
OLDER PEOPLE'S MENTAL HEALTH TRANSFORMATION JOINT COMMITTEE

10.00 to 11.30, Friday 1 December 2023

Microsoft Teams Meeting

AGENDA

1. Welcome & apologies
2. Declaration of Interests
3. Terms of Reference approval – Louise Hall
4. Older People's Mental Health Inpatient Transformation Programme for Calderdale, Kirklees and Wakefield – Vicky Dutchburn
5. Dates of Next Meetings



Meeting name:	Older People's Mental Health Transformation Joint Committee
Agenda item no.	3
Meeting date:	1 December 2023
Report title:	Terms of Reference for the Older Peoples Mental Health Transformation Joint Committee
Report presented by:	L Hall – Interim Governance Manager (Kirklees Place)
Report approved by:	N/a
Report prepared by:	L Hall – Interim Governance Manager (Kirklees Place)

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☐
Previous considerations:			
The Terms of Reference were previously approved by the West Yorkshire Integrated Care Board Board with delegation for minor amendments and finalisation of Membership to the Joint Committee.			
Executive summary and points for discussion:			
This report sets out the final draft Terms of Reference for approval by the Committee as delegated by the WYICB Board.			
Which purpose(s) of an Integrated Care System does this report align with?			
☒ Improve healthcare outcomes for residents in their system ☒ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☒ Support broader social and economic development			
Recommendation(s)			
The OPMHT Joint Committee is asked to adopt the Terms of Reference as set out in appendix 1			
Appendices			
1. Proposed Draft Terms of Reference			
Acronyms and Abbreviations explained			
WY ICB – West Yorkshire Integrated Care Board OPMHT – Older People's Mental Health Transformation ToR – Terms of Reference			

1. Main Report Detail

- 1.1 The CCGs, as the predecessor organisations, had previously agreed that there was a case for changing the way that local mental health services are provided and that making no change was not in the best interests of patients.
- 1.2 A phased approach to the development and implementation of changes to the older peoples' mental health inpatient and community services was agreed, proceeding first to strengthen community services as part of each place's respective Mental Health Care Closer to Home Programmes to enable people to gain confidence in them through direct experience, prior to the inpatient transformation.
- 1.3 The current phase of the programme has considered the development of the In-patient options through the programme board for further consideration by the appropriate decision takers. This work has been developed as a single system, of partners from Calderdale, Kirklees and Wakefield (the three affected places) and SWYPFT.
- 1.4 To progress to public consultation a decision on the proposed business case and consultation materials is needed and the programme board have worked in collaboration with each of the place governance leads and the WY ICB director of Corporate Affairs, to consider the various options for making this and future decisions relating to this programme.
- 1.5 As a result of this work, it was recommended to the WYICB Board that a joint committee of multiple places be established in order that a single decision could be taken by a 'balanced' group from the affected places.
- 1.6 The WYICB Board agreed the establishment of a Joint Committee and approved draft terms of reference, delegating final amendments to the Joint Committee as necessary.
- 1.7 The Draft Terms of Reference are attached at appendix 1 for consideration and approval for adoption is sought.

2. Recommendations

- 2.1 The OPMHT Joint Committee is asked to adopt the Terms of Reference as set out in appendix

3. Appendices

- 3.1 Proposed Draft Terms of Reference

Joint Committee of Calderdale, Kirklees & Wakefield ICBs Terms of Reference

Version control

Version: 24.0

Approved by:

Date Approved:

Responsible Officer:

Date Issued:

Date to be reviewed:

Change history

Version number	Changes applied	By	Date
0.1		V Dutchburn R Unwin	August 2023
<u>0.2</u>		<u>L Hall</u>	<u>November 2023</u>

1. Introduction

- 1.1 The Joint Calderdale, Kirklees and Wakefield Older People's Inpatient Reconfiguration Committee is established as a committee of the West Yorkshire ICB, in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation.
- 1.2 These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of this Committee and may only be changed with the approval of the ICB Board. The Committee has no executive powers, other than those specifically delegated in these terms of reference.
- 1.3 The ICB is part of the West Yorkshire Integrated Care System, which has identified a set of guiding principles that shape everything we do:
 - We will be ambitious for the people we serve and the staff we employ.
 - The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
 - We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
 - We will undertake shared analysis of problems and issues as the basis of taking action.
 - We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.
- 1.4 The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:
 - We are leaders of our organisation, our place and of West Yorkshire.
 - We support each other and work collaboratively.
 - We act with honesty and integrity, and trust each other to do the same.
 - We challenge constructively when we need to.
 - We assume good intentions; and
 - We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

- 1.5 The ICB has a shared vision to facilitate an integrated system that enables people to live longer in good health and to be able to get the care and treatment they need, in the right place, at the right time.
- 1.6 The Committee will abide by the values set out in the ICS Leadership and Behaviours Framework.

2. Membership & attendees

Nominations to the joint committee will be subject to confirmation by the place chairs and accountable officers. Membership will be approved in the Terms of Reference by the ICB.

Include:

Independent chair (~~as set out in xx eg: ICB Board Chair or INEM~~)

INEM or chair from each place

Exec rep from each place (nominated voting member of each place committee)

Quality

Finance

Workforce

Equality and inclusion lead

Healthwatch representative

<u>Members</u>	
<u>Liz Mear</u>	
<u>Jo Bibby</u>	
<u>Stephen Hardy</u>	
<u>Carol McKenna</u>	
<u>Robin Tuddenham</u>	
<u>Mel Brown</u>	
<u>In attendance</u>	
<u>Penny Woodhead</u>	
<u>Lesley Stokes</u>	
<u>Vicky Dutchburn</u>	
<u>Fatima Khan Shah</u>	
<u>Stacey Appleyard</u>	
<u>Workforce</u>	

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- 2.1 Mental Health Provider Representative~~s~~ from SWYPFT will be in attendance
- 2.2 ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.
- 2.3 Any member of the ICB Board can be in attendance subject to agreement with the Chair.

3. Arrangements for the conduct of business

3.1 Chairing meetings

Each independent Place Committee Member shall Chair meetings in rotation. In the event of the chair of the committee being unable to attend all or part of the meeting, one of the other independent members will chair the meeting.

3.2 Quoracy

For meetings to be quorate, a minimum of 50% of the membership is required and must include one member from each Place.

For the sake of clarity:

- a) No person can act in more than one capacity when determining the quorum.
- b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Members are expected to attend or, with the permission of the person presiding over the meeting, nominate a deputy to attend any meeting of the Committee that they are unable to attend. It is the responsibility of the nominating organisation to ensure the person is suitably experienced, meets the eligibility criteria and has the authority to act as a representative of the organisation or sector that they are representing. The deputy may speak and vote on their behalf. The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

3.3 Voting

In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each voting member of the Committee will have one vote, the process for which is set out below:

- a. All members of the committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at paragraph 2.1. Deputies attending on behalf of a committee member will be able to vote. Attendees and observers do not have voting rights.)
- b. Absent members may not vote by proxy.

- c. A resolution will be passed if more votes are cast for the resolution than against it.
- d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.
- e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.4 Frequency of meetings

The Committee will meet as required to fulfil its role and remit.

3.5 Urgent decisions

In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the committee to meet virtually. Where this is not possible the following will apply:

- a) decisions may be made by the Chair and the 3 place Executive representatives.
- b) such decisions shall be reported to the next formal meeting of the committee for formal ratification, where the Chair will explain the reason for the action taken.

3.6 Admission of the press and public

Meetings of the Committee will be open to the public.

The Committee may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

The chair of the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Committee's business shall be conducted without interruption and disruption.

The public may be excluded from a meeting to suppress or prevent disorderly conduct

or behaviour.

Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Committee.

A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least seven calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

3.7 Declarations of interest

If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The

chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

3.8 Support to the Committee

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The Committee's lead manager is the Kirklees Place Director of Operational Delivery and the Senior Responsible owner of the programme.

Administrative support will be provided to the Committee by the ICB. This will include:

- Agreement of the agenda with the Chair in consultation with the Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- Sending out agendas and supporting papers to members 7 calendar days before the meeting.
- Drafting minutes for approval by the Chair and ICB Lead Manager within five working days of the meeting and then distribute to all attendees following this approval within 10 working days.

~~• An annual work plan to be updated and maintained on a monthly basis.~~

4. Remit and responsibilities of the committee

The Joint Committee is established for the specific purpose of considering and ~~determining approving~~ the ~~business case for~~ reconfiguration of inpatient provision for older people with dementia and/or function~~als~~ mental illness for the populations of Calderdale, Kirklees and Wakefield District.

This will include:

- Reviewing and assuring the quality and safety implications of the Business Case, taking into account internal and independent sources of assurance
- Assuring the workforce plan set out in the Business Case, taking into account internal and independent assurances
- Reviewing the Equality Impact Assessment and assuring the mitigations
- Approving the consultation plan and assuring that it meets the statutory duties of the ICB and the expectations of the Joint Overview and Scrutiny Committee
- Reviewing the outcomes of public engagement and consultation.
- Approving the pre-consultation Business Case prior to consultation, including the capital and revenue requirements
- Approving the final Business Case including adjustments or mitigations made following consultation, including the capital and revenue requirements.

The Committee has specific delegated authority from the West Yorkshire Integrated Care Board to make decisions about the use of NHS resources for the purposes of providing inpatient assessment and treatment for older people with dementia and/or functional mental illness living in Calderdale, Kirklees and Wakefield district. The decisions reached are the decisions of the ICB, in line with the organisation's scheme of delegation.

- 4.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the Committee.
- 4.2 The Committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.
- 4.3 The Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the Committee must follow procedures put in place by the ICB for obtaining legal or professional advice.

5. Reporting

- 5.1 The Committee shall submit its minutes to the ICB Board meeting and to the Partnership Committees for Calderdale, Kirklees and Wakefield.
- 5.2 The Chair of the Committee shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB.
- 5.3 The Committee's minutes will be published on the ICB website once ratified.
- 5.4

6. Conduct of the committee

- 6.1 All members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures.
- 6.2 Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.
- 6.3 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

6.56.4

DRAFT

Meeting name:	Older Peoples Mental Health Transformation Joint Committee
Agenda item number:	4
Meeting date:	Friday 1 December 2023
Report title:	Older People's Mental Health Inpatient Transformation Programme for Calderdale, Kirklees and Wakefeld.
Report presented by:	Vicky Dutchburn, Director of operational delivery and performance and senior responsible officer for older people's transformation, NHS West Yorkshire Integrated Care Board Professor Subha Thiyagesh, Chief medical officer, Consultant in psychiatry for older people and clinical lead for older people's transformation, South West Yorkshire Partnership NHS Foundation Trust Ryan Hunter, Programme Manager
Report approved by:	Vicky Dutchburn, Director of operational delivery and performance
Report prepared by:	Ryan Hunter, Programme Manager

Purpose and Action:			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/com- ment/discuss/escalate)	Information ☐
Previous considerations:			
Various iterations have been through place-based sub committees. Informal briefing meeting held on 1st September 2023.			
Executive summary and points for discussion:			
Phase 2 of the older peoples mental health transformation programme. Phase 1 has been completed to improve and reconfigure community mental health services for older people. The paper attached covers: • The business case for change • The current position of mixed needs wards and current inpatient operating model. • The challenges of the current model, including mixed needs wards, pathways and movement of patients, and alignment of wards with other services. • The vision for the model of care and the gaps between the current model and the vision. • The thorough stakeholder engagement process that the programme has been through and the learning from this.			

- The options development process including the assessment criteria, the long-list of options, the clinical senate feedback on the options, and the detailed partnership approach to reviewing and testing the options.
- The financial implications of the options and the agreed approaches and principles to meeting financial requirements.
- The options to take to public consultation: subject to agreement
- The impact of the options, including travel, transport and parking impact, quality impact, equality impact, and sustainability impact.
- The proposed plan for public consultation.

With which purpose(s) of an Integrated Care System does this report align?

- ☒ Improve healthcare outcomes for residents in their system
- ☒ Tackle inequalities in access, experience and outcomes
- ☒ Enhance productivity and value for money
- ☒ Support broader social and economic development

Recommendation(s):

The Older Peoples Mental Health Transformation Joint Committee is asked to:

1. Note and approve the approach taken to date to engage with the public and stakeholders to support development of the options to be considered.
2. Endorse the business case progress the business case for use in a formal public consultation.
3. Endorse the financial planning to achieve the options proposed.
4. Approve the approach for public consultation.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

NA

Appendices:

Public papers:

MAIN REPORT: Joint ICB Committee Summary Report – OPS Transformation – 1 Dec 2023

Supporting documents:

- ICB Presentation – 1 December 2023
- SWYPFT OPS Inpatient Transformation PCBC Draft for ICB Committee Dec 2023
- DRAFT Consultation plan December 2023 ICB

Private DRAFT papers:

- SWYPFT OPS Inpatient Transformation PCBC Draft for ICB Committee Dec 2023
- Appendices to the business case as follows:
 - o Appendix 1: site visits and learning from others
 - o Appendix 2: options review workshop report May 23
 - o Appendix 3: Northern England Clinical Senate Report
 - o Appendix 4: Alignment with strategies – June 23
 - o Appendix 5: Estates Capital and Building works
 - o Appendix 6: Quality Impact Assessment
 - o Appendix 7: Sustainability Impact Assessment
 - o Appendix 8: Detailed Travel and Transport impact Analysis
 - o Appendix 9: Glossary of Terms
 - o Appendix 10: References
- Equality Impact Assessment
- Consultation Document
- Consultation Questions

Acronyms and abbreviations explained:

Outlined in the report.

What are the implications for:

Residents and Communities	As outlined in the report and will be fully explored through consultation.
Quality and Safety	Quality impact assessments included,
Equality, Diversity and Inclusion	Equality impact assessment included
Finances and Use of Resources	Finance and resources outlined in the report.
Regulation and Legal Requirements	This is in line with NHSE Major Service Change Framework. Legal framework for consultation is included in the report.
Conflicts of Interest	None to note
Data Protection	None to note
Transformation and Innovation	As outlined in the report
Environmental and Climate Change	Sustainability impact assessment included
Future Decisions and Policy Making	To follow in future papers
Citizen and Stakeholder Engagement	As outlined in the report and the proposed consultation plan.

Older People's Mental Health Inpatient Transformation

Joint Integrated Care Board Committee

Friday 1st December 2023

1 Business Case and Options Development

See draft business case document for more information.

1.1 Summary of business case

The older people's services (OPS) inpatient transformation programme has been a clinically led, partnership approach to focus on solutions that deliver a range of improvements across older people's mental health inpatient services. It predominantly seeks to address challenges of a model that mixes patients of different needs across the wards.

The programme has a shared governance across the Trust and the West Yorkshire Integrated Care Board (WY ICB), with a joint programme board chaired by ICB. Governance includes:

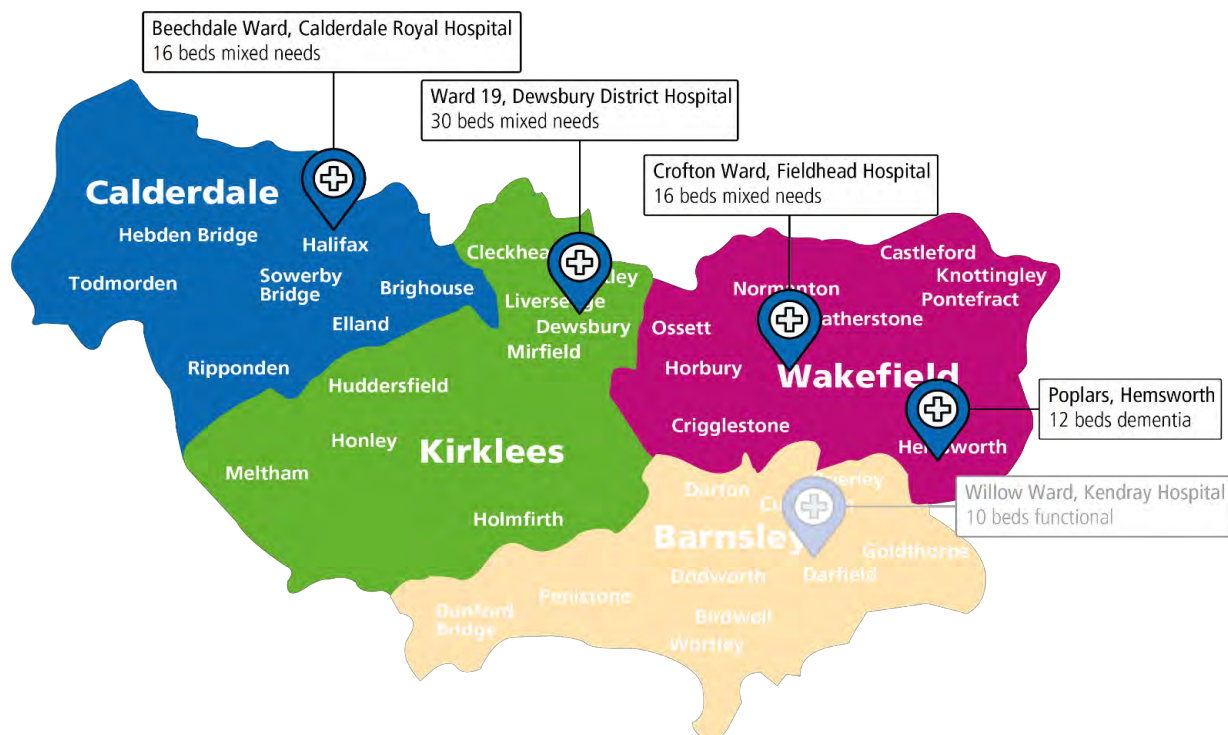
- Clinical senate – review of evidence and report in response to options.
- NHSE assurance gateway held to assess and assure the business case prior to public consultation.
- SWYPFT Trust Board
- Joint Health Overview and Scrutiny Committee.
- **Joint ICB committee of the places.**
- Partnership working groups to oversee different strands of work.

Further details of these governance arrangements can be found in **section 5.4** of the business case (link provided).

1.2 Current position

Commonly, inpatient wards see people with dementia (sometimes referred to as organic needs) or people with functional needs such as depression, anxiety or psychosis. People with each type of need share the same ward space in the current model.

Typically, there will be between 80-100 people with dementia admitted per year and between 150-200 people admitted with functional mental health needs across Calderdale, Kirklees and Wakefield. The map below shows the current inpatient operating model:



- 4 of the 5 wards are mixed needs (functional and dementia).
- Single sex accommodation guidance is met on all units except Poplars. Currently, 3 out of 5 of the wards are mixed gender, which can make clinical management an issue, especially for those patients with organic diagnosis.
- Note: Willow Ward in Barnsley (functional only) will not change and is not in scope.

1.3 Challenges with the current model:

- Mixed needs wards can create a challenging environment as the mix of patients doesn't work well from a clinical or therapeutic perspective and increases the risk of incidents.
- Often people move between wards, which can have a negative impact on wellbeing. 45% of people with dementia have more than 1 ward stay.
- Admissions have been reducing, length of stay (LOS) increasing over time, particularly for people with dementia.
- Not all wards are aligned with other services, for example, an isolated ward in Wakefield, the Poplars, which has issues admitting a high level of acuity and access to timely support when required. CQC has noted the challenges.
- Some ward environments are challenging. For example, Beechdale ward in Calderdale has narrow, twisting corridors that lead to 'dead ends', issues with staff line of sight and is difficult for patients to navigate.
- The workforce model is not adequate for the level of care required. The wards regularly need to bring in bank and agency staff.

The context and the current model are covered in more detail through **section 6** of the business case.

1.4 Current Workforce

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

To evidence this, we have used the Mental Health Optimal Staffing Tool (MHOST), Planning for the mental health support workforce (hee.nhs.uk), which was developed with NHSI, Imperial College London and 26 different Trusts and is the most evidence-based tool available and is part of NHSE's chief nursing officer's safer staffing fellowship programme as a recommended staffing/acuity tool.

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

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

The current workforce can also be found through section 6.

1.5 Vision:

A clinically led vision for the transformed model with:

- Separate wards for diagnosis, functional and organic, delivering the specialism to meet needs;
- Specialist ward environments;
- Accessible services for service users, carers, family staff and partner organisations;
- Improved pathways and fewer ward moves;
- Reduced length of stays;
- The right level of workforce and skills; meeting the needs of people from the protected characteristics.

The business case sets out what the model of care should deliver and how the current service model aligns with the model:

Safe Approaches	Requirements	Current model
The right environment in which service users are treated A safe approach to service user care and / or helps to prevent harm to service users Supports a risk management and safety systems Impact on partner organisations and any aspects of shared risk	▪ Separate wards for diagnosis - functional and organic/dementia, delivering the specialism to meet needs. ▪ A model with the best specialist ward environments to support people with design of the environment for gender needs and appropriate therapies and to support socialisation, for example, dedicated socialisation for people with similar needs. ▪ Wards sizes in line with or close to best practice guidance of 15 beds, ▪ Staffing to appropriate levels, in line with clinical need to support safety. ▪ Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards	▪ 4 of the 5 wards are mixed needs ▪ Single sex accommodation guidance is met on all units except Poplars. Currently, 3 out of 5 of the wards are mixed gender, which can make clinical management an issue, especially for those patients with organic diagnosis. ▪ Ward sizes are in line with best practice. ▪ Ability to have the right environment for therapies and socialisation is a challenge due to the mixed nature of the wards and configuration of some wards – for example Beechdale. ▪ Staffing is regularly short of the required level and bank/agency staff are required when dependency levels increase on the wards. ▪ There is a shortage of qualified members of staff, especially on a night shift where most of our wards have one registered nurse. ▪ Incidents, particularly falls and violence/aggression are much higher across the West Yorkshire wards than they are in the only functional ward.

	▪ Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	▪ Services are local to place but site isolation of Poplars ward does lead to challenges in terms of access to acute general hospital.
Effective Approaches	Requirements	Current Model
Staff understanding their role in improving the service user experience Consistency in care provision Positive outcomes of care Evidence-based practice Eliminating inefficiency and waste by design Staff teams and services, across pathways to work together to deliver safe, effective care	▪ Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care. ▪ Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge. ▪ Length of stay being appropriate for the level of need. ▪ People having continuity of care in their pathway with a single ward stay only until they are ready for discharge. ▪ Services that are accessible to staff teams, such as community services and other ward staff to work together.	▪ Staff do have general older age skills but feedback that it is not always possible to reinforce training received due to mix of patients on the wards. ▪ Staff feedback that they are often unable to provide therapeutic interventions to functional patients when they have a patient with dementia who needs more support or supervision. ▪ There are very different pathways and stays across the Trust, particularly for people with dementia. Most people with dementia from Wakefield have more than 1 ward stay and a typical stay of well over 100 days. In Calderdale, around 50% of people with dementia have had more than one ward stay, and LOS differs from place to place and is higher where people have multiple ward stays. ▪ Wards are local but the isolation of the Poplars ward creates issues in terms of access to cover, support in an emergency, shared facilities and medical out of hours support.
Caring Approaches	Requirements	Current model
Allows staff time to care for people Co-production	▪ The right staffing levels to support, including groupwork, based on people's needs. ▪ Staff, family and carers involved in design of care.	▪ The current staffing models fall short of what is required, particularly to deliver a specialist needs based model of care.
Responsive Approaches	Requirements	Current model
Delivery of strong service performance Promotes the principle of Right Care, Right Place, Right Time Timely service user pathway Fair access and the principles of the Equality Delivery system Access to services	▪ Evidence that service users are in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time. ▪ The service users, family and carers are able to access the service as needed. ▪ That people from across the protected groups are able to access services as needed and that services meet their needs. This includes travel needs for family and carers and environmental needs across the groups.	▪ The evidence shows that the mixed needs wards are not the most appropriate environment, exacerbated by some of the estates limitations, and this impacts on the care people receive, often people with functional needs when wards are managing people with dementia with behaviours that challenge. The systems we have are shown to increase the length of stay of patients on the wards. ▪ The current models do have enough capacity to meet demand and the local model does support access for family and carers, though in recent years approximately 30% of admissions have been outside of the patient's home locality (though within the Trust boundaries).

The business case also considers in detail the workforce required for the new model of care, the different roles and skills required on the wards, what a safe and effective rostered staffing level would be, and how we'll achieve the workforce, aligning with the workforce and great place to work strategies.

Further detail of the vision for the model is covered in **section 7** of the business case (workforce can be found in section 7.8.1 to 7.8.4), followed by gap analysis of current model in **section 8**. Benefits are **section 9**.

1.6 Public, Service User, Family, Carer and Staff Engagement

- A thorough clinically-led process using a Quality Impact assessment (QIA) has taken place to develop options, considering equality through the service level Equality impact assessments (EIA) and including engagement with 900 people, with 250 service users, family or carers. This has involved a range of stakeholders such as local authority (social care) and acute general hospitals, who have also supported the options review work.
- Partnership workshops with key stakeholders and clinical and operational experts agreed a shortlist of appropriate options.
- The NHSE clinical senate support the clinical model, the shortlisted options and the rationale for options not shortlisted.

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

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

- It was very upsetting and worrying for me coming in to contact with someone with dementia for the first time. I was worried all night hoping the person could not get into my room.
- I think the 'time element' of support currently is more geared to service users with dementia. We all need support.
- Some patient behaviour can be challenging and upsetting.
- Better calmer environment.
- Be easier for staff if functional only. The ward would be calmer and better especially for dementia patients, who required more care and looking after.

The business case also notes that some people were happy with or preferred a mix and that extra travel was a concern.

Staff engagement told us that there has been strong support for separate, needs based models.

Some of the benefits staff identified included:

- specialism of the unit and its staff. This could lead to reduced lengths of stay.
- Opportunity to create dementia friendly environments, allowing for service users to be managed with less medication in a less agitating environment.
- Specialist approach supports the provision of more focussed treatments
- Splitting functional and organic inpatient services would achieve a more person centred, needs led service.
- Potential to reduce the number of incidents.

They flagged the need to consider travel, potential increases in numbers of people with dementia, getting the staffing levels right, and approaches for the small proportion of people that might have both functional and dementia needs.

Section 10.1 of the business case gives a detail run through of engagement across a range of stakeholders through the programme.

A summary of feedback gathered can be found between **sections 10.2 and 10.4** of the business case.

1.7 Options Development

1.7.1 New builds:

Early in the options development consideration was given to whether solutions could be developed with bespoke new build estates and there was agreement in principle that a new build (or new builds) would be the best option for a specialist model of care. For example, there was consensus clinical view that a new build would achieve the best longer-term outcomes for people with dementia whilst enabling services for people with functional needs to be reconfigured into specialisms.

However, current capital constraints and the integration older people's services across sites with other wards that have complex lease agreements creates challenges in the likelihood of delivering such a solution in the medium term.

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

Section 10.5 of the business case

1.7.2 Partnership with ICS

We've also engaged with ICS to test whether there's scope in the medium terms to develop a model in partnership with other providers in the ICS or whether they had any planned activity that lends itself to considering a model in partnership. It was agreed there was no planned activity and as a medium-term development that we should go ahead and seek improve our model but that we should continue to engage, especially if in the future we explore longer term new build options.

Section 10.6 of the business case.

1.7.3 Options consideration

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

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

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

In 2023 we convened a partnership stakeholder review group to test the options, ensuring we considered key data to test which options were appropriate.

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

Section 10.7 of the business case

1.7.4 Assessment Criteria

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

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

Criteria:

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

The tables below show the headline criteria and more detail is in the business case (add pages here):

Domain - Quality	What we need to measure against
Clinical Quality and experience – service delivery	Delivery of the specialist clinical model
Skills and staffing	A model that supports the right staff and skills
Quality Environment	A model with the best ward environments to support people.

Domain - Access	What we need to measure against
Pathway	Most seamless pathways and less moves.
Travel access for family and carers	Travel impact for family and carers, particularly from the most deprived areas.
Access for staff and support	Access for staff, including partner organisations
Demand and capacity	Whether we have the right bed numbers to meet demand over time period of programme, including functional / organic and male / female split.

Domain - sustainability	What we need to measure against
Sustainable for time period required	Whether the model can be sustained for 10 years.
Delivered as soon as possible	Whether the model can be delivered in a timely way.
Cost effective	Cost effectiveness of the model
Recruitment and retention	Whether the model supports recruitment and retaining staff.

Domain - strategies	What we need to measure against
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Alignment with strategies	Whether the model aligns with strategies (including local, regional and national)
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Domain – Value for Money	What we need to measure against
Viability / Affordability	Is the capital affordable? Is the revenue affordable?
Use of resources	Makes best use of resources Economies of scale
Capital investment	Investment within budget and in SWYPFT estate

Options were weighted – 70% to the quality and safety aspects and 30% to finance and a scoring framework agreed, which included a lower range for each domain that if not cleared meant the option was not viable.

These are covered in section **10.7 and 10.8** of the business case.

1.7.5 Summary of options

The options that have been reviewed:

Option
Option 1 - No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.
Option 2 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.
Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.
Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.
Option 5 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds. Beechdale would be 16 bed functional. The Poplars site would not be in this model.
Option 6 –Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.

Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.

Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in Dewsbury, in a separate ward area in the Crofton ward and in the Willow ward. The Poplars site would not be in this model.

Option 9 - Crofton dementia unit, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards with 46 functional beds in total (The Poplars site not in this model) – *this option was added following feedback from clinical senate.*

Covered in **section 10.9** of the business case.

1.7.6 Clinical senate review

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

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

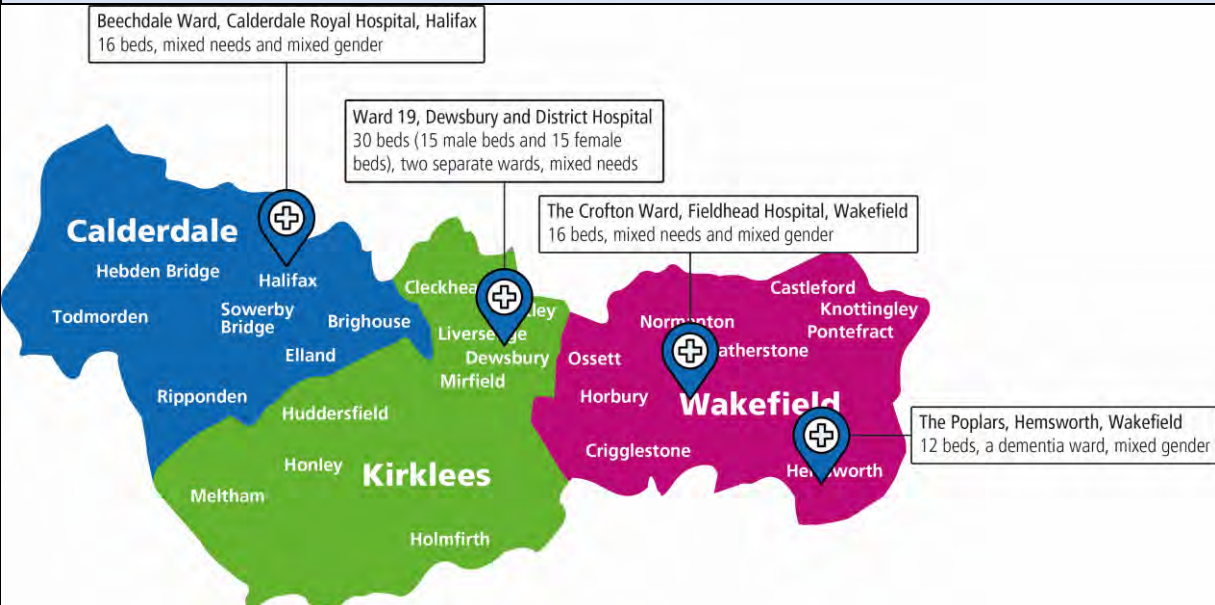
Information about the proposed models, with supporting evidence and travel impact assessments, were provided to the senate ahead of a virtual meeting to introduce the Senate panel to the programme.

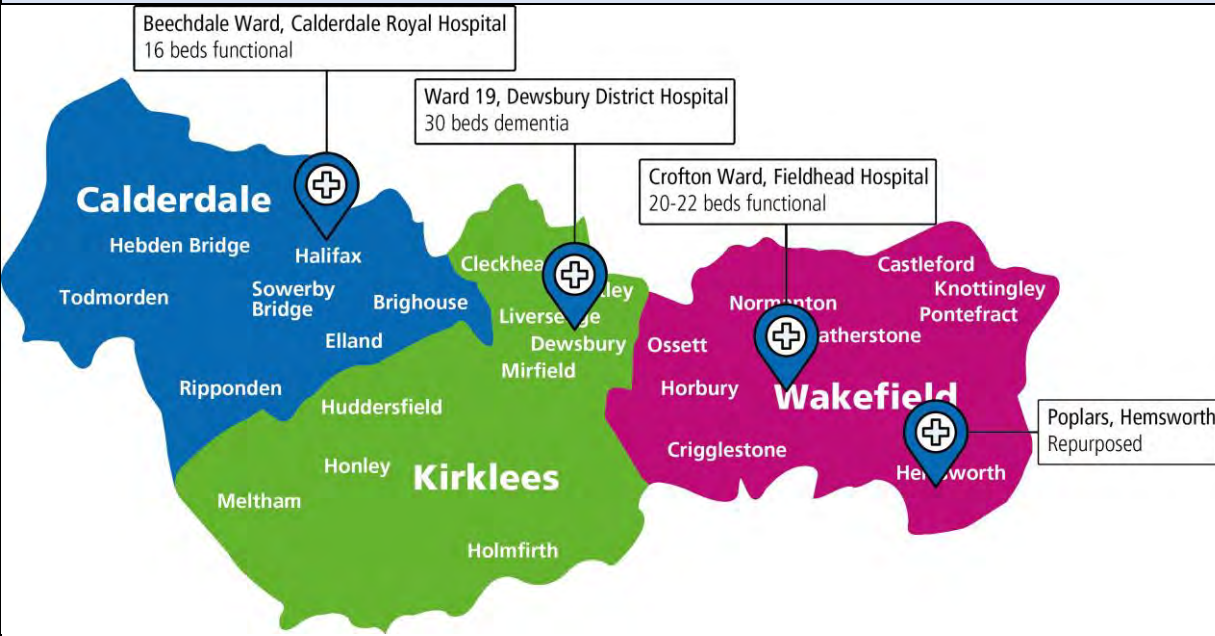
In June 2022 some members of the Senate panel made site visits to the four current inpatient units that accommodate both patients with dementia and those with functional mental health illnesses, to gain an understanding of the geography of the areas being served, the precise location of the units, the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

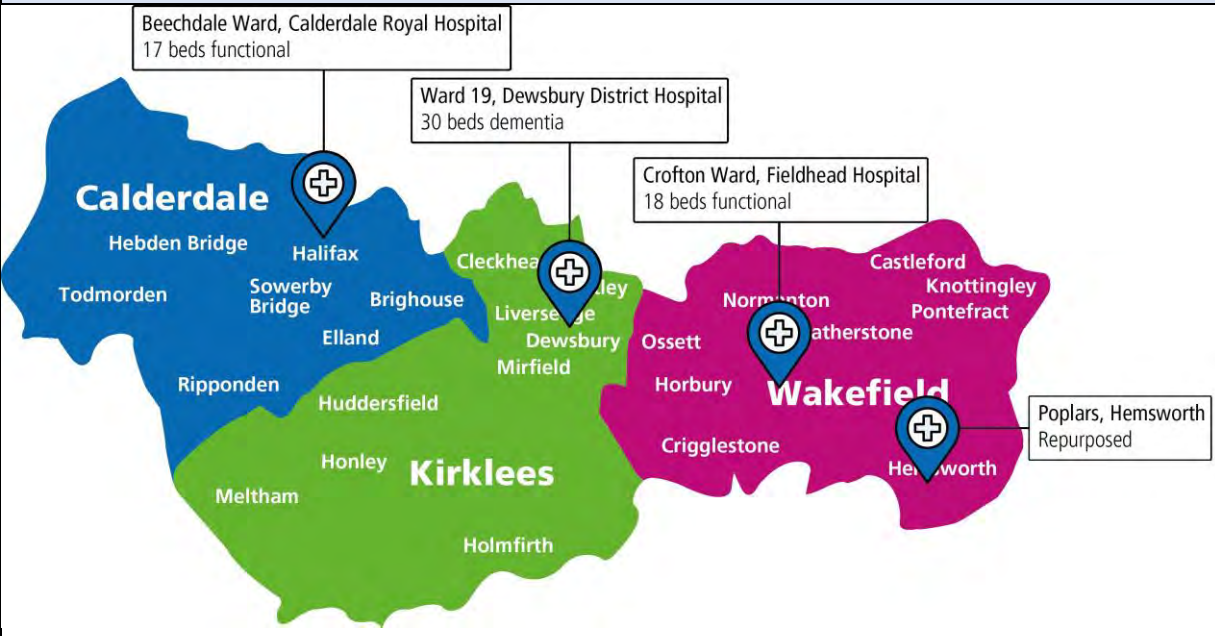
Summary of findings from the clinical senate include:

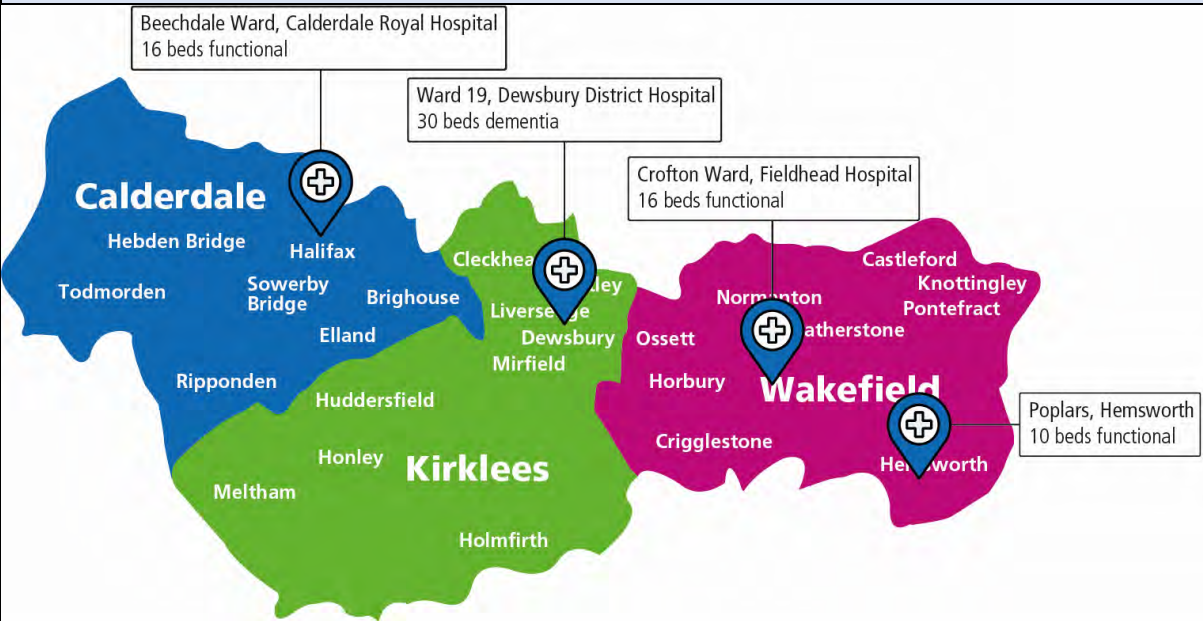
- The clinical senate were fully supportive of proposals, and “strongly concurs that patients with functional and organic disease should be cared for in separate distinct dedicated units”.
- The Trust were “commended on the way in which they have developed options to significantly improve the care of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

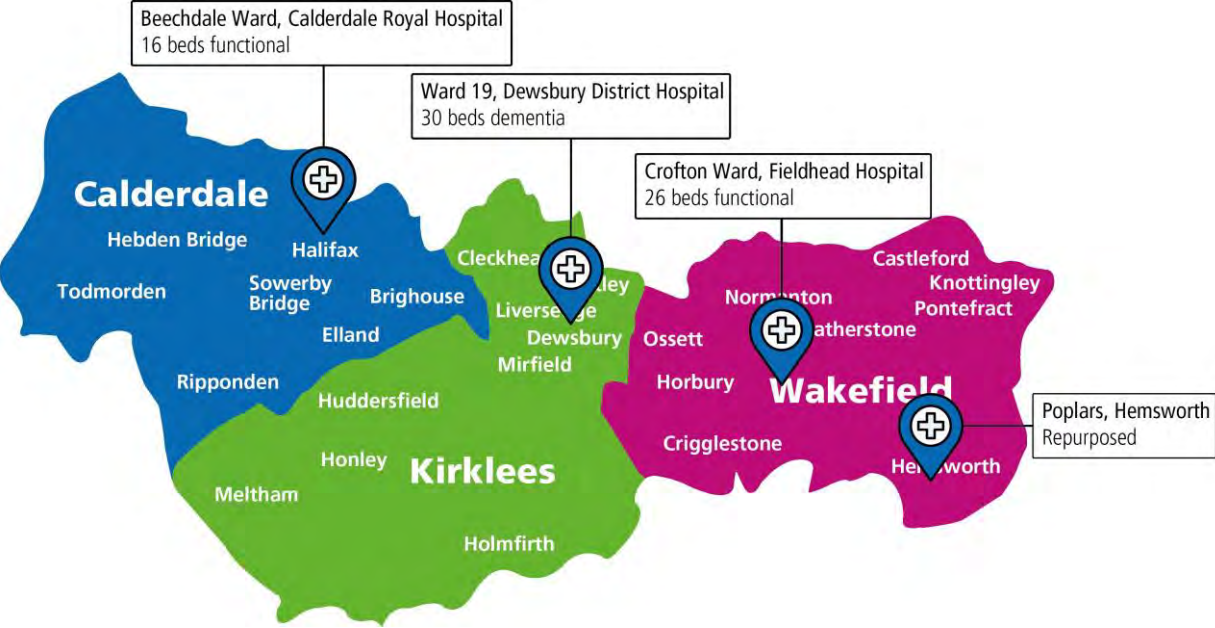
See tables below with options and clinical senate feedback (to note that clinical senate review and feedback is covered in section 10.11 of the business case):

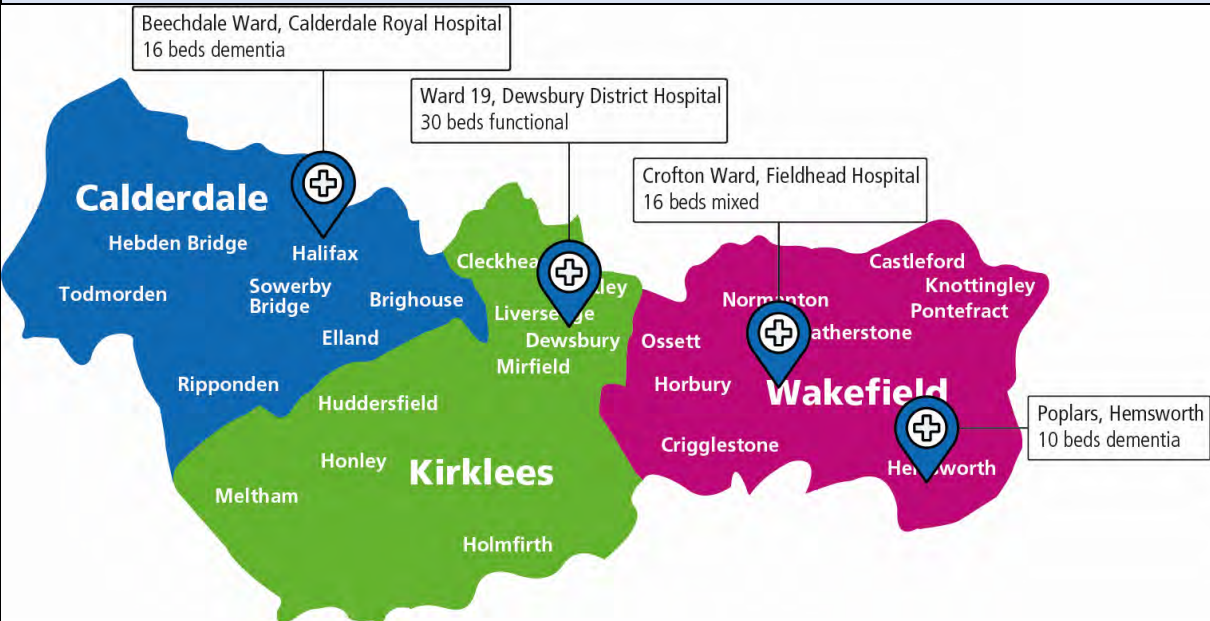
Option	Maps	Clinical Senate Feedback
Option 1- No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.	 The map displays three regions: Calderdale (blue), Kirklees (green), and Wakefield (pink). Calderdale includes locations like Hebden Bridge, Halifax, Todmorden, Sowerby Bridge, Brighouse, Elland, Ripponden, and Huddersfield. Kirklees includes Meltham, Honley, and Holmfirth. Wakefield includes Castleford, Knottingley, Pontefract, Normanton, Atherstone, Ossett, Horbury, Craggstone, and Hemsworth. Four hospital locations are marked with blue cross icons and callouts: Beechdale Ward, Calderdale Royal Hospital, Halifax (16 beds, mixed needs and mixed gender); Ward 19, Dewsbury and District Hospital (30 beds (15 male beds and 15 female beds), two separate wards, mixed needs); The Crofton Ward, Fieldhead Hospital, Wakefield (16 beds, mixed needs and mixed gender); and The Poplars, Hemsworth, Wakefield (12 beds, a dementia ward, mixed gender).	• Not a viable option • Does not achieve the ambition to develop a central specialist dementia unit • Maintains the mixed wards which negatively impact on patient experience and outcomes • Patients with organic (dementia) disease, and those with functional needs, benefit from a therapeutic environment dedicated solely to their needs. • National guidance and established practice has led to reconfiguration of services to achieve this. • Maintaining mixed wards is therefore not acceptable. • Maintains the clinical risks associated with current ways of working at The Poplars and Beechdale Ward.

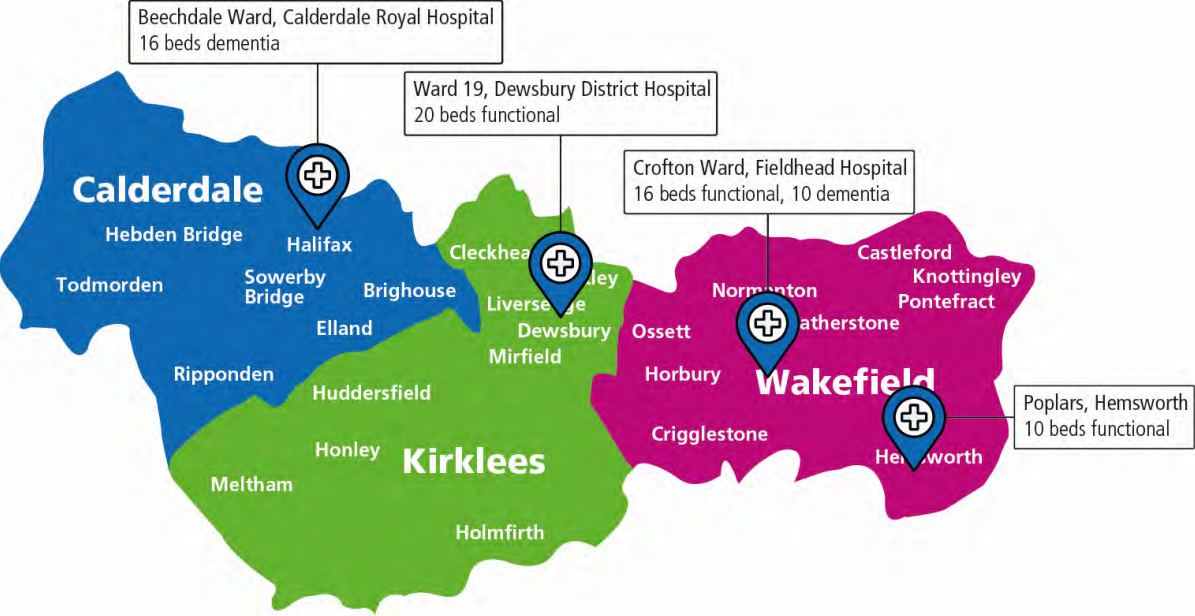
Option	Maps	Clinical Senate Feedback
Option 2 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.	 The map illustrates the geographical distribution of dementia beds across three wards in West Yorkshire. Beechdale Ward in Calderdale is designated for 16 functional beds. Ward 19 in Dewsbury District Hospital is designated for 30 dementia beds. Crofton Ward in Fieldhead Hospital is designated for 20-22 functional beds. The map also shows the boundaries of Calderdale (blue), Kirklees (green), and Wakefield (pink) and lists numerous towns within these areas, including Halifax, Huddersfield, and Wakefield.	• A viable option • Satisfies the ambition to develop a central specialist dementia unit • Offers an opportunity to centralise and consolidate specialist skills and expertise. • Addresses the risks and issues associated with mixed wards • Mitigates clinical risks attached to the current ways of working at The Poplars and Beechdale Ward. However, the panel noted that option 2 has 9 fewer beds than is currently the case and it heard that the SWYPFT team envisage a reduced length of stay in options that involve dedicated specialist units, thus reducing the need for as many beds. The panel also noted that this option meant that the Crofton Unit would offer a 22 bedded ward environment which the SWYPFT team felt may be too large.

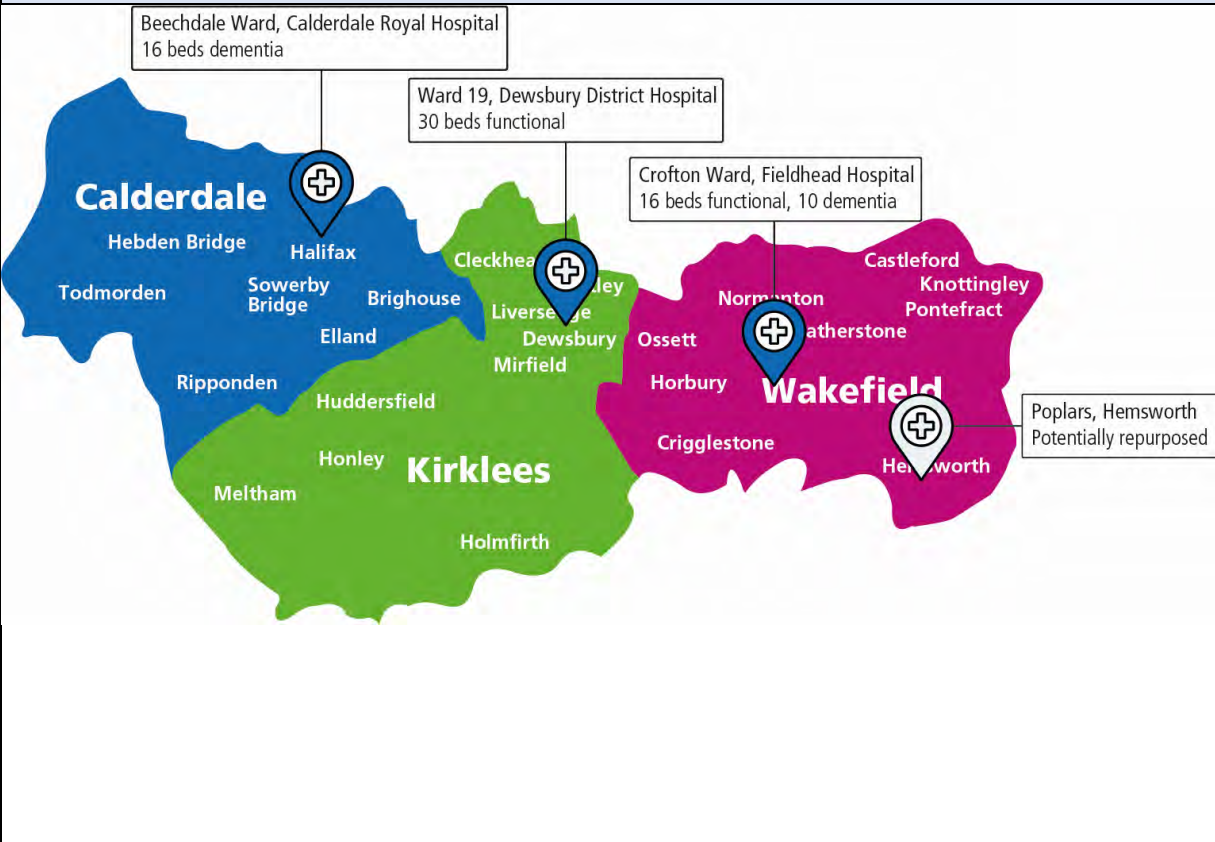
Option	Maps	Clinical Senate Feedback
Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.		The Clinical Senate felt that Option 3 was viable on the grounds that: • It satisfies the ambition to develop a central specialist dementia unit and offers an opportunity to centralise and consolidate specialist skills and expertise. • It addresses the risks and issues associated with mixed wards • It mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward. The panel noted that option 3 has 3 fewer beds than option 2 and 12 fewer than the current situation. As with option 2, the SWYPFT team envisage a reduced length of stay in options that involve dedicated specialist units, thus reducing the need for as many beds.

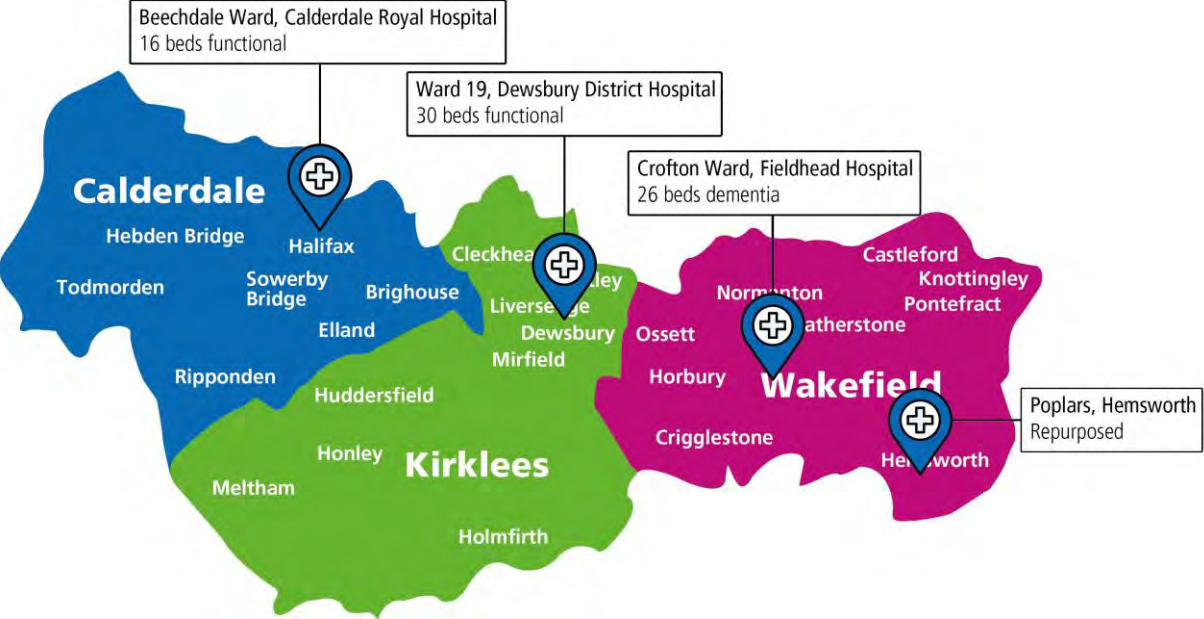
Option	Maps	Clinical Senate Feedback
Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.	 The map displays the geographical distribution of healthcare facilities across three local authority areas: Calderdale (blue), Kirklees (green), and Wakefield (pink). Hospital locations are marked with blue cross icons and callouts indicating ward and bed details: Calderdale: Beechdale Ward, Calderdale Royal Hospital (16 beds functional). Kirklees: Ward 19, Dewsbury District Hospital (30 beds dementia). Wakefield: Crofton Ward, Fieldhead Hospital (16 beds functional). Wakefield: Poplars, Hemsworth (10 beds functional). Other locations labeled on the map include: Hebden Bridge, Todmorden, Sowerby Bridge, Halifax, Brighouse, Elland, Ripponden, Huddersfield, Meltham, Honley, Cleckheaton, Liversedge, Dewsbury, Mirfield, Ossett, Horbury, Crigglestone, Normanton, Castleford, Knottingley, and Pontefract.	The Clinical Senate found that whilst Option 4 did create a dedicated specialised dementia unit and it did achieve dedicated inpatient units for patients with functional and dementia/organic illness, it was not felt to be a viable option given that: • The Poplars unit is suboptimal for patients that have a higher level of acuity, associated with functional illness, given its remote location. • The circuitousness of the Poplars unit means that it is not suitable for patients with a functional illness as this makes it difficult to observe patients.

Option	Maps	Clinical Senate Feedback
Option 5 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds. Beechdale would be 16 bed functional. The Poplars site would not be in this model.		The Clinical Senate felt that Option 5 was a viable option, in line with Options 2 and 3 in that: • It satisfies the ambition to develop a central specialist dementia unit with centralisation and consolidation of specialist skills and expertise • It addresses the risks and issues associated with mixed wards It mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward

Option	Maps	Clinical Senate Feedback
Option 6 – Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.	 The map displays the geographical distribution of dementia inpatient care under Option 6 across three local authority areas: Calderdale (blue), Kirklees (green), and Wakefield (pink). Hospital locations are marked with blue cross icons and callouts indicating their dementia bed capacity: Beechdale Ward, Calderdale Royal Hospital: 16 beds dementia Ward 19, Dewsbury District Hospital: 30 beds functional Crofton Ward, Fieldhead Hospital: 16 beds mixed Poplars, Hemsworth: 10 beds dementia The map also labels various towns and villages within these areas, including Todmorden, Hebden Bridge, Sowerby Bridge, Halifax, Brighouse, Elland, Ripponden, Huddersfield, Meltham, Honley, Holmfirth, Cleckheaton, Liversedge, Dewsbury, Mirfield, Ossett, Horbury, Normanton, Craggstone, Castleford, Knottingley, and Pontefract.	The Clinical Senate felt that Option 6 does not provide a viable solution to the clinical case for change because: • It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise • It maintains The Poplars and all of the described risks, not least its isolated location and lack of interdependent services • It maintains a mixed ward at Crofton which is not best practice and is detrimental to patient experience and outcomes.

Option	Maps	Clinical Senate Feedback
Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.	 The map displays three districts: Calderdale (blue), Kirklees (green), and Wakefield (pink). Hospital locations are marked with blue cross icons and callouts: Beechdale Ward, Calderdale Royal Hospital: 16 beds dementia Ward 19, Dewsbury District Hospital: 20 beds functional Crofton Ward, Fieldhead Hospital: 16 beds functional, 10 dementia Poplars, Hemsworth: 10 beds functional Localities shown include: Hebden Bridge, Todmorden, Sowerby Bridge, Halifax, Brighouse, Elland, Cleckheaton, Liversedge, Dewsbury, Mirfield, Normanton, Ossett, Horbury, Castleford, Knottingley, Pontefract, Huddersfield, Ripponden, Honley, Meltham, and Crigglestone.	Option 7 is not considered to be a viable option by the Clinical Senate: • It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialised skill and expertise • The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward • The Poplars is maintained as a functional unit which does not provide a satisfactory environment for patients due to the risks and issues with location, estate and lack of interdependent services

Option	Maps	Clinical Senate Feedback
Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in Dewsbury, in a separate ward area in the Crofton ward and in the Willow ward. The Poplars site would not be in this model.	 The map displays the geographical distribution of dementia inpatient care under Option 8. It shows three main hospital sites: Beechdale Ward in Calderdale (16 dementia beds), Ward 19 in Dewsbury (30 functional beds), and Crofton Ward in Wakefield (16 functional beds, 10 dementia beds). The map also identifies other locations like Poplars, Hemsworth, which is noted as potentially repurposed. The districts of Calderdale (blue), Kirklees (green), and Wakefield (pink) are clearly delineated, along with various towns and wards within these areas.	The Clinical Senate finds that option 8 is not viable: • It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise • The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

Option	Maps	Clinical Senate Feedback
Option 9 - Crofton dementia unit, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards with 46 functional beds in total (The Poplars site not in this model) – <i>this option was added following feedback from clinical senate.</i>		The panel suggested that a further option be considered if the requisite space were available to establish a dementia site at Fieldhead Hospital: The panel questioned whether the option for the central specialised dementia unit being sited at the Crofton Ward at Fieldhouse Hospital could be considered as an additional option. This is proposed given the unit's proximity to interdependent services and its optimal environment for patients with dementia. This then became option 9 in the long list of options.

1.7.7 Summary reasons for challenges with some options:

- Options including using Beechdale Ward as a dementia ward – challenges with the layout of the site mean it is not appropriate for people with dementia.
- Options which included retaining the use of The Poplars site either as dementia or changing it to functional mean that the model would continue to have challenges associated with an isolated ward.

1.8 Reviewing and testing the options

A range of clinical and operational staff members from both provider and partner side met in April and November 2022 to review and appraise the options. In addition, The OPS SWYPFT steering group reviewed the scoring for the 'Deliverability and sustainability' criteria domains for all the options and fed into the following programme board.

In addition, in October 2022 a workshop was held with a range of partners for Barnsley, Calderdale, Kirklees, and Wakefield. The workshop was initially targeted specifically at health and social care staff across the Trust footprint.

The workshop, held on Microsoft Teams, was attended by 50 health and social care staff from Barnsley, Calderdale, Kirklees, and Wakefield.

The workshop focused on the steps we took and the information we considered when developing the options. We also presented feedback from the clinical senate who provided insight on viability of each option. All options that had been considered were presented during the workshop, alongside how we scored and appraised each model.

Staff were asked to consider the process we took, the options presented and the feedback from the clinical senate. Following a presentation, staff were divided into six breakout rooms to discuss and feedback on three questions:

- Your thoughts on the proposals?
- Is there anything we should have/need to consider?
- Any other comments?

In December 2022 a wider event was held. The aim of the event was to listen to feedback from a wider group of partners, build on previous engagement, provide an opportunity for our key stakeholders and partners to contribute to the options for proposed models, and further inform our approach ahead of a potential consultation.

At the event we presented more detail on the work that has been done to date on the proposed models, including clinical considerations, engagement activity and equality. The workshop was attended, in total, by 67 people.

A summary of feedback from these events can be found on:

[Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust](#)

Covered in **section 10.15**.

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

It aimed to provide a check and balance for the options we've developed.

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

Represented were:

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

The following professional leads were in attendance:

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

An information and data pack was prepared for the review and following this, a separate subgroup was established with representation from each place (ICB) and SWYPFT with a remit to review a range of national, regional and local strategies.

Also, a separate finance group was established to oversee the VfM appraisal.

This is covered in section **10.13**.

1.9 Planning Application

Options that are viable for public consultation do require some site development work. SWYPFT need to progress this as soon as possible to enable spend of capital monies allocated to the Trust in 2024/25 and 2025/26. This won't predetermine any outcomes as it will be done in such a way that it can be adapted to the preferred option and should the outcome of the consultation lead to a change to our proposals, the planning application may be changed or withdrawn.

The planning application process will start in December 2023.

1.10 Summary of options development

In summary, we believe that there are options within the longlist that deliver a range of improvements to resolve challenges with the current model, including:

- Delivery of best practice model – in line with national guidance and model predominantly implemented across England.

- Separate wards based on diagnosis - functional and organic, delivering the specialism to meet needs.
- Improved specialist environments and resourcing to meet the needs of each group, supporting reduction of incidents and addressing risks associated with mixed wards.
- Delivering single sex accommodation on 4 of the 5 wards.
- Mitigating the clinical risks attached to the isolation of the Poplars and the environment of the Beechdale ward.
- Improving the consistency and pathway of care, removing the need to transfer most people across wards, and supporting reduced lengths of stays, particularly for people with dementia.
- Robust workforce model and enhanced staff skills to support improved clinical interventions and tailored therapeutic care.

1.11 Financial implications

Whilst acknowledging that options are being finalised, viable options range from a capital cost of £5.5M to £8.2M. Current planning assumptions are that capital costs will be spread across 2 financial years, 2024/25 and 25/26, with work being complete in spring or summer 2025 and this can be managed within the expected capital allocations of SWYPFT.

As well as the cost of capital there is a revenue cost to uplift the staffing and ensure that we have the right levels of staffing to deliver a specialist mode of care. SWYPFT has agreed to mitigate the difference between the budgets and actual costs (£1.37M) and the remaining funding gap is £1.2M between current costs and the highest cost option, which will be split between the 3 places on a weighted capitation methodology.

A series of key financial principles that have been agreed between SWYPFT and the ICB:

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.

“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.”

Jonathan Webb, Director of Finance, NHS West Yorkshire Integrated Care Board

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.

1.12 The options for consultation: subject to agreement

Proposed option 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:

1a) with additional functional bed capacity of 10 beds on Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 wards across the 26 beds ([option 5](#)).

1b) with additional functional bed capacity of 6 beds on Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward ([option 2](#)).

And:

Proposed option 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 ([option 9](#)).

To note: the options will be referenced as options 1a, 1b and 2 for impact analysis and consultation materials.

1.13 Impact of options

Travel Impact:

We know that any proposed option to create a specialist model can have an impact on travel, transport and parking.

We have undertaken a detailed travel impact analysis of various options which shows how people might be impacted as a result of changes (based on where people stayed in the current model and where they're most likely to stay in different options of a transformed model).

We want to understand what the impact would be for people getting to and from the services. We are keen to hear views through the public consultation so we can capture feedback on any impacts this may have.

This will help us think about solutions so we can make sure families, carers and visitors are supported.

Quality Impact:

- Clinically led quality impact assessment, developed in partnership with the quality leads in the ICB.
- Detailed review by the SWYPFT Quality and Safety Committee in October 2023.
- The viable options deliver overall improvements, some improvement areas identified in QIA:
 - o Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs.
 - o Specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation.
 - o Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety – for example mitigating risks due to current ways of working at Poplars and Beechdale
 - o Staff skilled and delivering specialist support based on evidence based best practice and tailored therapeutic care.
 - o Same care offer and pathway, ability to quickly stabilise people and facilitate timely discharge.
 - o Single sex accommodation improvements in some options (to note that Beechdale won't change but functional only will lead to improvements of managing the mixed genders on the ward).
- All viable options require mitigations in terms of travel support, remodelling ways of working with partners, and managing capacity limitations.

Equality:

- Service level EIAs described impacts relating to activity.
- Partnership and expert led Equality Impact Assessment (EIA) continued to inform the programme.
- Equality information used to inform options criteria.
- Key recommendations from EIA include single sex accommodation considerations, gender flexibility and finding solutions for travel, transport and parking, particularly for people from the most deprived places.
- The recommendations from EIA will drive consultation process.

Sustainability:

SWYPFT has two strategies which are our commitment to being sustainable. They are our Social Responsibility and Sustainability Strategy and our Green Plan and Estates Strategy.

We have looked closely at the impact of our potential options against sustainability and included this in our evaluation criteria. For our proposed options, we found:

- In the long term there will be a positive difference in the way we use our buildings, technology and pharmacy services, as well as less waste.
- Some families and carers may need to travel further to our wards as a result of any model that delivers specialist care.

SWYPFT is working on ways that we can be more sustainable across our services, this includes:

- Working on green travel, including our staff, service users, families and carers
- Installing low energy lighting across our Trust
- Increasing how we use renewable energy such as use of solar energy
- Improving how we manage waste
- Buying from local suppliers and businesses where we can.

2 Public Consultation (30 minutes)

See draft consultation plan for more detailed information.

2.1 Introduction

The purpose of the plan is to describe a process which will help South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) in partnership with Calderdale, Kirklees and Wakefield places and Integrated Commissioning Boards (ICB) consult on the future of older people mental health inpatient services for Calderdale, Kirklees, and Wakefield.

It includes:

- The background to this work
- What we already know
- The principles we should adopt to deliver the consultation across several local areas.
- The consultation approach and timescales
- How the information gathered from consultation will be used to inform a future service decision

The introduction can be found in section 1 of the plan and section 2 covers the background, (which is also covered in more detail in the business case).

2.2 Legislation

Section 3 of the consultation plan covers the legislation that we need to adhere to, including:

- Health and Social Care Act 2022
- The Equality Act 2010
- The NHS Constitution, referencing the Brown Principles for equality and the Gunning Principles of public consultation.

2.3 Consultation Mandate

Section 4 covers the consultation mandate.

2.4 Target Audience

Section 5 of the consultation plan covers the target audience, with it being:

- Anyone currently using older people mental health inpatient services.
- Families, relatives, and carers of people who are currently using older people mental health inpatient services.
- Voluntary and community groups representing, supporting, or advocating for older people, carers and families.
- Staff with an interest in older people mental health services, from all health and social care sectors, including but not exclusive to hospital, community, local authority, and primary care.
- Key partners and stakeholders who have an interest in older people mental health services.
- Anyone with an interest in older people's mental health services
- People who are identified as future service users.

It includes a more detailed stakeholder map, which will be monitored and reviewed throughout the consultation process.

This section flags that as part of equality duty that we will consider equality and diversity at each stage in the consultation process.

2.5 What do we already know

Section 6 covers what we already know, which is also described in the business case.

It summarises some of the key feedback from the different stakeholder groups and also summarises the outputs from the workshops and events of 2022.

2.6 Principles of consultation

Section 7 covers the principles of consultation and explores the Gunning Principles in more detail.

The Gunning Principles are:

- Consultation must take place when the proposal is still at a formative stage.
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response.
- The product of consultation must be conscientiously taken into account.

This section explains how as shared set of principles have been developed which set out a partnership approach to consulting people including our commitment to equality of opportunity.

The principles are set out below:

- We will use what we already know as a starting point.
- The consultation will be supported by **clear information** and opportunities for **communication**, so people feel informed and able to participate.
- We will ensure that we consult the right people at the right time in the **development and design** of services.
- We will ensure we are fully **inclusive** in our consultation approach.
- We will be **honest and transparent in our approach** which will include being honest about what people can and can't influence and the reasons why.
- For the things people can influence we will provide **a genuine opportunity for consultation**. This will include providing the right conditions for people to get involved.
- The views gathered will be properly **documented** so people can see the information they have provided and feel confident that it is gathered in such a way that it can inform a decision on future services.
- We will thank people for their contribution and **provide feedback** on our next steps.
- That we keep people **informed and in the loop** by providing a communication platform which everyone can access.

2.7 Approach to Consultation

Section 8 of the consultation document sets out the approach to consultation.

The consultation approach to support delivery is set out below:

Survey online and hard copy – in easy read, other formats, and translation.

- **A survey will be used to provide feedback on the consultation proposals.** These questions will ensure that we can fully understand and capture the impact of the proposed approach. Surveys will be provided online and in paper format. All responses will be collated centrally.
- **Face to face and/or digital meetings** - aimed at staff, stakeholders, and public audiences. These meetings will be supported by a presentation of the proposals. Clinicians and subject matter leads will be available to support responses to any questions. Meetings will ensure people can gain the information they need, provide an opportunity to have clarity on any proposals. The aim of the meeting is to support a clear understanding allowing for an informed consultation response.
- **Advocacy** - We know that the involvement of older people with dementia and functional mental health requires specialist input and that our independent advocacy teams work closely with our inpatients to provide much needed independent support. Advocacy services will support inpatients to respond to the consultation by providing information and/ or communicating in a way that meets the needs of that inpatient. Ensuring that all inpatients have been approached and included, and capacity to be involved assessed. Families, carers, loved ones and relatives will be contacted directly on day one of the consultation. A letter will be sent to the home address or email of an identified person for each inpatient, signposting them to information and resources so that they can also provide a response.
- **Asset based approaches** - Each locality has a wealth of assets and contacts that can be harnessed to support a consultation approach. Funding will be available to support asset-based initiatives to capturing feedback from communities. This will provide an opportunity for people who do not feel involved to have a say at a very local grass roots level those who cannot access digital meetings or online surveys.
- **Capturing views creatively** - For those who cannot respond using the proposed methods there will be an opportunity for creative methods of feedback.

2.8 Communications

Section 9 of the consultation plan covers the communications and sets out the aim to provide clear and timely information to our wide range of stakeholders, helping to build awareness, understanding, and encourage engagement at every stage of the consultation process.

As well as setting out the objectives, this section describes the different materials that will be produced. These include:

- Consultation document – electronic and hard copy, full version and summary version, Easy Read, text only webpage, audio only option
- Posters
- Q&A materials
- PowerPoint slide for use on digital screens
- Display boards for key locations across every place
- Social media graphics and content
- Website page(s) – to act as one source of information.
- Internal communications – including copy for use in newsletters, staff event(s), frequently asked questions (FAQs)

The programme will use a range of stakeholders in the development of materials including a dedication communications and engagement reference group.

Feedback channels include:

- Online form/survey
- Face to face conversations including advocacy and peer to peer approaches
- Dedicated email address
- Freepost address for return of paper-based consultation questionnaires
- An identified telephone number.

Face to face and virtual events throughout the consultation period will enable a two-way dialogue with our stakeholders and encourage people to ask any questions they may have. These will continue to form part of a Q&A which will be published and shared with those who are supporting the consultation.

All information will be produced in a variety of formats.

Communication channels include:

- **Internal channels:**
 - o Regular staff newsletters and briefings
 - o Events – face to face and virtual
 - o Staff networks
 - o Intranet
 - o Direct email
 - o Posters and leaflets
 - o Cascade via leadership teams
- **External channels:**
 - o Trust website
 - o Trust social media accounts
 - o Stakeholder websites and social media accounts
 - o Local media
 - o Direct email / mail
 - o Public events – face to face and virtual
 - o Public newsletters
 - o Cascade via partner and stakeholder networks / channels – including key stakeholder organisations working in the voluntary and community sector.

Proactive media planning will cover the public announcement of the consultation, consultation launch, social media, and ongoing media relations.

Reactive media will be managed by the marketing and communications team in SWYPFT. The consultation plan sets out the media protocol in more detail.

Communications will be evaluated via:

- Website data
- Social media data
- Media coverage
- Consultation response rates
- Consultation event attendance rates
- Anecdotal feedback

2.9 Equality

Section 10 of the consultation focusses on Equality. An Equality Impact Assessment (EIA) has been established.

The consultation will ensure that any gaps in our understanding from previous involvement work are addressed. We will make sure we reach the groups that have been identified in the EIA as being potentially more affected, through their underrepresentation in our services, the factors that influence the experience of mental ill health and dementia and by the other impacts service change may bring.

We understand from the data and insight that support the EIA that there is more likely to be potential impacts on the following groups:

- Black, Asian and minority ethnic communities
- Carers
- Trans people
- Lesbian, Gay and Bisexual people
- Faith groups – particularly Muslim and Sikh people
- Working age adults with dementia
- People with a disability – sensory, physical and learning disability

The consultation activity will specifically target these groups to ensure representative views are collected. Progress on this will be monitored and where there are gaps activity will be designed to address.

All respondents to the consultation will be asked to provide equality monitoring data to assess the representativeness of the views gathered during the process. A mid-point review will highlight any risks in under or over representation and the consultation approach will be refocussed where necessary.

Following the consultation process the data and insight will be analysed and used to update the EIA.

The EIA will provide an understanding of the potential impact of the options on different groups. The EIA will form part of the process for decision making and its conclusions will influence the outcomes.

2.10 Resources

Section 11 sets out the resources required to deliver the consultation plan, including survey development, consultation materials, discussion group hosts, circulation of materials, FREEPOST, analysis and report writing.

2.11 Analysis of data and presentation of findings

Section 12 of the plan explores the analysis of consultation and presentation of findings. The report will be shared initially with the ICB committees and the JHOSC in Calderdale, Kirklees, and Wakefield.

In parallel the report will be used to facilitate a workshop style event where the findings, including equality data will be considered against each of the proposed options.

2.12 High level timeline for delivery

Section 13 sets out the high-level timeline for the delivery of the public consultation.

Currently, we are considering a 12-week delivery period for the public consultation.

2.13 Appendix 1 – 3 – detailed deliver plan

This sets out in more detail the overarching plan, the SWYPFT plan and the place-based plans.

To note:

- Activity flagged as being required on day 1 and week 1 of the consultation.
- The public meetings – 2 in each place and could be scheduled between weeks 2 – 5 and plan to run 3 per week for 2 weeks in this period.

2.14 Appendix 4 – public meeting plan

This appendix covers more detail of the proposed public meetings.

The purpose of the public meeting is to provide an opportunity **for people, including staff, members of the public and key stakeholders to drop in and get information** on the proposed options so they can respond.

The purpose of the meeting is as follows:

- To have a visible presence in our communities to discuss the proposals supported by a range of clinical staff and system leads.
- Provide a local space for people to get information on the options.
- To support people to respond to the consultation.
- To listen to any concerns or queries and log them or sign post as needed to customer services.
- To capture any questions, not necessarily respond to all but to update the Q&A
- To respond to any questions in line with the business case, which will be supported by a core script.

The meeting will be central to our local communities and will run as a drop in. This means people can come at any time during the public meeting. Discussions with key members of the workforce will be crucial to ensure that people can get clarity on the proposals and ask questions. The **suggested timings of public meetings will be 2-7pm** – but time either side will be required to help set up and pack up. The venues have been suggested by our place leads and all will be fully accessible, risk assessed and have the space required to fulfil the venue plan. Current list options:

2.1 Calderdale central – one meeting in either:

Halifax Town Hall (preference)

Shay stadium.

To note, the following venues are not available on our date options:

Elim church, Halifax

Kings Centre, Halifax

Maurice jagger centre, Halifax

Hopwood Lane community centre

2.2 Calderdale upper valley – one meeting in either:

Hebden Bridge Town Hall (preference)
Todmorden town hall

2.3 Kirklees (Greater Huddersfield)– one meeting in:

Brian Jackson House

To note, the following venues are not available on our date options:

Hudawi centre

Huddersfield Town Hall

2.4 Kirklees (North Kirklees) one meeting in either:

Dewsbury Town Hall (preference)

Batley Town Hall

Al-Hikmah Centre-Batley

2.5 Wakefield – one meeting in either:

Wakefield Town Hall (preference)

Brook house working men's club.

St Swithuns centre

2.6 Wakefield – one meeting in:

Hemsworth community centre

The meeting plan also sets out how we intend to promote the meetings, as well as the communications, information and equipment required at the meetings.

It summarises the different staff roles required to support the meeting and what they will be responsible for.

The plan also has a suggested venue plan and layout for each of the public meetings.

2.15 Appendix 5: Advocacy plan

Appendix 5 sets out the proposal to utilise advocacy service skills to support the involvement of inpatients in the Older People Services inpatient consultation.

A large circular graphic composed of many small, slightly tilted blue rectangular tiles arranged in concentric rings, creating a mosaic effect.

Older People mental health inpatient transformation

**ICB Summary Slides
1 December 2023**

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

Phase 1 of Transformation – Community Services

An earlier phase of this programme's focussed on best practice community models of care. Comprehensive specialist mental health services for older people needed to be reconfigured and improved. Work on community models found a need to focus on the following areas:

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

A community model was established that operated as a framework to enable the community services to deliver transformation objectives.

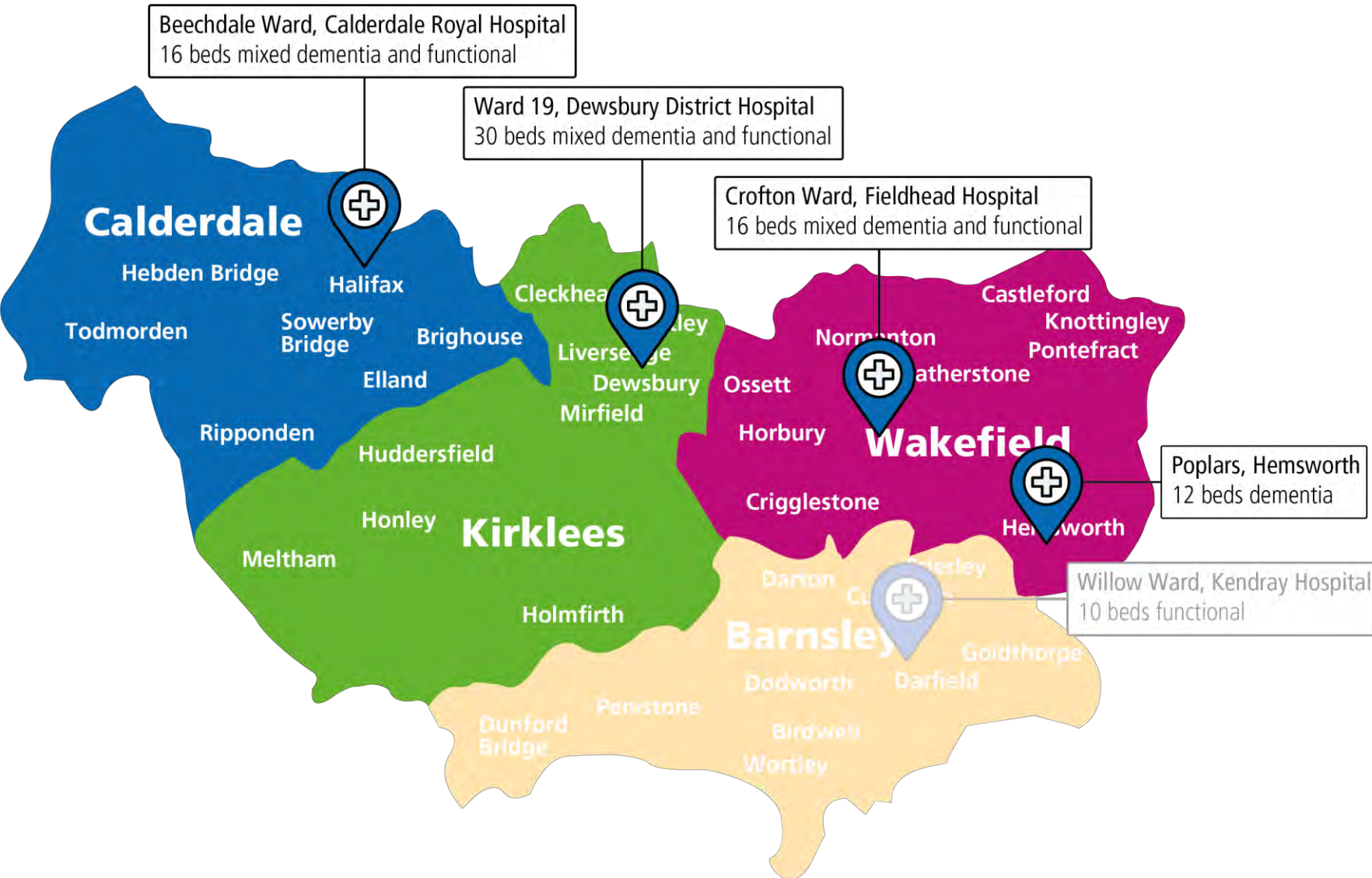
It includes core central services with close links into GP practices & community physical health teams across each locality.

These services support care being provided closer to home for those people accessing community services.

Vision for inpatient services

- **Separate wards** for diagnosis, functional and organic, delivering the specialism to meet needs;
- **Specialist ward environments;**
- **Accessible services** for service users, carers, family staff and partner organisations;
- **Improved pathways** and fewer ward moves;
- **Reduced length of stays;**
- **The right level of workforce** and skills;
- **Meeting the diverse needs of the population** – cultural, spiritual and inclusive

The current inpatient model



Wards see people with dementia or people with functional needs such as depression, anxiety or psychosis.

These share the same ward space in the current model.

Between 80-100 people with dementia admitted per year.
Between 150-200 people admitted with functional mental health needs across Calderdale, Kirklees and Wakefield.

4 of the 5 wards are mixed needs.

Single sex accommodation guidance met on all units except Poplars though 3 out of 5 of the wards are mixed gender, which can make clinical management an issue

Note: Willow Ward in Barnsley (functional only) will not change and is not in scope.

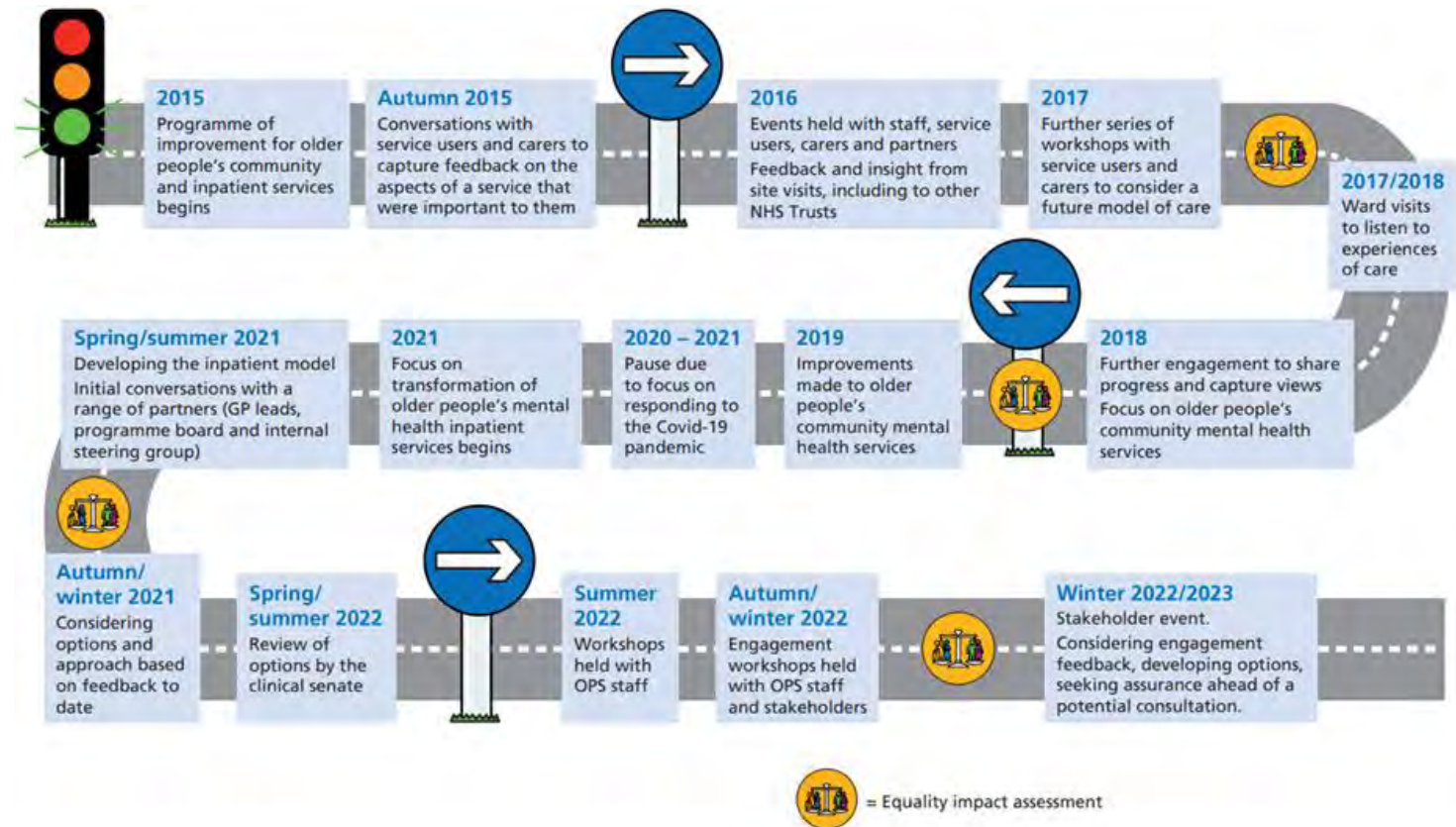
Challenges of the current model

More information on the clinical case for change is on slides 16-19

- **Mixed needs wards can create a challenging environment.** The mix of patients doesn't work well and increases the risk of incidents.
- Often **people move between wards**, which can have a negative impact on wellbeing. 45% of people with dementia have more than 1 ward stay.
- **Admissions have been reducing, length of stay (LOS) increasing** over time, particularly for people with dementia.
- **Not all wards are aligned with other services**, for example, an isolated ward in Wakefield, the Poplars, which has issues admitting a high level of acuity and access to timely support when required. CQC has noted the challenges.
- Some **ward environments are challenging**. For example, Beechdale ward in Calderdale has narrow, twisting corridors that lead to 'dead ends', issues with staff line of sight and is difficult for patients to navigate.
- The **workforce model is not adequate for the level of care** required. The wards regularly need to bring in bank and agency staff.

Our approach

- **Clinically-led** using a Quality Impact Assessment (QIA)
- **Voice and views of 900 people** - 250 service users, family or carers.
- **Equality Impact assessment (EIA)**– driving the consideration of impacts
- **Key stakeholders** such as local authority (social care) and acute general hospitals
- **Partner workshops** - clinical and operational input.
- The **NHSE clinical senate** - reviewed clinical model and options.
- **System leads** and stakeholders scoring criteria



Long list of options – to short-list	(See slides 20-28 for detail of options and slide 29 for rationale for not being on the final shortlist)
	Option 1- No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.
	Option 2 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.
	Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.
	Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.
	Option 5 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds. Beechdale would be 16 bed functional. The Poplars site would not be in this model.
	Option 6 –Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.
	Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.
	Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in Dewsbury, in a separate ward area in the Crofton ward and in the Willow ward. The Poplars site would not be in this model.
	Option 9 - Crofton dedicated specialist dementia unit, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards with 46 functional beds in total and 72 beds in total (The Poplars site not in this model) – <i>this option was added following feedback from clinical senate.</i>

Options development and scoring

Criteria domains:

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

All criteria domains were informed by quality and equality considerations taken from the QIA and EIA and the engagement feedback we received.

Weightings:

70% to the quality and safety aspects
30% to finance

Options were reviewed in a number of partnership workshops, see slide 30 for more detail

Options development and scoring

Slide 31 has further rationale for scoring

Option	Domain	Score	Total Score (%)
2– A specialised dementia unit, Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward.	Quality Domains (70%)	32	54
	VfM Domain (30%)	22	
5– A specialised dementia unit Ward 19 with 30 dementia beds across 2 wards on the site. Additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton). The site at Crofton would operate as 2 wards across the 26 beds. Beechdale would be 16 bed functional.	Quality Domains (70%)	49	68
	VfM Domain (30%)	19	
9 - Specialised dementia unit at Crofton Ward, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards.	Quality Domains (70%)	44	63
	VfM Domain (30%)	19	

The viable options subject to agreement:

Proposed option 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:

1a) with additional functional bed capacity of 10 beds on Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 wards across the 26 beds **(option 5)**

1b) with additional functional bed capacity of 6 beds on Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward **(option 2)**

And:

Proposed option 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 **(option 9)**

To note: from this point on the options will be referenced as options 1a, 1b and 2 for impact analysis and consultation materials.

Detailed impact assessments of these options have been developed with system leads (travel, transport and parking; quality, equality, sustainability) and a summary is on slides 32-41.

Shared financial principles and estate considerations

Principles

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). Older People Mental Health inpatient programme is **prioritised within the Trust Estates Strategy**.
3. **Revenue costs will be phased**, in agreement between system partners, with current modelled part year effect costs from 2025 / 26.
4. If **Mental Health Investment Standard funding continues** that the Older Peoples transformation programme is initially prioritised
5. That **SWYPFT and ICB will risk share any increases in costs**

Estates

All viable options require site development work. Progress to enable spend of capital monies allocated to the Trust in 2024/25 and 2025/26 means a planning application process must start no later than December 2023.

This **won't predetermine the outcome of consultation** but will mean we can progress quickly following a decision.

Description	Total Capital Cost	Comments
Option 1A Option 2	£8.2M	The 10-bed design would accommodate either of these proposed options, having a specialist dementia unit in Dewsbury or Wakefield.
Option1B	£5.5M	Would involve 6 bed reduction in the overall operational model. Ward 19 would be the dementia unit in this option as 22 bed in Wakefield would be below dementia required capacity.

Description / option	Cost £k	
Budgeted OPMH inpatient services 22 / 23	6,688	SWYPFT mitigation £1,374k
Actual Spend 22 / 23	8,062	
Option 1a	9,082	Modelled financial gap £1,020k
Option 1b	8,215	Modelled financial gap £153k
Option 2	9,272	Modelled financial gap £1,210k

Questions

12-week consultation process

The consultation approach has been co-designed with place leads and will include:

- A full document, summary and easy read – with surveys to match
- A microsite with document and materials available
- An online and paper survey
- Letters and feedback from stakeholders

Our approach

- Letter to those directly impacted
- Local community assets briefed and provided with a range of materials to liaise with local communities to gather feedback (i.e. Engagement Champions).
- Advocacy to gather views from existing service users.
- A range of public meetings organised across the Trust Footprint (2 face to face in each place and digital options).
- Mailing Trust Members and other stakeholders to signpost to key information.
- Presentations into various meetings and forums.
- Stands and literature across community and inpatient settings

Thank you

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

Supplementary slides:

- Extra information on clinical need / case
- Detailed review process and longlist
- Rationale and scoring of shortlist options
- Detailed rationale for not shortlisting options
- Impact Assessment Summary's, including:
 - Travel and Transport
 - Quality
 - Equality
 - Sustainability

Mixed functional and organic wards

- The clinical and personal needs of patients can be very different:
- Patients with a functional mental health need can find it hard to understand how to manage the behaviours of people with dementia.
- They can find loud noise from patients living with dementia distressing. They can often choose to stay in their rooms and become more socially isolated and inactive.
- They do not feel that they are at the right stage to be admitted to a ward with patients who have severe dementia.

A comment from one of our inpatients

“It was very upsetting and worrying for me coming in to contact with someone with dementia for the first time. I was worried all night hoping the person could not get into my room.”

Consultant clinical psychologist:

“It can be hard for people who are diagnosed with significant depression, or other functional mental health needs, to see and understand the impact that dementia has on some of our inpatients, it can be very upsetting and challenging. Our functional patients find that they are sometimes reluctant to get out on the ward as much as they would like to.”

Moving people between wards

- Around 50% of people with dementia move wards in their stay:
- **Impacts on the continuity of care**, patients need time to get used to being cared for by a new team, to build relationships with staff.
- **Increases the amount of time a person spends as an inpatient**
- **Has a negative impact on the wellbeing of people living with dementia**, moving to a new ward can increase confusion and lead to disorientation.
- **Delays care and treatment**, as patients, staff, and the wider care team rebuild relationships.
- **Prevents access** by carers, family members, friends and loved ones, as they may need to travel further and get used to different visiting arrangements on a new ward.

Physiotherapist:

“Transferring patients between wards can be a trigger which leads to aggressive behaviour.”

Consultant clinical psychologist:

“We try to transfer patients to be closer to home, but this meant that there is a new team and environment, for the patient it can be like starting from scratch. It can be frightening or disturbing to be in a new place.”

Site Isolation – the Poplars

- The location of the Poplars ward is not alongside any other hospital service:
- the nearest emergency department, or access to specialist help, is on average a 30-minute car journey away at Pinderfields Hospital, Wakefield.
- there may be a delay in patients receiving specialist medical input, especially during the night and over weekends.
- the ward is managed by a specialist nursing team who in the case of an emergency or incident do not have the ability to call on staff from neighbouring wards.

Consultant psychiatrist:

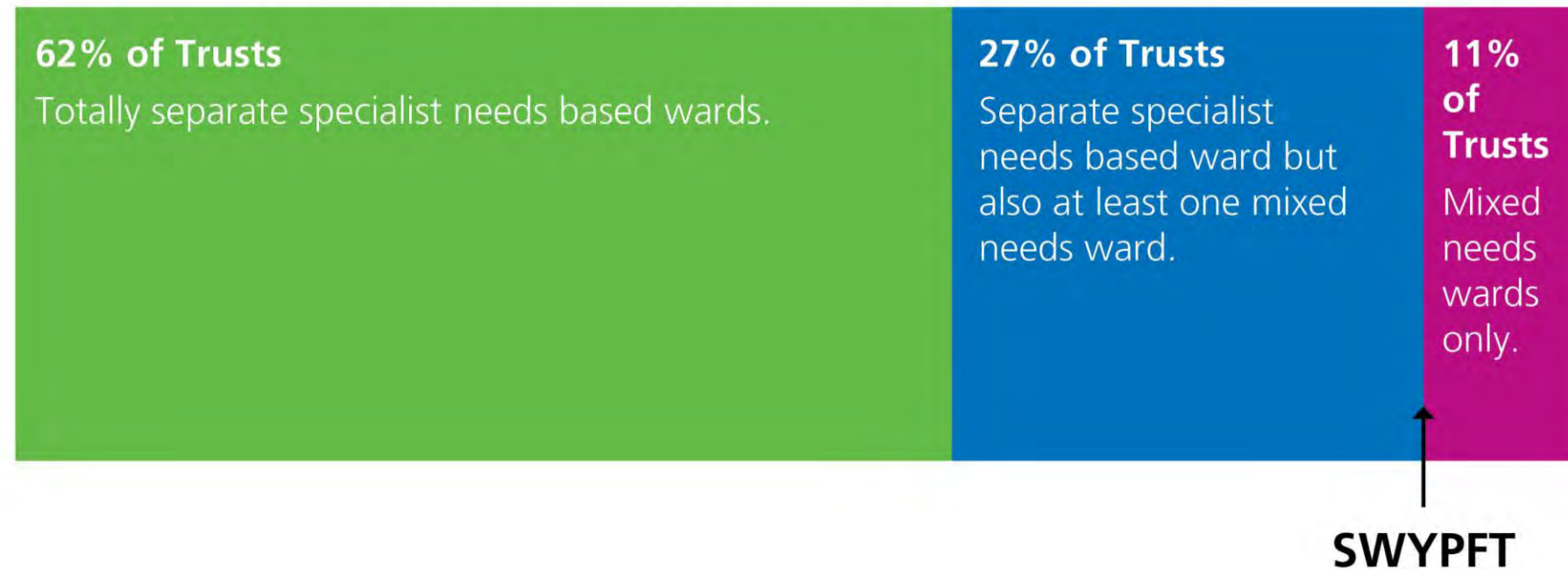
“Medical cover for The Poplars is difficult. When a junior doctor is on call out of hours, they are covering a number of wards at Fieldhead Hospital. They might have five things that they need to attend to over a night shift, and if they have to go to The Poplars, it takes two hours to drive there, manage the issue, and drive back.”

CQC Visit 2022:

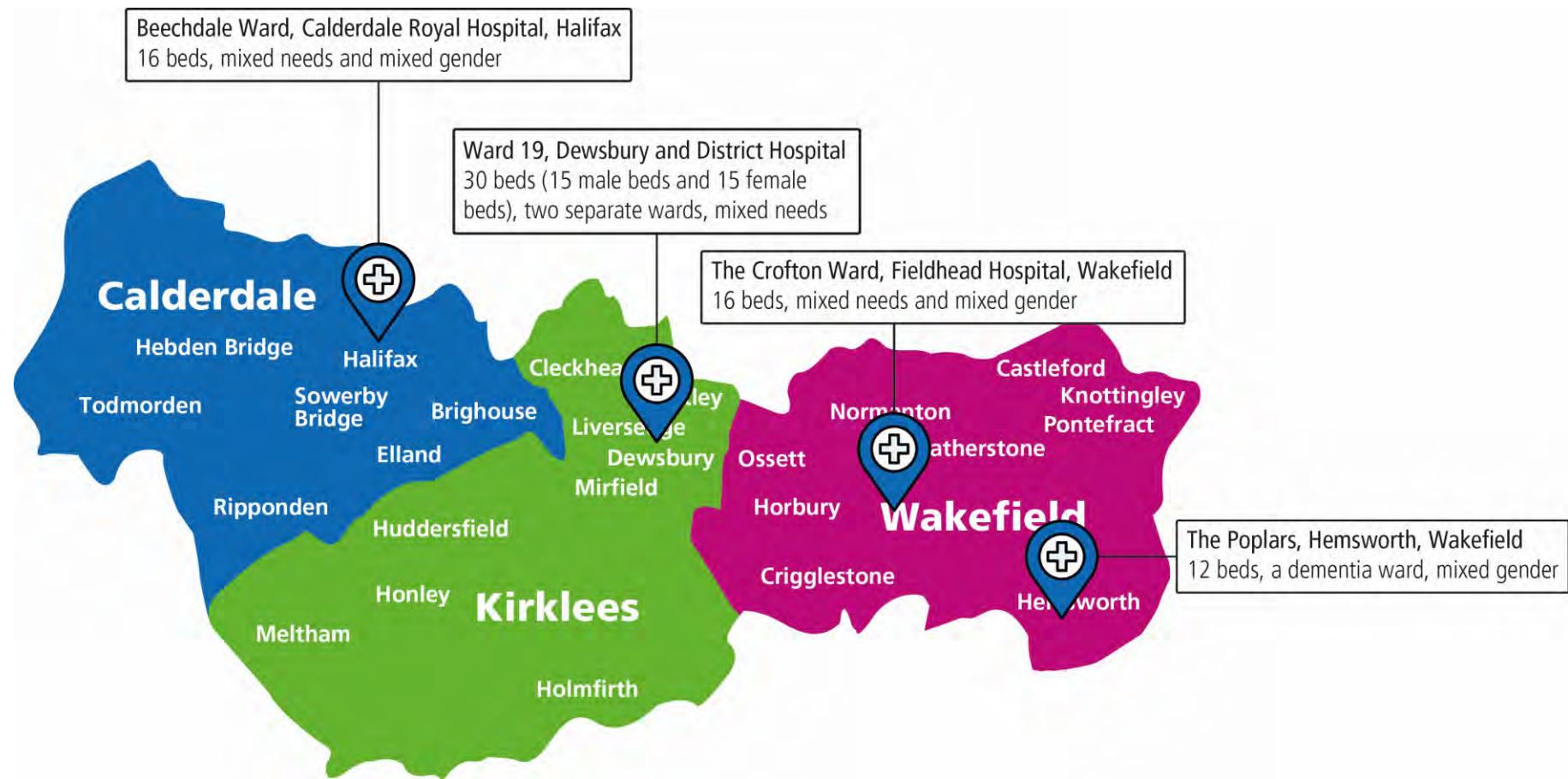
Noted the location of The Poplars meant that staff were isolated in terms of access to urgent support or cover for unplanned staffing issues. CQC also stated: “We were concerned that the distance from The Poplars to other trust locations would impact on out of hours medic assessments”.

What other Trusts have implemented

How our Trust benchmarks against others:

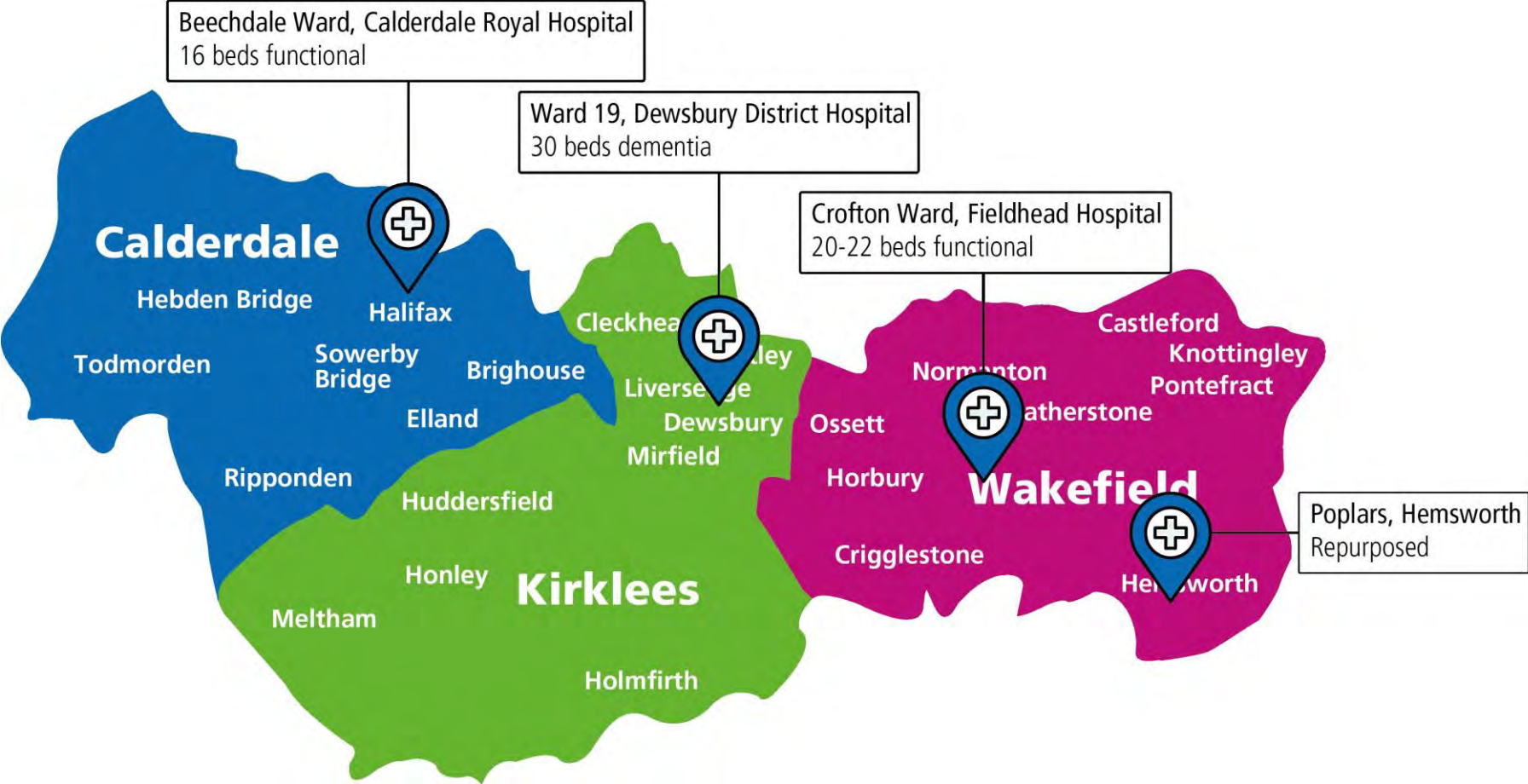


Option 1- No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.



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

Option 2 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.



A viable option.

Satisfies the ambition to develop a central specialist dementia unit.

Offers an opportunity to centralise and consolidate specialist skills and expertise.

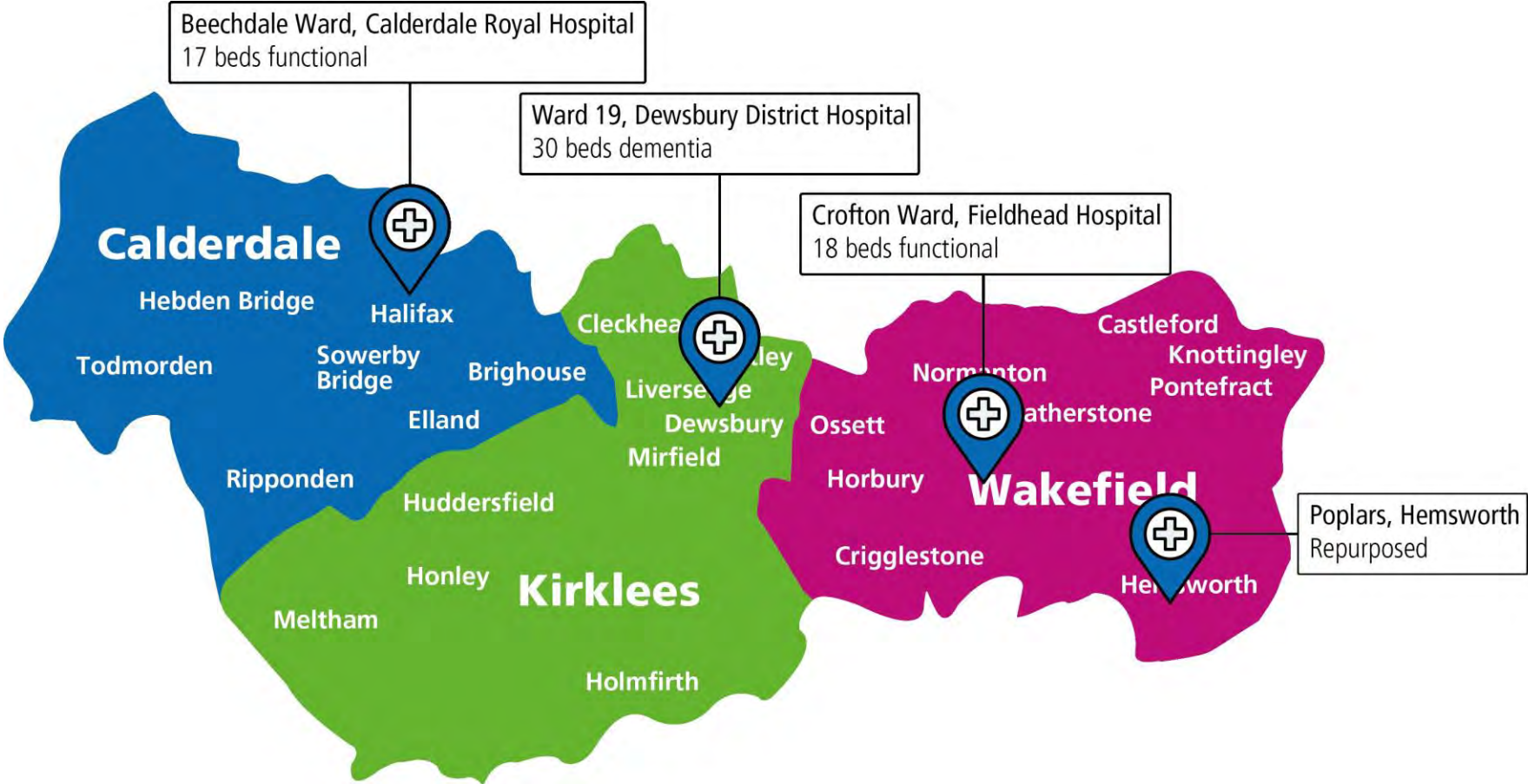
Addresses the risks and issues associated with mixed wards.

Mitigates clinical risks attached to the current ways of working at The Poplars and Beechdale Ward.

Panel noted that option 2 has 9 fewer beds than is currently. A reduced length of stay in options that involve dedicated specialist units, thus reducing the need for as many beds.

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

Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.

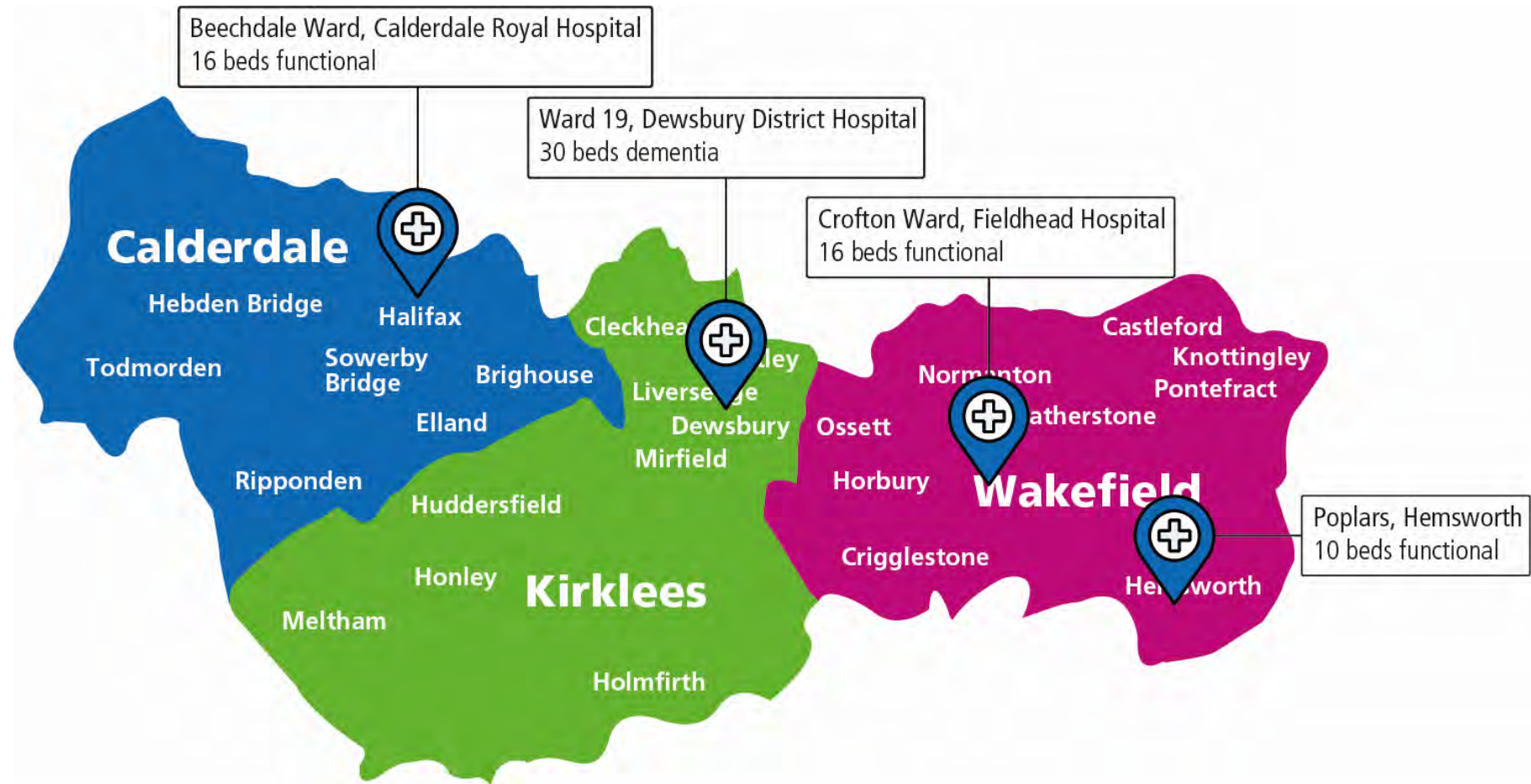


The Clinical Senate felt that Option 3 was viable on the grounds that:

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

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

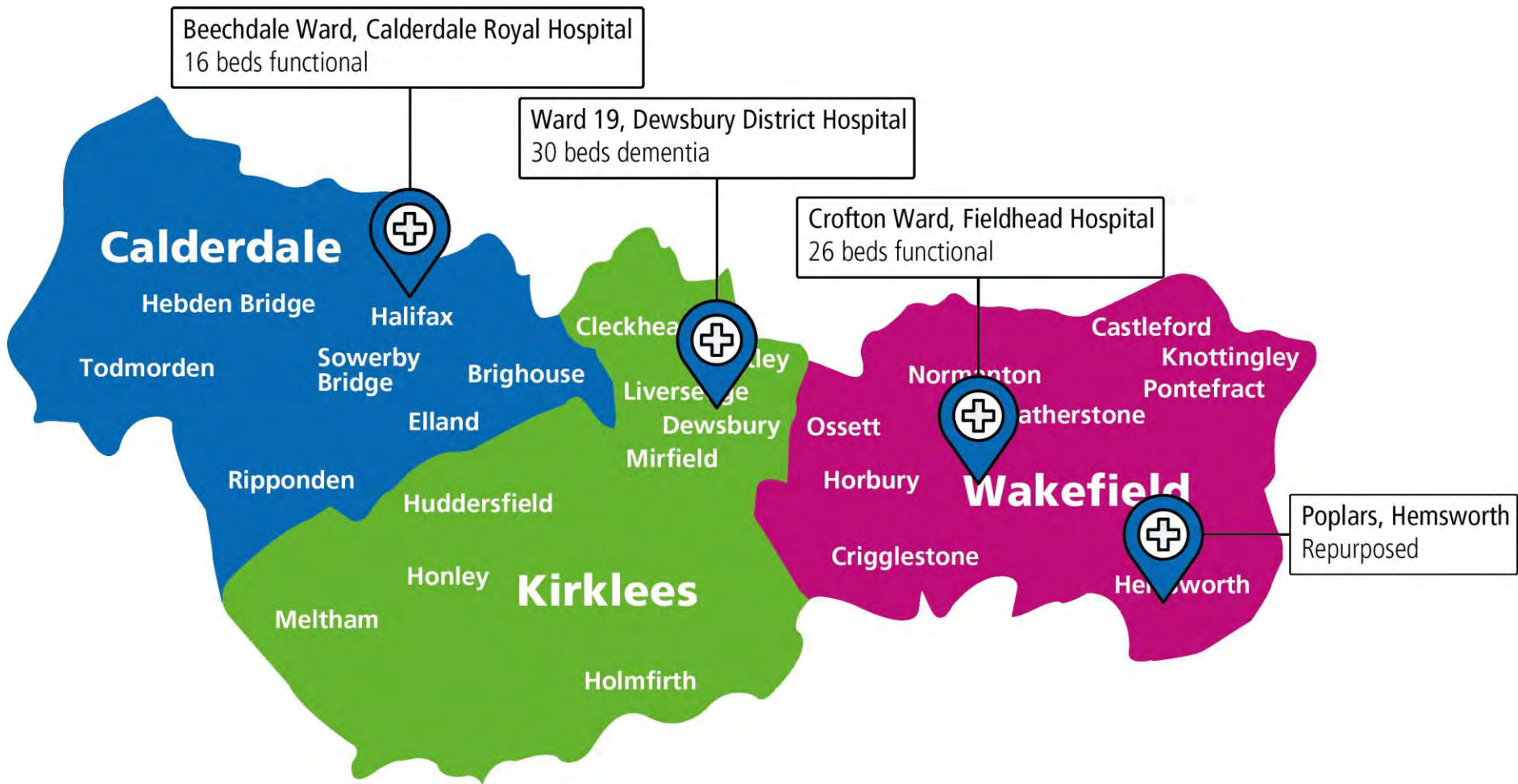
Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.



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

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

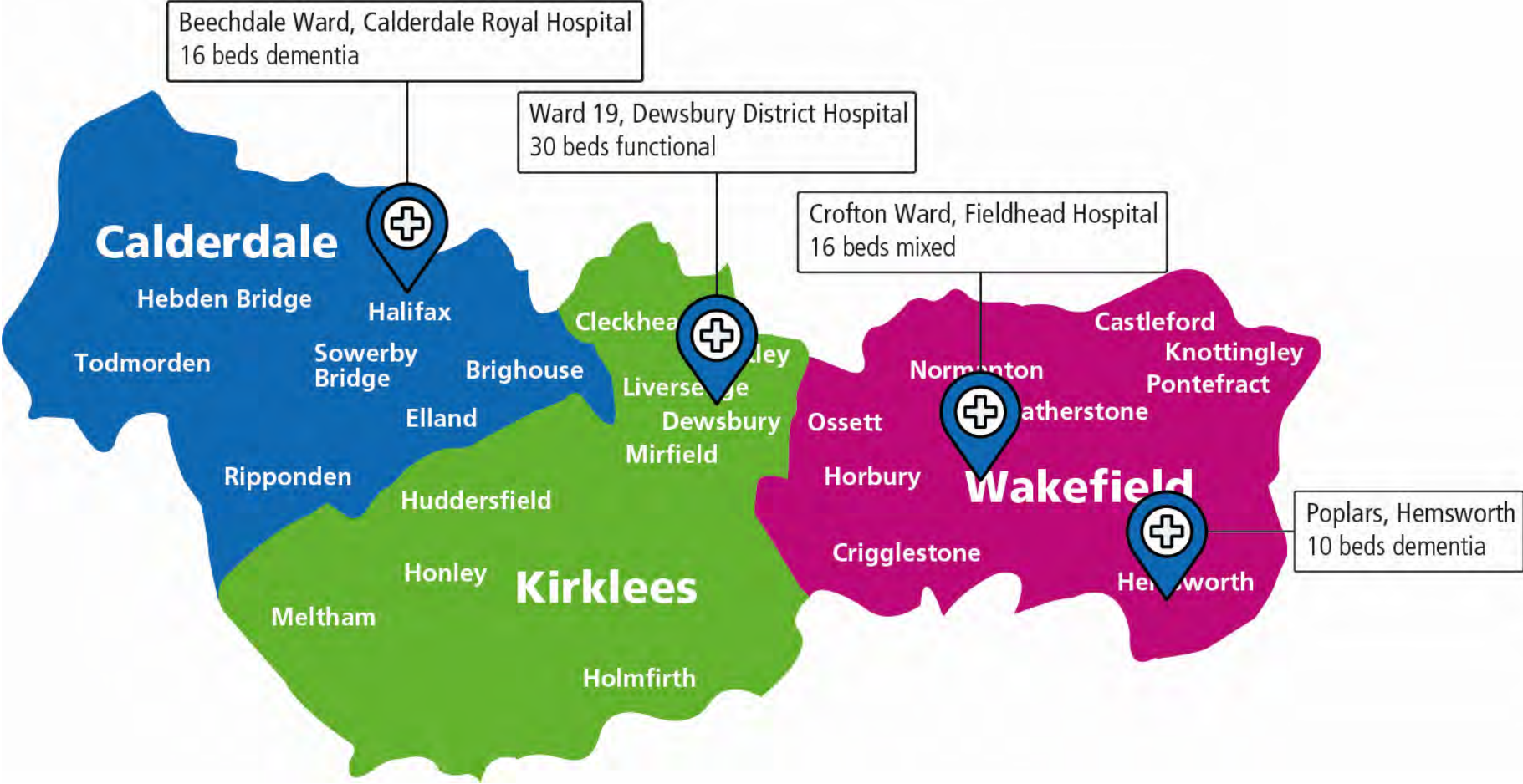
Option 5 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds. Beechdale would be 16 bed functional. The Poplars site would not be in this model.



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

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

Option 6 –Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.



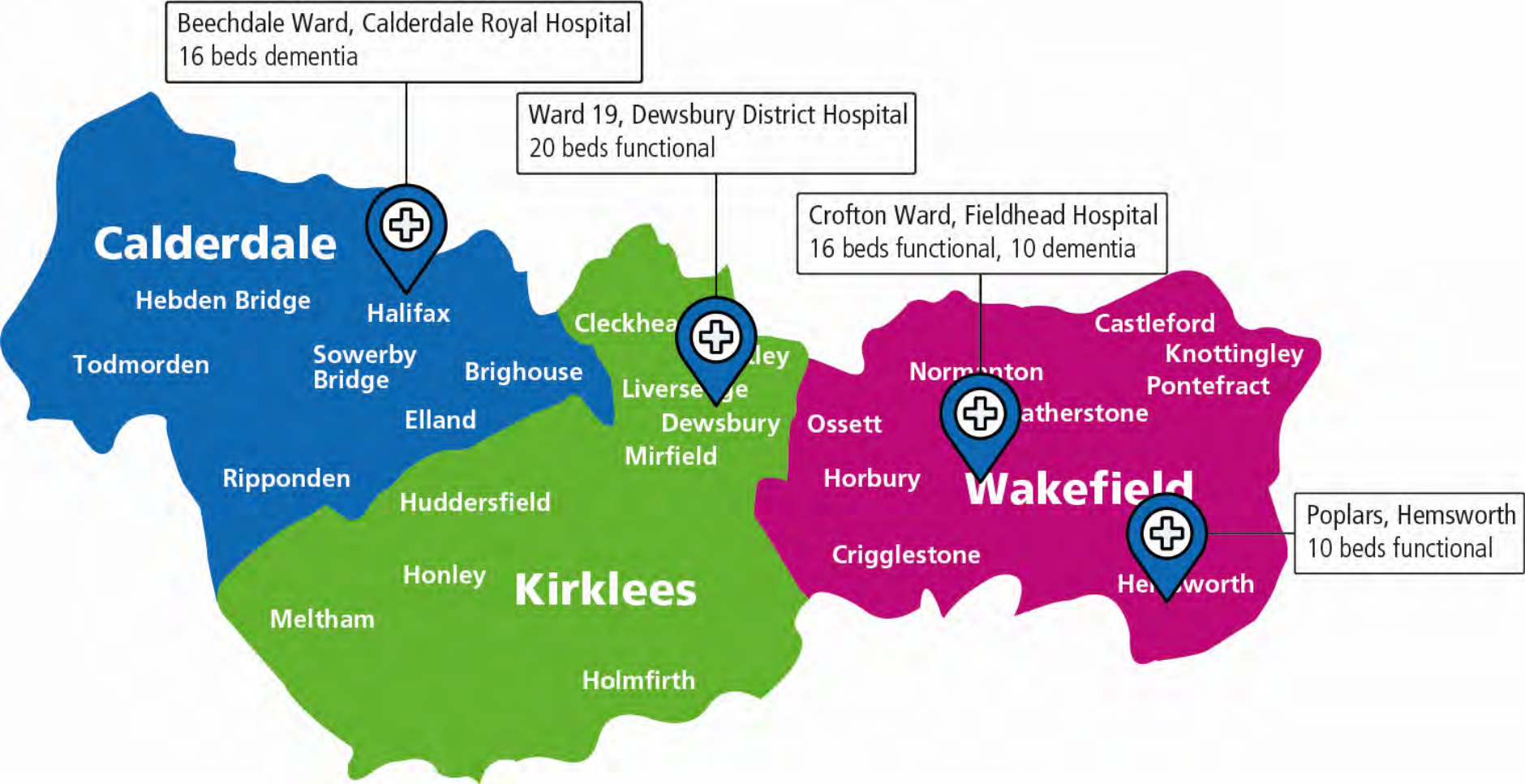
The Clinical Senate felt that Option 6 does not provide a viable solution to the clinical case for change because:

It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise

It maintains The Poplars and all of the described risks, not least its isolated location and lack of interdependent services

It maintains a mixed ward at Crofton which is not best practice and is detrimental to patient experience and outcomes.

Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.



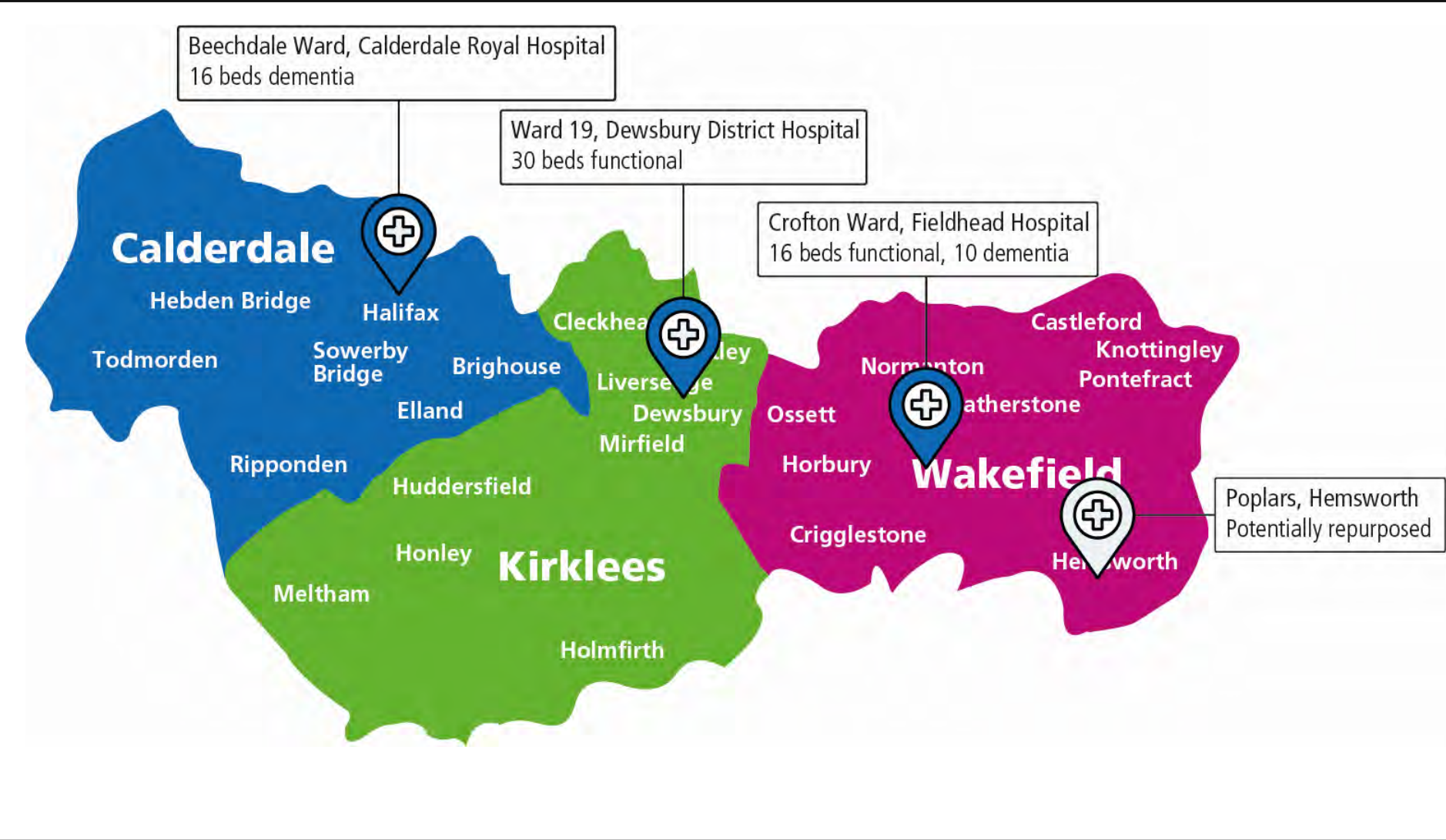
Option 7 is not considered to be a viable option by the Clinical Senate:

It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialised skill and expertise

The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

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

Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in Dewsbury, in a separate ward area in the Crofton ward and in the Willow ward. The Poplars site would not be in this model.

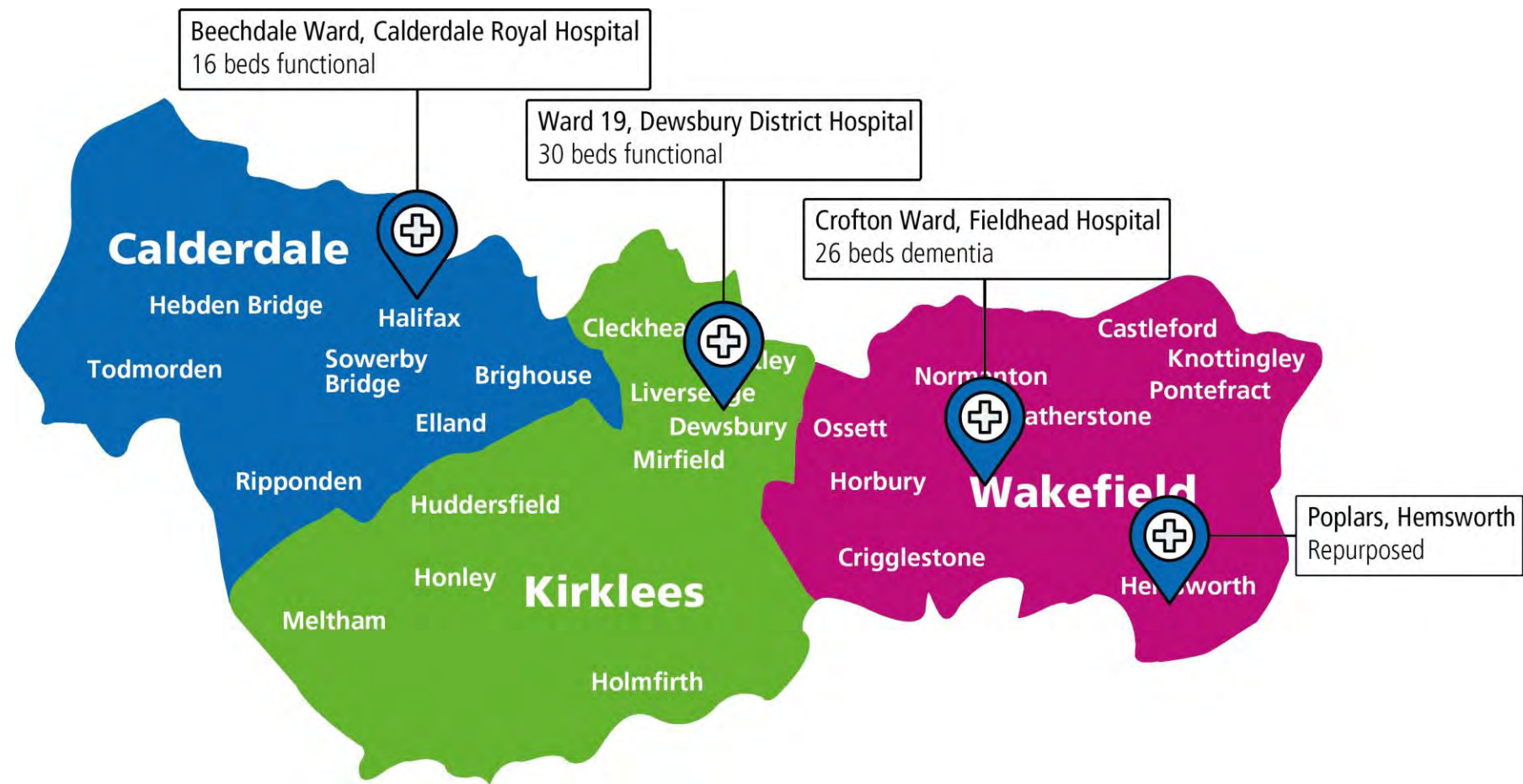


The Clinical Senate finds that option 8 is not viable:

It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise

The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

Option 9 - Crofton dementia unit, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards with 46 functional beds in total (The Poplars site not in this model) – *this option was added following feedback from clinical senate.*



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

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

Discounted options	Rationale
Option 1 - No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.	In summary: able to deliver good services overall (CQC) despite some challenges across the wards. Overall some key areas not met (pathway / moves, Length of stay, access to staffing/support at Poplars). In May 2023 review all groups agreed this option was not viable for the required period of time. This option does not meet the underlying strategic objective of delivering care in the most appropriate in-patient needs-based environment and the Poplars ward does not align well with the acute hospital model.
Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.	Overall it achieves the separation of needs and specialism without going over the accepted ward sizes, meaning that it meets the majority of requirements. May 2023 Group felt that adding more beds onto the Beechdale environment, within the existing space would have a negative impact on the environment. Group gave a low score for access primarily because this has fewer beds than has been modelled and represents 9 lower than current numbers. Capacity issue and risk of sending people out of area was felt to be a significant risk. 1 bedroom on Beechdale is not deliverable do not have the space. Difficult to achieve the space at the PFI site at Beechdale though the Crofton changes should take less time due to the smaller scope. Investing into the Beechdale PFI site to create one extra bedroom is not viewed as cost effective. Meets key areas but concerns that links to resilience to enable support for people locally and SWYPFT priorities.
Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.	Agreement with senate not a viable option given that: The Poplars unit is suboptimal for patients that have a higher level of acuity, associated with functional illness, given its remote location. The circuitousness of the Poplars unit means that it is not suitable for patients with a functional illness as this makes it difficult to observe patients.
Option 6 –Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.	It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise It maintains The Poplars and all of the described risks, not least its isolated location and lack of interdependent services It maintains a mixed ward at Crofton. This option uses Beechdale as a dementia unit, which it isn't appropriate for.
Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.	It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialised skill and expertise The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward The Poplars is maintained as a functional unit which does not provide a satisfactory environment for patients due to the risks and issues with location, estate and lack of interdependent services
Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in Dewsbury, in a separate ward area in the Crofton ward.	It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

Reviewing and testing the options

Options Review Meetings 2022: staff members from both provider and partner side met in April and November 2022 to review and appraise the options.

October 2022 workshop held with partners from Barnsley, Calderdale, Kirklees, and Wakefield.

Attended by 50 health and social care staff.

Focused on the steps we took and the information we considered when developing the options.

Presented feedback from the clinical senate who provided insight on viability of each option.

Staff were asked to consider the process we took, the options presented and the feedback from the clinical senate.

December 2022 wider event. Aim to listen to feedback from a wider group of partners, build on previous engagement, provide an opportunity for our key stakeholders and partners to contribute to the options for proposed models, and further inform our approach ahead of a potential consultation.

Presented more detail on the work that has been done to date on the proposed models, including clinical considerations, engagement activity and equality. The workshop was attended, in total, by 67 people.

May 2023 options review workshop including the evidence that has been gathered and make sure the right options are taken forward

Attended by a range of stakeholders (33 people in total) across a range of organisations and disciplines including SWYPFT; ICB from each place; Service managers from each local authority; both local acute Trusts; carer representation.

A wide range of professional leads were in attendance.

An information and data pack was prepared for the review and following this, a separate subgroup was established with representation from each place (ICB) and SWYPFT with a remit to review a range of national, regional and local strategies.

Also, a separate finance group was established to oversee the VfM appraisal.

Option	Domain	Rationale
2 (1B in refined list)	Quality	May 2023 group agreed that this is a stronger option rather than do nothing overall, but did have one key area not met which relates to the larger ward.
	Access	The option would be 6 beds lower than the current operating model though still within demand and capacity modelled numbers. Extra travel for family / carers for any specialist model.
	Sustainability and Deliverability	Will have right clinical mix but not the right ward size so could not sustain a ward size of 22 bed in the long term. Will attract staff to specialism but could have big ward on Crofton – previously suggested bigger wards lead to challenges so one offsetting the other.
	Alignment with strategies	Option 2 does have one key area not met – the ward size which leads to a score of 5 but does meet other areas of strategies.
5 (1A in refined list)	Quality	Overall - achieves the separation and specialism; addresses issues with location of the Poplars site whilst maintaining largely the existing and required bed numbers. With scope to adapt W19 to create a small number of en-suites for people most able with dementia this would differentiate the score further between this and option 9.
	Access	Supports robust workforce model; within range for functional / dementia split and with some gender flex on functional side; Travel would increase for family / carers; some impact on SWYPFT/partner impact across boundaries but workable.
	Sustainability and Deliverability	Does deliver a sustainable system up to 10+ years. Does include expensive capital but this invests in SWYPFT estate. Does also involve a rich workforce but this could prove cost effective over time. Will attract staff to specialism.
	Alignment with strategies	Aligns well with the vast majority of local, regional and national strategies. Travel impact would be very limited (in terms of sustainability strategies).
9 (2 in refined list)	Quality	Overall - achieves the separation and specialism; addresses issues with location of the Poplars site whilst maintaining largely the existing and required bed numbers. Pros and cons to where a dementia unit might this be. Elements of Crofton didn't quite work as well as a dementia unit, especially the use of space on the site.
	Access	Supports robust workforce model; within range for functional / dementia split and with some gender flex on functional side; Travel would increase for family / carers and be greater for people with dementia from the west part of the footprint; some impact on SWYPFT/partner impact across boundaries, extra impact to partners on west side reaching into dementia site, but workable
	Sustainability and Deliverability	Does deliver a sustainable system up to 10+ years. Does include expensive capital but this invests in SWYPFT estate. Does also involve a rich workforce but this could prove cost effective over time. Limit of 26 dementia beds at Wakefield if demand increases due to population changes.

Travel and transport, including equality considerations

We have done a full travel impact assessment which has considered public transport, driving times and parking costs.

With a dementia unit in Wakefield (option 2), overall, more people would have to travel further than if the dementia unit were in Dewsbury (options 1 a and b).

In options 1 a) and b) the Dewsbury (W19) dementia model, there are on average 80 people a year who have to travel further than now. In the Wakefield dementia model there would be around 100 people per year, though both would be offset by some people that would have shorter journeys.

When considering the 20% most deprived areas, findings highlight:

- Around 25-35 people per year would have further to travel as a result of the changes.
- Around 6 people per year from Calderdale's most deprived areas will have an average **70-minute** public transport journey to Dewsbury (option 1 a and b) and **95 minutes** to Wakefield (option 2).

To note, we will be asking people about travel, transport and parking as part of the consultation to fully understand the impact and mitigations, particularly in relation to protected groups / carers / deprivation

DOMAIN	Requirements	1A. Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1B. Dementia site ward 19 with 22 functional beds at Crofton
SAFE	Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs.	IMPROVEMENT - This model delivers separate wards for functional and organic needs. - This is evidence based and recommended by stakeholders and clinical bodies. - It would allow for improvements in environment, specialist staff skills and improve patient experience.		
	The best specialist ward environments to support people with design of the environment for appropriate therapies / socialisation.	IMPROVEMENT - Royal College of Psychiatry highlight the risks that dementia patients can often impact on the therapies of other people by not recognising personal space. - An environment for each specialist group could be modified to better meet the needs of that group e.g., reminiscence areas for dementia. - Staff feedback that space restrictions compound issues as it is difficult to get space for therapies that meet the need of only one group.		
	Single Sex Accommodation	IMPROVEMENT Single sex accommodation guidance would be fully met in all these models.		IMPROVEMENT BUT MITIGATIONS REQUIRED Guidance would be fully met but no option for a single gender ward for patients with functional illness.
	Wards sizes close to best practice guidance of 15 beds	IMPROVEMENT Ward sizes between 12-16 beds	IMPROVEMENT Ward sizes between 12-16 beds	MITIGATIONS REQUIRED Ward sizes between 15-22 beds
	Environment / resourcing to minimise incidents, deliver improvements to clinical quality / safety.	IMPROVEMENT - Addresses the risks and issues associated with mixed wards. - Mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward.		
	Staffing to appropriate levels, in line with clinical need to support safety.	IMPROVEMENT - Specialist model could improve recruitment and retention of staff. - More staff in model, especially on dementia specialist unit and more qualified nurses on each shift.		NEUTRAL IMPACT BUT MITIGATIONS REQUIRED - Similar to other proposed options. - Concern that staff retention and recruitment may be affected by the 22 bedded ward
	Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	IMPROVEMENTS BUT MITIGATIONS REQUIRED - Specialisation of wards would mean that more patients are likely to be admitted and discharged from wards that are not in the same LA area as their usual residence, although this happens already on our wards to a lesser degree. - Discussions with LA and VCSE partners have not highlighted any major issues with working across boundaries. - General Hospitals have fed back that there are no current plans to change their provision. - Transportation between mental health wards, acute general hospitals and other places of care will remain largely the same but journey times for ambulances/private transport providers will be shorter overall.		

DOMAIN	Requirements	1A. Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1B. Dementia site ward 19 with 22 functional beds at Crofton
EFFECTIVE	Staff skilled and delivering specialist support based on evidence based best practice and tailored therapeutic care.	IMPROVEMENT - Psychology clinical leadership model would be implemented on specialist dementia ward. - The type of supervision, clinical intervention and workforce skills needed for the two groups are quite different. - Targeted approach to a singular client group rather than having to design activity for a number of clinical issues and activities.		
	Same care offer and pathway, ability to quickly stabilise people and facilitate timely discharge.	IMPROVEMENT - Patients who need dementia beds will all access the same service, via a single unit. This will improve consistency of care. - Functional pathways will be improved by having specialist functional wards.		
	Stakeholders are involved in design and their input informs decision making.	IMPROVEMENT - Will continue to involve and engage via formal consultation process where will listen and use feedback to inform the agreed model. - We have involved service users and staff in this model design		
	Will deliver positive outcomes of care and allow for implementation of evidence-based practice.	IMPROVEMENT - The new model will provide a better environment through dedicated needs-based wards, tailored and appropriate therapeutic programmes. - Specialist training will be provided to staff on the wards.		IMPROVEMENT BUT WITH SOME MITIGATIONS REQUIRED: As other options but a 22 bedded ward could have potential impacts on clinical and therapeutic engagement.
	Clinical support staff teams and services, across pathways to work together to deliver safe, effective care	NEUTRAL IMPACT - The model involves a shared bed base so will be bringing people together with shared objectives. - The pathways through the wards should improve as people will generally not be transferred from ward to ward. - Reducing restrictive practice team, pharmacy and other centralised clinical support teams would also be better aligned to wards. - A challenge will be in working across place boundaries so measures will need to be put in place to support staff working on a shared pathway across these geographic boundaries.		
	Non-clinical support staff teams and services, across pathways.	IMPROVEMENT - Alignment with other trust sites would improve access to estates, domestic, catering and other non clinical services. - Improved access would provide better cover at busy times or in an emergency (such as flooding, or supply chain issues).		
	Patients received the right care at the right time. Pathway delays a minimised as much as possible.	IMPROVEMENT - Most patients will stay on the ward they're admitted to until ready to discharge. - Patients will also have access to appropriate therapies and interventions in a timelier manner, as separate organic and functional wards will have specialist staff who can focus solely on their needs.		

DOMAIN	Requirements	All Options
CARING	Ward staff who have skills, knowledge and experience that aligns to the patient specialism on their ward.	IMPROVEMENT ▪ Separate functional and dementia wards would mean that appropriate staffing based on people's needs. ▪ Having functional only units means that staff can dedicate their time to people with these needs. ▪ Separate need wards could lead to improvements in physical health care. ▪ Patients with organic disease benefit from a therapeutic environment dedicated solely to their needs.
	Improvement has been co-produced with patients and carers.	IMPROVEMENT ▪ Involved service users and staff in this model design, coproducing via workshops and events. ▪ We have used the feedback to inform the options development.
WELL LED	Objectives of the project align with the trusts.	IMPROVEMENT ▪ The vision of the transformation sets out clear objectives that align to trust values – see project vision and objectives (shared with Service Users) in the business case.
	The needs of stakeholders are reflected in the design of the service.	IMPROVEMENT ▪ A wide range of engagement has been held between 2015 and 2023 to ensure that these needs have been considered and factored into the design. ▪ Although much of the major public engagement was before 2020 a formal public consultation process will inform any future design of the options.

DOMAIN	Requirements	1A. Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1B. Dementia site ward 19 with 22 functional beds at Crofton
RESPONSIVE	Pathways that allow clinical interventions and discharge planning to happen as soon as clinically indicated.	IMPROVEMENT - Dedicated function for each ward and improved therapeutic environment will reduce the time it takes to reduce levels of acuity. - While a single streamlined ward stay does have the potential to improve the timeliness and reduce length of stays, we will need to ensure that the correct systems are put in place to support improved timeliness.		
	Most appropriate environment, most appropriate care, for the most appropriate time.	IMPROVEMENT - The programme and changes will lead to various improvements in performance. - Project team need to consider how they will measure service performance from a quality perspective.		
	That we have the right capacity in the system to meet the demand required, factoring in projected population increases.	NEUTRAL IMPACT/MITIGATION REQUIRED - Capacity caps created. - This option appears to have capacity for both organic and functional beds. - Potential challenge of demand surges for male dementia beds. - Mitigations include gender flex areas on ward 19.	MITIGATION REQUIRED - Capacity caps created. - This option will mean slightly low capacity for organic beds but be a little over capacity for functional beds. - This option will allow for significant gender flex on both functional and organic beds.	NEUTRAL IMPACT/MITIGATION REQUIRED - Capacity caps created. - This option may have lower capacity for functional beds but has the right capacity for organic beds. - As 1A, potential challenge of demand surges for male dementia beds and same consideration for gender flex mitigation required.
	The service users, family and carers are able to access the service as needed.	MITIGATION REQUIRED - All options involve additional travel impact for family and carers. - All sites in proposed models have good access to other acute sites. - The full Equality Impact Assessment considers any actions required to ensure the new system gives equal access to all. - Mitigations are considered in the business case and will be explored more in a consultation process. - Visiting times could be more flexible, especially for those who are travelling out of area. - Dementia specialist ward could have more flexible visiting time around mealtimes, to help with nutritional needs as appropriate.		
	Service is accessible for families, carers and support services.	MITIGATION REQUIRED - There will be some impact in terms of distance travelled to any specialist site for family and carers but the service users will be accessing better care and the model still delivers that care for all the people in the current model. - All sites in new function have good access to other acute sites. - Travel impact analysis has been undertaken and options to support people who are impacted will be explored in a consultation. - Equality impacts of travel, including areas of social deprivation are further explored in the EIA.		

Equality Impact – Key Considerations

Further impacts will be identified through consultation and EQIA updated to reflect equality themes

Options	Impact
Option 1a (originally option 5): A dedicated central specialised dementia unit in North Kirklees developed on Ward 19 with additional functional bed capacity adjoined to the existing Wakefield Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds. The Wakefield Poplars site would not be in this model.	• Higher capacity for people with dementia who need inpatient support • No ensuite facilities for dementia patients – shared bathing and toilets only • Longer stays for dementia patients may mean visitors paying for parking. • The specialist dementia unit would be geographically central to Calderdale and Wakefield • Single sex ward standards met. • Dewsbury dementia ward and Wakefield functional wards would be single gender, Beechdale in Calderdale would remain mixed gender. • Functional patients' visitors will have to pay for parking in Calderdale. • Proximity to acute general hospital care for functional patients would be co-terminus in Calderdale and via the nearby Pinderfields hospital in Wakefield. • Proximity to acute general hospital care for dementia patients would be co-terminus at the Dewsbury District Hospital site, which would benefit carers, families, loved ones. • Dementia and functional services are currently under represented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food, and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer.

These are the overarching impacts – detail of impacts and mitigations for each protected group forms part of the full EQIA which can be made available

Equality Impact - Key

Options	Impact
Option 1b: A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.	• Higher capacity for people with dementia who need inpatient support • No ensuite facilities for dementia patients – shared bathing facilities and toilets only • Longer stays for dementia patients may mean visitors paying for parking. • The specialist dementia unit would be geographically central to Calderdale and Wakefield • Single sex ward standards met. • Dewsbury dementia ward would be single gender, Beechdale in Calderdale and Wakefield would remain mixed gender. • Functional patients' visitors will have to pay for parking in Calderdale. • Proximity to acute general hospital care for functional patients would be co-terminus in Calderdale and via the nearby Pinderfields hospital in Wakefield. • Proximity to acute general hospital care for dementia patients would be co-terminus at the Dewsbury District Hospital site, which would benefit carers, families, loved ones. • Dementia and functional services are currently under represented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food, and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer.

Equality Impact – Key considerations

Options	Impact
Option 2: Crofton ward in Wakefield, as the dedicated central specialised dementia unit. This would operate as 2 wards with 26 beds in total. Ward 19 in North Kirklees and Beechdale ward in Calderdale would be functional only wards. The Poplars site would not be in this model.	• Higher capacity for people who use services with functional needs, lower dementia capacity. • No en-suite facilities for functional patients on ward 19 – shared bathing and toilets only. Only 2 functional e/s in the whole system at Beechdale. • The specialist dementia unit would be on the east side of the Trust footprint. • Dementia patients would have a single sex ward. • Functional ward would be mixed sex in Calderdale. • Functional patients' visitors will have to pay for parking in Calderdale and Kirklees. • Proximity to acute care for functional patients would be co-terminus. • Proximity to acute care for dementia patients could be either Mid York's which would benefit carers, families, loved ones. • Dementia and functional services are currently underrepresented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer. • Greater impact on travel, transport and parking for all localities including 20% most deprived populations.

The recommendations following from the EIA are as follows:

- Ensure the consultation reaches the identified audience impacted and can evidence the sample group is reflective of each protected group.
- Ensure the consultation responses are analysed by each protected group and any differential impact is highlighted, considered, and conscientiously considered with impacts mitigated and/or addressed.
- That the questions that are asked in consultation can ensure that responses inform the mitigations.
- That single sex accommodation is considered in future estates planning for both dementia and functional patients. This highlights the benefits of designing gender flex into the system, particularly for functional needs.
- That solutions for travel, transport and parking address the geographical impacts for populations, particularly those from the 20% most deprived postcodes.

Sustainability Impact

SWYPFT has two strategies which are our commitment to being sustainable. They are our Social Responsibility and Sustainability Strategy and our Green Plan and Estates Strategy.

We have looked closely at the impact of our potential options against sustainability and included this in our evaluation criteria. For our proposed options, we found:

- In the long term there will be a positive difference in the way we use our buildings, technology and pharmacy services, as well as less waste.
- Some families and carers may need to travel further to our wards as a result of any model that delivers specialist care.

SWYPFT is working on ways that we can be more sustainable across our services, this includes:

- Working on green travel, including our staff, service users, families and carers
- Installing low energy lighting across our Trust
- Increasing how we use renewable energy such as use of solar energy
- Improving how we manage waste
- Buying from local suppliers and businesses where we can.

Specific consultation questions will focus on sustainability impact and mitigations, in particular in reference to modes of travel.

SWYPFT OPS Inpatient Transformation Pre-Consultation Business Case

DRAFT

1 Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Professor Subha Thiyagesh,

Chief medical officer,

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



Vicky Dutchburn

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

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3 Executive Summary

3.1.1 Foreword

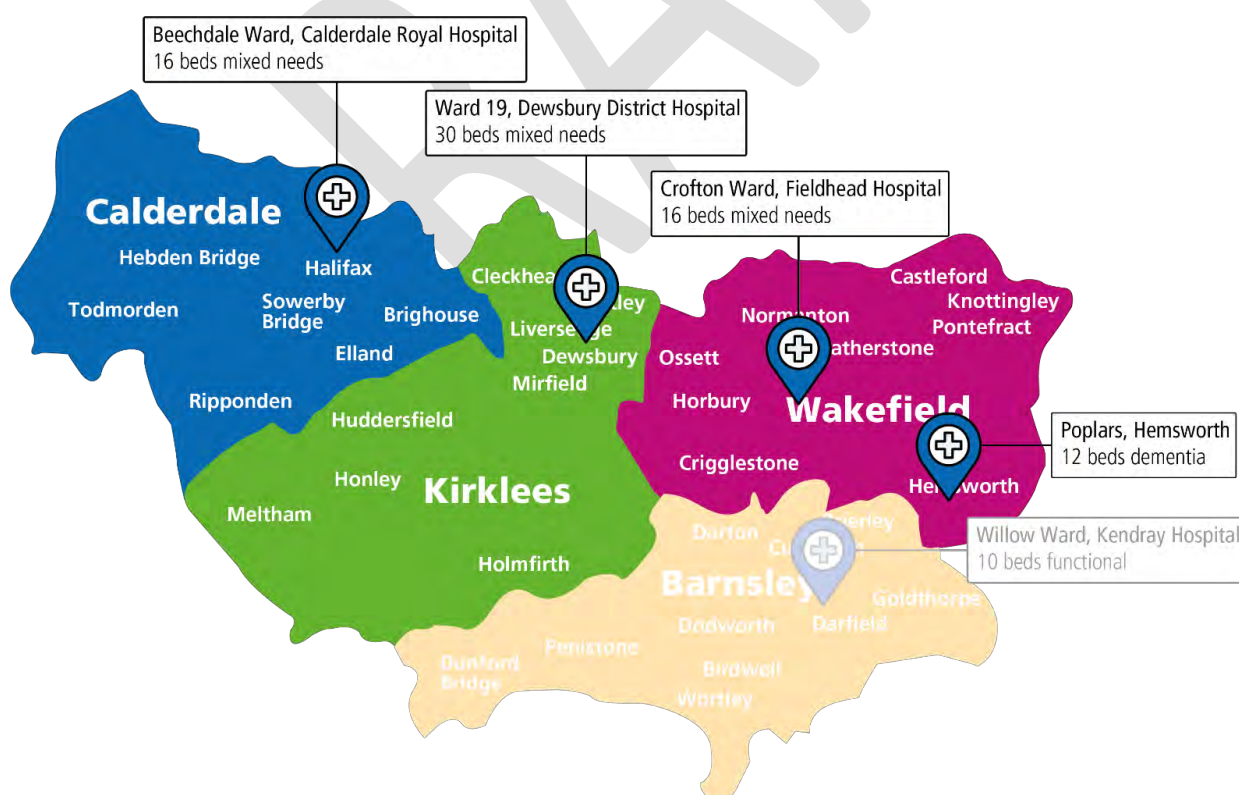
Professor Subha Thiyaresh, Chief medical officer and consultant in psychiatry for older people, South West Yorkshire Partnership NHS Foundation Trust, and Vicky Dutchburn, Director of operational delivery and performance, NHS West Yorkshire Integrated Care Board, outline the challenge to provide better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

3.1.2 Introduction

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

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

The map of the current model:



3.1.3 Context and Current Service Model

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

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

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

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

Commonly inpatient wards see:

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

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

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

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

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

3.1.4 How the current model works

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

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

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

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

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

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

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

3.1.5 Vision for the clinical model

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

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

3.1.6 How the current inpatient model compares to what we need

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

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

3.1.7 Benefits

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

3.1.8 Development of options

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

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

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

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

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

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

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

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

The programme undertook a detailed options review of the potentially clinically viable options, and the options were reviewed in 2023 with the most recent data and information to support this review.

DRAFT

4 Full Business Case

5 Introduction

5.1 Background

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

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

5.2 Aims and objectives of the Pre-Consultation Business Case

The pre consultation business case aims to:

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

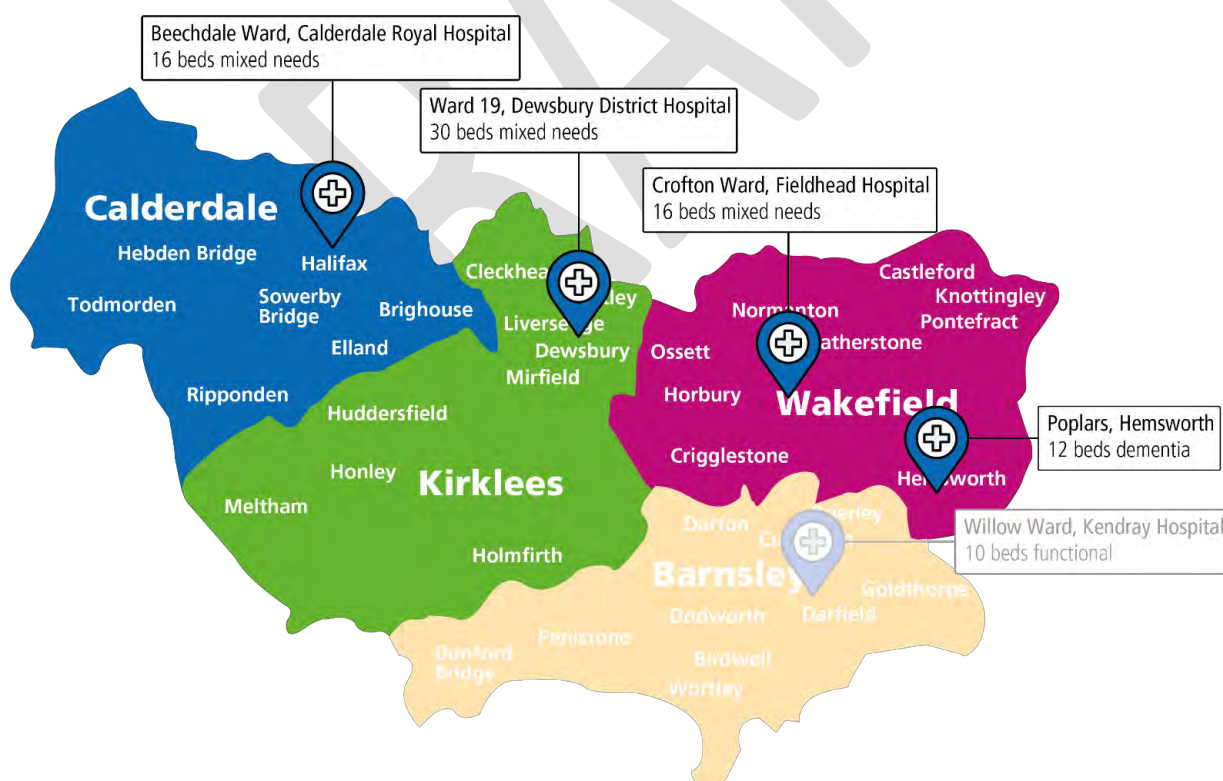
5.3 Scope of Business Case

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

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

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

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



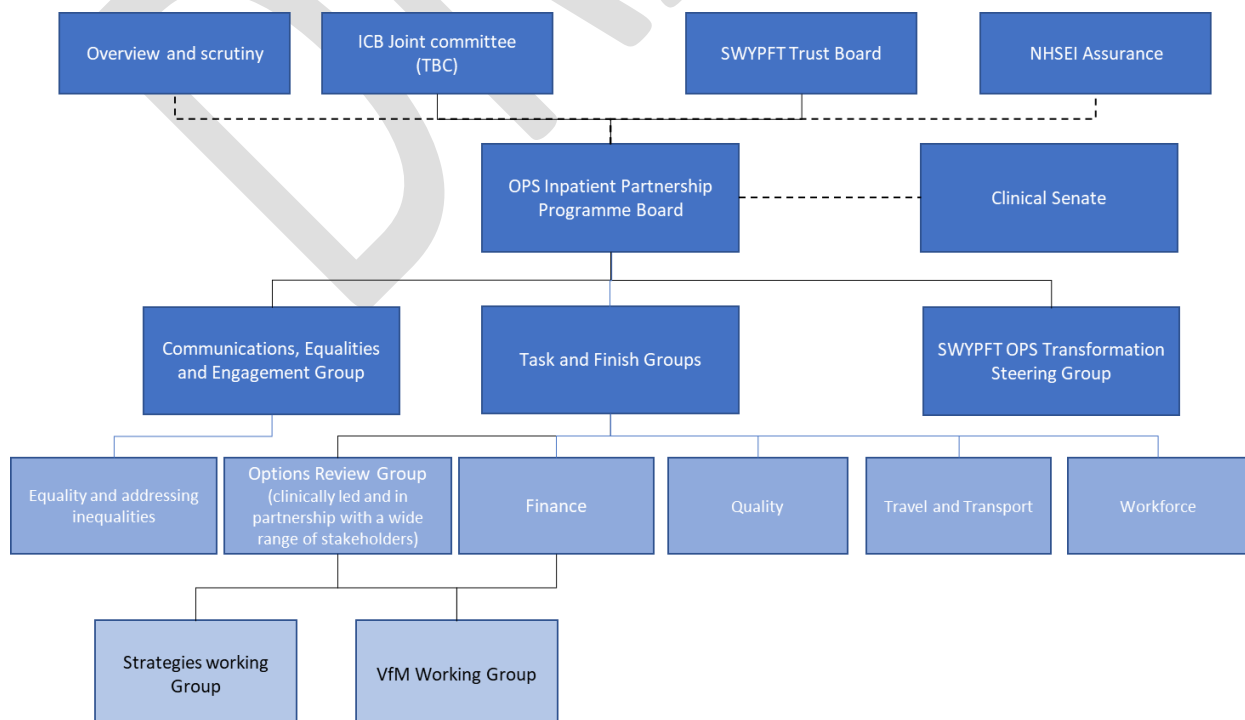
- In Calderdale, **Beechdale** is a 16 bedded, mixed gender and mixed needs, functional and dementia ward at the Dales in Halifax, which is located on the site of Halifax Royal Hospital.
- **Ward 19** constitutes 2 x 15 bedded single gender wards, both mixed functional and dementia needs, on the site of Dewsbury and District Hospital and people from Calderdale will often stay on this site in the current model.
- **Wakefield** currently has 2 wards, Crofton on the Fieldhead site and the Poplars, at Hemsworth. **Crofton** is a 16 bed, mixed gender, mixed functional and dementia acute needs ward. The **Poplars** is a mixed gender ward for people with dementia. People accessing services at the Poplars generally transfer to the ward after an admission to Crofton. It has been operating as a 12 bedded ward for several years.
- **Willow ward** on the Kendray site in Barnsley is the only exclusively functional only ward on the trust footprint and is a 10 bed, mixed gender ward.

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

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

5.4 Governance Arrangements

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



5.4.1 ICB Approval – Joint Committee

The programme board has agreed that we form a joint committee of the three places. The joint committee will make a single decision which is binding on all 3 places and will have representatives from each of the 3 places. Membership will broadly reflect the makeup of place committees, for example including non-executive representation.

5.4.2 SWYPFT Trust Board

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

5.4.3 Overview and Scrutiny (OSC)

The programme team are working with the scrutiny lead in each place to explore the possibility of joint scrutiny of the proposals. A joint informal workshop has been held to review the key elements of the business case and a proposal is being taken forward to hold a joint overview and scrutiny committee.

5.4.4 NHSE Assurance

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

5.4.5 Partnership Programme Board:

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

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

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

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

5.4.6 Clinical Senate

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

5.4.7 Communications Engagement and Equalities Group

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

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

5.4.8 SWYPFT Older People's Transformation Steering Group

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

5.4.9 Options Review Groups

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

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

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

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

5.4.10 Other groups

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

6 Context and Current Service Model

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

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

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

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

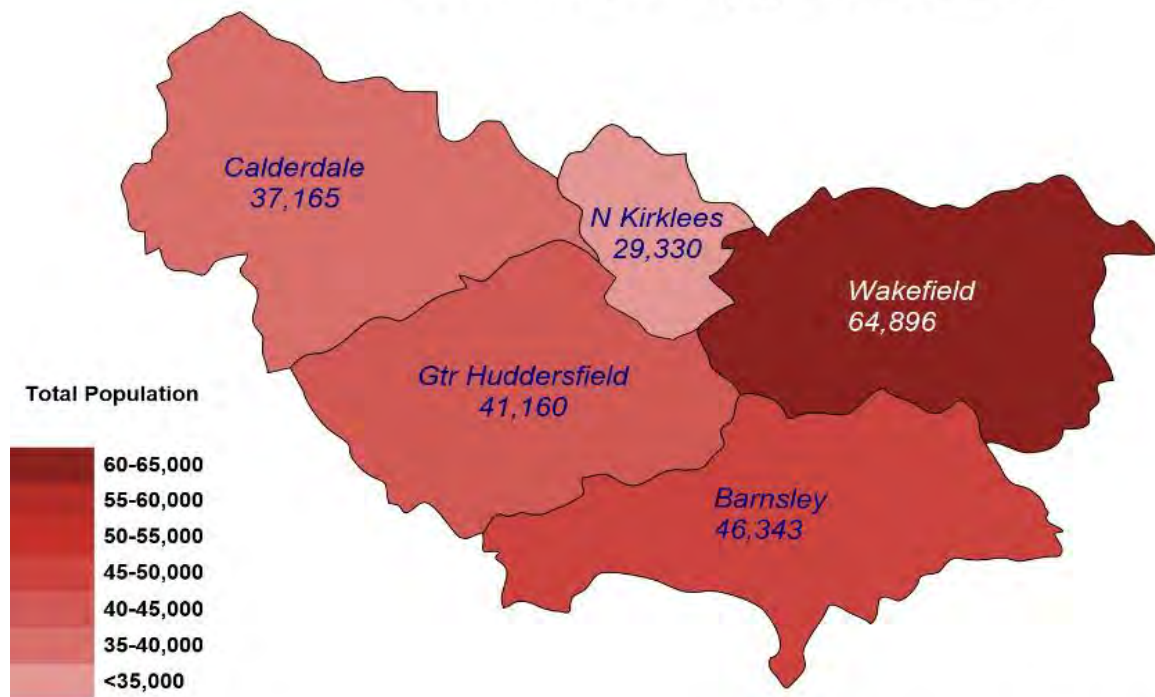
The Trusts works in all villages, towns, and cities from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east and to Hoyland and the Dearne Valley to the south of Barnsley – and all points in between.

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

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

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

Population Density (persons over 65)*



* Registration by GP Practice and CCG, Oct 2016

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

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

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

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

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

6.2 Community Model and Improvements

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

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

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

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

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

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

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

6.3 Community Pathways

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

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

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

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

6.4 Pathways with Partners

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

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

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

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

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

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

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

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

6.4.1 Calderdale:

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

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

Starting Well. Babies, very young children aged 0-5 and expectant families.	Starting Well All children are ready for school	• Joining up services to change lives for the better. All partners working together to achieve agreed health and wellbeing outcomes.
Developing Well. Childhood and young adulthood (ages 6-25).	Developing Well Every 15 year old has hope and aspiration	• A focus on prevention. Shifting more of our focus towards enabling people to be well and preventing ill health.
Living & Working Well. Working age adults.	Living and Working well Working age people have good emotional health and wellbeing and fewer suicides	• Addressing health inequalities. Working for good health and wellbeing for everyone, by tackling root causes of ill health.
Ageing Well. With a focus on older people, aged 50 and over.	Ageing Well Older people have strong social networks and live in vibrant communities	• Empowered and resilient communities. Enabling communities to play their part in creating health and wellbeing, making the most of what exists in our communities.

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

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

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

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

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

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

6.4.2 Kirklees:

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

Mental Wellbeing:

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

Healthy Places:

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

Connected Care and Support

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

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

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

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

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

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

6.4.3 Wakefield:

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



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

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

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

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

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

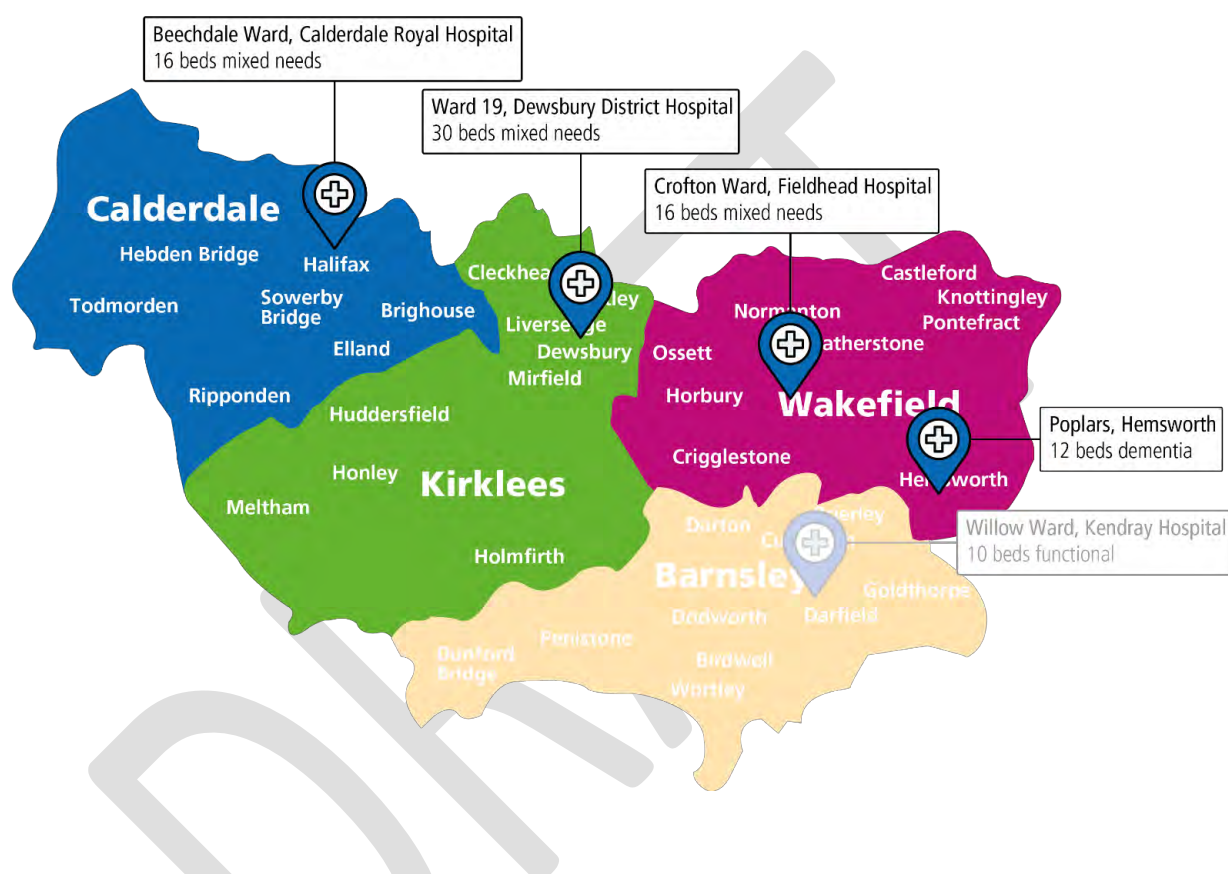
Community Teams and Intensive Support Services have further developed close working relationships to improve the care pathway. The care home liaison model is embedded within each element of the pathway. Primary Care Mental Health (MH) Practitioners are embedded in the Connecting Care Hubs and provide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

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

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

6.5 The current inpatient operating system

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



6.6 Who the wards serve:

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

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

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

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

We would not admit patients who:

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

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

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

6.7 Recent use of and demand for inpatient stays

6.7.1 How many people access the services each year:

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

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

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

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

Total West Yorkshire admissions by place over the period:

Calderdale:

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

Kirklees:

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

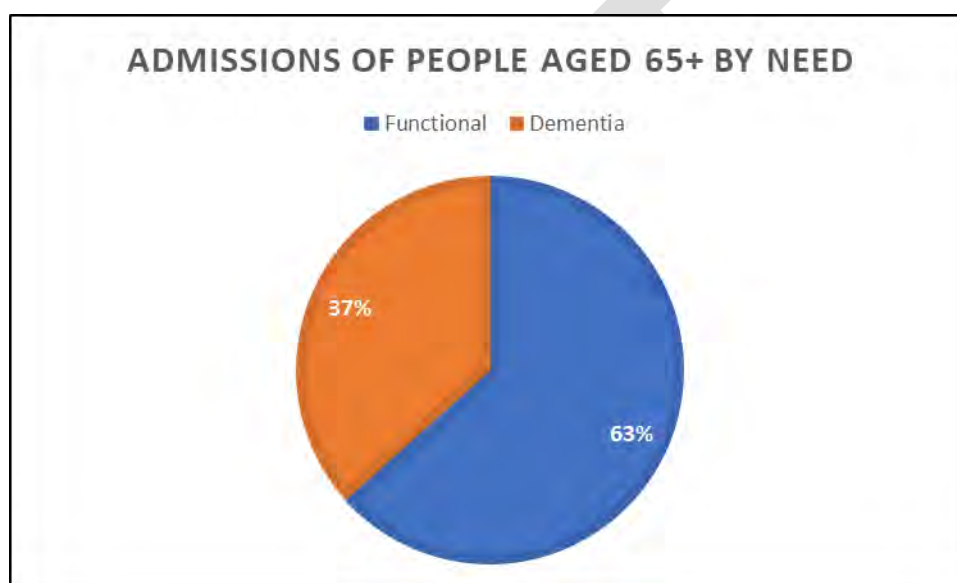
Wakefield:

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

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

6.7.2 Functional and Dementia Mix

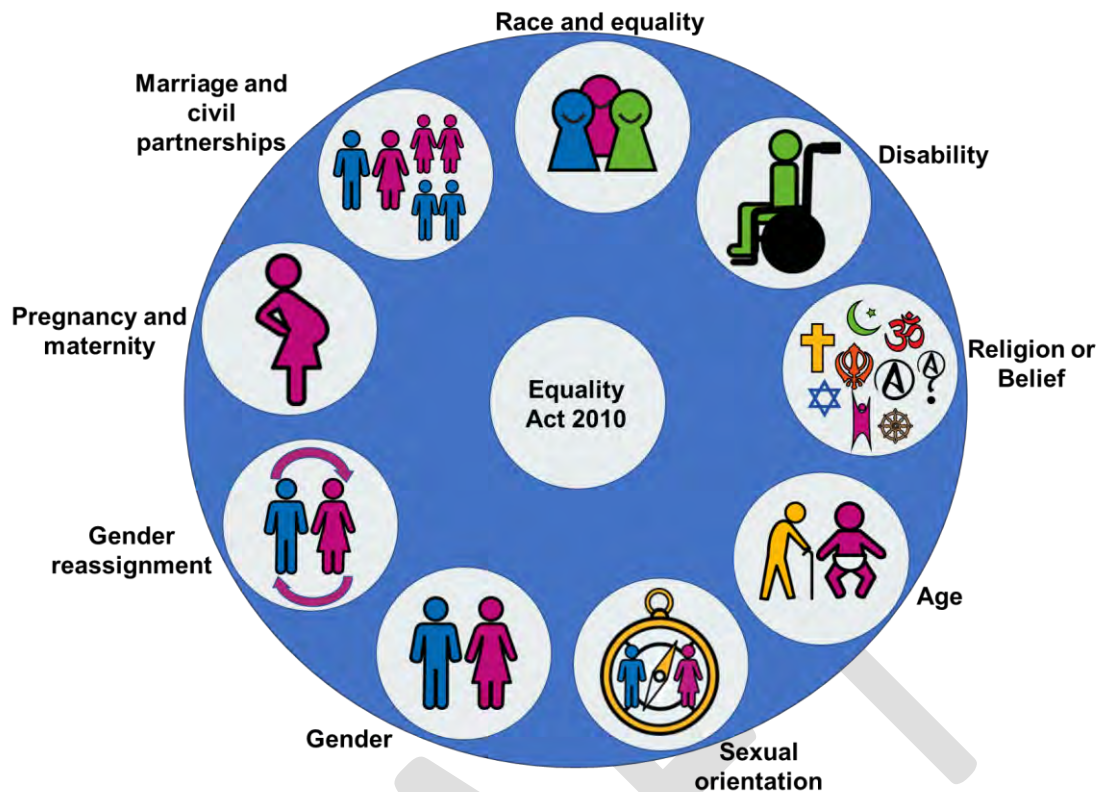
The chart below shows the totality of admissions of anyone aged 65+ from 2013 to 2021, split by functional and dementia needs from across Calderdale, Kirklees and Wakefield:



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

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

The diagram below shows the protected characteristics:

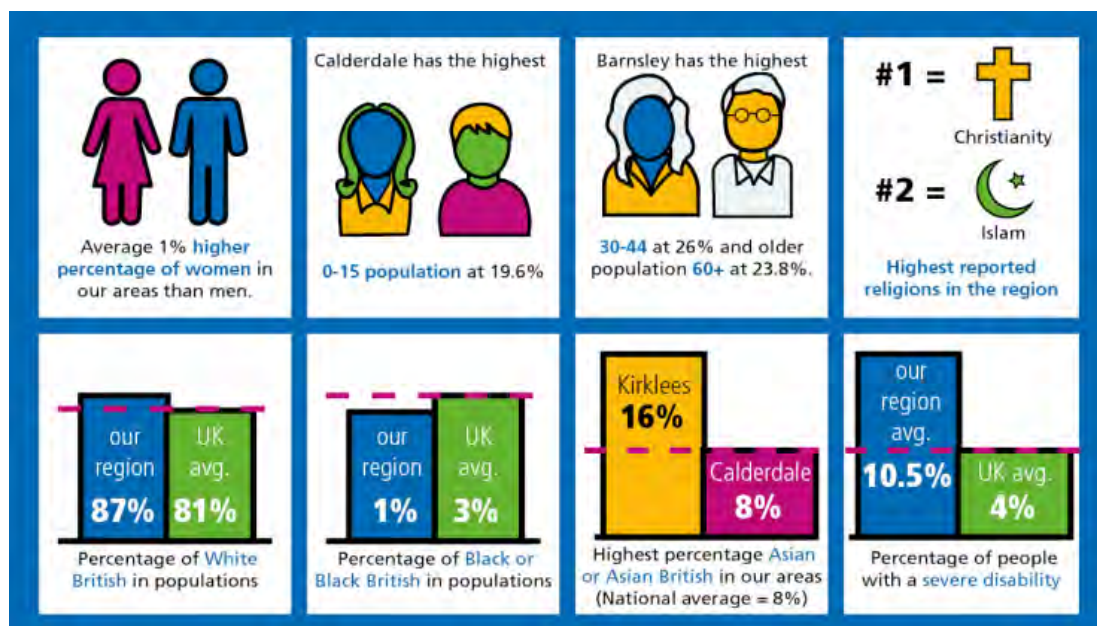


Carers are not one of the protected characteristics. However, 'carers and representatives' of individuals who use health services were specifically included in the legal duty to involve (s13Q of NHS Act 2006) as part of the 2022 Health & Social Care Act Changes, we recognise this as an additional consideration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

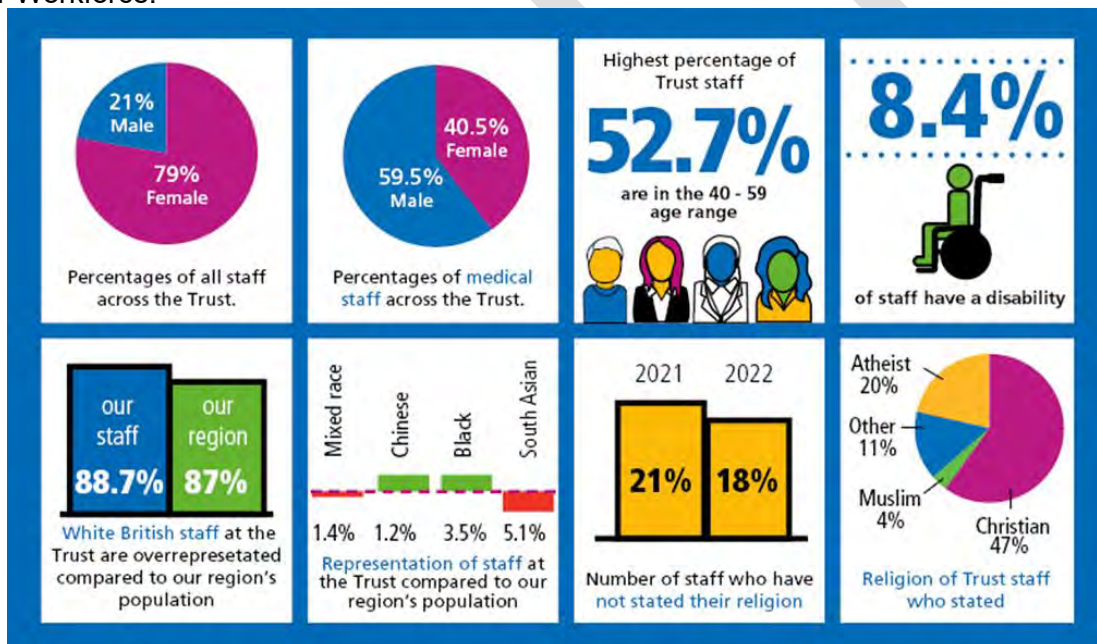
A desk top exercise to identify the specific impacts for each of the different protected groups based on national and local literature provided a baseline of insight.

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

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



Our Workforce:



6.8.1 Carers, family and friends:

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

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

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

6.8.2 Gender

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

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

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

6.8.3 Deprivation

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

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

Source of data on 60+ population in most deprived areas: [Mapping income deprivation at a local authority level - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/inequality/deprivationindices/mappingincome deprivationat a local authority level)

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

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

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

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

6.8.4 Who we cater for – acuity:

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

To evidence this, we have used the Mental Health Optimal Staffing Tool (MHOST), [Planning for the mental health support workforce \(hee.nhs.uk\)](https://www.hee.nhs.uk/planning-for-the-mental-health-support-workforce), which was developed with NHSI, Imperial College London and 26 different Trusts and is the most evidence-based tool available and is part of NHSE's chief nursing officer's safer staffing fellowship programme as a recommended staffing/acuity tool.

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

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

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

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

The following summarises the dementia profile:

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

Functional profile:

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

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

6.8.5 How many beds we use:

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

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

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

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

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

6.9 How demographic changes might impact on demand and bed use

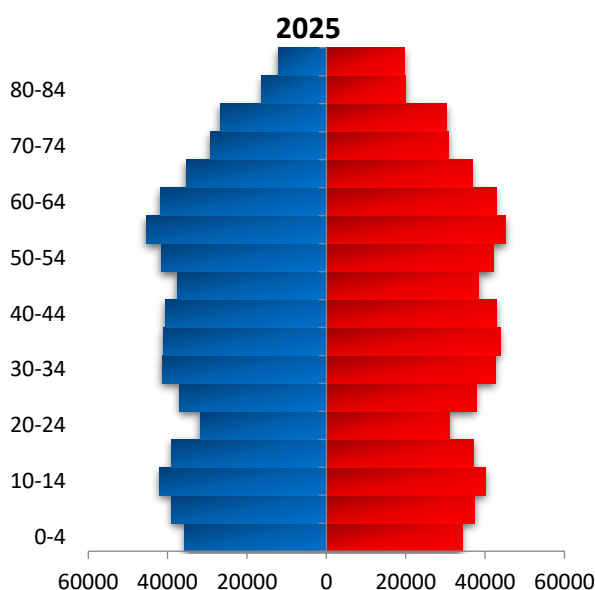
In the coming years, the number of older people in the UK population will increase significantly. By 2036 it is expected that 23.9% of the total population will be over 65 (<http://ons.gov.uk>) and over 5% of the population will be over 85 years of age. Mental Health issues and especially depression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

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

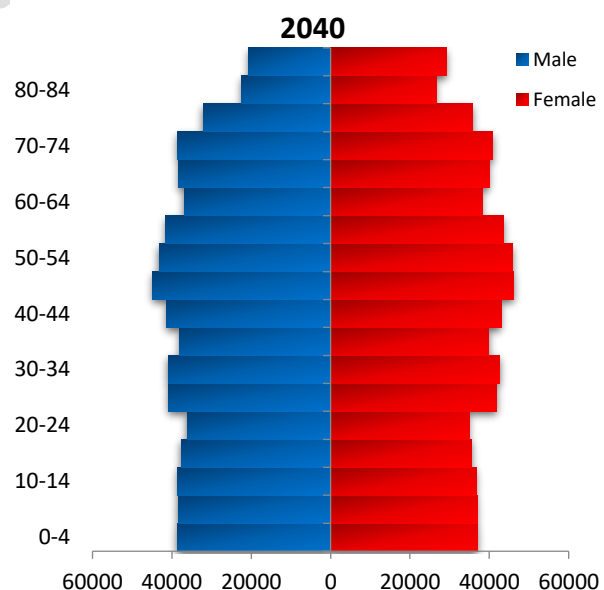
6.9.1 Population Trends with Projected Numbers

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

Projected Population 2025

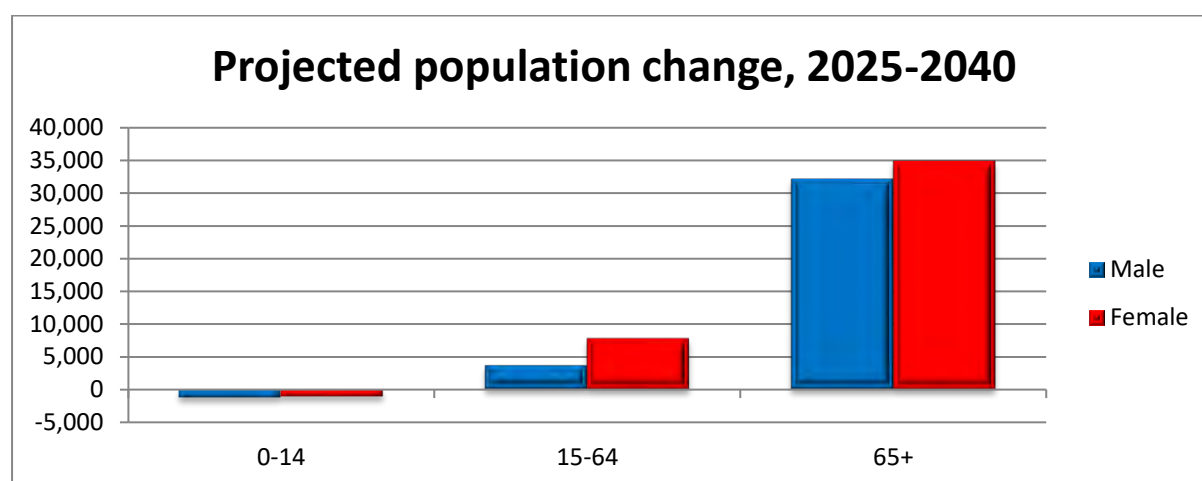


Projected Population 2040



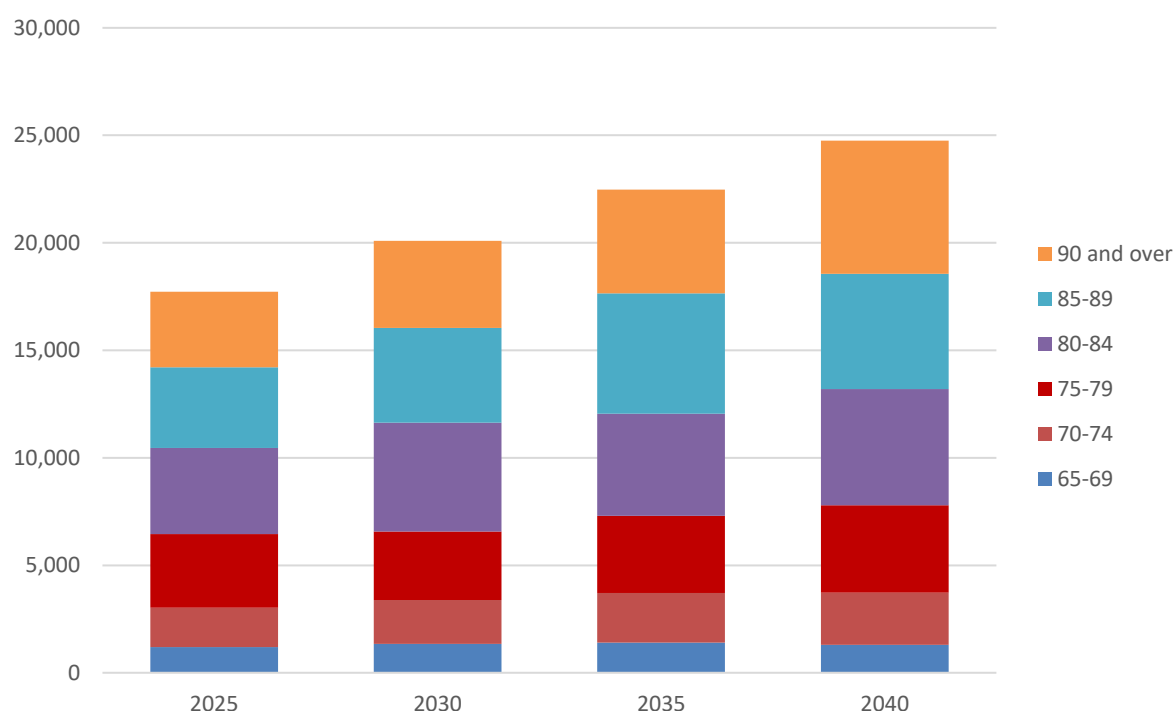
6.9.2 Projected population change 2025-2040

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



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

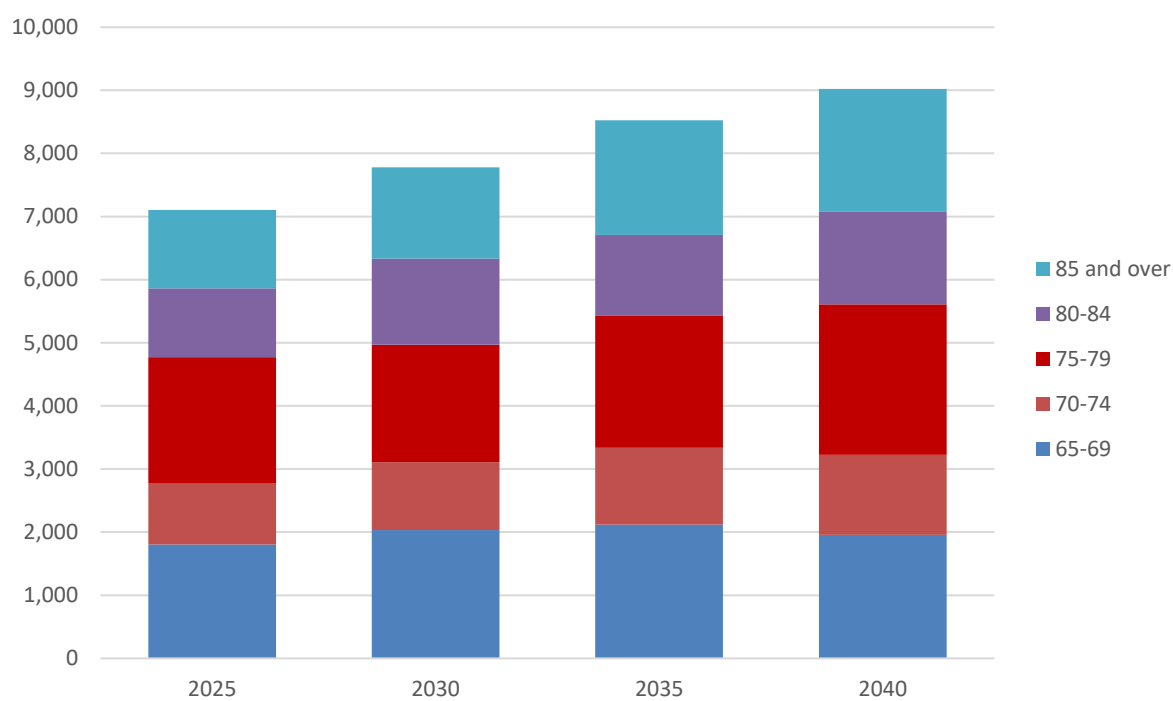
The number of people aged '65 and over' who have dementia are projected to increase by 56.0% between 2020 and 2040. The number of people aged '90 and over' with dementia are predicted to increase by 90.5% (the highest increasing age group).



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

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



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

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



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6.10 Admissions based on age group to our wards

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

Functional Patients Admitted by Age	% of admissions 2018-2021	Dementia Patients admitted by Age	% of admissions 2018-2021
85+	9.2	90+	2.6
80-84	10.3	85-89	11.6
75-79	16.0	80-84	21.3
70-74	29.9	75-79	27.1
65-69	34.6	70-74	26.5
total	100.0	65-69	11.0
		total	100.0

6.11 Factoring population changes in model:

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

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

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

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

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

6.12 How the current model works

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

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

6.12.1 Calderdale

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

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

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

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

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

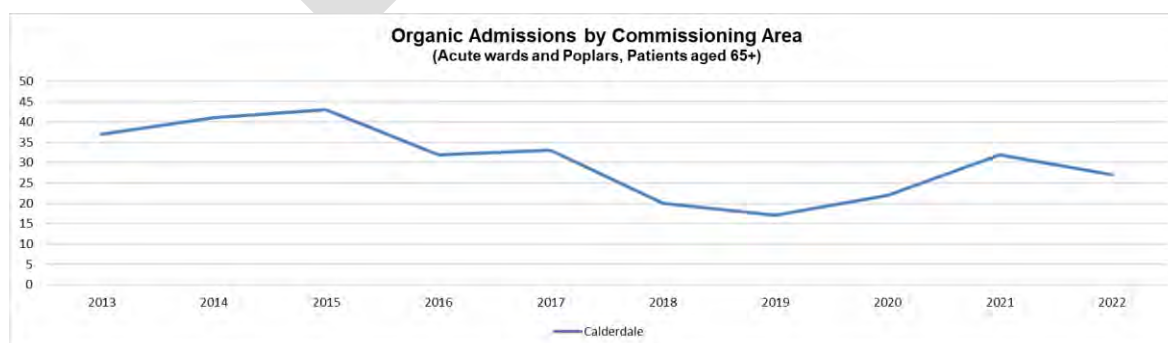
The bedroom corridors are designated by gender and there are separate lounges and communal bathroom for females. This meets single sex accommodation guidelines but there are potential issues with male and female patients with dementia being on the same ward, due to lack of inhibition or misinterpreting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

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

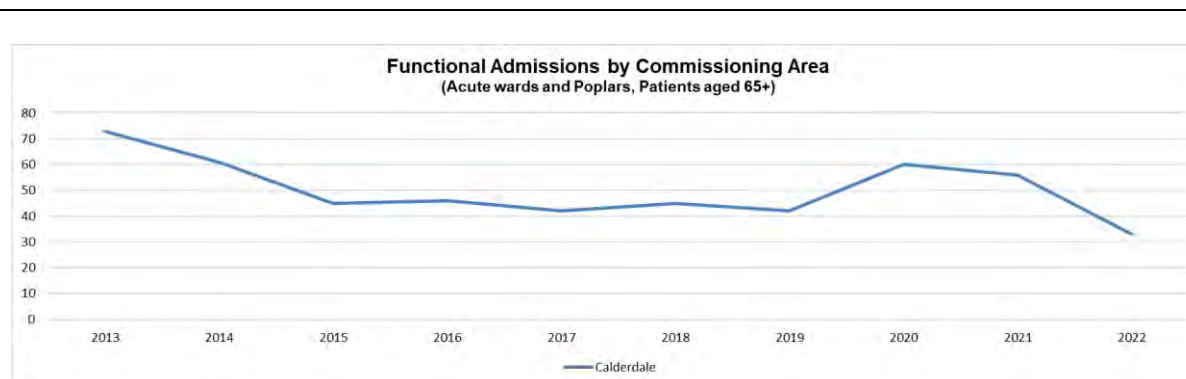
- There's no seclusion or extra care area here so it can feel unsafe to manage aggressive patients with dementia.
- There's no space for people with dementia to move about in here.
- It's difficult to provide stimulation for patients with dementia here.
- I run groups to help with pain, balance and exercise.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

Admissions

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



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



Pathway and moves

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

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

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

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

Admissions outside of local area from 2018-2021:

Barnsley Wards	Kirklees Wards	Wakefield Wards	Total
12	126	33	171

Length of Stay:

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

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

Incidents (2022) per bed

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

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

Workforce Models

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

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

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

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

Current Travel

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

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

6.12.2 Kirklees

Ward function

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

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

Location and Access

Ward 19 is located within the Priestly Unit and is co-located with a mental health ward for working age adults on the site of Dewsbury District Hospital

There is on-site access to the Emergency Department (ED) should any patient in the unit become physically and acutely unwell and there is access to physicians with expertise in looking after older people.

There is no access to ECT therapy at the Dewsbury site, meaning that people with functional needs that require this service need to travel to either Halifax or Wakefield to receive it.

Patient advocacy is provided by Touchstone advocacy service. Referrals are automatically picked up by the team and the advocate visits the ward at least once per week.

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

Ward environment

Ward 19 is configured to provide 15 beds for male patients and 15 beds for female patients in separate areas of the ward with dedicated staffing for each area.

The ward has considerable space for movement and wide corridors, with each ward having access to lounges, a dining room, an occupational therapies room and a garden conservatory. There is good courtyard space across the wards and an extra care area between the 2 wards.

The ward does not currently have en-suite facilities and whilst there might be potential to undertake work to make some bedrooms en-suite, the current drainage system won't support the whole unit changing to en-suite.

There are several features of Ward 19 that lend themselves to supporting people with dementia, for example, the space for movement and wide corridors, access to multiple lounges, a dining room, occupational therapies room and a garden conservatory.

The clinical senate, when visiting, were impressed with the garden areas available for patients to enjoy the outdoors and to take part in gardening activities and acknowledged that while the ward space does not provide a circuitous pathway for patients with dementia but it does have large, wide corridors.

The clinical senate did though feel that the environment in the ward appeared to be dark and sterile and it would benefit from being made brighter and with more stimulation and interesting décor for patients with dementia. Handrails and automatic lighting have been recently installed, which are essential to help reduce the amount of patient falls on the wards. A window has recently been created in the roof space of the central area for more natural light.

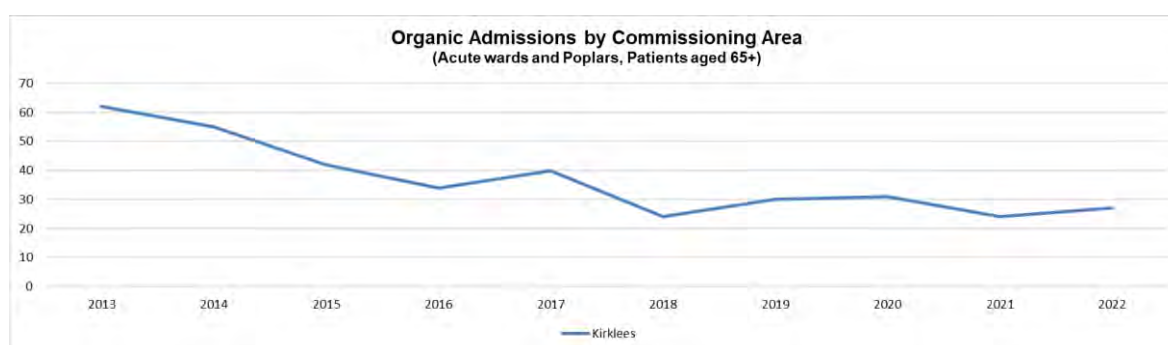
The theme of handrails was also raised via a CQC visit in late 2022, <https://api.cqc.org.uk/public/v1/reports/7ac7435c-4823-404d-9544-2c6349b312bf?20230315080038>. It stated that Ward 19 did not have handrails fitted but the trust was in the process of carrying out some renovations which would include the fitting of anti-ligature handrails.

Some staff feedback on the environment from March 2023 includes:

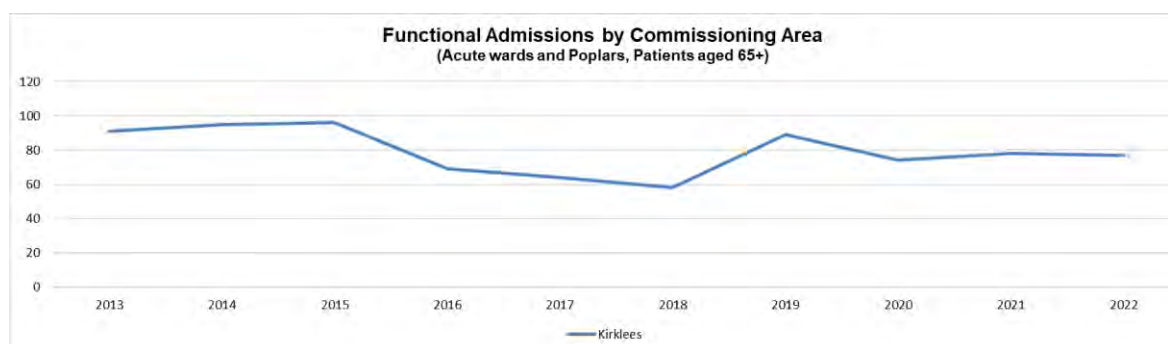
- Ward 19 has the space and the room to manage dementia need. More could be done to improve the environment such as sensory rooms.
- Dementia friendly wards need more space for patients to be able to get some quiet time. A low stimulus environment is needed. We've temporarily lost the use of a quiet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

Admissions

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



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



Pathway and moves

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

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

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

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

Admissions outside of local area from 2018-2021:

Barnsley Wards	Calderdale Wards	Wakefield Wards	Total
14	18	26	58

Length of Stay:

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

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

Incidents (2022) per bed

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

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

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

Workforce Models

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

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

Ward 19 M	2	2	1	1	2
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As well as this rostered staffing, we do have a range of specialist resource that works into the ward including medical staffing, advance clinical practitioners, psychology, physiotherapy, and occupational therapy.

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

Current Travel

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

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

6.12.3 Wakefield

Ward function
There are 2 older people's mental health wards in Wakefield, the Crofton ward and the Poplars unit. The Crofton ward, is a mixed sex unit that provides inpatient assessment and treatment for people aged 65 and over who are experiencing functional mental health problems or people with dementia that are acutely unwell. The Poplars ward is a mixed sex mental health unit for people who have been diagnosed with dementia, though not designed to deliver acute mental health care. Originally commissioned as 15 beds, the site has been operating with a maximum capacity of 12 beds for several years with capacity reduced to make space for a female lounge, clinical storage room and, more recently, a covid changing room. This is because of a change in the presentation of patients over time who now have more acute mental health needs.
Location and access
The Crofton ward is based on the Fieldhead Hospital site in Wakefield. As part of the Fieldhead site, there is access to support from across the ward base as this is co-located with several working aged adult wards. The unit is located on an acute mental health site and emergency and specialist geriatric care is provided from the nearby, but not co-located, Pinderfields Hospital.

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

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

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

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

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

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

Feedback from medical staff highlights some of the challenges:

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

The CQC also visited the Poplars ward in late 2022

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

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

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

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

Ward environment

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

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

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

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

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

Some feedback from staff includes:

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

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

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

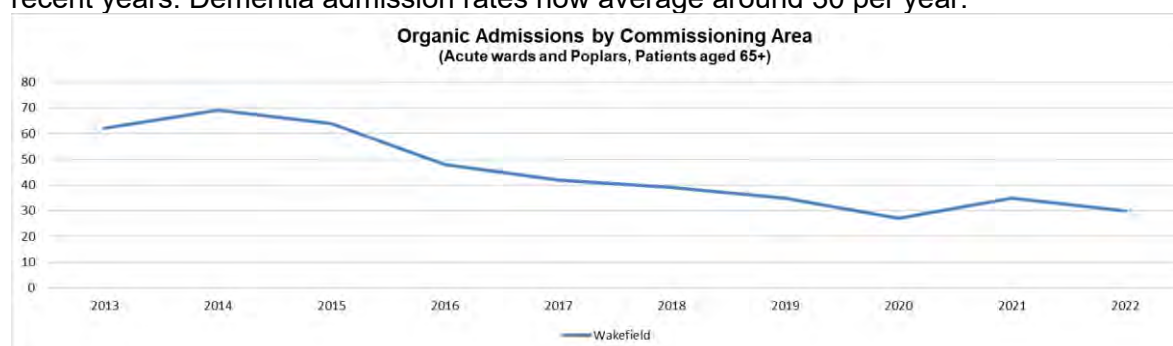
The unit is the oldest of all our older adult's inpatient wards and may need refurbishment.

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

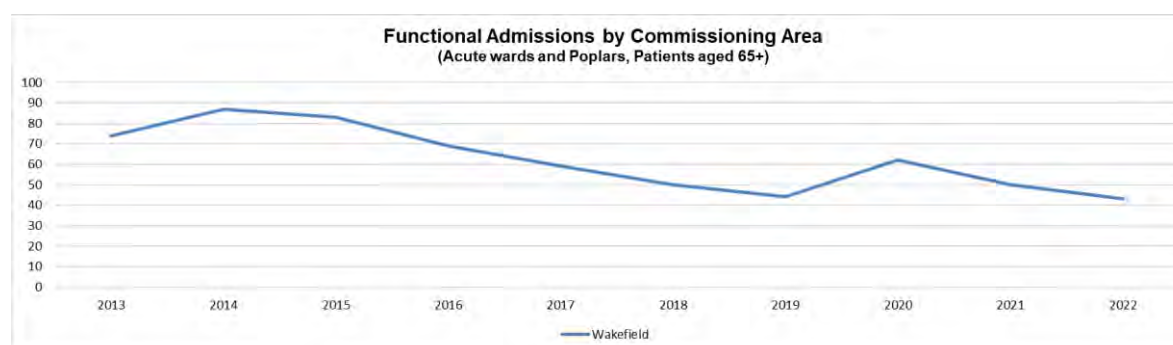
The CQC noted in their visit in late 2022 that female patients had to walk across a communal area used by male patients to reach a communal bathroom (they were always accompanied by a staff member when doing so).

Admissions

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



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



Pathway and moves

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

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

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

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

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

Admissions outside of local area from 2018-2021:

Barnsley Wards	Calderdale Wards	Kirklees Wards	Total
7	4	61	72

Length of Stay:

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

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

Incidents (2022) per bed

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

Workforce Models

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

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

Poplars	2	3		1	2
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As well as this rostered staffing, we do have a range of specialist resource that works into the ward including medical staffing, advance clinical practitioners, psychology, physiotherapy, and occupational therapy.

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

Current Travel			
The table below shows the average public transport time from the patient's home address to the ward that they were discharged on (more detail can be found in the travel impact section).			
Need	Place	Current average driving distance	Current public transport average travel (time mins)
Dementia	Wakefield	9.1	43
Functional	Wakefield	7.7	41

In summary:

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

More detail on current models is set out below:

6.13 Admission Pathways

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

These are:

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

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

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

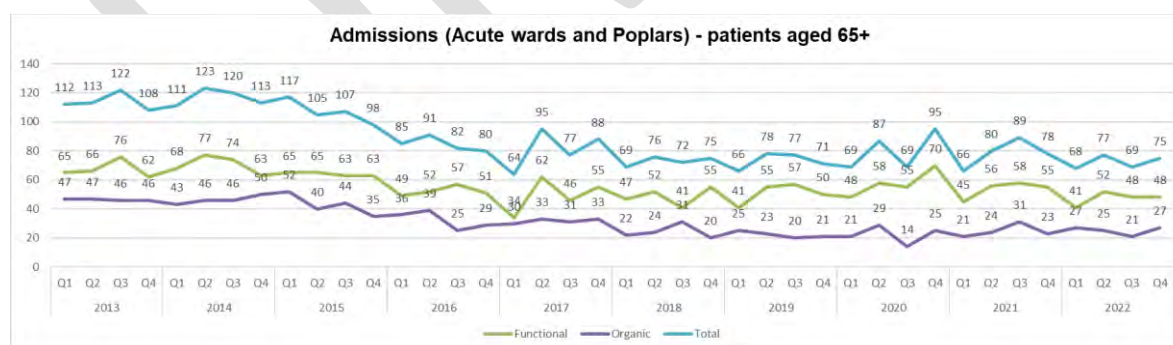
	Barnsley Wards	Calderdale Wards	Kirklees Wards	Wakefield Wards	Total
Calderdale	12		126	33	171
Kirklees	14	18		26	58
Wakefield	7	4	61		72
Total	33	22	187	59	301

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

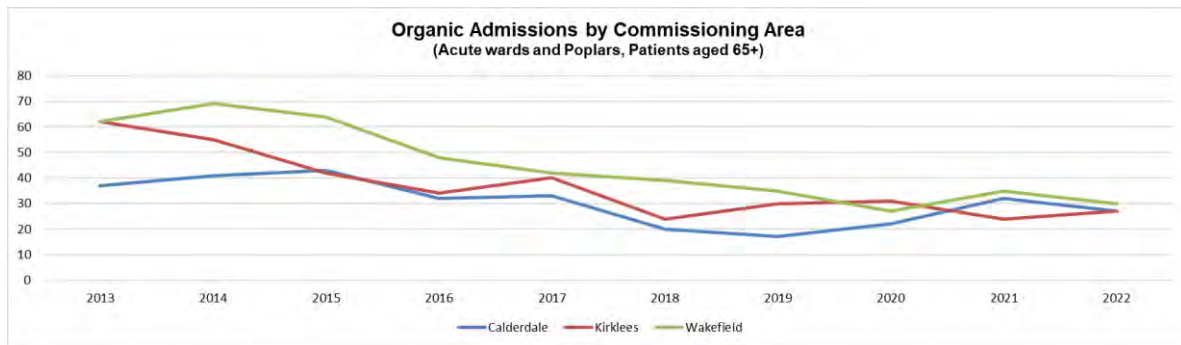
Approximately 70 people from Calderdale are admitted per year, 87 from Wakefield and 104 from Kirklees. From Calderdale, just under 50% of admissions are to that locality, Kirklees 85% and Wakefield 80% admissions to their own district.

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

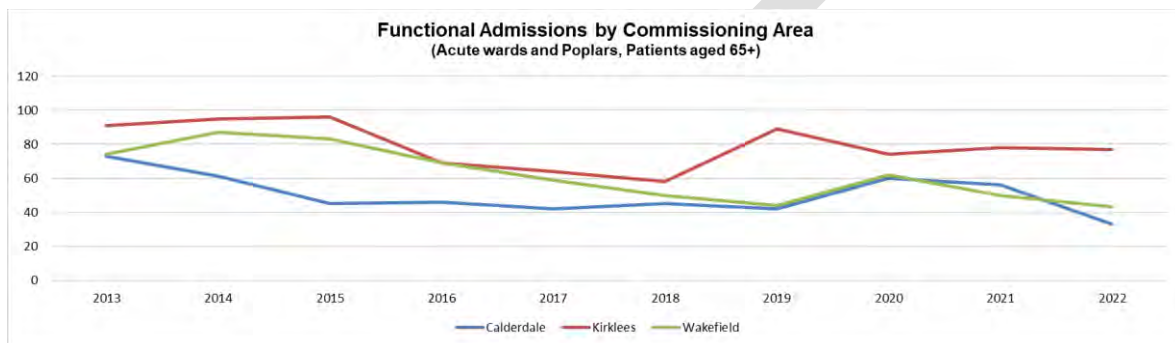
Data shows that over the past 10 years that there has been an overall downward trend in admissions, though rates have been more stable in the most recent 5 years.



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

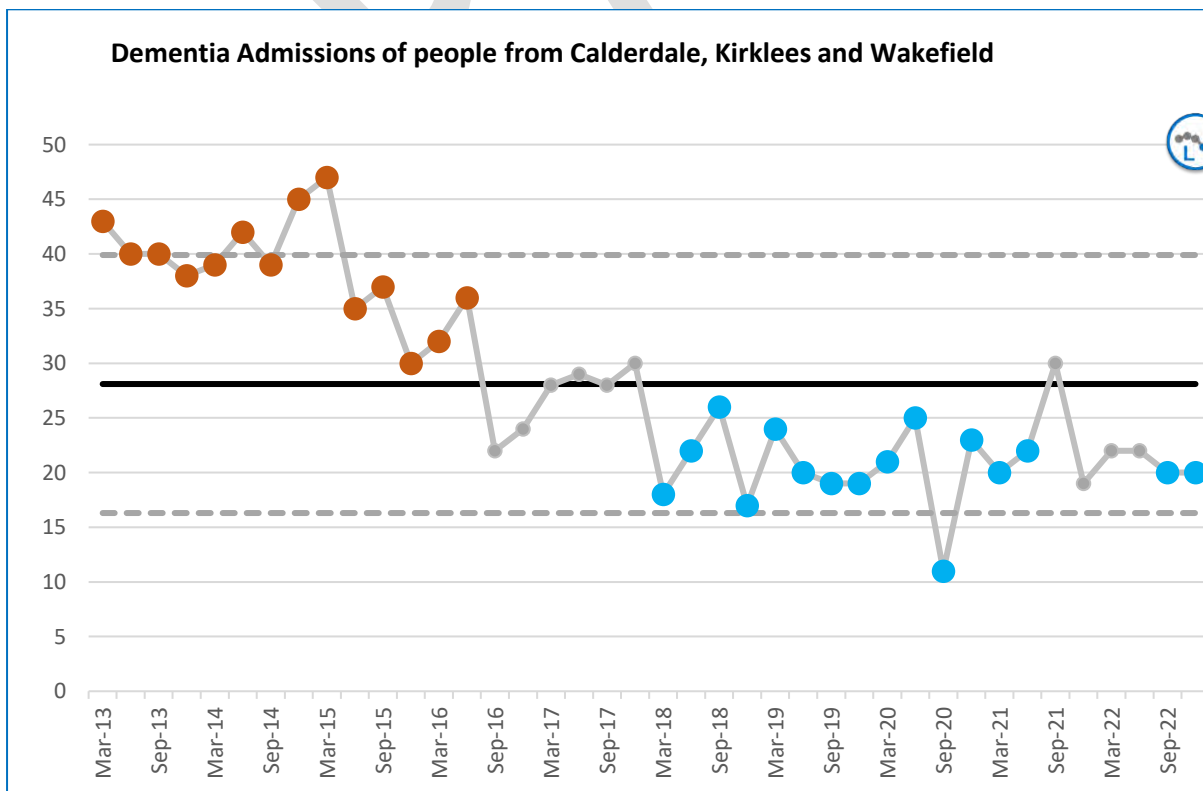


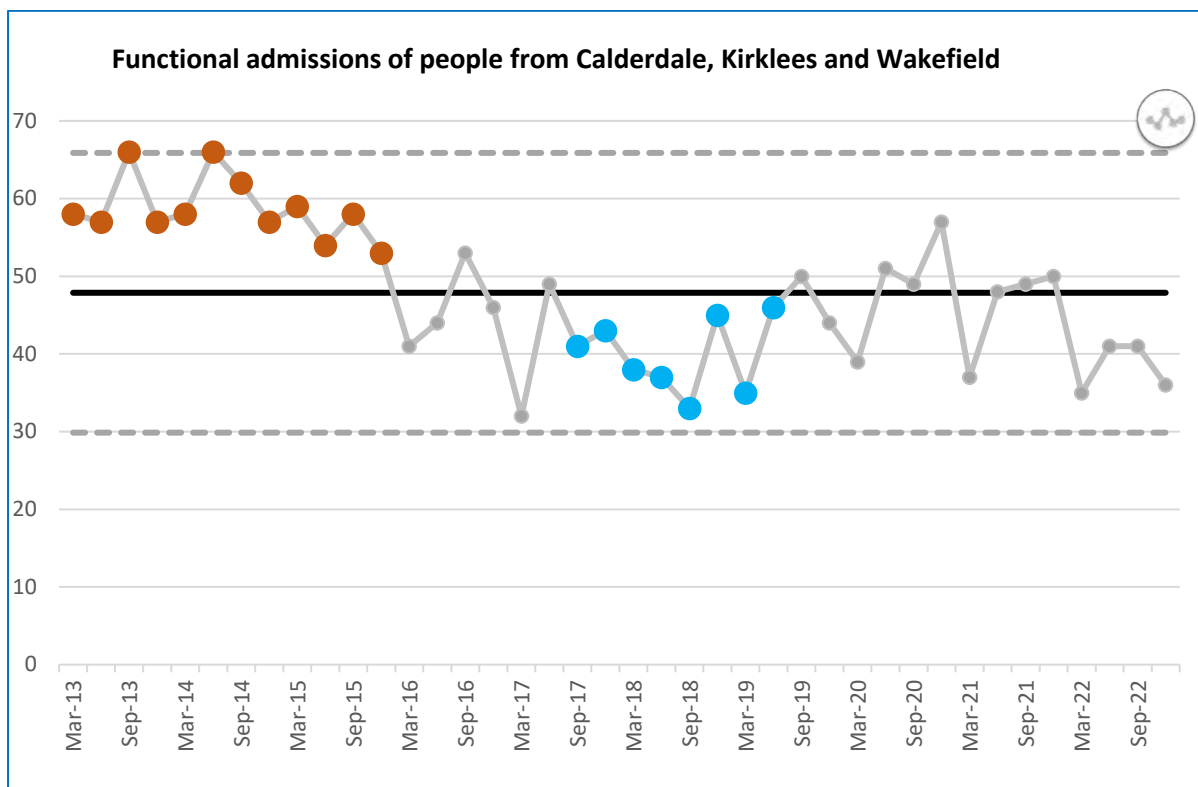
The table below shows the numbers of functional admissions by place:



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

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





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

6.14 Ward Stays

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

Potential benefits of a single stay are:

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

Potential risks of multiple ward stays are:

- Impairs continuity of care.
- Prevents the development and utilisation of therapeutic relationships.
- Hinders access by carers due to the geographical differences.

- Unnecessarily extends the Length of Stay.
- Means there is an additional period of assessment while a new care team and the service user get to know each other.
- Means an understanding of the wider multi professional team and their role in supporting care in the community has to be re-established.
- Means that relationships between the carer and the care team have to be re-established.
- Leads to attitudes to risks being lowered while impact is re-evaluated.
- Increases the risk due to the change of environment / change of staff, for example, can also lead to increased confusion when moving people. The changes can't always be mitigated and there can also be an impact on carers.
- Especially disruptive to the treatment of a person living with dementia:
 - o increased confusion.
 - o increased disorientation.
 - o staff not being able to interpret the person's needs appropriately.

6.14.1 What works well in the current pathways

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

6.14.2 What doesn't work well in the current pathways

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

6.14.3 Multiple stays

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

CKW	1	2+	Total
-----	---	----	-------

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

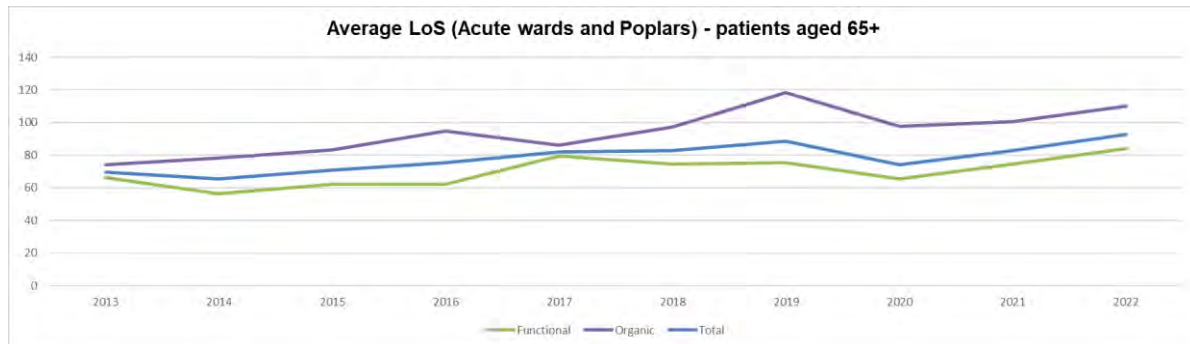
The table below shows the impact multiple stays has on the overall length of the stay, highlighting the length of the stays where people had just one ward stay compared to multiple stays:

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

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

6.15 Length of Stay overall

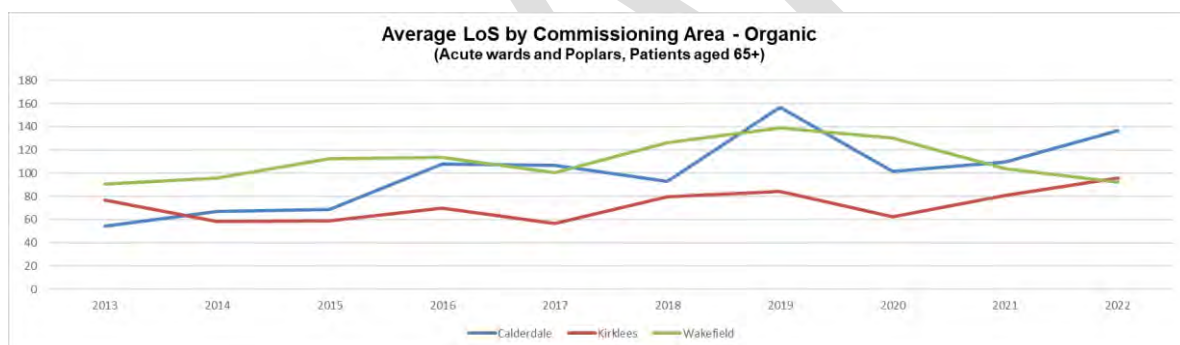
The average length of stay (LOS) has been increasing over time, with the greater increase being in dementia (organic) stays (average LOS increasing from around 80 days 2013-15 to over 100 days in recent years):



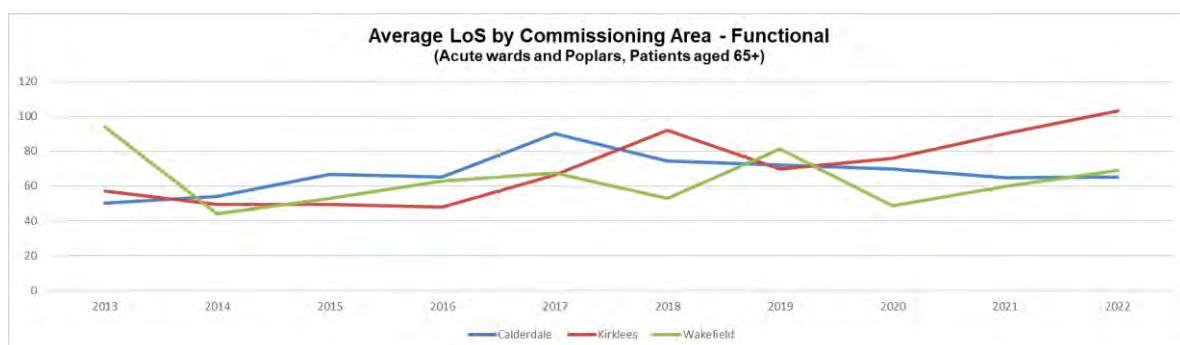
Place based breakdown:

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

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



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



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

6.16 Ward Environments

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

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

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

The table below summarises the wards from an access perspective:

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

6.17 Incidents

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

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

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

Rates per bed:

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

Yellow and above risks:

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

Rates per bed:

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

Slips, trips and falls (all risk categories):

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

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

Rates per bed:

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

Violence and aggression (all incidents):

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

Rates per bed:

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

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

6.18 Existing Workforce

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

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

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

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

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

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

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

6.18.1 Turnover rates:

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

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

Willow	0%
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50% of the older adult wards have a turnover rate in excess of the Trusts average rate of 12%.

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

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

6.19 CQC Inspections

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

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

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

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

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

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

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

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

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

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6.20 Benchmarking Data

6.20.1 Summary of how we compare to others

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

Older Adult

Benchmarking Network

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

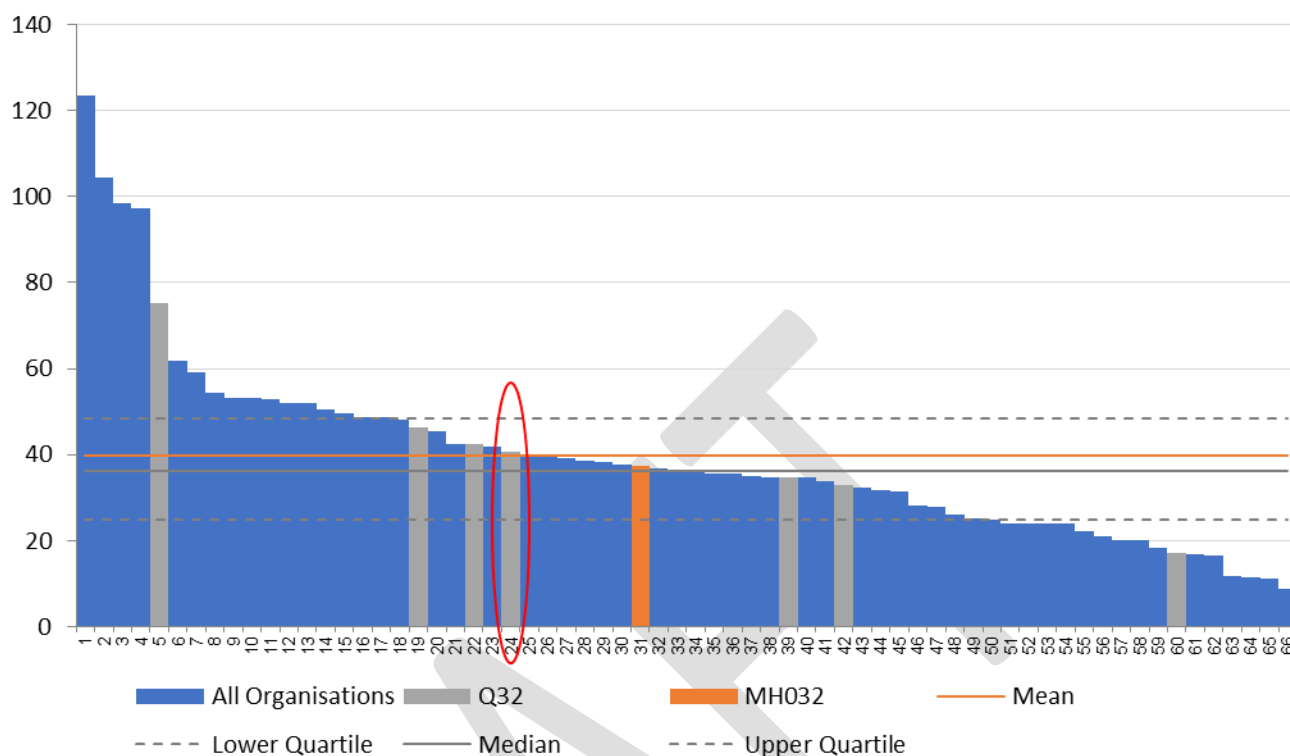
The national trend for admissions is a reduction and LOS is an increase which is in line with our trajectories.

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

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

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

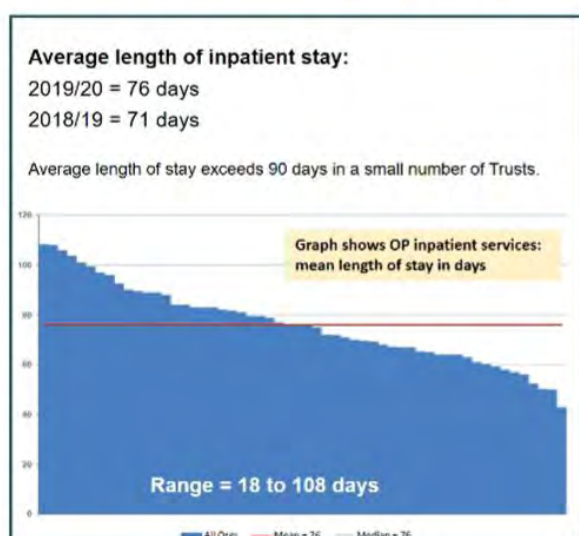
Older Adult - Total number of beds at 31/03/2021 per 100,000 ONS resident population



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

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

Older Adult Inpatient Services



12% of patients stay for **less than 2 weeks**

30% of patients stay for **more than 90 days**
 = **63%** of occupied bed days

In England in May, 8.3 people per 100k population stayed longer than 60 days in adult inpatient setting
 During the same time 9.4 people per 100k population stayed longer than 90 days in older adult inpatient setting

55% of occupied bed days in older adult inpatient services
 = patients with primary diagnosis at discharge of functional mental disorder

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

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7 Vision for the clinical model

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

7.1 Vision for the future

7.1.1 National Context

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

- Care is personalised
- Admissions are timely and purposeful
- Hospital stays are therapeutic
- Discharge is timely and effective
- Care is joined up across the health and care system
- Services actively identify and address inequalities
- Services grow and develop the acute inpatient workforce in line with national workforce profiles.

See [NHS England » Acute inpatient mental health care for adults and older adults](#) for more information.

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

7.2 West Yorkshire ICB

The West Yorkshire ICB has the 4 following aims:

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

- Use our collective resources wisely



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

7.3 SWYPFT Vision

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

Our vision:

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

Our mission:

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

Our values:

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

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

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

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

7.4 Evidence for a needs-based specialist model

7.4.1 Published evidence for needs-based model:

The evidence gathered in this section sets out how having separate in-patient beds for the two functional and dementia (organic) groups has been consistently regarded as good practice. They allow the older people who need an inpatient stay to have the right care and support, whether they have dementia, depression, psychosis or any other need.

Many of the standards for delivering separate specialist care were agreed several years ago. The joint commissioning panel (May 2013) for mental health guide advocates:

- Where possible, separate ward space for functional and dementia (organic) disorders
- Gender separation guidance for inpatient services being properly applied

In Scotland, the Mental Welfare Commission has undertaken several research studies into the ward environments, including their 2020 report ([Older people's functional mental health wards in hospitals - new report | Mental Welfare Commission for Scotland \(mwscot.org.uk\)](https://www.mwscot.org.uk/older-people-functional-mental-health-wards-hospitals-new-report)).

They found that:

"While it is appropriate that these wards can and do treat some patients who have both functional mental illness and dementia, the Commission is clear that mixing patients who are solely diagnosed with dementia with those who do not have that diagnosis is challenging, and does not meet the needs of either group".

The commission also found that where wards were mixed, nurses often described difficulties.

"Challenge of meeting all individual needs for functional patients and dementia patients as needs can be complex."

"When there is a higher percentage of patients with dementia this has a negative impact on patients with a functional illness."

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

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

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

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

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

The report also referenced a female patient said that:

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

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

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

The type of supervision and clinical intervention and workforce skills needed for the two groups may be quite different (Audit Commission, 2000 and 2002). This was reiterated in the document 'Everybody's Business' (Care Services Improvement Partnership, 2005b). The Health Education England (2017) Older People's Mental Health Competency Framework highlighted the need for skills and specialism based on patient group. On mixed needs wards, providing activities that would be stimulating and meet the needs of each person is cited as challenging.

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

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

A report for the Scottish Government recommended the provision of specialist dementia hospital care in 2018 Transforming Specialist Dementia Hospital Care, Alzheimer Scotland,

2018 for people with dementia who have an acute psychological presentation because of dementia or co-morbid mental health illness.

The report concluded that the modern specialist dementia unit should provide a centre of excellence to deliver quality treatment and care for the small number of people with dementia who will have a clinical need to be in hospital. It noted that this would provide a highly skilled practice area and an attractive specialism for ambitious and talented practitioners to deliver therapeutic interventions.

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

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

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

7.4.2 Models implemented elsewhere:

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

How our Trust benchmarks against others:



7.4.3 Why Places might not have separate provision:

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

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

7.4.4 What people told us about a needs based model

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

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

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

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

More information can be found in the engagement section.

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

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

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

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

In both dementia and functional need wards we ideally need:

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

In a dementia ward we ideally need:

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

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

In a functional ward we ideally need:

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

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

7.4.6 Learning from other site environments

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

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

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

7.4.7 Summary of benefits of specialist needs based wards

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

- Skilled staff able to better focus the right care and interventions based on the needs of the people on the ward and different needs can be met better. For example, functional admissions will often have some accompanying psychosis and carry a high level of risk.
- Having separate specialist wards for people with functional needs allow the quality of therapies to be improved, enables staff to have the right skills.

- Type of observation and input are different, meaning that we can get the right levels of workforce and supervision for both groups.
- Having functional and dementia / organic only units means that staff can dedicate their time to people with these needs. It means that they are not focussing disproportionately on the needs of people with dementia who often display the most behaviours that challenge.
- It will resolve issues where mixed needs wards can be counterproductive to the needs of patients, for example, invasion of privacy of functional patients by people with dementia or people with dementia surrounded by depressed patients.
- Having separate needs-based wards means that we can get the most out of the environment for the different groups, for example enhancing opportunities to create a dementia friendly environment on a specialist dementia only ward.
- Delivering improvements to inpatient pathways should help improve length of stay on the wards, which has increased overall in recent years, particularly for people with dementia, though work on forward pathways will also be needed to support improvements.
- Staff are able to focus on their preferred specialism, increasing their skills and knowledge and improving staff retention.

Potential issues could arise with the model, highlighted below:

- If there are issues with deciding on an admission to functional or - dementia wards due to uncertain diagnosis, then we will manage according to predominant presenting psychopathology. Feedback from services is that there may still be a small number of cases that are difficult to assess until the person is on a mental health inpatient ward due to comorbidity and a presentation that would make assessment in the community difficult. Clinical judgement would be required at time of admission and a transfer would be considered, if required, following assessment.
- Whilst staff will develop more specialist skills for supporting service users based on need, we've had feedback that there is a risk of deskilling more general skills across both needs group, which might still be required. This could be achieved through creating a set of competencies that are universal across both functional and dementia/organic wards, in addition to any competencies that are needed for staff in those specialist wards alone. Time spent working across other wards areas, training and supervision would be used to achieve these competencies.
- Capacity to meet demand of different needs groups: The current model has flexibility in the numbers of people with functional and dementia/organic needs and male and female patients within the overall capacity. A needs-based model will create a ceiling for both needs group and could create extra challenges in managing male/female demand.

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

7.5 Gender specific care for older people in mental health hospitals

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

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

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

7.6 Location of wards and access

7.6.1 Co-location with acute general hospitals

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

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

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

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

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

7.6.2 Co-location with other acute Mental Health Services

There are benefits of co-locating the ward with other mental health services and wards. This allows for better access to cross cover and medical support should needs and demands on the wards change. Emergency response is also improved when there is alignment with other mental health wards, such as a dedicated crash team or responding to safety incidents, for example, when a physical intervention or de-escalation is required.

7.6.3 Access to other services:

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

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

7.6.4 Patient Transport

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

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

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

7.6.5 Access for Families and Carers

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

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

7.7 Pathways

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

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

- Ensures continuity of care
- Supports the development and utilisation of therapeutic relationships

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

7.8 Workforce

7.8.1 Roles required across the wards:

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

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

The report concluded that the modern specialist dementia unit should provide a centre of excellence to deliver quality treatment and care for the small number of people with dementia who will have a clinical need to be in hospital. It noted that this would provide a highly skilled practice area and an attractive specialism for ambitious and talented practitioners to deliver therapeutic interventions. It recommended that any unit should take students of each profession to make it an attractive career choice for the future workforce.

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

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

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

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

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

Social stimulation and meaningful occupation would be required, so that people remain connected and engaged. This would include supporting continued involvement in the person's existing hobbies, interests and spiritual practices and may involve utilising connections with external agencies, voluntary organisations and community networks. It may

include patients being supported to take part in activities outside of the hospital and community resources coming into the unit to provide social engagement.

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

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

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

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

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

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

7.8.2 Required rostered levels for needs-based wards:

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

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

Dementia level profile:

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

Functional level profile:

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

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

7.8.3 Ward requirements:

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

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

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

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

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

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

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

7.8.4 Workforce strategy

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

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

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

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

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

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

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

7.9 Capacity Requirements

7.9.1 Overall capacity to deliver demand:

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

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

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

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

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

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

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

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

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

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

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

Capacity of 66 or lower may be achievable but there may also need to be further activity/investment to reduce demand or to ensure that population changes are not feeding through to increased demand over time.

Also, consideration is required to use of beds from outside of West Yorkshire as part of the Barnsley spot purchase beds and the functional shared bed base. The functional demand has been managed with capacity in several recent years, but did exceed capacity in 2022, whilst a small number of dementia beds have been used on an ongoing basis.

7.9.2 Length of Stay Targets

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

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

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

Based on data from 2013-22

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

7.9.3 Demand and Capacity Modelling

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

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

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

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

	2025	2030	2035	2040
Low Demand				
Functional	30.5	30.5	30.5	30.5
Organic	20.4	20.4	20.4	20.4
Overall	51.0	51.0	51.0	51.0

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

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

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

7.9.4 Gender mix

The table below shows the overall gender mix:

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

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

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

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

7.9.5 Functional and dementia mix

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

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

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

7.9.6 Surge Testing

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

Overall functional bed use:



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

The table below shows the overall dementia bed use:

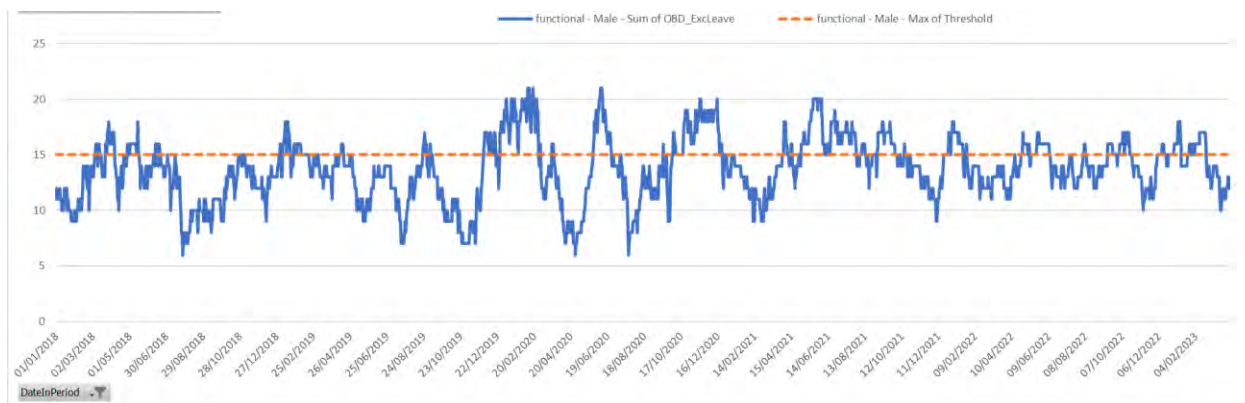


It shows that 30 beds is enough for the vast majority of time over the most recent 4 years, though there were several instances in 2018 and early 2019 where more than 30 beds were needed.

Functional female daily demand:



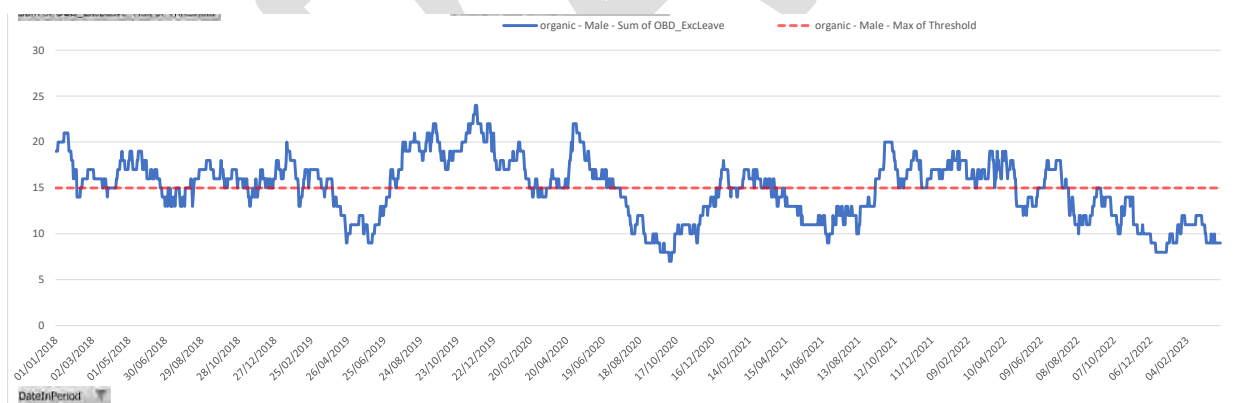
Functional male daily demand



Dementia Female:



Dementia Male:



Gender use:

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

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

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

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

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

7.11 Services to meet the needs of the population:

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

- **Gender** considerations include access to same sex clinician/staff, tailored activities.
- **Carer** considerations include:
 - Travel, particularly for older carers and those with other caring responsibilities.
 - Staff at all units.
 - Voluntary and other support organisations / community groups that signpost to and support patients around the service.
 - Visiting times and contact arrangements.
 - Estates facilities.
 - Involvement in care and discharge planning where appropriate.
- **Race and ethnicity considerations** include:
 - Addressing barriers of access – culturally appropriate environments, food and activities.
 - Faith and religious needs considered in built environments and through décor.
 - Reflective workforce, who are culturally and spiritually competent.
 - Access to an interpreter and translation materials.
 - Appropriate toilet facilities and consideration of bathing preferences.
- **Gender reassignment**
 - Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors.
 - Considering environments such as ward allocation, privacy, gender neutral facilities in line with trust policy and additional support through advocacy.
 - Considering how, for transgender people, how issues surrounding gendered wards can lead to poor experiences of care.
- **Sexual orientation**
 - Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe.
 - Visible symbols (such as the NHS Rainbow Badge, and/or use of badges and lanyards).
- **Religion or belief**
 - Access to faith and prayer rooms (including staff).
 - Ensuring parity of pastoral support for all faiths on inpatient wards.
- **Maternity and pregnancy**
 - Managing additional caring responsibilities.
 - Ensuring flexibility for visiting times.
 - Facilities are accommodating to visitors (for example parent access to changing facilities).
- **Disability**
 - Physical access to estates and built environments:
 - Parking bays.
 - Access to public transport.
 - Ease of access into buildings.
 - Visitor areas.
 - Accessible toilets.
 - Adult changing toilets.
 - Considering hidden disabilities.
 - Different types of seating and access:
 - Designated wheelchair seating areas.
 - Wider doorways and fewer heavy doors.
 - Automatic doors with ramps rather than stairs.

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

7.12 Summary of what we need from an inpatient model:

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

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8 How the current inpatient model compares to the vision:

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

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

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

Single sex accommodation guidance is met on all units except Poplars. Currently, 3 out of 5 of the wards are mixed gender, which can make clinical management an issue, especially for those patients with organic diagnosis.

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

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

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

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

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

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

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

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

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

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

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

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

Current levels:

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

Staffing required:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are very different pathways and stays across the Trust, particularly for people with dementia. Most people with dementia from Wakefield have more than 1 ward stay and a typical stay of well over **100 days**. In Calderdale, around 50% of people with dementia have had more than 1 ward stay, and LOS differs from place to place and is higher where people have multiple ward stays.

70% have a single stay	30% of people have more than 1 ward stay
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• Ensures continuity of care • Supports the development and utilisation of therapeutic relationships • Supports appropriate Length of Stay • Single period of assessment • Clear pathway and understanding of the wider multi professional team and their role in supporting care in the community. • A single relationship between the carer and the care team • Improves attitudes to risks • Reduces the risk due to the single environment / consistency of staff.	• Impairs continuity of care • Prevents the development and utilisation of therapeutic relationships • Hinders access by carers due to the geographical differences. • Unnecessarily extends the Length of Stay (as evidenced by people with dementia from Calderdale and Wakefield that often have 2 or more ward stays and have much longer stays). • Means there is an additional period of assessment while a new care team and the service user get to know each other • Means an understanding of the wider multi professional team and their role in supporting care in the community has to be re-established. • Means that relationships between the carer and the care team have to be re-established • Leads to attitudes to risks being lowered while impact is re-evaluated • Increases the risk due to the change of environment / change of staff, for example, can also lead to increased confusion when moving people. The changes can't always be mitigated and there can also be an impact on carers.
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Dementia LOS is well over 100 days overall and has been consistently so over recent years. In 2022 the length of stay of people from Calderdale, Kirklees and Wakefield in older people's inpatient services increased to 93 days.

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

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

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

The CQC also visited the Poplars ward in late 2022

<https://api.cqc.org.uk/public/v1/reports/7ac7435c-4823-404d-9544-2c6349b312bf?20230315080038>.

They noted that the location of The Poplars away from any other of the trust's location meant that the staff team were isolated in terms of access to urgent support or cover for unplanned staffing issues.

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

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

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

Patients and carers do give feedback through groups, friends and family feedback, complaints, compliments and serious incident reviews. This information is fed back to ward managers and quality leads and is used to inform smaller changes in practice.

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

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

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

The current model does support current and future demand.

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

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

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

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

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

8.2 Summary of deficit between current model and best practice

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

or helps to prevent harm to service users Supports a risk management and safety systems Impact on partner organisations and any aspects of shared risk	▪ A model with the best specialist ward environments to support people with design of the environment for gender needs and appropriate therapies and to support socialisation, for example, dedicated socialisation for people with similar needs. ▪ Wards sizes in line with or close to best practice guidance of 15 beds, ▪ Staffing to appropriate levels, in line with clinical need to support safety. ▪ Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards ▪ Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	especially for those patients with organic diagnosis. ▪ Ward sizes are in line with best practice. ▪ Ability to have the right environment for therapies and socialisation is a challenge due to the mixed nature of the wards and configuration of some wards – for example Beechdale. ▪ Staffing is regularly short of the required level and bank/agency staff are required when dependency levels increase on the wards. ▪ There is a shortage of qualified members of staff, especially on a night shift where most of our wards have one registered nurse. ▪ Incidents, particularly falls and violence/aggression are much higher across the West Yorkshire wards than they are in the only functional ward. ▪ Services are local to place but site isolation of Poplars ward does lead to challenges in terms of access to acute general hospital.
Effective Approaches	Requirements	
Staff understanding their role in improving the service user experience Consistency in care provision Positive outcomes of care Evidence-based practice Eliminating inefficiency and waste by design Staff teams and services, across pathways to work together to deliver safe, effective care	▪ Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care. ▪ Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge. ▪ Length of stay being appropriate for the level of need. ▪ People having continuity of care in their pathway with a single ward stay only until they are ready for discharge. ▪ Services that are accessible to staff teams, such as community services and other ward staff to work together.	▪ Staff do have general older age skills but feedback that it is not always possible to reinforce training received due to mix a of patients on the wards. ▪ Staff feedback that they are often unable to provide therapeutic interventions to functional patients when they have a patient with dementia who needs more support or supervision. ▪ There are very different pathways and stays across the Trust, particularly for people with dementia. Most people with dementia from Wakefield have more than 1 ward stay and a typical stay of well over 100 days. In Calderdale, around 50% of people with dementia have had more than one ward stay, and LOS differs from place to place and is higher where people have multiple ward stays. ▪ Wards are local but the isolation of the Poplars ward creates issues in terms of access to cover, support in an emergency, shared facilities and medical out of hours support.
Caring Approaches	Requirements	
Allows staff time to care for people Co-production	▪ The right staffing levels to support, including groupwork, based on people's needs. ▪ Staff, family and carers involved in design of care.	▪ The current staffing models fall short of what is required, particularly to deliver a specialist needs based model of care.
Responsive Approaches	Requirements	
Delivery of strong service performance	▪ Evidence that service users are in the most appropriate environment, receiving the most	▪ The evidence shows that the mixed needs wards are not the most appropriate environment, exacerbated by some of the

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

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

Overall, the main areas of benefit should be:

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

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

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

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

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

10 Development of Options

10.1 Patient, public, carer and wider stakeholder engagement

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

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



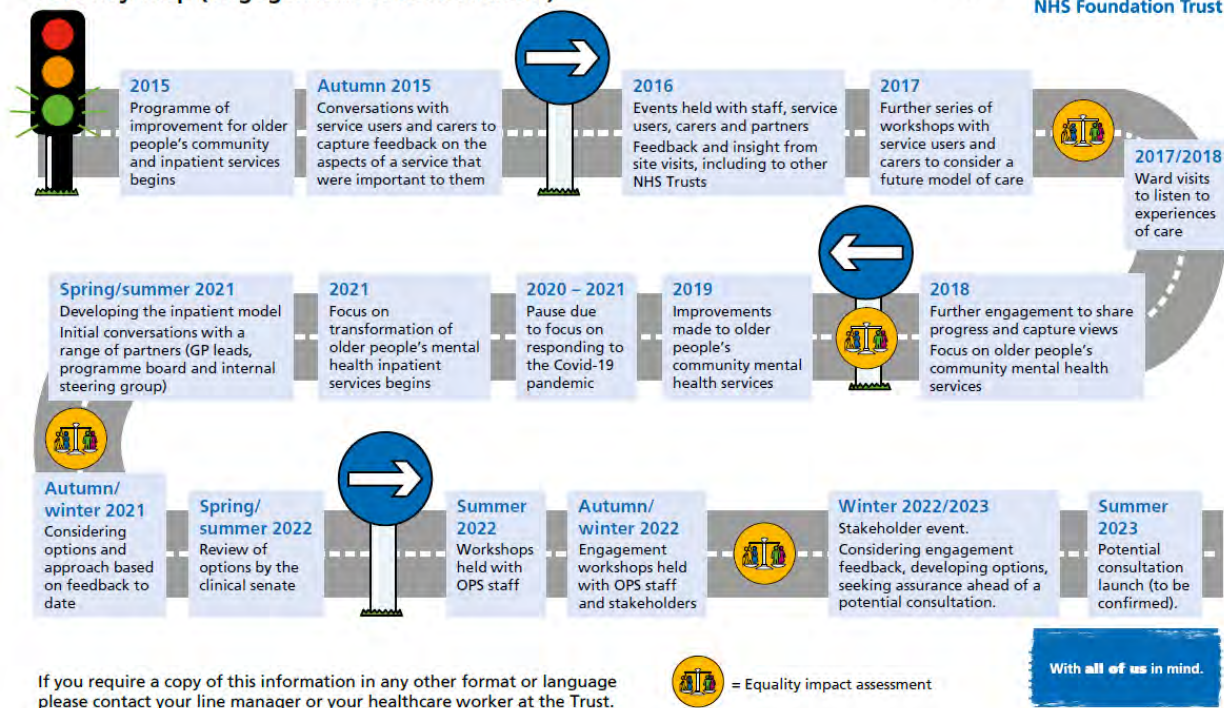
Source: Connor Farrell.

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

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

Older people's mental health inpatient services transformation

Journey map (engagement to consultation)



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

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

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

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

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

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

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

10.2 Service User, Carer and Family Feedback:

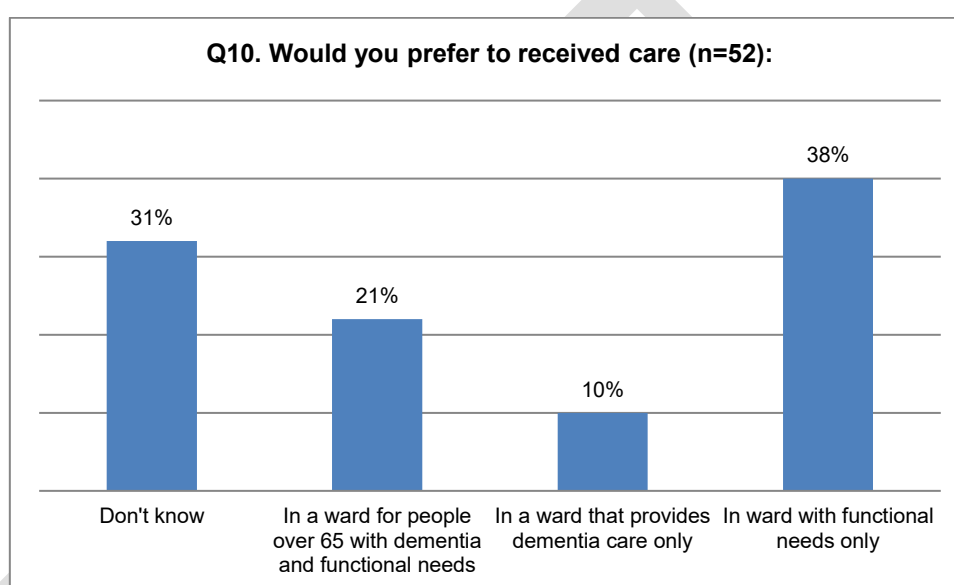
Across conversations with service users, family and carers, people saw benefits of having a separate needs-based model and thought a specialist dementia unit was a good idea and a move in the right direction.

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

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

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

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



Comments that supported separate needs-based wards included:

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

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

Comments that supported mixed needs on wards included:

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

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

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

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

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

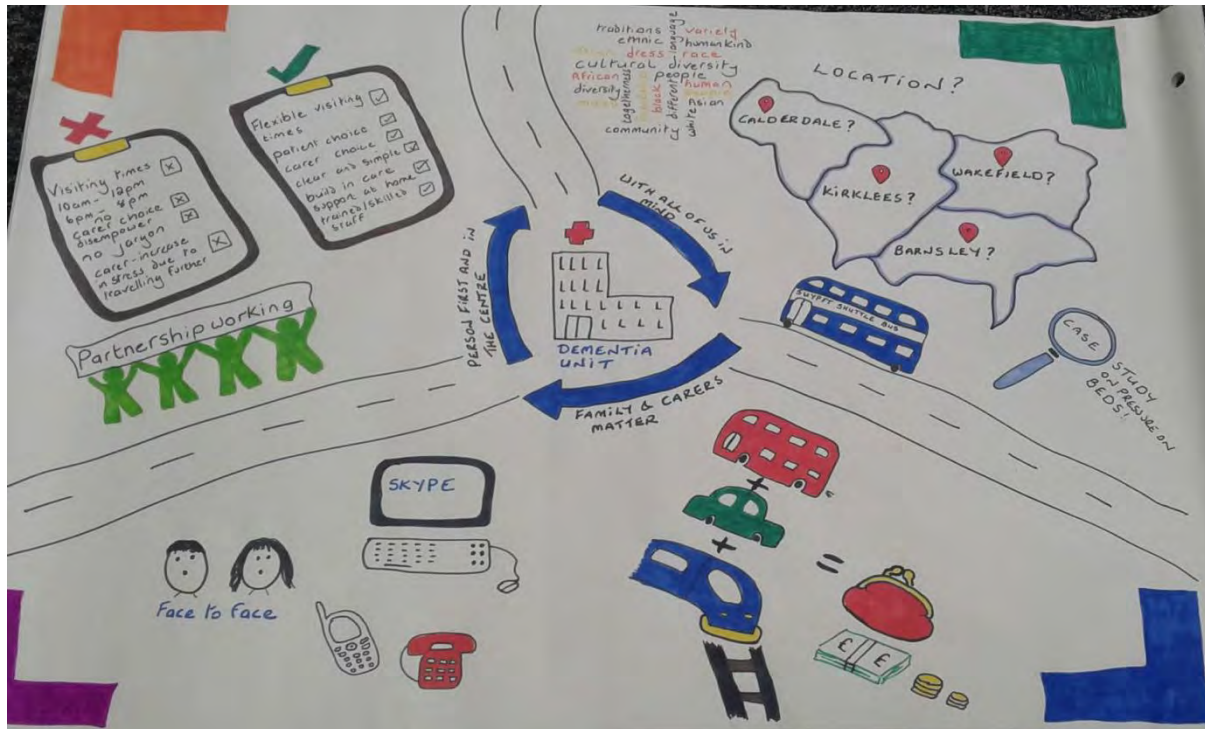
People were interested in the potential location of any specialised units. They raised that they might be further away from home and would need to travel further to the hospital than they would currently.

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

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

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

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



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

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

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

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

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

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

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

10.3 Staff engagement – summary of findings

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

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

Strengths:

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

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

Considerations

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

How to make the models work

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

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

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

Feedback on patient experience about being on the wards:

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

Considerations:

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

10.4 2023 Staff conversations to test relevancy

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

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

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

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

10.4.1 Functional Needs not being addressed:

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

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

10.4.2 Dementia Environment and need:

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

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

10.4.3 Mixed activity challenges:

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

10.4.4 Challenges on mixed gender wards with people with dementia

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

10.4.5 Challenges moving people in the current system

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

10.4.6 Travel Impact

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

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10.5 Developing options – long or medium term

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

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

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

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

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

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

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

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

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

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

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

Feedback from the clinical senate in 2022 supported this:

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

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

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

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

10.6 Potential opportunities to work in partnership in the ICS

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

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

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

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

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

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

Other opportunities not progressed into options work:

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

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

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

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

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

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

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

In 2023 we convened a partnership stakeholder review group to test the options, ensuring we considered key data to test which options were appropriate to take forward into consultation.

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

10.8 Assessment criteria

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

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

Criteria:

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

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

10.8.1 Quality

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

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

10.8.2 Access

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

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

		Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors. Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe Ensuring parity of pastoral support for all faiths on inpatient wards	
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10.8.3 Sustainability

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

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

10.8.4 Strategies

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

Domain - strategies	What we need to measure against	Measures	Supporting information / comments
Alignment with strategies	Whether the model aligns with strategies.	Demonstrates sufficient flexibility to align with and improve partnership working Aligns with national strategies Aligns with regional strategies	Strategy summary document

		Aligns with local strategies, including place and Trust strategies. Maximise resilience to wider system	
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10.8.5 Value for money

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

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

10.9 Weightings of options

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

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

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

Agreed scoring for the quality domains are:

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

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

10.10 Options Reviewed

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

Option
Option 1 - No change to the current way of delivering services with three mixed units, one functional only unit and a dementia only unit in the region with an overall inpatient bed number of 74 operational beds in West Yorkshire.
Option 2 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Functional bed capacity would be increased by 6 beds on the Crofton Ward and Beechdale ward being functional only, with Crofton ward being a 22 bedded mixed gender functional ward. Beechdale would be a 16 bed mixed gender functional ward. There would be of 68 operational beds in West Yorkshire. The Poplars site would not be in this model.
Option 3 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. A variation on the distribution of the functional bed capacity at Beechdale (one bedroom added) and the Crofton ward (2 bedrooms) and an overall inpatient bed number of 65. The Poplars site would not be in this model.
Option 4 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. All other estate maintained as now but with The Poplars becoming a unit for functional illness patients only and with an overall bed number of 74 beds.
Option 5 – A dedicated central specialised dementia unit developed on Ward 19 with 30 dementia beds across 2 wards on the site. Additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds. Beechdale would be 16 bed functional. The Poplars site would not be in this model.
Option 6 –Dementia inpatient care delivered from Beechdale and The Poplars (28 dedicated dementia beds in total) with the Crofton ward remaining as a mixed facility with ward 19 being a functional ward.
Option 7 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. The Poplars, Ward 19 at Dewsbury, and a ward on the Crofton ward would provide functional inpatient beds.
Option 8 – Dementia inpatient care delivered from Beechdale ward and a dedicated ward area on the Crofton ward. Functional beds would be provided from Ward 19 in

Dewsbury, in a separate ward area in the Crofton ward and in the Willow ward. The Poplars site would not be in this model.

Option 9 - Crofton dementia unit, 26 beds (as 2 separate wards). Ward 19 and Beechdale would be functional wards with 46 functional beds in total (The Poplars site not in this model) – *this option was added following feedback from clinical senate.*

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

10.11 Clinical senate review and feedback

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

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

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

1. the viability, sustainability, and appropriateness of the proposed models of care, and support those that are suitable for implementation
2. the extent to which the proposed models are likely to:
 - a) Deliver improvements in the quality of care
 - b) Impact on access to services
 - c) Be sustainable for a period of 5-10 years
 - d) Be in line with the drivers for change
3. the alignment of other interdependent services required to make the models effective and safe
4. the robustness of the quality and equality impact analysis associated with the proposed models and the appropriateness of any mitigations identified
5. whether there are any other options that might be workable and to provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made

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

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

Summary of findings from the clinical senate include:

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

Specific feedback on options:

Option 1

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

Option 2

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

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

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

Option 3

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

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

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

Option 4

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

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

Option 5

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

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

Option 6

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

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

Option 7

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

- It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialised skill and expertise
- The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward
- The Poplars is maintained as a functional unit which does not provide a satisfactory environment for patients due to the risks and issues with location, estate and lack of interdependent services

Option 8

The Clinical Senate finds that option 8 is not viable:

- It does not deliver a centralised specialist dementia unit and as such it does not provide the benefits of such a unit in terms of centralisation and consolidation of specialist skills and expertise

- The Beechdale ward is not a suitable environment for dementia patients due to the physical configuration of the ward

Option 9

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

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

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

Conclusions of the senate:

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

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

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

- e) Deliver improvements in the quality of care*
- f) Impact on access to services*
- g) Be sustainable for a period of 5-10 years*
- h) Be in line with the drivers for change*

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

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

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

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

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

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

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

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

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

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

10.12 Summary reasons for challenges with some options:

- Options including using Beechdale Ward as a dementia ward – challenges with the layout of the site mean it is not appropriate for people with dementia.
- Options which included retaining the use of The Poplars site either as dementia or changing it to functional mean that the model would continue to have challenges associated with an isolated ward.

10.13 Options Review Workshop – 2023

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

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

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

Represented were:

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

The following professional leads were in attendance:

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

The following information was available to support the review:

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

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

National:

- NHSE: Draft Acute Inpatient Mental Health Care for Adults and Older Adults: guidance to support timely access to high quality therapeutic care, close to home and in the least restrictive setting possible (October 2022)

- The Royal College of Psychiatrists (2019) Standards for Older Adult Mental Health Services
- NHSE service specifications: <https://www.england.nhs.uk/commissioning/spec-services/highly-spec-services/>
- NHS Confederation 2022/23 NHS priorities and operational planning guidance
- DH guidance on ward sizes: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_03-01_Final.pdf

Regional:

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

Place:

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

Other:

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

Also, a separate finance group was established to oversee the VfM appraisal.

10.14 Summary of options development

In summary, we believe that there are options within the longlist that deliver a range of improvements to resolve challenges with the current model, including:

- Delivery of best practice model – in line with national guidance and model predominantly implemented across England.
- Separate wards based on diagnosis - functional and organic, delivering the specialism to meet needs.
- Improved specialist environments and resourcing to meet the needs of each group, supporting reduction of incidents and addressing risks associated with mixed wards.
- Delivering single sex accommodation on 4 of the 5 wards.
- Mitigating the clinical risks attached to the isolation of the Poplars and the environment of the Beechdale ward.
- Improving the consistency and pathway of care, removing the need to transfer most people across wards, and supporting reduced lengths of stays, particularly for people with dementia.

- Robust workforce model and enhanced staff skills to support improved clinical interventions and tailored therapeutic care.

10.15 Testing the options

In October 2022 a workshop was held with a range of partners for Barnsley, Calderdale, Kirklees, and Wakefield. The workshop was initially targeted specifically at health and social care staff across the Trust footprint.

The workshop, held on Microsoft Teams, was attended by 50 health and social care staff from Barnsley, Calderdale, Kirklees, and Wakefield.

The workshop focused on the steps we took and the information we considered when developing the options. We also presented feedback from the clinical senate who provided insight on viability of each option. All options that had been considered were presented during the workshop, alongside how we scored and appraised each model.

Staff were asked to consider the process we took, the options presented and the feedback from the clinical senate. Following a presentation, staff were divided into six breakout rooms to discuss and feedback on three questions:

- Your thoughts on the proposals?
- Is there anything we should have/need to consider?
- Any other comments?

Following the discussion and feedback, we identified the following key themes:

Theme 1: Consider the travel impact of all options, factoring in cost-of-living challenges and using travel impact analysis which should include travel by car and public transport.

Theme 2: Ensure we address inequalities identified through the equality impact assessment in the development of options. This includes the impact on people who use services staff and carers.

Theme 3: Consider flow and length of stay by considering potential solutions which enable a reduced length of stay and consider other developments which could support this ambition, such as step-down facilities.

Theme 4: Consider the impact on staff of the potential changes and ensure that staff are fully engaged in the process and are consulted on the changes. It is important that staff feel involved in the process and can deliver the proposed approach solving any current staffing pressures.

Theme 5: Consider the additional option to centralise specialist services in Wakefield - Following feedback from clinical senate and discussions which took place at the workshop it is evident that the Trust need to option appraise centralising specialist services on the Wakefield site.

Theme 6: Describe what the Trust mean by re-purposing Poplars in the proposed options so that we are able to articulate this clearly to key stakeholders and the public.

Theme 7: The length of time since engagement should be considered and the Trust need to make sure that any gaps in information or target audience is picked up in consultation.

A full summary of feedback from the workshop can be found on the Trust Website: [Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust](#)

In December 2022 a wider event was held. The aim of the event was to listen to feedback from a wider group of partners, build on previous engagement, provide an opportunity for our key stakeholders and partners to contribute to the options for proposed models, and further inform our approach ahead of a potential consultation.

At the event we presented more detail on the work that has been done to date on the proposed models, including clinical considerations, engagement activity and equality. The workshop was attended, in total, by 67 people. There were 2 breakout discussions and people were divided into 6 smaller mixed groups, each group had a facilitator and scribe

Themes

Theme 1: Clinical Model - General agreement across several group discussions that a change is needed. Separating the services out and having a specialist dementia ward and the staffing was seen as positive dependent on the correct staff numbers with the right training and skill being in place. The change would provide better outcomes for patients and doing nothing was not seen as an option.

Theme 2: Use of estates – Several groups discussed the inpatient estate and there was a general view that Ward 19 would work better as a dementia ward in the model than Crofton. Overall, the ward environment of Ward 19 lends itself more to being a site for dementia due to design, layout and use of space. More work would be required on the site to further improve the environment, though some improvement activity is already taking place. Need to consider spaces for families particularly for patients nearing end of life.

Theme 3: Bed numbers and ward sizes - The number of beds and ward sizes within the proposed model and how capacity will be managed. Ensuring the model is still fit for purpose in 10 years, given the predicted population increase.

Theme 4: The Poplars – Most people felt Poplars should not be part of the proposed acute model but could be used in other ways to support people. The future use of the Poplars site needed to be clearly articulated as there are several identified potential uses.

Theme 5: Barnsley patients – how Barnsley patients would be accommodated in the model, given that some patients are currently admitted to West Yorkshire, needs to be described. Also, to clearly articulate why there is no impact for Barnsley public in the consultation.

Theme 6: Alignment with other services – Need to ensure that the proposed options align with the wider systems including both SWYPFT teams and partner organisations that will need to work in new ways and across boundaries to support a different model.

Theme 7: Workforce – Need to consider the workforce implications for all proposed options including staffing to the right levels, roles, staff specialist skills for each group but not losing overall old age specialism. The workforce model needs to be clearly articulated for each option to ensure that the workforce implications can be considered fully.

Theme 8: Travel, transport, and parking - The impact of travel, transport and parking for both patients, carers, families, loved ones and staff should be considered. This includes transport times and aligning with visiting, the age of people travelling (including access) and the frequency and reliability of transport networks. Transport during discharge should also be considered if the patient is out of their local area.

A full summary of feedback from the event can be found on the Trust Website: [Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust](#)

The **options review workshop and follow up activity in 2023** further tested the options and did so in a clinically led way that was also supported by a range of stakeholders. This work took place with the purpose of reviewing the options with a wide range of stakeholders, with the evidence that has been gathered and make sure they're the right ones to take into consultation.

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

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

The outputs from the work were the final recommended options to take to consultation and also the assurance that within the scope and constraints of the programme that the most appropriate options are the ones that are being taken into the public consultation.

Consultation plan

Older People's Mental Health Inpatient Service Transformation

Calderdale, Kirklees, and Wakefield

Version control			
Version	Name and title	Date	Status
V0.1	Dawn Pearson	5 May 2021	Initial draft
V0.2	CEE OPS steering group member comments	29 June 2021	Initial draft
V0.3	Dawn Pearson	July 2022	Updated
V0.4	Kamal Wrathall	January 2023	Updated
V0.5	CEE OPS steering group member comments	March 2023	updates
V0.6	OPS programme board comments	25 April 2023	updates
V0.7	CEE OPS steering group member comments	July 2023	updates
V0.8	Dawn Pearson and Ryan Hunter	Sept 2023	EIA alignment and delivery plans
V0.9	Sarah Mackenzie- Cooper	October 2023	updates
V0.10	Dawn Pearson	November 2023	Additional content

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Final draft

1 Introduction

The purpose of the document is to describe a process which will help South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) (referred to as 'The Trust') in partnership with Calderdale, Kirklees and Wakefield places and Integrated Commissioning Boards (ICB) consult on the future of older people mental health inpatient services for Calderdale, Kirklees, and Wakefield.

The plan describes the scope of the consultation including the approach we will take to deliver the consultation process. The plan also includes the communication materials and the process for ensuring due regard to equality is demonstrated throughout the process. The document includes:

- The background to this work
- What we already know
- The principles we should adopt to deliver the consultation across several local areas.
- The consultation approach and timescales
- How the information gathered from consultation will be used to inform a future service decision

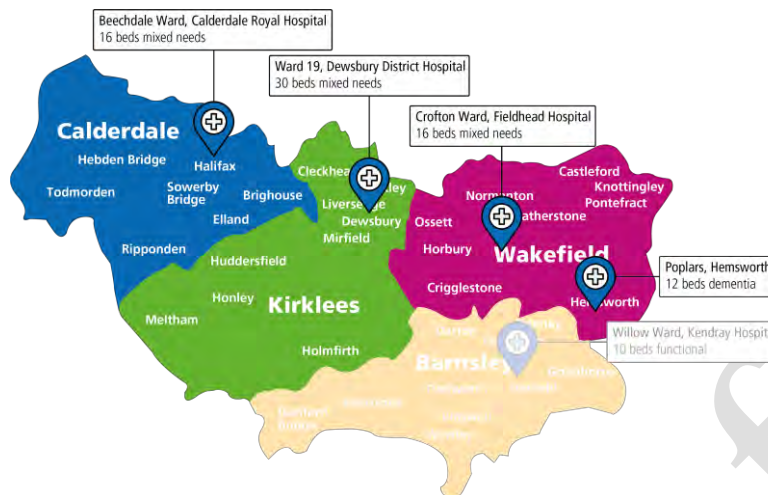
2 Background

The Trust alongside our partners and commissioners are reviewing how we provide mental health care for older people within our inpatient wards. This follows service improvements to our community mental health service in 2015.

In West Yorkshire, the Trust has five older people's mental health wards. These are:

- A ward in Halifax at Calderdale Royal Hospital (16 beds)
- Two wards in the Priestley Unit in Dewsbury, located in Dewsbury and District Hospital (30 beds; 15 male beds and 15 female beds)
- Two wards in the Wakefield district at Fieldhead Hospital (16 beds) and at The Poplars in Hemsworth (currently operating as 12 beds).

In South Yorkshire, the Trust has a ward for people with functional mental health needs (10 beds) at Kendray Hospital Barnsley, which we do not plan will change as part of this transformation.



There are two groups of older adults who use our inpatient wards. These are:

- People with needs such as dementia, and
- People with other mental health needs such as depression, anxiety, and psychosis (often referred to as functional needs).

Evidence shows that the care of people diagnosed with dementia, and people with functional needs is very different.

There are different types of supervision, clinical intervention, and workforce skills required to provide specialist care for people with dementia and people with functional needs. The living space, and the activities which are needed to effectively support and provide the best care for each group are also different.

People with dementia may require more specialist care and support. Currently, our wards support a mixture of mental health needs, which means that not everyone gets the specialist care they may need.

The CQC also highlighted the challenges of managing patients with dementia and functional needs on mixed wards during their visit in 2019.

We also face challenges with some current estate which does not provide an optimum layout for managing the care of people with dementia and functional needs on a mixed ward.

From a patient perspective, we know from previous engagement that patients, carers, and families also agree that specialist care would provide better outcomes for both groups of patients.

Therefore, we are looking at how we might separate care for people based on their needs, which is consistently regarded as a model of good practice.

3 Legislation

The legislation we must adhere to and demonstrate to is set out below.

3.1 Health and Social Care Act 2022

In its responsibilities for public involvement and consultation under section 13Q of the National Health Service Act 2006, NHS England, and Integrated Care Boards (ICB) has a duty to consult individuals to whom services are being or may be provided, in the planning and development of commissioning arrangements for those services. The Act extends this to include “carers and representatives” of people receiving a service or who may do so. The extension of this duty is replicated in an equivalent duty on integrated care boards.

3.2 The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act - age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, and belief, sex, and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance ‘Equality of Opportunity’, and c) foster good relations. All public authorities have this duty so partners will need to be assured that “due regard” has been paid through the delivery of consultation activity, and in the review.

3.3 The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains several patient rights, which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

The consultation approach and mandate should also satisfy key tests. The test for both consultation and equality are set out below:

The **Brown Principles** for equality state an organisation must be aware of their duty set out below:

- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigor and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.

- The duty is a continuing one.

The 'Gunning Principles' state that:

- Consultation must take place when the proposal is still at a formative stage (i.e., no decision until the process has concluded)
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response (clearly describe the model, criteria used to determine the model and reasons)
- Adequate time must be given for consideration and response (the length of the consultation is important to ensure it allows for this)
- The product of consultation must be conscientiously taken into account (demonstrate clearly how the product of consultation has been considered)

4 Consultation mandate

We, South West Yorkshire Partnership NHS Foundation Trust and West Yorkshire Integrated Care Board (ICB) want to understand views of the target audience set out in section 6 of the consultation plan concerning the transformation of older people mental health inpatient services so that South West Yorkshire Partnership NHS Foundation Trust can take into consideration the views of those consulted by Spring 2024, to make a decision on the future transformation of older people services which will be implemented across the geographical areas of Calderdale, Kirklees and Wakefield District.

5 Target audience

The key audiences and communities for this consultation will be the following groups in Calderdale, Kirklees, and Wakefield (EIA reference)

- Anyone currently using older people mental health inpatient services.
- Families, relatives, and carers of people who are currently using older people mental health inpatient services.
- Voluntary and community groups representing, supporting, or advocating for older people, carers and families.
- Staff with an interest in older people mental health services, from all health and social care sectors, including but not exclusive to hospital, community, local authority, and primary care.
- Key partners and stakeholders who have an interest in older people mental health services.
- Anyone with an interest in older people's mental health services
- People who are identified as future service users.

We do not plan change to services in Barnsley, but we will seek views from the following groups as Barnsley is within the Trust footprint:

- Key partners and stakeholders who have an interest in older people mental health services.
- Anyone with an interest in older people's mental health services
- People who are identified as future service users.

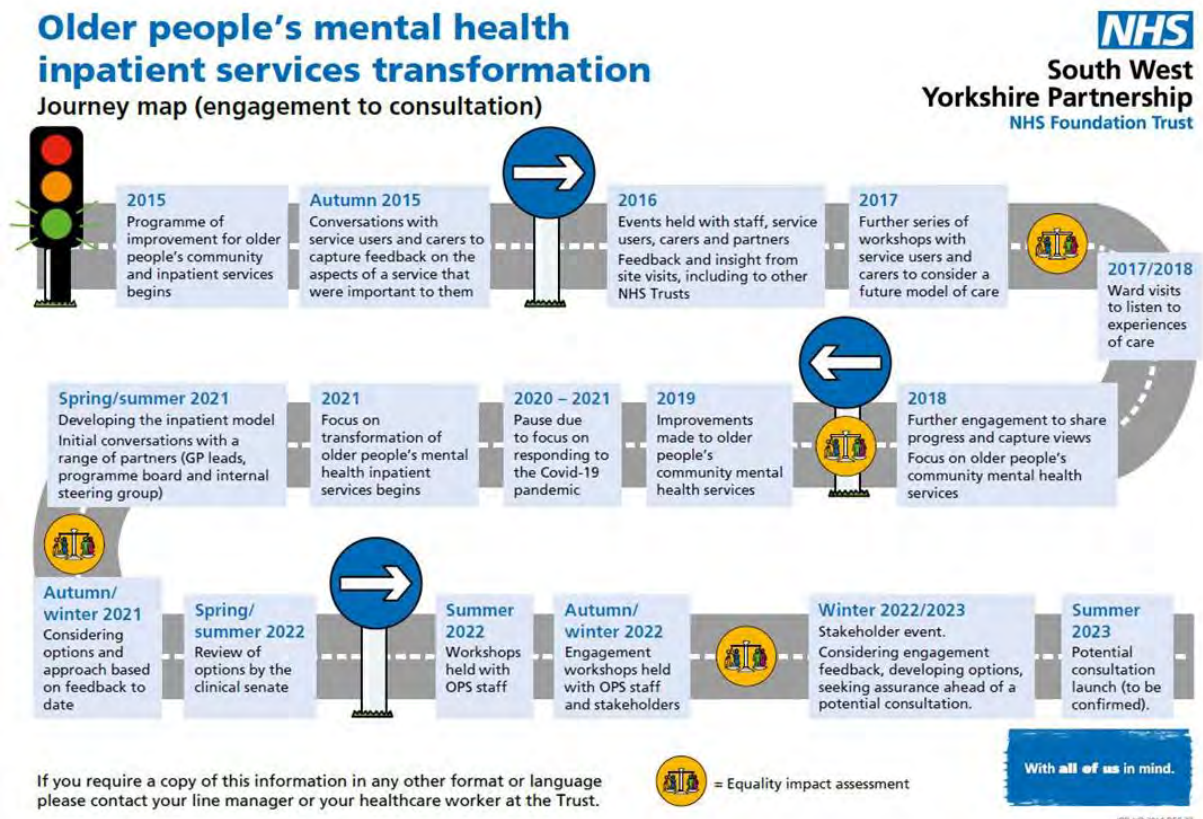
A more detailed stakeholder map can be found below. This will be monitored and reviewed regularly throughout consultation planning and delivery to ensure we are reaching the right audiences.

Participants	Key players
• South West Yorkshire Partnership NHS Foundation Trust staff • Overview and Scrutiny Committees - Barnsley, Calderdale, Kirklees, and Wakefield • Health and wellbeing boards - Barnsley, Calderdale, Kirklees, and Wakefield • West Yorkshire ICB • Staff networks • Patients, families, carers, and members of the public	• South West Yorkshire Partnership NHS Foundation Trust executive management team and operational management group • West Yorkshire ICB • South Yorkshire ICB
Observers	Contributors
• Local media • Campaign groups • Community groups	• Primary care providers • Voluntary and community sector groups • Local Medical Committees • Local Pharmacy service providers via West Yorkshire Pharmacy services • Healthwatch organisations • Local authorities • Hospital trusts • MPs and local councillors • Care homes • West Yorkshire Police, South Yorkshire Police • Fire and rescue service • Yorkshire Ambulance Service • Education providers – including colleges and University of Huddersfield

As part of our equality duty, we will ensure we consider equality and diversity at each stage in the consultation process. What this means in practice is that we will consider equality in the development of our plan to ensure we reach people identified in the target audience using an equality impact assessment. That we will ensure that we have a representative view which reflects the communities we serve so that we can make fair and informed decisions for everyone. To use the consultation process to identify any action required to mitigate any negative impacts or maximise any positive impacts on equality, and ensure we comply with our statutory responsibilities under the Equality Act 2010.

6 What do we already know

The Trust has already delivered several conversations across Barnsley, Calderdale, Kirklees, and Wakefield on older people inpatient services. This engagement has been captured into a report of findings. The journey to capturing views is highlighted below:



The findings collectively report on engagement from 2015 and all reports can be found here: [Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust](#)

- Conversations with service users and carers in Autumn 2015 which captured feedback on the aspects of a service that were important to them.
- A range of mixed audience events which took place in March 2016. These events were attended by staff, service users, carers and partners.
- Feedback and insight from site visits including other NHS Trusts
- A further series of workshops with service users and carers which took place in May 2017. These workshops focussed on the consideration of a future model of care.
- Several ward visits which resulted in listening to current service user and carer accounts of care in the winter of 2017/2018.
- Further engagement took place in 2018 to share progress and capture views.

From all the engagement work which took place there were some key themes that started to emerge. These themes told us that.

- People were generally positive about the community proposals, and they prefer to be supported to have their **care closer** to home or in the home, for as long as possible.
- People were keen to ensure that the **hours of service were appropriate**, with extended hours available for people as needed.
- People were keen to ensure **dementia awareness within a care home** setting is built into a future model.
- People were positive about **benefits of a specialist dementia unit**.
- There were **concerns about potential extra travel for families**.

Following on for this work the engagement findings were used to inform the criteria to determine the options. Proposals were tested against a set of criteria informed by national guidance and clinical good practice. The engagement provided additional considerations for each of the criteria to ensure that the findings were used to inform the proposals. The criteria headings and 'what people told us' are set out below.

People told us what 'Good Quality Care' would like:

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

People told us what 'Access to Care' means to them:

- Early intervention – help people understand the process to access services.
- Services that are responsive and accessible
- Access to the right person to receive the right treatment in the most appropriate setting.
- More support at the stage of diagnosis
- Minimise delays in care and ensuring the prompt action of staff.
- Distance to travel and transport routes
- Good access to travel, transport, and car parking
- Access to physical health care and other clinical support
- Access for carers which include flexible visiting times.
- Good care coordination – one person overseeing the patient journey.

People told us what ‘Value for Money’ means to them:

- Reimbursement of travel expenses if travelling further
- Explore the concept of funding a shuttle bus.

People told us what should be ‘Delivered and Sustained’:

- Safe, effective, and well led outcomes.
- Standard referral criteria
- Admiral nurses and nurse prescribing built into the model.
- Specialist dementia wards were seen as a good idea.

People told us what other factors we should consider:

- More links with local health and social care providers
- Physical, mental, and social care needs are met.
- Focus on care closer to home where possible – community hubs and clinics.
- Promoting an independent healthy, active lifestyle
- Supporting people at home
- Preventative approaches
- Involvement from the third sector

Previous engagement can demonstrate through equality monitoring that a range of views were gathered from a diverse audience. The equality monitoring from this engagement was captured separately to the feedback. We do know who we reached and will address any identified gaps through the consultation.

In addition, the Trust further involved key stakeholders in two events. The events and key themes are set out below.

6.1 October 2022 Workshop for health, social care, voluntary and community sector staff

A workshop was held in October 2022 to further involve health, social care, voluntary and community sector staff in the development of options. In total the event was attended by **50** health and social care staff from Barnsley, Calderdale, Kirklees, and Wakefield. The key themes for the event are summarised as:

- **Theme 1: Consider the travel impact of all options**, factoring in cost-of-living challenges and using travel impact analysis which should include travel by car and public transport.
- **Theme 2: Ensure we address inequalities** identified through the equality impact assessment in the development of options. This includes the impact on people who use services staff and carers.
- **Theme 3: Consider flow and length of stay** by considering potential solutions which enable a reduced length of stay and consider other developments which could support this ambition, such as step-down facilities.
- **Theme 4: Consider the impact on staff** of the potential changes and ensure that staff are fully engaged in the process and are consulted on the changes. It is important that

staff feel involved in the process and can deliver the proposed approach solving any current staffing pressures.

- **Theme 5: Consider the additional option to centralise specialist services in Wakefield** - Following feedback from clinical senate and discussions which took place at the workshop it is evident that the Trust need to option appraise centralising specialist services on the Wakefield site.
- **Theme 6: Describe what the Trust mean by re-purposing Poplars** in the proposed options so that we can articulate this clearly to key stakeholders and the public.
- **Theme 7: The length of time since engagement** should be considered and the Trust need to make sure that any gaps in information or target audience is picked up in consultation.

6.2 December 2022 Stakeholder event

A stakeholder event was held in December 2022 with further wider stakeholders from Barnsley, Calderdale, Kirklees, and Wakefield. In total 67 attendees attended the event. The key themes for the event are summarised as:

Theme 1: Clinical Model - General agreement across several group discussions that a change is needed. Separating the services out and having a specialist dementia ward and the staffing was seen as positive dependent on the correct staff numbers with the right training and skill being in place. The change would provide better outcomes for patients and doing nothing was not seen as an option.

Theme 2: Use of estates – Several groups discussed the inpatient estate and there was a general view that Ward 19 would work better as a dementia ward in the model than Crofton. Overall, the ward environment of Ward 19 lends itself more to being a site for dementia due to design, layout, and use of space. More work would be required on the site to further improve the environment, though some improvement activity is already taking place. Need to consider spaces for families particularly for patients nearing end of life.

Theme 3: Bed numbers and ward sizes - The number of beds and ward sizes within the proposed model and how capacity will be managed. Ensuring the model is still fit for purpose in 10 years, given the predicted population increase.

Theme 4: The Poplars – Most people felt Poplars should not be part of the proposed acute model but could be used in other ways to support people. The future use of the Poplars site needed to be clearly articulated as there are several identified potential uses.

Theme 5: Barnsley patients – how Barnsley patients would be accommodated in the model, given that some patients are currently admitted to West Yorkshire, needs to be described. Also, to clearly articulate why there is no impact for Barnsley public in the consultation.

Theme 6: Alignment with other services – Need to ensure that the proposed options align with the wider systems including both SWYPFT teams and partner organisations that will need to work in new ways and across boundaries to support a different model.

Theme 7: Workforce – Need to consider the workforce implications for all proposed options including staffing to the right levels, roles, staff specialist skills for each group but not losing overall old age specialism. The workforce model needs to be clearly articulated for each option to ensure that the workforce implications can be considered fully.

Theme 8: Travel, transport, and parking - The impact of travel, transport and parking for both patients, carers, families, loved ones and staff should be considered. This includes transport times and aligning with visiting, the age of people travelling (including access) and the frequency and reliability of transport networks. Transport during discharge should also be considered if the patient is out of their local area.

Going forward the consultation will need to specifically identify any positive or negative impacts of the options on each of the protected groups to ensure that the option considered provide an opportunity to demonstrate due regard, reduce health inequalities and advance equality of opportunity.

7 Principles of consultation

To ensure we meet our statutory obligations we must satisfy the principles set out in Gunning. The 'Gunning Principles' are applied if a decision is taken to judicial review. The Gunning Principles are:

- Consultation must take place when the proposal is still at a formative stage.
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response.
- The product of consultation must be conscientiously taken into account.

It is worth noting that it is not the decision that is tested but the process that has been followed to come to that decision. In addition, a shared set of principles have been developed which set out a partnership approach to consulting people including our commitment to equality of opportunity.

The principles are set out below:

- We will use what we already know as a starting point.
- The consultation will be supported by **clear information** and opportunities for **communication**, so people feel informed and able to participate.
- We will ensure that we consult the right people at the right time in the **development and design** of services.
- We will ensure we are fully **inclusive** in our consultation approach.
- We will be **honest and transparent in our approach** which will include being honest about what people can and can't influence and the reasons why.

- For the things people can influence we will provide a **genuine opportunity for consultation**. This will include providing the right conditions for people to get involved.
- The views gathered will be properly **documented** so people can see the information they have provided and feel confident that it is gathered in such a way that it can inform a decision on future services.
- We will thank people for their contribution and **provide feedback** on our next steps.
- That we keep people **informed and in the loop** by providing a communication platform which everyone can access.

8 Approach to Consultation

The purpose of the consultation is to deliver the agreed mandate which is described and set out in section 4 gathering feedback from the key stakeholders set out in section 5. The Trust will do a mid-point review at week 6 to ensure that we are gathering a representative population sample based on our local census data 2021. Targeted approaches to capture the views of those underrepresented will take place using community contacts, and the Trust equality and involvement team.

The consultation approach to support delivery is set out below:

8.1 Survey online and hard copy – in easy read, other formats, and translation.

A survey will be used to provide feedback on the consultation proposals. These questions will ensure that we can fully understand and capture the impact of the proposed approach. Surveys will be provided online and in paper format. All responses will be collated centrally.

8.2 Face to face and/or digital meetings

Face to face and/or digital meetings will take place, these will be aimed at staff, stakeholders, and public audiences. These meetings will be supported by a presentation of the proposals. Clinicians and subject matter leads will be available to support responses to any questions. Questions will be submitted in advance where possible. Meetings will ensure people can gain the information they need, provide an opportunity to have clarity on any proposals. The aim of the meeting is to support a clear understanding allowing for an informed consultation response.

8.3 Advocacy

We know that the involvement of older people with dementia and functional mental health requires specialist input and that our independent advocacy teams work closely with our inpatients to provide much needed independent support. As service reconfiguration may have an impact on our workforce we will be inviting staff to respond to the consultation. This means that we need to maintain a level of independent support for those inpatients so they can respond without relying on Trust staff.

Advocacy services will support inpatients to respond to the consultation by providing information and/ or communicating in a way that meets the needs of that inpatient. Ensuring that all inpatients have been approached and included, and capacity to be involved assessed. Families, carers, loved ones and relatives will be contacted directly on day one of the consultation. A letter will be sent to the home address or email of an identified person for

each inpatient, sign posting them to information and resources so that they can also provide a response.

8.4 Asset based approaches.

Each locality has a wealth of assets and contacts that can be harnessed to support a consultation approach. Funding will be available to support asset-based initiatives to capturing feedback from communities. This will provide an opportunity for people who do not feel involved to have a say at a very local grass roots level those who cannot access digital meetings or online surveys.

8.5 Capturing views creatively.

For those who cannot respond using the proposed methods there will be an opportunity for creative methods of feedback. Prompts will be used but people can respond using other media for example:

- A short film
- By providing a story
- Through the creation of an image/art
- Pictures and images

9 Communications

9.1 Aim

The aim of our communications approach is to provide clear and timely information to our wide range of stakeholders, helping to build awareness, understanding, and encourage engagement at every stage of the consultation process.

9.2 Objectives

- To be respectful, honest, open, and transparent.
- Work with our partners and stakeholders to ensure a broad and relevant reach across our geographical locations, particularly amongst those groups who are typically under-represented.
- Produce clear, concise, and accessible information available in a range of formats.
- Proactively inform, involve, and engage our stakeholders at each stage.
- To inform, engage and support our staff through each stage, and encourage them to give feedback.
- Make appropriate connection to other transformation work which may be happening in other health and social care organisations.
- Make it easy for people to give their views.
- To keep people informed and up to date, in a timely manner, on the progress and outcome of the consultation.

9.3 Outputs

The Trust will develop the following communication outputs to support the delivery of the consultation, with the main aim of ensuring that the information provided is accessible and inclusive to all audiences including those who do not English as a first language, people requiring reasonable adjustments and accessible materials and formats. We will be testing in consultation the quality of the information we provide and whether it was accessible. We will ensure we adjust our offer accordingly in line with feedback. The following media will be used (note that this is not an exhaustive list and further outputs may be created):

- Consultation document – electronic and hard copy, full version and summary version, Easy Read, text only webpage, audio only option
- Posters – including a general poster, and posters tailored for each consultation event/local place – electronic and hard copy.
- Q&A materials
- PowerPoint slide for use on digital screens
- Display boards for key locations across every place
- Social media graphics and content
- Direct mail to carers and families of current inpatients
- Website page(s) – to act as one source of information.
- Internal communications – including copy for use in newsletters, staff event(s), frequently asked questions (FAQs)
- Consultation events – face to face, virtual
- Digital assets – including use of video and graphics.
- Media release – consultation launch, and localised media releases tailored to each local place, aligned to consultation events.
- Toolkit for partners/stakeholders to facilitate promotion – including printable posters, social media planner, website content, shared narrative, and briefing packs, and content for onward cascade.

9.4 Insight and involvement

The Trust will involve our staff and stakeholders in the development of our communications to ensure that they are clear, cohesive, and accessible to our stakeholders.

Insight and involvement will be sought from:

- A dedicated communications and engagement reference group, consisting of communications, involvement, and equality professionals from our partners, and representing the broad scope of our geographical locations.
- Communications and involvement professionals with expertise in producing accessible information.
- Staff, including those working in older people's mental health inpatient services and staff networks.
- Appropriate stakeholders – such as voluntary and community sector organisations who work with older people, their families, and carers.

9.5 Feedback channels

We want to make it as easy as possible for people to give their feedback. To do this we will use a variety of channels, including (but not limited to):

- Online form/survey
- Face to face conversations including advocacy and peer to peer approaches
- Dedicated email address
- Freepost address for return of paper-based consultation questionnaires
- An identified telephone number.

Our approach to run face to face and virtual events throughout the consultation period will enable a two-way dialogue with our stakeholders and encourage people to ask any questions they may have. These will continue to form part of a Q&A which will be published and shared with those who are supporting the consultation.

As stated Information will be produced in a variety of formats, this will include a word version of all publications on our website. For those who, for accessibility reasons, require information in an alternative format, a point of contact will be given to be able to request this and a timely alternative will be provided using our Trust Translation and interpretation service who will receive a full and summary word version of all materials to support quick and easy alternatives. All documents, including the survey will be in plain English summary and easy read.

9.6 Communication channels

The Trust will utilise the following communication channels to ensure messages are cascaded to stakeholders (note that this is not an exhaustive list and further channels may be added):

- **Internal channels:**
 - o Regular staff newsletters and briefings
 - o Events – face to face and virtual
 - o Staff networks
 - o Intranet
 - o Direct email
 - o Posters and leaflets
 - o Cascade via leadership teams
- **External channels:**
 - o Trust website
 - o Trust social media accounts
 - o Stakeholder websites and social media accounts
 - o Local media
 - o Direct email / mail
 - o Public events – face to face and virtual
 - o Public newsletters

- o Cascade via partner and stakeholder networks / channels – including key stakeholder organisations working in the voluntary and community sector.

We will work with colleagues and named leads within our partner organisations to ensure delivery to our key target audiences. Some key target audiences and delivery methods are outlined below:

Target audience	Delivery method
People who have had direct experience of health and care services –all older people currently using our older people’s mental health services (inpatient and community), families, relatives, and carers	Raise awareness of the consultation through: • Direct mail to carers and families of current inpatients • Third sector networks and assets • Patient groups • Carers groups • Via staff working on wards • Display boards located on site/in wards. • Consultation events • Posters and leaflets • Direct with our communities via community representatives • At relevant appointments with service users/patients (e.g., our Trust, GPs) • Social media – organic and paid (if budget) • Websites and newsletters • Local media • Video • Public newsletters
Voluntary and community sector organisations who support, represent or advocate for older people, carers, and their families	• Direct briefings to organisations • Toolkit for onward cascade and to support promotion. • Consultation events • Via relevant meetings • Local media • Websites and newsletters • Social media • Posters and leaflets • Video • Public newsletters
Staff working in older people’s mental health services (inpatient and community)	• Direct briefings • Internal staff bulletins • Staff intranets • Cascade via leadership team and managers • Posters and leaflets • Direct email • On site display boards

Key NHS partners and stakeholders with a stake/interest in older people's mental health services	• Direct mail out to all Trust members • Direct briefings to organisations • Toolkit for onward cascade and to support promotion. • Consultation events • Via relevant meetings • Local media • Websites and newsletters • Social media • Posters and leaflets • Video • Public newsletters
People identified as future service users	• Third sector networks and assets – the reach of these groups can be found in the place-based delivery plans in the appendix. • Patient groups • Carers groups • Consultation events • Posters and leaflets • Direct with our communities via community representatives • At relevant appointments with service users/patients (e.g., SWYPFT, GPs) • Social media – organic and paid (budget dependant) • Websites and newsletters • Local media • Video • Public newsletters
Under-represented groups / those who are seldom heard	• Third sector networks and assets • Patient groups • Carers groups • Consultation events • Local media – including specialist media outlets. • Communications assets (e.g., posters and leaflets) – adapted to meet accessibility needs
Other patients and the public	• Patient groups • Carers groups • Consultation events • Posters and leaflets • Social media – organic and paid (if budget) • Websites and newsletters • Local media • Video • Public newsletters

9.7 Media protocol

Proactive media planning will cover the public announcement of the consultation, consultation launch, social media, and ongoing media relations.

Reactive media will be managed by the marketing and communications team at our Trust, working with partners in the West and South Yorkshire ICBs, local HCPs, and appropriate stakeholders as required.

Media protocol will include:

- An approvals process for proactive and reactive media. This will include arrangements for handling media enquiries out of hours if required.
- Identified communications leads within our Trust and partner organisations.
- Identified senior management and clinical spokespeople.
- Media briefings planned for appropriate milestones in the consultation timeline.
- Frequently asked questions which will be published on our website, and regularly reviewed as the consultation progresses.
- Media monitoring, including social media.

9.8 Evaluation

The effectiveness of communication and engagement activity will be monitored using the following measures (not an exhaustive list):

- Website data
- Social media data
- Media coverage
- Consultation response rates
- Consultation event attendance rates
- Anecdotal feedback

We will regularly review each of these measures throughout the consultation so we can adapt our communications and involvement approach as required. Where possible, this data will capture equality data and geographic information. This will enable us to target further communications more effectively to the areas and communities we may not have reached.

10 Equality

An Equality Impact Assessment (EIA) has been developed on all the options and this has informed the consultation approach. The consultation will ensure that any gaps in our understanding from previous involvement work are addressed. We will make sure we reach the groups that have been identified in the EIA as being potentially more affected, through their underrepresentation in our services, the factors that influence the experience of mental ill health and dementia and by the other impacts service change may bring.

We understand from the data and insight that support the EIA that there is more likely to be potential impacts on the following groups:

- Black, Asian and minority ethnic communities
- Carers
- Trans people
- Lesbian, Gay and Bisexual people

- Faith groups – particularly Muslim and Sikh people
- Working age adults with dementia
- People with a disability – sensory, physical and learning disability

The consultation activity will specifically target these groups to ensure representative views are collected. Progress on this will be monitored and where there are gaps activity will be designed to address.

The approach to capturing feedback has been designed to be appropriate and accessible, but there are also ways for people to access additional support where there are unaddressed needs.

All respondents to the consultation will be asked to provide equality monitoring data to assess the representativeness of the views gathered during the process. This will include a mid-point review. The mid-point review will highlight any risks in under or over representation and the consultation approach will be refocussed where necessary to ensure feedback is reflective of the groups identified by the EIA as potentially more likely to be impacted.

Following the consultation process the data and insight will be analysed and used to update the EIA.

The EIA will provide an understanding of the potential impact of the options on different groups. The EIA will form part of the process for decision making and its conclusions will influence the outcomes.

11 Resources

There will be a resource and budget implication for the delivery of the consultation, and some may be sought using in house contributions. The overarching list of resources required to deliver this work are set out below:

- Developing a survey – online and paper version – printing
- Consultation materials, including document, summary version, posters and displays – printing.
- Discussion group hosts – cost implications
- Circulation of materials to a range of audiences – partners commitment and time of staff to do this.
- FREEPOST host and costs
- Communication plan – dedicated time to create materials for circulation.
- Analysis of findings and report writing
- Report publication

12 Analysis of data and presentation of findings

Following the consultation all the feedback generated including equality monitoring will be analysed and a report of findings will be developed. The report will be shared initially with the ICB committees and JHOSC in Calderdale, Kirklees, and Wakefield. In parallel the report will be used to facilitate a workshop style event where the findings, including equality data will be considered against each of the proposed options. As part of this approach the

EIA will be further updated with any additional considerations and impacts that were raised during the consultation.

In addition, using the consultation plan and report of findings the local ICB committees will review the consultation process. As the duty to consult sits with the commissioner each local ICB committee will want to be assured that the approach and process were robust, that the feedback reflects and represents adequately the views of those agreed in the mandate and that there are no gaps in representation that require further work to capture.

Feedback from the local ICB committees and OSCs will be triangulated with internal conversations and our Trust will use all the feedback to make recommendations to inform a decision on the future of older people's mental health inpatient services.

13 High level timeline for delivery

Process	Action for Equality, Involvement, and communication	Timeline
Prepare for formal consultation process	Preparation and planning for Consultation including a review of engagement and EIA documents and stakeholder mapping	
	Develop a draft consultation plan, including consultation mandate, document and survey which articulates the proposals to be formally consulted on	
	Share draft consultation plan and collateral with the ICB and NHSE for comment and assurance	
	Following ICB/NHSE approval share the consultation plan and collateral with the Overview and Scrutiny Committee for any final comments and considerations	
Preparing for launch	Develop collateral required to deliver formal consultation	
Consultation Launch and delivery	Website updated with consultation materials, consultation in the public domain	Considering school holidays and religious festivals – launch (tbc)
	Consultation (12 weeks) – will include clinical support to front conversations with resources to support/ social media and media publicity maintained throughout	12 weeks delivery
Consultation assurance	Mid-point review of reach – approach adjusted if required	6 weeks in consultation

Post consultation	Report of findings on consultation including equality section. EIA updated	4 weeks post consultation
	Report of findings and EIA shared with ICB and OSC for comment and assurance	6 weeks post consultation
Deliberation	Internal deliberation of the findings from consultation and EIA – including feedback from ICB and OSC	10 weeks post consultation
Decision	Business case updated for decision.	14 weeks post consultation

Final draft

14 Appendix 1: Overarching delivery plan

Audience	Activity	Pre Consultation		Consultation (mid point review)											
		2 WEEKS BEFORE	1 WEEK BEFORE	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
Briefing for all place Leads	facilitator packs, Q&A and script	MS teams meeting													
Consultation documents: locations in each place plan	distribution of requested documents to each ICB place		documents sent direct to ICB place	Documents distributed											
website	SWYPFT website goes live - link on all ICB and place websites		send link and website narrative for upload to ICB comms leads	Day 1 - website goes live											
Healthwatch	send link and website narrative for upload to ICB comms leads			week 1											
Briefing of community assets Calderdale (7) Kirklees (12) and Wakefield (2)	Presentation, materials distributed and sign post to consultation information			week 1											
Community assets deliver - 19 + Wakefield	A range of activities taking place														
Staff directly impacted	letter, consultation document and survey			Day 1											
All SWYPFT Staff	Information on the intranet/ promoted via Headlines, The														
Staff side	Presentation and sign post to consultation information														
staff networks	Presentation and sign post to consultation information														
People currently in older people MH services	Letter, consultation document and survey -			Day 1											
Families, carers and loved ones of people currently in	Letter, consultation document and survey			Day 1											
Governors	Presentation and sign post to consultation information														
Members council – all members on database	Letter/ email and sign post to website				Week 2										
Local Councillors and MPS	Letter and sign post to information			week 1											
Health and social care leaders	Letter and sign post to information			week 1											
Digital meetings															
Public Meetings x 6 (ideally week 2-3 or could be week 3-4)	panel, presentation, Q&A		Briefing		3 x meetings	3 x meetings	3 x meetings	3 x meetings							
Information stands	roller banner stands in all SWYPFT hospital entrances,			Day 1											
Road shows Calderdale (4) Kirklees (7) and Wakefield (7) town centre and supermarkets	stands in various public locations	schedule in place	facilitator Briefing												
Stakeholder meetings (24) - Calderdale (11) Kirklees (7) and Wakefield (8)	Presentation and sign post to consultation information	schedule in place	facilitator Briefing												
News article	article in local newspapers to promote consultation and public meetings, sign post			week 1	week 2										
local radio				week 2									week 10		

15 Appendix 2: SWYPFT delivery plan

Audience	Activity	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
Staff directly impacted	Direct mail One to one	DAY 1											
Staff	Consultation document Online tools	DAY 1	PROMOTE WEEKLY IN HEADLINES AND THE VIEW										
Staff side	Presentation												
People in our services	Consultation documents and survey – all formats	DAY 1					PUSH						
	Healthcare comms – tablets												
	Chatpad												
	Creative activities												
Families, carers and loved ones	Letter to named contact. Consultation documents and survey – all formats Focus group?	DAY 1											
Governors	Presentation												
Members council – all members on database	Via Website												
BAME staff network	Presentation Intranet												
Disability staff network	Presentation Intranet												
LGBTQ+ staff network	Presentation Intranet												
Carers staff network	Presentation Intranet												
Volunteers	Volunteer newsletter Website												
Befriending service	Volunteer newsletter Website												
Spirit in mind	Pastoral newsletter Website												
Creative Minds	Artwork submission												
Wakefield mental health Alliance and partners Healthwatch Wakefield Nova Wakefield VCS organisations Wakefield PCN's Local councillors	Email details of the consultation and promote response options												
Kirklees mental health partnership board Healthwatch Kirklees Third sector leaders VCS organisations Kirklees PCN's Local councillors	Email details of the consultation and promote response options												
Calderdale mental health partnership board Healthwatch Calderdale VAC VCS organisations Calderdale PCN's Local councillors	Email details of the consultation and promote response options												
South Yorkshire ICS ICS Barnsley Barnsley Local Authority Barnsley PCN	Letter to chair/CEO with opportunity to provide a written response												
MPs – Calderdale, Kirklees, and Wakefield	Letter to MP with details of the consultation and an opportunity to provide a written response												

16 Appendix 3: Place based delivery plan

	Calderdale Key contacts: ICB – wyicb-cal.comms@nhs.net CIEEC partners – ICB Jill Dufton (jill.dufton1@nhs.net) Healthwatch - Karen Huntley (karen.huntley@healthwatchcalderdale.co.uk) Calderdale Council - TBC VCSI / VAC – Emma Worsley (emma.worsley@cvac.org.uk) VAC ECs – Tamsin Woodhead (Tamsin.Woodhead@cvac.org.uk) Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)	Kirklees Key contacts: ICB Comms – wyicb-kirk.comms@nhs.net ICB engagement – wyicb-kirk.engagement@nhs.net LA – Ambreen Mirza – ambreen.mirza@kirklees.gov.uk Healthwatch – helen.barlow@healthwatchkirklees.co.uk Third Sector Leaders – comms@tslkirklees.org.uk VAC - Tamsin Woodhead - Tamsin.Woodhead@cvac.org.uk Community Pharmacy WY (Alison Hemsworth – alison@cpwy.org)	Wakefield Key contacts: ICB – wyicb-wak.communications@nhs.net CIE partners – ICB Dáša Farmer / Claire Vodden (dasa.farmer1@nhs.net / clairevodden@nhs.net) Healthwatch – Gary Jevon (gary.jevon@healthwatchwakefield.co.uk) Wakefield Council – Charlotte Parker charlotteparker@wakefield.gov.uk; Emma Samardzija – esamardzija@wakefield.gov.uk Ebony Ellis ebonyellis@wakefield.gov.uk NOVA – Scott Copeland Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)
Activity	Action	Action	Action
Commissioning of community outreach and briefing assets. Assets will be briefed no later than day 3 and will use peer to peer approaches to help communities respond to the consultation.	- Calderdale Forum 50plus - Age UK Calderdale and Kirklees - ACE (Advancement of Community Empowerment CIC) - Healthy Minds - Mums on a Mission - Stainland & District Parish Council - Our Place & Girlguiding Elland	- Simba's Friends - Kumon Y'all - Thornton Lodge Action Group - IMWS / MEDO / Al-Ehsan trust - Jamaica National Council Huddersfield - Ravensthorpe Community Centre - Ready Steady Active - Shaping Care in Kirklees CIC - Moldgreen United Reform Church - ACE (Advancement of Community Empowerment CIC) - JJ Heartisan (One Good Turn) - Locorum Care	Awaiting confirmed list from Nova
Distribution of consultation documents/ summary, full and posters	Place based distribution to: - Calderdale Councillors – briefing to all councillors so they can have conversations with residents in their wards. - GP practices (21 practices) each to receive 2 posters and 5 summary documents or 10 leaflets depending on what the comms pack contains. GP practices to receive a briefing document on what is expected, how to contact for more copies and/or support – this to be shared with all venues / distribution channels. - Community anchors - PCNs - Engagement Champions – summary documents, easy read, other formats sent to VAC. - Community centres - posters and summary documents - Westgate House – local authority - Libraries – via Council - Pharmacies – via Community Pharmacy WY (Alison Hemsworth – alison@cpwy.org)	Place based distribution to: - LA including communities' team/Social Prescribing - CVS - Third Sector Leaders - PRG Network - HCP C&E Network - Your health, your say - Kirklees Councillors – briefing to all councillors so they can have conversations with residents in their wards. - GP practices including Health centres – Batley, Dewsbury, Heckmondwike, and Liversedge – (64 practices) each to receive 2 posters and 5 summary documents or 10 leaflets depending on what the comms pack contains. GP practices to receive a briefing document on what is expected, how to involve their PRGs, who to contact for more copies and/or support. 9 PCNs - Community anchors linked to PCNs. - Community Voices – summary documents, easy read, other formats sent to VAC.	Place based distribution to: - PPG Network - HCP CIE group - ICB engagement database - Peer Leaders, Social Care Citizen Panel, Covid Community Champions - People Panel - Wakefield Councillors – briefing to all councillors so they can have conversations with residents in their wards. - GP practices (36 practices) each to receive 2 posters and 5 summary documents or 10 leaflets depending on what the comms pack contains. GP practices to receive a briefing document on what is expected, how to involve their PRGs, who to contact for more copies and/or support – this to be shared with all venues / distribution channels. - Connecting Care Hubs - Organisations signed up to outreach activity via NOVA. - Community centres - posters and summary documents - Alzheimer's UK - Age UK

		- Community centres - posters and summary documents - Norwich Union House	
Stakeholder meetings	Presentations to: - Involving People Network (Jill Dufton (jill.dufton1@nhs.net)) - Calderdale Collaborative Community Programme Board (3CPB) (Shabana Kausar (shabana.kausar5@nhs.net)) - MHLNDND delivery group - Calderdale Health and Wellbeing Board - Ageing Well Board / Sub Group (contact TBC) - Acute and community Geriatricians and older people specialist teams including safeguarding. - PCN clinical directors and GPs and other primary care/community HCPs with special interest in geriatric medicine/links with care homes - Social care colleagues and managers with responsibilities for older people's services (Contact TBC) - VCSE assembly - Chief Officers - Volunteer managers	Presentations to: - PRG Network - Kirklees Mental Health Alliance - Ageing Well Board - Kirklees Health and Well-being Board - Acute and community Geriatricians and older people specialist teams including safeguarding. - PCN clinical directors and GPs and other primary care/community HCPs with special interest in geriatric medicine/links with care homes - Social care colleagues and managers with responsibilities for older people's services	Presentations to: - PPG Network - Wakefield Mental Health Alliance including - Stakeholder Forum - Dementia Steering Group - Wakefield Health and Wellbeing Board - Acute and community Geriatricians and older people specialist teams including safeguarding. - PCN clinical directors and GPs and other primary care/community HCPs with special interest in geriatric medicine/links with care homes. - Social care colleagues and managers with responsibilities for older people's services.
	Roadshow stands (suggested locations) tbc - Supermarkets (Asda – Thurn Hall, Morrisons - Cousin Lane) - Shopping centres (Woolshops, outside M&S) - Maurice Jagger Centre	Roadshow stands (suggested locations) tbc - Supermarkets - Shopping centres	Roadshow stands (suggested locations) tbc - Supermarkets - Shopping centres – The Ridings, especially linked to organised events e.g. AgeUK WD and Silver Sunday
Public meetings	There will be 2 public meetings in Calderdale: - Halifax town Centre - Hebden Bridge	There will be 2 public meetings in Kirklees: - Huddersfield town centre - Dewsbury/Batley	There will be 2 public meetings in Wakefield: - Wakefield town centre - Hemsworth

17 Appendix 4: public meeting plan

Older People Transformation consultation – Public meeting plan

The working assumption is that prior to this event a briefing has taken place in the form of a meeting and event pack with all staff in attendance which includes executive leads, clinical leads, and key stakeholders. The briefing pack will consist of:

- Consultation document and survey
- Script of key messages
- Q&A document
- Data capture form – to capture any questions and feedback.
- Public meeting plan.
- Layout of the venue and who is in the room.
- Customer service information leaflet
- Membership information – if people express a desire to become involved with the Trust

1. Purpose of the plan

The purpose of the plan is to provide information on the public meeting format for the older people transformation, including:

- The purpose of the public meeting
- Set up and pack up.
- The layout of the building – planned use of spaces.
- List of programme leads and facilitators required.
- Presentation and consultation material.

2. Purpose of the public meeting

The purpose of the public meeting is to provide an opportunity **for people, including staff, members of the public and key stakeholders to drop in and get information** on the proposed options so they can respond. The purpose of the meeting is as follows:

- To have a visible presence in our communities to discuss the proposals supported by a range of clinical staff and system leads.
- Provide a local space for people to get information on the options.
- To support people to respond to the consultation.
- To listen to any concerns or queries and log them or sign post as needed to customer services.
- To capture any questions, not necessarily respond to all but to update the Q&A
- To respond to any questions in line with the business case, which will be supported by a core script.

The focus of the public meeting is to support our gunning and brown principles by ensuring people get the information they need in the required format so they can provide an informed response to the consultation.

The meeting will be central to our local communities and will run as a drop in. This means people can come at any time during the public meeting. Discussions with key members of the workforce will be crucial to ensure that people can get clarity on the proposals and ask questions. The **suggested timings of public meetings will be 2-7pm** – but time either side will be required to help set up and pack up. The venues have been suggested by our place leads and all will be fully accessible, risk assessed and have the space required to fulfil the venue plan (see section 5). The suggested venues are 2 in each location, and they are:

2.1 Calderdale central – one meeting in either:

Halifax Town Hall (preference)

Shay stadium.

To note, the following venues are not available on our date options:

Elim church, Halifax

Kings Centre, Halifax

Maurice Jagger Centre, Halifax

Hopwood Lane community centre

2.2 Calderdale upper valley – one meeting in either:

Hebden Bridge Town Hall (preference)
Todmorden town hall

2.3 Kirklees (Greater Huddersfield)– one meeting in:

Brian Jackson House

To note, the following venues are not available on our date options:

Hudawi centre

Huddersfield Town Hall

2.4 Kirklees (North Kirklees) one meeting in either:

Dewsbury Town Hall (preference)

Batley Town Hall

Al-Hikmah Centre-Batley

2.5 Wakefield – one meeting in either:

Wakefield Town Hall (preference)

Brook house working men's club.

St Swithuns centre

2.6 Wakefield – one meeting in:

Hemsworth community centre

Provisional dates and venues (table below shows booking times to include set up and packing up:

No	Date	Venue	Locality
Week 2			
1	Tuesday 16 January 2024 12:00 -20:00	Wakefield Town Hall	Wakefield Central

2	Wednesday 17 January 2024 12:00 - 20:00	Halifax Town Hall (Calderdale)	Calderdale Central
3	Thursday 18 January 2024 12:00 - 20:00	Brian Jackson House	Kirklees (Greater Huddersfield)

Week 3			
1	Tuesday 23 January 2024 12:00 -20:00	Hemsworth community centre (Wakefield)	Wakefield wide
2	Wednesday 24 January 2024 12:00 - 20:00	Dewsbury Town Hall	North Kirklees
3	Thursday 25 January 2024 12:00 - 20:00	Hebden Bridge Hall	Calderdale upper valley

2.7 Promoting public meetings.

Public meetings will be promoted through the following channels:

- o Internal communication channels for workforce and people who use services.
- o Trust website
- o Trust social media accounts
- o Stakeholder websites and social media accounts
- o Local media
- o Direct email / mail

- o Public events – face to face and virtual
- o Public newsletters
- o Cascade via partner and stakeholder networks / channels – including key stakeholder organisations working in the voluntary and community sector.

We will work with colleagues and named leads within our partner organisations to ensure delivery to our key target audiences. Some key target audiences and delivery methods are outlined below:

3. Communication and information required to deliver a public meeting.

The communications collateral required for public meetings is set out below these materials will be managed centrally by SWYPFT to ensure the event is accessible and inclusive for all. Staff attending will already have been briefed and will receive a facilitator pack. The Q&A part of this pack will be updated following each public meeting and this will be refreshed in facilitator packs periodically. The information and communication materials required on the day will be:

3.1 To deliver the event:

- Facilitator pack (spare packs) – updated Q&A.
- Signing in sheet – log of attendance.
- Evaluation – emoji sign in and out approach.
- Display boards on – case for change, our estates finances and workforce, clinical model, travel, transport, parking, and sustainability.
- The case for change film and equipment – projector, speakers, and screen.
- A range of seating – high and low.
- A feedback board – post it notes available.

- Light refreshments – tea, coffee, soft drinks, biscuits etc... (no single use plastic please).
- Box to collect completed surveys.
- Portable loop system.
- Extension cables and hazard tape
- Staff name badges/ names displayed on tables.
- Who is in the room welcome board.

3.2 For public attending the event:

- Tablet to complete surveys x 2
- QR codes around the room – links to survey via android phone.
- Full consultation document.
- Summary consultation document.
- Easy read documents
- Range of word version full and summary - large print, black on yellow and black on pink, braille.
- Paper surveys – including easy read, large print, black on yellow and black on pink, braille.
- Other resources: customer services, membership, being a volunteer and connecting people leaflets.
- Pens and pencils.
- Interpreters on request.

4. Facilitators, support staff and roles

4.1 Resourcing each meeting.

Organisation	Senior leadership	CEE leads	Support
--------------	-------------------	-----------	---------

SWYPFT	TBC but likely to include 1 to 2 SWYPFT EMT members and/or NED's	Dawn Pearson Zahida Mallard Heather McKnight Kamal Wrathall	A mix of programme team support, operational and clinical support and other key programme board members.
Calderdale	TBC – at least one senior leader from ICB	Jill Dufton Amiee Haggas	Healthwatch - Karen Huntley (karen.huntley@healthwatchcalderdale.co.uk) Calderdale Council - TBC VCSI / VAC – Emma Worsley (emma.worsley@cvac.org.uk) VAC ECs – Tamsin Woodhead (Tamsin.Woodhead@cvac.org.uk) Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)
Kirklees	TBC – at least one senior leader from ICB	Kirsty Wayman Zubair Mayet Siobhan Jones	LA – Ambreen Mirza – ambreen.mirza@kirklees.gov.uk Healthwatch – helen.barlow@healthwatchkirklees.co.uk Third Sector Leaders – comms@tslkirklees.org.uk VAC - Tamsin Woodhead - Tamsin.Woodhead@cvac.org.uk Community Pharmacy WY (Alison Hemsworth – alison@cpwy.org)
Wakefield	TBC – at least one senior leader from ICB	Dasa Farmer Claire Vodden Helen Haythorne	Healthwatch – Gary Jevon (gary.jevon@healthwatchwakefield.co.uk) Wakefield Council – Charlotte Parker charlotteparker@wakefield.gov.uk; Emma

			Samardzija – esamardzija@wakefield.gov.uk Ebony Ellis ebonyellis@wakefield.gov.uk NOVA – TBC following meeting with SWYPFT Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)
Other		Karen Coleman Colin Hurst	

4.2 Welcome and support staff

Welcome and support staff will be responsible for ensuring the following:

- People are signed in and navigated to each part of the meeting.
- People are aware of fire/ evacuation procedure.
- People get the information they require.
- People have support to complete the survey – using the available resources.

4.3 Facilitators

Facilitators will host a table or display and they will talk to people about the area they are presenting. The facilitator will also navigate to colleagues in the room and note down any helpful information to support Q&As.

4.4 Specialist support

Specialist staff will include:

- Digital or IMT support

- Communication – management of press enquiries

5. Venue plan and layout:

Key requirements:

- fully accessible,
- risk assessed
- have the space required to fulfil requirements

See generic venue plan and layout below which will be adapted for each event based on site specific layout.

Draft Generic Floor plan (depending on windows and doors layout)

OPS public consultation meetings for 16, 17, 18, 23, 24 and 25 January

Tables/networking space

1. Clinical
2. Executive Directors / Non-Executive Directors
3. Programme team
4. Staff side
5. Estates
6. Facilitator
7. Special support
8. Marshall
9. Support Staff – IT

Plus:

The OPS team will be showing a video presentation on the consultation.

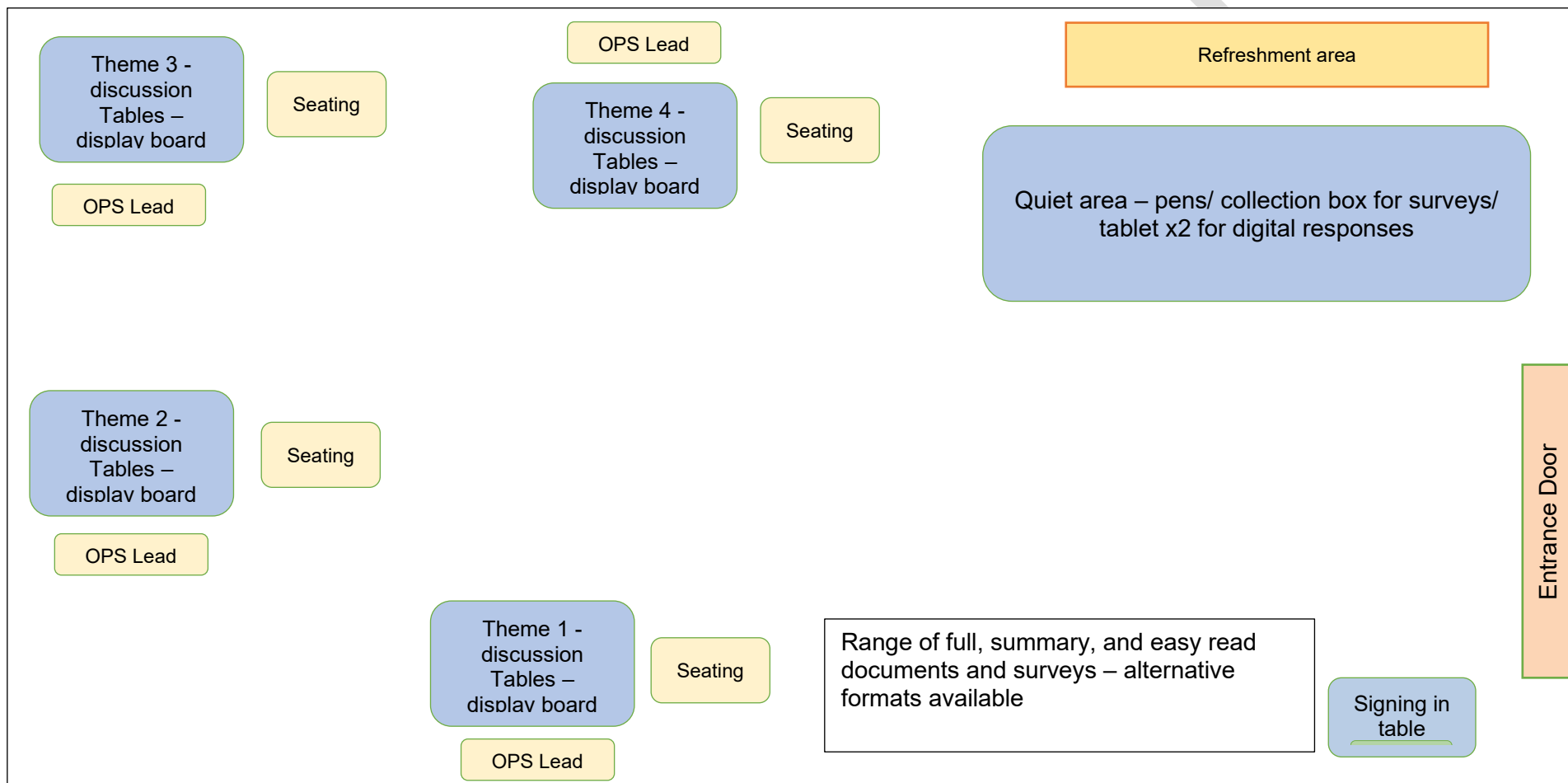
Schedule

1200 noon	Room set up
1300	Facilitator briefing
1345 – 1400	Facilitators needed
1400 -1900	Public access
1400-1900	Refreshment available
1900- 2000	Close down and leave venue

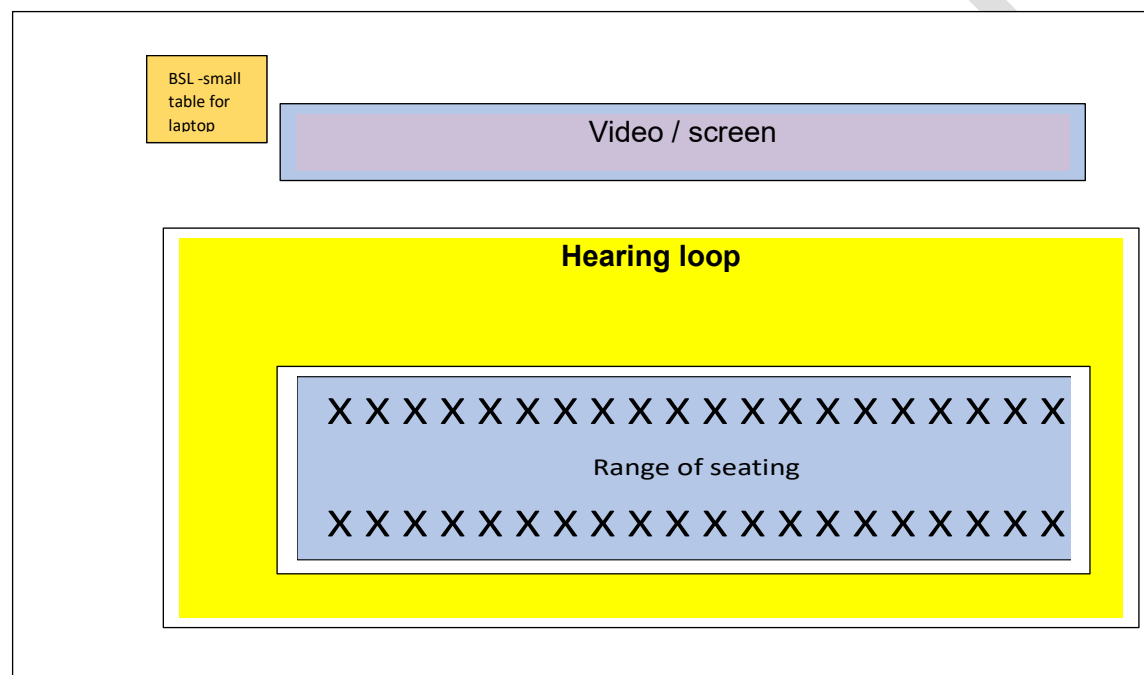
The video and presentation will be set up by the venue.

A portable hearing loop will be in the video room and we will also have two BSL interpreters in the at each meeting (subject to availability).

Room layout example



Video room



18 Appendix 5: Advocacy plan

Proposal to utilise advocacy service skills to support the involvement of inpatients in the Older People Services inpatient consultation.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

1. Purpose of the proposal

To identify if the Trust can utilise advocacy services to support inpatient involvement in a formal consultation. The proposal sets out:

- The background to the consultation
- The scope of the work
- Indicative timescales

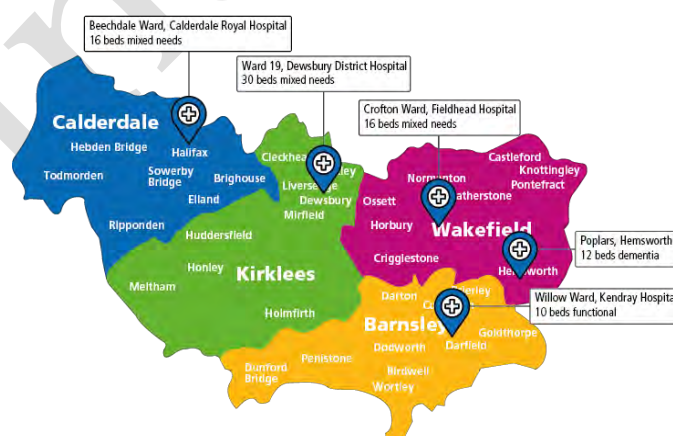
The proposal aim is to engage advocacy services in the approach and identify if they can support this work and identify any additional costs that may be associated with delivery.

2. Background

South West Yorkshire Partnership NHS Foundation Trust and the Calderdale, Kirklees and Wakefield Health and Care Partnerships have been working together to review how we improve mental health care for older people in our inpatient wards. There is a need to better support the small proportion of people who are acutely unwell, who present with complex needs and co-morbidities, and therefore require admission to an inpatient ward. The Trust has five older people's mental health wards. These are:

- Halifax at Calderdale Royal Hospital (mixed functional and dementia patients, 16 beds)
- Priestley Unit in Dewsbury, located in Dewsbury and District Hospital (mixed functional and dementia patients, 30 beds; 15 male beds and 15 female beds)
- Two wards in the Wakefield district – one on the Fieldhead Hospital site (mixed functional and dementia patients, 16 beds) and one at The Poplars in Hemsworth (dementia patients, 12 beds).

In South Yorkshire, the Trust has a ward for people with functional mental health needs (10 beds) at Kendray Hospital in Barnsley. This ward will not be in scope. A map of where all our services are located is set out below (please note that mixed functional and dementia wards are referred to as 'mixed needs'):



Map of locations of older people's mental health inpatient services within the South West Yorkshire Partnership NHS Foundation Trust footprint

3. Scope

We know that the involvement of older people with dementia and functional mental health requires specialist input and that our independent advocacy teams work closely with our inpatients to provide much needed independent support.

As service reconfiguration may have an impact on our workforce we will be inviting staff to respond to the consultation. This means that we need to maintain a level of independent support for those inpatients so they can respond without relying on Trust staff.

Families, carers, loved ones and relatives will be contacted directly on day one of the consultation. A letter will be sent to the home address or email of an identified person for each inpatient, sign posting them to information and resources so that they can also provide a response.

The scope of the project would be:

- To **act as an independent** who could ensure that the Trust has demonstrated a desire to capture the views of inpatients in a way that is appropriate, accessible, and inclusive as part of formal consultation.
- To **support inpatients to respond to the consultation** by providing information and/ or communicating in a way that meets the needs of that inpatient. Ensuring that all inpatients have been approached and included, and capacity to be involved assessed.
- To **capture the voice and views of those inpatients using the consultation survey or an alternative structure** that simplifies the consultation questions. For example:
 - Asking if a person understood the information.
 - Asking if they had any views.
 - Asking if they had any concerns.
- **For anyone that can't complete a survey please document their response anonymously** in the form of a report – one report per ward and if possible split by views relating to gender or other diverse characteristic that would help us understand the impact for different protected groups.
- **Provide an independent and written response to the consultation** on behalf of the inpatients and using professional judgement to help the Trust understand any impacts or feedback that would help inform a decision.

4. Project timeline

The time scale for delivering formal consultation is not yet agreed but we anticipate that it could be as early as December 2023 or as late as early to mid-January 2024. We will have more information early November. The **consultation will be 12 weeks** from this start date. The timescales to note would be:

- The timeline for delivering consultation conversations will be within this 12-week window.
- A report would have to be with us on the last day of consultation to be included as a response.
- We will produce a report of findings from consultation no more than 4 weeks following the end date and the report from advocacy will be analysed along with other responses, and the report will be added in the main body of the report or as an appendix. This report will be published so all findings will be publicly available at least 3 months after formal consultation.

- Feedback on the outcome of consultation could be up to 6 months after and we will ensure that advocacy services receive a briefing that they can share back with inpatients.

5. Next steps

For advocacy services to consider the proposal and provide any feedback on the approach by Friday 20th October. Could you advise on the following:

- If you can support the approach – if yes we will set up a briefing at least one week before consultation.
- If there any additional costs associated with delivering the approach.
- Any additional resources you may require to support you.

Your help to involve our patients would be crucial to ensure their voice is heard, we very much hope you can support us, thank you.

Final draft