expectations. The ICB can confirm that this is our priority for funding future MHIS and forms the basis of financial planning.

The Trust has confirmed that it is continuing to develop its medium-term financial sustainability plan, in line with the wider development within the ICB, and is taking actions to ensure delivery of this and the 24 / 25 in year breakeven target”.

1.8 Implementation considerations

A number of mitigations have been identified for the new model of care and for the recommended option. These include:

- support for people to travel who are impacted as a result of the changes;
- improvements to ward environments that factor in the needs of differing protected groups and working groups to ensure inclusive approaches are taken;
- partnership working to facilitate new pathways of care across places,
- staff support,
- implementing creative solutions,
- green travel solutions and energy efficient building works in line with the green plan.

A Travel and Transport working group was established in 2024 with a mix of carers, governors, SWYPFT and ICB staff. It was tasked with making recommendations to support family, carers and loved ones that have difficulty travelling to a transformed model, considering feedback from the public consultation and agreeing principles for when support is needed as a result of the transformed model.

The group has recommended the implementation of a visitor support pathway for a 5-year period, which would take a needs based and personalised approached to supporting people impacted by changes. This has a range of features and aims to:

- Provide guidance on travel, provided by the wards.
- Ensure flexible visiting is adopted.
- Offer digital solutions.
- Factor in needs of carers, for example the triangle of care model and principles.
- Work with partners including the Combined Authority to influence improvements public transport solutions that better link hospitals and improve ease of public transport journeys.
- Ensure there is a failsafe / contingency in place for essential visitors such as carers / next of kin that are unable to visit as a result of changes made which factor in the visitors financial circumstances, ease of travel and disability/frailty. This could include volunteer drivers, VCSE support or paid taxis.

1.9 Recommendations

There is a clear and thorough evidence and rationale to make the following recommendations:

- That option 1A is endorsed for implementation.

- That commitment is made to progressing solutions identified, particularly for people impacted by travel and transport.

Also, that agreement is reached to approve the formation of an implementation team reporting to the programme board, SYYPFT Executive Management Team / Trust Board and the Joint Integrated Care Board Committee to feedback on the implementation process.

2 The case for change

2.1 Introduction and Background

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides community, mental health and learning disability services to 1.22m people across Barnsley, Calderdale, Kirklees and Wakefield. Part of the service offer includes mental health services for older people. Following improvements to community services the focus of this programme is on making changes and improvements to the inpatient model.

The acute mental health inpatient services are provided as follows:

- 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 Calderdale Royal Hospital.
- In Kirklees, **Ward 19** constitutes 2 x 15 bedded single gender wards, both mixed functional and dementia needs, on the site of Dewsbury and District Hospital.
- **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. The Poplars ward 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.

The map below shows the services that are in scope the programme:

Activity on the programme has been progressed 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.

More background and governance context can be found the pre consultation business case.

2.2 The case for change

As set out in the pre consultation business case, there is a compelling need to change the current system.

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.

In line with best practice, mixed needs wards do not help us provide the best possible care or support the wellbeing of our patients, because:

- the clinical and personal needs of patients can be very different
- activities are not stimulating and appropriate for all patients
- the ward environment does not help patients be independent
- there is more chance of incidents
- the space could be used better to support therapies, safety and wellbeing for all our patients.

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 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.

An improved model can improve care, wellbeing, and give a better experience for our inpatients, carers, families and staff.

2.3 Strategic context

Best practice guidance highlighted in the pre consultation business case, is that there should be specialist inpatient wards for people living with dementia and dedicated wards for people with functional mental health and this is common in other older people's mental health inpatient wards in the NHS.

National guidance sets out the context for delivery of acute inpatient care, from delivering care via purposeful admissions, therapeutic inpatient care, and proactive discharge planning, through to guidance on appropriate ward sizes (15 beds).

The West Yorkshire ICB also sets in its vision when local and specialist inpatient care should be delivered. It 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".

2.4 Clinical safety and quality

The pre-consultation business case clearly identified that change is required to maintain clinical safety and quality.

As well as not delivering an optimal model of care, challenges with the current system include 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 and challenges at this site have been flagged by CQC.

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 this is not always possible and data shows that around 40% of patients with dementia experience ward moves as part of their inpatient stay. Risks associated with multiple ward stays include impairing continuity of care, preventing the development and utilisation of therapeutic relationships, increasing risk due to change of environment and unnecessarily extends the Length of Stay.

Data shows the average length of stay of people with dementia who have one ward stay is 69 days, compared with 126 for people that have more than 1 ward stay.

Some ward environments are challenging. Beechdale ward in Calderdale, for example, has narrow winding corridors and issues with staff line of sight on the ward and the mix of people with dementia and functional needs is a challenge to manage on an ongoing basis.

2.5 Workforce

As outlined in the pre-consultation business case, detailed 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.

The programme team engaged with other Trusts that have specialist needs based models to understand the different levels and roles of staff required in a more specialist service. We also used the Mental Health Optimal Staffing Tool (MHOST), which was developed with NHS Improvement, Imperial College London and 26 different Trusts and is the most evidence-based tool available, to model required staffing levels.

The workforce plan for this programme aligns with the NHS Long Term Workforce plan (NHSE 2023), which 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 and the areas in the workforce plan that are to train, retain and reform.

The proposed models will 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.

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.

The proposals in the workforce model developed for this programme aligns with these principles.

2.6 Financial case

The pre consultation business case set out the financial requirements for the model and options to take into consultation. Whilst there are clear inefficiencies in the current model, for example, linked with overstaffing at an isolated site and lengths of stay for people moving wards, there is also a requirement to invest into a new model. The investment includes capital for a new ward on the Fieldhead hospital site so that the Trust can cease operating at an isolated site, and staffing into the specialist dementia service, where a higher level of support will be needed.

This means there is investment required to deliver the new service model.

However, the NHS as a whole currently faces many financial challenges. Recognising the priority of the programme and need to make these improvements a series of principles were agreed to support the programme. These were:

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.

The pre consultation business case has more information on the financial requirements of the model and further details can also be found in section 6 of this document.

3 Decision making context and progress to consultation

3.1 Pre consultation engagement

Engagement and consultation took place over three phases, the first being the broader engagement phase, followed by pre-consultation engagement and then formal public consultation. Each stage of the process supported by an equality impact assessment (EIA).

The timeframes have taken longer than initially expected with early thinking and broader engagement 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. It recommenced in 2021 before moving forward at a faster pace from 2022.

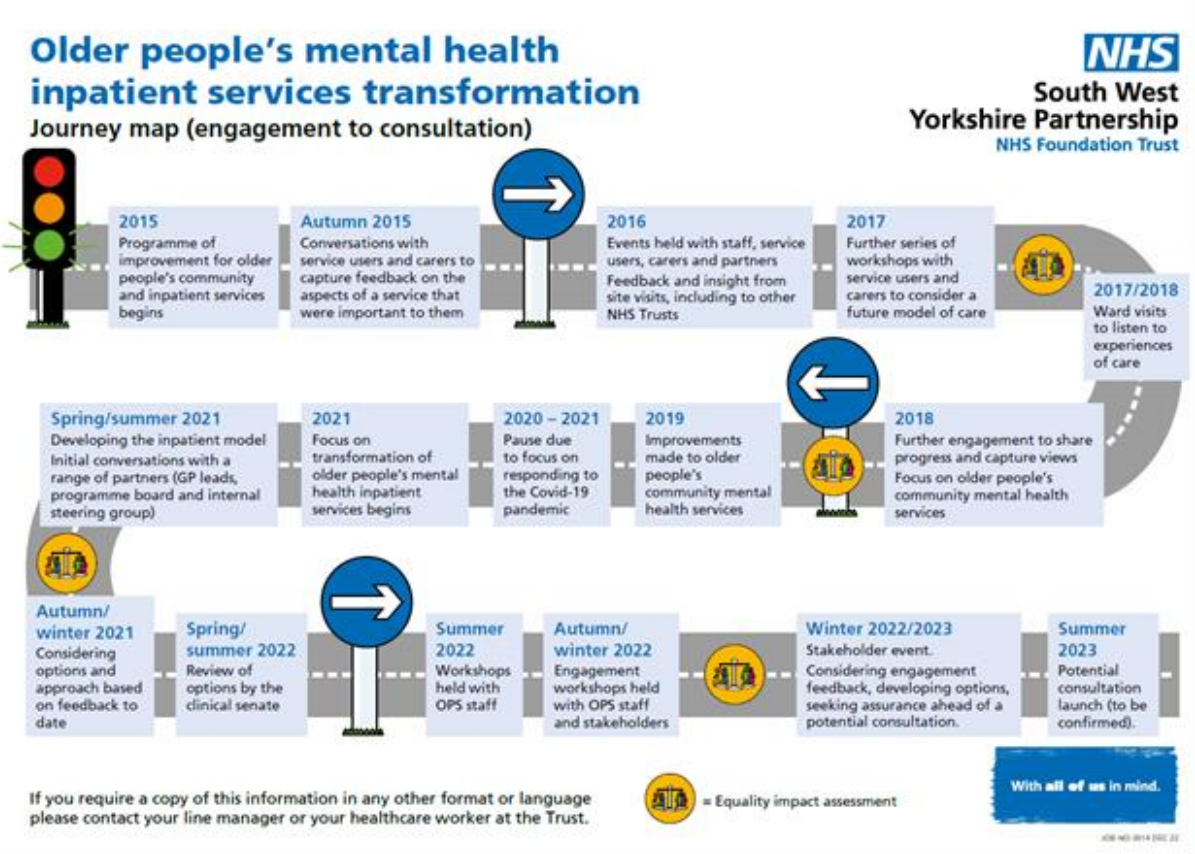
The initial engagement took place over several years in each of our local places of Barnsley, Calderdale, Kirklees and Wakefield, where we spoke to a range of stakeholders, staff, public and voluntary and community sector representatives. Through conversations it was identified that the transformation of inpatient services would only be possible if the initial focus was on improvements to community services to support care closer to home.

This initial engagement focussed on challenges with the current model, helped inform early options development and collect patient, family and carer experiences of people accessing our wards which would be the next stage of transformation.

Following the pandemic, the pre-consultation engagement phase was mobilised, using what intelligence we already had gathered, with a clear focus on stakeholder engagement to help identify and support the development of viable mental health inpatient service options for older people. At this stage, it was identified that any developments would only impact people form Calderdale, Kirklees and Wakefield only. Barnsley remained informed but out of scope.

Staff, patient, carer, public and wider stakeholder engagement has been central to the development of the options. The approach has used best practice approaches to ensure a range of stakeholders have helped to co-design and inform the development of options.

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



Through this period, we spoke to around 1000 people across a whole range of stakeholders including the patients on the wards and their family and carers, clinical staff and a range of partners.

The feedback gathered through this exercise was used initially to help design the high-level model and options, with option development being clinically led and then we tested the options developed with a range of stakeholders via workshops and events.

More information is in the pre consultation business case.

3.2 Options development

Clinically-led design teams developed potential options for change as part of the programme, informed by the pre-consultation process including engagement with patients, family, carers, and other stakeholders, and overseen by clinical and non-clinical leaders from Integrated Change Boards, and the Foundation Trust. A long list of multiple options was developed and assessed against criteria, which resulted in a small number of potentially viable options to take to consultation.

The SWYPFT Trust template for options appraisal was used for the options review process. Specific detail was added to each section based on the quality requirements to deliver the vision for the model. Key feedback from patients, 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.

The domains were also weighted, with 70% allocated to quality domains and 30% to value for money to ensure that quality domains are the most heavily weighted but also that affordability and value of the options is fully factored in.

Criteria:

- Quality of Care 30%
- Access to Care 20%
- Deliverability and sustainability 10%
- Co-dependencies with other strategies 10%
- Value for Money 30%

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 were:

Score	Description	Viability
10	meets fully and exceeds requirements	Viable
9	Fully meets requirements	Viable
8	meets the vast majority of requirements	Viable
7	meets the vast majority of requirements with additional work required	Viable
6	meets most with more work required	Viable
5	meets most but a key area not met	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	Viable – but sub optimal and need to consider how to improve model
3	limited criteria met with several key areas not met or one significant risk	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

Options were scored then weighted to result in a total score of from 100.

All the options were reviewed by the Clinical Senate, an independent advisory body, see section below for more information, and several options were removed as they did not meet clinical criteria. The Clinical Senate endorsed a shortlist of options which were then tested at

public workshops through 2022 and finalised in a stakeholder workshop in May 2023. More detail on these can be found the pre-consultation business case and the 2022 engagement is published here.

The table below summarises the overall scoring across the domains when weighted (for example, 8 out of 10 for quality would be weighted to 24 (out of 30)). This is based on the work done through to May 2023 to inform which options should be taken into public consultation. The fields highlighted in red indicate where an option fell short of the required level based on key criteria:

	Quality Domains				Total quality score	Value for Money	Total
Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
	30	20	10	10	**70**	30	**100**
No change	12	8	2.5	4	**26.5**	25.2	**51.7**
W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15	8	4	5	**32**	21.6	**53.6**
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**
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**
Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	**44**	19.2	**63.2**

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

1. 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:

b. 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.

c. 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.

And:

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.

The detailed process followed can be found in the pre consultation business case.

3.3 Independent advice and assurance

Following the development of the list of potential options, the programme team invited the North East and Yorkshire Clinical Senate to review the options and proposals in 2022. 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 Clinical Senate were fully supportive of proposals and strongly agreed that patients with functional needs and dementia should be cared for in separate distinct dedicated units. 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.

Prior to moving into consultation NHSE assured the pre consultation business case in a letter from Richard Barker CBE, NHSE Regional Director, (North East and Yorkshire):

"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.

NHSE acknowledges that the isolated nature of the Poplars site has been raised in both Care Quality Commission and Northern England Clinical Senate (2022) reports, presenting some risks around staffing and access to out of hours' assessments."

"The ICB has confirmed that it will prioritise the proposed changes from a capital and estates expenditure perspective, with capital costs to be met by SWYPFT's 2024/25 and 2025/26 operational CDEL capital allocations. However further assurance is required to demonstrate that this scheme is prioritised for system capital across all conflicting priorities in West Yorkshire, not limited to place. Prioritisation continues to apply within the wider system mental health context, where there are competing priorities and pressures on the system CDEL capital budget."

More information on the Clinical Senate review and NHSE assurance can be found in the pre consultation business case.

3.4 Risk and impact assessments

A series of impact assessments were established to support the process of developing and shortlisting options. These assessments have been updated in 2024 to inform decision making and will be further reviewed to support implementation.

Identifying and reducing health inequalities in access, experience and outcomes is essential to the delivery of high quality, mental health care. From the outset of the programme, the **Equality Impact Assessment** (EIA) has been established and maintained, with the aim to ensure that all mental health care is responsive to the strengths and needs of each individual and community's identity and culture. Not only are there moral, legal, and economic imperatives for advancing equality, but learning and collaborating with all sections of society provides a valuable opportunity to innovate and enhance the way we provide care.

The most up to date equality impact assessment can be found here.

Other impact assessments included:

A clinically led **Quality Impact Assessment** (QIA) has been 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. The most up to date QIA can be found in appendix 1.

A **Travel Impact Assessment** (TIA) was established to consider the potential impacts of changes on patients, visitors and staff for each of the options developed. This includes 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. The most up to date TIA can be found in appendix 2.

The **Sustainability Impact Assessment** (SIA) was developed using recommended sustainability impact assessment provided by West Yorkshire ICB sustainability lead, to enable scrutiny of the potential impact of the options for this transformation as part of the SWYPFT strategic approach to the environment supported by the Trusts Social Responsibility and Sustainability (SRS) strategy, Trust Green Plan and the Estates strategy. The most up to date SIA can be found in appendix 3.

In addition, a document was established to review alignment of the model and options with national, regional and local strategies. This can be found in appendix 4.

Alongside the impact assessments a robust risk assessment process has taken place with risks identified through impact assessments and through consultation identified and appropriate mitigations established.

4 Consultation process

4.1 Consultation plan

A consultation plan was developed in partnership with subject matter experts from across the ICB who lead on involvement, communication, and equality, which included the consultation approach and mandate. The approach to consultation was co-designed with expert advice from leads across each of our places and tested through scrutiny to ensure the approach could reach the intended audience using a variety of approaches, including groups identified in the EIA.

The consultation approach and mandate set out how the consultation would satisfy the key tests for both consultation and equality, which are the Gunning and Brown Principles. See appendix 5 for the consultation plan.

The public consultation was set for a period of 12 weeks to ensure there was adequate time for the proposals and issues to be considered and responded to, as per Gunning Principle that “adequate time must be given for consideration and response”.

As the proposals were complex, the consultation material ensured that information was accessible, easy to read and understand used a range of formats and approaches. This ensured sufficient reasons were put forward for the proposal “to allow for intelligent consideration and response” which is one of the four Gunning Principles tests.

4.2 Consultation activity

The public consultation took place between Friday 5 January and Friday 29th March 2024.

A multi-faceted approach was taken to ensure that the consultation had a wide reach in terms of geographic spread, engaging with people with protected characteristics, the use of different types of media and approaches to engage with people.

Information distributed through the consultation included:

- More than 15,000 direct communications (letters, emails and text messages) were sent at key milestones to patients, staff working in older people’s mental health services, trust members and a range of other key stakeholders.
- A range of materials were printed and distributed across many community sites including thousands of consultation documents and summary documents, surveys, posters, and leaflets.
- A dedicated website was established to be a single source of information.
- A communication toolkit was developed for partner organisations. This included social media messaging and imagery, digital screens, newsletter copy, website copy and a link to a dedicated resources area on the consultation website where digital versions of information could be downloaded.
- A video was created explaining the rationale for the consultation and the options as well as an animation describing the different options. These were published on the

consultation website, used in the consultation events and posted on social media. The consultation video and animation included subtitles and a transcript.

- Easy read materials were produced, text only webpages of the consultation documents were created for use with assistive software, a British Sign Language (BSL) version and transcript of the video and animation were made, translations of documents were made available on request and information was published to accessible standards. All consultation materials included a phone number to support those who did not have digital access, where they were able to contact the team managing the consultation and obtain any information they required. Additionally, all consultation materials stated information could be requested in other formats.
- A number of media releases were circulated to support the launch, and the consultation was reported in local newspapers, as well as several radio interviews, and promoted widely across social media.
- Information about the consultation was regularly shared in bulletins and newsletters by the Trust and partner organisations. This included bulletins to staff, GP practices, and newsletters aimed at the public.

Through the consultation, programme team met and engaged with hundreds of people at public events, roadshows, and meetings, both with people in the community and with stakeholders.

The programme team worked closely with partners in the voluntary and community sector, partnering with VCSE organisations to raise awareness and gather views from communities across Calderdale, Kirklees and Wakefield, and in particular help to gather feedback from seldom heard groups. Partnering with advocacy organisations, the trust and ICB were able to reach current patients.

The consultation included events held in community venues widely across Calderdale, Kirklees and Wakefield. Events were run in the evening, at weekends, and online, to help ensure that people had the opportunity to attend.

A key focus of the consultation was to gather information via a survey. This was available online and 8,000 copies were printed and distributed.

As well as this, feedback was sought using:

- a feedback capture form for people attending events
- a contact phone number and email address
- social media
- responses from key partner organisations.

An independently chaired midpoint review took place on 12 February 2024, just under halfway through the 12-week consultation period, with a range of stakeholders attending including members of the Joint Health Overview and Scrutiny Committee, the Joint ICB Committee and Trust Governors.

The purpose of the midpoint review was to assess how well we have consulted to date to ensure we provided the best opportunities for people to have their say. The midpoint review

helped measure the plan against metrics, ensure the programme was reaching and consulting the right people and identify activity required through the second half of the consultation.

4.3 Responses to the consultation

In total there were 1,697 responses to the consultation, comprising of 1,554 survey responses, 21 advocacy organisation-led involvement survey responses, 6 correspondence, 110 pieces of feedback from event participants, and 6 pieces of feedback from social media channels:

Below is an overview of the geographical and demographic profile of the consultation survey respondents:

- **Geography:** 536 (34%) respondents were from the Kirklees area, 288 (19%) were from the Calderdale area and 172 (11%) were from the Wakefield area
- **Sex:** 769 (67%) said they were female, 327 (29%) were male and 6 (1%) were non-binary
- **Age:** 9 (1%) respondents said they were under 18, 286 (25%) were 18 to 39, 410 (36%) were 40 to 59, 285 (25%) were 60 to 79 and 47 (4%) were 80 and over
- **Country of birth:** 963 (85%) respondents said they were born in the United Kingdom and 103 (9%) said they were born in another country
- **Religion:** 432 (38%) respondents said they were Muslim, 376 (33%) were Christian, 19 (2%) were Hindu, 9 (1%) were Sikh, 8 (1%) were Buddhist, 5 (0.4%) were Jewish and 219 (19%) said they did not have a religious affiliation
- **Ethnicity:** The majority of people taking part in the consultation were from the following ethnicities: White British (542 / 48%), Pakistani (371 / 33%), Indian (61 / 5%), Bangladeshi (17 / 2%), Caribbean (15 / 1%), African (12 / 1%) and White Irish (11 / 1%)
- **Disability:** 830 (74%) respondents said they did not have any disabilities while 238 (21%) said they did have a disability
- **Long-term conditions, impairments or illnesses:** 206 (25%) respondents said they had a mental health condition, 201 (24%) had a long-term condition, 163 (20%) had a physical or mobility impairment, 85 (10%) had a hearing impairment, 38 (5%) had a neurodivergent condition, 32 (4%) had a sight impairment, 16 (2%) had issues

with learning, understanding, concentrating or memory, and 153 (18%) said they did not have a disability
- **Carers:** 729 (66%) respondents said they were not carers, while 335 (30%) said they were carers
- **Sexual orientation:** 930 (84%) respondents said they were heterosexual, 17 (2%) were gay, 17 (2%) were lesbian, 16 (1%) were bisexual / pansexual and 3 (0.3%) were asexual
- **Transgender:** of all the survey respondents, 5 said they were transgender
- **Cost of living:** 65 (6%) respondents said they were very comfortable, 373 (33%) were quite comfortable, 322 (29%) were just getting by and 247 (22%) were really struggling
- **Pregnant or recently given birth:** 33 (3%) respondents said they were currently pregnant or had recently given birth. 1,062 (93%) said they were not pregnant, nor had they given birth recently
- **Parent / primary carer of children:** 322 (30%) respondents said they were parents or the primary carers of children, 737 (69%) said they were not
- **Relationship status:** 597 (57%) respondents said they were married or in a civil partnership, 219 (21%) were single, 81 (8%) lived with a partner and 76 (7%) were widowed
- **Deprivation:** 521 (34%) respondents were from postcode areas where less than 40% of the locality are from the most deprived deciles, 168 (11%) were from postcode areas where 40% to 49% of the locality are from the most deprived deciles and 339 (22%) were from postcode areas where more than 50% of the locality are from the most deprived deciles.

4.4 Post consultation Assurance

The ICB joint committee reviewed the consultation activity and reach against the plan in June 2024 and confirmed that it was assured of the consultation process.

An independently produced report of the consultation findings was published on 17 July 2024 and a workshop held 5 weeks later, on 23 August, with a range of stakeholders to test, review and reflect on the findings.

In this period, feedback was also sought from key stakeholders, including holding a Joint Health Overview and Scrutiny (JHOSC) meeting held on 15 August 2024, on assurance of the consultation process and equality impact assessment.

The Committee confirmed that they felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.

> “Members of the JHOSC were provided with the consultation report and the EIA on the 17 July 2024, and although these documents ran to nearly 500 pages, sufficient time was allowed prior to the formal meeting of the JHOSC on the 15 August 2024. A presentation at Committee was helpful in segmenting key points whilst maintaining a necessary overview to allow meaningful discussion, questions and comment.”

See appendix 6 for feedback from JHOSC.

The ICB committee also found that due regard has been paid to equality and diversity through the delivery of consultation activity, and in the independent report of findings and adequate time had been given for you to consider the responses contained in the independent report of findings.

5 Options Appraisal

5.1 Options summary

The options shortlist for consultation are set out below:

Summary of consultation options

<table>
<tr><th></th><th colspan="2">Option 1</th><th>Option 2</th></tr>
<tr><td>The dementia service</td><td colspan="2">A dementia service on Ward 19, Dewsbury and District Hospital
2 separate male and female wards
30 beds</td><td>A dementia service on Crofton Ward, Fieldhead Hospital, Wakefield
2 separate male and female wards
26 beds</td></tr>
<tr><td rowspan="2">The functional mental health needs service</td><td>Option 1a</td><td>Option 1b</td><td></td></tr>
<tr><td>On Crofton Ward, Fieldhead Hospital, Wakefield, 2 separate male and female wards, 26 beds, and,
On Beechdale Ward, Calderdale Royal Hospital, 1 mixed-gender ward, 16 beds
There would be 42 beds for a functional mental health needs service in total.</td><td>On Crofton Ward, Fieldhead Hospital, Wakefield, 1 mixed-gender ward, 22 beds, and,
On Beechdale Ward, Calderdale Royal Hospital, 1 mixed-gender ward, 16 beds
There would be 38 beds for a functional mental health needs service in total
This is 4 fewer beds than in option 1(a)
There would be only mixed-gender wards for functional mental health needs.</td><td>On Ward 19, Dewsbury and District Hospital, 2 separate male and female wards, 30 beds, and,
On Beechdale Ward, Calderdale Royal Hospital, a mixed-gender ward, 16 beds.
There would be 46 beds for a functional mental health needs service in total.</td></tr>
<tr><td>Total beds</td><td>72</td><td>68</td><td>72</td></tr>
<tr><td>Cost to set up</td><td>£8.2 million</td><td>£5.5 million</td><td>£8.2 million</td></tr>
<tr><td>Cost to run each year</td><td>£9.1 million</td><td>£8.2 million</td><td>£9.3 million</td></tr>
</table>

5.2 Consultation findings

The consultation responses were analysed independently of the programme, by NHS Arden and Greater East Midlands Commissioning Support Unit (CSU) and NHS Midlands and Lancashire CSU. The CSU used their analysis to produce the report of findings of the consultation.

The following sections summarises key findings reported. The full report can be found here.

5.2.1 Feedback on proposed options:

People were asked 4 questions about each option and whether it would:

- improve care for people living with dementia
- improve care for people living with a functional mental health need
- offer the right care for patients with mental health needs
- offer value for money

When comparing the level of agreement with each statement across the 3 options, The table below shows agreement with all 4 statements is highest for option 1a, and lowest for option 1b.

Comparing the level of agreement to each option

-	Strongly agree / agree	Not sure	Disagree / strongly disagree	*Base*
Improve care for people living with dementia				
Option 1a	82%	11%	8%	*1160*
Option 1b	58%	18%	24%	*1149*
Option 2	75%	12%	13%	*1138*
Improve care for people living with a functional mental health need				
Option 1a	80%	13%	7%	*1158*
Option 1b	56%	19%	25%	*1149*
Option 2	75%	14%	11%	*1136*
Offer the right care for patients with mental health needs				
Option 1a	79%	14%	7%	*1156*
Option 1b	51%	24%	25%	*1145*
Option 2	70%	18%	12%	*1138*
Services offer value for money				
Option 1a	65%	26%	8%	*1153*
Option 1b	46%	32%	23%	*1142*
Option 2	61%	26%	14%	*1133*

5.2.2 Place Analysis

All places have the same overall ranking, though with different profiles – for example, the gap is narrower between the 3 options in Calderdale than elsewhere – tables can be found in the full consultation report of findings.

5.2.3 Other Consultation Feedback

When thinking about older people's mental health services, the most important factors highlighted by respondents were being cared for as close to home as possible (363 / 32%) and being cared for in a safe supported environment (355 / 31%).

661 (59%) respondents said they felt the Trust had considered everything around sustainability and environmental impacts when considering the proposals. However, 240

(21%) respondents felt they had not, and these respondents were invited to share their rationale. The top themes raised were:

- Neutral – Transport – Consider the impact of travel (e.g. mileage, transport links, costs) (35 / 17%)
- Negative – Transport – Consider the environmental implications of travelling long distances (24 / 12%)
- Negative – General – Environmental impact has not been considered (e.g. long-term effects) (23 / 11%).

When asked if there was anything further to consider for the proposals the top themes raised were:

- Neutral – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (40 / 12%)
- Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport, ability of person travelling, environmental impact) (38 / 12%)
- Neutral – Quality of care – Consider the needs of individuals to give the best care (23 / 7%).

5.2.4 Travel and Transport Consultation Findings:

Most respondents said they expect to travel up to 45 minutes for both specialist inpatient dementia care (1011 / 88%) and for functional inpatient mental health care (1016 / 89%).

The top 3 options for transportation were driving a petrol / diesel car (582 / 50%), walking (368 / 32%) and travelling by bus (364 / 31%). And, when asked if there was anything else that should be considered around making travel easier, the top themes raised were:

- Neutral – Transport – Parking should be free (149 / 29%)
- Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%)
- Neutral – Transport – Consider providing a free local bus / shuttle bus service (111 / 21%).

5.2.5 Conclusions of consultation findings:

5.2.5.1 Feedback on option 1a

Most respondents strongly agreed or agreed that this option would improve care for people living with dementia (946 / 82%), would improve care for people living with a functional mental health need (929 / 80%), would offer the right care for patients with mental health needs (909 / 79%) and would offer value for money (755 / 65%). The top themes raised by survey respondents about this option were:

- Neutral – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (98 / 27%)
- Positive – Access – Option 1a is a good option (46 / 13%)
- Positive – Quality of care – Separating dementia and functional mental health needs services would be beneficial (39 / 11%).

5.2.5.2 Feedback on option 1b

Around half of respondents strongly agreed or agreed that it would improve care for people living with dementia (661 / 58%), would improve care for people living with a functional mental health need (645 / 56%), would offer the right care for patients with mental health needs (588 / 51%) and would offer value for money (520 / 46%). The top themes raised by survey respondents about this option were:

- Negative – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (203 / 47%)
- Negative – Access – Option 1b is not a good option (36 / 8%)
- Negative – Quality of care – Concern over the reduction of beds (33 / 8%).

5.2.5.3 Feedback on option 2

Most respondents strongly agreed or agreed that it would improve care for people living with dementia (850 / 75%), would improve care for people living with a functional mental health need (854 / 75%), would offer the right care for patients with mental health needs (802 / 70%), and would offer value for money (690 / 61%). The top themes raised by survey respondents about this option were:

- Neutral – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (56 / 18%)
- Positive – General – Option 2 is a good option (38 / 12%)
- Negative – Finance – This is not a cost-effective option (28 / 9%).

In summary, the consultation feedback shows the most important factors and key considerations are around:

- the provision of single-gender wards with high levels of disagreement in response to mixed-gender wards
- the location of services and the potential impact this could have on the ability of patients and carers to travel
- the impact on carers, family members and visitors to support patients
- the staffing requirements for these revised services
- the quality of care provided to patients – with respondents highlighting the need for care to be provided closer to home and in a safe, supportive environment.

Of the 3 proposed options, **the highest levels of agreement are in response to option 1a** and lowest levels of agreement are in response to option 1b among participants for improving care for people living with dementia and functional mental health needs.

More information can be found in the consultation report of findings.

5.3 Equality Impact

The consultation findings have been analysed in detail and used to update the impacts and mitigations required for all proposed options. This has ensured that any gaps in our understanding from previous involvement work continue to be highlighted and the actions required to address these impacts are understood.

When considering the feedback by the different equality characteristics, the levels of agreement across most groups is highest for option 1a, followed by option 2 and 1b.

Carers: Option 1a scored the highest with variations for option 2 with option 1b scoring the lowest.

Religion: **Option 1a and option 2** (variations across faith groups) scored the highest with option 1b scoring the lowest.

Ethnicity: Option 1a and option 2 (variations across groups) scored the highest with option 1b scoring the lowest.

Disability: Option 1a scored the highest with variations for option 2 with option 1b scoring the lowest.

Age: **Option 1a** highest on all questions with some age variations. Under the age of 18 - option 2 was viewed as the best option to improve dementia care and best value for money. Over the age of 80 - option 2 would provide the best functional care.

Sexual orientation: Option 1a scored the highest.

Gender: Option 1a scored the highest on all questions relating to options.

Transgender: Option 1a scored the highest but option 1b scored joint highest on improving care for dementia and functional patients.

Consideration was also given to addressing inequalities, including a question about the impact of the cost of living.

Option 1a scored the highest with option 2 scoring joint highest for improving the care of people living with dementia for people who are really struggling.

Option 1a scored highest for all questions in the areas with most deprivations. Option 1b scored lowest for all questions.

The impacts and mitigations can be found in the updated EIA.

5.4 Consultation deliberations

The joint health scrutiny committee confirmed key themes are adequately reflected in the consultation report of findings, and the report demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation.

The Committee also flagged importance of travel and transport in considerations, welcoming “the emphasis placed on transport, travel and parking and notes the commitment to consider

the implications on those people impacted by the proposed options. However, there is no indication in the consultation report as to how much weight the decision-maker will place on transport considerations, as opposed to clinical quality, for example. The Committee understands there will be conflicting views as the decision-maker seeks to balance 'trade offs' between local access and the provision of centralised specialist services".

The Joint ICB committee confirmed their view that the "key themes, identified and considered in the report, fully reflect those areas the joint sub-committee expected to be included based on the consultation scope and plan." They also welcomed the emphasis on travel and transport.

Similar themes were raised at the stakeholder workshop on 23 August, with strong support for the findings, feedback that there were comprehensive and thorough findings, positive feedback that travel and transport has been identified and a desire to ensure that solutions are found. Other key feedback related to factors that should be considered as the programme progresses toward implementation, such as pathways and partnership working including voluntary and community sector, creative solutions, ward environments and staffing.

A report of workshop including attendees and more detailed theming can be found in appendix 7.

5.5 Quality Impact Assessment of options

A quality impact assessment was established prior to consultation which supported the options development and shortlist of options for consultation. This was reviewed and updated in 2024 by a clinically led group, see appendix 1 for more information. All options deliver improvements across many quality domains.

Option 1B delivers fewer improvements and requires several more mitigations than either of the other options.

Key specific challenges with option 1B are:

- Functional mixed gender wards only, which would create a challenge for functional admissions that would benefit from gender specific ward environments.
- Large 22 bedded ward, much larger than ideal and requires staffing consideration and impacts on clinical and therapeutic environment.
- Reduced overall capacity.

Option 1A and option 2 have similar overall profiles but none of the 3 key challenges identified above with option 1B.

Option 2 would require additional considerations:

- Crofton ward better designed for functional needs (existing space) so would require additional adaption whilst option 1A would need less as the Ward 19 environment is well suited to people with dementia.
- Dementia bed numbers lower, at the low end of the acceptable range.

Options 1A and 1B has additional dementia beds compared but wouldn't have the gender flex that option 2 has with dementia beds.

All options would require the following mitigations:

- Improvements of ward environments, including development of some e/s at Ward 19.
- Support for visitors (see travel impact)
- Work on pathways with partner organisations

Therefore, option 1A and 2 deliver many quality improvements but option 1A would require fewer mitigations from a quality perspective.

5.6 Travel Impact

A travel impact assessment was undertaken prior to public consultation and reviewed and updated, factoring in the feedback from the consultation and the proposed mitigations. For the purposes of the Travel Impact Assessment (TIA), both options 1A and 1B are considered together given their geographical parallels.

The TIA found that both of the options will have some negative impact.

The highest numbers of people impacted will be essential visitors, carers and next of kin, of people admitted to wards, given that stays can range from 60 to 100 plus days.

Some staff will be impacted as a result of the transformation, most notably staff based at the Poplars ward in Hemsworth.

There will be limited impact for patients, some functional patients will have ward leave prior to discharge and this might be further to travel from home. The Trust has policies and procedures to support people to access this and impact therefore will be very limited.

Visitor travel:

Feedback from the consultation showed that a high proportion of carers of people with dementia had access to cars. Analysis of car travel impact shows that the majority of people would be able to travel within the expected travel time, as established via the consultation questions on travel, for the most part, though some distances and journeys will be long.

Therefore, while essential visitors will be impacted in both options, in terms of driving time and driving distance, for the majority, people able to drive will be able to access services.

However, data in the travel impact assessment shows that some next of kin / carer visitors will rely on public transport and that in either option there will be a negative impact.

There will be slightly more people negatively impacted in option 2 than option 1 and the impact will be higher for people from Calderdale with dementia. People from South Kirklees with dementia would not be impacted with option 1 and would have a negative impact overall with option 2.

In terms of parking, whichever option is implemented, some people from Wakefield will be admitted elsewhere and be subject to car parking charges. The net impact of car parking is neutral though for any option as some people outside of Wakefield will be admitted to Fieldhead, with free parking.

Staff impact:

There will be some impact on staff for either option, with staff in Poplars impacted. Analysis in 2023 found that Poplars was a similar distance on average to Fieldhead overall from staff's home but that staff in lower pay bands were more likely to live closer to the Poplars. Some staff might wish to relocate to ward 19 in either option. Whilst further overall, 40% of staff were similar distance / closer to Ward 19.

Summary:

Option 1 would have negative impacts for some visitors which is likely to make travel difficult, with solutions required. Option 2 would have negative impacts for more people and those impacts would be greater, given the distances – meaning more people would require solutions and those solution might be more difficult.

The TIA and travel and transport working group have established a series of improvements that could support people visiting who are impacted by the change.

A staff consultation will be established post decision to include focus on staff directly impacted.

5.7 Sustainability Impact

All options will deliver / enable benefits in terms of in terms of pharmacy, technology, improved estate at the Fieldhead site.

Option 1B has a smaller estates footprint so lower carbon footprint.

All options will benefit from not having the isolated site and extra travel associated with it (for example, pharmacy, acute hospital admissions and transfers).

All options do lead to extra travel for visitors and there will be some additional travel for visitors in option 2 over either option 1A and 1B.

5.8 Alignment with strategies

To support the review of options for the pre-consultation business case, a full assessment took place of how each option adhered to relevant national, regional and local strategies. This was updated in 2024 to reflect any new strategies or guidance.

Findings were that Options 1A and 2 remained very closely aligned with best practice and regional / national strategies, in terms of models of care and delivering in a specialist environment.

In terms of regional / local strategies, all options align with ICB aims around specialist MH inpatient care and aligns well with acute hospital aspirations, for example Mid Yorkshire's aim for delivery of centres of excellence models and aligning their older people's wards in Wakefield and Dewsbury.

Option 1B does not align with national guidance on ward sizes but does for many other elements.

5.9 Review of all findings and recommendations

To evaluate the different options, five evaluation categories were determined and evaluated prior to the public consultation. This evaluation took place in a partnership approach.

Key feedback that we'd heard from patients, family and carers as well as key considerations highlighted in the quality and equality impact assessments were factored into each category. The criteria are outlined below:

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

No other options were identified during formal consultation.

As part of the decision-making process, consideration was be given by the programme board as to whether the options assessment remained viable. The original options appraisal and rationale were reviewed. The review to reach a recommended option used the same criteria to rescore.

Updated information used included:

- Quality Impact Assessment
- Travel Impact Assessment
- Sustainability Impact Assessment
- Strategic Alignment Assessment
- VfM assessment

- Equality Impact Assessment – updated post consultation
- Consultation findings, including independent report of findings, the feedback from key stakeholders and the stakeholder workshop outputs.

Each of these documents was considered in detail for impact against the different domains and fond the following:

5.9.1 Quality Domain

Option 1a is the strongest option from an equality perspective. 1a Gives the best option for more people over a greater span of time. **1a – increased score from 7 to 8.**
Option 1b received negative feedback in relation to the lack of single gender wards for functional needs.

- No single gender option for functional needs if a patient wants or requires this.
- Inequality of access – this maintains a barrier of access, but 1a and 2 offer options to address the barrier as they include a single gender functional ward.
- Score for option **1b reduced from 5 to 4 in quality** as it means that there is more than one key area that can't be met: though mitigations could be put in place to manage, this is sub optimal.

Option 2 – no change.
People with functional needs more likely to benefit from en-suite but no / very limited access to this in option 2. Option 1a has no/very limited en-suites for dementia, but patients with dementia more likely to need bathroom/bathing support.

5.9.2 Access Domain

Calderdale most impacted by the options and there is a greater impact with option 2. Extra travel for option 2 raised as key specific negative themes by people in Calderdale:

- This option will create difficulties around transport for patients, carers and families (14 / 19%)
- Locations are hard for patients, families and carers to reach (9 / 12%)

The updated Travel Impact Assessment identified that whilst all options created extra travel, the overall impact of option 2 is greater (more people impacted and a bigger impact for those that are).

Consultation theme in relation to access: the lower number of dementia beds in option 2 and whether there is capacity to meet demand.

Consideration was given as to whether the access score for option 2 should be reduced but these issues were identified in 2023 options assessment and scored accordingly then.

For criteria of access for **1a, 1b, and 2 options scores remain the same.** No additional considerations.

5.9.3 Sustainability

The focus of the sustainability criteria was primarily on whether each solution could be sustained for a period of up to 10 years and there was nothing new to indicate a change to scores based on these criteria

5.9.4 Strategic Alignment

Following review there no significant changes to policy or strategies that would impact on the proposed transformation. Both option 1a and 2 scored well from strategic perspective and therefore there was no new information to date that changes the assessment.

5.9.5 Value for Money

Whilst it was noted though that option 1b was not recognised as offering the same value for money in the consultation feedback compared to other options, even though it is lower cost., the assessment rating did not change as the costs and other factors considers in the value for money assessment remained the same.

5.9.6 Updated options matrix

The table below shows the revised scores following the review of findings:

		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**
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21 **rescored to 24**	14	6	8	**49**	19.2	**72.2**
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15 **rescored to 12**	8	4	5	**32**	21.6	**50.6**
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18 **no change**	12	6	8	**44**	19.2	63.2

Based on the updated findings of the consultation and impact assessments, the overall ranking hasn't changed but some scores have. Out of a weighted total of 100, the 3 options now scored as follows:

- Option 1A: 72.2
- Option 1B: 50.6
- Option 2: 63.2

Though some scores to the options appraisal were changed as a result of consultation, the findings supported the previous analysis and options appraisal that has taken place, **with option 1A ranking highest** and being the most appropriate option to take forward to implementation.

For more information see appendix 8, options and recommendations.

6 System prioritisation and financial assurance

6.1 NHSE Requirements

NHSE acknowledged prior to consultation that the ICB has confirmed that it will prioritise the proposed changes from a capital and estates expenditure perspective, with capital costs to be met by SWYPFT's 2024/25 and 2025/26 operational CDEL capital allocations. However, they sought further assurance prior to decision making business case demonstrate that this scheme is prioritised for system capital across all conflicting priorities in West Yorkshire

Further to this, NHSE requested the following information in place pre decision.

Financial plan
Evidence documents:

- Draft finance chapter of business case
- SWYPFT Medium term Financial Plan

Key content:

- Complete picture of costs with total costs and funding sources and applicable increases e.g., in contingencies, agenda for change pay increases since PCBC was published and impact on both provider and commissioner budgets/bottom lines
- Detail of workforce costs (WTE increase, timeline and on-going impact on revenue position), including contingencies if recruitment plans aren't fulfilled
- Incorporation of stranded costs and associated revenue costs into the financial model but clarifying exactly what these costs are and their associated value.
- Detail of any transition costs
- Inflation calculations for both revenue and capital including appropriate, quantified tolerances and mitigations
- Evidence of how financial modelling aligns with workforce and capacity and demand modelling (and that growth has been considered in relation to the latter) ie: triangulation
- Comparison of proposed option's costs to business-as-usual costs from both a capital and revenue perspective
- Process for estimating optimism bias (use of external consultants with supporting documentation etc)
- Profiling of planned capital/revenue expenditure (£ per year) and how capital falls within CDEL allocations
- Description of governance for planned spend and sign up at all relevant levels (provider and commissioner, as well as system given that WY is now identified as a deficit system for 24/25). As such, confirmation required that the business case has gone through the ICS governance process and affordability has been confirmed by the system.
- Description of all capital/revenue risks with evidence that these are understood, owned, monitored and planned mitigations supported at a system level
- Poplars site – our understanding is that under the options being considered, this site will become vacant. Please detail what the Trust intends to do with this site and the financial impacts, along with relevant timelines e.g.: is the intention to sell the asset,

in which case a capital receipt will arise that requires to be factored into the business case financial modelling, if the site is to remain vacant then there will be on-going associated revenue costs to be factored into the business case financial modelling.

Strategic prioritisation:
Evidence documents:

- Letter of support from MH Provider Collab & Programme Board for the specific change proposals

Key content:

- Confirmation that the OPMH change proposals are viewed as a system priority for the collaborative/board
- Assurances that there has been an impact assessment and review undertaken collectively, within the system, that has considered and established the MH priorities for West Yorkshire and has thereby confirmed that this investment is indeed a priority, given the competing needs of other schemes to access CDEL.

System level controls/checks & balances
Evidence documents:

- Finance section and separate supporting letter/email from the system, which has been taken through ICS governance.

Key content:

- Description of additional financial controls/checks/governance that has been applied to change programme to reflect the now very different financial position of WY ICS, evidencing the need to assure the use of resources within the system.
- Evidence of considerations undertaken and that the planned spend remains supported at a system level, whilst also demonstrating how the business case will provide both financial sustainability and address the underlying financial deficit of the Trust.

6.2 Financial plan

6.2.1 Capital Costs:

Estimated capital financial values have been calculated in line with NHS standards and align with HM Treasury Green Book and NHS England and Department of Health and Social Care (DHSC) business case requirements and processes. As such each estimate includes optimism bias, inflationary assumptions and contingencies. 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. These costs will be updated and finalised following a procurement process post consultation.

The table below gives a high-level summary of capital costs:

Option	Description	Total Capital Cost	Comments

Option 1A	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.

There is a revenue implication for the model and the £8.2 capital option will add approximately £500K annual revenue costs.

Current planning assumptions are that capital costs will be spread across 2 financial years, 2024/25 and 2025/26, with work being complete in spring or summer 2025. These values are contained within the current SWYPFT capital allocations as part of the West Yorkshire ICB capital allocation process.

2024 / 25	2025 / 26
£2.5M	£5.7M

6.2.2 Workforce Modelling

The workforce section of the pre consultation 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 1A
Registered Nurse	70.24	80.62	61.67	75.88
Healthcare Assistant	84.61	99.04	122.4	114.84
Total	154.85	179.66	184.07	190.72

Option 1A does 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 the option can't be expected immediately, 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.

6.2.3 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. Recent recruitment drives into the Trust have had positive results and as such we believe that the ability to recruit into the workforce model carries low risk. Should this increase, there is the option to re-open 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 posts 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.

6.2.4 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**	**Willow**	**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
No change (costed at current roster templates)	1,158	1,243	1,164	1,164	1,151	1,035		6,914
uplift /safer staffing	1,342	1,350	1,308	1,429	1,528	1,017		7,975
Option 1A) 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

The proposed option 1A 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.

The costs in the table above, per ward, are staffing costs related only and are based on costed rota's in line with Trust standard costing principles. There are no assumed recurrent non pay cost changes in any scenario as no change in activity, and therefore variable costs, has been assumed. Fixed costs will remain the same with the exception of additional capital charges (depreciation and Public Dividend Capital) arising from the additional capital expenditure proposed. This is included in the revenue for capital column above.

From a SWYPFT perspective there will be no impact to Trust bottom line as costs, which are over and above existing SWYFPT costs, incurred will be funded by commissioners in line

with the partnership agreement set out in the agreed principles. These have been factored into commissioners medium planning arrangements.

Workforce modelling and costs continue to be reviewed. No fundamental differences have been identified as a result of this and costs will be finalised following the recommendation of and decision on the option to implement.

6.2.5 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).

6.2.6 Timing

Current modelling assumptions are that a preferred model could be live from late in the financial year **2025 / 26**. It needs to be clear that this is an assumption and actual timing will be dependent 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 have incorporated and prioritised funding from that point. Recruitment plans, and part year effects, profiling, etc, will be agreed with system partners once timescales are finalised.

6.2.7 Financial implications – revenue

Whilst the actual costs will depend on the decision on the recommended option, confirming of final staffing models and agreed national pay rates, the financial modelling, used to inform the preferred options to take to consultation, highlighted a current difference of £1.2m between current costs and the highest cost option (which is option 2). The difference to option 1A is £1.0m.

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 Already included in SWYPFT financial position
Actual Spend 22 / 23	8,062	
Option 1A	9,082	Modelled financial gap £1,020k

It is proposed that the additional cost would be apportioned between the three places (Calderdale, Kirklees and Wakefield using a methodology yet to be defined and agreed). No additional non pay or overheads have been included within the financial modelling. These are not expected to significantly change from current costs incurred.

6.2.8 Financial implications – capital

The capital cost has been incorporated into the SWYPFT capital programme which has been developed in support of the long-term Estates strategy. This will utilise SWYPFT capital allocations and 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 WYICB has confirmed prioritisation of this scheme from a system capital and 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. This programme is included within the WYICB 10 year infrastructure plan which is currently under development.

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 are 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.

6.2.9 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.

6.2.10 Financial implications – transition costs

There will potentially be a limited amount of 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.

6.2.11 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 any 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

Poplars disposal costs will be overall in the region of £10k based on the market value of circa £150k disposal will take approx. 12 months but this is market dependent.

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.

Any receipts from the disposal will be returned into the overall Trust to be used in delivering services throughout the Trust.

6.2.12 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.

As covered, key principles that have been applied throughout across the partnership to ensure financial viability which include prioritisation of spend / funding and sharing of risk.

6.3 Strategic Prioritisation

The programme is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme.

A letter from Keir Shillaker, Programme Director: Mental Health, Learning Disability & Autism, West Yorkshire, confirms that business case for the development of specialist inpatient mental health services for older people is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme. It supports the ICB's overarching goals of improving outcomes, reducing inequalities, and enhancing the quality, accessibility and experience of mental health services for older adults, while also promoting sustainability and environmental responsibility.

The letter also states that the proposed specialist inpatient services will specifically benefit the populations and communities across Calderdale, Kirklees and Wakefield, addressing the identified clinical and quality gaps in specialist mental health provision for older adults in these places. However, this provision will also contribute to the overall enhancement of services across West Yorkshire, strengthening the region's ability to deliver high-quality, equitable care for older people with complex mental health needs.

See appendix 9 for more information.

6.4 System level controls/checks & balances

South West Yorkshire Partnership Foundation Trust (SWYPFT) has confirmed the following:

- That the OPS inpatient transformation scheme is their capital priority as identified in their Trust Estate Strategy. This forms the Trust key scheme within the developing WY ICB infrastructure plan.
- Based upon current agreed capital allocation methodology this is contained within the SWYPFT allocation. The capital programme is scheduled to accommodate this scheme without creating additional estates risks.
- The Trust will be using its own cash reserves and therefore does not require cash support from the ICB.

In addition, the West Yorkshire ICB finance director, Jonathan Webb, has confirmed the following statements (see appendix 10):

- The agreed methodology for capital allocation would need to change from the current model to have a direct impact on other Trusts.
- During 2024/25, the WY infrastructure plan has been developed and agreed, with this programme identified as a priority.

In late 2023, the NHS WY ICB confirmed prioritisation of this scheme from a system capital & estates perspective. This was 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.

In 2024, wider system challenges have emerged. However, based on proposed costs remaining as planned, it is our expectation that SWYPFT will receive the capital allocation they require to deliver the programme, factoring in their prioritisation of the programme and plans to spread costs across financial years.

The ICB is committed to delivering MHIS in line with NHSE expectations. The ICB can confirm that this is our priority for funding future MHIS and forms the basis of financial planning. As this will be apportioned across place it does not represent the entirety of the MHIS and will allow other investment.

The incremental revenue impact for SWYPFT and Calderdale, Kirklees and Wakefield place is c. £1m in total, which is approximately 5.1% of the WYICB MHIS growth for 2024/25.

The revenue costs will be phased, in agreement between system partners, with current modelled part year effect costs from 2025 / 26. As system partners, we have agreed that if Mental Health Investment Standard funding continues that the Older Peoples transformation programme is initially prioritised to meet the revenue costs over the agreed period. SWYPFT and ICB will risk share any increases in costs that emerge as a direct result of the programme.

The business case for the transformation evidences that the investment, whilst improving operational services, quality and safety, it also helps to mitigate a number of other risks including financial pressures arising from the current structure, in particular increasing costs associated with keeping patients with high acuity dementia safe in an isolated site. This will help support the overall financial sustainability for SWYPFT.

The Trust has confirmed that it is continuing to develop its medium-term financial sustainability plan, in line with the wider development within the ICB, and is taking actions to ensure delivery of this and the 24 / 25 in year breakeven target. This includes review and support of all guidance and advice.

7 Implementation considerations

7.1 Travel and Transport mitigations and actions

A working group was established in 2024 with a mix of carers, governors, SWYPFT and ICB staff. It was tasked with making recommendations to support family, carers and loved ones that have difficulty travelling to a transformed model, considering feedback from the public consultation and agreeing principles for when support is needed as a result of the transformed model.

From the findings of consultation and the evidence provided to the group, it was clear that some protected characteristics, and health inclusion groups may experience more of an impact than others when having to travel long distances, to unfamiliar places, or use public transport. The group identified these as: people who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties. The mitigations identified aim to address the issues for all groups identified but will benefit all patients, carers, and visitors impacted.

As such, the group has recommended the implementation of a visitor support pathway, which would take a needs based and personalised approached to supporting people impacted by changes, including:

- Provide guidance on travel by the wards.
- Ensure flexible visiting is adopted.
- Offer digital solutions.
- Factor in needs of carers, for example the triangle of care principles, carers' passports and carers' assessments.
- Work with partners including the Combined Authority to influence improvements public transport solutions that better link hospitals and improve ease of public transport journeys.
- Ensure there is a failsafe / contingency in place for essential visitors such as carers / next of kin that are unable to visit as a result of changes made which factor in the needs of the service user and the ability of next of kin to visit. This could include volunteer drivers, VCSE support or paid taxis.

If the measures above do not provide enough support to allow an essential carer to visit the ward, a range of circumstances will be considered including:

- Needs of service user – how beneficial visiting is, how frequently they would benefit from visits.
- Visitor circumstances:
    - If it requires a complex and long journey, for example, more than 1 change of public transport, or the journey takes over 1 hour.
    - If the visitor has disabilities or a condition, including frailty, that makes the journey difficult.
    - High cost of travel makes the journey unaffordable.

In these situations, where an essential visitor is unable to travel, it is proposed that the provider will work with the next of kin to capture the evidence of need and find a way to support the visitor to access the ward as appropriate.

It is proposed that the pathway is supported for a 5-year time period, with reviews factored in, potentially annually. 5-years would give the time for new ways of working to be fully embedded. The reviews would focus on access and usage of the pathway to ensure it is working effectively for people.

7.2 Equality Mitigations and Actions

The updated equality impact assessment includes an updated series of mitigations, factoring in feedback from the public consultation. The following are mitigations included in the equality impact assessment:

Consider improvements to ward 19 in relation to toilet and bathing facilities, factoring in patient and carer views, in particular in relation to options to add en-suite to any bedrooms on the site.

Ensure that options are in place to care for people from Calderdale and Kirklees admitted to Beechdale on a single gender ward in Wakefield if required.

As part of estates work consider décor, pictures and facilities to ensure inclusivity and consider arrangements for ablutions such as a Wudu. As part of implementation planning think about cultural approaches to cooking and storing food and menu choices and activity that consider diversity.

Ensure the Trust transgender policy is considered in the design and development of services. Further engage transgender groups to confirm design options and preferences.

Ensure environments meet the needs of people with a disability, considering flooring contrast, colour, lighting and accessible facilities and work with a rage of disability groups to test out access

Staffing: Recruitment of staff representing a range of faith backgrounds and appropriate gender mix.

The equality impact assessment will continue to be reviewed and updated as the programme progresses towards implementation.

7.3 Quality Mitigations and Actions

The quality impact assessment identified potential mitigations linked to travel and toilet / bathroom facilities on ward 19 and some work should take place on general environment, in line with dementia design guidance.

In additional mitigations are required around pathways and partnership working across place.

Mitigations could include:

- An increased used in video conferencing for ward meetings to reduce travel impact.
- Reorganising ward reviews so that they are held on different days for each geographic area.
- A review of clinical pathways for patients admitted to general hospitals, to reduce the number of admissions to general hospitals

Further work to take place to focus on new ways of working.

Mitigations also may be required due to capacity limitations of having separate male and female needs-based wards. Mitigations would be to place someone in the next most appropriate ward, increasing observation levels while required, and further exploring whether any additional gender flex can be created.

7.4 Sustainability Impact Mitigations

A theme raised in the consultation was that although most respondents felt the Trust had considered everything around sustainability and environmental impacts, around 20% felt they had not and shared their rationale.

Every Trust is required to deliver a net zero carbon roadmap and activity in this programme will support the roadmap. All future reports to board on sustainability will be made available on the Trust website, which will fully explain rationale for sustainability activity, of which this programme will form part.

The building infrastructure for development work at Fieldhead will be in line with the green plan. We will continue to improve the energy efficiency of our buildings, equipment and practices as part of relocation and ensuring that all new buildings and refurbishments meet sustainability standards.

Visitor support solutions will be part of the active travel plan programme which explores all elements of green travel including increased support for electric vehicle use, for example more charging points, and use of public transport. Part of this includes exploring the potential for much improved public transport that better links hospitals and encourages people to use public transport rather than private transfer.

7.5 Other considerations identified

Other considerations identified, for example, via the consultation review workshop include:

- Partnership working – in particular with voluntary and community sector partners to improve patient pathways.
- Developing, using and optimising creative solutions

- Ensuring that there is a plan to support the staff through transition and staff wellbeing.

The mitigations identified across each impact assessment have been used to inform and drive the development of implementation planning and working group. Initial high level workstream plan and drivers can be found in appendix 11.

8 Recommendations

The programme has been on a journey for several years to reach a position where we are able to reach a recommendation on the preferred option, with mitigations, that have been robustly tested across a wide range of key stakeholders.

In presenting this business case, there have been conclusions throughout and based on the strong evidence and consistent feedback on options from a quality, equality and access perspective, the programme board make the following recommendations:

- That option 1A is endorsed for implementation.
- That commitment is made to progressing solutions identified, particularly for people impacted by travel and transport.

As well as these recommendations, ongoing governance and oversight will be required through to implementation and agreement is sought to approve the formation of an Implementation Team, reporting to the programme board, SYYPFT Executive Management Team / Trust Board and the Joint Integrated Care Board Committee on the implementation process.

9 List of appendices

Appendix 1. Quality Impact Assessment
Appendix 2. Travel Impact Assessment
Appendix 3. Sustainability Impact Assessment
Appendix 4. Review of strategies
Appendix 5. Consultation plan
Appendix 6. Feedback from JHOSC
Appendix 7. Report of workshop
Appendix 8. OPS Options and Recommendations
Appendix 9. WY ICB OPMH Supporting Statement
Appendix 10. Finance Supporting Statement
Appendix 11. OPS Workstreams Post Decision

9.1 Other documents for reference

Clink the links below to access other relevant documents referenced in this business case:

Pre consultation business case
Independent report of consultation findings
Equality impact assessment
Transforming older people's inpatient mental health services – 2022 engagement