Inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire

Pre-consultation business case for submission to NHS England

Midlands Partnership NHS Foundation Trust and

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

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1 Executive summary

Inpatient services in south east Staffordshire for adults and older adults experiencing severe mental illness or dementia

NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) and its mental health partners, including Midlands Partnership NHS Foundation Trust (MPFT), are united in our ambitious programme to transform mental health services.

We are committed to ensuring that through greater integration we will enable high-quality treatment and support for people with mental health needs who need it most, while helping people to remain independent. We want our communities to be able to:

- Stay in control of their lives
- Access high-quality services when they need them
- Receive care which is focused on recovery and independence.

To do this our clinicians, patients and staff have told us we need to continue to work differently:

- **Community first**: building on our work over recent years, to enhance community services. Clinical evidence shows that most patients get the best outcomes (the best experience and the best chance of recovery) if mental healthcare is provided in the community, rather than in a hospital. Getting the right support and treatment, while living in their usual home with loved ones close by, gives people the best chance to recover and stay well. This means building local community networks, for example between the NHS, social care and the voluntary sector to wrap support around a patient
- **Dementia care**: patients with dementia should receive specialist support, in their usual place of residence for as long as possible. If their condition worsens, or their carers need respite, a hospital stay should not be our first resort and a range of alternatives should be available.
- **Inpatient care**: Only a minority of people, with serious mental illness need a hospital stay. We want to help this small group to access quality inpatient facilities, with access to the right clinicians, timely support in the event of a crisis and a range of therapies to support their recovery.

Why is change needed

For many years commissioners have been working with providers to enhance community mental healthcare and reducing reliance on a bed-based model of care.

This is consistent with the growing body of evidence and recent national NHS guidance, including the NHS Long Term Plan and the Mental Health Implementation Plan both published in 2019. This gives a clear direction of travel, supporting mental health transformation with an increased focus on prevention and community care.

This strategic backdrop is central to the system's mental health transformation agenda, which has informed the development of this pre-consultation business case for inpatient mental health care in south east Staffordshire.

We know that our inpatient mental health services cannot operate on their own and need to be part of an integrated mental health system. We have been investing in our community mental health services for many years, so that they can provide quality care for the majority of patients who do not need a hospital stay.

Through this work and by working with local communities, new services and networks have been established to support people with mental health needs within their own community, taking a proactive approach to prevention. Figure 1 at the end of this section outlines the process we have undertaken over the past few years.

How services have previously been provided in south east Staffordshire

Our work to transform mental health care is happening across Staffordshire and Stoke-on-Trent. We recognise there is a local need to work with our partner provider, MPFT, to develop a long-term solution for inpatient mental health care in south east Staffordshire.

Until 2019 there were two main sites that provided inpatient mental health care for residents in south east Staffordshire.

- The vast majority (75%) of patients with serious mental health needs, would travel to and use the specialist St George's Hospital in Stafford, which could provide the full range of hospital (acute) mental health care. This includes access to a range of arts and therapies, specialist restraint rooms for people in crisis and other specialist teams including eating disorders.
- 25% of local residents who needed an inpatient stay used a small, standalone facility at the George Bryan Centre near Tamworth. This included:
    - The West Wing which had 19 beds for adults aged 18 to 65 with severe mental illness – like mood disorders, psychosis, anxiety and depression
    - The East Wing which had 12 beds for older people (65 and over) with dementia and/or other mental health problems.
- A small number of patients may have used other specialist services, or out of area placements if these were most appropriate for their needs.

Although feedback from local patients showed that the George Bryan Centre was a popular service with supportive staff, even in 2019 there were signs that partners needed to consider a new approach. Delivering services was becoming increasingly challenging due to the isolated nature of the site. Examples included:

- It was increasingly difficult to cover for staff sickness because of the limited specialist mental health workforce
- Patients would have to travel, or wait to access specialist arts and therapy services, which can support recovery and wellbeing
- If a patient's condition worsened, there could be long transfer times (up to six hours) to admit people to St George's Hospital (as multiple clinicians were needed to accompany the patient)

- The police were often called to the centre to support with patients who were in crisis, because of estate and workforce constraints. This could be distressing for patients, family members and the staff involved. It also impacts on a patient's long-term wellbeing.

A fire in February 2019 led us to accelerate the work we had already started to transform mental health care. This necessitated trialling new ways of working, aligned to the national guidance of enhancing community based services. The fire destroyed the West Wing of the George Bryan Centre and patients in this wing were immediately moved to St George's Hospital.

Soon after the fire, the board of MPFT decided to temporarily close the East Wing, for safety reasons. Although the Sir Robert Peel Community Hospital was next door to the George Bryan Centre, it is not a mental health hospital and so could not offer the specialist support that such a facility requires.

Developing and enhancing our way of working

Since the fire, and during the COVID-19 pandemic, partners worked to develop and enhance an approach to delivering dementia and inpatient care:

- We used our workforce differently, so that more staff worked in community teams to offer earlier support and treatment
- We followed the latest clinical best practice, by supporting people with dementia to be looked after in their usual place of residence, or in other specialist care settings, rather than being admitted to hospital.

The small numbers of people who needed an inpatient stay were admitted to the specialist St George's Hospital in Stafford. It is estimated this meant an additional five patients a month were admitted there. When patients were transferred to St George's Hospital in 2019, they moved into a ward that was kept for use during peaks in demand, like winter. Since then, this ward has been refurbished and provides 18 mental health beds.

This new approach has been in place since 2019 and it has given time to review the impact on patients, families and carers and staff. Our clinicians and staff have used this experience, alongside the insight from various engagement activities, to inform a long-term proposal for inpatient mental health care in south east Staffordshire.

ICS mental health alignment

The vision of the Integrated Care System (ICS) for mental health is consistent with the recent, national publications on mental health best practice and have reinforced our commitment to the improvements already happening locally. The vision will remain the central tenet of our programme as it moves forward to 2024 and beyond, implementing improvements to services set out in the plan. Older people, adults, young people and children in Staffordshire and Stoke-on-Trent will feel supported whether they find themselves in need of help, in crisis or want to maintain their day-to-day mental health and wellbeing. We will work in an integrated and collaborative way to ensure their mental health is given equal priority to their physical health needs and that people receive the help and support they need closer to home and family.

The national commitment, which will support local delivery of improved mental health services, is strong. Funding is being ring fenced, the deliverables for improved services set out up to 2023/24 are clear and in many cases mandated. Systems such as our own are measured against the progress they make and NHS organisations are regulated in accordance with this. The Staffordshire and Stoke-on-Trent ICB is therefore committed to delivering in line with the Mental Health Implementation Plan (2019). We have developed our local response, the Staffordshire and Stoke-on-Trent Mental Health Implementation Plan, jointly with commissioners, the two NHS Mental Health Trusts and most importantly our service user and carer advocates.

The Mental Health Programme Board provides the strategic direction for development of mental health services and ensures that the deliverables as outlined in the Mental Health Implementation Plan are achieved across the whole ICS on time and in a cost-effective manner. Strategic leadership, partnership engagement and assurance are delivered through the Programme Board and wider project structures, ensuring the priorities set out in the NHS Long Term Plan are realised. Assurance is provided to regulators and external partners, as and when required that the Staffordshire and Stoke-on-Trent system is delivering the requirements laid out in the national plan.

The ICS Mental Health Programme Board has received regular updates on the progress of this inpatient mental health programme and more recently endorsed the model of care outlined within this business case.

What is the long-term proposal?

Our mental health clinicians and staff have been working for many years to find a long-term solution for the inpatient services that were based at the George Bryan Centre.

We have involved patients and carers, staff, mental health clinicians and the public throughout this journey. You can read more about our approach to involvement in Section 6. We have considered the findings from the public involvement, along with clinical evidence, while developing and reviewing proposals.

We used a series of technical events to consider proposals for change against a set of essential criteria: strategic fit, clinical safety, and meeting the needs of the local population. Two proposals were considered through most of the process. After listening to our clinicians, staff, service users, carers and representatives, and carefully considering their input, the outcome of the final stage of the process is that we believe only one of these proposals will deliver the standard of care required for local people. That proposal is to make permanent the service changes we made in 2019. We have not reached this conclusion lightly.

In this pre-consultation business case, we explain how we have reached the recommendation to keep inpatient mental health services at St George's Hospital. We also explain the potential advantages and disadvantages of the proposal for local people.

In summary, evidence suggests that an isolated ward at the George Bryan Centre would not:

- be clinically safe
- be sustainable in terms of staffing

- provide the same high-quality care that patients could access at the specialist site at St George's Hospital.

Working with clinicians and staff, we have followed a robust process to inform this proposal and have benefitted from advice and support from external agencies, such as the Consultation Institute, who are specialists in involvement, to design engagement activities and test our proposals, at every step of the journey.

Clinical safety and workforce

At the centre of this proposal is clinical safety for patients. The relative isolation of the George Bryan Centre could have implications for staff safety and would have implications for recruitment.

In terms of clinical quality and safety, the location and facilities at St George's Hospital provide a better opportunity for the optimum care and treatment of inpatients with severe mental illness. This can be demonstrated by the comparative lengths of stay between St Georges (22.94) and the George Bryan Centre (30.62).

A strong driver for the proposal to make permanent the temporary consolidation of inpatient services at St George's Hospital is that community mental health services in south east Staffordshire have been transformed since 2019. This has in part been achieved by the realignment of staff to support the temporary way of working, including more staff in the community and additional staff at St George's Hospital.

The ICB is assured that the existing service model that has been in place since 2019 provides a sustainable workforce model that will meet future population needs. This is further evidenced through the current enhanced service model showing sustained improvements to outcomes including reducing patient length of stay and improved access (where there are no waiting times in accessing community provision or inpatient beds due to the dynamic nature of the way different teams work together and balance risk). This has meant that patients and families/carers are supported in their own home/usual place of residence improving overall quality and experience of care. Additionally, historical data has been used to determine future demand of both community and inpatient services.

Re-introducing a second, isolated site would create the risk of destabilising the existing workforce given national and local shortages in skilled mental health workers. We need to be open and honest about the realities of the workforce challenges, and the need to maximise our existing resource to deliver the best care possible.

Independent clinical review

Following best practice and as part of our robust process for this programme, we commissioned the West Midlands Clinical Senate to independently review our work in June 2022. The Clinical Senate is an established source of independent and objective clinical advice and guidance to assist health systems in making the best decisions about healthcare for their populations.

Under the terms of reference, the Clinical Review Panel was asked to:

- Provide an opinion on the clinical model and recommended proposal

- Explore the proposed clinical model and its alignment with the national strategy for mental health services to move from a bed-based model to one where patients are supported in the community where possible, with inpatient stays only where there is no alternative
- Explore the proposal to centralise beds at the St. George's Hospital site in Stafford and to provide an opinion on the impact on patients.

The review panel has now published its report which includes five recommendations to support the transformation programme to move forward through the NHS England assurance process for major service changes.

The ICB have accepted the recommendations of the panel and MPFT have responded to these recommendations (see Section 8.6), to inform this pre-consultation business case.

Travel policy

From listening to patients, carers, and the Health Overview and Scrutiny Committee on this journey towards a long-term solution, we have heard that their main concern is around people travelling to visit loved ones at St George's Hospital in Stafford, compared with visiting the George Bryan Centre.

We know that visits and support from family, friends and carers are very important to patients in hospital, and that this supports their wellbeing and recovery.

In recommending that we keep the mental health beds at St George's Hospital, we have thought carefully about the potential disadvantage caused by travel difficulties for some patients and carers. On balance, we believe the following advantages mean this is the right way forward:

- Our community mental health services are giving better support to people with severe mental illness in the community, so that fewer people need to stay in hospital
- Through the right specialist treatment hospital stays can be shorter and people are helped to stay independent
- Better care through on-site access at St George's Hospital to a bigger range of mental health specialists, more treatment options and activities, and the safer care that the facilities help provide
- We are improving our services to offer better support for people in crisis.

Prior to February 2019 analysis shows that 75% of south east Staffordshire patients admitted for an inpatient mental health stay were admitted directly to St George's Hospital, this his was because their illness was too serious for them to be treated at the George Bryan Centre.

Since February 2019 through to July 2022 783 patients who live in south east Staffordshire have been admitted to a mental health inpatient stay which equates to 5 patients a month who would have been admitted to the George Bryan Centre, had it remained open.

Like travelling for other specialist treatments, it does potentially mean a longer journey for visitors. We recognise the important role visitors have for mental health patients, and we are balancing this against the need to deliver the best quality care.

We understand that visits are very important for patients, families and carers, and we are exploring ways to help manage any impact on this. This PCBC includes MPFTs proposals to support family members wishing to have contact with their loved ones.

Next steps

This pre-consultation business case will be subject to NHS England assurance, before being reviewed by the NHS Integrated Care Board (ICB) as the statutory decision makers. The ICB will then determine if further involvement activity is needed to inform a decision on long-term provision.

Throughout this process the ICB and MPFT are committed to maintaining an honest and transparent dialogue about the challenges and opportunities faced locally. Importantly, partners remain open to new, viable considerations throughout this process. At the heart of this work, is delivering the best care possible for local patients.

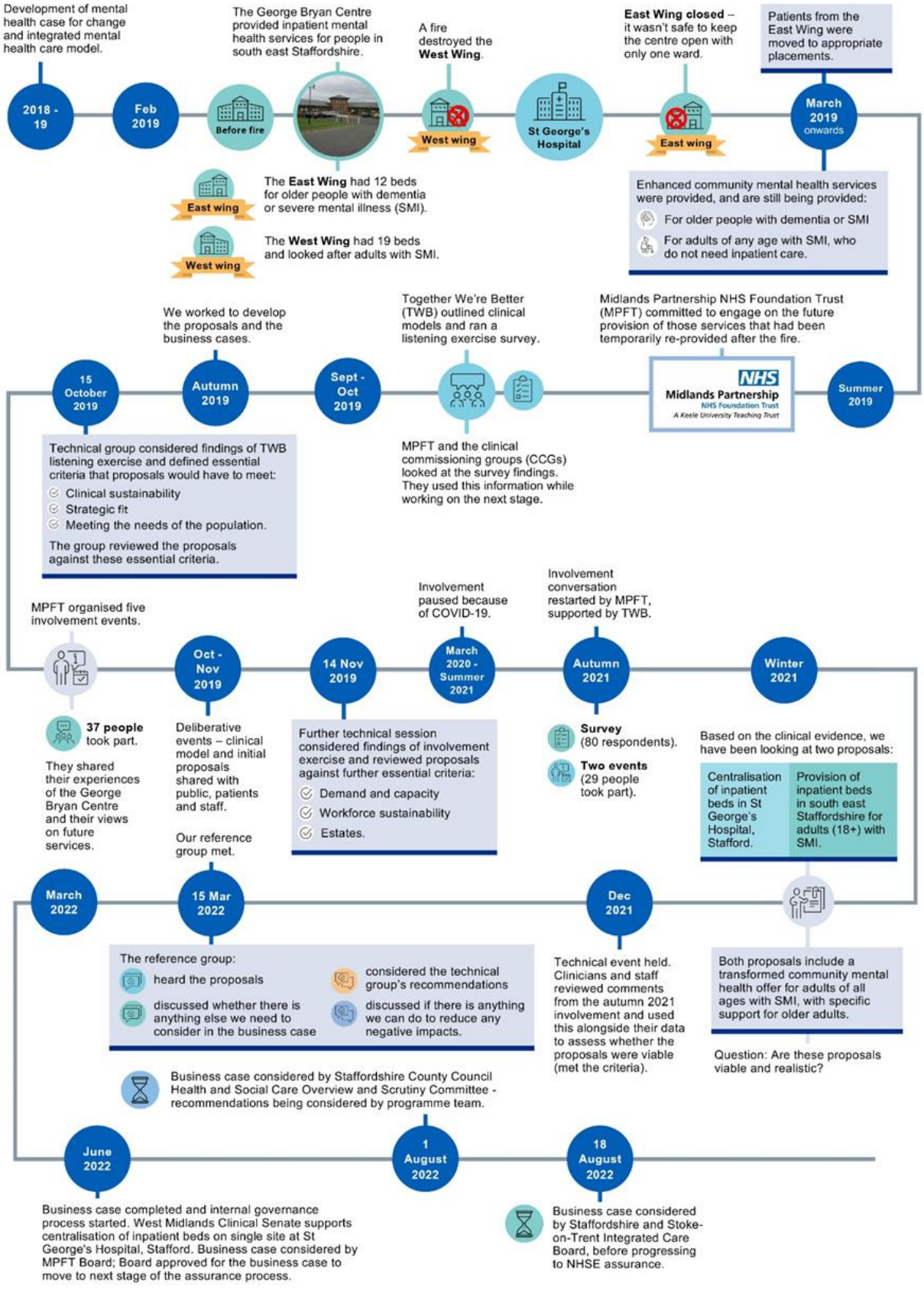


Figure 1 Process timeline leading to the development of this pre-consultation business case

2 Introduction

This pre-consultation business case (PCBC) is presented by Staffordshire & Stoke-on-Trent Integrated Care Board together with Midlands Partnership NHS Foundation Trust (MPFT)/the Trust) to align commissioning arrangements for the provision of acute mental health inpatient services in south east Staffordshire with national policy, system-wide strategic vision and the established operational position.

The geographic area covered in this proposal includes Stafford, Tamworth, Lichfield and East Staffordshire including Burton upon Trent. The proposal takes account of national best practice, clinical quality and safer staffing. It is set against the background of reduced admissions and shorter patient hospital stays achieved by transforming mental health community services in south Staffordshire over the past few years. Those services provide enhanced support to adults with severe mental illness and older adults experiencing severe mental illness or dementia.

Meeting the needs of our population

Nationally around 19% of adults aged 18-64 are estimated to have a mental health condition. In Staffordshire and Stoke-on-Trent that equates to 125,500 adults. Based on 2017/18 Quality and Outcomes Framework (QOF) registers, around one in ten (11%) Staffordshire adults are on a depression register and 0.8% are recorded as having a severe mental illness.

East Staffordshire Primary Care Network (PCN) and Mercian Primary Care Network (PCN) (which covers the Tamworth area) report that in their areas, there is a lower prevalence of people with severe mental illness on QOF registers than England as a whole, and that the highest number of referrals in order by service (excluding Improving Access to Psychological Therapies (IAPT)) are to adult mental health, children's and Child and Adolescent Mental Health Services (CAMHS).

In 2020/21 there were one in three (33%) emergency hospital admissions in Staffordshire for adults with a recorded diagnosis of a mental health condition. Whilst overall in Staffordshire this was lower than the national rate, East Staffordshire and Tamworth have the highest admission rates are statistically higher than national.

Population projections predict an increase in the older population and lower numbers of those of working age. This trend is certainly the case in Staffordshire as currently the percentage of the population aged 65 or over is 20% (higher than the national average of 18%) and is predicted to grow by 34% by 2039.

More detail can be found in Appendix 1 – Communities we serve.

The strategic case for change

In line with national ambitions set out in the Five Year Forward View for Mental Health (2016)[1], the NHS Long Term Plan (2019) and a Case for Change[2] published in 2019 by the Staffordshire and Stoke-on-Trent Integrated Care System (formerly Sustainability and

[1] Five Year Forward View for Mental Health, 2016

[2] Case for Change, Together We're Better, 2019

Transformation Partnership (STP)), work to transform community mental health services has been taking place across the MPFT footprint in south Staffordshire over several years.

The new national model of mental health services supports community-based care wherever possible.

Clinical evidence demonstrates that treating patients with severe mental illness as close to home as possible is better for care and outcomes, with community services at the heart of provision *(NHS Providers, 2019)* and that being in hospital for longer than necessary can make it harder for people to return to normal life *(Improving acute inpatient psychiatric care for adults in England, 2015).*

For patients with dementia, hospital admissions can make the symptoms of dementia worse, permanently reduce the person's independence and make it more likely that the patient will be discharged into residential care and/or readmitted to hospital *(Evidence from the Dementia Care Pathway, National Collaborating Centre for Mental Health, 2018).*

The aims of the ICS detailed in the Staffordshire and Stoke-on-Trent ICS Designation Development Plan [see Appendix 2], published in December 2020, include for mental health:

- Strong crisis response integrated into community-based offer.
- Community transformation programme with all partners.

This vision, coupled with the national context for mental health described in Section three which also emphasises shifting from a bed-based model to a community-based model (see below), is the strategic backdrop to the proposals for the future of inpatient mental health services previously provided at the George Bryan Centre. The figure below shows MPFT's model for mental health services:

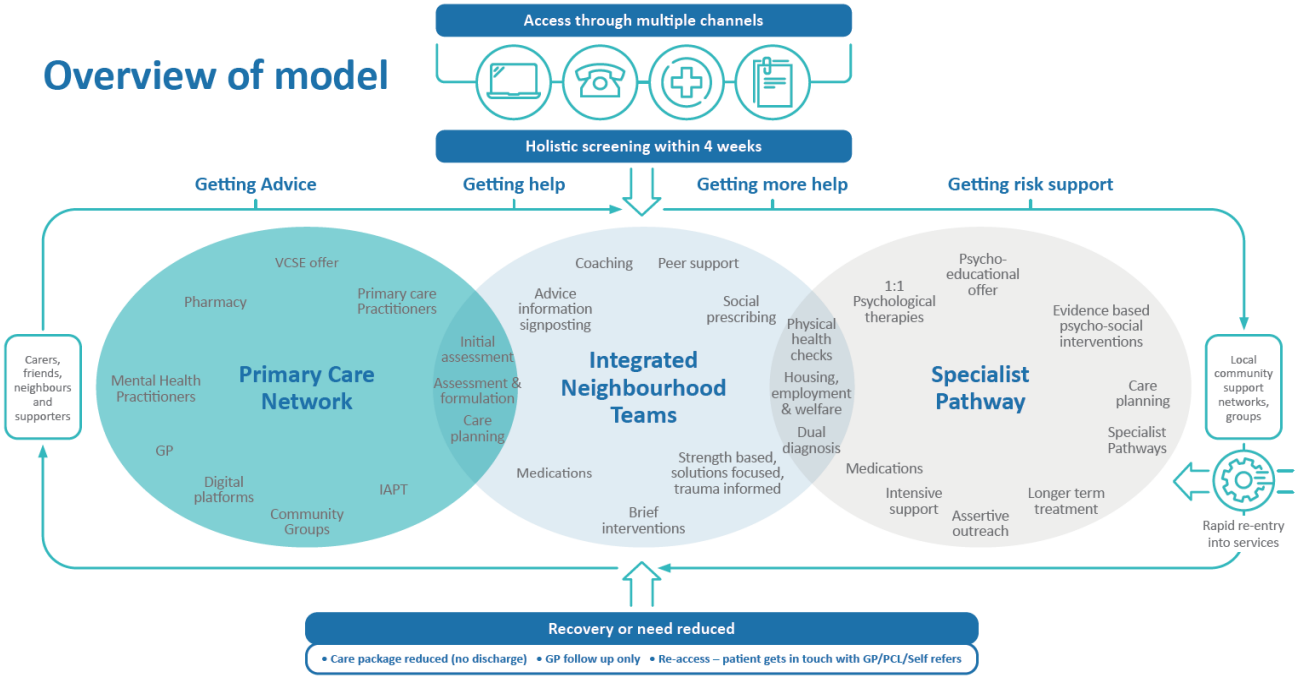


Figure 2 MPFT's model for mental health service

Designed and delivered in partnership with service users, carers, public and the voluntary and community sector, these enhanced community services support adults with severe mental illness and older adults with severe mental illness and dementia to remain well and provide intensive intervention and support at times of need to help service users avoid the need to be admitted to hospital.

For those patients who may require an inpatient stay, the strengths of St George's Hospital in terms of staffing levels, range of specialisms, interventions and therapies means that patients have as short a stay as possible before being discharged with support wrapped around them via the community teams.

To support this model of care, the workforce model has been developed to ensure we use our staff appropriately, have a wide skill mix from different professions, and can ensure staff and patient safety.

Inpatient services for adults experiencing severe mental illness across south east Staffordshire have in recent years been provided from two locations:

- **St George's Hospital** in Stafford, providing inpatient accommodation for up to 168 people and a range of specialist assessment and treatment services for adults and older adults experiencing severe mental illness and dementia, psychiatric intensive care for adult men, perinatal, eating disorders, and forensic psychiatry.
- **The George Bryan Centre**, just outside Tamworth, providing inpatient services for the people of Tamworth, Lichfield, Burton upon Trent and surrounding areas. Its two wards provided assessment and treatment services for up to 31 adults and older adults with severe mental illness and dementia, including mood disorders, psychosis, anxiety and depression. This facility did not admit high acuity (very

seriously ill) patients. The need to enhance services for people experiencing mental illness has long been recognised by health and care system leaders in Staffordshire and Stoke-on-Trent.

On 12 February 2019, a fire destroyed the West Wing of the George Bryan Centre. The 19 patients from the West Wing were moved to St George's Hospital. Following the fire, an assessment was made about the safety of the East Wing. As a result, MPFT decided it was necessary to close the East Wing temporarily on safety grounds. The ward was closed to new admissions immediately and the patients on the ward were discharged as appropriate over the next few weeks.

At the time of the fire, the transformation of community mental health services in line with national guidance had begun. An enhanced community model was already in place to care for patients with dementia.

Following the fire, plans for enhanced community services were accelerated. A new pathway to support older adults with severe mental illness such as depression, anxiety and psychosis and a new community-based team was put in place to support those who had been inpatients in the East Wing along with the existing team for those with dementia. Plans to upgrade and extend contingency accommodation at St George's Hospital approved in 2018 and paused in response to system winter pressures were revised and implemented. The building work was completed in July 2021.

The current position continues with the arrangements described above. The adults (aged 18 plus) with severe mental illness who would previously have been admitted to the George Bryan Centre are currently admitted to St George's Hospital.

Older adults (aged 65 plus) with severe mental illness or dementia who would have been admitted to the East Wing continue to be cared for by the community team and are only admitted to a hospital or nursing/care home if they are no longer safe to remain in their usual place of residence. The ICB and MPFT continue to review and develop service provision with the implementation of the community mental health services transformation programme.

Further details can be found in Section three.

Clinical sustainability case for change

A strong driver for the consideration of proposals is that community mental health services in south Staffordshire have been transformed over the past four years.

This aligns community mental health services in south Staffordshire with the national mental health strategy to support patients better by caring for them in the community as much as possible, with inpatient stays only where there is no alternative.

The case for change for inpatient services provided to adults with severe mental illness

Since the fire at the George Bryan Centre in February 2019, the patients from south east Staffordshire who need to be admitted to hospital for assessment or treatment have, with few exceptions, been admitted to wards at St George's Hospital, Stafford.

Between 2017 and 2019, the average length of stay for patients in the George Bryan Centre by ward was 30.62 days and by total admission 48.44 days. Since the fire, when acute inpatients moved to St George's Hospital, the average length of stay for those in acute wards has fallen to 22.94 by ward and 42.18 by admission. The number of beds required is assessed on a regular basis by a centralised bed manager at St George's Hospital.

The inpatient services for adults with severe mental illness are supported by a comprehensive community service which helps to keep the length of stay to a minimum. The reduced length of stay illustrates that this is a successful approach.

The size of the St George's Hospital site enables a much greater range of specialist services than the George Bryan Centre was able to offer, including electroconvulsive therapy (ECT). Allied health professionals (AHPs) providing services such as art and music therapy or occupational therapy are able to work across several wards, which is a more efficient use of their time and expertise than at a smaller unit such as the George Bryan Centre. Moreover, patients often needed to travel to St George's Hospital to receive therapy when they were inpatients at the George Bryan Centre.

George Bryan Centre patients whose condition deteriorated needed to be transferred to St George's Hospital. The centre's distance from St George's Hospital made responding to psychiatric emergencies difficult. Transfers could take up to six hours because of the need for secure travel.

The relative isolation of the George Bryan Centre could have implications for staff safety and would have implications for recruitment.

In terms of clinical quality and safety, therefore, as described the location and facilities at St George's Hospital provide a better opportunity for the optimum care and treatment of inpatients with severe mental illness.

It should be noted that some visitors may now need to travel further to St George's Hospital than they did to visit patients in the George Bryan Centre.

The case for change for older adults with severe mental illness or dementia

Following the fire that destroyed the West Wing at George Bryan Centre the care of the patients who would have occupied the beds in the East Wing transferred to a community-based model.

A team was already in place for older adults with dementia, providing multi-disciplinary support to people with dementia and their carers who are affected by complex and challenging needs.

A team for older adults with severe mental illness was put in place including:

- Enhanced crisis home treatment with skilled, experienced older adult specialists.
- Addition of a nursing/therapy lead.
- New clinical psychologist to focus on older adults.
- A training plan for the team.

There is a Hospital Avoidance Team (HAT) and wider community support as described earlier.

There is clear evidence that providing care to older adults through community teams produces better outcomes. National and local policy and research evidence indicate that this is a better method of supporting this cohort than admission to hospital and this has been taken into consideration when deciding on the final proposal for the future of the services. This evidence includes:

- NICE guidance (NG97[1], 2018) states that, when admission to hospital is considered for a person living with dementia, the value of keeping them in a familiar environment should be considered.
- National Collaborating Centre for Mental Health (2018) Guidance on the Dementia Care Pathway[2] notes that hospital admissions can exacerbate symptoms of dementia, permanently reduce independence, and increase the likelihood of discharge to residential care and re-admission to hospital. Necessary admissions should be as brief as possible to minimise adverse consequences of hospitalisation.
- The Health Evidence Network (part of the World Health Organisation in Europe) synthesis report on the effectiveness of old-age mental health services[3] states that overall, the strongest evidence supports the development of community multi-disciplinary teams as a major service-delivery component.

Further details can be found in Section three.

The workforce case for change

The key points regarding workforce planning and considerations underpinning the pre-consultation business case are:

- A shortage of appropriate staff and the particular difficulties of recruiting to small, isolated units and the associated costs of providing agency staff.
- The safety considerations which could mean an augmented workforce for a separate unit, at additional cost.
- The limited therapies that would be available at a small, standalone unit, with a limit to interventions as a result.
- The greater sustainability of the bed model on a larger site.
- The leadership of the community teams spans both older adults with severe mental illness and those with dementia, and this is more sustainable than working separately.

Further details can be found in Section four.

[1] Dementia: assessment, management and support for people living with dementia and their carers, NICE guideline NG97, 2018

[2] Guidance on the Dementia Care Pathway, National Collaborating Centre for Mental Health, 2018

[3] What is the effectiveness of old-age mental health services?, Health Evidence Network, 2004

The safer staffing case for change

MPFT operates a system using the Mental Health Optimal Staffing Tool (MHOST) to calculate safe levels of staffing. Using this system, the Trust has calculated the staffing that would be needed for the two options of either centralising beds at St George's Hospital in Stafford or reinstating the beds at the George Bryan Centre.

The calculation shows that to meet safer staffing requirements, 46.2 whole time equivalent (WTE) staff would be required to reinstate inpatient services at the George Bryan Centre as a standalone site. The community team currently supporting patients who would previously have been cared for at the George Bryan Centre is 20 WTE strong. Reinstating inpatient services at the George Bryan Centre for adults experiencing severe mental illness would require 9.9% (16.6 WTE) more staff than centralising beds at St George's Hospital, Stafford.

Recruitment to mental health posts is under pressure throughout the country, and staff are reluctant to work in small, isolated units. Creating a new standalone facility alongside the beds centralised at St George's Hospital and the increased community posts would involve staffing pressure at a time when recruitment is difficult, particularly into isolated facilities.

Further details can be found in Section four.

The financial case for change

Financial analysis provides assurance that the proposed model is sustainable within the overall financial plan for MPFT and commissioners, and continues to offer better value than reverting to the legacy arrangements.

Calculations from a baseline of the cost of running the George Bryan Centre up to the time of the fire, including extrapolating the cost to the present day, have shown that the cost of providing support in the community for older adults who were previously inpatients together with the cost of centralised inpatient beds for adults with severe mental illness is slightly less than the cost of running the George Bryan Centre.

The cost of rebuilding the George Bryan Centre to current standards is calculated as £11.5 million.

This should be considered alongside the clinical advantages of providing more care in community and home settings, as described in this business case.

Further details can be found in Section five.

Patient and public involvement

Patient and public involvement is a priority for Midlands Partnership NHS Foundation Trust and NHS commissioners in Staffordshire and Stoke-on-Trent. Patients, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of mental health services in south east Staffordshire from the outset.

In June 2019 Staffordshire and Stoke-on-Trent health and care system published its Case for Change[1] document as part of its service transformation plan for services across the area. The Case for Change included mental health services. From June to August 2019 system partners conducted a patient and public listening exercise on the document to gather and report feedback on those services.

In addition to the listening exercise, MPFT involved patients, families, carers, and other local people and stakeholders in a series of events in autumn and winter 2019/20 specifically looking at the experience of inpatient mental health services following the fire at the George Bryan Centre.

COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent, and to a pause in specific plans for mental health inpatient services in south east Staffordshire.

In 2021 there was once again scope to look at developments in health services, following the initial pressures of COVID-19. In October 2021, a listening exercise was held to sense-check previous engagement about inpatient mental health services in south east Staffordshire, and the proposals for the future were once again considered.

Staff had opportunities to complete surveys and attend meetings and clinicians were involved in a Clinical Advisory Group (CAG) and in the proposal development process.

Further details can be found in Section six.

Proposal development process

Staffordshire and Stoke-on-Trent NHS ICB have worked closely with MPFT throughout the process of developing and evaluating the proposals.

An options appraisal process commenced in autumn 2019. A series of technical events were held which included the involvement of clinicians and stakeholders. At each stage of the process the reports of findings from the patient and public involvement stages were taken into due consideration and any new or emerging findings were taken into account. A series of hurdle criteria were used to test the proposals under consideration.

Two proposals were carried through the majority of the process. The technical session in December 2021 reviewed feedback from the sense-check involvement exercise, and evidence regarding sustainability of workforce and safer staffing requirements. The outcome of this final stage of the proposal development process is that the evaluators believe only one of these proposals will deliver the standard of care required for local people:

- Centralisation of inpatient beds in St George's Hospital, Stafford together with the transformed community offer, across the MPFT footprint in south Staffordshire. This community offer has two elements – one enhanced offer for people with severe mental illness and one for the older population with severe mental illness or dementia.

1 Case for Change, Together We're Better, 2019

The impact of approving this proposal would be that inpatient mental health services would not be reinstated at the George Bryan Centre just outside Tamworth in the Lichfield District Council area. These services have been suspended since spring 2019 after a fire destroyed part of the unit.

Consideration of the future of the George Bryan Centre building and site will follow a decision about the future of these inpatient services and is not in the scope of this pre-consultation business case.

Further details can be found in Section seven.

Evaluation of clinical model and proposal by West Midlands Clinical Senate

The clinical model that is outlined within the pre-consultation business case has been independently reviewed by the West Midlands Clinical Senate (WMCS). A copy of the report can be found at Midlands Clinical Senates - Clinical Reviews - Recent. The programme team is satisfied that the proposal meets the Government's four tests applied to service change, and in addition, NHS England and NHS Improvement's (NHSEI) Patient Care (bed closure) Test.

A full Quality Impact Assessment [Appendix 15] and an Equality Impact Assessment are in place.

MPFT uses a range of qualitative and quantitative methods to measure the quality of care.

A key factor in the proposal is that people from some areas of Staffordshire would now need to travel further to visit patients in St George's Hospital. A travel analysis has been undertaken to understand the full impact of this and the pre-consultation business case outlines proposals to support carers in maintaining contact with their loved ones during an inpatient stay.

The situation with regard to the George Bryan Centre is unusual in that because of the need to find a rapid solution following the fire, and because of the pause in all but core services created by the COVID-19 pandemic, the services described have been implemented and delivered in this new way for nearly three years.

It is therefore clear that they are deliverable.

Further details can be found in Section eight.

Governance

Full details of the governance arrangements for this process have been included in Section nine. The timeline for signing off the pre-consultation business case has been as follows:

Date (2022)	Committee/Board
10 June	West Midlands Clinical Senate
23 June	ICS Mental Health Programme Board
28 June	MPFT Major Transactions Committee
30 June	MPFT Board

1 Aug	Staffordshire Health and Care Overview and Scrutiny Committee
18 Aug	Integrated Care Board
21 Sept	Informal NHSE Assurance
17 Oct	Staffordshire Health Overview and Scrutiny Committee
30 Nov	NHSE Assurance

There will be continued liaison with the Staffordshire Health and Care Overview and Scrutiny Committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

If the Scrutiny Committee recommends further involvement, the ICB will decide what further appropriate public involvement is needed. This pre-consultation business case will be updated to reflect the outputs of that involvement activity and be presented to the Board of MPFT and the Integrated Care Board for consideration and decision.

A risk register for the programme is in place, with appropriate mitigations.

A draft plan for any further patient and public involvement or consultation has been developed. Details can be found at Section 9.4.

3 The strategic case for change

3.1 Introduction

This section sets out the case for change which would mean permanently providing for adults with severe mental illness and older adults with severe mental illness or dementia enhanced community services supported by the inpatient services on a single site: St George's Hospital, Stafford.

It includes:

- National policy
- Local policy
- The operational case for change including:
    - the case for change for adults with severe mental illness
    - the case for change for older adults with severe mental illness or dementia

3.2 National policy

3.2.1 Long Term Plan

The NHS Long Term Plan[1] (LTP), formerly known as the 10-year plan, was published in 2019 setting out key ambitions for the NHS over the following 10 years until 2029. It sets out mental health as a priority.

The LTP builds on the policy platform laid out in the NHS Five Year Forward View[2] (published March 2017) which articulated the need to integrate care to meet the needs of a changing population.

In terms of the wider workforce implications of the LTP, the coming years will require imaginative approaches to workforce solutions and the development of new and different roles rather than traditional approaches to provide greater workforce mobility and flexibility. The NHS People Plan[3] was published in June 2020 and sets out guidelines for employers and systems and outlines behaviours and actions that staff can expect from leaders and colleagues. This forms the background to the recruitment policies for those working in MPFT, including those working with inpatients with severe mental illness or dementia.

Severe mental illness and changing care

The LTP described how the life expectancy of people with severe mental illnesses can be up to 20 years less than the general population. Investment in these services forms a major part of the LTP.

[1] NHS Long Term Plan, 2019

[2] NHS Five Year Forward View, March 2017

[3] NHS People Plan, June 2020

The way in which these services are delivered is now changing. The NHS England website states that *"Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible*'[1].

The Five Year Forward View for mental health, published in 2016, stated:

> *"By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission[2]."*

The COVID-19 pandemic slowed the implementation of this aim, but the ambition for community-based services is at the heart of the planning for the future of these services in south east Staffordshire, including the services previously delivered at the George Bryan Centre.

With regard to inpatient beds, the LTP sets out:

> *"By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission."*
>
> *"For people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. Purposeful, patient-orientated and recovery-focused care is the goal from the outset. Units operating beyond capacity may struggle to offer such care and cannot admit new patients, who are then looked after further away from home or in non-specialist settings. The recent Crisp Commission highlighted a wide variation in the quality and capability of these acute mental health units across the country. The Five Year Forward View for Mental Health programme is working to eliminate inappropriate out of area placements for non-specialist acute care by 2021. We will work with those units with a long length of stay and look to bring the typical length of stay in these units to the national average of 32 days. This will contribute to ending acute out of area placements by 2021, allowing patients to remain in their local area – maintaining relationships with family, carers and friends. In addition, as recommended by Professor Sir Simon Wessely's Mental Health Act review, capital investment from the forthcoming Spending Review will be needed to upgrade the physical environment for inpatient psychiatric care."*

Care for older adults experiencing a severe mental illness or dementia

The NHS England website states "*Generally, someone over the age of 65 might be considered an older person". '*Older adults' is the term normally used for the people over 65 cared for at the George Bryan Centre.

[1] NHS Community mental health services

[2] The Five Year Forward View for Mental Health, Feb 2016

With regard to the adults (aged 18 plus) experiencing severe mental illness and to older adults (over 65 with severe mental illness or dementia) treated at the George Bryan Centre, the LTP includes this recommendation:

> *"New and integrated models of primary and community mental health care will support adults and older adults with severe mental illness. A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. This includes maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities.*
>
> *Local areas will be supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks. By 2023/24, new models of care, underpinned by improved information sharing, will give 370,000 adults and older adults greater choice and control over their care, and support them to live well in their communities."*

The original plan in the LTP was that by 2023/24, funding for primary and community care would be at least £4.5 billion higher than in 2019/20.

The LTP's commitment to developing *"fully integrated community-based health care"* involves developing multi-disciplinary teams, including GPs, pharmacists, district nurses, and allied health professionals working across primary care and hospital sites. The original plan was that five years following 2019, all parts of the country would be required to increase capacity in these teams so that crisis response services can meet response times set out in guidelines by the National Institute for Health and Care Excellence (NICE). Access to social prescribing would be extended, and the original aim was that more than 1,000 trained link workers would be in place by the end of 2020/21.

The mental health system

As with primary and community services, the LTP reasserted the commitment to improving mental health services, both for adults and for children and young people. The original plan was for mental health funding to outstrip total NHS spending growth in each year between 2019/20 and 2023/24 so that by the end of the period, mental health investment would be at least £2.3 billion higher in real terms.

In adult services the LTP extended the commitments in the Five Year Forward View for mental health beyond 2020/21 to 2023/24, to create a more comprehensive service system - particularly for those seeking help in crisis - with a single point of access for adults and children and 24/7 support with appropriate responses across NHS 111, ambulance and A&E services. It also highlighted the need for capital investment (as identified by the 2017 review of the Mental Health Act[1], and the government's response in 2021) to ensure suitable therapeutic environments for inpatients.

The LTP contained significant commitments to developing new models of care.

[1] Review of the Mental Health Act, 2017

Although many aspects of the implementation of the LTP paused with the advent of COVID-19 the essential plan remains the same and underpins local planning in Staffordshire and Stoke-on-Trent.

3.2.2 National standards and aims

Following on from the LTP, the Community Mental Health Framework[1] published in September 2019 by the National Collaborating Centre for Mental Health emphasised the modernisation of place-based community mental health services, stating that:

> *"This Framework… sets out how the vision for a new place-based community mental health model can be realised, and how we can modernise community mental health services to shift to whole person, whole population health approaches. In particular, we want to drive a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care "thresholds"."*

The Framework also stated:

> *"Additional 2019/20 CCG [Clinical Commissioning Groups] baseline funding must be used to "stabilise and bolster core adult and older adult community mental health teams and services for people with the most complex needs". Alongside this, preparatory work needs to be undertaken "for the mobilisation of a new integrated primary and community model"."*

These two areas of mental healthcare are the focus of this pre-consultation business case.

The 2017 review of the Mental Health Act and the government's White Paper response to the review in 2021[2] contains changes to mental healthcare aiming to make sure that:

- People are detained for shorter periods of time, and only detained when absolutely necessary.
- When someone is detained the care and treatment they get is focused on supporting their recovery.
- People have more choice and autonomy about their treatment.
- Everyone is treated equally and fairly and disparities experienced by people from black and minority ethnic backgrounds are tackled.
- People with a learning disability and autistic people are treated better in law and reduce the reliance on specialist inpatient services for this group of people.

The Royal College of Psychiatrists' Core Standards for Mental Health[3] lay out best practice for mental healthcare. They are used by the clinical audits, quality networks and accreditation programmes within the College Centre for Quality Improvement (CCQI).

[1] Community Mental Health Framework, Sept 2019

[2] Government's White Paper response to the review, in 2021

[3] Royal College of Psychiatrists' Core Standards for Mental Health, 2019

These standards provide key guidance about how mental healthcare is provided and organised, including the best type of environments for care.

Already, in line with the aims set out in the LTP, national best practice in mental health has shifted from a bed-based model to a community-based model. Staffordshire and Stoke-on-Trent have secured funding to continue implementing this national model, locally. Their transformation plans for mental health reflect this.

Taken from the outline of 3-year delivery plan – Community Mental Health Transformation Framework					
	2019/2020	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Transformation Programme provisional 'fair shares' transformation funding allocation as per Analytical Tool (non-cumulative)	n/a	n/a	£2,170,703	£5,281,898	£6,534,610

Table 1 Funding for the Community Mental Health Transformation Framework

3.3 The Staffordshire context

The Staffordshire and Stoke-on-Trent Together We're Better Integrated Care System (ICS) in 2019 developed a draft Case for Change which included mental health. They presented this to NHS England for stage 1 assurance prior to an engagement process and options appraisal.

NHS England's response stated:

> *"The panel concluded that we generally supported the direction of travel that you have presented to us. The challenges across the system are significant and will require strategic, clinically led redesign of provision to address both operational and workforce challenges.*
>
> *Due to the scale of the change required and that some areas of your proposals are under-developed we will hold a further informal check point meeting following completion of your engagement exercise and development of your model of care."*

In August 2019 the TWB Case for Change[1] was published setting out the challenges for healthcare across Staffordshire and Stoke-on-Trent and explaining the local vision for a future clinical model.

Relating to mental health, the Case for Change specified:

> *"Enhanced primary care and community services, aiming for continuity of care pathways which will be improved by working alongside social care and the voluntary sector*
>
> *We are supporting care that provides integrated mental and physical health services within the community."*

[1] Case for Change, Together We're Better, 2019

3.3.1 ICS Designation Development Plan

In December 2020 the ICS published the Staffordshire and Stoke-on-Trent ICS Designation Development Plan [see Appendix 2].

The ICS development plan says:

> *"The majority of the objectives of the LTP and our Five Year Delivery Plan (FYDP) remain as valid now as when first written, but Covid-19 has highlighted the urgency with which we should take action, and the need to focus on working as a system to make rapid change to improve services…"*
>
> *"For residents, greater integration would allow people to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations we can take big decisions around how and where care is delivered to make the most impact. This could include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible."*

The vision described in the plan is:

> *"To make Staffordshire and Stoke-on-Trent the healthiest places to live and work".*

The plan goes on:

> *"This means:*
>
> *1. Helping our population live well, for longer, and supporting you to be as independent as possible so we can be there when you need us.*
>
> *2. Delivering care as close to home as possible, ensuring that experience of health and care is the best it can be.*
>
> *3. Treating people rather than conditions and giving mental health equal priority to physical health.*
>
> *The aims are to:*
>
> *1. Promote prevention strategies and empower people for self-care and shared decision making.*
>
> *2. Co-ordinate and integrate care, with early intervention and step-down possible where appropriate and greater use of digital technologies.*
>
> *3. Reduce unwarranted clinical variation, through providing evidence-based, effective care and using our workforce in the best way."*

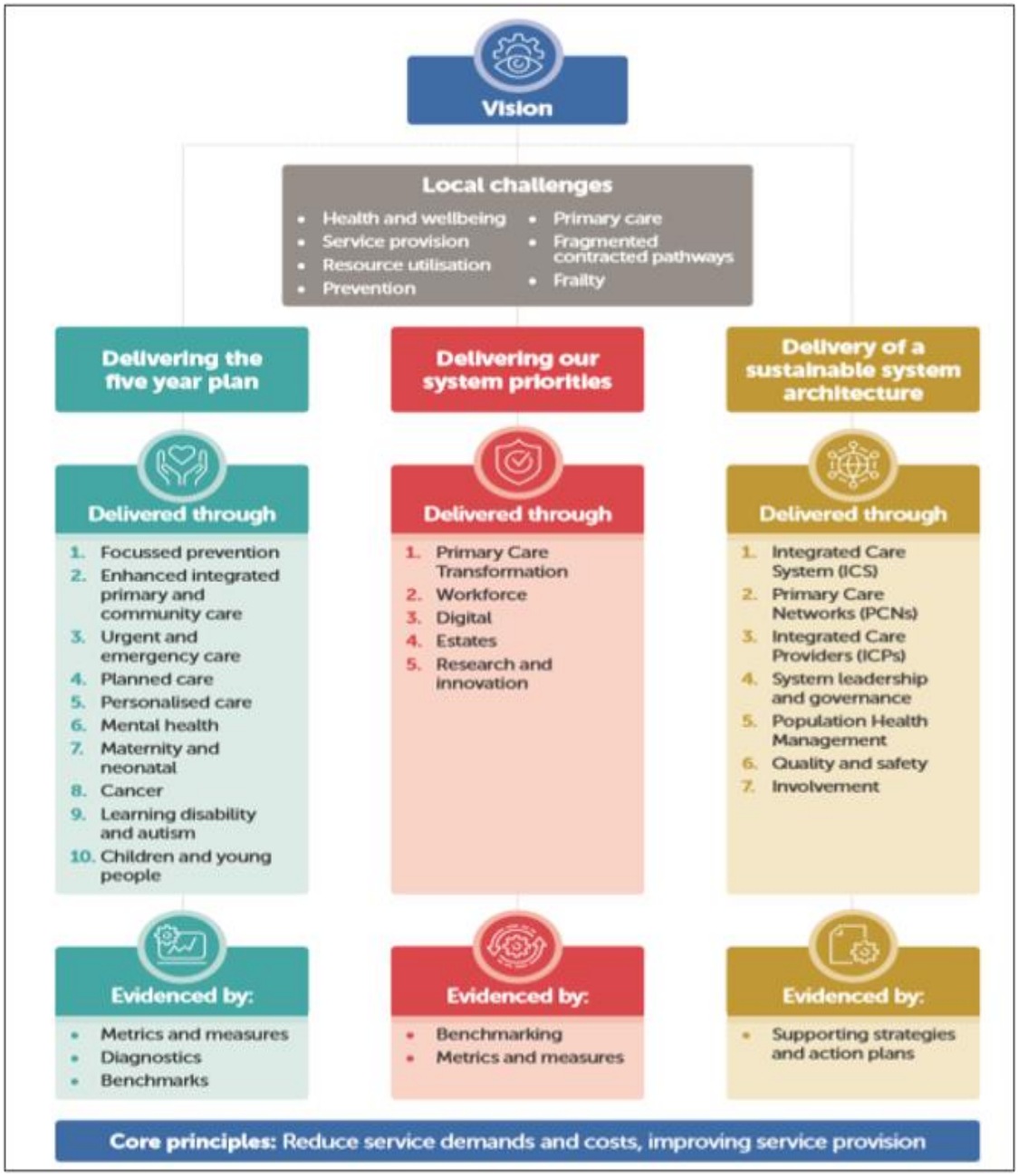


Figure 3 Strategic framework from the Staffordshire and Stoke-on-Trent ICS Designation Development Plan

The ICS Development Plan is aligned to the ICS's Five-Year Delivery Plan that continues to pursue the ambition to make Staffordshire and Stoke-on-Trent the healthiest places to live and work. This includes the following bullet points relating to mental health:

- *Treating people rather than conditions and giving mental health equal priority to physical health*
- *Providers and commissioners working collaboratively across primary, community and mental health services, including health and care professionals and the voluntary and independent sector to promote behavioural change and deliver service transformation – co-ordinated by Integrated Care Partnerships*

- *Setting clear aims and outcomes for our clinical models of care, aligning with a strength-based social care model, which will continue to evolve as we listen to our public*
- *Delivering increased value in everything that we do with a focus on the sustainability of our health and care system*

3.3.2 ICS Mental Health Transformation

Across Staffordshire and Stoke-on-Trent we have strong collaborative relationships between public sector bodies around Mental Health, this was underpinned by the strategy '*Mental Health is Everybody's Business*' that was in place with the former 6 CCG's.

That strategy set out our commitment to ensure that through greater integration we will enable positive behaviour and support for people with Mental Health needs, who need it most, whilst helping people to remain independent. And that we want our communities to be able to; Stay in control of their lives; Access high quality services when they need them; and Receive care which is focused on recovery and independence.

As the strategy matured over time a number of NHS key policy drivers have been issued and as a new ICB we continue to work alongside our Local Authority partners to refresh our strategic direction and recognise and celebrate our achievements to date.

Most recently the NHS Long Term Plan renewed the commitment to pursue the most ambitious transformation of mental health care England has ever known. The subsequent publication of the Mental Health Implementation Plan[1] (2019) provides the new framework to ensure delivery of this commitment and the detail of what this means for us at a local level in Staffordshire and Stoke-on-Trent.

The national commitment, which will support local delivery of improved mental health services, is strong. Funding is being ring fenced, the deliverables for improved services set out up to 2023/24 are clear and in many cases mandated. Systems such as our own are measured against progress and NHS organisations regulated in accordance with this. The Staffordshire and Stoke-on-Trent ICB is therefore committed to delivering in line with the Implementation Plan and therefore developed our local response jointly by commissioners, the two major NHS Mental Health Trusts and most importantly our service user and carer advocates. The document sets out the key priorities and deliverables of the plan in the context of the local ICS environment, existing service delivery and the financial envelopes available and is the work plan of the Mental Health Programme Board.

The vision of the ICS for mental health has not changed and will not change with the recent publications and refresh of our ambitions. The vision will remain the central tenet of our programme as it moves forward to 2024 and beyond, implementing improvements to services set out in the plan. Older people, adults, young people and children in Staffordshire and Stoke-on-Trent will feel supported whether they find themselves in need of help, in crisis or to maintain their day-to-day mental health and wellbeing. We will work in an integrated and collaborative way to ensure their mental health is given equal priority

[1] NHS Mental Health Implementation Plan 2019/20 – 2023/24, July 2019

to their physical health needs and people receive the help and support they need closer to home and family.

The Mental Health Programme Board provides the strategic direction for development of mental health services and ensures that the deliverables as outlined in the Mental Health Implementation Plan are achieved across the whole ICS on time and in a cost-effective manner. Strategic leadership, partnership engagement and assurance is delivered through the Programme Board and wider project structures, ensuring the priorities set out in the NHS Long Term Plan are realised. Assurance is provided as and when required to regulators and external partners that the Staffordshire and Stoke-on-Trent system delivers the requirements laid out in the national plan.

The business case was agreed by the ICS Mental Health Programme Board as part of the governance process to determine strategic fit and alignment across all system partners.

3.3.3 COVID-19

The COVID-19 pandemic has led to widespread review of services. The ICS Designation Development Plan highlights the lessons learned from COVID-19

> *"Covid-19 has undoubtedly been one of the greatest challenges the system has faced. Against that back drop there is a constant theme of collective pride in the responsive action which was mobilised and in the many specific improvements and innovations across health and care. We acknowledge the lives lost or damage experienced across our population and amongst public servants and that further strengthens our resolve to make our local health system the very best it can be for the population that we serve. Together we have a collective determination to learn from the experience so that improvements can be made in the future management of Covid-19 or learning embedded into mainstream practice."*

The learning points include:

> *"The availability of co-ordinated data around population health and health inequalities has been shown even more starkly. We have to prioritise this over the coming months and use intelligence to direct our efforts"*

and this also helps to describe the strategic context.

The Health Foundation published *'Emerging evidence on COVID-19's impact on mental health and health inequalities*'[1] in June 2020. Already at this stage there was evidence that the pandemic was having a negative impact on people's mental health, with particular impact on those living with health inequalities, and those with a diagnosed mental illness.

A slide presentation given by MPFT to Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) [see Appendix 3] on 19 October 2021 forecasting future impacts of mental health due to COVID-19 looked at potential changes in mental health condition

[1] Emerging evidence on COVID-19's impact on mental health and health inequalities - The Health Foundation, June 2020

prevalence for the general adult population in Staffordshire and Stoke-on-Trent ICP and said:

> *"We have created a set of assumptions to model prevalence for Anxiety and Depression generated by the pandemic in the SSOT [Staffordshire and Stoke-on-Trent] general adult population. This has been done using evidence from past viral epidemics, and emerging evidence from the current pandemic.*
>
> *"The assumptions suggest that there will be a significant increase in adults with anxiety and depression in Staffordshire & Stoke-on-Trent, however it is unclear how many and when these patients will present to mental health services. They also show significant potential relapses for known Psychosis patients."*

In response to evidence like this, the ICS Designation Development Plan states under the heading *Health Inequalities and Prevention*:

> *"The Five Year Delivery Plan outlined the ambitions and priorities to work collaboratively to increase the scale and pace of progress of reducing health inequalities. This now includes protecting the most vulnerable from Covid-19, with our system Phase 3 recovery plan setting out a clear commitment to tackling inequalities. The work programme identified and PHM (Population Health Management) approach will support ensuring that inequalities are mainstream activity, core to, and not peripheral to, our work across the system".*

In terms of delivery priorities, the plan states about mental health:

- *Strong crisis response integrated into community based offer.*
- *Community transformation programme with all partners.*

3.4 Clinical sustainability case for change

3.4.1 MPFT context

Mental health services in Staffordshire and Stoke-on-Trent are provided by Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHC).

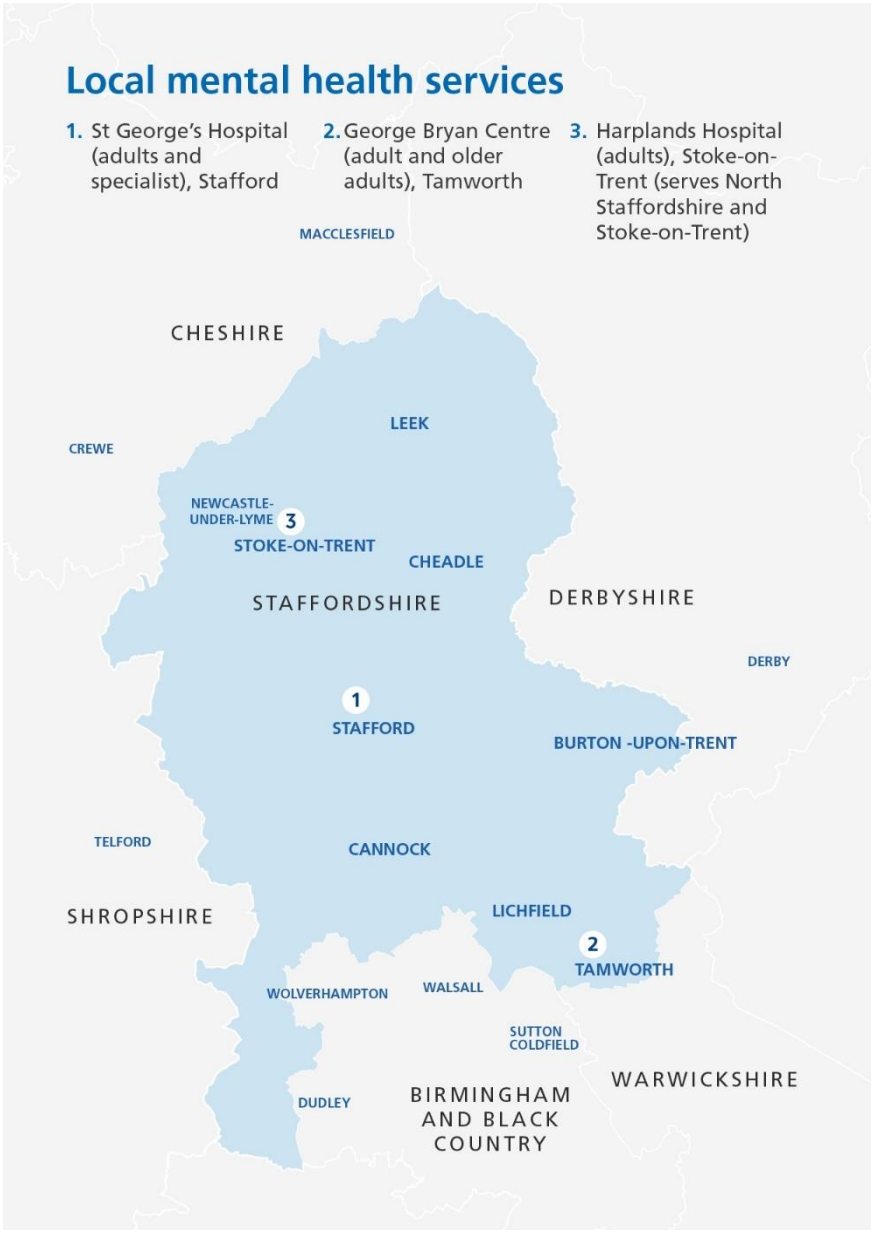


Figure 4 Care provided across the whole of the Staffordshire and Stoke-on-Trent system

The figure above shows the mental health care provided across the whole of the Staffordshire and Stoke-on-Trent system. In the figure, '1' refers to St George's Hospital, Stafford and '2' refers to the George Bryan Centre. Both serve south Staffordshire. '3' refers to the mental healthcare provided at Harplands Hospital, Stoke-on-Trent, which serves north Staffordshire and Stoke-on-Trent.

For the purposes of the pre-consultation business case North Staffordshire Combined Healthcare NHS Trust is not included in the scope. The information below relates to mental health services provided by MPFT.

The mental health outcomes the NHS commissions for are detailed at Appendices 5a to 5i.

The NHS Benchmarking Network report from November 2021 [see Appendix 4] compares MPFT's services for the Staffordshire area with other mental health trusts across the UK. Data are presented per 100,000 weighted population.

This indicates that MPFT has a low number of older adult beds, in line with the national direction of travel, as inpatient capacity for older adults from this report is the smallest since the benchmarking project began. MPFT also has low length of stay. Re-admissions, as a percentage of overall admissions, are average compared to the rest of the UK, an indicator that the move to community-based care is working well in Staffordshire. Data for older adults demonstrates how Staffordshire has, more quickly than average, moved care away from inpatient beds and into the community.

The two key measures of how well community capacity is managed are caseload and contacts. MPFT's total community caseload is above the UK average, as are their contacts. MPFT also demonstrate strong performance for post-discharge follow ups. Whilst this benchmarking data is from 2021, MPFT and the clinical teams review clinical caseloads and the management of risk versus workforce on a regular basis.

Due to the dynamic nature of the way the different teams work together and balance risk, MPFT does not have a waiting list for inpatient mental health beds or for patients in crisis to be supported in the community.

3.4.2 Community mental health transformation for Staffordshire and Stoke-on-Trent

Since 2018 MPFT, which delivers mental health care including the services at the George Bryan Centre, has been working with existing service users, carers and staff to find a way to realise locally the national vision for the place-based community mental health model. Overall, the Trust's work has resulted in an enhanced model which fits with the wider model for TWB and will be refined over the next three years.

The vision is that the Trust works with the integrated care system in Staffordshire and Stoke-on-Trent to create mental health services that are inclusive, accessible, that value people as they are and are responsive to their needs.

This will embrace innovation and new ways of working to remove traditional barriers, improve communication and training, and provide personalised support that enables people to live well and realise their full potential.

The guiding principles are:

- To improve and simplify access to care.
- To use a Trusted Assessor Model so patients don't have to re-tell their story every time.
- To have one digital plan which all services can access and update.
- For patients to have a named worker.
- To provide flexible and personalised care that meet patients' needs.
- To provide safe services for patients, their carers and staff.
- For all partners to work closely together to join-up their services.

- To support patients' physical health needs.

MPFT's Care Group Business Plan for 2020-2022 includes the following plan for adult mental health services:

Adult mental health			
Improving population health	**Collaboration (Proactive approach to partnership working)**	**A culture of continuous improvement**	**Deliver the day job**
1)	1)	1)	1)
Implementing ambitions of the Long Term Plan (LTP) for mental health linked to local population health needs	Developing a new community-based offer to people with mental health problems in line with LTP	Deploy Quality Improvement to deliver LTP objectives across all services	Promoting the benefit of mental health outcomes within the Care Group particularly around Primary Care Networks and Information and Communication Technologies (ICTs), and linked to Trust Wide governance
2)	2)	2)	2)
Provide a more proactive approach in the services provided to support the move to 'population health management' through early intervention and the promotion of wellbeing and recovery through self management	Expansion in the Improving Access to Psychological Therapies (IAPT) programme, particularly for people with long-term physical conditions	Embed quality roles across all teams to support innovation and continuous improvement	Delivery of all Key Performance Indicators (KPIs) and outcome metrics aligned to the ambitions in the Long Term Plan
3)	3)	3)	3)
	Building on the expansion of the current crisis care models including pathways within urgent care system	Embed supervision processes across all professional groups	

Once again we can see here an emphasis on community-based care in line with the Long Term Plan and national best practice approaches.

3.4.3 Working with partners to deliver the model

As well as developing community services for adults and older adults with severe mental illness or dementia, and providing crisis hubs for those experiencing crisis, other community-based mental health services have been developing in parallel, all reinforcing the move from bed-based to community-based care.

The Staffordshire and Stoke-on-Trent Community Mental Health Transformation Model (in Figure 2 above) creates a framework for supporting people in the community as much as possible, in line with national policy.

The model involves partnership between council providers, NHS providers, and Primary Care Networks (PCNs), with involvement from the voluntary care sector.

Within the three-year programme there are various initiatives supporting people with severe mental illness including early intervention for people with psychosis.

Crisis care and crisis café service

The crisis café proposal has changed since the original business case following a review of need across the area, and the opportunity for additional capital money has provided for the system. The crisis café will now be located in the Tamworth area. A crisis café is a safe, welcoming place where people with mental health needs can go outside of A&E or other urgent services if they are feeling emotionally distressed or are in a mental health crisis, particularly outside of normal working hours.

The benefits of the community-based crisis support are:

- Reduction in the number of Section 136 assessments.
- Reduction in the number of unnecessary mental health emergency department (ED) attendances.
- Reduction in the number of mental health presentations to the police.
- Reduced admissions to acute psychiatric beds.
- Offering a safe and effective resource for mental health and substance misuse assessment.

By diverting people to more appropriate services and away from EDs there will be a positive impact across the health system:

- Fewer inappropriate attendances in EDs contributing to improved performance against the four-hour target.
- Reduced delays in acute medical units from mental health patients blocking beds.
- Reduced demand for mental health inpatient services (crisis café presenting as an alternative to admission).
- Reduced ambulance conveyances.
- Savings to police time (each police transfer to an ED is estimated to take two police officers four hours).

People who use the crisis café will have their needs met at a much earlier stage in the escalation to a crisis. Where these models have been used in other areas it is felt by staff

and service users alike that they are somewhere individuals can self-refer when needed to and may be able to access help and support quicker in an environment they feel safe and comfortable in and thus avoiding going into crisis. The provision is often in partnership with voluntary, community and social enterprise providers with peer support workers.

The scheme is in line with the expectation in the 2019 Long Term Plan that mental health crisis teams would be strengthened and there would be the development of complementary and alternative crisis services, ensuring a localised and community focus in the transformation of services.

The police have the authority to detain individuals under Section 136 of the Mental Health Act where they feel they are in "*immediate need of care and control*". In these circumstances individuals are most likely to be transported to EDs even though there may be no physical health requirement.

The crisis support services together with a number of other support groups, are transforming the landscape of mental health support in south Staffordshire and mean that those who might have previously been admitted to acute mental health beds can now remain in the community.

National evidence suggests that safe havens such as crisis cafés both reduce pressure on EDs and reduce the number of individuals who require formal detainment under Section 136 of the Mental Health Act.

Crisis House service

Brendan House is a mental health short-term intervention service delivered by a voluntary and community sector provider serving the population covered by the MPFT geographical footprint. The service is open 6 days a week and service users can stay there for up to 3 nights to receive support for their mental health away from their home. The service is currently based in Cannock. As part of the transformation of mental health community services we are reviewing the provision with a view to relocate to a more appropriate location to support our crisis care pathway.

Core24 Service

Core24 service at Queens Hospital, Burton and Liaison Services in County Hospital functions as a multi-disciplinary team for individuals who are admitted or self-presenting to the acute hospital as its sector population. The service operates on a consultation and liaison basis and extends beyond patient contact into the education of medical, nursing other health and social care disciplines developing policy to promote the needs of patients with mental health problems presenting in a general acute hospital. Ensuring that all people who experience a crisis can access timely and effective crisis care could help to relieve pressure on other services. Our liaison services enable timely access to MPFT mental health services as detailed in Figure 5 below.

3.4.4 Primary Care Networks (PCNs)

From April 2021 every PCN became entitled to a fully embedded full time equivalent (FTE) mental health practitioner, employed and provided via a service agreement by the PCN's local provider of community mental health services.

The mental health practitioner can be any registered mental health clinician – band 5 to 8a. They:

- Work with patients to support shared decision-making about self-management; facilitate onward access to treatment services; and provide brief psychological interventions, where qualified to do so and where appropriate.
- Work closely with other PCN-based roles to address wider patient needs, e.g. PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support.
- Operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and booking mechanism between PCN and provider.
- Provide a consultation, advice, triage and liaison function, supported by the local community mental health provider through robust clinical governance structures to maintain quality and safety, including supervision where appropriate.

The following information describes the employment and funding.

The mental health practitioner role is funded jointly between PCNs and community mental health providers. The role is employed by the community mental health service provider but fully embedded within the PCN Multi-Disciplinary Team (MDT) via a service agreement between the PCN and the Community Mental Health Team (CMHT). NHS commissioners should broker agreement if needed. The entitlement is for one FTE in 2021/22 and will increase to two whole time equivalent (WTE) in 2022/23 and three WTE by 2023/24, subject to a positive review of implementation.

For PCNs with more than 100,000 patients the entitlements are double. The role is additional to those mental health practitioners and co-located Improving Access to Psychological Therapies (IAPT) practitioners already embedded within general practice. The new obligation on mental health providers is set out in the NHS Standard Contract and NHS planning guidance, supported by additional Long Term Plan funding already available for mental health.

There are currently (August 2022) 11 whole time equivalent (WTE) Mental Health Practitioner roles in place within primary care networks across the MPFT geographical area. There are an additional 15 WTE practitioners due to start in October 2022. There will be further expansion in 2023/24. The Staffordshire and Stoke-on-Trent ICB is currently in discussion with Mercian PCN around two WTE practitioners that have yet to be agreed to be recruited too.

3.4.5 Integrated way of working

There is also a more integrated way of working between drug/alcohol and mental health pathways – approaches focussing on the needs/aspirations of the person, rather than treating conditions/pathologies in isolation.

An integrated team will provide a coordinated (i.e. single care plan) approach to people with 'greatest need' - either due to the complexity or multiplicity of their challenges - and provide a gateway between the two services to facilitate the smooth operation of revised pathways for generic staff in both disciplines to use in order to jointly work with people with less complex co-occurring needs/aspirations.

Furthermore, the local CCG used to jointly fund some provision with Staffordshire County Council around social inclusion and recovery. Those contracts came to an end in March 2022 and the Council and NHS commissioners have worked with MPFT to jointly commission voluntary sector providers to provide support around lifestyle management, housing related support and financial wellbeing. These are the sorts of services that people with mental illness say are important as without these in place their recovery is impeded. This support is coordinated by a Hospital Avoidance Team (HAT).

Although it is difficult to itemise completely how the individual additional services in the community impact on likelihood of admission to inpatient beds and length of stay, the various community initiatives mean that adults and older adults with severe mental illness or dementia are more likely to receive support which does not require admission to inpatient beds or involves shorter stays. Data later in this section illustrates that, for example, length of stay in general has fallen as the community-based initiatives have been introduced. This supports the proposal to confirm the current delivery of mental health inpatient services in south Staffordshire.

MPFT and the ICB are committed to ongoing investment in voluntary sector services (VCSE) which work in conjunction with the clinical service model. We see the VCSE as integral to our service delivery and as full and equal partners to our model of care. We recognise the unique position they are in, able to innovate and reach communities the NHS is not always able to engage with as effectively as we would like, and we will continue to resource them appropriately. We want to use the skills of the VSCE sector as much as possible to free our clinical workforce up to focus on specialist delivery where only they can provide interventions and support. Our VSCE partners are part of our whole team approach to ensure we are wrapping the most appropriate expertise around patient need.

3.4.6 The patient pathway

The figure below (Figure 5) shows how a patient with severe mental illness currently navigates the mental health system.

MPFT operates a 24/7 helpline - Urgent Help: Midlands Partnership Foundation Trust - and people are able to self-refer to Improving Access to Psychological Therapies (IAPT) services - Staffordshire and Stoke-on-Trent Wellbeing Service. Referral to specialist services mainly comes via the GP, including the mental health practitioners in primary care.

The figure illustrates how, wherever possible, the patient is cared for in community settings including their own home with the help of a Hospital Avoidance Team (HAT), rather than in an inpatient setting, and how the care wraps around them to provide not just clinical but social support.

This is achieved through a multi-disciplinary team approach, drawing upon skills of the wider team to support patient and their family/carers. There is also additional support, from the voluntary sector for services to support mental health patients in the community.

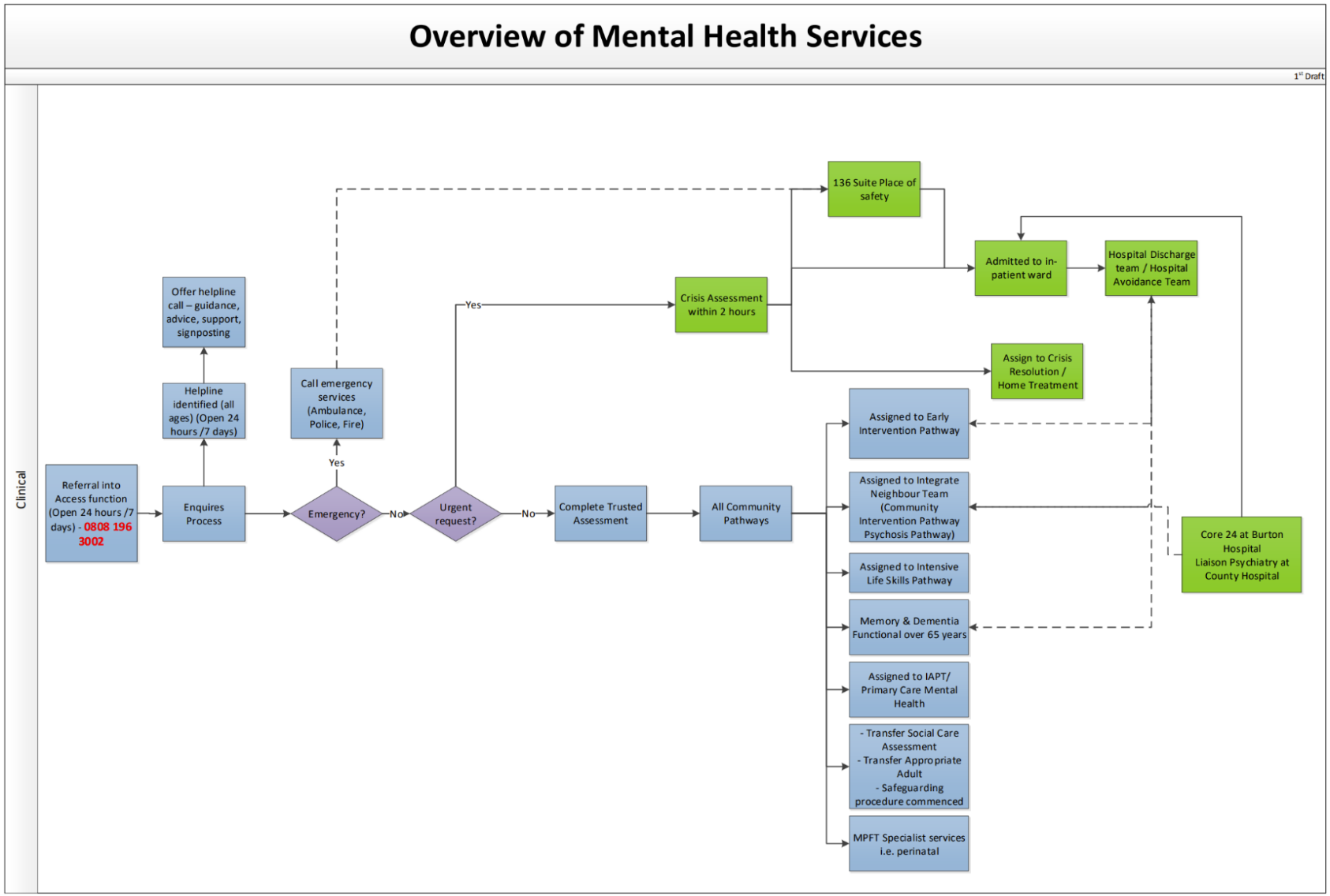


Figure 5 Overview of Mental Health Service

3.4.7 Hub and spoke model of care

As outlined in the previous sections the framework for supporting people in the community includes a range of services provision from MPFT, the voluntary sector and allied health professionals. A large proportion of care will be delivered in patients' own homes or usual place of residence. In addition to this there are mental health services available in each locality via a range of community venues. The table below shows the venues which make up the hub and spoke model for providing clinical and non-clinical space across the east and south east of Staffordshire.

Area	Hub location	Spoke locations
East Staffordshire	Horninglow clinic, Burton	Balance St clinic, Uttoxeter Cross St Clinic, Burton
Tamworth	Sir Robert Peel Hospital	Humankind Offices, Tamworth Merlin House, Tamworth Manna House, Glascote Tamworth Library
Lichfield/Burntwood	St Michaels Court, Lichfield	Lichfield fire station

Table 2 Venues which make up the hub and spoke model for providing clinical and non-clinical space across the east and south east of Staffordshire

The list below outlines the range of mental health community services or teams that are based within the hub and spoke model of community of community venues.

- Integrated Neighbourhood teams (Adult Community Mental Health integrated with VCSE provision commissioned via transformation – Burton Mind, Everyone Health, Trent and Dove Housing, Mercian CAB, Alzheimer's society)
- Depot / Clozapine clinics
- Physical health clinics for individuals with SMI
- Memory assessment and review clinics
- Dementia Home Treatment
- IAPT
- Group sessions including psychological and therapeutic interventions
- Intensive life skills (PD pathway)
- Older adults pathway
- Crisis Resolution and Home Treatment
- Arts for health
- Admin to support local teams

The community mental health team for south east Staffordshire is currently based at the Sir Robert Peel Hospital. We are working with a range of voluntary sector providers who

will provide services with a footprint in Tamworth. Tamworth Library and Humankind offices in Tamworth are venues that are currently used in the locality.

MPFT is actively working towards bringing Cherry Orchard, Tamworth back online as an adult mental health community venue and the current plan is to deliver this by March 2023 (subject to planning).

3.4.8 Case studies

The case studies in this section illustrate how the wrap around community service supports those with mental health needs, including those who have recently been discharged, and helps to prevent admission to hospital. As noted above, the support is provided jointly by health and social care and the voluntary sector.

Case Study – Community Home Treatment Service MPFT:

Background
An eighty-year-old living in Tamworth referred to memory services (by her GP via the MPFT ACCESS point) with suspected memory problems. Daughter had highlighted to GP and mother had agreed to be referred. Routine referral from GP so diagnostic assessment arranged and appointment letter sent out.
Daughter telephoned the number on the letter received as she was concerned her mother was deteriorating rapidly. Call passed to the Dementia Duty Worker who contacted the daughter on the same day to establish the problem and level of risk. Daughter reported to duty worker increased disorientation and episodes of acute confusion which resulted in her mother becoming hostile and physically aggressive when family tried to intervene. She added that her mother also appeared to be experiencing visual hallucinations and constantly asking for her husband, who passed away 6 years ago. Daughter reported that she had gone to stay with her mother over the weekend and found the oven left on, burnt food and that her mother had not been taking her medications correctly.
Given the current concerns and risks, the Duty Worker agreed to request input from the Dementia Home Treatment Team and that a diagnostic assessment could be completed as part of these assessments. Note: this service is in place for service users already diagnosed with dementia however in instances such as these they flex and provide input despite a diagnosis not being confirmed.

Actions:

- Community Mental Health Nurse (CMHN) allocated from the Home Treatment team
- Home Visit agreed with daughter within two days
- Assessment taken at service user's home with daughter present - discussed findings with multi-disciplinary team and noted a possible leg ulcer infection
- CMHN requested GP review urgently due to increased confusion and possible toxicity from the infection
- Contact with daughter maintained (calls and visits) to support in caring for mother whilst leg was being actively treated
- CMHN also passed case to the Occupational Therapist (OT) working in the same Home Treatment team in order to complete functional assessments, given the risks within the kitchen and Activities of Daily Living (ADL).

- Prompt District Nurse assessment arranged after CMHN discussed with GP - prescribed antibiotics and legs dressed over the coming weeks, however brief hospital admission required due to severity.
- CMHN remained allocated whilst in hospital and supporting daughter
- Consultant Psychiatrist assessment completed (requested by CMHN) within four weeks post discharge from acute hospital and dementia diagnosis reached - treatment and intervention plan agreed.
- CMHN and OT completed further visits to address the risks and monitor the treatment plans
- Daughter feels huge improvement (within five to six months of initial contact) in mother's quality of life now. Anti-dementia drugs being utilised at stable dose (Memantine).
- Support from the team is ongoing but frequency is much reduced. As diagnosed service user remains on caseload at MPFT as "none discharge" pathway. Level of support decreased to three-monthly reviews by CMHN.
- CMHN referred to partner provider "The Alzheimer's Society Dementia Advisers" who are supporting daughter and service user post diagnosis. This includes carers support, housing and benefit support etc…
- CMHN also referred to Social Services via Staffordshire Cares to assess care at home as daughter feels more support is needed with mother's ADL and personal hygiene needs. Social Care scheduled assessment date and time with daughter at mother's home. CMHN attended to support and care package agreed.

MPFT Dementia review case study

Background

A seventy-nine-year-old residing in an assisted living complex in the Lichfield area, with established diagnosis of dementia, open to MPFT's Dementia Review team for annual review and needs-led support.

Last reviewed six months ago by the MPFT Dementia Review team. At this time there were no concerns raised. Package of care in place and living in assisted accommodation so next review arranged in 12 months' time.

A call was taken to the telephone number provided by the review team which was immediately directed to the duty worker in the dementia service. Family (son) were requesting an earlier than scheduled review due to concerns over his mother leaving her property to look for people or to attend the hospital. They believed she had done this on three or four occasions and the assisted living staff were highlighting it as a risk. No other issues were reported as the diagnosis of dementia was known with the level of disorientation relatively stable and well managed with the use of daily anti-dementia medication and access to support in the complex.

The service user was in receipt of one care call a day from a domiciliary care company and also had access to the onsite support.

Actions

- Assistant Practitioner (AP) from the MPFT review team attended the property the same week to ascertain details.
- Urgent multi-disciplinary discussion later that day resulted in the team's Occupational Therapist (OT) arranging with family to visit two days later and assess risks on leaving the property and how this could be safely managed. This

included why this was happening and how this could be facilitated should it be needed. This also prompted a safeguarding referral due to the risk of harm to the service user when outside of her property alone.

- Social services facilitated a safeguarding review date which resulted in increase to the care package, possible access to day facilities and ongoing work via the OT and support staff from the MPFT review team, working on occupational activity in the daytime to increase stimulation and meaningful activity.

Positive outcome

Service user began accessing a day facility three times a week locally to increase meaningful contact and activity, as well as reducing the time at home alone therefore reducing the risk of leaving. Support staff from MPFT Dementia Review team supporting first day attendance and settling in period.

Care package increase supported with personal hygiene and getting ready for day facility days. Also ensuring medications had been taken as prescribed as this was picked up as an issue when OT completed further visits.

MPFT support worker visited weekly to offer stimulation conversation at home and facilitate a safe walk out of home when requested.

OT put in place assistive technology (with consent from service user and son) to monitor safe movement in the home and ensure that the risks were suitably managed. Incidents of leaving the home unsupported stopped.

Hospital Avoidance Team (HAT) case study:

Background

An eighty-one-year-old living in Lichfield area. Unknown to secondary mental health services but GP aware of anxiety and depressive symptoms over the past month.

Referred in to the MPFT Access Team via liaison psychiatry at Good Hope Hospital following being taken to A&E due to taking an overdose of prescribed medication and subsequently falling and hitting head. Found by neighbour and ambulance called.

As patient not yet discharged from Good Hope, ACCESS sent the referral to the Older Adult Community Team MPFT to open and respond in order to support returning home.

Referral triaged by Older Adult worker in ACCESS. Diagnosis of probable early dementia was established whilst in hospital (by the liaison psychiatry team) so allocated to a Community Mental Health Nurse (CMHN) in the Dementia Home Treatment Team to make contact prior to discharge from hospital.

Discharged from Good Hope on a Thursday afternoon to home address.

Medically fit but still at high risk of self-harm due to levels of anxiety and depression. Also now diagnosed with dementia which added further concern.

Daughter supporting but finding the situation very difficult.

Due to level of risk HAT were asked (via a call from the Home Treatment CMHN) to support out of hours and over the weekend.

Actions

- Home Treatment Team provided intervention during the week (CMHN, Psychology input for Anxiety Management and Support Workers daily telephone calls or home visits).
- HAT mobilised at the weekends to sustain level of input during the at-risk period. Mostly telephone contact support from HAT with one home visit when staff were concerned after calling.

- Daughter (main carer) had contact with the Home Treatment team's Psychologist for Compassion Focussed Therapy support.
- Community Psychiatric Nurse (CPN) and Healthcare Support Worker (HCSW) were involved carrying out regular visits and contacts.
- Plan was to improve access to the community / leisure facilities and groups - HCSW assisted with locating and access. Also to stabilise on medication for mood.
- HAT were mobilised successfully on five different occasions over three months during the period of higher risk, avoiding further self-harm and / or hospitalisation of any type.

Positive outcomes

- There have been no further episodes of self-harm since coming into our service. Psychology continued to work with daughter and mother moving to a more stable situation for both.
- CMHN in Home Treatment referred to Social Care for carers' assessment and possible need for home care due to self-neglect being evident.
- Care package in place to support mother with independent living and to take pressure away from daughter as the man contact.

3.5 Case for change for adults with severe mental illness

Over the past several years the clinical model described in the previous section has evolved in line with the national direction of travel and has seen more patients supported in their normal home environment, or with access to community service support. This has reduced the requirement for inpatient services. For those patients where a stay in hospital is required, the length of stay has reduced.

3.5.1 Bed capacity

The national best practice for treating patients with severe mental illness (SMI) has moved from a bed-based model to a community-based model. Figure 6 shows this 'stepped' model of care, with most people living in the community and receiving different levels of care depending on their need.

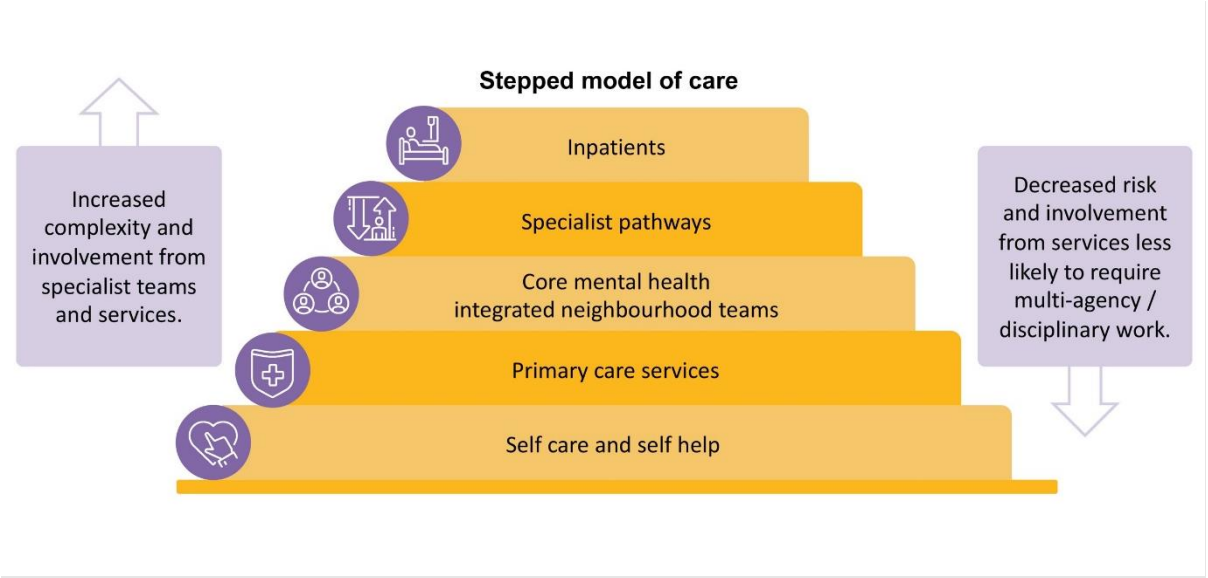


Figure 6 Stepped model of care

Between 2017 and 2019 the average length of stay for patients in the George Bryan Centre by ward was 30.62 days and by total admission 48.44 days. Since 2019, when acute inpatients moved to St George's Hospital, the average length of stay for those in acute wards was 22.94 by ward and 42.18 by admission. This shows a reduction in length of stay which reflects the move towards more support in the community and indicates that the new configuration of beds since the move to St George's Hospital has not had an adverse impact on patients.

	11 Feb 2017 – 11 Feb 2019		12 Feb 2019 to 23 Nov 2021	
	Average length of stay by ward (Days)	Average length of stay by total admission (Days)	Average length of stay by ward (Days)	Average length of stay by total admission (Days)
George Bryan Centre	30.62	48.44		
St George's Hospital			22.94	42.18

Table 3 Length of stay

The numbers of patients needing acute admission out of area because of unavailability of beds was small and has remained small since the temporary centralisation of beds at St George's Hospital. Patients require timely access to required mental health care and treatment regardless of location, however following initial treatments the primary concerns are service user experience, and appropriateness of care which is best served through their home system who are often familiar with the patient. A family/support network may also be better utilised in the home locality.

It is the responsibility of all mental health trusts within the Midlands region to ensure every effort is made to expedite clinical, operational, and commissioning acceptance of referrals in order to facilitate prompt repatriation. The ICB has signed the Midlands Regional Guidance to support the repatriation of people who find themselves out of their normal catchment area (acute adults).

All other out of area acute admissions have been because they were admitted while away from home; or because the patient is a member of MPFT staff. The bulk of MPFT's out of

area admissions are due to the unavailability of beds is for psychiatric intensive care (PICU). MPFT does not provide female PICU services.

The table below shows the bed capacity before and after the fire at the George Bryan Centre. The reference to 'removal 12 beds' refers to the 12 beds for older adults with severe mental illness or dementia provided in the East Wing. Changes to services for them are described lower down.

	Pre- George Bryan Centre Fire Configuration		**Post-Fire Configuration**
	George Bryan Centre Site	St George's Hospital, Stafford Site	St George's Hospital, Stafford Site
Number of beds	31	66 Beds	84 Beds (18 of 19 beds created) – removal 12 beds

Table 4 Configuration of beds before and after the fire

Since 2019, the vast majority of patients, including those with severe mental illness from south Staffordshire who need hospital assessment or treatment have been admitted to wards mostly at St. George's Hospital (Stafford), with smaller numbers to Harplands (Stoke-on-Trent) or Redwoods (Shrewsbury) hospitals.

The number of beds required is assessed on a regular basis by a centralised bed manager at St George's Hospital.

There is no national bed modelling tool to determine the number of mental health beds required to support the needs of the local population. MPFT has developed a performance management framework monitoring bed usage by clinical teams with analysis of diagnostic groupings, length of stay and use of facilitated early discharge procedures to ensure MPFT's bed capacity is appropriately optimised:

- Bed Manager – MPFT has a designated Bed Manager who is responsible for co-ordinating all bed management issues and coordinating patient flow.
- Out of area placements – The numbers of patients needing acute admission 'out of area because of the unavailability of beds is small. MPFT is upper quartile performance when benchmarked with other mental health trusts.
- Gate keeping - A system of bed management is likely to be less efficient where there are many points of access to admission. Evidence from the National Audit of Crisis Response and Home Treatment Teams in England suggests that where there is a single gate-keeping function within Crisis Response and Home Treatment (CRHT), then beds are better managed.
- Crisis House - The gate-keeping function undertaken by MPFT's Crisis team will determine if an admission is necessary or whether a support in the community Crisis house would be more appropriate.
- Discharge planning - The planning of discharge commences at the point of admission. During discharge planning MPFT takes into consideration all agencies that might be involved in managing the discharge process and should lead to the estimation of a date of discharge around which appropriate planning can be made. Multi-disciplinary discussions are held every day from Monday to Friday to facilitate discharges and free up beds for weekends This enables the shortest possible

length of stay, MPFT is upper quartile performance when benchmarked with other mental health trusts.

As with the bed modelling tool there is also no national model to determine the caseload and numbers managed in the community. As outlined within the workforce section later on in the pre-consultation business case, the bed manager liaises with the Crisis Response and Home Treatment team to determine if a patient can be safely managed at home. From April 2021 to March 2022 the team supported 5843 patients with a total of 22,705 appointments.

3.5.2 Range of services at St George's Hospital

The size of the St George's Hospital site enables a much greater range of specialist services than the George Bryan Centre was able to offer. At St George's Hospital Allied Health Professionals (AHPs) providing services such as art and music therapy or occupational therapy are able to work across several wards.

Recruiting staff to a larger unit with a wider range of services such as St George's Hospital is easier than recruitment to a smaller unit because staff have the opportunity for a wider range of experience and development opportunities in larger units.

St George's Hospital provides more specialist services such as electroconvulsive therapy (ECT). For certain treatment and interventions patients at the George Bryan Centre had to travel to St George's Hospital on a regular basis, escorted by members of staff from the ward.

Patients at the George Bryan Centre whose condition deteriorated so that they needed higher levels of observation or a period of treatment in a Psychiatric Intensive Care Unit (PICU) needed to be transferred to St George's Hospital with its more specialist services.

MPFT was shortlisted for a number of national Health Service Journal (HSJ) awards in 2021, including Mental Health Trust of the year and the HSJ Value Award. St George's Hospital, and the range of services, is an important element of this.

Patient transfers

The George Bryan Centre's distance from St George's Hospital made responding to psychiatric emergencies difficult. Transfers could take up to six hours because of the need for secure travel. This was sub-optimal care for distressed patients and raised staff safety risks.

The table below shows the number of transfers of the George Bryan Centre West Wing patients to St George's Hospital in the period from 11 February 2017 to when the fire took place on 11 February 2019.

Patients transferred between the George Bryan Centre and St George's Hospital 11 Feb 2017 to 11 Feb 2019				
	2017	**2018**	**2019**	**Total**
Older adults with functional mental illness Baswich Ward	2	8	2	12
Older adults with functional mental illness Bromley Stafford	8	10	7	25

Working age adults with serious mental illness Brocton Stafford	9	43	13	65
Working age adults with serious mental illness Chebsey Stafford	12	64	7	83
Working age adults with serious mental illness Milford Stafford	5		13	18
Working age adults with serious mental illness Norbury Stafford		17	6	23
Total	**36**	**142**	**48**	**226**

Table 5 Number of transfers of George Bryan Centre West Wing patients to St George's Hospital 11 February 2017 to 11 February 2019.

The move of the George Bryan Centre patients to St George's Hospital after the fire immediately means that there is no need for transfers between the two locations which also reduces the impact on patients who are already distressed. If patients needed to transfer between wards for care they could move from one to another on the St George's Hospital site.

This refers to patient transfers only. The impact on visitors is detailed within the travel impact analysis in Section 8.5.2.

3.5.3 Serious incidents

If a patient at the George Bryan Centre had needs that escalated or deteriorated, this had implications for staff safety, and again could mean the patient would need to be transferred. The table and figure below show the number of staff safety incidents recorded at St George's Hospital until 2021 and at the George Bryan Centre pre-closure. In the case of serious incidents occurring at the George Bryan Centre, it is likely that the patients would have been transferred to another site with more specialist facilities such as St George's Hospital.

Count of Incident Number	2017	2018	2019	2020	2021	Total
George Bryan Centre	13	6	1			**20**
St George's Hospital	24	24	15	16	14	**93**
Total	**37**	**30**	**16**	**16**	**14**	**113**

Table 6 Number of staff safety incidents recorded at St George's Hospital until 2021 and at the George Bryan Centre pre-closure

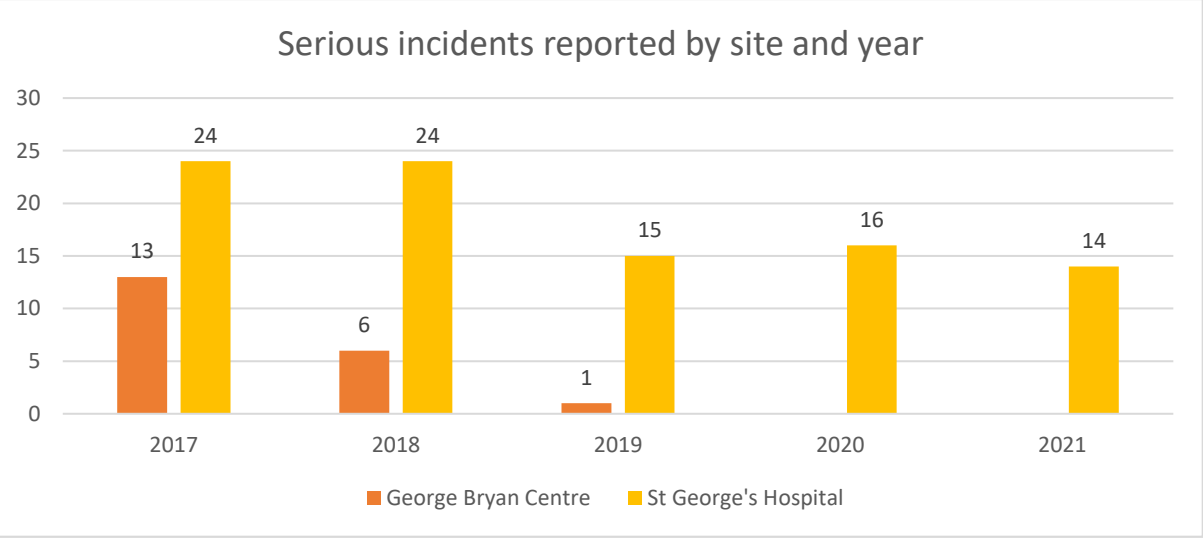


Figure 7 Number of serious incidents reported by site and year

The table below shows the number of incidents to which the police were called at the George Bryan Centre and at St George's Hospital between 2017 and 2021. It should be noted that the only support for staff in the event of a crisis at the George Bryan Centre was from the police, and it was not appropriate or legal for them to intervene with patients.

The table shows a reduction in the number of police call outs following the centralisation of inpatient beds at St George's Hospital. This can partly be explained because the facilities for supporting patients in crisis at St George's Hospital are more comprehensive than those that were available at the George Bryan Centre and there is a wider range of staff able to support patients in crisis, so the police rarely need to be called. It should be noted that in 2019 there were only six weeks when the West Wing was operational and only four months when the East Wing was operational.

Site	Ward	2017	2018	2019	2020	2021	Total
St George's Hospital	TOTAL (adult wards)	83	65	64	57	35	304
George Bryan Centre	TOTAL	32	47	7			86
George Bryan Centre	West Wing	32	44	7			83
George Bryan Centre	East Wing	0	3	0			3
St George's Hospital	Chebsey House	42	26	13	15	5	101
St George's Hospital	Brocton House	29	21	15	13	14	92
St George's Hospital	Milford House			22	18	9	49
St George's Hospital	Bromley Ward	1	2	2		1	6

Table 7 Number of police call outs to George Bryan Centre and St George's Hospital, Stafford

3.5.4 Clinical quality and safety

In terms of clinical quality and safety, the location and facilities at St George's Hospital provide a better opportunity for the optimum care and treatment of patients with severe mental illness. The measures used to assess patient care are described in more detail in Section eight.

3.5.5 CQC inspection

The latest CQC inspection of MPFT[1] was in 2019. The overall rating was Good. The report stated that the Trust had a good rating for safety. Patient safety incidents were managed well.

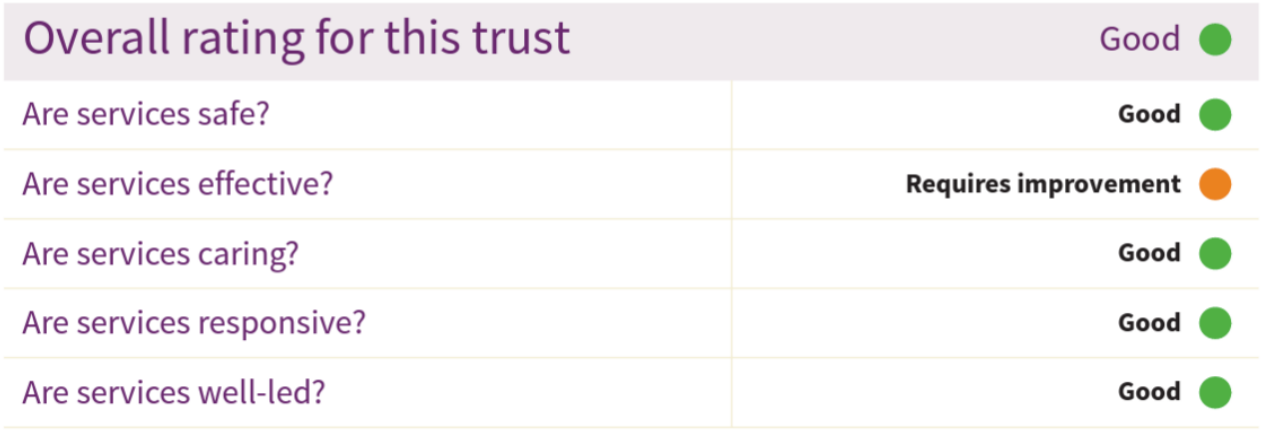


Figure 8 Midlands Partnership NHS Foundation Trust Inspection report 05/07/2019 overview

The report on the condition of the estate at St George's Hospital did not identify any drawbacks in the buildings. *"The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy."* (p.8). This is in contrast with the fact that drawbacks with the estate at the George Bryan Centre were identified by the CQC as early as 2013.

3.5.6 Benefits realisation and outcomes framework

The table below, taken from the Information Pack from the reference group deliberative event on 15 March 2022, illustrates the pros and cons of the two proposals for the future of inpatient services, showing the benefits of centralising beds at St George's Hospital, and the potential outcomes of either proposal.

[1] CQC inspection report of MPFT, 2019

Centralised beds at St George's Hospital	18-bed unit on site of George Bryan Centre
Patient safety	
Advantages	**Disadvantages**
Timely access to intensive psychiatric care As a larger hospital, now with 84 beds for adults with severe mental illness, St George's Hospital has a wider range of specialist staff. Its facilities include a psychiatric intensive care unit (for male patients) and seclusion rooms. The most unwell patients have faster access to specialist care, without having to be transferred from another site.	**No on-site access to intensive psychiatric care** There were concerns in 2017 that the George Bryan Centre was a remote site with a small pool of staff. It did not have a psychiatric intensive care unit or isolation facilities. If a patient became very unwell, they had to be transferred to St George's Hospital. A unit with 18 beds on the George Bryan site would have fewer specialist staff because of the lower number of patients there, with less complex needs. The most unwell patients would still have to be admitted to St George's Hospital. Some patients might need to be transferred from the 18-bed unit to St George's Hospital – which may create risks and cause disruption of care.
Staff cover for illness With more staff and a wider skill mix, it is easier at St George's Hospital to provide cover across different areas when colleagues are unwell.	**Reduced staff cover for illness** With a smaller pool of staff at the 18-bed unit, it would be harder to provide cover and maintain a high level of care.
Fewer emergency call-outs There have been fewer police call-outs since the centralisation of beds at St George's Hospital (nine in 2021) than at the George Bryan Centre before the fire, even though there are more patients. This reflects that a larger site with senior clinical back-up, more staff, and intensive psychiatric care facilities, can manage crises more effectively.	**More emergency call-outs** The number of police call-outs to the George Bryan Centre West wing before the fire was high (32 in 2017, 44 in 2018). This reflects that in a smaller, remote unit with fewer staff to support other areas during absences, and no isolation facilities, it is harder to manage crises when they happen.

Duty of quality			
Advantages	**Disadvantages**	**Advantages**	**Disadvantages**
Meeting a wider range of needs A bigger staff, with a wider skill mix, at St George's Hospital can meet a wider range of needs. Patients can be looked after by staff with a wider range of skills and specialisms. Additional interventions available at St George's Hospital that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy.	**Greater risk of health inequalities** Evidence shows that being in touch with family, carers and friends is beneficial to patients with severe mental illness. Some patients and carers will have to travel further to visit a person who is admitted to St George's Hospital in Stafford. This could have an impact on people living in rural areas without good transport links, people without a car and those on low incomes – with a risk of greater risk of health inequalities for some patients.	**Lower risk of health inequalities** If inpatient services were re-provided on the existing George Bryan site, carers, friends and family of patients from the local area would face fewer difficulties in terms of travel.	**Less able to meet a wide range of needs** Not all treatments and interventions were available to people staying in the George Bryan Centre and so some people who had severe mental health needs were admitted to St George's Hospital because of the more intensive support that can be offered in a larger hospital. Staff who provide therapeutic interventions are skilled and specialist, so it can be difficult to recruit and keep these staff. It would be particularly hard to recruit to a smaller, isolated site. In a bigger hospital, they would work across wards as required.

Patient experience			
Advantages	**Disadvantages**	**Advantages**	**Disadvantages**
Location Some involvement comments have suggested that St George's location is an advantage – patients with approved leave have access to activities outside hospital in Stafford town centre.	**Travel impacts** Some patients and carers will be impacted by having to travel further to visit a person who is admitted to a bed in St George's Hospital in Stafford. This could affect those who live in rural areas without good transport links, people without a car and those on low incomes. Travel was a major concern raised in both the 2019 and 2021 public involvement sessions	**Easier travel** Visiting and being involved in care will be easier for carers/families in south east Staffordshire if a loved one is admitted to a local inpatient unit.	**Location** Location of 18-bed unit at the existing George Bryan site may have negative impacts on inpatient experience if fewer activities are available. There will be fewer specialist staff to provide activities in a smaller, remote unit.
Clinical effectiveness			
Advantages	**Disadvantages**	**Advantages**	**Disadvantages**
More consistent care provision More consistent care provision in a centralised site, as no need for disruptive transfer to intensive psychiatric care or to access therapeutic interventions.	**Travel impacts** Centralisation of beds at St George's Hospital would impact on travel for some carers and there is evidence that family / carer visits improve outcomes.	**Positive clinical impact of easier travel** As noted, evidence shows that being in touch with family, carers and friends is beneficial to patients with a severe mental illness.	**Less consistent care provision** Some patients needed transfer to St George's Hospital for either access to a higher acuity bed (psychiatric intensive care unit, for example) or for therapeutic interventions unavailable at the George Bryan Centre. This reduced consistency of care for a cohort of people previously, and the same problems

			would be likely if services were provided in the same location.
Fewer emergency call-outs Fewer police call-outs since the centralisation of beds at St George's Hospital (nine in 2021) than at the George Bryan Centre before the fire. This reflects that a larger site with senior clinical back-up, more staff, and intensive psychiatric care facilities, can manage crises more effectively.			**More emergency call-outs** The number of police call-outs to the George Bryan Centre West wing before the fire was high (32 in 2017, 44 in 2018). This reflects that in a smaller, remote unit without a full-time consultant and with fewer staff to support other areas during absences, it is harder to manage crises when they happen.

Table 8 Pros and cons of the two proposals as presented at the deliberative event on 15 March 2022

3.6 Case for change for older adults with severe mental illness or dementia

The MPFT Community Dementia Service provides multi-disciplinary support to people with dementia and their carers who are affected by complex and challenging needs. The service delivers person-centred treatment or care, in line with evidence-based approaches to the management of challenging and complex behaviour in dementia. The service was in place at the time of the fire and had already reduced the number of patients with dementia admitted to the George Bryan Centre by enabling more patients with dementia to stay in their home setting.

At the same time, commissioners were developing an enhanced community model for older adults with severe mental illness. It had been recognised that the community offer in place was the same for all adults over 18, and that older adults often had additional needs because of physical frailty and the experience of bereavement that comes with old age.

After the fire, the Trust recognised that the East Wing would need to close on safety grounds.

Commissioners issued an updated service specification, and the enhanced community support was put in place. The East Wing was closed to new admissions, and existing patients were discharged as appropriate. After two months no patients remained at the George Bryan Centre and the ward was closed.

A Clinical Delivery Model was developed that reflected MPFT's model for integrated care delivered according to the recommended pathways. It included detail about the staff skills needed to treat older people with a number of functional mental health conditions including:

- Adversity, loss or disability
- Anxiety
- Depression
- Bipolar disorder
- Psychosis

The new team included a dedicated staff member (one whole time equivalent) at a single point of access who could assess the requirements of each patient and recommend the appropriate care pathway.

The team also included:

- Enhanced crisis home treatment with skilled, experienced older adult specialists.
- Addition of a nursing/therapy lead.
- New clinical psychologist to focus on older adults.
- A training plan for the team.

The Trust also invested in creating a Hospital Avoidance Team (HAT), a specific team of nurses and therapists working across seven days to help support people with dementia in crisis at home and prevent hospital admissions.

Admission to an inpatient bed

Admissions for older adults (over 65) with severe mental illness or dementia to the George Bryan Centre from 2017 to 2019 were:

	2017	2018	2019	Total
IDEM* George Bryan Centre	15	41	13	69
IMH** George Bryan Centre Tamworth	2	17	1	20
Total	**17**	**58**	**14**	**89**

Table 9 Admissions for older adults (over 65) with severe mental illness or dementia to the George Bryan Centre from 2017 to 2019

Key:
**IDEM = adults over 65 with dementia*
***IMH = adults over 65 with severe mental illness (SMI)*

Admissions for older adults (aged over 65) with severe mental illness or with dementia to St George's Hospital from 2017 were:

	2017	2018	2019	2020	2021	2022	Total
IDEM* Baswich Ward		19	15	56	62	24	176
IDEM* Bromley Stafford	25	56	62	120	102	15	380
IMH** Brocton Stafford	2	15	10	7	6	1	41
IMH** Chebsey Stafford	6	17	28	18	11	2	82
IMH** Milford Stafford	3		10	16	6	2	37
IMH** Norbury Stafford		1	2	1			4
Total	**36**	**108**	**127**	**218**	**187**	**44**	**720**

Table 10 Admissions for older adults (over 65) with severe mental illness or dementia to St George's Hospital from 2017

Key:
**IDEM = adults over 65 with dementia*
***IMH = adults over 65 with severe mental illness (SMI)*

The change from assessing and treating people in the ward at the George Bryan Centre to treating them in the community was in line with the general move towards mental health care based in the community wherever possible. The earlier part of this section describes in more detail the national and local policy behind this move.

In summary, since spring 2019 the 12 beds at the George Bryan Centre for assessment and treatment service of older adults (over 65) with severe mental illness or dementia have been replaced by an enhanced service in the community, with admission to hospital when they are no longer safe to remain at home. National and local policy and research evidence indicate that this is a better method of supporting this cohort than admission to

hospital and this has been taken into consideration when deciding on the final option for the future of the services.

4 Workforce plans supporting the proposal

4.1 Introduction

This section of the pre-consultation business case analyses the workforce implications of the business case. It looks at:

- The process used to develop workforce plans.
- Previous and current workforce levels and profiles.
- The impact on the workforce of the two scenarios that have been considered. It analyses future workforce capacity and competency requirements and demonstrates sufficient staff supply and safe staffing levels.
- Examining measures taken to ensure future sustainability.

4.2 Process used to develop workforce plans

The workforce plans for the mental health staff in MPFT take into account a number of national drivers and have a robust governance structure.

The MPFT Board approved the refreshed Workforce and Development Strategy in April 2019. Three priorities are outlined for delivery of the Strategy:

- We're base safe - Through a capable and effective workforce, ensure and assure the delivery of safe, high quality services.
- We're Future Proof - To influence and enable the organisation and wider heath economy to respond to changes in demand and ensure future sustainability through leading edge workforce and development.
- We're Great to Work For - To ensure the organisation is a place where people want to come to work, feel engaged, and are supported and developed to maximise their contribution

An update against these three priorities was presented at the MPFT Board meeting on 26 May 2022.[1]

Workforce planning, transformation and development is a year-round activity and as such the plan is likely to change as learning progresses, more granular detail becomes available and in response to the rapidly changing commissioning, political and policy landscape.

Planned growth within mental health services, submitted as part of the operational plan, is shown below.

[1] MPFT Board meeting on 26 May 2022.

Mental Health Aggregated Submission as at 3rd June 2021 by Job Role

Organisation Group (All)

Job Role	SIP 31/03/2021	Establishment 31/03/21	Planned Est. Q1 2021/22	Planned Est. Q2 2021/22	Planned Est. Q3 2021/22	Planned Est. Q4 2021/22	Vacancy WTE	Vacancy Rate	Planned Growth WTE				Planned Growth Rate %			
									Qtr 1	Qtr 2	Qtr 3	Qtr 4 (Annual Change WTE)	Qtr 1	Qtr 2	Qtr 3	Qtr 4 (Annual Change %)
Admin	223	220	230	230	230	230	-3	-1.5%	10	10	10	10	4.5%	4.5%	4.5%	4.5%
Non-Clinical Staff	272	263	266	266	266	266	-9	-3.5%	3	3	3	3	1.2%	1.2%	1.2%	1.2%
Nursing	768	897	994	994	994	994	129	14.4%	97	97	97	97	10.8%	10.8%	10.8%	10.8%
Occupational Therapists	70	79	79	79	79	79	9	11.5%	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Other therapists \ other STT	30	29	60	60	60	60	-1	-4.6%	32	32	32	32	111.2%	111.2%	111.2%	111.2%
Paramedics	-	-	-	-	-	-	-	-	0	0	0	0	-	-	-	-
Peer support worker	8	12	19	19	19	19	4	32.5%	7	7	7	7	55.0%	55.0%	55.0%	55.0%
Pharmacist	0	0	0	0	0	0	-	0.0%	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Physicians Associates	0	-	-	-	-	-	0	-	0	0	0	0	-	-	-	-
Psychiatrist - consultant	45	56	60	60	60	60	11	19.8%	4	4	4	4	7.9%	7.9%	7.9%	7.9%
Psychiatrist - non consultant	18	23	23	23	23	23	6	23.5%	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Psychologist	72	81	96	96	96	96	9	11.0%	15	15	15	15	17.9%	17.9%	17.9%	17.9%
Psychotherapists and psychological professionals	232	255	266	266	279	279	23	9.0%	11	11	24	24	4.4%	4.4%	9.4%	9.4%
Social worker	70	59	59	59	59	59	-11	-19.0%	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Support to clinical staff	369	399	457	457	457	457	30	7.5%	58	58	58	58	14.6%	14.6%	14.6%	14.6%
Total Dementia Workforce	119	117	117	117	117	117	-2	-1.6%	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Total LDA Workforce	171	199	222	222	222	222	27	13.7%	24	24	24	24	11.8%	11.8%	11.8%	11.8%
Grand Total	**2,468**	**2,688**	**2,948**	**2,948**	**2,961**	**2,961**	**221**	**8.2%**	**260**	**260**	**273**	**273**	**9.7%**	**9.7%**	**10.1%**	**10.1%**

Table 11 Mental Health Aggregated Submission as at 3rd June 2021 by job role

Overall, the mental health workforce is showing a planned increase of 10.1% (273 whole time equivalents (WTE)).

Planned growth for nursing is at 10.8% (97 WTE). Other roles with planned significant growth are support to clinical staff 3.7% (17 WTE), psychiatrist consultant growth 5.2% (4 WTE) and non-consultant 3.5% (4 WTE).

It is important to note that the way in which the data was categorised within the mental health template means that the support to nursing staff growth is included within the overall nursing growth.

4.2.1 Strategic forces impacting on services and workforce planning

A number of strategic factors will impact upon the system's services and will have workforce implications that will need to be considered. These are set out in this section.

4.2.2 System level governance

A robust governance structure is in place through a system-wide Mental Health Programme Board. The existing ICS Mental Health Programme Board has an established schedule of meetings with terms of reference and an identified reporting structure. The ICS Mental Health Programme Board receives highlight reports from delivery groups describing progress against the key deliverables and milestones, including the escalation of risks and issues.

The year 2020/21 was spent reviewing current positions and establishing a transformation plan for the next 12-18 months through a defined process with NHS England. 2021/22 will continue to evolve and implement the commitments within the plan.

Central to the success of transforming mental health services is a rich and inclusive community offer, providing support and connections outside of traditional models of support. Vital to this is the partnership of mental health providers working collaboratively across the system, which includes local authorities, primary and secondary care and local voluntary sector organisations. A person-centred and holistic vision ensures support is wrapped around individuals and the model is clinically led only when necessary.

Through the transformation the ICS can enable system-wide collaboration to develop robust and consistent initiatives, pathways, services and skills to reduce the inequity of access, care and information experienced by the area's diverse communities and work in partnership with education, community and faith-based organisations and leads/workers to improve and better the health outcomes for them and their families.

The ICS has used population health analysis through Health Equity Assessment Tool (HEAT) data packs to determine the wider determinants of mental health; this has been overlaid with community asset mapping to identify gaps in the workforce. HEAT will be utilised to further enable a range of professionals and practitioners to systematically identify and address health inequalities and equity in programmes and/or services.

The workforce strategy is weighted on utilising new roles and working closely with system partners and the voluntary sector to develop joint roles. In addition, mental health services in the south of the county are currently engaged in the Clinically Led workforcE and Activity Redesign (CLEAR) programme supported by Health Education England. Opportunities for sharing the outcomes from this work will be identified and actioned.

Workforce planning is pivotal in delivering the transformation plan and is supported by programmes of work on system-wide cultural improvement, leadership development and health and wellbeing. This will enhance the workforce planning approach to recruit and retain the workforce.

Workforce plans span across patient pathways and integrate expertise in voluntary, primary and secondary care and local authority and will be clinically-led. Non-traditional workforce models and multi-disciplinary team (MDT) expansion will enhance workforce growth and redesign that has been undertaken to date. Workforce supply is challenged in certain professions; the ICS has already begun to develop advanced mental health practitioners and non-medical accountable clinician roles across professional groups and mental health pharmacists. This will be expanded further over the longevity of the plan, recognising the lead in time to train and to bring about cultural change where necessary.

Through this system-wide workforce plan rewarding career pathways and enhanced roles will be developed, the peer support workforce will be enhanced and supply will be maximised through growing our own using apprenticeships and extending student placements across non-health providers in nursing (including nurse associates), occupational therapy, social work and clinical associate psychologists.

4.3 Previous and current workforce levels and profiles

4.3.1 Safer staffing

The Mental Health Optimal Staffing Tool (MHOST) is used by MPFT to calculate safe levels of staffing.

Data has been collected over 12 years where the needs of patients over a 24/7 period has been looked at including all their interactions with a health professional. That is documented, and a scoring system is applied in relation to dependency levels from one to five. The table below shows the levels of dependency.

Adult Acute Admission Mental Health Wards

Acuity and Dependency Level	Descriptor
Level 1 – Low dependency	Self-caring and able to do most daily living activities of unaided. Patient has capacity to engage with therapeutic interventions. Patient is at pre-discharge state. Risks can be managed by community services.
Level 2 – Medium dependency	More dependent on ward staff for his/her mental, social or physical health needs. Patient has capacity to engage with therapeutic interventions. May be potential barriers preventing a safe and timely discharge.
Level 3 – Medium-high dependency	Heavily reliant on ward team for his / her care. Presents as medium- to high-risk or fluctuating risk. Has high-level mental, social or physical health needs. Low or inconsistent engagement with therapeutic interventions. There may be potential barriers preventing a safe and timely discharge.
Level 4 – High dependency	Dependant on ward team for his/ her care. Requires high engagement and intervention. Major mental, social or physical health needs. Presents as high-level risk to self and/or others. Minimal engagement with therapeutic interventions.
Level 5 – Highest dependency	Requires one to one care. Major mental, social or physical health needs. Is a significant risk to self and/or other people. Leave from the ward isn't allowed other than planned hospital appointments with escort. May be awaiting step up to PICU or low-secure environment.

Table 12 Adult acute admission mental health wards

Dependency Level one is the least dependent, and Level five requires one-to-one observations. There is also dependency Level six, which requires two-to-one observations, and Level seven, which requires three-to-one observations. These are most commonly seen in the forensic area of St George's Hospital.

On the wards, there are three census periods, three times a day, when the acuity of patients is checked and looked at against what staffing is coming on at the next shift. The assessment will be made whether to reduce services to maintain safety.

Twice a year, there is a review of the system to identify what staffing was required over a six-month period, looking at the entries made three times a day by the clinical professionals and turning them into what this would look like as a whole time equivalent (WTE). The review also looks at the number of incidents there have been and where they are, the geography of the wards, for example lines of sight, and what is generally happening at the time. The information is inputted and this helps to calculate how many beds are required, assessing the level of acuity in the patients and therefore how many staff are needed. This is discussed with the relevant service manager.

There are multipliers for the individual mental health specialties and they are all based on the five dependencies. Each one breaks down into care hours per patient day.

An example of how it is applied is if the assessment is looking at 18 beds and at the time the majority of acuities is mid to high, that would give an idea of how many care hours are required per week - looking at how many whole time equivalents are required to be able to safely staff 18 patients based on Level three and Level four.

Computer software analyses the information to help produce a health roster. If there are any unfilled shifts they are visible and staff with a bank posting can see those unfilled shifts and book directly through their own employee online account.

The figure below is an example of levels of acuity at the George Bryan Centre in November 2017.

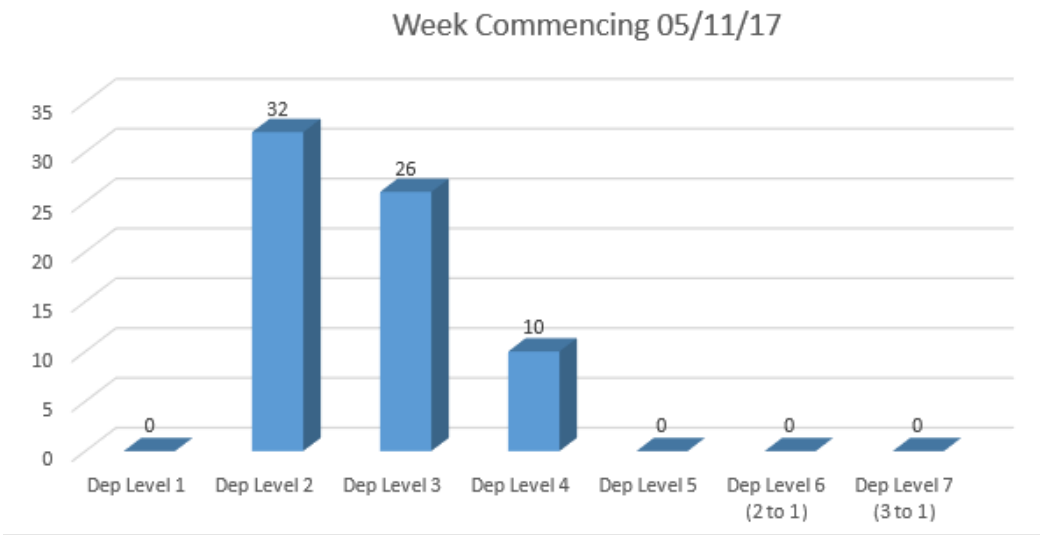


Figure 9 Acuity for the George Bryan Centre in November 2017

The figure below is an example of levels of acuity levels at Milford Ward in 2021. This is one of the wards at St George's Hospital where adults with severe mental illness are now admitted; it was extended in 2020/21. It also includes those isolating because of COVID-19, which would have a further impact on staffing.

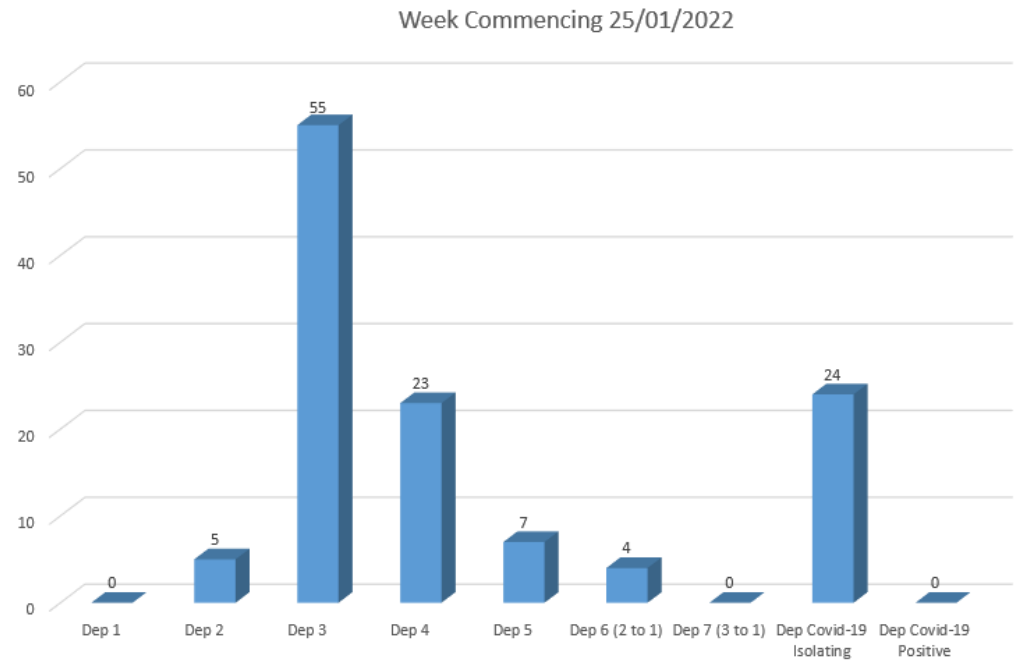


Figure 10 Acuity for Milford in January 2022

It is important to note that, in general, patients with lower levels of acuity were admitted to the George Bryan Centre because of the lower level of rehabilitation resource and support for patients in crisis, and that this would be likely to continue in any smaller standalone facility.

4.3.2 Workforce profiles

Analysis of the George Bryan Centre workforce at the end of 2018 shows that 40% of the staffing complement was aged 51 or above, the highest proportion were within the support to clinical staff workforce. This was coupled with the highest leaving reason being retirement which accounted for 50% of all 12 month leavers. The vacancy rate at this time was 12.43 WTE or 19.84%.

In comparison, analysis of the workforce at St. George's Hospital site shows that 21.62% of staff were aged 51 or above, with the highest leaving reason being voluntary resignation. The vacancy rate was 21.23 WTE or 10.44%.

The Staffordshire community mental health services workforce analysis shows that 37.88% of the workforce were aged 51 or above, with the highest leaving reason for the previous 12 months being voluntary resignation and the vacancy rate being 46.54 WTE or 11.36%.

4.3.3 Implications of analyses

Whether the rate of turnover has changed as a result of moving some staff to St George's Hospital, and other staff into the community, is difficult to calculate because of many factors.

These include the impact of the COVID-19 pandemic, the travelling distance from home to the new base and early retirement. Staff at the George Bryan Centre were all supported with enhanced travel and engaged about where they wanted to work.

With the opportunity for retirement at 55 with special class status for some staff there are potential risks to workforce supply against demand which would further exacerbate the Trust's challenges around shortages of qualified professionals.

4.3.4 Changes to bed numbers and resulting staff requirements

As a result of the fire at the George Bryan Centre, the 12 beds for older adults with severe mental illness or dementia were closed on clinical safety grounds. Of the patients in the East Wing:

- Some were close to discharge and MPFT worked closely with the local authority to expedite these discharges into appropriate care settings.
- Some could move to community with an enhanced offer.
- Some were repatriated to Baswich (dementia ward) and Bromley Ward at St. George's Hospital.

As described in Section three, the enhanced community pathway was developed to support older adults by Older Adult teams treating patients in home settings in the community.

The table below shows the pre-George Bryan Centre fire bed configuration and the number of staff employed. It shows the post-fire configuration, and finally the staffing that would be needed for the two options of either centralising beds at St George's Hospital in Stafford or reinstating the beds at the George Bryan Centre. Both of these options have been fully considered.

	Pre- GBC Fire Configuration		Post-Fire Configuration	Options for involvement	
	George Bryan Centre Site	St Georges Hospital, Stafford Site	St Georges Hospital, Stafford Site	Option 1 – Centralised beds Stafford	Option 2 – Reinstate beds at GBC
Number of beds	31	66 Beds	84 Beds (18 of 19 beds created) – removal 12 beds	84 Beds	18 (66 beds in Stafford)
Nursing	26.68 WTE	55.8 WTE	66.39 WTE	66.39 WTE	19.20 WTE
HCA	21.87 WTE	54.57 WTE	68 WTE	68 WTE	19.20 WTE
AHP	3.6 WTE	9.57 WTE	11.68 WTE	11.68 WTE	3 WTE
Psychologists	2.6 WTE	3 WTE	4 WTE	4 WTE	1.6 WTE
Medics	2.5 WTE	5.59 WTE	7.06 WTE	7.09 WTE	1.6 WTE
Admin	3.37 WTE	6.85 WTE	4.37 WTE	11.0 WTE	1.6 WTE
Totals Workforce	**63.62 WTE**	**135.38 WTE**	**161.53 WTE**	**168.16 WTE**	**46.2 WTE (138.53 WTE in Stafford) = 184.73 WTE**

Table 13 Pre and Post fire configuration of beds at the George Bryan Centre site and St George's Hospital site in Stafford

It should be noted that because of the enhanced community support for patients with severe mental illness, the level of severity for those admitted to hospital is now higher than it was because patients are more likely to be supported in the community unless they become seriously ill.

Safe staffing requirements are calculated using the Mental Health Optimal Staffing Tool (MHOST). The 'Option 2' column in Table 13 (above) shows the total whole time equivalent (WTE) required for the George Bryan Centre as a standalone site, while meeting safe staffing requirements. The table shows that to meet safe staffing requirements, reinstating beds at the George Bryan Centre would require 9.9% (16.6 WTE) more staff than centralising beds at St George's Hospital, Stafford. This potential recruitment requirement should be considered alongside three key recruitment and staffing pressures:

1. It has proven persistently difficult to recruit staff to standalone establishments such as the George Bryan Centre;
2. Recruiting to these positions could impact negatively on our community team of around 20 WTE staff who are required to support the community offer for adults and older adults with severe mental illness or dementia; and

3. Many staff have special staff status, by which staff employed in the NHS before a certain date can retire at the age of 55 and this creates a further staffing pressure. The workforce profiles below demonstrate the number of people over the age of 51.

4.4 Workforce impact for each scenario

A number of workforce challenges would be more acute if inpatient beds in south Staffordshire were provided in a location in addition to St George's Hospital.

4.4.1 Recruitment

A major challenge is the difficulty of recruiting staff. Nursing staff, including mental health nurses, are on the national shortage occupation list. Allied Health Professionals and Band 8A Psychologists are also on the shortage list. The location of Tamworth is also an issue when recruiting, as the Trust is competing with larger trusts across Birmingham and surrounding areas, which also provide mental health services.

Moreover, with regard to specialist skills, staff who provide therapeutic interventions are skilled and specialist, therefore tend to be a limited resource. It is difficult to recruit and retain these staff and it would be particularly challenging to recruit to a smaller, isolated site, as they work across wards as required and tend to prefer being part of a larger team.

As highlighted above, a percentage of staff who work in mental health are reaching retirement age and this could add to recruitment pressures.

MPFT has run numerous recruitment campaigns working with Hayes Agency to target those who may not actively look in Staffordshire but these are not delivering significant workforce.

4.4.2 Safety

As noted above, in order to provide a safe standalone unit, the establishment would need to be calculated - current estimates are for around 46 WTE staff. In a smaller establishment staff would not have the protection afforded by the larger numbers of staff in a larger hospital such as St George's Hospital.

4.4.3 Therapies

Additional interventions that are available for acutely ill patients at St George's Hospital which were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy.

St George's Hospital also provides access to specialist services that may be able to support the presenting need of inpatients on that site, for example, perinatal, mother and baby units, forensics, eating disorders, electro-convulsive therapy.

With a relatively small number of staff at a rebuilt standalone unit, interventions would be limited to their competencies.

For older adults with severe mental illness including dementia, work on a new pathway in the community identified the skill mix required for working with frail older people and the service was able to recruit staff with these skills.

4.5 Measures for sustainability

MPFT is carrying out a number of initiatives so that it knows it has the workforce capacity for adults with severe mental illness and older adults with severe mental illness or dementia. This includes ensuring staff have the right competencies.

4.5.1 Training and competencies for sustainability

As described above, the Trust uses the Mental Health Optimal Staffing Tool (MHOST) to understand at any point how the numbers of patients and their needs impact on workforce requirements.

By applying measures of patient acuity, they are able to assess how many staff they need to safely care for and treat patients, and they review this twice a year.

They also review the staffing situation on a daily basis, using the Safe Care live tool, which provides them with the same data as MHOST but based on a daily forecast. They add the acuity three times a day within the Safe Care live system, and then are able to calculate staff needs based on the care hours required to look after the patient with that level of need.

The decision about what staff are needed will include registered nurses, inpatient nurses and healthcare support workers and anybody else identified by the ward manager. Staffing is then flexed based on need.

There are regular reviews of the workforce skill mix to see whether there are any gaps and provide training as appropriate, with the help of the Trust's clinical education team. All staff including support staff have a training matrix including mandatory training (for example safe handling training for staff working with older adults) and where there are any gaps in available training the Trust sources that training.

The Trust monitors training guidance on an ongoing basis, including NHSEI and National Institute for Health and Care Excellence (NICE) guidance and provide appropriate training as required. The Trust is in the process of employing a mental health specialist onto the clinical education team to develop more robust training programmes. This will help with the development of new roles coming through from NHSEI including Assistant Practitioner and Clinical Associate Psychology roles.

The Trust is working with Health Education England on training for Nurse Associates and mental health and wellbeing practitioners. It has direct links with Keele University and is

developing a course for clinical associate psychologists. The first intake for this course will be in September 2022.

Think Ahead is a national programme led by social care, encouraging people to become social workers. MPFT is leading this initiative in Staffordshire and supporting with placements and training.

The Trust is looking at developing peer support workers and has recruited a professional lead for peer recovery workers, working with service users across the community, linking into their communities and working with people where they live. There is a competency framework for peer recovery workers to enable them to go into clinical roles if they wish.

There is a similar competency framework for other non-clinical roles, such as call handlers which would enable them to go into clinical roles ultimately, if they wished.

4.5.2 Recruitment for sustainability

In terms of recruitment to support sustainability, MPFT is currently running a huge recruitment drive. It has employed a talent acquisition specialist to support advertising and seek out people from different employment backgrounds, not just the NHS. There are also two members of staff dedicated to recruitment supporting the operational managers for services across community and inpatients. They are focusing on areas that have had the most challenge in terms of workforce replacement across the whole of mental health inpatient and community services.

MPFT is undertaking a Trust wide initiative (Project Synergy) which is in process. This aims to transform the way MPFT recruits, attracts, and retains and on-boards staff across the Trust.

Specific objectives have been set around reducing reliance on agency staff, reducing staff turnover and developing more contemporary workforce, ensuring workforce requirements are fit for the future.

4.5.3 Partnership working for sustainability

The transformation funding for the community model also provides more opportunities to contract the voluntary sector to work with the NHS in a more integrated way, working to service specifications and providing holistic non-clinical support in areas such as housing, finance and day-to-day living.

The Trust is looking at creative ways of ensuring that people are supported effectively after discharge and are actively working in partnership arrangements with the voluntary sector for this. There is a requirement for a home visit within 24 to 48 hours for people who have been discharged and the Trust is looking at whether this provision can be discharged without the need for a clinical team member. They are working with the voluntary sector and have an arrangement with the Alzheimer's Society through which the Society's dementia advisors support patients in their own homes. Their partnership with the Alzheimer's Society also

includes the Society providing maintenance groups for patients following cognitive stimulation therapy for dementia. In Stafford, the charity organisation The Mase Group also helps with support for dementia.

Brighter Futures help deliver the Trust's helpline. A specialist financial wellbeing advisor from the Citizens Advice Bureau provides financial support, and there is specialist support on substance misuse, delivered by Burton MIND. The Trust also accesses library support groups and are in the process of finalising contracts for housing support with both housing associations and local councils.

4.5.4 Bed model

The staffing model at St George's Hospital is more sustainable than having a standalone unit because there is a much larger number of staff at the hospital. The staff, particularly those in support worker roles, are able to move between wards as acuity levels require. With a smaller staffing establishment this would be more difficult or impossible.

Healthcare support workers are employed both in St George's Hospital and in community mental health teams and are a very flexible element within the staff. They are trained in the team they work in as apprentices, working in an area of care for three days a week and spending two days a week at university. They are able to provide support for people with serious mental illness including the specialist care needed for older adults. They are part of the safer staffing establishment in the hospital and are trained in observation and in therapeutic holding.

Healthcare support workers cannot take charge of a shift on a ward and cannot perform the role of Band 5 nurses, who are an essential part of a safer staffing establishment and would be more difficult to recruit to a standalone unit.

There is a bed manager at St George's Hospital who manages access to beds throughout the week, supplemented by site managers out of hours – all of whom are clinicians. They manage the beds from an acuity perspective (as described above) and the roles would become more complex with two sites, particularly because of the overall level of staffing at a standalone unit compared to a central single site.

The Crisis Resolution Home Treatment Team acts as initial gatekeepers to ascertain if a patient can be supported at home with intensive home treatment. If the risks are too high, or there is a Mental Health Act Section 136 in place, a bed is needed. The bed manager finds a bed, and there is a call system wrapped around this.

This process is more sustainable on one site, as there would be a limited call system at a site such as the George Bryan Centre.

The centralised model is also more sustainable in terms of staffing, because of the challenges described above.

The ICB is assured that the existing service model that has been in place since 2019 provides a sustainable workforce model that will meet future population needs. This is further evidenced through the current enhanced service model showing sustained improvements to outcomes including reducing patient length of stay and improved access (where there are no waiting times in accessing community provision or inpatient beds due to the dynamic nature of the way different teams work together and balance risk). This has meant that patients and families/carers are supported in their own home/usual place of residence improving overall quality and experience of care. Additionally, historical data has been used to determine future demand of both community and inpatient services.

5 Financial case

5.1 Introduction

This section describes the financial impact of the proposal - the permanent re-provision of severe mental illness adult inpatient services formerly provided from the George Bryan Centre at the St George's Hospital inpatient facility in Stafford, incorporating the establishment of community intervention services as part of the evolving model of care in accordance with national and local guidance.

The section includes:

- Community Mental Health Investment Standards
- MPFT baseline financial situation.
- Staffordshire ICB finances.
- The impact on MPFT.
- The refurbishment of Milford Ward.
- Future prospects and funding.

The financial plan reflects the current scale, nature and acuity of the patients supported in the temporary model, location and configuration of services provided by MPFT within its inpatient and community delivery model. Inevitably of course, this is very different to the picture which existed at the point of the fire, and this section will demonstrate that.

Accordingly, true like-for-like comparisons are impractical as wherever based, the service would have inevitably evolved over time rather than remain static. Nevertheless, this section will provide assurance that the proposal is sustainable within the overall financial plan for MPFT and its commissioners and continues to offer better value in financial terms than reverting to the legacy arrangements.

Community Mental Health Investment Standards

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICB's in England to increase their planned spending on Mental Health services by a greater proportion than their overall increase in budget allocation each year. The MHIS compliance statement is a statement to the public from NHS commissioners of healthcare (ICB) stating whether the ICB has met the MHIS.

The change from assessing and treating people in the ward at the George Bryan Centre to treating them in the community was in line with the general move towards mental health care based in the community wherever possible. Staffordshire and Stoke-on-Trent have secured funding to implement this national model locally, with the following figures showing the new money associated with Community Mental Health Transformation for all adults with severe

mental illness (SMI) including older adults, called Service Development Funding, this is ring fenced for this purpose only. We have also shown in the table below the existing spend on community mental health services, adult community crisis and improving access to psychological therapies (IAPT), across the ICB. The table below demonstrates our increasing investment in community mental health services.

Adult Community Mental Health Expenditure 2019/20 to 2022/23					
		2019/20	**2020/21**	**2021/22**	**2022/23**
		£000's	**£000's**	**£000's**	**£000's**
		Recat plan	**Recat plan**	**Actual**	**Forecast**
1. Community A – community services that are not bed-based / not placements (MHIS = Mental health Investment Standard)	MPFT	0	0	19,214	20,999
	NSCHT	0	0	21,894	23,209
	Other Providers	0	0	7,842	9,546
	Provider Split Unavailable	50,325	54,337	0	0
	Sub Total - MHIS	**50,325**	**54,337**	**48,950**	**53,754**
Adult Community Crisis	MPFT	0	0	2,114	2,457
	NSCHT	0	0	2,409	2,470
	Other Providers	0	0	863	1,050
	Provider Split Unavailable	3,488	4,285	0	0
	Sub Total - MHIS	**3,488**	**4,285**	**5,386**	**5,977**
Improving Access to Psychological Therapies (IAPT)	MPFT	11666	14,536	14,544	14,736
	NSCHT	0	0	0	0
	Other Providers	0	0	0	0
	Provider Split Unavailable	0	0	0	0
	Sub Total - MHIS	**11,666**	**14,536**	**14,544**	**14,736**
Adult Mental health Community (SDF & SR)	MPFT	0	0	1,048	2,573
(SDF = Service Development Funding)	NSCHT	0	0	1,048	2,573
	Other Providers	0	0	75	75
	Provider Split Unavailable	0	0	0	0
	Sub Total - SDF	-	-	2,171	5,220
TOTAL Community Mental Health	MPFT	11,666	14,536	36,920	40,764
	NSCHT	-	-	25,351	28,252
	Other Providers	-	-	8,780	10,671
	Provider Split Unavailable	53,813	58,622	-	-
	Total	**65,479**	**73,158**	**71,051**	**79,687**
Percentage increase over 4 years					**21.70%**

Table 14 Investment in community mental health services.

During the years reflected in the table MHIS categories were updated to reflect the priorities of the NHS Long Term Plan and this led to considerable change to some category descriptors. The MHIS has continued to grow year on year in line with the national mandate that ICB's must spend proportionately more on mental health than their overall increase in budget allocation. The table outlines the investment in Adult Community Services only.

Staffordshire and Stoke-on-Trent ICB/System is committed to meeting the Mental Health Investment Standard in 22/23 and all future years.

5.2 MPFT baseline financial situation

The table below provides a high-level summary of the operating expenditure attributed to the George Bryan Centre service line, dating back prior to the reprovision of the service following the fire in 2019. For the purposes of establishing a 'do nothing' or 'standstill' baseline, the expenditure and funding has been uplifted to current year values in line with published NHS operating framework inflationary indices. This projects the baseline forwards to produce a counter-factual view of what a normalised expenditure would have looked like in the current year under a 'standstill' scenario.

	2018/19	2019/20	2020/21	2021/22
	£'000	£'000	£'000	£'000
Direct Operating Expenses - Pay Costs	2,410	2,458	2,507	2,582
Direct Operating Expenses - Non Pay	136	139	141	143
Other Indirect Costs	439	450	456	462
Total Operational Expenditure	2,984	3,047	3,105	3,188

Table 15 Baseline (George Bryan Centre) Summary Financial Trajectory

Notes:

- 2018/19 extracted from Trust Service Line Reporting (SLR) data

- 2019/20 through to 2021/22 based on 18/19 plus pay and tariff inflation in line with National Operating guidance

- Excludes fixed corporate overheads which may be attributable to the service line for a 'full absorption' expenditure view, but this is notional and variable based upon changing methodology over time, and would be fixed in the medium term regardless of changes in operating models.

5.3 Staffordshire and Stoke-on-Trent ICB finances

The Staffordshire and Stoke-on-Trent ICB estimated an underlying deficit of circa £200m before the pandemic. Over the past year the system has implemented a financial strategy which has started the process of financial improvement, and the latest estimate of the underlying deficit is £133m at the end of 2021/22. The system financial strategy has helped contain activity growth which has supported this improvement.

Achieving financial sustainability will continue to be a significant control issue facing the ICB in the short term, as partners work collaboratively to manage activity growth and reduce the underlying deficit further. The system is working to maximise the significant opportunities for productivity improvements across all areas, which will be used to drive out the remaining deficit over the next three years. Whilst these medium-term strategies are delivered to achieve a sustainable financial position the system will use short term, non-recurrent measures to mitigate the underlying deficits.

The costs associated with this proposal have been covered and it poses no risk to system finances. No additional capital resource is required to progress with the viable proposal.

5.4 Impact on MPFT

Comparing the cost of past and present models.

The table below attempts to draw a comparison between the operating cost (revenue) of the baseline model - former George Bryan Centre as set out earlier in Table 15 with the current model that has evolved, based at St George's Hospital (including Milford Ward) and services in the community. This is necessarily notional given the limitations:

- The former George Bryan Centre model ceased in 2019 and indicative costs have been projected forward on a 'stand still' basis with inflationary indices applied to bring costs to present day values.
- The care formerly provided at the George Bryan Centre is now assimilated into wider and different models of care, and hence are not identifiable discretely. Costs have been apportioned accordingly where relevant and necessary to provide a reasonable proxy for the patient cohort in-scope of the review.
- The workforce pressures experienced in inpatient facilities with regard to recruitment / retention and double running costs associated with the COVID-19 pandemic over the last two years makes comparisons with the baseline complex.

In accordance with above, Table 17 shows the derived expenditure for the "current model" of the services in the scope of this case compared to the "baseline" derived earlier under Table 15. The "current model" operating spend is based upon the underlying budget for those services in the scope of the case. This resource emerged from the re-engineering of financial resources from the former George Bryan Centre service line budget to reflect the re-provision

of services into St George's Hospital (including Milford Ward) together with the enhancement of services in the community as described earlier. This provides a reasonable equivalent like-for-like comparison between the former model within the George Bryan Centre and the current model, but recognising the limitations set out above.

	Baseline				Current Model
	2018/19	2019/20	2020/21	2021/22	2022/23
	£'000	£'000	£'000	£'000	£'000
Direct Operating Expenses - Pay Costs	2,410	2,458	2,507	2,582	2,395
Direct Operating Expenses - Non Pay	136	139	141	143	102
Other Indirect Costs	439	450	456	462	474
Total Operational Expenditure	2,984	3,047	3,105	3,188	2,971

Table 16 Subjective Summary of Financial Trajectory – 2018/19 to 2022/23

The above table provides a subjective summary of the financial trajectory, based upon the methodology set out earlier. Table 17 below draws out a summary of the comparison by service model, showing, in particular, the efficiency emerging from the re-provision of care into the community in line with national and local expectations.

	Baseline Provision		Current Provision	
	£'000	Provision	£'000	Provision
Severe Mental Illness	1,848	19 Beds	1,893	18 Beds
Older Adult With SMI (incl dementia)	1,340	12 Beds	1,078	12 Community
Total	3,188		2,971	

Table 17 Comparison of Baseline Financial Resource to Current Resource

Noting the limitations of this comparison, it shows that the current equivalent provision is within the original baseline resource overall, representing efficiency of around 7% over the legacy 'stand still' model.

This should be considered alongside the clinical advantages of providing more care in community and home settings, as described elsewhere in this section.

5.5 Refurbishing Milford Ward

5.5.1 Milford Ward

A business case for redeveloping Milford Ward was first approved in June 2018. The business case was approved for the outturn projected costs identified within the detailed summary table below. The business case was undertaken using an internal programme management office (PMO) business case template. The outturn cost estimate identified and approved was for the value of £1.375 million.

A number of factors led to delays implementing the original business case. These included the use of Milford House to support winter pressure acute bed numbers as a contribution to system demand.

The scheme was reviewed in 2019 with a revised plan agreed in October 2019. Tenders were reviewed in March 2020 just as the COVID-19 pandemic impacted the NHS resulting in the delay of approving the spend to June in 2020.

Because of this, the scheme needed to develop an occupied ward, obtain full planning permission, and to be fully designed and tendered. Clinical leads agreed and signed off layout, scope and specification of works.

With the fire at the George Bryan Centre resulting in the decant and full occupation of the Milford Ward, though with a reduced number of beds, the scope of works and delivery method was significantly varied, mainly to undertake the internal refurbishment within an occupied mental health inpatient facility. The complexity of extending mechanical and electrical systems was also a major factor as will maintaining fire escapes. All these added to the cost.

A full assessment was undertaken of the RICS Chartered Quantity Surveyors' comprehensive tender report and cost analysis, offering assurance that the scheme can be delivered against the tendered design and specification package set out below.

Based on the returned lowest priced tender that was checked and validated, there was an outturn budget deficit of £630,842.36 (inclusive of VAT and Fees) against the initial high level costs developed within the original cost plan submitted in the 2017 business case. It is noted that the business case costing was not based on a competitive tender so some variation would be expected. The original cost plan was also 30 months out-of-date and based on vacant possession. The final returned costs and updated financial position were summarised as follows:

	Cost (£)
PM14 – SSSFT Business Case estimated costs – vacant possession	£1,375,000.00
Updated estimated out-turn project cost plan (based on returned tender) – Occupied wards on a phased development	£2,005,842.36
***Variance on approved business case budget =**	**£630,842.36**

Table 18 Final returned costs and updated financial position

This was funded through the Trust's annual capital plan.

5.5.2 Re-instating inpatient services at George Bryan Centre

MPFT has developed cost estimates for two approaches to building works that would enable inpatient beds for adults with severe mental illness to be reinstated at the George Bryan Centre.

The cost estimate for the first approach - refurbish and rebuild the George Bryan Centre on its existing footprint - would be in the region of £8 million. This approach has challenges as the existing building is not compliant with current regulations.

The cost estimate for the second approach - to replace the existing building with a new build 18 bed ward and support accommodation that complies with current guidance on planning and designing adult acute mental health units in England – is £11.37m

If beds were to be re-instated at the George Bryan Centre it should be noted that the Milford Ward would as a consequence become under-utilised, as a fixed number of beds are commissioned.

Additionally, it should also be noted that it would be expected that the revenue operating cost of the beds for adults with severe mental illness would be more expensive if they were re-instated at the existing scale in a stand-alone facility rather than the current centralised setting of St George's Hospital as economies of scale would be lost. Furthermore, there is currently a shortage of mental health staff and it is difficult to recruit staff to smaller units because of isolation. If staff could not be recruited, there are likely to be additional costs for providing bank/agency cover.

The greater number of inpatient sites the more is spent on administrative and other support services and the less efficient the Trust is overall.

MPFT received £1m from the insurers of the George Bryan Centre. In line with NHS financial rules, this money is received as revenue and not capital. It will be released into this year's accounts (2022-2023) and will be spent on community services. Revenue cannot be spent on buildings.

NHS insurance cover is capped at £1m. Investment in buildings (capital) is managed by NHS England, through an established process involving the writing of separate business cases and is based on the rebuild cost. In the case of the George Bryan Centre, this is estimated to be £11.37m.

5.6 Future prospects and funding

The financial challenges for the ICS, and partners like MPFT within it, are being reviewed as part of responding to the requirements of the NHS Planning framework for 2022/23. The landscape within which NHS systems have operated has changed considerably since the COVID-19 pandemic emerged. A funding regime has been established for 2022/23 as part of the journey back towards financial improvement targets, and this will pose increasing financial challenges, particularly for those systems like Staffordshire that remain in an underlying forward deficit.

A draft plan submission for each ICS, and providers within it, was submitted in March with a final submission at the end of April. The financial plan for MPFT within that is approved as a balanced and sustainable financial target, but there remain challenges in relation to managing forward demand growth, recruitment and retention of workforce, and delivery of efficiency targets.

The service model within the spotlight of this financial case is important, but a relatively small proportion of the overall spend of the Trust, around £550m in 2021/22.

Looking further forwards, the financial model of all services will be kept under review to ensure the services not only remain safe and contemporary in terms of quality standards, and follow the national direction, but also that they offer value for money, compared against benchmarks, reference costs and other comparators. Workforce planning and building community capacity is essential.

The Mental Health Strategy Delivery plan for 2022/23[1] reinforces the funding commitment and ambitions within the Mental Health Implementation plan (2019/20 – 2023/24)[2] and the Five Year Forward View[3]. This set a commitment to grow investment in mental health services faster and greater than the overall NHS average. The mental health investment standard mandates that each ICS must grow investment at least equal to the ICB baseline growth year on year. By 2023/24, community resources supporting SMI in the community will have grown by £16.6m per annum over the course of the Five Year Forward Plan.

Though not a panacea, this is crucial to helping manage growing demands and increasing access to critical mental health services at the right time and in the right way.

As part of that, specific transformation growth funding has been earmarked towards supporting community-based models of care over the course of the Five Year Forward Plan.

This includes growth funding for the services provided in the community which support adults, including older adults, with severe mental illness and are likely to lead to shorter inpatient stays. In addition, the Long Term Plan requires that we go further in improving the care we

[1] Mental Health Strategy Delivery Plan for 2022-23, July 2022

[2] Mental Health Implementation Plan 2019/20 – 2023/24, July 2019

[3] NHS Five Year Forward View, March 2017

provide to people with dementia whether they are in hospital or at home. This includes improving dementia diagnosis rates and pathways; implementing NICE guidance around post-diagnostic treatment and support; personalised care planning and jointed up integrated care and collaboration, and all NHS staff receiving training on dementia appropriate to their role.

6 Public and patient, clinical and staff involvement

6.1 Introduction

This section of the pre-consultation business case describes briefly:

- Phase one - the patient, public and stakeholder involvement that took place during 2019-20 as mental health services in south east Staffordshire were considered as part of the wider Together We're Better transformation programme
- Phase two - the involvement carried out by MPFT in September and October 2019 to understand people's views specifically of the services at the George Bryan Centre.
- Phase three – The process of developing proposals for the future of these services was paused in 2020 as a result of the COVID-19 pandemic. In late summer 2021 the process was started again with further engagement in autumn 2021 and spring 2022 to understand whether there were any additional considerations about the future of mental health services
- The ongoing engagement with local authority Health Overview and Scrutiny Committees.

Patient and public involvement is a priority for Midlands Partnership NHS Foundation Trust (MPFT) and NHS commissioners in Staffordshire and Stoke-on-Trent. Patients, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of mental health services in south east Staffordshire from the outset.

MPFT and the ICB used this collective feedback to inform the development of the proposals and this pre-consultation business case and its proposal for the future of the services formerly provided at the George Bryan Centre, more detail on the options appraisal process can be found in Section seven.

6.2 Phase one - Together We're Better Engagement in 2019

Engagement about the future of mental health took place within the context of the wider programme for transformation in Staffordshire and Stoke-on-Trent, under the name Together We're Better (TWB).

The mental health case for change was developed through the Sustainability and Transformation Partnership (STP) Mental Health Programme Board, building on the NHS Long Term Plan. This was included in the Staffordshire and Stoke-on-Trent Case for Change[1]

[1] Case for Change, Together We're Better, 2019

developed in 2019 setting out the needs of the population, the current provision of health and care and outlines the vision and aims for local health and care in the future.

A Clinical Advisory Group (CAG) for the transformation programme met four times in 2019/20. The CAG is an expert group of clinical leads from across the clinical programmes and organisations, GPs and Public Health clinicians, with the purpose of reviewing the clinical models in the transformation programme throughout the options appraisal process. Mental health, as one of the elements in TWB, was included in their discussions. More information about the clinical involvement in the development of proposals for mental health services is detailed in Section seven.

The case for change was articulated to the public during a 12-week listening exercise in summer 2019.

6.2.1 TWB engagement 2019

In order to articulate the mental health case for change a range of materials were produced to inform stakeholders about the listening exercise in summer 2019 and to gather feedback. A mix of communication channels were used to raise awareness about the listening exercise and encourage participation. Information was also shared with stakeholders via the TWB monthly newsletter which was sent to MPs along with members of the public, the voluntary sector, Overview and Scrutiny Committee (OSC) members and chairs, Chief Executives, providers and staff.

There was involvement with a number of organisations who could provide links to seldom heard groups and areas of health inequality including Local Equality Advisory Forum (LEAF), Healthwatch, Support Staffordshire (which provides county-wide support for the Voluntary, Community and Social Enterprise Sector) Burton YMCA, Burntwood Town Council and Staffordshire Sight Loss Association. The communications and engagement team worked with Assist in the north, and with Mind in East Staffordshire, asking for their support to promote the listening exercise across their members.

You can read more about our approach in our report of findings[1].

6.2.2 Findings - TWB engagement 2019

Findings from this engagement exercise were shared with participants at options appraisal events for the public and one for staff on 5 November 2019, and technical events on 15 October and 14 November 2019 for evaluators, including clinicians, observers, including a patient and public engagement (PPI) representative, and advisers including senior staff.

In addition, the report of findings from the engagement work was presented in a workshop for programme leads/clinical leads and shared by email offering them the chance to ask for any further information /clarity to inform the development of proposals. The Governing Body of

[1] Together We're Better Listening Exercise Report of Findings, 25 October 2019

Staffordshire CCGs formally received the report on 7 November 2019. A summary, public facing report of findings was published in February 2020[1].

6.3 Phase two - MPFT Engagement in 2019

Whilst the TWB listening exercise included the system case for change and the clinical model for mental health services across Staffordshire and Stoke-on-Trent, it was also important that more focused involvement activity was undertaken.

MPFT organised a further programme of engagement specifically to gather feedback about patients' experiences of the George Bryan Centre. The planning and delivery of the programme of engagement was fully co-produced with representation from people with lived experience.

6.3.1 Event dates and times – MPFT engagement 2019

- Lichfield, Cathedral Hotel, 25th September 2019, 9.30am-12.30pm
- Tamworth, Coton Centre, 16th October 2019, 2-5pm
- Tamworth, Coton Centre, 16th October 2019, 6-9pm
- Burton upon Trent, Library, 17th October 2019, 2-5pm

At the request of Christopher Pincher MP, an additional drop-in session was organised at:

- Sir Robert Peel, Hospital, 24th October 2019 10am-2pm

Excluding MPFT colleagues, 37 people attended an event.

The events were attended by patients, the public and staff, including commissioners.

For those who could not attend an event, the presentation and template were published on the MPFT website, with a link from the home page. This included the leaflet used at the drop-in session. MPFT also received a number of emails and the person with lived experience on the planning group also provided feedback.

Glascote Patient Participation Group also invited a representative to attend their meeting, where 14 people were present.

6.3.2 Findings - MPFT engagement 2019

There was a great deal of support for local mental health services. This extended beyond inpatients to community services. Many positive experiences were shared. This included staff being commended for being caring and the quality of the food was mentioned at a number of

[1] Together We're Better Listening Exercise, Report of Findings, October 2019

sessions. People expressed feeling safe and ‘restful’ at the George Bryan Centre. More than one person described the Centre as saving their lives – or that of a relative.

The main themes from the feedback were:

- Support to rebuild the George Bryan Centre like-for-like.
- Additional beds.
- Using the centre as a base for community-based services (including young people and all types of mental health support). Some extended this to other health services and the voluntary sector.
- The greater range of services in Stafford was mentioned – art, music and occupational therapy.
- Travel was the most common theme – distance, cost and accessibility of public transport.

A report of findings[1] from this engagement was published on 30 January 2020 as part of the Trust Board papers for the Board of Directors of MPFT.

The report of findings was shared with the TWB programme team and was incorporated into the evidence base for the options appraisal process.

6.3.3 Pause in engagement and involvement

The programme was paused in March 2020 to enable clinicians and staff to prioritise the response to the COVID-19 pandemic.

6.4 Phase three - engagement in 2021

It was recognised that services and people’s experiences have had to adapt during the pandemic, and so further sense-check involvement activity took place during summer/autumn 2021 to understand any new context and to inform this pre-consultation business case, and as this work has connections with the involvement activity for the Community Mental Health Transformation Programme and the Mental Health Strategy for Staffordshire any comments received are also being shared with these programmes to support the wider mental health vision.

The engagement sought to:

- Find out what people’s experiences were of the temporary service changes before and during COVID-19.
- Discover if there were any new considerations / impact (negative/positive) when designing the new model of care and future proposals.

[1] George Bryan Centre Engagement Outcome Report in MPFT Trust Board Papers, 30 Jan 2020

The objectives of this work were to:

- Gather any further information needed to inform proposals for future service change.
- Sense-check the model of care and emerging proposals to inform the business case.

6.4.1 Stakeholder map and engagement - 2021 engagement

Key stakeholders were identified for communication and engagement at each step of the journey. The stakeholder map can be found at Appendix 5.

The relevant stakeholders received briefings, bulletins and updates, including information sent to organisations' communications teams so that they could pass on the link to the survey and information about the events. Local MPs were kept up-to-date with regular briefings with the CCG accountable officer and the interim Integrated Care System (ICS) chief executive.

6.4.2 Engagement activity - 2021 engagement

Engagement activity included a short survey available from 7 to 31 October and two engagement events held on 14 and 18 October.

Altogether 80 responses were received to the survey and 29 people attended the engagement events. Eighty-five phone calls were made, 783 stakeholders engaged with and 3,014 emails sent.

The questionnaire is available at Appendix 6.

A mid-point review of the engagement [see Appendix 7] took place in October 2021 to identify any gaps in the groups responding. The mid-point review identified lower return rates from service users, NHS employees and carers. Demographic data showed the majority of respondents to the survey and attendees to the workshops were white.

As a result of the review, care homes and hospices were sent messaging about the involvement activity and encouraged to participate. The engagement team also worked with partners and connections in the voluntary sector to help reach the specific special interest groups and organisations whose members aligned with those they hoped to hear from.

Summary of responses – 2021 engagement

In summary, the engagement responses about experience of mental health care since February 2019 were:

- Quality of care was good at George Bryan Centre.
- Difficulty in accessing mental health services.
- Communication requires improvement.
- Mixed feedback on care during pandemic.

Responses about the national model of care were:

- Agreement with the model and principles.
- Need to implement the model effectively.
- Need further consultation about changes.

Further detail is available in the full report of findings[1] on the MPFT website.

6.4.3 Supporting seldom heard groups - 2021 engagement

An involvement Equality Impact Assessment (EIA) was produced that outlines the approach to involving seldom heard groups. The communications and engagement team worked closely with the CCGs' Local Equality Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

They ensured communications were accessible. The presentation slides[2] at the engagement events and the questionnaire both included information about accessibility including a variety of opportunities to provide feedback, including attending the events, a survey, by phone or in writing.

The communications and engagement team built on relationships with the voluntary and community sector to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, they worked with trusted advocates, for example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that was approachable and understandable. Reminder emails about the survey were sent during October to Gypsy, Roma, Traveller contacts, sports clubs, places of worship and community groups and the top five local employers.

6.4.4 Deliberative event March 2022

In March 2022, we held an online event for a reference group of service users, carers, staff and seldom heard groups. Developed with the support of the Consultation Institute, the event was designed to:

- Deliberate the proposals developed to date.
- Hear people's views on whether there was anything else that needed to be considered in the business case.
- Consider the recommendations that the technical group had made.
- Discuss anything that could be done to reduce any potential negative impacts.

The event is described in detail in Section 7.3.3.

[1] Finding a long-term solution for the mental health services that were provided from the George Bryan Centre, Summary of findings,

[2] George Bryan Centre presentation. 18 October 2021

6.4.5 Staff and clinical involvement

Commissioning and provider staff were involved in the various engagement programmes through internal communications including the intranet and staff newsletters and briefings. They were able to complete questionnaires and were invited to attend events.

Staff were offered one-to-one interviews to help share their feedback. You can read more about this in Appendix 9.

6.4.6 Continuous involvement

Throughout our involvement activity we have regularly undertaken gap analysis to understand the reach of our work, this includes reviewing responses both in terms of geographical and demographic representation. Our reports of findings show that we have captured the feedback of people with lived experience of using and working within mental health services, including the former George Bryan Centre, St George's Hospital and community services. Working closely with the Consultation Institute at every step of this journey, we are assured that we have followed a tried and tested process to seek continuous involvement.

We have used available population data and service data to help inform our Equality Impact Assessment and involvement activity. We have received a wealth of feedback through these activities, which has helped inform our findings.

Although attempts were made to reach seldom heard/protected groups during the different phases, we recognise response rates from some groups, for example the Gypsy and Traveller Liaison community, and some ethnic minority communities, remain low. We aspire to reach higher numbers of respondents from these groups during any future involvement activity. We will continue to build relationships with trusted advocates for these groups, over the coming months, to understand their specific needs and support them to get involved in any future involvement activity.

6.4.7 Use of feedback

Clinicians and staff at MPFT used the collective feedback from pre- and post-COVID-19, and the reference group in 2022, to inform the development of this pre-consultation business case and the proposal for the future of the services formerly provided at the George Bryan Centre.

6.5 Engagement with Health Overview and Scrutiny Committees

Overview and Scrutiny Committee responsibilities are outlined at the beginning of the pre-consultation business case. NHS commissioners and MPFT have kept the Staffordshire County Council Health and Care Overview and Scrutiny Committee up-to-date with information about the Together We're Better transformation programme. Information shared and discussed includes mental health services in south east Staffordshire and the situation at the George Bryan Centre, and details of patient and public involvement on these issues.

They have also provided updates to Lichfield District Council's Community Housing and Health (Overview and Scrutiny) Committee and Tamworth Borough Council Health and Wellbeing Scrutiny Committee. Both of these local councils are represented on the Staffordshire County Council Health and Care Overview and Scrutiny Committee

Full detail of the meetings attended is available at Appendix 10.

Key feedback

The following points should be particularly noted:

The minutes[1] of the Lichfield District Council Community Housing and Health (Overview and Scrutiny) Committee on 25 March 2019 state:

> *"It was noted that any permanent plan for the George Bryan centre would be subject to consultation."*

The minutes[2] of a meeting of Healthy Staffordshire Select Committee on 15 July 2019 (the previous name of the Overview and Scrutiny Committee) states:

> *"RESOLVED – That:- (a) The CCGs and Midlands Partnership Group be informed that the Committee felt that the 12 bed based facility, should remain in Tamworth. (b) Following the consultation, the CCG should bring detailed proposals to the Committee for consideration."*

Following an item at the meeting of Healthy Staffordshire Select Committee on 28 October 2019 the minutes[3] state:

> *"RESOLVED: That the report be received, and that the following information be requested: .... d) The Committee be formally consulted on any proposed changes to the George Bryan Centre."*

On 9 August 2021 NHS Staffordshire and Stoke-on-Trent CCGs presented an update to Staffordshire County Council Health and Care Overview and Scrutiny Committee about the temporary closure of the George Bryan Centre.

Members of the committee were asked to note the report and to advise on any additional information that was required by members to feel that due process and sufficient involvement activity would be undertaken to inform the proposals in the pre-consultation business case.

The minutes from the committee's response resolved[4]:

[1] Community Housing and Health (Overview and Scrutiny) Committee Agenda and Minutes- Monday, 25th March 2019

[2] Minutes of the Healthy Staffordshire Select Committee Meeting, 15 July 2019

[3] Minutes of the Healthy Staffordshire Select Committee Meeting, 28 October 2019

[4] Minutes of the Health and Care Overview and Scrutiny Committee Meeting, 9 August 2021

"1. That the update report and presentation were noted.

2. That Committee requested the link to more detailed information from engagement feedback, data of re-admissions to ensure clinical evidence was included in the business case and confirmation of the insurance funding details.

3. That the final draft proposal be considered by the Committee at a future meeting."

On 15 March 2022 NHS Staffordshire and Stoke-on-Trent CCGs presented an update[1] to Staffordshire County Council Health and Care Overview and Scrutiny Committee about the Together We're Better transformation programme.

This included an overview of the autumn 2021 engagement and a summary of the feedback.

The paper summarised the position with regard to the options appraisals process for the transformation programmes, including inpatient mental health services in south east Staffordshire.

It emphasised the continued involvement of staff, service users, carers and other interested groups and detailed the development of reference groups including service users and carers, workforce and members of protected characteristic groups.

It underlined that no decisions had yet been made and confirmed that the CCGs would keep the committee informed of the progress in developing future business cases, and to inform their approach to any future involvement activity.

The minutes[2] of the meeting note:

- Members highlighted the importance of reliability and value of data in the options appraisal to inform decision making for the George Bryan Centre. Assurance was given that the information gathering process was the same as used in other work, and that a range of evidence and impact assessments had been taken into account in the development of proposals. The stakeholder session to consider the proposal for the George Bryan Centre later that day would provide a sense check and would take into account the findings. The business case would go through an assurance process and be reported to committee in Summer 2022.
- Members understood that local intelligence and knowledge of trusted voices in the community was the best way to reach out and were assured that links were being built in to processes to speak to all communities.

It was resolved:

[1] Health and Care Overview and Scrutiny Committee agenda and reports pack, 15 March 2022

[2] Minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 15 March 2022

- That the Health and Care Overview and Scrutiny Committee received the reports of findings in the Transformation Programme update report and requested a report to a future meeting to consider the final proposals.

On 1 August 2022 NHS Staffordshire and Stoke-on-Trent ICB presented[1] to Staffordshire County Council Health and Care Overview and Scrutiny Committee the draft business case to provide from St George's Hospital, Stafford the inpatient services in south east Staffordshire formerly provided by MPFT from the George Bryan Centre for adults with severe mental illness and older adults with severe mental illness or dementia.

The presentation introduced by Steve Grange, Deputy Chief Executive at MPFT, and delivered by Paul Edmondson-Jones MBE, Chief Medical Officer Staffordshire and Stoke-on-Trent (SSOT) ICB, summarised the case for change and process to date.

Members asked questions of SSOT ICB and MPFT representatives and held a wide ranging discussion covering points including workforce safety on hospital sites and in the community; wider community safety; community mental health services; the reach of involvement to date; transport and service accessibility; the requirement for greater contractual commitment to services from commissioners; the insurance money from the fire at the George Bryan Centre and future use of the site; and the relationship with social care services.

The Chairman thanked presenters for providing a detailed and useful presentation and detailed analysis of the questions raised. The Chairman established that Committee was broadly in support of the principle to move towards Community Services and that further information would strengthen the proposal. Committee was in support of the principle to move people with dementia into community services if it benefitted those individuals.

The committee formally noted the report and set out the information it wishes to see when the matter is next raised for discussion.

On 17 October 2022 NHS Staffordshire and Stoke-on-Trent ICB presented to Staffordshire County Council Health and Care Overview and Scrutiny Committee the consolidated response to the questions raised at the meeting held on 1 August 2022.[2]

The ICB will maintain an ongoing dialogue with the Staffordshire County Council Health and Care Overview and Scrutiny Committee. The next stage of the process will be to share a copy of the Communication and Involvement Plan with committee members and outlining the timeline for any future involvement activity to take place.

The Director of Communications and Corporate Services has monthly meetings with the OSC chair and officer. The ICB Chief Executive has regular meetings with the OSC Chair.

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[1] Draft minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 01 August 2022

[2] Agenda and draft minutes from the Health and Care Overview and Scrutiny Committee - Monday 1st August 2022.

7 Proposal development and shortlisting/selection process

7.1 Introduction

This section describes how proposals have been developed for services for adults of any age in south east Staffordshire experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital. The shortlisting and selection process is included.

It includes:

- Requirements for developing proposals.
- Proposal development phase one.
- Proposal development phase two.

This process has been applied in line with the guidance *Planning, Delivering and Assuring service change for patients*[1], published by NHS England in 2018.

The way in which the proposal for change has been arrived at will, if progressed, be exposed to scrutiny by local authority health overview and scrutiny committees (OSCs), by patients, the public and other stakeholders, possibly by the courts and possibly by the Independent Reconfiguration Panel (IRP) if a referral is made to the Secretary of State.

It is important that when proposals are developed, a comprehensive range of perspectives is sought to identify the full range of service change solutions that could meet the stated objectives of the programme within available resources.[2]

There is no duty to carry forward to public consultation proposals that in the view of the commissioners are unrealistic, unviable or unsustainable.[3]

Current state description

The objective of the options appraisal process was to develop proposals for the future of services for adult (18 to end of life) patients from south east Staffordshire who experience severe mental illness or dementia that, until February 2019, included the possibility of admission to the George Bryan Centre. The aim being that proposals that emerge from the process should:

- Fit with the national and local strategy for mental health services.

[1] NHS Planning, assuring and delivering service change for patients, April 2018

[2] p25, NHS Planning, assuring and delivering service change for patients, NHS England 2018

[3] R(Nettleship) v NHS South Tyneside CCG and Sunderland CCG [2020] EWCA Civ 46

- Provide the highest quality of care, clinically and in terms of safety and therapies.
- Make best use of workforce and financial resources and are fit with the overall estates strategy for MPFT.

Healthcare organisations have a statutory duty to ensure that individuals to whom current or potential future services are being or may be provided are *"involved in the development and consideration of proposals [for changes] where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them [at the point where the services are received by users]"*[1] and this has been taken into account throughout the development of proposals for mental health services in south Staffordshire, including services at the George Bryan Centre. Details of public, patient and stakeholder engagement are described in Section six.

Figure 1 in Section one illustrates the process that programme team have undertaken to support the development of proposals. As with the involvement activity described in the previous section this was impacted by the pause for our systems response to COVID-19. The outputs from the involvement activity have provided valuable information and the options appraisal process included key stages where further patient, public and stakeholder feedback was used to shape and review proposals.

7.2 Proposal development phase 1

The Staffordshire and Stoke-on-Trent system-wide Case for Change[2] sets out the needs of the population, current provision of health and care and outlines the vision and aims for local health and care in the future.

Whilst developing the case for change a series of interdependency workshops took place to identify challenges and opportunities within and across each clinical programme. A standard approach was undertaken to identify a range of potential scenarios. These in turn were refined in a structured way through the options appraisal process. To generate a theoretical longlist, the mental health programme considered the fixed points for their service, which included minimal staffing levels, interdependencies with other services such as primary/community care, benefits of co-location as well as the benefits and outcomes for patients.

For mental health, this includes the introduction of integrated care teams and community hubs, as well as community-based crisis response and intensive home treatment as an alternative to acute inpatient admissions.

The Case for Change also specifies the need to consider the model of care for patients from east/south east Staffordshire who require inpatient provision – those who would have used

[1] S13Q & 14Z2 National Health Service Act 2006 as amended Health and Social Care Act 2012

[2] Case for Change, Together We're Better, 2019

the services at the George Bryan Centre before the fire. This strategic view is the background to the development of proposals for the future of the services previously provided by the George Bryan Centre. The mental health specific elements outlined within the case for change were developed through the Sustainability and Transformation Partnership (STP) Mental Health Programme Board, building on the NHS Long Term Plan.

In May 2019, the Case for Change was presented to the West Midlands Clinical Senate. The Clinical Senate was of the view that the STP articulated a credible case for change and the aspirational principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance. In June 2019, this was presented to NHS England and NHS Improvement (NHSEI). They gave permission to hold engagement events in the summer of 2019.

The Case for Change was then articulated to the public during a 12-week listening exercise in summer 2019. Throughout this period of public involvement, the Clinical Advisory Group (CAG) met to further develop the clinical model, based upon the case for change and emerging clinical guidance.

7.2.1 Initial proposal development

During autumn 2019 MPFT and system partners worked to develop proposals for the future of services at the George Bryan Centre and an initial business case.

The two proposals they developed were:

Centralisation of inpatient beds in St George's Hospital, Stafford

This proposal would make permanent the solution that has been provided since the fire.

- Patients who need inpatient treatment are admitted to St George's Hospital in Stafford. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital.
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services.
- There are distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia, so that patients get the specialist support that they need.

Provision of inpatient beds in south east Staffordshire for adults (aged 18 plus) with serious mental illness

Provide a ward with 18 beds at the George Bryan Centre. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital.

- Wherever possible, patients are treated at home, supported by the enhanced community mental health services.
- There are distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia, so that patients get the specialist support that they need.

These were the 'medium list' of proposals for these services.

7.2.2 Technical event 1

On 15 October 2019 a technical group consisting of clinicians, operational leads, strategic leads and communications colleagues considered the findings of the TWB listening exercise and defined essential criteria that proposals would have to meet (these criteria would be applied to any proposals within the transformation programme). These were:

- Clinical sustainability.
- Strategic fit.
- Meeting the needs of the population.

The group reviewed the proposals against these criteria. It was agreed at this event that both proposals should remain on the medium list. Alongside the details from the report of findings, the presentations given on the day outlined both qualitative and quantitative evidence. The previous sections of the pre-consultation business case give detail of the strategic fit, clinical sustainability and needs of the population that were taken into account during the technical event.

7.2.3 Deliberative events Oct/Nov 2019

Following the first technical event (15 October) and as part of the proposals appraisal process for the whole transformation process, four deliberative events were held, one for patients and the public in each of the geographies of Staffordshire and Stoke-on-Trent; North, and South East and South West plus one event for staff:

- 24 October Port Vale football Club (this did not cover the George Bryan Centre due to the geography)
- 28 October Lichfield, George hotel
- 30 October Stafford, Entrust

The staff event was held in November.

The events covered the five service areas of urgent and emergency care, integrated community services, maternity care services, planned care services and mental health services. The vision, aims and partners involved in the Transformation Programme were outlined and the clinical case for change was presented. In addition, participants heard a summary of the feedback about mental health from the listening events held in Summer 2019.

They were shown the clinical model for mental health services, and received data packs to inform their deliberations. The data packs included demographic information, geographical information on service provision and activity level data.

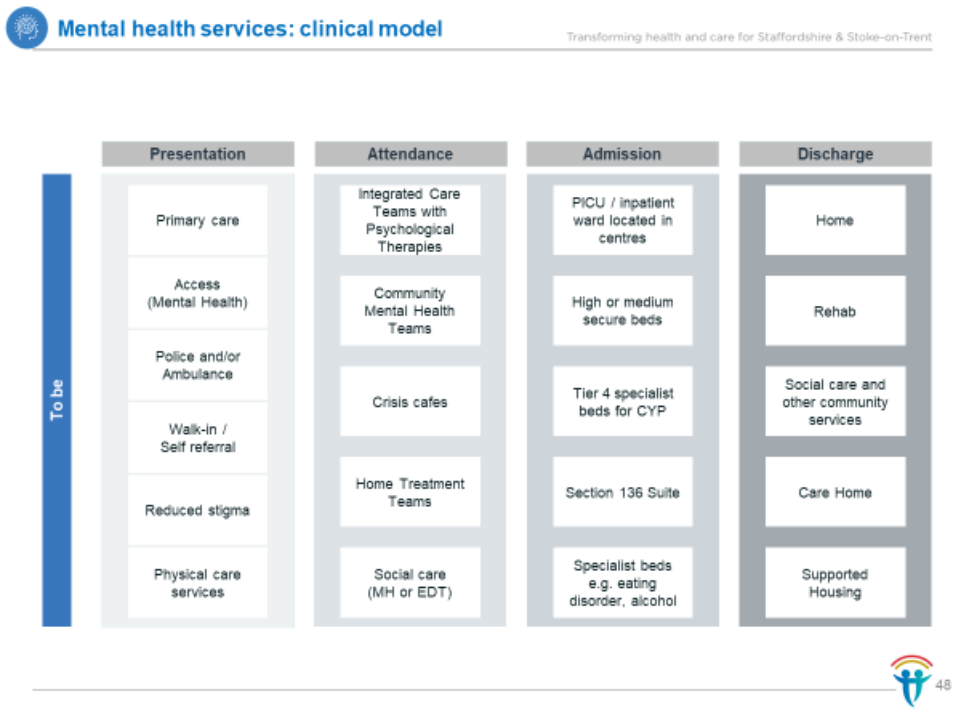


Figure 11 Mental health services: Clinical model

They heard that, given the temporary closure of the George Bryan Centre, there was a need to consider how best to re-provide services.

They heard that the current proposals for provision of services previously provided at the George Bryan Centre included:

- Rebuilding on the current site.
- Absorbing capacity into current sites.

They were asked three questions:

1. **Are there any other ways to provide inpatient mental health beds in the south of the county?**
2. **Are there any essential services / locations missing in the area?**
3. **Which services might people be prepared to travel further for?**

We heard feedback on the following themes; dementia care, location of services, service provision, integration of service provision, location and access, patient transport and the travel requirements for family members and carers.

The full details of the feedback are outlined with the report of findings[1].

This feedback was presented and considered at the second technical event (14 November).

7.2.4 Technical event 2

On 14 November 2019 a further technical session was convened for evaluators and attended by advisors and observers. The evaluators were nominated clinicians from across the system, in addition to workforce, estates, and quality representatives. The group were provided with data packs as used at the deliberative events to aid discussion.

The evaluators received a report on the outputs of deliberative events held in October and November (see Section 7.2.3) and reviewed proposals against further essential criteria:

- Demand and capacity,
- Workforce sustainability, and
- Estates

A presentation of the quantitative data analysis for each hurdle criteria led to a wide ranging discussion which included the increase in community provision, alignment with other services in the system, that specialist services such as those for substance users are not included in these considerations, and the need for data to demonstrate the low level of inappropriate out of area placements.

After these discussions, it was agreed that both proposals should remain on the medium list.

7.2.5 The continuing process

In January 2020, technical events were held in relation to the other clinical areas subject to the TWB proposal appraisal process, the group were appraised of the process pertaining to mental health services in light of the interdependencies across programme areas.

The short list of proposals was shared with the Programme Board on 10 February 2020, and the Programme Board which included CEOs on 9 March 2020. A briefing paper was developed and circulated to all provider organisations to provide details of the proposals as they stood at that point in time ahead of progressing to the next stage of the business case development.

It should also be noted that a further workshop was held on 3 March 2020. The aim of this workshop was to develop the desirable criteria for all clinical programmes in the TWB transformation programme. This included examination of the proposals for the future of

[1] Together We're Better Listening Exercise Report of Findings, 25 October 2019

inpatient mental health beds in south Staffordshire with discussion of what needed to be considered when deciding options.

The programme was then paused in March 2020 due to the response to the COVID-19 pandemic and re-deployment of staff to manage the response required across system partners to implement COVID-19 safe services and the vaccination programme.

7.3 Proposal development phase 2

In autumn 2021 the involvement conversation was restarted by MPFT, supported by TWB. The transformation programme began again, with involvement activity to sense-check the outputs of the paused process. A survey to sense-check information and comments already received was launched on 7 October, running until 31 October. This was completed by 80 people. Two public events were held on 14 and 18 October 2021 which were attended by 29 people. The findings from the engagement were gathered in a report[1]. More information is available in Section six.

7.3.1 Technical event to review proposals

At a technical event held on 10 December 2021, a group comprising representatives of commissioners and providers including the deputy chief executive of MPFT, directors and/or leads for mental health services, continuous improvement, quality, strategic commissioning and finance, and the community outreach lead from Healthwatch reviewed the interim reports of findings from the autumn 2021 involvement. In addition, the group discussed the process to date and confirmed the vision statement and essential criteria. The group heard details of both the national and local clinical model, bed configuration data and workforce analysis to assess whether the proposals were viable.

The context for mental health in Staffordshire and Stoke-on-Trent was summarised, with the reminder that a national model of community mental health has been published, Staffordshire and Stoke-on-Trent have secured funding to implement this national model locally and national best practice has shifted from a bed-based model to a community-based model.

No questions or comments were received on the presentation.

The two proposals presented were:

1. Centralisation of inpatient beds in St George's Hospital, Stafford.
2. Provision of inpatient beds in south east Staffordshire for people aged 18-65 with serious mental health needs.

Participants were told that *"for both of these proposals, the provision of a transformed community mental health offer will be provided, which includes enhanced crisis*

[1] Report of findings from engagement, 22 December 2021

home treatment with skilled older adult specialists, a nursing/ therapy lead and new clinical psychologist to focus on older adults".

They were asked "*Are these proposals viable and realistic?*"

It was made clear that for either of the proposals, the level of provision of inpatient beds would not be the same as it was before, because for both proposals the beds previously provided for older adults with severe mental health illness, largely problems with dementia, have been replaced by an enhanced service in the community received in their own homes or care homes.

The group agreed that even if there had not been a fire at the George Bryan Centre, they would still be having a strategic debate about the future of services there because of the following factors:

- National guidance about best practice and the ethos of the national mental health strategy to strengthen the community mental health offer.
- Issues of safety with regard to the estate at the George Bryan Centre and the remoteness of the site.

They debated the two proposals of centralising the inpatient beds at St George's Hospital or providing inpatient beds in south east Staffordshire for people aged 18-65 with serious mental health needs.

With regard to the acute beds provided in the George Bryan Centre West Wing they noted that the Milford Ward at St George's Hospital has already been extended to accommodate the increase in adult acute beds following the fire at the George Bryan Centre. If beds were reinstated at the George Bryan Centre or elsewhere in south east Staffordshire, this would result in the Milford ward becoming an empty (or 'decant') ward.

With regard to the age of those accessing the acute beds, the meeting agreed that this should not be limited to those aged 18-65 but should include older adults where they needed these acute services, so the age range should be described as 18-plus.

The model of caring for older people with severe mental illness or dementia in the community has kept people out of psychiatric hospital. Since the model was implemented, there have been fewer admissions from this group to a psychiatric hospital (as illustrated in Table 9 in Section three). This means people are receiving the level of care they need either in their own home environment or a care home. The meeting noted that there is very little evidence for the need to place people with dementia routinely in psychiatric hospitals. Evidence indicates that removing a person who already has a level of cognitive impairment to another environment does not have a good outcome.

Even if the 18 acute beds were reinstated, re-instatement of the 12 older adult beds was not recommended, as there is strong evidence that this cohort should be cared for in their usual place of residence.

It was agreed that it is not safe to run an inpatient mental health unit with 18 beds as a stand-alone site, given the clear safety issues of remote service provision. This is essentially what option two proposes. There were already issues to do with remote working that are discussed earlier in this pre-consultation business case and reinstating beds in a remote unit would not address those issues.

The meeting discussed the debate about continuing health care for people with dementia as they deteriorate. They noted that at Queen's Hospital, Burton upon Trent there is a Core24 service, which is an enhanced mental health support to prevent admissions into hospital. There is a specific older adult specialist working as part of that team as well as a children's and learning disability specialist. In addition to that, MPFT had recently submitted an application to NHSEI for a crisis café, and for areas where there can't be a physical building, there has been an application submitted for a crisis bus.

It is recognised that some people struggle to understand what services are already in place in their area and how to obtain support required. A representative from the local Healthwatch provided an example to support this. The single point of access will navigate people through this in future. It was suggested that further engagement may be required with carers.

7.3.2 Our proposal

The technical group agreed that this leaves a single viable proposal:

- To provide acute mental health inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia living in south east Staffordshire on a single site: St George's Hospital, Stafford

This is supported by the transformed community offer, across the MPFT footprint in south Staffordshire.

It was noted that this is a continuation of the service offer currently in place as an interim arrangement. Therefore, there is evidence that this model is working in practice and is a tested option. The clinicians present noted that some elements of the community offer have not been in place since the fire, as the transformation has been more recent. It was agreed that a timeline of changes implemented would be useful to document the process in the narrative (see Section two).

The Chair summarised that for people with serious mental health needs who require an inpatient bed, there is evidence to demonstrate that St George's Hospital provides an offer with good outcomes. For people with dementia, evidence tells us outcomes are improved by avoiding admissions and providing an enhanced community offer (more information about the evidence is available in Section three). All agreed that this is the single model that the public will be engaged on.

It was noted that a reference group would be organised early 2022, with a balanced room of service users, staff and seldom heard groups to discuss at a deliberative event the process to date, the feedback received through previous engagement and the viability tests.

In preparation for the deliberative event, it was determined that a scoring or consensus approach to the final stages of the options appraisal process would not be required, due to only having one viable proposal.

7.3.3 Deliberative event March 2022

On 15 March 2022, a deliberative event with a reference group was held online to discuss finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre.

The purpose of the event was to:

- Present the proposals to date.
- Hear people's views on whether there was anything else that needed to be considered in the business case.
- Consider the recommendations that the technical group had made.
- Discuss anything that could be done to reduce any potential negative impacts.

We worked with the Consultation Institute to design the methodology for this event. This recognised that the technical group had recommended only one viable proposal and as a result a scoring approach would not be appropriate. This event aimed to be open and transparent, sense-check the process so far and understand if there were any new considerations that would impact the viability of these, and any new proposals.

The reference group was recruited to form a balanced room of service users and carers, staff and seldom heard groups to discuss the process to date, the feedback received through previous engagement and the viability tests.

Fourteen people attended. Some attendees had used the George Bryan Centre. Some had been part of the ongoing conversation but two had not.

Those attending received an information pack [see Appendix 11] in advance of the meeting, explaining the background and issues and the process so far. It included the findings from the 2019 and 2021 involvement events and information about enhanced community mental health services in south east Staffordshire.

The two proposals that have been considered were described. The information pack stated:

> *"At this stage, no decisions have been made. However, at our technical event on 10 December 2021, our clinicians and managers recommended that there is only* ***one viable proposal – centralising inpatient treatment at St George's Hospital in***

***Stafford** – and that this one proposal will be presented to the board of MPFT in the spring."*

At the deliberative event, those attending heard a recap of the process so far. They heard that new information or suggestions from the reference group would be included when the business case was finalised. The two proposals were explained again, together with the view of the technical group that there is only one viable proposal.

The reference group were asked a number of questions.

In answer to a question about whether they had confidence in the steps taken to develop proposals and reach a single viable proposal, participants made the following points:

- The information pack explained the proposals well.
- The pros and cons list in the pack was unbalanced / one-sided.
- Consider the population size of Tamworth.
- Consider greater emphasis on the technical aspects.
- Both proposals need to be underpinned by enhanced community health services.
- More detail is required about the mental health service provision for each proposal.
- Concern over low response rate to the involvement.
- Inpatient services are needed in Tamworth to meet the needs of vulnerable people.

In answer to the question about whether they had any issues or concerns about the steps taken the following points were made:

- Query over whether models consider population density.
- Consider outlining the advantages of each hospital.
- Query over what additional services will be put in place.
- Query over whether there will be an increase in GP or community services.
- Provide a plain English / easy read version of the pack.

In answer to whether the group could suggest other ways to support people who are affected by having to travel further the following suggestions were made:

- Need to consider physical and financial accessibility, as well as mental health (e.g. anxiety).
- Provide free shuttle buses (e.g. between central locations and the hospital).
- Provide funded support for patients who need to use public transport.
- Provide a closer to home public transport option.
- Consider the need for environmentally-conscious travel options.

- Consider learnings about patients travelling to Tamworth after the closure of the Margaret Stanhope Centre.

Additional comments and queries included:

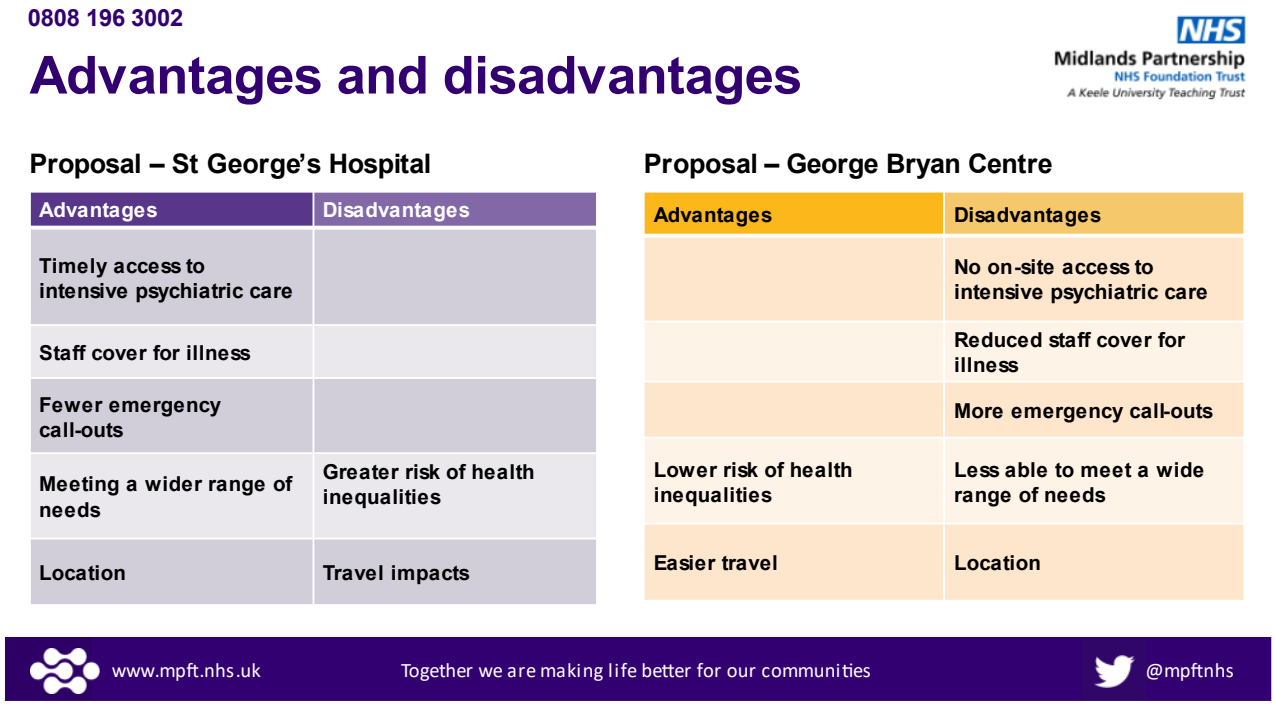
- Query over whether no decision has been made or no decision has been approved.
- Consider the rise in number of people with mental health issues during COVID-19 pandemic.
- Consider re-opening George Bryan Centre for mental health difficulties, leaving critical care to St. George's Hospital.
- Query over whether there will be extra beds at St. George's Hospital if the George Bryan Centre does not re-open.
- Tamworth is the 'forgotten place' – increased resources and services are required in Tamworth.
- George Bryan Centre is needed – inpatient services are required in Tamworth.
- Matching learned and lived experiences is a key to success.
- Consider lack of direct bus service from Stafford to Tamworth.
- Concern over the use of iPads and loss of the human touch.
- Weekend help and support is needed.
- Suicidal patients need instant support.
- Inefficient services in Tamworth and Lichfield are failing patients.

Participants felt that the following additional points should be taken into consideration:

- Consider a pool of staff to cover shortages and sickness.
- Need to ensure support services are available in Tamworth.
- Need to highlight how community services can be accessed.
- Query over source of the extra mental health resource.
- Need to address the backlog and new patients.
- Proposals currently read as 'jargon' and need to be simplified.
- Consider that dementia patients have specific needs.
- Clarity is required on the enhanced community model.
- Query over what has happened to the fire insurance money.
- Query over whether the George Bryan Centre will be re-opened if this is the consensus.
- Query over how much weight given to the views of the population.

The full report of findings from this reference group has been published. The feedback was considered and noted at a meeting of the transformation steering group on 13 May 2022 and it was agreed that taking the feedback into account, the '**one viable proposal – centralising inpatient treatment at St George's Hospital in Stafford**' would go forward to this pre-consultation business case.

The slides below show the information provided at the deliberative event. The first slide is an analysis of the advantages and disadvantages of the two proposals. The second slide provides information about the single viable proposal.



0808 196 3002

Advantages and disadvantages

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

Proposal – St George's Hospital

Advantages	Disadvantages
Timely access to intensive psychiatric care	
Staff cover for illness	
Fewer emergency call-outs	
Meeting a wider range of needs	Greater risk of health inequalities
Location	Travel impacts

Proposal – George Bryan Centre

Advantages	Disadvantages
	No on-site access to intensive psychiatric care
	Reduced staff cover for illness
	More emergency call-outs
Lower risk of health inequalities	Less able to meet a wide range of needs
Easier travel	Location

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Figure 12 Advantages and disadvantages for the St George's Hospital proposal

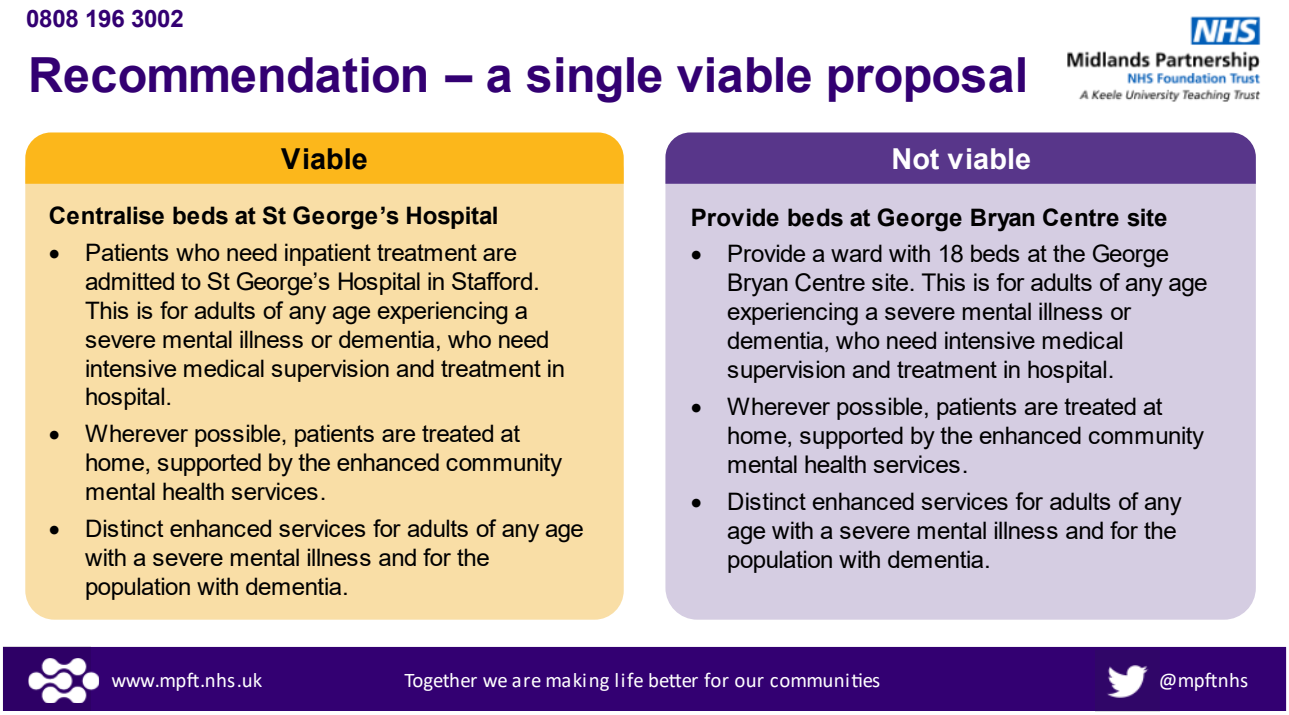


Figure 13 Recommendation for one viable proposal

7.3.4 Impact assessment of proposals

MPFT conducted impact assessments as the operational model changed. A joint impact assessment [see Appendix 12] has been conducted as part of the process to develop the pre-consultation business case. Further detail can be found in Section eight.

8 Evaluation of scenarios / options

8.1 Introduction

This section describes the evaluation of the scenarios/options for the future of the services previously provided at the George Bryan Centre. It includes evaluation against:

- The Government's 'four tests' and bed test applied to service change.
- Quality, safety and clinical sustainability.
- Deliverability.
- Equality and health inequalities.

The proposal for these services is:

- Centralisation of inpatient beds in St George's Hospital, Stafford.

Beds would no longer be provided at the George Bryan Centre in Tamworth.

8.2 The Government's four tests of service change and NHS England patient care test

NHS commissioners are required[1] to apply the tests of service change.[2] These include the Government's four tests of service change:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test.

This final test requires that local NHS organisations show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or

[1] R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors [2013] EWHC 2381 & R (Cherwell District Council & Ors) v Oxfordshire CCG [2017] EWHC 3349 (Admin)
[2] p13, Planning, assuring and delivering service change for patients, NHS England 2018

- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

The proposals for the services previously provided at the George Bryan Centre have been developed in line with these tests.

8.2.1 Strong public and patient engagement

Sections five and six explain in detail the extensive public and patient engagement carried out for several years whilst developing the options for the services previously provided at the George Bryan Centre. The two sections detail engagement activity and plans, together with records of relevant meetings with stakeholders such as the Overview and Scrutiny Committee, and information about engagement with people from the nine protected characteristics and in areas of health inequality.

8.2.2 Consistency with current and prospective need for patient choice

Patients with severe mental illness who require inpatient services are allocated to beds based on the acuity of illness and availability of beds. The process they go through is detailed in Section three. Data shows that most adults with severe mental illness are cared for within Staffordshire with very few out of area placements needed because of the unavailability of beds. Patients are able to choose to be admitted out of area. The bulk of MPFT's out of area admissions are for female psychiatric intensive care (PICU), which is not commissioned locally.

All patients are assessed on level of need and supported in the community when they no longer need inpatient services.

Section three describes in detail the case for change for change in the future of the services delivered at the George Bryan Centre, including whether it is feasible to continue providing services separately from those provided at St George's Hospital, Stafford. The section explains the limitations of providing services in a different location and discusses the wider choices of treatment available to patients at St George's Hospital and why it would not be possible to provide all of these choices at a smaller facility. Section seven describes the process followed to arrive at the final option for the future of services, including the criteria applied.

8.2.3 Clear, clinical evidence base

Section three explains the national direction of travel towards transformed/enhanced community mental health services which means patients are cared for closer to home and therefore less reliant upon inpatient services which become a last resort. In addition, this will

lead to shorter hospital stays for patients with mental illness, including acute patients who might have been treated in the George Bryan Centre. These patients are currently usually admitted to St George's Hospital but the emphasis on treatment in the community wherever possible is leading to shorter lengths of stay for these patients, and this is supported by the facilities offered both at St George's Hospital and in the community.

The information in Section three references the strong evidence for treating dementia patients in their own homes and in the community compared to care in hospital.

8.2.4 Support for proposals from clinical commissioners

The mental health case for change was developed through the Sustainability and Transformation Partnership (STP) Mental Health Programme Board, building on the NHS Long Term Plan. The Case for Change[1] sets out the needs of the population, the current provision of health and care and outlines our vision and aims for local health and care in the future.

In May 2019, the Case for Change was presented to the West Midlands Clinical Senate. The Clinical Senate was of the view that the STP articulated a credible case for change and the aspirational principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance. In June 2019, this was presented to NHS England and NHS Improvement (NHSEI).

Detail of clinical involvement in the development of the proposals is detailed in Sections six and seven, including clinical involvement in technical events evaluating the proposals.

The ICB has written to all neighbouring ICBs and has received confirmation of support for the proposal outlined within the business case from Shropshire, Telford and Wrekin ICB, North Staffordshire Combined NHS Trust and the SSoT ICS Mental Health Transformation Programme Board.

The governance process that the proposal will go through will include agreement to the proposal from the Integrated Care Board.

8.2.5 Bed test

When looking at the bed test, bullet point one is the most relevant to this business case:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

Mental health beds are not commissioned in the same way as physical health beds (there is no national modelling tool). MPFT is commissioned to provide a number of bed days.

[1] Case for Change, Together We're Better, 2019

There is no national evidence for the number of mental health beds per head of population.

One important function of the MPFT Crisis Resolution and Home Treatment Team (CRHTT) is to gatekeep requests for admission, via the Mental Health Act and/or voluntarily on request (this is what is commissioned nationally). This is to ensure that admission to an inpatient bed is the right treatment plan for the patient

The length of stay is important, and trusts aim to keep this low, as evidence demonstrates improved outcomes for most people who receive treatment and care in their usual place of residence. This is benchmarked against other trusts.

As outlined earlier in the document, the ICB is signed up to the Midlands Regional Guidance to support the repatriation of people who find themselves out of their normal catchment area (acute adults).

8.2.6 Beds for older adults

As described earlier in the pre-consultation business case, the East Wing at the George Bryan Centre was not damaged by the fire in 2019, but the 12 beds on the East Wing for older adults with severe mental illness or dementia were temporarily closed on clinical safety grounds in April 2019 after a decision taken at MPFT's February board meeting, which comprised public and confidential sections.

As an alternative, which relates to the bullet point in the bed test on 'alternative provision', the existing community pathway was enhanced to support older adults by Older Adult Services/Care Teams treating patients in the community. This was in line with the policy drivers described in Section three of this pre-consultation business case, with the emphasis on more care for mental health service users in the community rather than in hospital bed settings. MPFT had already developed robust community support but following the fire there was the opportunity to enhance this by providing specific support for older people with severe mental illness. Support in the community for older adults with dementia was already in place.

The aim of an effective care pathway for people with a severe mental illness is that as service users become more ill, intensive community support both enables them to recover without requiring acute inpatient admission and if this is unavoidable, facilitates early discharge. Admission remains an option, but only for a short period and a small minority of service users. The purpose of an effective care pathway for people with dementia is that there is a range of community support services able to respond to individuals' needs. The pathway was developed with evidence-based practice and underpinned by analysis of patients' journeys.

The community support now in place includes:

- Enhanced crisis home treatments with skilled, experienced older adult specialists and Hospital Avoidance Team.

- Addition of a nursing/therapy lead to ensure interventions are evidenced-based and focussed on enabling individuals to maintain their independence at home.
- New clinical psychologist to focus on older adults.
- A training plan for the team, including Equality training and Dementia training. The Trust is in the process of commissioning cultural sensitivity training and demographic information collection training.

The funding for the service has not reduced.

The following figures show the new money associated with Community Mental Health Transformation for all adults with severe mental illness including older adults across the Staffordshire and Stoke-on-Trent system.

Taken from the outline of 3-year delivery plan – Community Mental Health Transformation Framework					
	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Transformation Programme (TP) provisional 'fair shares' transformation funding allocation as per Analytical Tool (non-cumulative)	n/a	n/a/	£2,170,703	£5,281,898	£6,534,610

Table 19 Funding for the Community Mental Health Transformation Framework

Workforce

Section four describes the measures MPFT has put or is putting in place for recruitment and training of the appropriate number and expertise of staff for future needs.

Acute beds

The 18 beds provided for adults with acute mental illness in the West Wing of the George Bryan Centre are now provided at St George's Hospital, usually in the Milford Ward, so there has been no reduction in the number of beds available for this cohort.

8.2.7 Bed modelling

MPFT knows that it has enough beds now and for future demand because of the enhancement of community services, in line with national policy not to admit to an inpatient bed unless absolutely necessary. The acuity of patients being admitted to inpatient beds has changed significantly over recent years and lower acuity patients are likely to be able to be managed safely in the community.

Bed occupancy / capacity is monitored for older adults and acute beds through a central bed management function, who perform daily reviews and create plans to manage flow. The time between the decision to discharge and actual discharge is short, as there is an on-site

pharmacy, one benefit of a larger, centralised site. The Crisis Resolution Home Treatment Team are based on site and arrange to follow up patients in the community post-discharge (there was not a crisis team on site at the George Bryan Centre).

There is currently very low use of out of area provision across Staffordshire and this is for services not commissioned locally. For example, the provision of female psychiatric intensive care unit (PICU) beds is not commissioned locally, so for this cohort of patients, a placement would be appropriate and required.

8.2.8 Risk of proceeding with a single proposal

The ICB has sought advice from its legal advisors and the Consultation Institute as to whether it is legitimate to consult on one option only. It is lawful to consult on one option only. As with previous involvement activity the ICB, through further involvement activity/consultation, will ensure that members of the public have the opportunity to suggest alternative options and if they do so, those options will be given genuine consideration.

8.3 Quality, safety and clinical sustainability

A Quality Impact Assessment has been completed for this service change [see Appendix 13].

Monthly service specific quality reports go to MPFT's Performance and Quality Assurance Forum South Staffordshire Mental Health meeting. After this the services are included in more over-arching reports through governance process committee meetings to MPFT's Board. The table at Appendix 14 shows the process.

The mental health service initiated and currently uses a variety of measures to monitor the quality of care.

8.3.1 Adult wards

Quantitative data measures

The older adult team is on RiO – a clinical IT system for patient records. The data includes:

- Length of stay, any reduction due to early discharge.
- Admission prevention analysed at patient level by the team.

Qualitative measures

Psychologists have also been completing problem-specific outcomes with older people (again when they have consented), which may include The Geriatric Depression Scale, the Geriatric Anxiety Scale and individualised therapeutic goal achievement scales. The service has documented any outcomes that have been completed on service user clinical notes. Other professionals have been completing outcome measures on a case-by-case basis.

These outcome measures are used on the adult wards. They are presented in order of most to least frequently used:

Mental health

- DIALOG (not an abbreviation)
- SWEMWBS (Short Warwick and Edinburgh Mental Wellbeing Scale)
- IES-R (Impact of Events Scale Revised)
- ACE III (Addenbrooke's Cognitive Examination)
- AQ-10 and AQ 50 (Autism Spectrum Quotient 10 and 50)
- HADS (Hospital Anxiety and Depression Scale)
- GAD 7 (Generalised Anxiety Disorder Assessment) and PHQ 9 (Patient Health Questionnaire 9)
- FAB (Frontal Assessment Battery)
- LDSQ (Learning Disability Screening Questionnaire)
- DES-II (Dissociative Experience Scale)
- WAIS IV (Wechsler Adult Intelligence Scale)
- MCMI III (Millon Clinical Multiaxial Inventory).

Occupational Therapy:

- Creative participation assessment
- Model of Human Occupation Screening Tool - MHOST
- Large Allen Cognitive Leather Screen - LACLS
- BARS (behavioural activity rating scale) for the sensory room outcomes.

Older adults

Psychologists have also been completing problem-specific outcomes with older people (again, when they have consented), which may include The Geriatric Depression Scale, the Geriatric Anxiety Scale and individualised therapeutic goal achievement scales. The service has documented any outcomes that have been completed on service user clinical notes. Other professionals have been completing outcome measures on a case-by-case basis.

Occupational Therapy:

- Large Allen Cognitive Leather Screen – LACLS
- APO
- Model of Occupation Screening Tool (MOHOST)

- MEAMS OT older adults

Physiotherapy

- Tinetti

Dietetics

- St Andrews Nutritional screening tool

The safety at the George Bryan Centre and at St George's Hospital is discussed in Sections two, four and six. Anecdotally, staff feel safer at St George's Hospital because it is a larger establishment and there are more people available to help if there is an emergency. The site is also less isolated.

Clinical sustainability at St George's Hospital is supported by the fact that it is easier to recruit staff to larger establishments where there are more opportunities for development and teams are larger. The current move to more community-based care also provides opportunities to develop strong community teams to support older adults in their own homes rather than inpatient beds.

8.4 Deliverability

The situation with regard to the George Bryan Centre is unusual in that because of the need to find a rapid solution following the fire, and because of the pause in all but core services created by the COVID-19 pandemic, the services described have been implemented and delivered in the new way described in the preferred option for nearly three years.

It is therefore clear that they are deliverable.

Information in Section three shows the advantages of the new arrangement, and the report of engagement in Section six illustrates the views of patients, the public and stakeholders.

Anecdotally, the smaller bed base has not caused problems finding beds for patients. The member of staff quoted in Section six stated that they "*never heard that there's no beds*" – whenever a patient needs a bed, one is available. Data shows that the only out of area placements in the period since the fire have been female patients needing psychiatric intensive care beds, which are not commissioned locally.

A bed manager is employed at St George's Hospital to coordinate beds, as outlined in Section 3.5.1. Alongside the new arrangements for providing more care in the community so that patients are less likely to be admitted, and admitted for shorter periods, the deliverability has been demonstrated.

The figures in the finance section (Section five) show that the new arrangement for delivering these services for people in south east Staffordshire, including the provision of additional community services, is slightly less costly than the previous arrangement.

8.5 Impact analysis

8.5.1 Equality Impact Assessment including health inequalities

An Equality Impact Assessment (EIA) [see Appendix 8] was completed in March 2022. It supported the 2021/22 options appraisal process on the proposed centralisation of inpatient beds to the St George's Hospital site supported by enhanced community services. The service changes were initially discussed at a confirm and challenge session in August 2019. The discussion and outcome of this session are relevant to the current proposal which will be to re-affirm and consolidate the existing arrangements.

Staff would work under the values and behaviours of the Trust which promote service user inclusion, dignity and respect. All staff members maintain dignity and respect of service users and will always be inclusive of all abilities and disabilities, ages, genders, race, religion or beliefs and sexual orientation embracing differences that may exist and flexing approaches.

The EIA identifies the protected characteristics of age, gender and disability as the most likely to be impacted. The impacts are as follows:

- For **age** there is a positive impact because for patients with dementia, (which impacts more people over 65 years old), the transformed and enhanced community offer will ensure they can receive appropriate care, in their usual place of residence where possible.

  Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can exacerbate the symptoms of dementia, permanently reduce independence and increase the likelihood of discharge to residential care and readmission to hospital. NICE guidelines (NG97, 2018) request that, when considering admission to hospital for a person living with dementia, the value of keeping them in a familiar environment is considered.

  The enhancements to the community mental health teams includes enhanced crisis home treatment with skilled older adult specialists, a nursing/therapy lead and new clinical psychologist to focus on older adults.

- For **disability** there is a positive impact because for those people who live in a rural location and/or have difficulties with transport, the enhanced community mental health offer will reduce admissions for a cohort of people who can be cared for at home, thus removing any barriers to access for the patient or carer.

  For those patients who require admission to a centralised bed in St George's Hospital, additional interventions are available that were not available at the George Bryan Centre including art therapy, music therapy and occupational therapy. This centralisation of bed provision will ensure equal access to these facilities based on

need and will eliminate the need to transfer patients between these sites to access appropriate therapy, leading to improved outcomes for these patients.

- For **gender reassignment** there is a positive impact because it would be expected that both inpatient and community mental health services support patients who have undergone gender reassignment. The provision of an enhanced community mental health services team increases the likelihood that the patients will be cared for in their usual place of residence and by clinicians who know them.
- There is a potential negative impact for a cohort of patients and carers who would **need to travel** further to visit a person who is admitted to a bed in St George's Hospital in Stafford (approximately 26 miles from Tamworth). This could adversely impact those who live in rural areas without good transport links, ability to afford the cost of travel and those in households without access to a vehicle. Where admission is required, there is potential difficulty for carers of elderly patients to be able to travel at all (no direct transport from some areas of Lichfield / Tamworth / East Staffordshire). This may impact on patient outcomes as visiting is known to promote recovery.

In mitigation, the enhanced community offer makes it more likely that a person will be cared for in their usual place of residence, rather than being admitted to an inpatient bed. People on low income who claim certain benefits can reclaim transport costs to hospital. MPFT staff will signpost people to any voluntary car schemes that are in place at the time. Digital solutions such as *Komp*[1] are also being explored, following the successful use of technology throughout health and social care during the COVID-19 pandemic.

Komp is accessible, assistive technology that can remind individuals appointments and to take medication, or enjoy a visit from family or friends. It is classed as 'warm' technology linking individuals with their family and friends though an app. The device is easy to operate with users simply having to plug the *Komp* in and turn the button located on the front. This button acts as the both the on/off switch and the volume. *Komp* is available with 4G connectivity, removing digital barriers for some who may not have their own wi-fi in their home. The system enables one way calling from family, friends and healthcare professionals, ensuring the safety of users by limiting who can contact them. *Komp* means users who would ordinarily have been sociality isolated to be connected to their family, friends and healthcare professionals.

Key demographics of the most impacted areas are highlighted below.

Area	Proportion of people living in rurality (2017)	Proportion of people living in deprived areas (IMD 2015)	Households without a car (2011)
Cannock Chase	9.1%	13.8%	20.2%
East Staffordshire	21.7%	18.2%	21.4%

[1] Komp website, accessed October 2022

Lichfield	29.8%	3.9%	13.6%
Newcastle-under-Lyme	20.0%	11.5%	22.1%
South Staffordshire	40.1%	1.4%	13.2%
Stafford	32.4%	5.3%	17.5%
Staffordshire Moorlands	30.5%	4.7%	14.8%
Tamworth	0.0%	17.5%	20.6%
Staffordshire	24.2%	9.3%	18.0%
West Midlands	14.7%	29.8%	24.7%
England	17.0%	20.4%	25.8%

Source: Indices of Deprivation 2015, Department for Communities and Local Government, 2017 mid-year population estimates, Office for National Statistics, Crown copyright. The Rural and Urban Classification 2011, Office for National Statistics, Crown copyright. 2011 census,

Table 20 Key demographics of the most impacted areas

The full Equality Impact Assessment is available as part of the overall impact assessment and has been reviewed and approved in November 2022.

8.5.2 Travel impact analysis

Travel emerged as a key concern of patients, carers, and the Health Overview and Scrutiny Committee, on this journey towards a long-term solution. Travel for patients and travel for family, friends and carers visiting loved ones at St George's Hospital in Stafford, compared with visiting the George Bryan Centre.

A detailed access analysis has been carried out to understand the impacts of reopening beds at the George Bryan Centre for those residing in Stafford, Cannock Chase, East Staffordshire, Lichfield, South Staffordshire and Tamworth local authority district areas who are driving or using public transport. A very small proportion of the George Bryan Centre admissions came from out of county prior to the fire. The full analysis is available at Appendix 16, including information about how the assumptions were made in deciding how potential patients might travel and where they would be travelling from.

In summary, key findings for those travelling by car are:

- Male residents would benefit slightly more from a replacement site at the George Bryan Centre, though their current actual travel times are higher than those for women.
- Older adults (aged 65 plus) requiring admission would have the greatest reduction in journey time for all travel modes.
- All minority ethnic groups with the exception of White-Irish would have slightly smaller reductions in travel time than the white population. Though the numbers of admissions from these groups are all very small.
- Patients from all Indices of Multiple Deprivation (IMD) deciles would save journey time if the George Bryan Centre were reinstated. Those living in quantile 2 areas (more deprived) would have the greatest reduction and those in quantile 4 areas (less deprived) the least reduction.

- Unsurprisingly, patients living in Tamworth and Lichfield would have the greatest benefits of reduced travel. A small number from Stafford area might have to travel further if the reason for admission to the George Bryan Centre is that local beds are not available.

Key findings for those travelling by public transport are:

- Male residents would benefit significantly more from a replacement site at the George Bryan Centre than women on the assumption these admissions are representative.
- Older adults (aged 65 plus) requiring admission would have the greatest reduction in journey time by public transport.
- A small number of black and mixed ethnic groups might have to travel for longer on public transport to access the George Bryan Centre.
- Patients from the middle IMD quantile would save the most journey time by public transport if the George Bryan Centre is reinstated. Those living in quantile 2 areas (more deprived) might have to travel longer to reach the George Bryan Centre site.
- Those patients and visitors from Stafford, Cannock Chase and South Staffordshire who are admitted to a potential George Bryan Centre site would have to travel significantly further than they currently do. The large majority of patients in these areas however would still likely be admitted to St. George's Hospital in Stafford.

As has been described, before the fire at the George Bryan Centre there were two potential sites across south Staffordshire where a patient with a serious, acute mental health need could be admitted – St George's Hospital in Stafford and the George Bryan Centre near Tamworth. However, not all treatments and interventions were available to people staying in the George Bryan Centre and so some people who had severe mental health needs were admitted to St George's Hospital in Stafford, because of the more intensive support that can be offered in a larger hospital.

Additional interventions that are available at St George's Hospital that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy. The centralisation of bed provision will ensure equal access to these facilities based on need and will eliminate the need to transfer patients between these sites to access appropriate therapy.

For those people who live in a rural location and/or who have difficulties with transport, the enhanced community mental health offer for people who can be cared for without an admission, will provide a service in that person's usual place of residence.

The travel mapping has outlined:

- Public transport does not cover all areas in Staffordshire, which means people need to walk to their local public transport connection or rely on neighbours or family members to even start their journey at a local bus stop or at the train station.

- Lack of direct services can mean getting two or three buses each way. This is especially difficult for older carers or family members.
- Buses don't run all evening, so it is hard for some family members to visit in the evenings. This could mean they can only make visits on their days off.
- Traveling by car can take over 50 minutes to travel from some parts of Tamworth to Stafford (no real difference in travel time between peak travel and weekend).

Because of rising fuel prices, the public have also told us that they are worried about the cost of travel, whether by public transport or by car.

We know that visits and support from family, friends and carers are very important to patients in hospital, and that this supports their wellbeing and recovery.

We have listened to the concerns raised during the engagement process about the additional travel that visitors will need to undertake to see their friends and relations who have been admitted to St George's Hospital and have reviewed its existing transport arrangements. Some families would experience difficulties with the additional costs and travel time needed to visit loved ones at St George's Hospital, this may be balanced by the advantages for patients in terms of the specialist treatment they can receive there. Ward staff will do what they can to support visiting arrangements for friend and/or family. This is an informal arrangement and is not recorded. Examples of what can be done include being flexible about visiting times.

During the COVID-19 pandemic, MPFT used technology to enable patients to keep in touch with people outside hospital. This offer will continue ensuring that both patients and their relatives have access to digital devices, including tablets, to support virtual visiting or regular telephone communication.

The only transport arrangements in place are the commissioning of a Non-Emergency Patient Transport Service (NEPTS). This is a non-urgent pre-booked transport service to and from NHS funded points of care (excluding GP appointments) for patients, who are too ill or otherwise physically unable to make the journey themselves.

This policy does not cover visitors and so could not be used in the circumstance under consideration.

So, given the only existing arrangements are not transferrable to this situation, MPFT has drafted a standard operating procedure that will apply only to the programme to find a long-term solution for inpatient mental health services in south east Staffordshire and only to support the transition from one location to the other. (George Bryan Centre to St George's Hospital).

This is being shared with key stakeholders for comment, including the voluntary and community sector, and Staffordshire Health Overview and Scrutiny Committee.

8.6 Engagement with West Midlands Clinical Senate

8.6.1 Introduction

The clinical senate review of proposals for inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire was jointly commissioned by Staffordshire CCGs and Midlands Partnership NHS Foundation Trust. Chaired by Professor Neil Gittoes, the review was carried out by a panel of 13 experts from the West Midlands Clinical Senate, most of whom are practicing clinicians. The review took place on 10 June 2022.

The purpose of the review is to offer external clinical assurance on the proposal to provide acute mental health inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia living in south east Staffordshire on a single site: St George's Hospital, Stafford. The clinical senate review and responses to the points raised in its recommendations form an essential part of the preparation for the stage two assurance checkpoint process as set out in NHS England's service change guidance: '*Planning, assuring and delivering service change for patients'*.

The report[1] contains five recommendations for the programme to consider. These are outlined below.

8.6.2 Clinical senate recommendations

Recommendation 1

The current use of surplus dementia beds (average 5 out of 12 occupied) are being utilised by functional adult mental health patients[2], this is considered sub-optimal practice and the panel recommended alternatives should be sought to cease this from occurring and to prevent a poor patient experience for both patient groups.

Recommendation 2

The panel recommends a review of the current Crisis Resolution and Home Treatment (CRHT) team to assure themselves that there are no barriers to older people accessing the service and that older peoples' needs would be met in the service. This is to ensure that patients that would have ordinarily been admitted to the George Bryan Centre and the dementia ward in Stafford will have alternative community provision for them.

Recommendation 3

The panel recommends utilisation of both real time and process and outcome data is more widely used to both monitor and drive improvements. There is strong leadership at MPFT

[1] Report of the Independent Clinical Senate Review Panel, 10th June 2022

[2] The term 'functional' mental illness applies to mental disorders other than dementia and includes severe mental illness such as schizophrenia and bipolar mood disorder

which is enabling the transformations to take place however, the use of data will ensure these remain on track, with progress assessed regularly against a set of agreed process and outcome measures.

Recommendation 4

The panel recommends engaging with operational and clinical colleagues to understand the need for community sites for staff to use as a base, for clinics and to run events. This will support the focus of bringing care closer to home for patients.

Recommendation 5

The panel recommends a review of staffing shortages and recruitment and retention plans to ensure MPFT remains an employer of choice and does not see attrition at a level which will have a detrimental effect on patient care and safety. In addition, ensuring any risks are presented on the relevant risk registers.

8.6.3 Programme response to recommendations

Recommendation	Programme response
Recommendation 1 - The current use of surplus dementia beds (average 5 out of 12 occupied) are being utilised by functional adult mental health patients; this is considered sub-optimal practice and the panel recommended alternatives should be sought to prevent this from occurring and poor patient experiences for both patient groups.	The bed management function shows beds that are available to the system that a patient can be admitted to and this is a key part of managing patient flow and using resources effectively. The Five Year Forward View and the NHS LTP set out a clear directive that inappropriate out of area placements should be eliminated. Any vacant bed needs to be considered for residents of Staffordshire and Stoke-on-Trent, to avoid the negative impact of any out of area placement. Out of area placements are characterised by a lack of continuity which impacts on the delivery of a safe and effective acute mental health care pathway. Patients are admitted to MPFT and placed based on their needs not necessarily age as this is not always an indicator of frailty or vulnerability. This to ensure continuity of care is provided which is clinically preferable to admitting out of area. If a patient with functional mental illness is admitted to a dementia bed, as there is no Older Adult Acute bed available at that time, MPFT will aim to move the patient to the ward that is better placed to meet their needs as soon as a bed becomes available. While it is not ideal to mix patients in this way, the enhanced community offer aims to ensure that length of stay is kept to a minimum – MPFT is in upper quartile performance when benchmarked against similar trusts for length of stay.

	The Baswich and Bromley wards (older adult and dementia wards) consist of individual rooms with some shared bathroom facilities. These are not purpose built and MPFT is looking to enhance these environments as part of future capital programmes. While the environment may not be purpose built, care is improved from being on a centralised site, as additional needs of an individual or cohort of patients can be supported by flexing staff across wards as required.
Recommendation 2 - The panel recommend a review of the current Crisis Resolution and Home Treatment (CRHT) team to assure themselves that there are no barriers to older people accessing the service and that older peoples' needs would be met in the service. This is to ensure that patients that would have ordinarily been admitted to the George Bryan Centre and the dementia ward in Stafford will have alternative community provision for them.	The CRHTT is commissioned for all adults (18+) with no upper age limit and therefore there are no gaps to access. MPFT is working to recruit additional staff with older adult training. It is currently undertaking a review of older adult activity data from the past four years to inform the Trust on the resource required to further enhance this service. This review includes scoping what other trusts have in place and the evidence around CRHT for older people. Early indications from this review are that the home treatment element of the service could be strengthened for older people. MPFT is already working with the voluntary sector to enhance home support services.
Recommendation 3 - The panel recommend utilisation of both real time and process and outcome data are more widely used to both monitor and drive improvements. There is strong positive leadership at MPFT, which is enabling the	The response needs to respond to the following 3 areas (further details pg. 23): 1) *PROMs - Patient Reported Outcome Measures (PROMs) will be integral to the reporting about the delivery of patient-centred care for all mental health services.* Section 8.3.1 in the business case outlines outcome measures used within MPFT. MPFT has a working group comprising clinical and business intelligence (BI) colleagues meeting regularly to look at both PROMs and reporting needs to ensure that these

transformations to take place, however, greater use of data will ensure these remain on track, with progress assessed regularly against a set of agreed process and outcome measures.	recommendations are implemented. We are also following guidance from NHSE regarding PROMs and this is being monitored through the current Commissioning for Quality and Innovation (CQUIN) framework. 2) *KPI's – the Trust should develop a suite of process and outcome measures, the Trust will be able to monitor more closely the improvements being made and opportunities available. It will also support being able to benchmark performance to peers and enable the identification of unwarranted variation across services and corporate functions. An example on the day was whether the Trust had easy sight of the average wait times to access care in the community teams, with mixed replies being returned – there was no one clear answer or signpost provided.* The mental health outcomes the NHS commissions for are detailed at Appendices 5a to 5i. These tables show how Staffordshire and Stoke-on-Trent's mental health services compare with those in the rest of the country. MH181 refers to the whole of Staffordshire and Stoke-on-Trent. 3) *Interoperability of systems - it was noted that digital integration is always a challenge when working across multiple services and organisations, but having appropriate access is imperative to ensure seamless care for patients.* VCSE (Voluntary, community and social enterprise) partner providers contracted by MPFT have been given access to MPFT clinical systems to avoid service users repeating their stories, to allow the updating of progress notes and the seamless transfer of care. We have initiated projects to improve interoperability with GP practices.
Recommendation 4 - The panel recommends engaging with operational and clinical colleagues to understand the need for community sites for staff to use as bases for clinics and	Through our CMH transformation commitment we are working on delivering our services closer to home and within community settings. There is a hub and spoke approach (outlined in section 3.4.7. of the business case which shows the existing sites for community teams to work from and provide support to patients and families. The community mental health team for south east Staffordshire is based at the Sir Robert Peel Hospital.

to run events. This will support the focus of bringing care closer to home for patients.	There are mental health services available in Tamworth locality via a range of community venues (see Section 3.4.7). We have a solution to provide a Crisis Cafe in Tamworth as well as agreeing shared accommodation opportunities with community and voluntary sector partners. Tamworth Library and Humankind offices in Tamworth are venues that are currently used in the locality. We are delivering our memory services from a church building in Tamworth and holding service user group intervention sessions in local community buildings across the locality. Our integrated mental health teams and specialist pathways are identifying where they can take their services closer to home for service users by utilising alternative and local venues. MPFT is actively working towards bringing Cherry Orchard back online as an adult mental health community venue and the current plan is to deliver this by March 2023 (subject to planning).
Recommendation 5 - The panel recommends a review of staffing shortages and recruitment and retention plans to ensure MPFT remains an employer of choice and does not see attrition at a level which will have a detrimental effect on patient care and safety. In addition, ensuring any risks are presented on the relevant risk registers.	It is recognised that recruiting staff is a major challenge. Nursing staff, including mental health nurses, are on the national shortage occupation list. Allied Health Professionals and Band 8A Psychologists are also on the shortage list. This challenge is recognised and is on MPFT's risk register. The strategy has been developed to mitigate this risk. In terms of recruitment to support sustainability, MPFT is currently running a huge recruitment drive. It has employed a talent acquisition specialist to support advertising and seek out people from different employment backgrounds, not just the NHS. There are also two members of staff dedicated to recruitment supporting the operational managers for services across community and inpatients. They are focusing on areas that have had the most challenge in terms of workforce replacement across the whole of mental health inpatient and community services. The transformation funding for the community model also provides more opportunities to contract the voluntary sector to work with the NHS in a more integrated way, working to service specifications and providing holistic non-clinical support in areas such as housing, finance and day-to-day living.

8.6.4 Conclusion/summary

This section outlines the recommendations produced by the West Midlands Clinical Senate in relation to proposals for inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire following their visit on 10th June

2022. These recommendations have been accepted and considered by the programme team who continue to work to address them. Information on the work undertaken and work being pursued is included in this pre-consultation business case.

9 Management and governance

9.1 Introduction

This section of the pre-consultation business case:

- Explains the management and governance of the programme deciding the future of the services provided at the George Bryan Centre until the fire in 2019.
- Outlines the timeline and governance for sign off of the business case and the evaluation plan, together with the appropriate and agreed Health Overview and Scrutiny Committee arrangements. Normally with a business case involving a move of services or a rebuild there would be an implementation timeframe, with metrics and an evaluation plan. However, this business case is recommending a single option for the future of the services, and it is an option that is already in place on a temporary basis, so implementation in this case would simply mean confirming the changes as permanent.
- The programme risk register is explained together with any mitigations.
- Includes plans for appropriate engagement in the next stage, and this may include a public consultation. Throughout the process of developing the final proposal for the future of the services, there has been extensive public and patient, clinical, staff and stakeholder engagement.

9.2 Timeline and next steps

Legislation relating to NHS bodies changed on 01 July 2022, when the Staffordshire and Stoke-on-Trent Integrated Care Board took over health service commissioning responsibilities from the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups. Governance for this programme transitioned seamlessly from the CCGs to the ICB.

This pre-consultation business case has been reviewed and approved for submission to the Staffordshire Integrated Care Board for consideration. It has been reviewed by senior clinicians from of the West Midlands Clinical Senate and shared with the Staffordshire Health Overview and Scrutiny Committee for discussion.

There will be continued liaison with the Staffordshire Health and Care Overview and Scrutiny Committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

If the Scrutiny Committee recommends further involvement, the ICB will decide what further appropriate public involvement is needed. This business case will be updated to reflect the outputs of that involvement activity and be presented to the Board of MPFT and the Integrated Care Board for consideration and decision.

9.2.1 MPFT Trust Board

The MPFT Board of Directors considered this draft business case as part of its meeting in public on 30 June 2022.

This section of the meeting included a presentation[1] from the programme team, a board discussion, and questions and representations from patients and stakeholders in the public gallery.

The Board formally approved the recommendation from the Major Transactions Committee meeting of 28 June 2022 to approve the business case and the proposal contained within it with respect to the provision of acute mental health inpatient services for south east Staffordshire on a single site at St George's Hospital, Stafford and endorsed the next steps contained within Section eight of the business case.

9.2.2 Staffordshire and Stoke-on-Trent Integrated Care Board

The ICB met on 18 August 2022 to consider this draft business case. The meeting received a presentation [see Appendix 17] on the development of the business case and heard from a patient and a local councillor who had taken the time to attend.

The ICB agreed it was assured by the process undertaken by MPFT to date in developing the proposal and business case, and approved the business case to be passed to NHS England for its assurance process.

9.2.3 Next steps

The upcoming milestones and indicative dates for the process as it proceeds have been set out as:

Date	Milestone
November 2022	NHS England assurance
December 2022/January 2023	Update to Staffordshire County Council Health and Care Overview and Scrutiny Committee (status of programme and potential plans for involvement)
January 2023	ICB decision on whether to proceed with involvement
February 2023	Potential involvement activity
April-June 2023	Analysis of outputs from involvement activity
Summer/Autumn 2023	Develop decision-making business case

9.3 Risk management

The programme has created a risk register, with appropriate mitigations. These have been managed throughout the process.

[1] GBC presentation to the MPFT Board, 30 June 2022

9.4 Plan for involvement/consultation

A communication and involvement plan, draft consultation document and questionnaire sit alongside this document and will be updated pending the outcome of NHSE assurance process and subsequent governance.

Current position

The Communications and Involvement plan has been developed to cover the period *after* the completion of the business case and the relevant corresponding governance steps required; it has been prepared in the event that further involvement is necessary. Given the uncertainty, this plan includes two potential scenarios:

- Involvement to gather views before a decision is made.
- Involvement to share information about a decision, after a decision has been made.

The document will support planning in the event that further involvement activity may be required to articulate the outputs of the activity since 2019, and to explain the latest position and proposed future of inpatient mental health services previously provided at the George Bryan Centre. Insights from the work in 2021 has identified a need to articulate the wrap around services and community offer to ensure people are aware of the additional support available. If required, any further involvement would include the service users, staff, the wider public, and other stakeholders.

Scope of the work

The involvement activity will inform the decision-making about the long-term solution to the inpatient services that have temporarily been suspended at the George Bryan Centre.

We are aware that this work has connections with the involvement activity for the Community Mental Health Transformation Programme and the Mental Health Strategy for Staffordshire. Comments received will also be shared with these programmes to support the wider mental health vision.

Aims and objectives

In the event that further involvement activity to gather views is required, the aims of this would be to:

- Inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the single viable proposal identified through the options appraisal process and wider involvement activity since 2019
- Understand views about the business case and the technical group's recommendation about the single viable proposal detailed within it
- Listen to the views of the service users, carers and their representatives, staff and interested stakeholders to inform a decision.

We will seek to understand:

- People's views about the single viable proposal

- If there are any new considerations/ impact (negative and/or positive) we need to plan for, if we decide to go ahead with this proposal
- how we can support people if these changes are agreed, including how we can support people with travel.
- The objectives of this work will be to:
- Gather any further information needed to inform the decision by decision-makers to meet our statutory duties.

Ongoing dialogue would continue with service users and other stakeholders through the usual and current channels during service delivery.

Key messages

- We're committed to an open and transparent dialogue with service users, carers and carer representatives, staff, and partners as we develop long-term proposals for inpatient mental health services in south east Staffordshire.
- Feedback from our staff shows that we can deliver better care for inpatients, by focusing our workforce at a dedicated hospital in St George's Hospital. By consolidating our workforce, we can support personalised care wrapped around a patient's needs. We can also respond more quickly to emergency mental health needs, offering the specialist support on-site, rather than spreading our limited mental health specialists across two sites. This will help us attract more staff, but also, we believe deliver better care for patients.
- Clinical feedback and best practice show that we should place more of our resource in a community-led model of mental health rather than hospital beds (inpatient). By having more mental health teams in the community, they can spot the warning signs that a person is going into crisis and through early support often avoid an inpatient stay. When an inpatient stay is needed, we want to help people stay in the county and by having better support in the community we can help be discharged home more quickly and reduce the risk of readmission.
- Since 2019 we have enhanced our community services available in the south east, which we believe are delivering better care for patients. However, we will want to seek your experiences of this new way of working to inform our long-term approach.
- We are investing in long-term community mental health services.
- We recognise the history and legacy of the George Bryan Centre. However, we also recognise healthcare evolves. We want a dialogue with you on the services people need for the future, rather than be tied to buildings and infrastructure. Once we understand people's needs, we can design the right services and then look at the buildings needed to support them.
- The community-led model is an enhancement of, rather than a removal of, services and will help to improve the patient experience through a more personalised, wraparound care focused on the patient's needs.

Stakeholders

Our work to map stakeholders has been an iterative process throughout this programme of involvement activity and continues to be so. We have developed a comprehensive database of stakeholders; this is a live stakeholder management system which is updated as details change, and new or additional stakeholders are identified.

Approach to involvement

Recognising that this phase follows involvement activity in 2019 and 2021 for this project, we will seek to build on the relationships already established and previous conversations with stakeholders. We would also be looking to launch a range of activities, including but not restricted to:

- A roadshow of drop-in events, workshops, and one-to-one in-depth interviews – these would be face-to-face, subject to any Government guidance and organisational policy in place at the time, as well as organisational policy - and virtual workshops online
- Survey to gather views about the business case and understand if there is anything else that should be taken into consideration. The survey will also allow us to understand any impacts of the business case to centralise beds at St George's Hospital, Stafford, and the community-led model as well as any impact of this emerging model of care. We would also be able to understand if there are any alternatives to this proposal.

Channels

Our approach to communications and involvement includes use of a range of channels including, but not limited to:

- Internal channels – newsletters, intranet, team meetings.
- Stakeholder bulletin.
- One-to-one virtual briefings and correspondence as required with stakeholders or stakeholder group representatives.
- Website – dedicated pages on MPFT's website and that of the Integrated Care System to share information, encourage participation and host public-facing documents for download/print.
- Media – briefings, interview opportunities (as appropriate), press releases and media enquiry responses to share information or address concerns.
- Social media – promotion to share opportunities to participate and share views.
- In-depth interviews with seldom heard group representatives and/or individuals.
- Roadshow of workshops to gather people's experiences and views.
- Survey – seeking comments and responses to questions.

Supporting seldom heard groups

An Equality Impact Assessment (EIA) will be produced that outlines the approach to involving seldom heard groups. We will work closely with the ICS's Local Equality

Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

We will ensure our communications are accessible by:

- Writing in plain language.
- Using visuals (including diagrams, animations and easy read documents).
- Providing access to other languages, other document formats (large print, Braille, etc.) and British Sign Language (BSL) interpretation when needed.
- Arranging events to be at various times and days of the week to maximise attendance.
- Asking people if there are any reasonable adjustments needed when attending virtual events and offering alternative ways for people to share their feedback (e.g. telephone).
- Providing reasonable adjustment and support, for example using interpreters or offering smaller focus groups with existing networks where appropriate.

We will build on our relationships with the voluntary and community sector, to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, we will work with trusted advocates, for example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that is approachable and understandable.

Analysis and reporting

A midpoint review is scheduled into the plan at week 4 and will guide whether there is a need to undertake more targeted activity with certain groups and whether there is a need to extend this timeline.

A detailed analysis report will be produced by Midlands and Lancashire Commissioning Support Unit (MCSU) on the comments from the necessary involvement activity; this will include a thematic breakdown of comments received and demographic analysis from participants, subject to them sharing this information when asked to do so during their participation.

These reports will be shared with the programme team to conscientiously consider the findings to inform the next steps. The report will be carefully considered by the Staffordshire and Stoke-on-Trent NHS Integrated Care Board (ICB) which is legally responsible for making a decision. The report of findings will be published on our website. We will also continue to involve the Overview and Scrutiny Committee at every step of this process.

Appendix 1

Business case with proposal for a solution to the services formerly provided at the George Bryan Centre

Communities we serve

1. Introduction

This chapter sets out a summary of the latest information relating to mental health within the local population demographic make-up, in order to provide background to this business case about the future of inpatient mental health services for adults with severe mental illness and older adults with severe mental illness or dementia in south east Staffordshire. It provides a particular focus on Lichfield, East Staffordshire (including Burton on Trent) and Tamworth.

2. The local population

Population size and projections

The population of Staffordshire stands at 871,000. This population is projected to increase by around 4% between 2019 and 2039.[1] There is a lower number of under-45s than the West Midlands region and England, and a higher number of over-45 year olds. This is due in part to a larger number of retirees in Staffordshire.

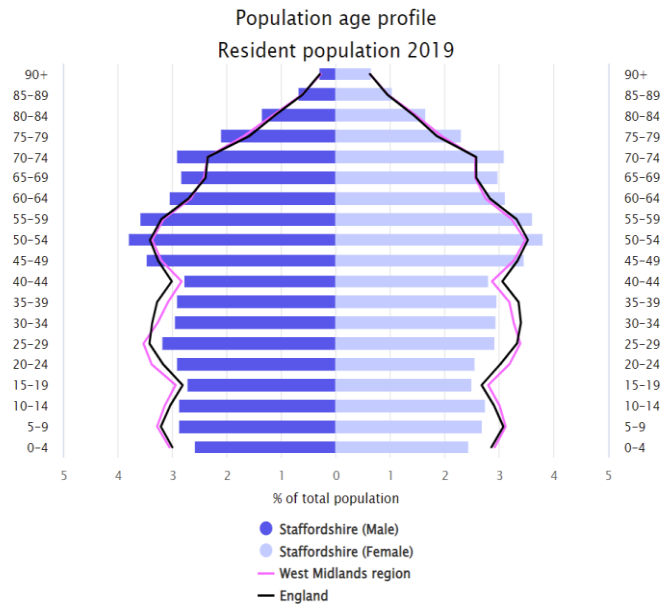


Figure 1 Age profile of the resident population of Staffordshire[2]

Residents from minority ethnic backgrounds make up around 8.1% of the population of Staffordshire and Stoke-on-Trent, compared to 20% across England, with higher

[1] ONS Population projections, March 2020

[2] Local Authority Health Profiles, accessed Feb 2022

concentrations in Burton, East Staffordshire (13.8%)[1], with the largest minority group being Pakistani[2]. It has been shown that many black and minority ethnic populations are in poorer health and find it harder to access services in many healthcare systems.3

Staffordshire is considered a largely rural area as a higher number of people live in areas defined as rural (19%) than the average for England (17%).4 Rural populations tend to have higher life satisfaction but do encounter difficulties when accessing services, especially the older population, which can lead to increased isolation.

Life expectancy and healthy life expectancy

Men and women in Staffordshire have a life expectancy similar to that of the England average at 79.3 years for men and 83.1 years for women. There are variations across the area.[5]

	Men	Women
	Life expectancy at birth (years)	**Life expectancy at birth (years)**
Cannock Chase	78.4	82.6
East Staffordshire	78.2	82.5
Lichfield	80.3	83.5
Newcastle-under-Lyme	78.5	82.3
South Staffordshire	80.1	84.1
Stafford	80.0	84.0
Staffordshire Moorlands	80.1	83.2
Tamworth	78.6	82.4
Staffordshire	79.3	83.1
Stoke-on-Trent	75.9	79.7
West Midlands	78.5	82.5
England	79.4	83.1
Key: Statistically better than England; statistically worse than England		

Figure 2 Life expectancy at birth across Staffordshire and Stoke-on-Trent 2018/20[6]

With an ageing population and those with poor lifestyles there will likely be an increase in the instances of long-term conditions as well as multiple conditions. Healthy life expectancy has fallen in Staffordshire for men and women, to nearly 62 years for men, falling by 1.8 years, and to 64 years for women, falling by 1.1 years. This means that the healthy life expectancy for men is the third worst amongst similar authorities.7

[1] ONS 2011 census data

[2] Staffordshire Evidence Base: Population Demographics and Adult Social Care Needs, Feb 2019

[3] PGMJ (2005) Access to health care for ethnic minority populations.

[4] ONS Rural and Urban Area Classification 2011

[5] Local Authority Health Profiles, accessed Feb 2022

[6] Local Authority Health Profiles, accessed Feb 2022

[7] Staffordshire JSNA 2021

More than one in two people over 65 suffer from two or more long-term conditions, which will affect their quality of life and increase their chance of hospital admission.1

Mortality

There are variations in mortality rates across the area although as a county Staffordshire is in line with the England rate of mortality overall (2018/20).2

Staffordshire is in line with the England rate for under 75 mortality overall, with a better mortality rate from cancer but a worse rate for liver disease.3

Excess mortality for the under 75s with severe mental illness is worse than the England average.4

Mortality owing to COVID-19 is slightly higher than the national average owing to the older population in the county, with the highest rates in Tamworth and East Staffordshire.5

Wider determinants of health

Many socio-economic factors influence how healthy the population is. These include employment levels, housing conditions, education and various lifestyle factors.

Rates of employment are rising across Staffordshire despite the pandemic. Staffordshire has an unemployment rate of 3.7% which is lower than the national rate of 4.9% (Jan 2022). Income discrepancies between men and women in some parts of Staffordshire are outside the national averages.[6]

In some areas of the county there is a high proportion of low skilled and low paid jobs such as East Staffordshire and Tamworth which are also some of the areas with experience health issues such as lower life expectancy and higher rates of mental health emergency admissions.7

In terms of housing as reported in the 2011 Census, on average 20% of households in England are socially renting. Across the West Midlands region it is slightly less than average at 19% and in Staffordshire it is lower still at 15%.[8]

Those living in fuel poverty across Staffordshire is 15.2% which is slightly higher than the national average (13.4%).[9]

[1] Staffordshire JSNA 2019

[2] Local Authority Health Profiles, accessed Feb 2022

[3] Public Health Outcomes Frame work - Staffordshire, accessed Feb 2022.

[4] Public Health Outcomes Framework, accessed 29 April 2022

[5] Staffordshire JSNA 2021

[6] ONS, Regional labour market: Local indicators for counties, local and unitary authorities, Jan 2022

[7] Staffordshire JSNA 2021, accessed 29/04/2022

[8] ONS, Census data (2011)

[9] Public Health Outcomes Frame work - Staffordshire, accessed Feb 2022.

The number of residents living with long-term conditions across the area is on the increase with a higher-than-average number of people with high blood pressure, coronary heart disease, asthma, stroke and diabetes than the national average.[1]

Across England, 62.8% adults are classified as overweight or obese. This figure rises to two thirds in Staffordshire (2019/20).[2]

In 2020 the percentage of adults who smoked in Staffordshire was 13.0% which is just slightly above the England figure (12.1%).[3]

Alcohol-specific mortality in Staffordshire was similar to that in England, but the county experienced higher than average admissions for alcohol-related reasons.[4]

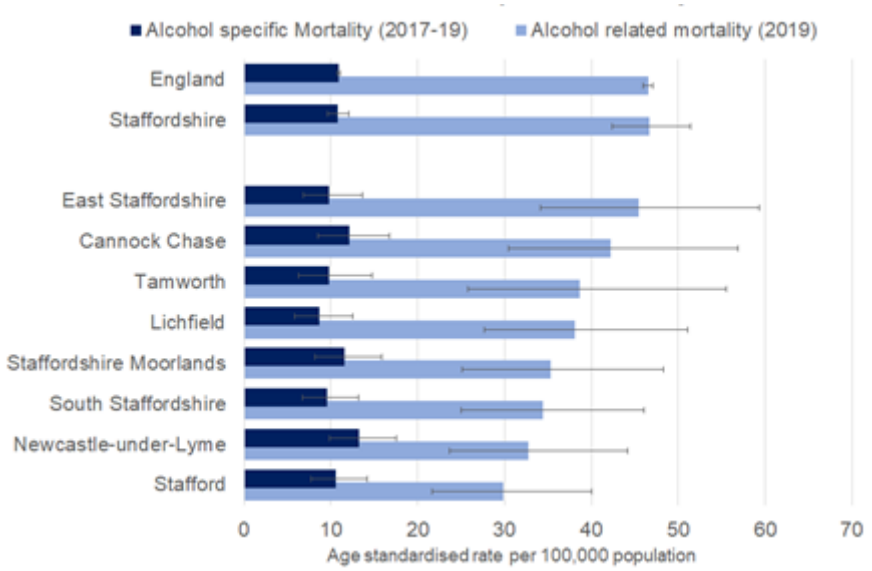


Figure 4 alcohol-specific and alcohol-related mortality in Staffordshire

Average annual earnings have increased by 2% across Staffordshire since 2020 although are still lower than the national. There are more Staffordshire residents in lower paid, manual and routine jobs compared to national, with the lowest levels in the county found in East Staffordshire and Tamworth. These areas also experience health issues such as lower life expectancy and higher rates of mental health emergency admissions.[5]

Adult Social Care

The increase in the elderly population in Staffordshire will impact on the needs of the adult social care provisions, placing more demand for the services in particular for people with complex and long-term conditions.

Demand for new assessments increased in the year 2019/20 to 2020/21 from people living in the community as well as those being discharged from hospital.[6]

[1] Staffordshire JSNA 2021
[2] Public Health Outcomes Framework - Staffordshire, accessed Feb 2022.
[3] Public Health Outcomes Framework - Staffordshire, accessed Feb 2022.
[4] Local Alcohol Profiles for England, accessed Feb 2022
[5] Staffordshire JSNA 2021
[6] Staffordshire JSNA 2021

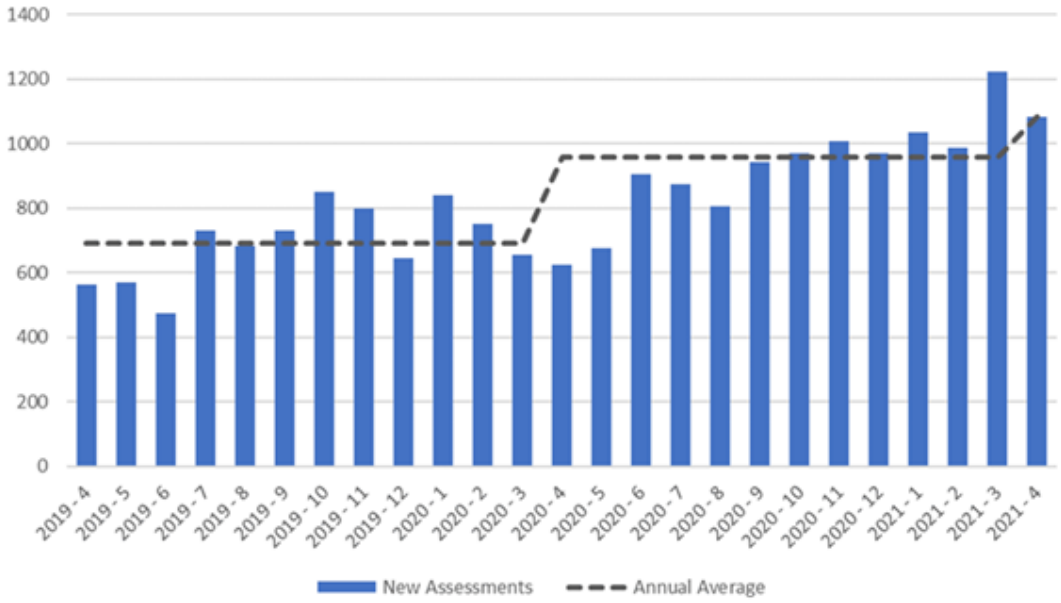


Figure 5 New assessments Staffordshire – April 2019 to April 2021[1]

3. Local population mental health

There are some stark differences in outcomes between those with a mental illness and the general population in Staffordshire which runs across all areas of life such as education, employment, housing and health and wellbeing outcomes. For people who experience with poor mental health or who have a mental health diagnosis, stigma and discrimination present significant barriers to full participation in health care, education and citizenship.

Generally, the adult population of Staffordshire pre-pandemic experienced good wellbeing. Since the pandemic started however, all areas have been a decrease in life satisfaction, feeling worthwhile and happiness, and an increase in anxiety.[2]

Nationally around 19% of adults aged 18-64 are estimated to have a mental health condition. In Staffordshire and Stoke-on-Trent that equates to 125,500 adults. Based on 2017/18 QOF registers, around one in ten (11%) Staffordshire STP adults are on a depression register and 0.8% are recorded as having a severe mental illness. Deprived communities have poorer health and wellbeing and higher levels of mental illness.

In 2020/21 one in three emergency hospital admissions were for adults with a mental health diagnosis across Staffordshire, which is lower than England. Whereas East Staffordshire and Tamworth recorded admission rates which were higher than the national average.

[1] Staffordshire JSNA 2021

[2] ONS - Personal well-being in the UK: April 2020 to March 2021

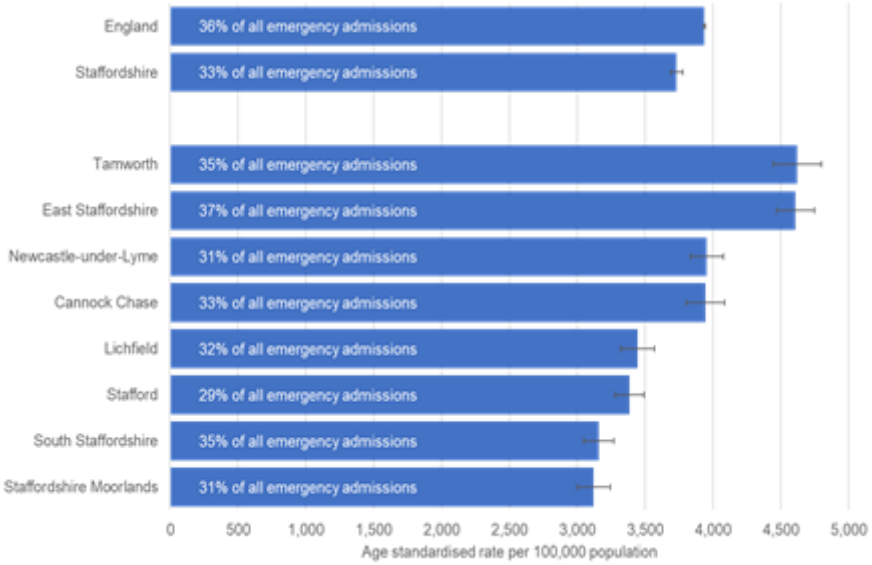


Figure 6 Emergency admissions to hospital for adults (age 20+) with a mental health diagnosis in any diagnosis field, 2020/21[1]

More recent unpublished data (2020/21) sees a general fall in admissions due to COVID-19 with rates similar to national, however Stafford and Tamworth remain high.[2]

Impacts of COVID-19[3]

MPFT has created a set of assumptions to model future mental health needs of the general population in Staffordshire and Stoke-on-Trent by using evidence from previous epidemics and emerging information from the COVID-19 epidemic. These assumptions point to a significant rise in the number of adults with anxiety and depression, as well as significant potential for relapses for known psychosis patients.

These assumptions suggest that nearly 200,000 adults in Staffordshire and Stoke-on-Trent are currently experiencing some anxiety, an increase of nearly 33,000 from before the pandemic. And an increase of 113,000 adults are estimated to be experiencing some level of depression, although it is unknown how many of those experiencing anxiety and/or depression will present themselves to their local mental health services and it could take several years before the full impact is known.

It is estimated that 10% of known psychosis patients across Staffordshire and Stoke-on-Trent will relapse in the first 6 months, increasing to 20% between 6 and 12 months. This equates to just over 900 patients in the first six months increasing to over 1,800 by 12 months.

A further impact of the COVID-19 pandemic is the increase in the number of adults who will develop prolonged grief disorder, estimated to be 535 adults across Staffordshire and Stoke-on-Trent.

[1] Hospital Episode Statistics, HSCIC, ONS Population Estimates

[2] Staffordshire JSNA 2021

[3] MH Forecasting due to COVID-19 pandemic SSOT, Oct 2021

As of 19 April 2021, 4,271 patients had been discharged from Staffordshire and Stoke-on-Trent hospitals following treatment for COVID-19 since the start of the pandemic in March 2020.

Midlands Partnership Foundation Trust (MPFT) modelled the number of patients who spent time in hospital with COVID-19 who may go on to develop certain mental health conditions through the analysis of evidence from studies relating to critical care patients and advice from consultant psychiatrists. This has been applied to both non-critical care and critical care hospitalised patients.

- PTSD – 811 or 19% patients after 6 months
- Depression – 1,418 or 33.2% discharged patients after 6 months
- Anxiety – 1,281 or 30% discharged patients after 6 months
- Psychosis – 43 or 1% discharged patients after 6-12 months

Suicide rates

Suicide rates across Staffordshire (12.2 per 100,00) are higher than the England average (10.4 per 100,000) (2018-2020). The number of admissions for people who self-harm is 179 per 100,000 compared to the England average of 181.2 per 100,000 (2020/2021).[1]

Whilst three-quarters of deaths from suicides in Staffordshire are male, the suicide rate in females is increasing and higher than the England rate. In terms of age, people aged 30-49 are over-represented in suicides.[2]

Dementia

Over 13,600 residents of Staffordshire are estimated to be living with dementia. Diagnosing dementia enables appropriate treatment to be provided and in most areas of Staffordshire the diagnosis rate is similar to the national rate, although at their lowest in East Staffordshire.

Dementia prevalence is also set to increase by 3,500 people across Staffordshire by 2030.[3]

[1] Public Health Outcomes Frame work - Staffordshire, accessed April 2022

[2] Staffordshire JSNA 2021

[3] Staffordshire JSNA 2021

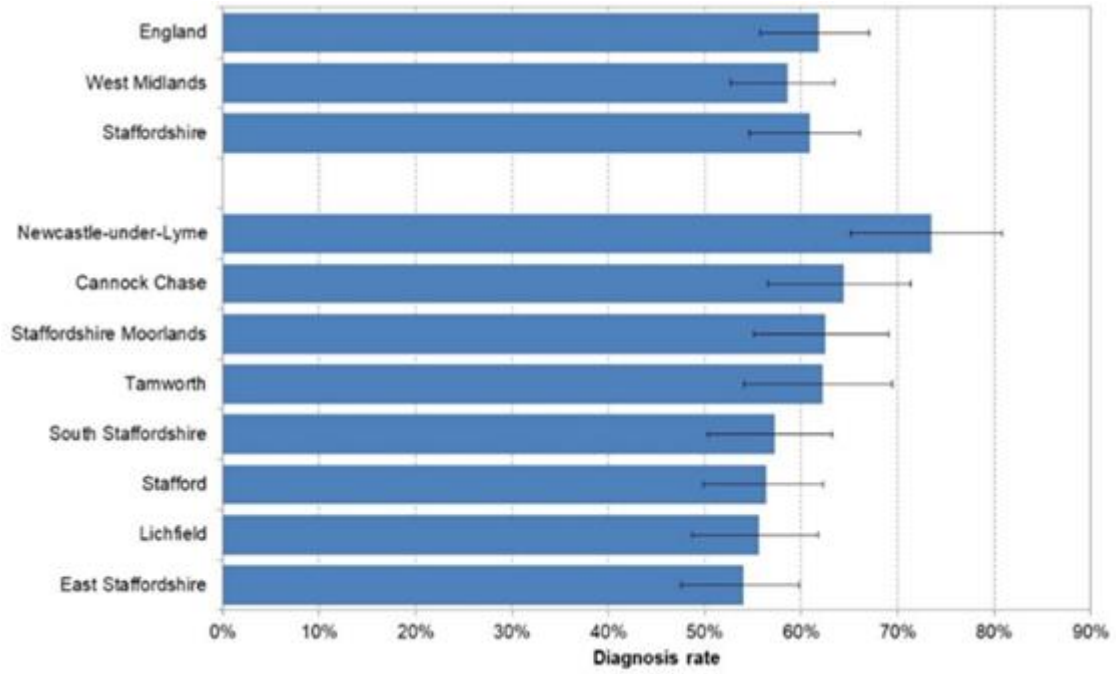


Figure 7 Dementia diagnosis rates, May 2021[1]

Mental health referrals

East Staffordshire Primary Care Network (PCN) and Mercian Primary Care Network (PCN) (which covers the Tamworth area) report that in their areas, there is a lower prevalence of people with severe mental illness on Quality and Outcomes Framework (QOF) registers than England as a whole, and that the highest number of referrals in order by service (excluding Improving Access to Psychological Therapies (IAPT)) are to adult mental health, children's and Child and Adolescent Mental Health Services (CAMHS).[2]

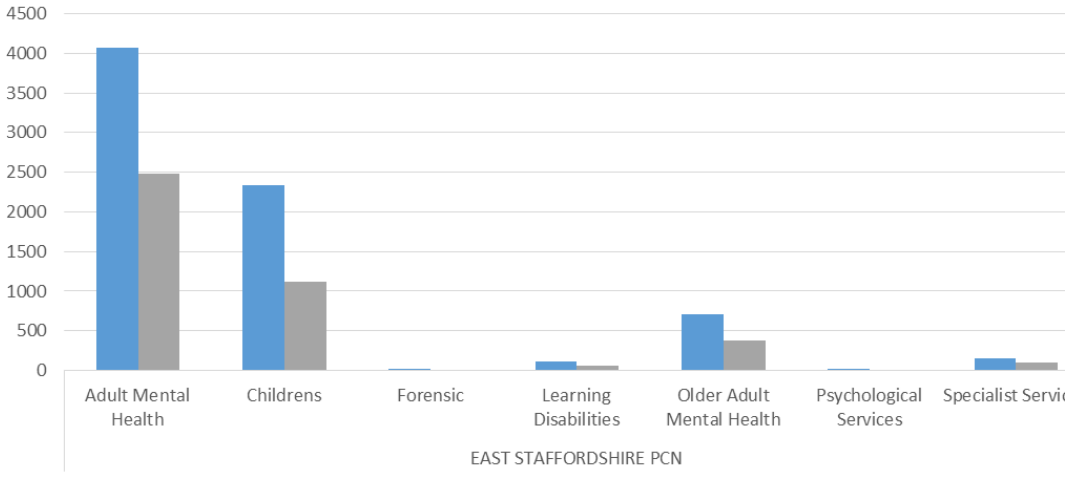


Figure 8 Referrals to Midland Partnership Foundation Trust in East Staffordshire by service[3]

[1] Health and Social Care Information Centre (Numerator from GP clinical systems extract. Denominator estimated based on rates from the Medical Research Council Cognitive Function and Ageing Study II)

[2] CMHF insight overview summary - East Staffordshire V2.2a

[3] CMHF insight overview summary - East Staffordshire V2.2a

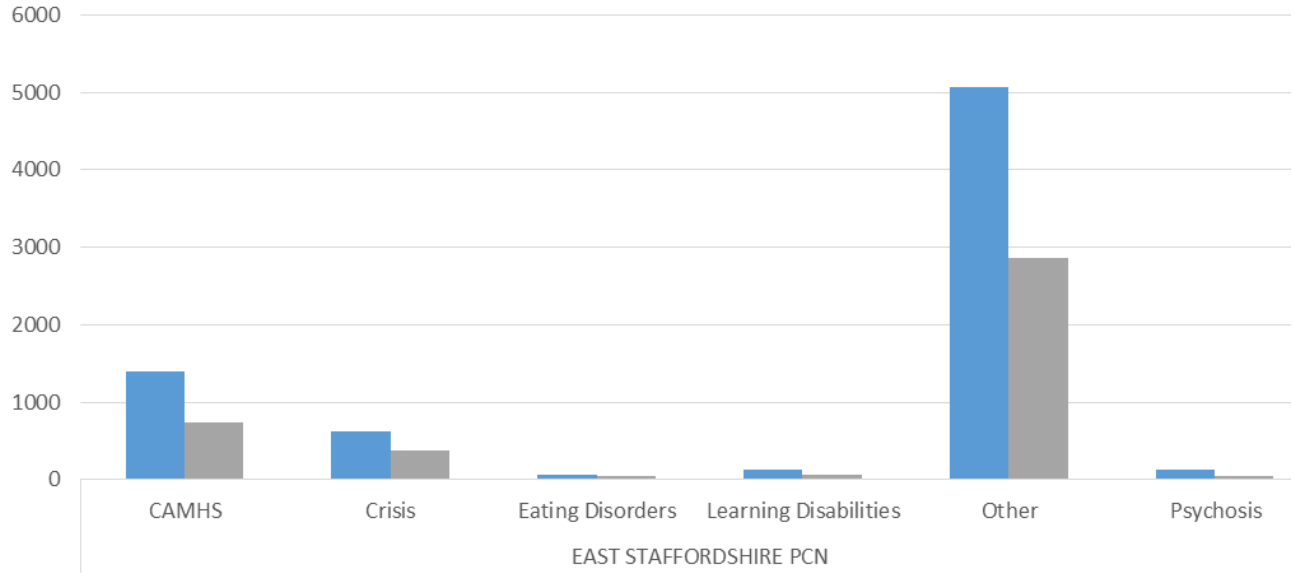


Figure 9 Referrals to Midland Partnership Foundation Trust in East Staffordshire by service *continued*[1]

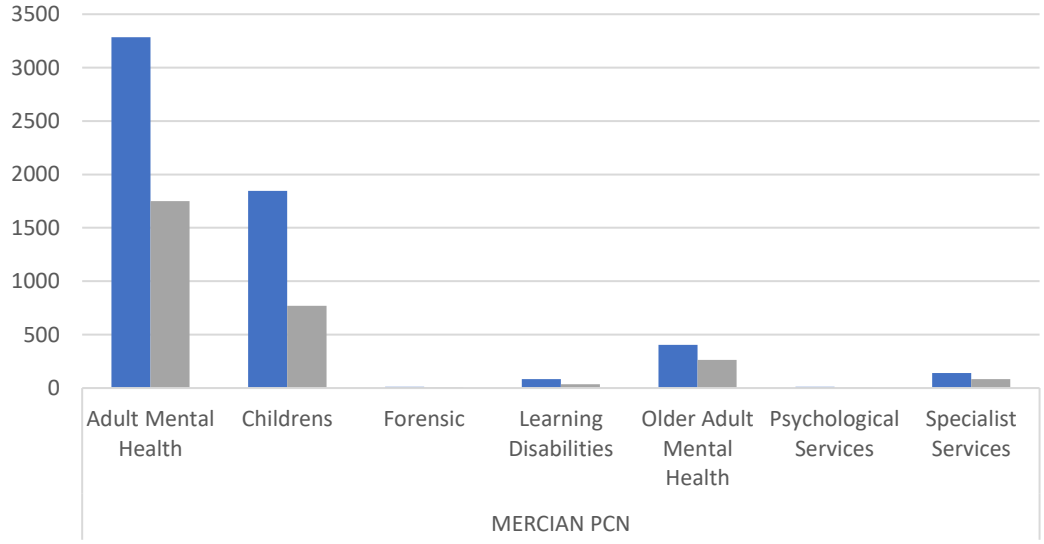


Figure 10 Referrals to Midland Partnership Foundation Trust in Mercian by service

[1] CMHF insight overview summary - East Staffordshire V2.2a

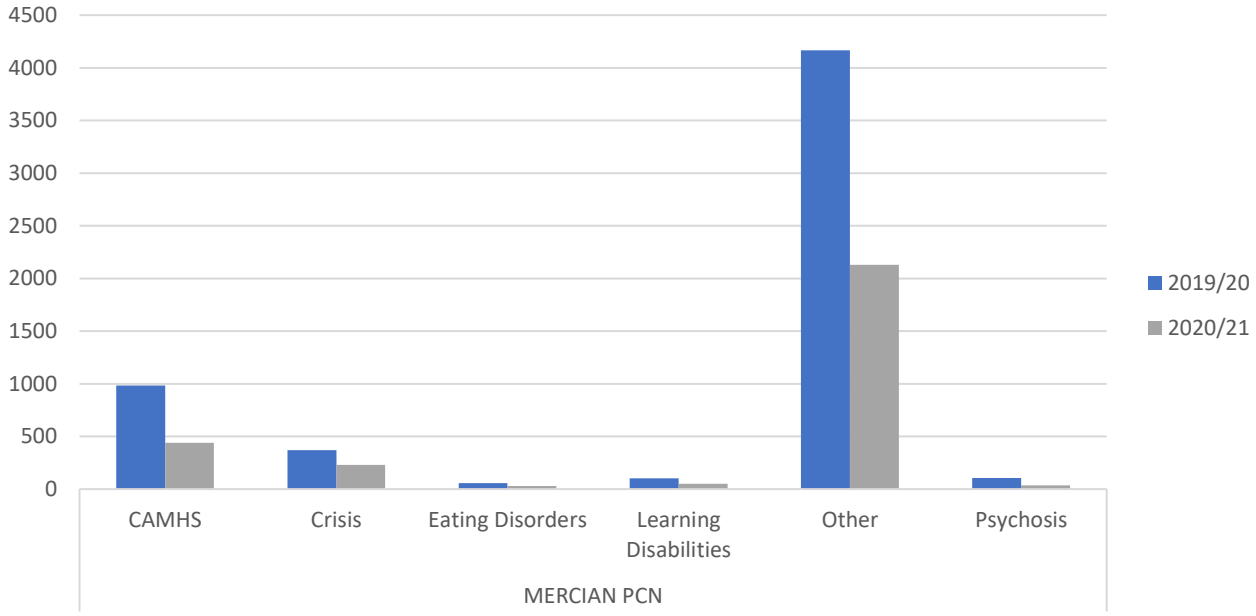


Figure 11 Referrals to Midland Partnership Foundation Trust from Mercian PCN by service continued[1]

Mercian and East Staffordshire PCNs report that they have similar numbers of referrals to mental health services (not IAPT) in males and females.

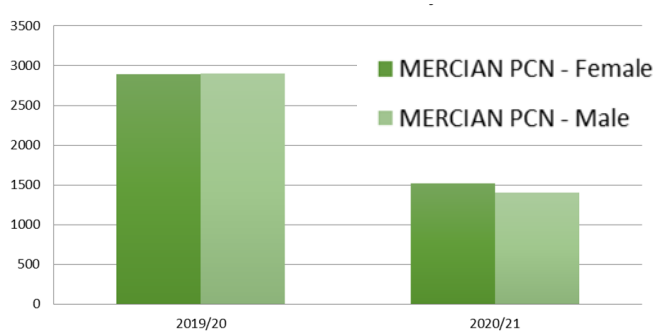


*Figure 12 Numbers of referrals to mental health services (not IAPT**) in Mercian PCN by gender*

[1] CMHF insight overview summary -Mercian V1.4b.pptx

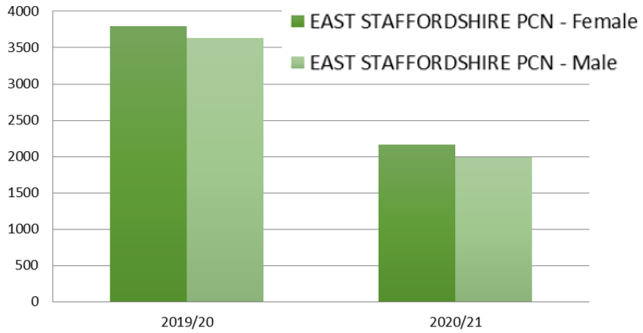


*Figure 13 Numbers of referrals to mental health services (not IAPT**) in East Staffordshire PCN by gender*

Acute care and crisis

In 2020/21 there were one in three (33%) emergency hospital admissions in Staffordshire for adults with a recorded diagnosis of a mental health condition. Whilst overall in Staffordshire this was lower than the national rate, East Staffordshire and Tamworth have the highest admission rates and statistically higher than national.[30]

There is estimated to have been a rise in the number of people detained under the Mental Health Act 1983 of 4.5% between 2019/20 and 2020/21. Detention rates were higher for males (94.8 per 100,000 population) than females (87.9 per 100,000 population). [1]

NHS Clinical Commissioning Group (CCG)	Number of detentions	Base population	Crude rate per 100,000 population
NHS Cannock Chase CCG	75	137,595	54.5
NHS East Staffordshire CCG	90	129,944	69.3
NHS North Staffordshire CCG	255	219,600	116.1
NHS South East Staffordshire and Seisdon Peninsula CCG	150	226,837	66.1
NHS Stafford and Surrounds CCG	90	157,308	57.2
NHS Stoke on Trent CCG	345	264,651	130.4

Table 1 Number of people detained under the Mental Health Act 2020-21 by CCG[32]

GP Recorded Depression

There is an increasing trend in the number of Staffordshire adults with GP recorded depression (12%), doubling since 2012/13 and higher than the England rate. However there are lower levels of GP recorded severe mental illness. [2]

[1] Mental Health Act Statistics, Annual Figures, England 2020-2021

[2] Staffordshire JSNA 2021

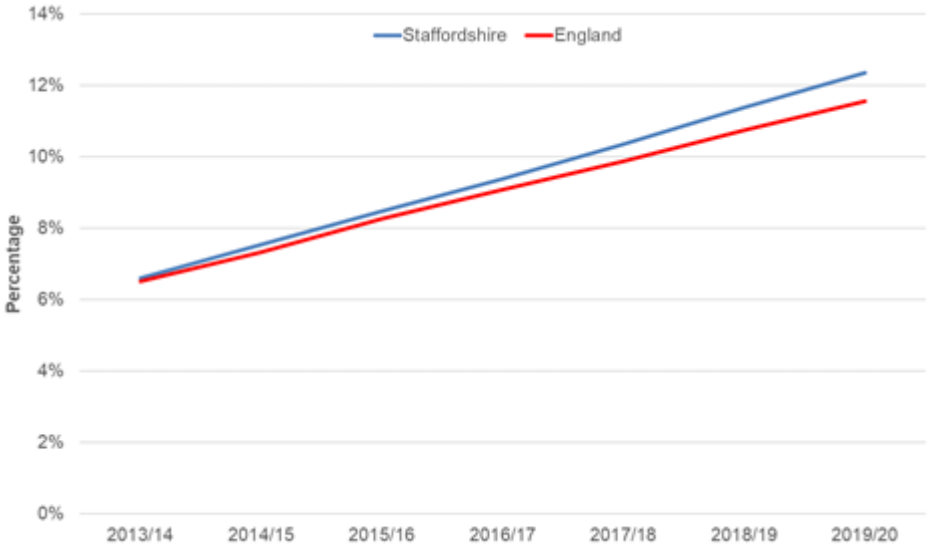


Figure 15 Trends in GP recorded depression[1]

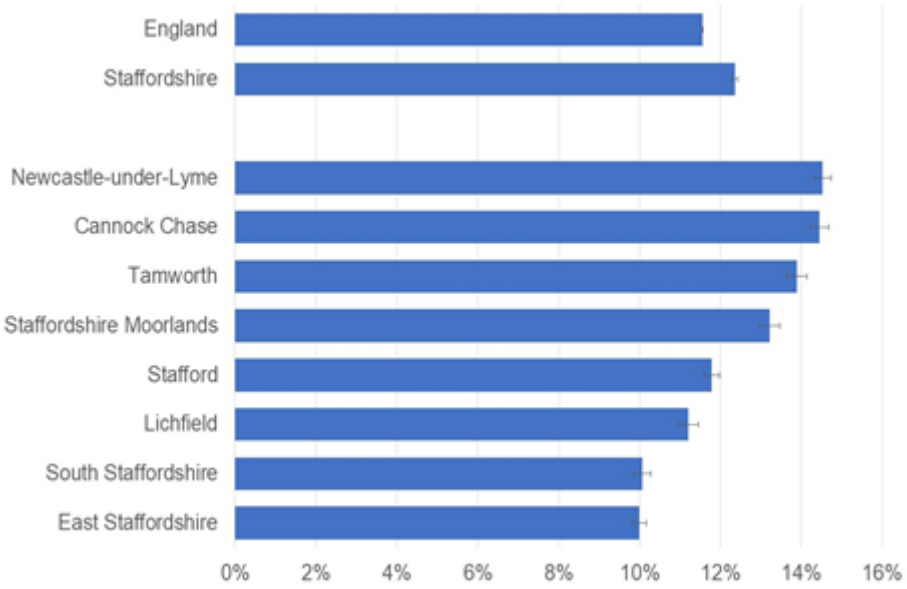


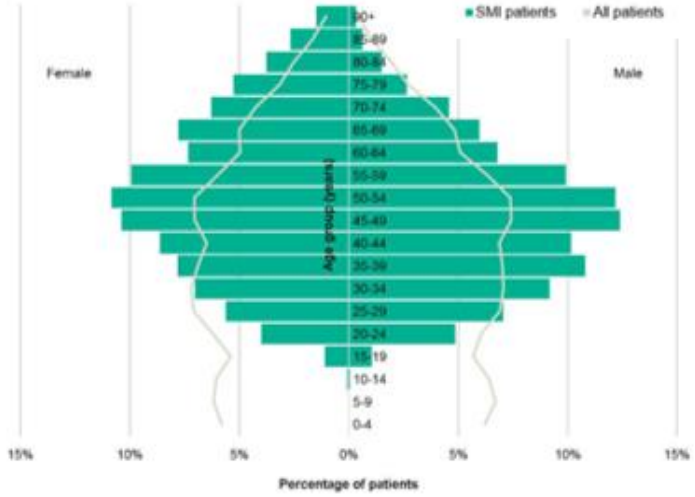
Figure 16 GP recorded depression in adults aged 18+ (2019/20)[2]

Note: High rates may indicate a high underlying pathology, but alternatively could be due to local recording practice.

Severe mental illness

There is a higher prevalence of severe mental illness amongst women in middle age, whilst prevalence is higher amongst men in younger age groups.[3]

[1] Staffordshire JSNA 2021
[2] Staffordshire JSNA 2021
[3] Staffordshire JSNA 2021



Source: The Health Improvement Network (THIN), Active patients in England; data extracted May 2018

Figure 17 Age (years) and sex distribution of patients with a diagnosis of Severe Mental Illness (SMI) compared with all THIN patients across England[1]

Life expectancy

Figures show that life expectancy for those who have died who had contact with mental health services in the 3 years prior to their death reduces by 19.6 years for males and 16.37 years for females across Staffordshire compared to those who do not have contact.[2]

4. Lichfield current population profile

Current population

There are currently around 105,500 people living in Lichfield. In comparison with the average in England, there are lower than average under 45 year-olds and higher than average over 45 year-olds.[3]

[1] CMHF insight overview summary -Mercian V1.4b.pptx

[2] CMHF insight overview summary -Mercian V1.4b.pptx

[3] Public Health Outcomes Framework, accessed Feb 2022

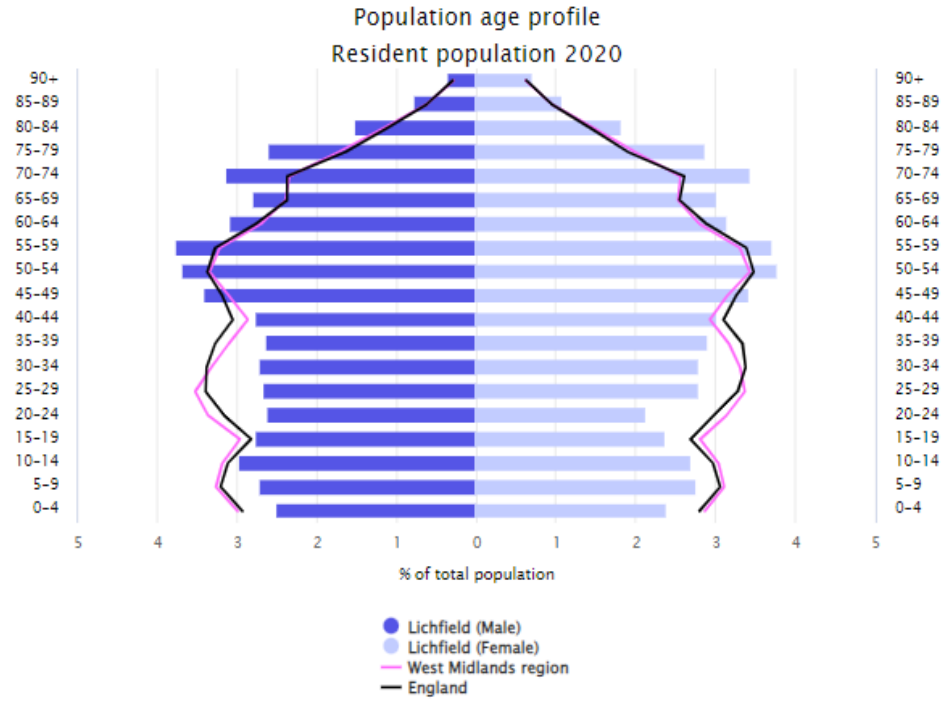


Figure 18 Age profile of the population of Lichfield in comparison to the West Midlands region and England 2020 [1]

Life expectancy

Life expectancy at birth in Lichfield is 80.3 years for men which is higher than the England average of 79.4. For women life expectancy is 83.5 years, also higher than the England average of 83.1 (2018/20).[1]

In 2020 the under 75 mortality rate from causes considered preventable was in line with the England rate overall and for respiratory disease, liver disease, cardiovascular disease, and much lower in the mortality rate for cancer.[2]

Adult health

The number of alcohol-related admissions is in line with the England average (2020/21), although it is expected that the number of admissions will have increased as a result of the pandemic. The alcohol-related mortality rate is slightly less than England rate.[3]

Figures from 2020 show that Lichfield has the lowest number of adult smokers in the region, at 2.8% significantly lower than the England figure of 12.1%.

The number of adults who are physically active is similar to the national average (2019/20).[4]

[1] Local Authority Health Profiles, accessed Feb 2022
[2] Public Health Outcomes Framework, accessed Feb 2022
[3] Local Alcohol Profiles for England, accessed Feb 2022
[4] Public Health Outcomes Framework, accessed Feb 2022

In 2019/20 Lichfield had a similar percentage of adults classed as overweight or obese as the average in England.

In 2020/21 the number of emergency hospital admissions for self-harm - 143 per 100,000 - was significantly lower than the national rate (181.2 per 100,000).[1]

Whilst the number of people out of work has increased considerably during the pandemic, figures still show that the number of people in employment in 2020/21 was in line with England[2].

In 2019/20 the gap in the employment rate between those with a long-term health condition and the overall employment rate was 19.8% compared with the national rate of 10.6%.[3]

A&E attendances (including Walk-In and Minor Injuries Units) in 0- 19 ages are higher than the Staffordshire average (2018/19)

Mental Health

The suicide rate in Lichfield is slightly higher than the national average at 12.3 per 100,000 compared to the England rate of 10.4 per 100,000.[4]

In 2021 the estimated dementia diagnosis rate for those aged 65 and over was slightly less than the England rate.[5]

One in four emergency admissions also have a mental health diagnosis, which is similar to the overall rate in Staffordshire.

5. East Staffordshire current population profile including Burton upon Trent

Please note that separate data for Burton upon Trent is not available – it is included in the data for East Staffordshire.

Current population

There are currently around 121,000 people living in East Staffordshire. In comparison with the average in England, there are relatively fewer 15-45 year-olds and a larger than average over 45 population.[6]

[1] Public Health Outcomes Framework, accessed Feb 2022
[2] Public Health Outcomes Framework, accessed Feb 2022
[3] Public Health Outcomes Framework, accessed Feb 2022
[4] Public Health Outcomes Framework, accessed Feb 2022
[5] Public Health Outcomes Framework, accessed Feb 2022
[6] Public Health Outcomes Framework, accessed Feb 2022

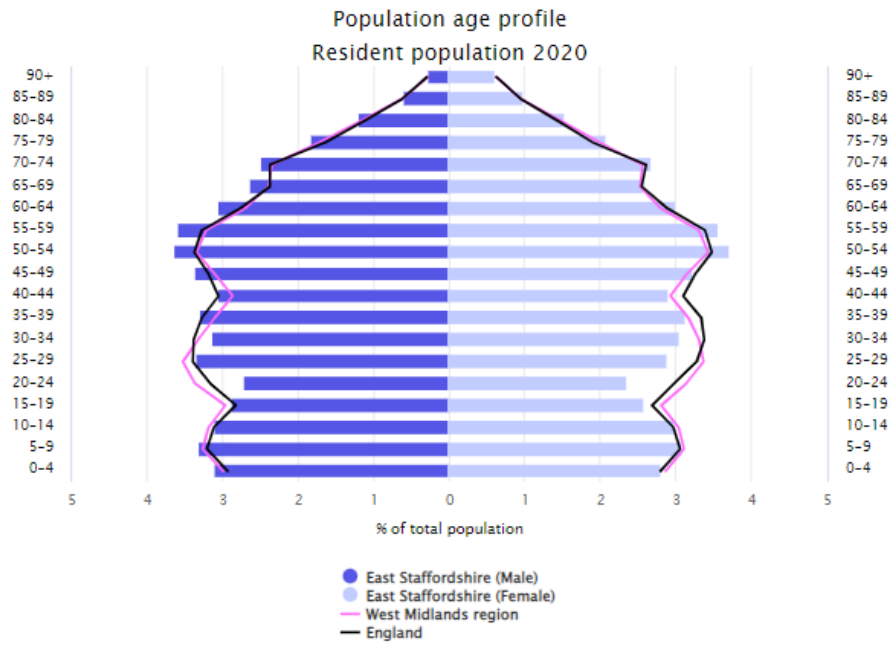


Figure 19 Age profile of the population of East Staffordshire in comparison to the West Midlands region and England 2020[1]

Life expectancy

Life expectancy at birth in East Staffordshire is 78.2 years for men which is similar to the England average of 79.4. For women life expectancy is 82.5 years, just slightly less than the England average of 83.1 (2018/20).[1]

In 2020 the under 75 mortality rate from causes considered preventable was higher than the England rate overall and for liver disease and cardiovascular disease, respiratory disease and cancer.[2]

Healthy life expectancy in East Staffordshire is longer than the national figures at 64 years for men and 65 years for women. Women in East Staffordshire spend more of their lives in poor health than men (17 years compared to 16).[3]

Adult health

The number of alcohol-related admissions is 580 per 100,000, higher than the England average at 456 per 100,000 (2020/21) [4]

Figures from 2020 show that the number of adults in East Staffordshire who smoke (18.8%) is significantly higher than the England figure (12.1%).

[1] Public Health Outcomes Framework, accessed Feb 2022

[2] Public Health Outcomes Framework, accessed Feb 2022

[3] CMHF insight overview summary - East Staffordshire V2.2a

[4] Local Alcohol Profiles for England, accessed Feb 2022

The number of adults who are physically active is similar to the national average (2019/20).[1]

In 2019/20 East Staffordshire had a higher number of adults classed as overweight or obese than the average in England.

In 2020/21 the number of emergency hospital admissions for self-harm - 176.6 per 100,000 - was lower than the national rate (181.2 per 100,000).[2]

Whilst the number of people out of work increased during the pandemic, figures still show that the number of people in employment in 2020/21 was 77.5% which is slightly more than the England number (75.1%).[3]

In 2019/20 the gap in the employment rate between those with a long-term health condition and the overall employment rate was 8.9% compared with the national rate of 10.6%.[4]

Claimant numbers are below average across all age groups.[5]

Housing appears to be a key issue in East Staffordshire with high levels of overcrowding and fuel poverty. A higher number of houses live in fuel poverty (14%) than the England average of 11.%. This is also the highest proportion in Staffordshire. This most prevalent in most deprived wards.[6]

Mental Health

The suicide rate in East Staffordshire 2018/20 was 13.9 per 100,000 compared to the England rate of 10.4 per 100,000.[7]

In 2021 the estimated dementia diagnosis rate for those aged 65 and over was below the England rate, with East Staffordshire having the lowest rates in the county.[8]

6. Tamworth current population profile

Current population

There are currently around 77,000 people living in Tamworth. In comparison with the average in England, there are relatively fewer 20-35 year-olds and over 85 year olds.[9]

[1] Public Health Outcomes Framework, accessed Feb 2022
[2] Public Health Outcomes Framework, accessed Feb 2022
[3] Public Health Outcomes Framework, accessed Feb 2022
[4] Public Health Outcomes Framework, accessed Feb 2022
[5] CMHF insight overview summary - East Staffordshire V2.2a.pptx
[6] CMHF insight overview summary - East Staffordshire V2.2a.pptx
[7] Public Health Outcomes Framework, accessed Feb 2022
[8] Staffordshire JSNA 2021
[9] Public Health Outcomes Framework, accessed Feb 2022

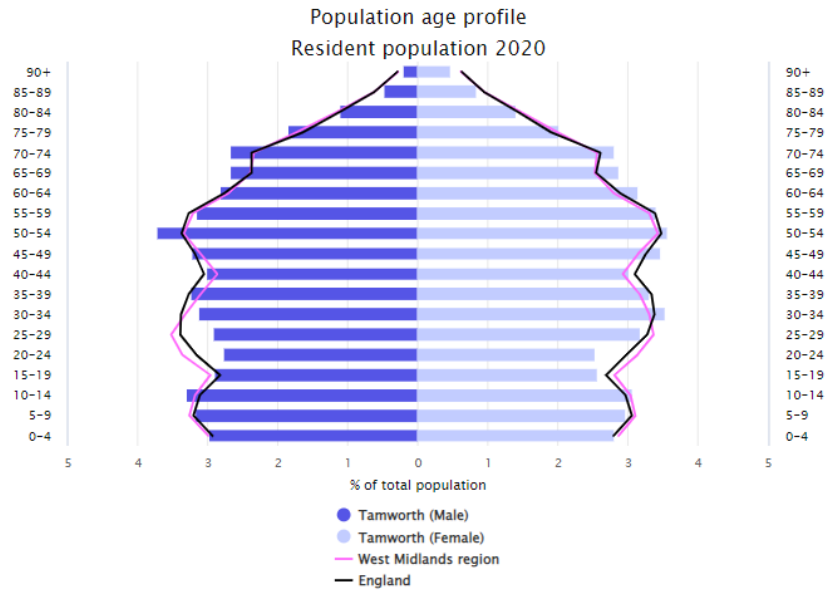


Figure 20 Age profile of the population of Tamworth in comparison to the West Midlands region and England 2020 [1]

Life expectancy

Life expectancy at birth in Tamworth is 78.6 years for men which is lower than the England average of 79.4. For women life expectancy is 82.4 years, just slightly less than the England average of 83.1 (2018/20).[1]

In 2020 the under 75 mortality rate from causes considered preventable was in line with the England rate overall and for respiratory disease, liver disease, cardiovascular disease and cancer.[2]

Adult health

The number of alcohol-related admissions is higher than the England average (2020/21), although it is expected that the number of admissions will have increased as a result of the pandemic.[3] The alcohol-related mortality rate is in line with the England rate.

Figures from 2020 show that slightly more adults in Tamworth smoke (14.6%) than the England figure (12.1%).

The number of adults who are physically active is similar to the national average (2019/20).[4]

In 2019/20 Tamworth had a higher number of adults classed as overweight or obese than the average in England.

In 2020/21 the number of emergency hospital admissions for self-harm - 215.5 per 100,000 - was significantly higher than the national rate (181.2 per 100,000).[5]

[1] Public Health Outcomes Framework, accessed Feb 2022
[2] Public Health Outcomes Framework, accessed Feb 2022
[3] CMHF insight overview summary -Mercian V1.4b.pptx
[4] Public Health Outcomes Framework, accessed Feb 2022
[5] Public Health Outcomes Framework, accessed Feb 2022

There is a higher number of emergency hospital admissions than the national average and more long-term users of adult social care.[1]

Overcrowding and fuel poverty is not a significant problem in Tamworth.[2]

Pre-COVID-19 the unemployment rate in Tamworth was lower than the national average (May 2018). Whilst the number of people out of work has increased considerably during the pandemic figures still show that the number of people in employment in 2020/21 was 81.1% which is higher than the England number (75.1%)[3]. A survey carried out during the COVID-19 pandemic - the Tamworth Social Impact Survey - reported that only 18% felt their job was not at risk.[4]

In 2019/20 the gap in the employment rate between those with a long-term health condition and the overall employment rate was 16% compared with the national rate of 10.6%.[5]

Mental Health

The suicide rate in Tamworth was 11 per 100,000 compared to the England rate of 10.4 per 100,000.[6]

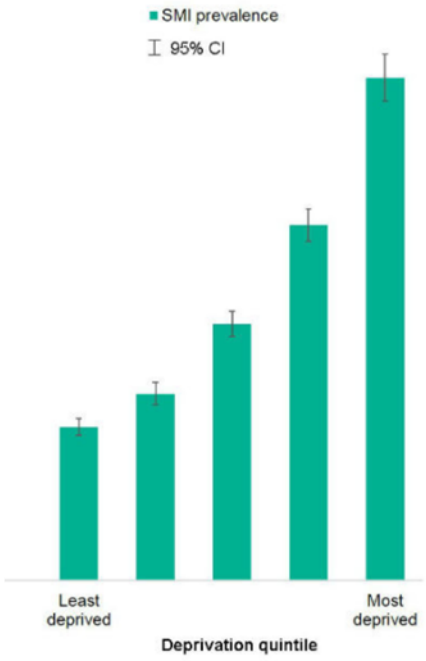
In 2021 the estimated dementia diagnosis rate for those aged 65 and over in line with the England rate.[7]

7. Deprivation

A wide range in levels of poverty and deprivation can be observed across the area. Staffordshire is relatively affluent with some highly deprived urban pockets.

Areas such as Stafford, Lichfield and South Staffordshire are among the least deprived in Staffordshire.[8] Those residents who live in economically deprived areas will suffer poorer health outcomes, including lower life expectancy.

[1] CMHF insight overview summary -Mercian V1.4b.pptx
[2] CMHF insight overview summary -Mercian V1.4b.pptx
[3] Public Health Outcomes Framework, accessed Feb 2022
[4] CMHF insight overview summary -Mercian V1.4b.pptx
[5] Public Health Outcomes Framework, accessed Feb 2022
[6] Public Health Outcomes Framework, accessed Feb 2022
[7] Public Health Outcomes Framework, accessed Feb 2022
[8] English indices of deprivation 2019 Statistical release - main findings.



Source: The Health Improvement Network (THIN), Active patients in England; data extracted May 2018

Figure 21 Prevalence of Severe mental Illness (SMI) in patients aged 15 to 74 by deprivation, across England

The graphs below show the number of MPFT patient referrals in 2019/20 against the Indices of Multiple Deprivation (IMD) in the Mercian PCN and East Staffordshire PCN, with the most deprived being at 1 and the least deprived at 10.

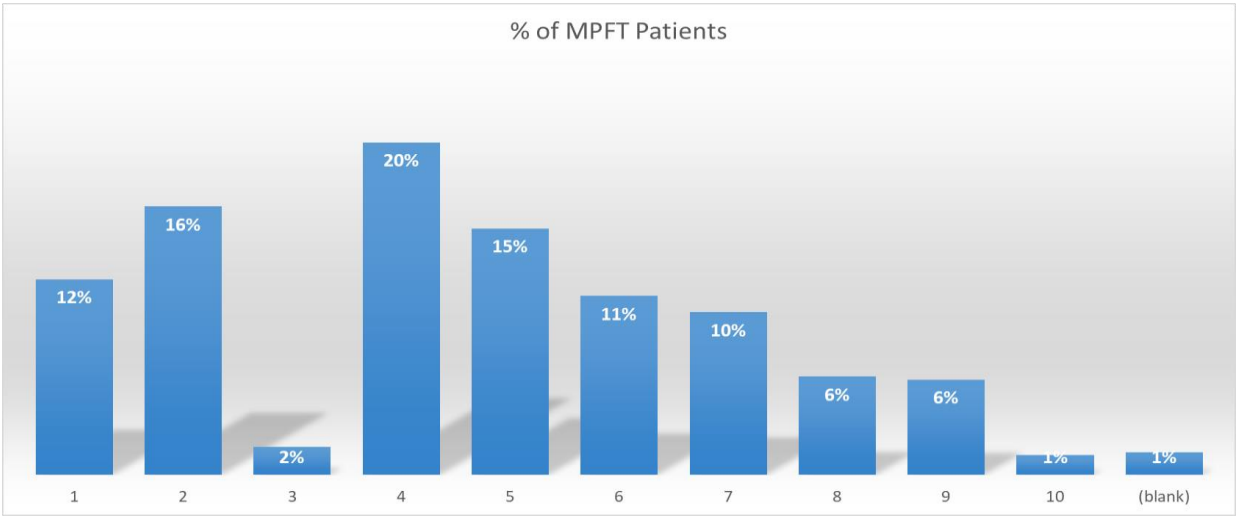


Figure 22 Mercian PCN IMD Profile of MPFT patient referrals in 2019-20[1]

[1] CMHF insight overview summary - Mercian V1.4b.pptx

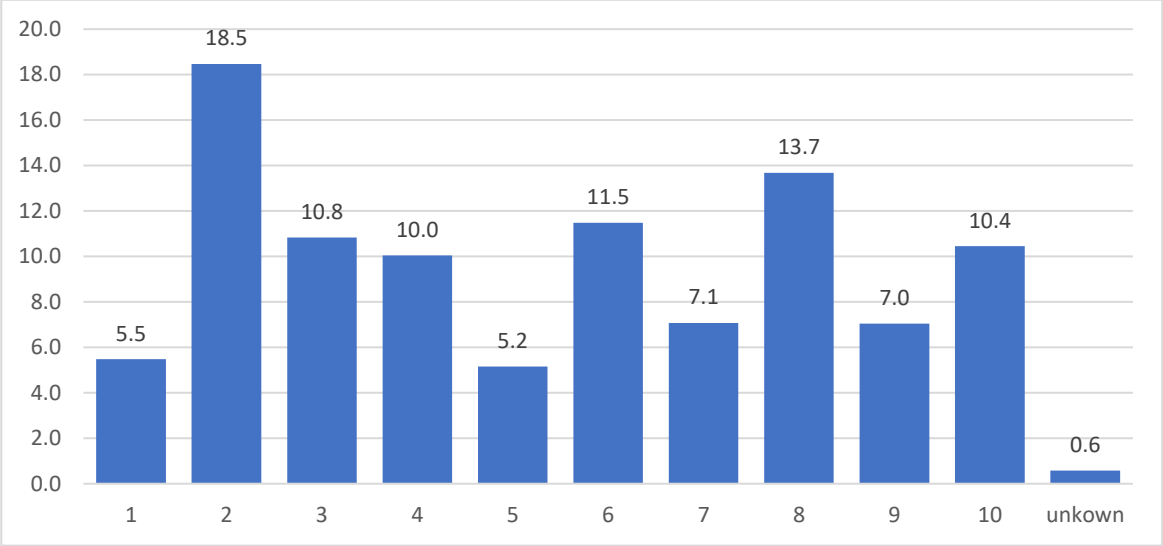


Figure 23 East Staffordshire PCN IMD Profile of MPFT patient referrals in 2019-20 in percentages[1]

8. Health inequalities

A range of factors affect people's health and lead to inequalities. These factors include levels of poverty, deprivation, lifestyle factors, employment and education.

There are significant health inequalities across Staffordshire and Stoke-on-Trent, with Stoke-on-Trent being the 14th most deprived upper tier local authority in England.

Compared to other areas in the West Midlands, Staffordshire and Stoke-on-Trent have one of the largest gaps between life expectancy and healthy life expectancy. As a result, a long time is spent in ill health which results in them becoming major users of health and care services.

The number of people with long-term conditions is on the increase, with more than half of over-65s having one or more long-term health conditions.[2]

A reduction in the amount of time people spend in ill health will result in a reduction in the demand for these services and have better health outcomes for the local population.

The COVID-10 pandemic has drawn further attention to the health inequalities showing that deprived and people from ethnic minority communities are more likely to have poorer outcomes. This is due to existing poorer health and lifestyle factors and a disproportionate impact on these communities from the restrictions and measures implemented during the pandemic, such as the lockdowns and changes to routine care. Structural disadvantages and discrimination faced by the ethnic minority communities have also been brought into focus during the pandemic.[3]

Analysis by Public Health England (PHE) showed that people of Bangladeshi ethnicity were twice as likely to die from COVID-19 and those of Chinese, Indian, Pakistani, other

[1] CMHF insight overview summary - East Staffordshire V2.2a

[2] East Staffordshire Annual Report 2020-2021

[3] East Staffordshire Annual Report 2020-2021

Asian, Caribbean and other Black ethnicity were at between 10 and 50% more likely to die from COVID-19 in comparison to White British.

In terms of mental health, Bangladeshi, Indian, Pakistani and White British men have all reported significant declines in their mental health, whereas there was no evidence for a different in mental health decline across ethnic groups in women.[1]

COVID-19 has disproportionately impacted the elderly residents of Staffordshire, with 62% COVID-19 deaths being those over 80 years old. There have been a large number of cases among young adults. The highest case rates and mortality has been experienced in East Staffordshire.[2]

9. Demographic changes

Population projections predict an increase in the older population and lower numbers of those of working age.

The population of the West Midlands is projected to increase by around 6.1% between 2018 and 2028.[3] There is a lower number of under-45s than the West Midlands region and England, and a higher number of over-45 year olds.

The Staffordshire Joint Strategic Needs Assessment 2021[4] states that the age structure across the UK is changing as the number of people over 65 is growing faster than any other age group. This trend is certainly the case in Staffordshire as currently the percentage of the population aged 65 or over is 20% (higher than the national average of 18%) and is predicted to grow by 34% by 2039. A decline in the ratio of working aged people (aged 16-64) to older people (aged 65 and over) from 2.9 in 2019 to 2.1 by 2039 is also predicted.

By 2031 Staffordshire's over 85 population is expected to rise by 42%, a rise of 10,200, which will place further demand on health and care services.

[1] Office for Health Improvement and Disparities, COVID-19 mental health and wellbeing surveillance, Nov 2020.

[2] Staffordshire JSNA 2021

[3] ONS Population projections, March 2020

[4] Staffordshire JSNA 2021

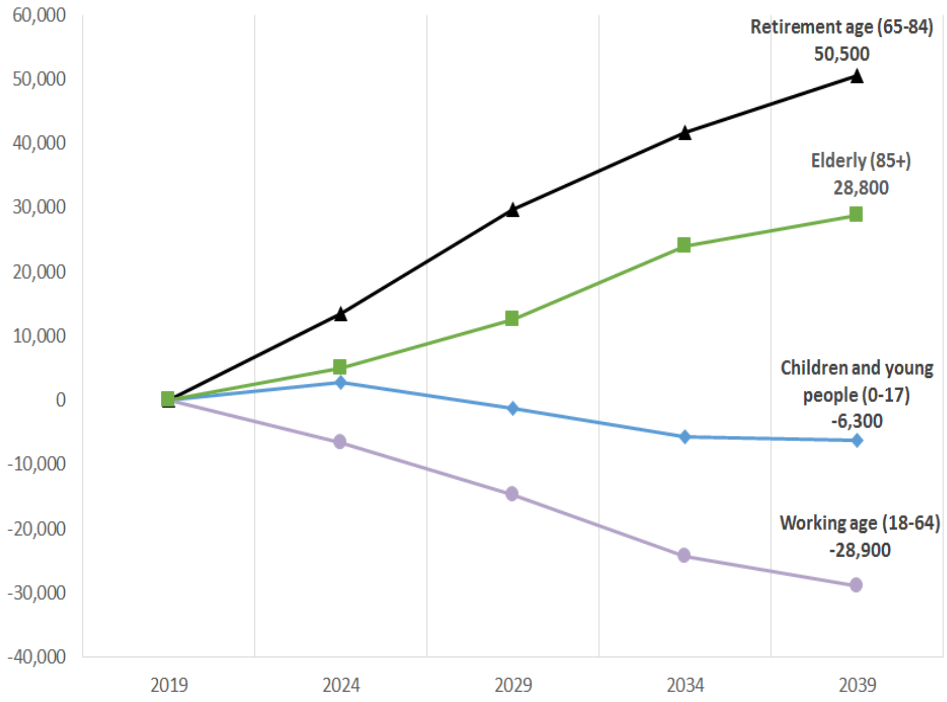


Figure 2: Projected changes in population structure 2019 to 2039[1]

These shifts in the population structure will lead to further challenges to the health and social care provided as the over 65s place a higher demand on our healthcare system. Currently the over 70s, who comprise 15% of the population already account for more than 30% of acute attendances in 2017/18. This is expected to increase to 35% by 2028[1], having an impact on all aspects of the healthcare system in Staffordshire.

TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Staffordshire and Stoke-on-Trent

ICS Designation Development Plan

December 2020

Final Version



Foreword

The system response to Covid-19 has demonstrated the personal and collective commitment, we have as a system, to work together in the interests of our workforce and population. Equally there has been considerable learning from how system partners responded to the initial impact of Covid-19 and the subsequent ongoing response.

We will continue to capture and build on this learning to find ways to embed the improved ways of working and collaboration. System partners also recognise that there are perhaps 4 things that define external opinions of us as a system-

1. System relationships. Partners have worked hard to tackle some of the previous long-standing relationship issues that existed in the system. Good progress has been made on this front. However, there is an acceptance that we need to continue to focus on this area to ensure that we can bring constructive challenge and honest disagreement to the table without impacting on the relationship. The development of our OD approach will help with this at a senior level and maturity of relationships will also develop.
2. The financial position of the system. Significant progress has been made in this regard with the system expected to deliver on its breakeven position for 20/21. Whilst we recognise that this is an unusual year, we continue to take great strides in terms of setting a different financial strategy and an aligned approach that will support the 3 spatial levels that will exist with an ICS. The bold steps taken to move to the Intelligent Fixed Payment Approach have set the necessary foundations to progress the place-based delegation discussions
3. Urgent Care. The systems response to Covid-19 has demonstrated an ability to work collectively and in an integrated manner to best support each other and to focus on the best outcome for the resident / patient. There is more to do though, and we are committed to build on the Covid-19 response in a way that tackles some of our continued challenging performance across the urgent care agenda.
4. Forming a single strategic commissioning organisation (SCO). System partners recognise the importance of ensuring that the GP membership vote to support the merger of the 6 CCGs. This is recognised as a system responsibility and a priority that we will deliver on. Positive progress has been made in recent discussions with the LMC and with lead GPs across the system.

- System partners are clear that ICS designation is not an end, but rather, is a process that continues to evolve as the system tackles the challenges that it is facing. For our population, greater integration would allow them to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations, we can take big decisions around how and where care is delivered to make the most impact. This will include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible.

- We recognise that across our system there are very real health inequality challenges, many of which have worsened as a result of the Covid-19 pandemic. This is not an acceptable position and not one that sits comfortably with any of us. We have to do more to tackle these inequalities, but we know that one organisation working in isolation will not be able to solve these issues. We have to work differently at every level, and we have to make the local communities the focus of our approach to care.

- Our staff are undoubtedly our greatest asset and it is essential that we create the environment and conditions where they can deliver outstanding care in a coordinated and joined up manner. Too many times in the past we have allowed artificial barriers or boundaries to impede this. Our commitment is to find solutions to these blocks and to enable more integrated care to be the ever-increasing norm rather than the case study or the exception. The staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in current organisational structures. It is important to us that staff feel valued and are able to work in the way that enables them to provide high quality, compassionate and safe care.

- This development plan sets out how we will embrace the opportunities that integration provides for us and use it to tackle the health inequality challenge that exists. This is an exciting period and one that we embrace fully as we look to ensure that the residents of Staffordshire and Stoke-on-Trent get the very best health and care that they deserve.

Prem Singh
Independent Chair
Together We're Better

Who we are and who are our partners

- Around 1.1 million people live in Staffordshire and Stoke-on-Trent, across a geographical area of 1,048 square miles.
- Together We're Better is the partnership working together to transform health and care for the people of Staffordshire and Stoke-on-Trent.
- Together We're Better is one of 44 Sustainability and Transformation Partnerships (STPs) in England, which brings together local NHS organisations, Stoke-on-Trent City Council, Staffordshire County Council, voluntary, and the two Healthwatch organisations. Our partners are committed to changing the way we provide health and care, so that it better meets the needs of our local people and improves everyone's lives. (Diagram 1)
- Our partner organisations work together across two local authorities and six clinical commissioning groups (CCGs) as part of Together We're Better.

Diagram 1: Partners



Who we are and who are our partners

- The two local authorities within the footprint are Staffordshire County Council and Stoke-on-Trent City Council, which are both upper tier local authorities.
- Staffordshire County Council is split into eight districts and boroughs: Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands, and Tamworth.
- The clinical commissioning groups are:
    - North Staffordshire CCG
    - Stoke-on-Trent CCG
    - Stafford and Surrounds CCG
    - East Staffordshire CCG
    - Cannock Chase CCG
    - South East Staffordshire and Seisdon Peninsula CCG
- As a partnership, we work with a range of other organisations across the area to deliver care, including:
    - Acute trusts including University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and The Royal Wolverhampton NHS Trust (RWT)
    - Mental health trusts including North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership NHS Foundation Trust (MPFT)
    - NHS community trusts, including University Hospitals of Derby and Burton NHS Foundation Trust and Midlands Partnership NHS Foundation Trust (MPFT)
    - 151 General Practices, Vocare (urgent care services) and West Midlands Ambulance Service
- The local health and social care service landscape is complex. In terms of NHS capacity, there are five other main acute hospitals on the borders of the STP footprint that deliver services to Staffordshire and Stoke-on-Trent population:
    - New Cross (The Royal Wolverhampton NHS Trust)
    - Good Hope (University Hospitals Birmingham NHS Foundation Trust)
    - Walsall Manor (Walsall Healthcare NHS Trust)
    - Royal Derby (University Hospitals of Derby and Burton NHS Foundation Trust)
    - Leighton (Mid Cheshire Hospitals NHS Foundation Trust)
- NHS elective services are also provided to the local population by the following non-NHS providers: Nuffield North Staffordshire, Nuffield Derby, Nuffield Wolverhampton, Rowley Hall, Malling, Ramsey, Spire Little Aston, and Spire Regency.
- The voluntary, community and social enterprise (VCSE) sector plays an important role in providing services in the community and we recognise their ability to access those who may be considered ‘seldom heard’ but may in fact be the daily contact for the sector.

Introduction

- NHS England published the NHS Long Term Plan (LTP) in January 2019 that sets out a phased programme of improvements that all systems are expected to deliver on over the next five years.
- The STP responded to the national priorities set out in the LTP with a Five-Year Delivery Plan (FYDP). The plan set out our priorities and commitments to the population of Staffordshire and Stoke-on-Trent.
- The majority of the objectives of the LTP and our FYDP remain as valid now as when first written, but Covid-19 has highlighted the urgency with which we should take action, and the need to focus on working as a system to make rapid change to improve services.
- The impact of Covid-19 has meant that all our plans and ways of working have needed to be reviewed and updated to ensure they remain relevant and appropriate for the challenges that we face.
- The response to the Covid-19 pandemic demonstrated our personal and collective commitment, as a system, to work together in the interests of our workforce and population: we provided (and relied upon) mutual aid, we coordinated PPE, we enabled flexible staffing, increased frequency of communication messages and ensured we shared vital clinical and operational intelligence.
- Our Phase 3 submission set out how we would look to tackle some of the resulting issues from the initial Covid-19 response and restore services to meet the needs of the population that we serve. This submission helps to ensure a line of sight through from the LTP to the systems FYDP submission and through into the ICS designation process
- Staffordshire and Stoke-on-Trent have a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation, as well significant health inequalities. In order to address these inequalities, a place-based system of care is crucial so that clinicians and professionals, from areas with very different healthcare needs, are empowered to deliver different models of care.
- We have an established Health & Care Senate (H&CS) which has had increased focused in response to Covid 19; demonstrating the strength in working together across Staffordshire & Stoke on Trent as health, care and clinical leaders.
- This document sets out our development plan around how the system will continue to collaborate and deepen its approach to partnership working to tackle the challenges set out in the FYDP, whilst continuing to respond to the Covid-19 pandemic.
- It is essential that this development plan be read in conjunction with the system wide Five-Year Delivery Plan and the Phase 3 Recovery Plan. Each of these documents sets out some of the population and health inequality challenges. Read together they provide a compelling evidence base to support the need for integration of services that are focussed on the resident being at the heart of everything that we do.
- For residents, greater integration would allow people to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations we can take big decisions around how and where care is delivered to make the most impact. This could include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible.
- Staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in current organisational structures. We want to remove more barriers to let people work in the way that they already know makes the most sense for local people. It is important to us that staff feel valued and are able to work in the way that enables them to provide high quality, compassionate and safe care.

Our Vision and Aims – Long Term Plan submission

Diagram 2



Our vision is to ***make Staffordshire and Stoke-on-Trent the healthiest places to live and work.***

This means:

1. Helping our population live well, for longer, and supporting you to be as independent as possible so we can be there when you need us.

2. Delivering care as close to home as possible, ensuring that experience of health and care is the best it can be.

3. Treating people rather than conditions and giving mental health equal priority to physical health.

Our aims are to:

1. Promote prevention strategies and empower people for self-care and shared decision making.

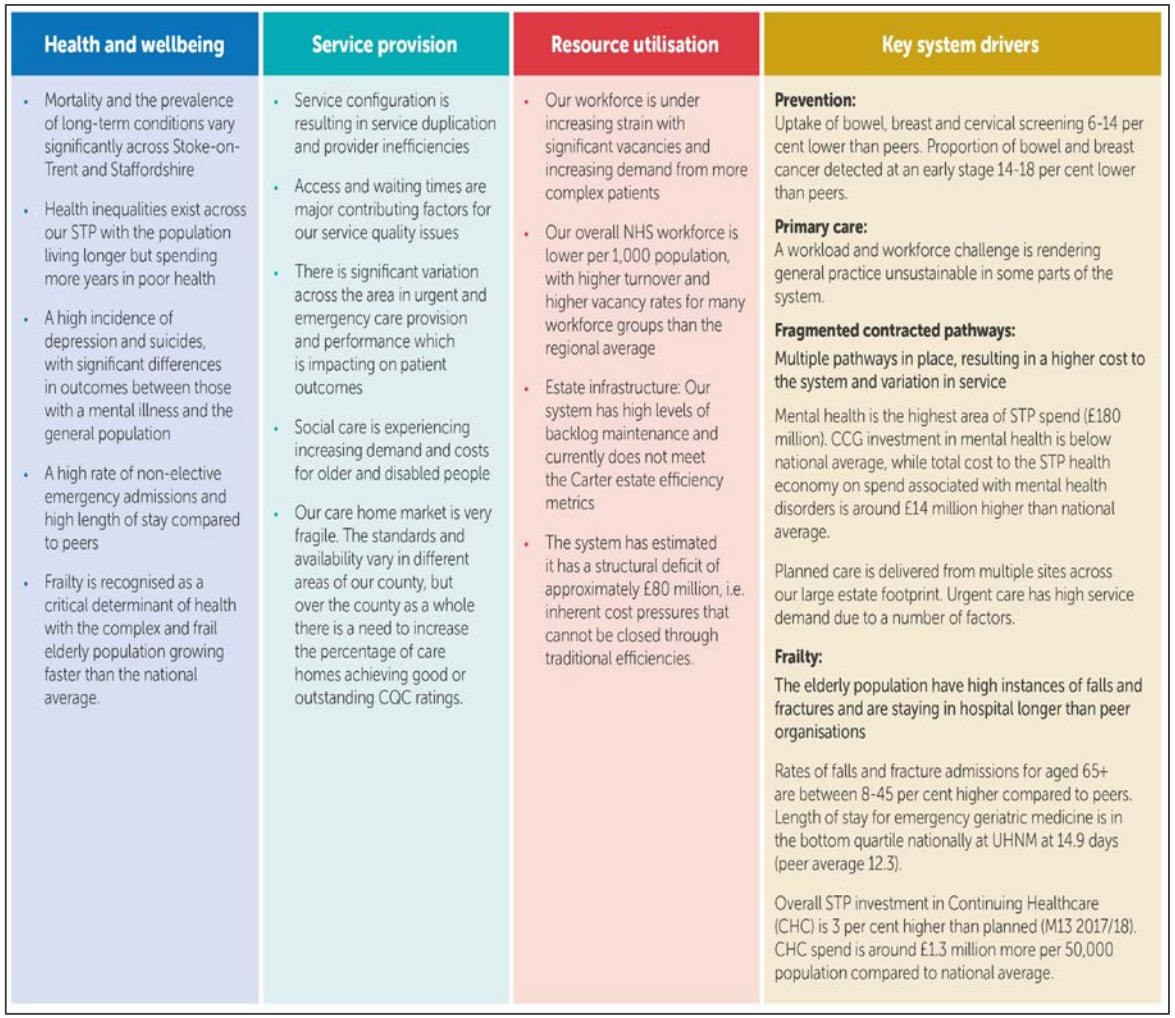
2. Co-ordinate and integrate care, with early intervention and step-down possible where appropriate and greater use of digital technologies.

3. Reduce unwarranted clinical variation, through providing evidence-based, effective care and using our workforce in the best way.

System Challenges and Opportunities

- We have been fortunate to be supported by regulators in the development of a range of strategic system diagnostics and thematic reviews. There are a range of population health and wellbeing drivers along with some key system drivers that were identified as part of the system diagnostic work.
- The drivers and issues identified are outlined in diagram 3 and have been tested and validated with partners. These areas will continue to inform our decision-making and focus our transformation agenda.
- A fundamental aspect of the system wide ICS Development Plan is how we use and evolve the initial work (that delivered an agreed and ambitious system FYDP) in order for us to meet the challenges of Restoration and Recovery from Covid-19.
- There is significant learning from the Covid-19 response that will support the ICS delivery programme and we will ensure that these do not sit in isolation of each other.
- Partners from across the system are aware that the frameworks developed to support delivery of the FYDP will need to be reviewed and updated to ensure that they remain fit for purpose given the impact of Covid-19.
- The frameworks that exist, such as the anchor institution approach, should enable the NHS to use its scale and size to develop better opportunities for local people. We need to maximise on these frameworks and approaches in manner that supports the development of our future workforce but also creates local momentum to improve the ambitions of local people.

Diagram 3: Drivers and Issues



Health and wellbeing	Service provision	Resource utilisation	Key system drivers
• Mortality and the prevalence of long-term conditions vary significantly across Stoke-on-Trent and Staffordshire • Health inequalities exist across our STP with the population living longer but spending more years in poor health • A high incidence of depression and suicides, with significant differences in outcomes between those with a mental illness and the general population • A high rate of non-elective emergency admissions and high length of stay compared to peers • Frailty is recognised as a critical determinant of health with the complex and frail elderly population growing faster than the national average.	• Service configuration is resulting in service duplication and provider inefficiencies • Access and waiting times are major contributing factors for our service quality issues • There is significant variation across the area in urgent and emergency care provision and performance which is impacting on patient outcomes • Social care is experiencing increasing demand and costs for older and disabled people • Our care home market is very fragile. The standards and availability vary in different areas of our county, but over the county as a whole there is a need to increase the percentage of care homes achieving good or outstanding CQC ratings.	• Our workforce is under increasing strain with significant vacancies and increasing demand from more complex patients • Our overall NHS workforce is lower per 1,000 population, with higher turnover and higher vacancy rates for many workforce groups than the regional average • Estate infrastructure: Our system has high levels of backlog maintenance and currently does not meet the Carter estate efficiency metrics • The system has estimated it has a structural deficit of approximately £80 million, i.e. inherent cost pressures that cannot be closed through traditional efficiencies.	**Prevention:** Uptake of bowel, breast and cervical screening 6-14 per cent lower than peers. Proportion of bowel and breast cancer detected at an early stage 14-18 per cent lower than peers. **Primary care:** A workload and workforce challenge is rendering general practice unsustainable in some parts of the system. **Fragmented contracted pathways:** Multiple pathways in place, resulting in a higher cost to the system and variation in service Mental health is the highest area of STP spend (£180 million). CCG investment in mental health is below national average, while total cost to the STP health economy on spend associated with mental health disorders is around £14 million higher than national average. Planned care is delivered from multiple sites across our large estate footprint. Urgent care has high service demand due to a number of factors. **Frailty:** The elderly population have high instances of falls and fractures and are staying in hospital longer than peer organisations Rates of falls and fracture admissions for aged 65+ are between 8-45 per cent higher compared to peers. Length of stay for emergency geriatric medicine is in the bottom quartile nationally at UHNM at 14.9 days (peer average 12.3). Overall STP investment in Continuing Healthcare (CHC) is 3 per cent higher than planned (M13 2017/18). CHC spend is around £1.3 million more per 50,000 population compared to national average.

Strategic Framework

- In response to our challenges and to deliver the Long-Term Plan, we have developed a strategic framework (diagram 4) that captures our vision, aims, objectives, and delivery priorities in a way that is accessible to our staff and our partners.

- We have used a series of strategic tests to model our thinking and provide a framework as we develop our maturity into an integrated care system:

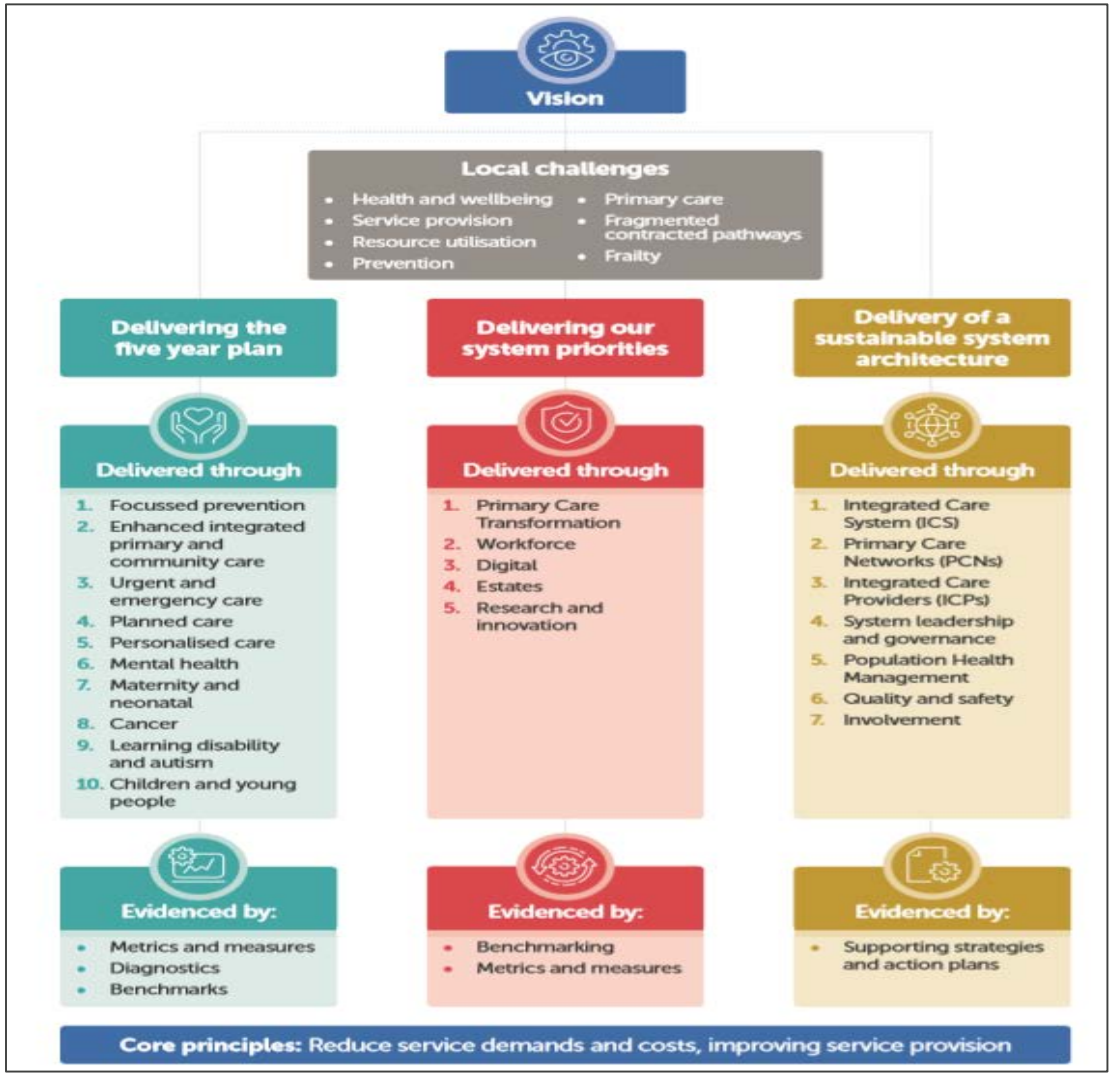
    - Do we have the right level of care for our population?
    - Are we doing this at / in the right place and at the right time?
    - Are we as efficient as we should / could be?
    - Do we have the right outcomes for people, communities and our population?

- We will use this framework to inform and align our organisational operational plans and as the baseline against which we will agree projects and schemes to deliver improvements.

- We recognise that this will need to be refreshed and revisited as the system continues to develop. However, it is essential to recognise that we are not starting from a blank sheet of paper and that the local challenges are not new.

- Our approach to integration, based around the strategic framework, enables us to genuinely tackle these issues and develop solutions in the best interests of the population that we serve.

Diagram 4: Strategic Framework



Delivering the Five-Year Delivery Plan and Phase 3 Recovery Plan

The ICS Development Plan is aligned to our Five-Year Delivery Plan to ensure that we continue to pursue our ambition to make Staffordshire and Stoke-on-Trent the healthiest places to live and work by:

- Treating people rather than conditions and giving mental health equal priority to physical health
- Becoming an Integrated Care System by April 2021 that is clinically and professionally led and focussed on system-wide, sustainable improvement
- Working in partnership to streamline the commissioning approach and to develop a system-wide strategic commissioner across health and care, which will align, and, for some services, be integrated with social care commissioners
- Providers and commissioners working collaboratively across primary, community and mental health services, including health and care professionals and the voluntary and independent sector to promote behavioural change and deliver service transformation – co-ordinated by Integrated Care Partnerships
- Strengthening primary and community services through developing sustainable primary care networks and the implementation of integrated care teams to cover the entirety of the population – adopting a population health management approach and driving the local place-based integration agenda
- Setting clear aims and outcomes for our clinical models of care, aligning with a strength-based social care model, which will continue to evolve as we listen to our public
- Transform our urgent and emergency care offer that reduces fragmentation and is focussed on meeting the needs of those in urgent need of health and care services
- Delivering effective elective services that are pathway-based and ensure activity is evidence-based and improves outcomes
- Tackling the prevention agenda at every level for our main long-term conditions of CVD, respiratory and diabetes
- Delivering increased value in everything that we do with a focus on the sustainability of our health and care system

Our aspirations for the success of this journey will result in the delivery of our key objectives as determined within the FYDP, deliver the local priorities that are unique to Staffordshire and Stoke-on-Trent, and create a sustainable and integrated system for health and care.

Learning from Covid-19 and Impact of National Legislative Proposals

Learning from Covid-19

Covid-19 has undoubtedly been one of the greatest challenges the system has faced. Against that back drop there is a constant theme of collective pride in the responsive action which was mobilised and in the many specific improvements and innovations across health and care. We acknowledge the lives lost or damage experienced across our population and amongst public servants and that further strengthens our resolve to make our local health system the very best it can be for the population that we serve. Together we have a collective determination to learn from the experience so that improvements can be made in the future management of Covid-19 or learning embedded into mainstream practice.

As part of the regional work undertaken on learning from Covid-19 we have looked to focus our efforts on a number of main themes:

- The clear and common purpose which was understood by all health and care partners and their workforce was hugely empowering. This was supported by a strong sense of freedom to act.
- The robust governance arrangements that were implemented were felt to be supportive, enabling rapid decision making and implementation.
- The removal of the existing financial arrangements facilitated cross organisational working. Investment decisions were fast tracked, often in care delivery models which crossed organisational boundaries.
- Consistent and prolonged high levels of energy from staff with the emergence of new leaders from a range of organisations and professions, many with clinical backgrounds. This assisted the adoption and spread of new approaches.
- A reflection on our focus on place. This was where services and multi-organisational responses came together and there is an even stronger desire to really now strengthen and support local people in their own communities. We will make this a central feature of our continued transformation and improvement plans.
- The availability of co-ordinated data around population health and health inequalities has been shown even more starkly. We have to prioritise this over the coming months and use intelligence to direct our efforts

Legislative Proposals

The publication of 'Integrating care: Next steps to building strong and effective integrated care systems across England' sets out a clear direction of travel regarding the future of integrated care for the NHS. We broadly welcome the proposals that are detailed in the paper. However, there is recognition that any proposed change such as this can be unsettling for staff that are directly affected by it. It is our collective responsibility to ensure that we work as a system to maximise on the skills and attributes that currently support our health and care system.

We have reviewed the proposals, the ICS consistent operating arrangements and maturity matrix to establish a select number of key priorities that will help us to make significant progress. These are as follows:

- building on the success and learning from Covid-19
  - embedding the shift to agile leadership and decision making,
  - refresh and strengthen the common purpose that sets us apart as a system,
  - digital and innovative approaches to delivering care
- stepping up efforts to build on place through our approach to clinical and professional leadership and provider collaboratives;
- rapidly progressing transformation work – we are part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System work that is being led out by the region and we are keen to roll the approach t across a number of pathways;
- stepping up our efforts to work collaboratively to tackle the wider determinants of health and well-being,
  - focussing the NHS contribution towards social and economic development using frameworks for collective effort such as anchor institutions
  - building a different relationship with our voluntary and community sector partners that links us into communities and closer to the challenges
  - fully supporting the children and young people agenda across health and local government to give local children the very best start in life
- developing as a learning system, further OD/system effectiveness work such as PCN development and board effectiveness;
- an immediate demonstration of openness and transparency - board meetings in public (alternate months from February 2021) with papers published and in the public domain.

Strategic Risks

Risk	Mitigations
Insufficient system resource and capacity identified to assure and deliver the ICS Development plan.	• A transparent work programme that constituent organisations lead. • ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements. • Agree 2021/22 budget with system partners based on review of functions required. • Agree budget hosting arrangements until primary legislation in place. • Review of core team resource required as part of the functional review and agree any new posts required to support transition to ICS.

Impact of a 'negative' vote from the CCG membership, to forming a single strategic commissioning organisation (SCO).	• Campaign Steering Group (CSG) discussions and process; supported by
	  • NHSE approved Communications & Engagement Plan for Merger;
	  • Additional CCG Clinical Chair and Executive discussions with key opinion formers / clinical leaders - e.g. Local Medical Committees, Primary Care Network Clinical Directors and GP Federations
	  • Member-facing narratives developed for financial strategy and devolved functions / staff / budgets to support ICP development during transition;
	• "Protected Primary Care" pledges included.
	• STP/ICS Chair and Executive Lead working collaboratively with the CCG Accountable Officer and CCG Clinical Chairs to promote the merger as part of the direction of travel to becoming an ICS.

Retention of valued workforce due to the national ICS proposals and an anticipated further period of organisational change.	• A detailed plan to support delivery of the Strategic Commissioner Development with an Executive Lead. • A communications plan and HR plan to support the workforce regarding alignment of posts to Strategic Commissioning or ICP based upon the functions.
PCN and place based engagement with delivery of Population Health Management (PHM) during Covid-19, acknowledging clinical time now until February is at a premium	• Progress is being made with the PHM Strategy readiness phase and foundations of PHM are in place. • PHM approach agreed and signed off through the Health and Care Senate.
Integration of Health and Social Care due to the spend assessments Local Authorities are currently subject to.	• Joint working on key service changes impacting health and social care looking at pathways in their entirety within existing budgets and identifying joint efficiencies. • Identification of lead commissioner arrangements and pooled budgets. • Moving towards joint posts working across health and social care.

Summary of Alignment of Development Plan Actions and Delivery Priorities

ICS Establishment Priorities	ICS Delivery Priorities	Development Plan Alignment (minimum operating requirements)	Impact
Development and implementation of our future model of care Underpinned by: 1. strong place based approach to care through our ICPs; 2. strategic commissioning arrangements that support a focus on outcomes and are underpinned through population health management; 3. simplified and understood governance; 4. integrated reporting that adds value and enables partners to focus their collective efforts in the right areas; 5. Clinical and professional leadership that is core to everything that we do and supports decision making as close to the resident as possible.	**Integrated delivery of UEC priorities to enable safe navigation of winter and future Covid-19 waves** • Digital first approach where this adds value and improves outcomes. • Agreed priority projects refreshed. **Restoring Elective and diagnostic capacity** • Clinical prioritisation of waiting lists. • Improve and maintain cancer pathways and support diagnostic developments. **Integration of Primary Care and Community Services** • Support development of Primary Care Networks (PCN) • Alignment of community physical and mental health services around a PCN to meet population needs. • Increased collaboration with local authority (LA) and Voluntary Community and Social Enterprise (VCSE) partners. **Health Inequalities** • Detailed review and refresh of current approach. **Children and Young People** • Alignment to refreshed LA strategies and targeted approach to joint commissioning. **Mental Health** • Strong crisis response integrated into community based offer. • Community transformation programme with all partners.	**System Planning/System Functions** • Develop and embed System Outcomes Framework. • Maximise system learning from Covid-19. • Develop our approach and implement population health management (PHM). • Finalise and embed system-wide approach to managing Finance, Quality and Performance. • Update Five-Year Delivery plan through reprioritisation exercise for 2020/21. • Finalise Operating Model confirming work at System, Place and Neighbourhood levels. • Estates Programme to oversee system-wide programme, future prioritisation and capital funding bids. • A system capital prioritisation and risk criteria developed. • Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery. • Take a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.	• Undertaking the development Plan actions will put in place the key enablers to drive the development of integrated models of care in areas detailed in our delivery priorities. • Build on the approach of the Intelligent Fixed Payment (IFP) model to further strengthen the collaborative approach to developing solutions and reducing avoidable transactional costs. • Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure. • Set clear outcome improvement targets at both system and place level to enable demonstration of delivery. • Use PHM to prioritise effort and to show outcomes in tackling the health inequality challenges. • Enable us to use our collective workforce resources more wisely, and support our staff to work in different ways with a “system” ethos.

Summary of Alignment of Development Plan Actions and Delivery Priorities

ICS Establishment Priorities	ICS Delivery Priorities	Development Plan Alignment (minimum operating requirements)	Impact
Transition of STP Governance to ICS Governance refreshed for system decision making and accountability for system strategy, performance and planning.	• Put our residents first, delivering person-centred care, close to home, and give them confidence that the changes we are making work well for them. • Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area. • Integrated reporting underpinned by the principle of subsidiarity. • Alignment of priorities with the two Health and Well Being Boards and use necessary governance to support improved outcomes – challenge duplication and bureaucracy.	**System Leadership and Governance** • Appointment of ICS Lead Director. • Potential further additions to ICS Core Team as per the nationally indicated direction of travel with NHSE/I Board paper on options for primary legislation. • ICS Board to meet in public and for papers to be available to the public. • Focussed organisational development approach to support ICS Board membership development – support to have challenging conversations and build on previous OD work. • Distributive leadership approach.	• Clear and owned transition to ICS status with clarity on partners roles and responsibilities. • Governance approach that is light touch and proportionate to support agile decision making. • Clinical and professional leadership empowered to make decisions and then supported to implement at pace.
Developing and ensuring system accountability within, Safety, Quality, Performance and Finance.	• Delivery of Phase 3 submission with refreshed trajectories. • Integrated approach to reporting that reduces burden on individual organisations but improves timeliness of decision making.	**System Leadership and Governance** • Refresh of STP / ICS governance. • ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements. • Strengthening of core STP team to support transition to ICS. • Refresh and update of current programme boards and transformation plans to ensure that there is clarity and alignment with system wide priorities. • Dedicated development time for committees and executive.	• Established ICS that meets the core operating requirements.

Executive Summary: Progress Against Consistent Operating Requirements

	Theme	Strengths	Development plan
System Functions	System Capabilities	• An established System Strategy, Finance and Performance (SFP) Committee • A System Performance and Assurance Working Group (SPAWG) • Confirmation of successful Wave 3 PHM Development Programme application • An established Health and Care Senate (H&CS) at ICS level with health inequalities as a priority • Investment in a central communications and engagement resource • System workforce planning has taken an 'open book approach' • Providers, Local Authorities, WMAS and GP practices are partners in the Integrated Care Record (ICR) • Commissioned the National Development Team for Inclusion (NDTI) to support in the development and delivery of a Community Led Support (CLS) programme.	• Finalise and embed system-wide approach to managing Finance, Quality and Performance • Agreed way of working to deliver PHM at scale to inform service and system change and integration • Communications and engagement team supporting the health inequalities programme, with a focus on reaching seldom heard groups • Consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce • Continued development of the ICR
	Streamlined Commissioning	• A confirmed and finalised CCG merger timeline and roadmap • A detailed plan to support delivery of the Strategic Commissioner Development • A shared care record • During Covid-19 worked increasingly more as partners rather than commissioners and providers	• Achieve single CCG covering the STP footprint by April 2022 • Implement the plan to deliver a Strategic Commissioner function • Deployment of personal health records application • Develop work to plan and deliver specialised services as locally as possible
System Planning	System Plans	• System approach to developing Phase 3 recovery plans • An agreed Five-Year Delivery plan (FYDP) in response to the long term plan • Submission of a system Phase 3 Recovery plan agreed by relevant organisational boards • ICP plans outlining priorities identified in the summer of 2020 • A system ICS development plan • Part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System	• Stocktake of system plans to be completed • UEC plan and priority areas to be reviewed and refreshed • Covid-19 lessons learnt review to be progressed • Develop the system level strategic framework and system operating plan • Development of Digital Financial planning
	Capital and Estates Plans	• A system estates plan and strategy, rated "Good" • A System Capital Prioritisation Group to support a system by default approach. • System Local Estates Forum	• A system capital prioritisation and risk criteria • A system Estates Strategy (covering capital and estates), to include disposals • An agreed broader system section 106 policy
System Leadership and Governance	Leadership Model	• ICS Independent Chair appointed and in place • Clinical and professional input provided by the H&CS • A health inequality executive at board level within each organisation and a system inequalities lead • ICPs have been developed with PCNs at their heart • Provider collaboration across a number of levels	• Appoint to ICS Lead Director • Ongoing leadership development of health and care professionals • Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning • Development of provider collaboration – vertical and across neighbouring STPs where this makes sense and is in the best interest of our residents
	System-Wide Governance	• Agreed terms of reference and membership of the ICS Partnership Board (ICS PB) • System Strategy Finance and Performance Committee • Good relationships with the Overview and Scrutiny Committees • H&CS, Healthwatch and voluntary sector partners on the ICSPB • Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level. • A culture of transparency, openness and collective ownership in relation to finance	• Progress the ICS PB to meet in public and to publish its papers • Integrated quality, finance and performance dashboard reported into the ICSPB • Delegation of financial responsibility to ICPs • A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets

Self-assessment and areas of development:
Consistent operating requirements



Self Assessment: System Capabilities

Theme	Strengths	Development Plan
System capabilities in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21. Confidence in the system leadership to resolve current performance challenges	*Co-ordination of Transformation - System, Place and neighbourhood* • Agreed terms of reference and membership of the ICS Partnership Board (ICS PB) • An agreed FYDP. • An ICP Programme Board to coordinate ICP development activity. • A detailed ICP plan developed to support achievement of the critical path of ICP development. • Each ICP has aligned Director of Strategy capacity to provide the connection back to individual organisation and system wide transformation activity. • We have adopted an 'asset based' approach which means each ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups. • We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme. *Collective Management of System Performance* • An established System Strategy, Finance and Performance (SFP) Committee. • A System Performance and Assurance Working Group (SPAWG). • Strong system delivery of mental health standards. • Recognition of areas e.g. urgent care where we have struggled to meet emergency care standards. • Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited. *Resolving performance challenges* • Consistent approach to performance reporting and agreed data sets • Honesty of challenge and debate with agreed actions set out • Collaborative approach to problem solving • Build on system response to Covid-19 and UEC pressures *Population Health Management (PHM)* • An Executive Director providing senior leadership and expertise, acting as SRO for this programme of work. • A CCG Public Health Consultant in post leading delivery of PHM. • Active involvement with the NHSE PHM programme, and use of external experts Milliman, which supports the development of PHM capacity and capability across the system. • Confirmation of successful Wave 3 PHM Development Programme application with funding of £50k. • An established Health and Care Senate (H&CS) which has health inequalities as one of it's core priorities ensuring that inequalities are a key issue for wider clinical and professional leadership groups. • An inequalities strategic oversight group involving clinical and public health expertise to bring together the inequalities and prevention work streams.	*Co-ordination of Transformation - System, Place and neighbourhood* • Identify key transformation / change programmes that are likely to be locally and system driven. • OD plan to support system and place clinical leadership. • Identification and development of ICP leadership *Collective Management of System Performance* • Finalise and embed system-wide approach to managing Finance, Quality and Performance. • Continue to develop our performance reports to become an Integrated quality, finance and performance dashboard which provides appropriate and accurate information that is effectively processed, challenged and acted upon. • Clear and effective processes for managing risks, issues and performance. • Develop a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues. *Resolving Performance Challenges* • Ensure that the system SFP has the correct membership and intelligence to support decision making and challenge • Clear route of escalation through to the CEO forum • Agree priority areas of focus and simplify list to an agreed and appropriate level *Population Health Management (PHM)* • Agreed way of working to deliver PHM at scale to inform service and system change and integration. • Continue to develop data sharing particularly in primary care. • An OD programme for the H&CS including PHM and inequalities. • Co-production of outcome measures, both qualitative and quantitative, with ICS and ICP representation. • Refreshed approach to PHM and full engagement with the PHM national programme. • PHM approach to be widened from public health colleagues and repurposed to support ICP development. • Approach to be set out for the January ICS Board and workplan to be agreed with confirmed timelines. • PHM priorities to be agreed by the January meeting of the ICS Board. • Clarity on resource available and LA partner engagement to be part of that key discussion.

Self Assessment: System Capabilities

Theme	Strengths	Development Plan
System capabilities in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21.	*Communications, Involvement and Engagement* • Investment in communications and engagement (C&E) resource providing focused support across key development areas. • Integrated approach to C&E with a shared Director of Communications across the CCGs and ICS footprint, with a seat at the ICSPB. • Strong partnership working across C&E recognised regionally. *Workforce* • System expertise in place around workforce planning and workforce information/data. • Long-term workforce planning at system level as taken an 'open book approach', with all providers engaged in the process and sharing their workforce projections across the system. • A strong ICS workforce team in place to improve workforce supply and solutions are created in partnership as "System by Default." • Our system wide leadership programmes all have equality, health/wellbeing, fairness and reduction of bullying/harassment and violence at work as a golden thread running through them. *Digitisation* • A well established Digital Board comprising senior Digital, Clinical and Service leaders from all of main partners within the ICS footprint, chaired by a current CCG Clinical Chair. • A digital strategy that focuses around six strategic goals which collectively describes how digital technology will help transform health and care for citizens, health and care professionals and the wider system. • A Digital Clinical Advisory Group and Digital Design Authority. • Technology enabled care implemented prior to Covid-19 and rapidly expanded during the Covid-19 pandemic. *Resourcing* • Current resource supporting STP identified and based on partner contributions (NHS) • Small core team at present and reliant upon resource in kind from system partners • Core finance and workforce teams good examples of collaboration • Partner commitment to shared resource to support ICS Development • Integrated approach to communication and engagement with a shared Director of Communications across the CCGs and ICSPB footprints, with a seat at the ICSPB	*Communications, Involvement and Engagement* • Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21). • Supporting the equality programme, with a focus on reaching seldom heard groups. • System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23). *Workforce* • Further develop the People Hub locally to make it the route into health and care careers in Staffordshire and Stoke-on-Trent. • Consider and develop consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce. • Focus on inclusivity and diversity in our workforce utilising targeted approaches. *Digitisation* • Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS. • Development of the Digital Financial planning (sub-group of the Digital Board) to agree financial planning and management activities and prioritise and manage capital investments. *Resourcing* • Review national direction of travel and agree core STP / ICS transition team • Agree 21/22 budget with system partners based on review of functions required • Confirm partner commitment to supporting the ICS core functions • Agree budget hosting arrangements until primary legislation in place • A clear funding model for the collective functions that sets out how core capabilities will be funded across the system and agreement that resources will be shared and flexible.

Self Assessment: Streamlined Commissioning

Theme	Strengths	Development Plan
Streamlined commissioning arrangements, including one CCG per system with clearly defined commissioning functions at system, place and neighbourhood.	• A confirmed and finalised CCG merger timeline and roadmap. • Strategic Commissioning identified as a priority programme by the CEO Forum and the ICSPB. • A detailed plan to support delivery of the Strategic Commissioner development . • The Strategic Commissioner blueprint has been reviewed and detail added behind the identified functions. • During our response to Covid-19 we have worked increasingly more as partners rather than commissioners and providers, instead operating as a single team with clear lines of accountability.	• Formal merger application to be submitted by July 2021 (at the latest). • Delivery of programme of work to deliver the strategic commissioning function. • Identify hand over points from strategic commissioning into ICPs for delivery at a place based level. • LA and CCG integrated commissioning development - to develop an approach towards integrated health and social care services that improves outcomes for service users and efficiencies within resource allocated at the most appropriate level. • Develop an approach for planning and delivery of specialised services as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.

Self Assessment: Implementing a full shared care record

Theme	Strengths	Development Plan
Plans for developing and implementing **a full shared care record,** allowing the safe flow of patient data between care settings, and the aggregation of data for population health.	• The system has a live Integrated Care Record Solution, which is already well populated with data from partner organisations and provides the foundation upon which to build integrated care tools and enhanced data to improve health and care for the local population. • Active members of the Local Health and Care Records (LHCR) Group across the West Midlands and accordingly are committed to sharing the data in the Integrated Care Record with partners across the region through the LHCR programme. • Close collaboration with Shropshire, Telford and Wrekin STP will see the Staffordshire and Stoke-on-Trent ICR shared to create a single integrated care record covering both regions, which will prove especially useful for MPFT who provide services in both areas.	• During 2021, continued development of the ICR through our Shared Care Record (One Health & Care) delivery plans. • Deployment of personal Health records app, by February 2021, to the local population to empower the self-management agenda. • Core reviews planned of foundation IT services and planned maturity assessments utilising the HIMMS continuity of care model. • Digital and PHM work streams to continue to collectively work on data sharing protocols.

2 Self Assessment: System Plans

Theme	Strengths	Development Plan
System plans that reflect the key local recovery, performance and delivery challenges and that incorporate a development plan for the system. This should explicitly reference delivery across the system architecture, i.e. place and provider collaborative(s). **Confidence in reprioritised LTP delivery and recovery plans**	• The system development plan is contained within this document and is based on a detailed review of the ICS must dos, consistent operating arrangements and the ICS maturity matrix. • An agreed FYDP that was determined ready to publish pre Covid-19. • For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan. • System partners developed a Phase 3 delivery plan which set out how the STP would recover health and care services, whilst managing the additional demand of winter pressures, and living alongside Covid-19. • Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level. • ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP. • A Transformation Delivery Unit in place that supports the transformation agenda with recognition that this will need to be refreshed in order to fulfil the system wide PMO function. • Strong engagement with PCN CD to ensure alignment with the place agenda.	• Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning by *March 2021.* • UEC plan and priority areas to be reviewed and refreshed. • Develop the system level strategic framework and system operating plan. • Focus on delivery on of the trajectories in the Phase 3 recovery plan. • Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards. • Directors of Strategy take the leadership on development of the system operating plan. • Delivery of the ICP priority areas with a refreshed focus on place • Confirmation of place leadership to help drive local delivery and implementation

2 Self Assessment: Capital and Estates Plans

Theme	Strengths	Development Plan
Capital and estates plans agreed at a system level, as the system becomes the main basis for capital planning, including technology.	• A system estates plan and strategy, rated “Good”. • A System Capital Prioritisation Group, to review and prioritise capital plans across the system. • A system approach to developing plans (Phase 3, FYDP, system savings plans etc.) that involve strategy, finance and operational directors.	• A system capital prioritisation and risk criteria. • A system Estates Strategy (covering capital and estates), to include disposals. • An agreed broader system section 106 policy.

3 Self Assessment: Leadership Model

Theme	Strengths	Development Plan
A leadership model for the system, that explicitly includes the following: **1. ICS core leadership** team including: a. an STP/ICS leader with sufficient capacity and a non-executive chair appointed in line with NHSEI guidance and with delegated authority from system partners to act on their behalf and for the good of the local population. b. Sufficient leadership and delivery capacity to carry out the functions above **2. Place leadership** arrangements for each place within the system, ensuring that primary care (as a provider) is reflected in these arrangements. **3. Provider collaborative**(s) lead arrangements for "hospital systems", ambulance services and "acute mental health systems"	*ICS Core Leadership* • The role of the ICS Independent Chair appointed to and in place. • Clinical and professional input provided by the Health and Care Senate (H&CS) and its associated sub-groups. The structures support clinical and professional input from the front line of care. This professional leadership is readily accessible to the ICS Board. • A health inequality executive at board level within each organisation and a system inequalities lead. *Place Leadership* • Each of our ICPs are developing arrangements that reflect their unique identities and partners in the local system. • There is an established commitment to the three ICPs, each with leadership and governance in place which has been and will continue to be developed on an inclusive basis, including key partners and stakeholders. • The H&CS is supported by Health and Care Assemblies. • ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS. *Provider Collaboratives* • Provider CEO's have taken lead roles on the 5 system workstreams. • Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS. • UHNM is part of the N8 pathology network. • MPFT and NSCHT are actively involved in the development of the Regional mental health provider collaborative. • NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN). • Long-term workforce planning across the system has taken an 'open book approach'. • Acute provider and Community Teams already work closely to ensure that for patients with Long Term conditions (LTCs) every opportunity is taken to ensure care can be provided close to home.	*ICS Core Leadership* • Our focus will now concentrate on the appointment of the ICS Leader. The Regional Director will be part of the final appointment panel and decision-making process in line with NHSE/I guidance. • Ongoing leadership development of health and care professionals. • Review of core team resource as part of the functional review and agree any new posts required to support transition to ICS *Place Leadership* • Develop shared and collectively agreed view of placed-based leadership. • Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning. • Develop 'Values /Behaviour Charter' to support collaborative working approach via Accelerated Design Events. • OD support programme aligned to System-Wide OD Programme. • Agree joint OD programme to support transition to locality commissioning arrangements. • Confirm ICP leadership and ensure there is clear PCN visibility and involvement *Provider Collaboratives* • Review all current collaborations – internal and external. • Establish simplified review process to identify specific risk areas re provider collaboration. • Facilitate vertical provider collaborations to support the integration agenda into ICPs. • Develop diagnostic collaborative with UHNM and other acute partners from neighbouring STPs.

3 Self Assessment: System Wide Governance

Theme	Strengths	Development Plan
System-wide governance arrangements to set out clear roles of each organisation and enable a collective model of responsibility, and nimble decision-making between system partners. These arrangements will include a system partnership board that sits in public and should be complemented by a public engagement approach that ensures full transparency of decision-making. The system-wide governance arrangements should be underpinned by agreed decision-making arrangements across the system architecture (i.e. place and neighbourhoods/PCNs) and agreements with respect to financial transparency.	*System-wide governance* • An interim governance structure based on 'function' has been established. The sub committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work. • The Terms of Reference and Membership of the ICSPB have been agreed and has continued to evolve as the role and task of the system wide Board becomes clearer. • Membership of the ICSPB includes all Statutory Organisations (Chair and CEO), both Local Authorities (elected members and officers), HealthWatch, Voluntary Sector and representatives of the PCN Clinical Directors. • The ICS Shadow Board is chaired by the Independent Chair of the STP. *Decision making* • Covid-19 response has demonstrated that system partners can be agile in decision making and make rapid progress when unified around a single compelling objective • Care home support response with both LA's, MPFT and the CCGs • Workforce deployment cell to trigger mutual aid across partners through a single approach • Tackling MFFD through rapid deployment of joint teams across both NHS and LA partners to free up hospital beds and to get people home safely and quickly *Public Engagement* • Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level. • Over 12 weeks during the summer of 2019, we worked with health and care professionals, partners and the public to understand their priorities for local health and care services. Their feedback helped inform our FYDP and priorities. • During summer/autumn 2020 we undertook further engagement with local community groups, to understand people's experiences during Covid-19, including future priorities. Working with our Healthwatch partners a wider public survey was carried out. This feedback will be considered by the restoration and recovery programmes and the ICSPB to inform future priorities and the approach to wave two. Financial Transparency (Place and neighbourhood) • A culture of transparency, openness and collective ownership and accountability in relation to finance.	*System-wide governance* • The governance structure will be reviewed as part of the ICS designation process and is part of our system development plan. • Progress the ICS Shadow Board to meet in public and to publish its papers by February 2021. • Develop the decision making arrangements. • An integrated quality, finance and performance dashboard reported into the ICSPB. Decision making • Review of current decision making forums and light touch governance review to enable clear base line to be set out • System wide review of lessons learnt report and gap analysis presented back to the ICS Board *Public Engagement During 2020/21* • Delivery of the Winter C&E plan and response to Covid-19 *(2020-21).* • Primary care, partner and public engagement on the development of the Strategic Commissioner function *(2020-21).* • System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care *(2021-23).* • Significant mental health transformation programme over three years *(2020-23)* • Supporting the equality programme, with a focus on reaching seldom heard groups *(2020-21).* Financial Transparency (Place and neighbourhood) • A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets. • Delegation of financial responsibility to ICPs. • Refinement of the IFP approach to make sure that delegation of budgets is meaningful and supports integration • System approach to capital prioritisation that is built on place based priority areas

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Information Governance/ PHM	Maximisation of the use of data to improve health and care for the local population. by establishing clear data sharing models.	• Data sharing agreements in place across the system. • Population health management tools that can be used at system and place level. • A defined and agreed IG structure across the system.	• National directive for data sharing resolved. • Population health management support re 'best in class' tools and shared learning
Performance	A system based approach for collectively managing performance across Staffordshire and Stoke-on-Trent. Delivering assurance that is based on partnerships for improvement.	• System Strategy, Finance and Performance Committee. • A system-wide outcomes framework across health and care. • Integrated quality, finance and performance dashboard reported into the partnership board. • Single point of contact agreed for any system performance queries.	• NHSE/I are fully integrated into our Partnership Board as a key partner to support a fully integrated model of assurance, commissioning and delivery. • Agreed alignment of resource and staff into the ICS to support the continued devolution of specialised commissioning and independent contractor commissioning
Quality	A system-wide approach to quality and safety to achieve the best health outcomes for our population. Our shared vision and underpinning framework will not only focus on quality assurance but also quality improvement.	• A shared QI approach and methodology to support system wide change projects in line with system priorities. • A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement. • A system wide Quality Impact Assessment process. • A system wide approach to harm and mortality reviews	• Support for understanding how regulatory frameworks will apply to a system by default model and delivery of the frameworks.
Workforce	Delivery of the Staffordshire and Stoke-on-Trent People Plan which sets outs our plans for leadership & culture, education, CPD, new roles and recruitment in order to create a sustainable model of care for our population and its projected future needs.	• An STP/ICS People, Culture and Inclusion Board with agreed governance model for decision making, prioritisation and ensuring delivery and accountability. • A System Workforce Group with an STP/ICS Workforce lead and team to deliver our Local People Plan. • A Staffordshire People Hub which will hold system wide contingent workforce to support the recruitment, retention and deployment of workforce both in line with urgent pressures (but also as a career development mechanism in the medium term. • Leadership development programmes: High Potential Scheme pilot, Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes, Winter Inclusion school, Cultural Racial Inclusion development programmes. • An STP Black, Asian and Minority Ethnic (BAME) network, networking with individual organisation BAME networks. • A System Health and Wellbeing Group developing the collective Health and Wellbeing offer. • Sharing practice (as regional leads) on People Hub, BBS and Reservists with other STPs.	• Clarity on the expected functionality of the ICS People function and devolved funding to resource this. • Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce. • Clarity of funding allocations for learning/development and leadership between HEE/NHSI/E and transparency of destination for these. • Ongoing support from regional HEE and NHSEI leads. • Clarity on the governance of the Primary Care Training Hub within the ICS and funding commitment confirmed for 3 years minimum rather than annually.

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Digital Transformation	A digitally enabled health and care system underpinned by a strategy that focuses around six strategic goals which collectively describe how digital technology will help transform health and care for citizens, health and care professionals and the wider system.	• A Digital Board with a single governance model for overseeing decision making, assurance and accountability. • A Digital Clinical Advisory Group and Digital Design Authority before being turned into defined work packages for delivery. • Quality assurance approach for signing off new digital systems and process. • Use of pioneer new technologies where appropriate and acting as a fast follower in others, learning from and sharing our learning and best practice with other systems. • Digital technology and processes wrapped around the needs of our citizens rather than directed by organisational boundaries. • Use of system wide digital maturity models to establish a common baseline and drive for common standards. • A commitment to the use of common tools, technologies and services within the ICS where applicable to simplify access for staff, achieve common data and information standards, deliver a seamless patient experience and gain best value for money.	• Strong engagement with our system to shape national digital policy and strategy and make the most exploit national opportunities and available funds. • Devolved allocation of Staffordshire and Stoke-on-Trent transformation funding will be used against our digital strategy priorities. • Fast follower funding where applicable. • Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce.
Clinical priorities for our ICS model	An agreed approach by the Health and Care Senate (H&CS) to identify system clinical priorities against which we will test our ICS model of care against in terms of both devolved commissioning and provision of care.	• Clinical and professional input provided by the H&CS, its associated sub-groups & the Health and Care Assemblies. • An established H&CS which has health inequalities as one of it's core priorities. • ICP place based priorities aligned to the FYDP and Phase 3 Recovery Plan.	• OD plan to support system and place clinical leadership.
STP Boundaries	Partners recognise the importance of coterminous boundaries and being able to be clear in regards to a defined population. Recognition that the system has flows across boundaries and into other areas.	• Three ICPs established with defined geographical footprints and formal place leadership confirmed. • Agreement to work with neighbouring STPs on boundary flows. • Work with Staffordshire County Council and Stoke-on-Trent City Council to ensure full engagement and added value for the work of the ICS. • Defining place in a way that works for residents and takes care as close to their normal place of residence as possible.	• National clarity / guidance on the role of the Health and Well Being Board in any future legislative change.

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Finance	Allocation of resources to incentivise the best outcomes for our population. There will be a focus on collaboration and on system resources, rather than organisational, with an “open book” approach.	• A System Strategy, Finance and Performance Committee, supported by a System Finance Sub-Committee. • An agreed system financial strategy that articulates how the system and the organisations within it will work together to deliver its financial objectives & targets, and the roles and responsibilities of ICPs within this. • System allocation and agreement on distribution of resources, including a financial framework for ICPs. • Evolution of the current “Intelligent Fixed Payment” arrangements in place locally, including risk sharing arrangements. • Agreed system financial reporting and modelling, at system and place based level. • A culture of transparency, openness and collective ownership and accountability. • An agreed funding model for collective functions, recognising the required core capabilities.	• Clarity on broader longer term financial framework and expectations, coupled with the local flexibility around implementation models. • Confirmation of multi-year settlements, including capital, will support the development of a system by default arrangement to finance. • Clarity and transparency of specialised commissioning budgets, pressures, risks, and opportunities to help the system consider phasing of any future devolved direct commissioning as our system financial framework evolves.
Estates	An STP estates strategy to maximise the value from our public estate, outside of NHS boundaries and to embrace integrated service opportunities more widely with other partners beyond health and social care.	• An agreed system estates strategy and plan including estates pipeline and disposal plans; alignment to overarching capital planning. • A combined STP/OPE Estates Programme Board with a single governance model for overseeing decision making, assurance and accountability. • An agreed broader system section 106 policy across all planning authorities, with broader consideration of health infrastructure needs and increased engagement with health. • A System Capital Prioritisation Group, with multi functional representation to review and prioritise capital plans across the system.	• Ongoing access to capital funding to deliver our overarching strategy e.g. community hospitals. • Sharing of best practice around development of funding models.

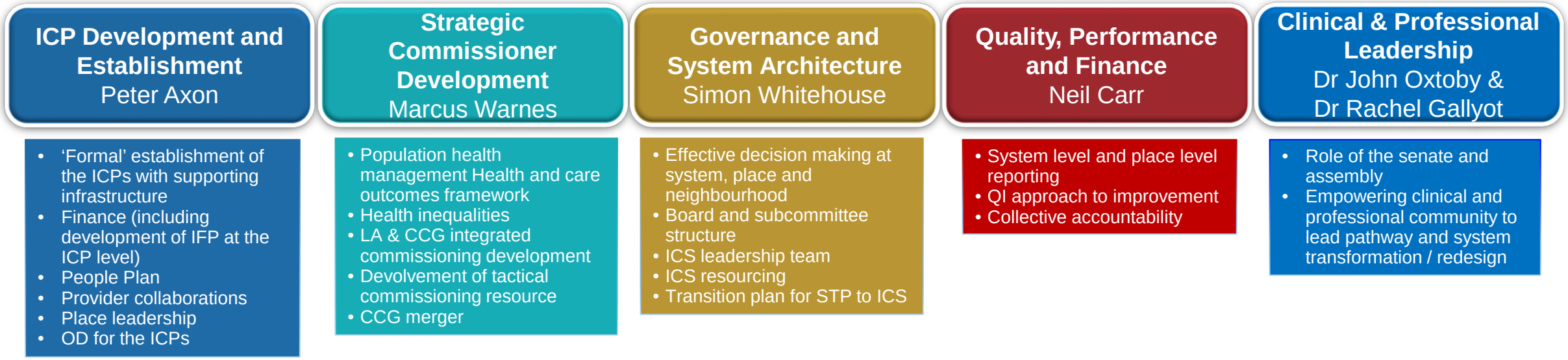
Development Plan



Introduction

- The following sections describes the 5 system priorities agreed by the CEO Forum and the ICSPB, as key areas for development.
- These areas form the foundation of the ICS development plan, each with an identified Executive lead, as outlined in diagram 5 below.

Diagram 5: Agreed System Development Priorities



High Level Timeline

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Overarching Timeline	Develop plan post September submission	Draft ICS submission to Regional Team	· Present readiness assessment to QSRM · Final submission of system application for Feb review point	· Formal regional decision point · Documentation is submitted to national team for review.	RD presents submission to national team for discussion & ratification	Transition to ICS →									
ICP Development and Establishment	Establish ICP Programme Board	· Develop place leadership, shared vision & values charter	Agree shadow governance arrangements and links to statutory organisational and system governance	· Shared view of ICP population health · Health outcome monitoring and reporting system · Planning for Change and Signs for Change workshops		· Co-design of financial framework · Strengthened involvement of patient and voluntary groups.	Co-design of future contracting models		· Embed a process to develop joint priority setting at place-based level						
Strategic Commissioner Development	Establish programme structure	· Set out output of functions mapping work	· Agree IG structure · Identify clinical leadership · Develop vision · Develop outcome frameworks linked to the Phase 3 recovery plans and FYDP (PHM)	Present PHM work plan to the ICSPB setting out the approach	Agreed way of working to deliver PHM at scale	· Co-production of inequalities outcome measures · Implement OD framework supporting new ways of working · IFR and the Covid-19 funding arrangements utilised to reconsider the future role of commissioning.	Identify hand over points from Strategic Commissioning into ICPs for delivery at a place based level		· Embed a process to develop joint priority setting · Membership Vote	· Formal Merger Application		· LA & CCG integrated commissioning development			
Governance and System Architecture	System Partners reviewed ICS development plan and signed off interim governance structure	Appoint ICS independent Chair		Engagement with major out of area acute providers and neighbouring STPs to ensure inclusion in system and ICP development work	· ICS Board Public Meeting · Establishment of ICP	· Appointment of ICS Director (TBC) · Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning	· ICS Board Membership reviewed · Light touch review of ToR & supporting committee membership	Self-assessment against the ICS maturity matrix	Quarterly review of board acheivements	Transition to ICS →					
Quality, Performance & Finance	Approval of pathway to a financial strategy.		Engagement with out of STP providers for system assurance report	Establish clear links with clinical senate to enable alignment of priorities	· An integrated quality, finance and performance dashboard reported into the ICSPB. · System Quality and Safety Committee established. · Agreement of 2021/22 IFP arrangements.	· Increased provider level data in the system assurance report · Mobilisation of ICPs and PCNs, agree delegated scope & accountability framework · Agreed 2021/22 system finance plan and strategy	A system wide approach to harm reviews in place	A shared QI approach and methodology to support system wide change projects	An integrated quality strategy that is aligned to organisational plans as well as the system, place and neighbourhood need		Development of a system wide customer care culture				
Clinical & Professional Leadership	Identified dedicated resources for the Senate to support its business	· OD support programme aligned to System-Wide OD Programme	Vision, Role and Terms of Reference in place for the Staffordshire & Stoke-on-Trent Health & Care Senate	· Role and ToR are in place for the Health and Care Assemblies · Conduct a Needs Assessment for the development of cross health economy pathways	· Develop and introduce an OD Leadership Programme that will help the Senate to deliver an ICS · Deployment of personal Health records app, by February 2021	· Process, tools and method to develop evidenced based health, care and clinically led strategy established	· Health & Care Senate and Assemblies launched · Achieve state of readiness to receive Population Health Management intelligence		· Empower the health, care and clinical community to develop clinically led system strategy and to lead the delivery of local transformation / redesign						

Integrated Care Partnership (ICP): Development and Establishment

ICP development and establishment

- A detailed ICP development plan has been produced to support achievement of the critical path of ICP development and establishment, built around three core themes of-
  - culture
  - governance and
  - operations

- The plan has been co-produced in collaboration with the Strategic Commissioner workstream to ensure that relevant interdependencies have been identified and a consistent approach agreed. It has been used to inform the ICS Roadmap and as a companion piece to the Phase 3 Recovery plan.

- The ICP Programme Board coordinates the ICP development activity whilst continuing to provide space for locally tailored responses to local issues.

- Oversight of the plan is coordinated through the ICP Programme Board, led by Peter Axon (CEO, NSCHT), which includes representatives from all three ICPs and the CCGs. This ensures that there is a strong local context to development, General Practice is represented as a provider in each ICP and that the link to neighbourhoods is strong.

- There is an established commitment to the three ICPs, each with leadership and governance in place which has been and will continue to be developed on an inclusive basis, including key partners and stakeholders.

- The ICPs have developed organically and at a pace that reflects local factors. ICS and ICP boundaries reflect local authority boundaries with good engagement at all levels of the ICS and ICPs, including opportunities for District and Borough Councils to engage at ICP level.

- There will be three core products that will support development:

  1. ICP Visioning Document – This articulates agreement between the ICS and ICP on key aspects of ICP development
  2. ICP Partnership Agreement - ICP level publication that sets out membership and governance of the individual ICPs
  3. ICP Delivery Plan - ICP level publication that sets out plans for improving health and care outcomes for local people within the ICP footprint

What is different about an ICP? Developing an Asset Based Approach

- The transition to an ICP provides a fundamental opportunity to place a new emphasis on the strengths and assets of our communities and open up new ways of thinking about improving health.

- We have adopted an 'asset based' approach which means each ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups.

- We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme. This approach and the work that we have commenced is outlined in the **Appendices** of this development plan.

ICP Development and Establishment

ICP (Place) Agreed Priority Areas for Transformation

The matrix below shows the individual ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP. The self-assessment has been developed further to reflect consistent alignment for each ICP to the FYDP priorities. These priority areas form the work plans for the place agenda across our 3 geographical place footprints. These have been shared with Shadow ICS Board and each ICP has been working to deliver these through their agreed governance arrangements

ICP Priorities ↓	FYDP Priorities →	Focused Prevention	EPCC	UEC	Planned Care	Personalised Care	Mental Health	Maternity & Neonatal	Cancer	Learning Disability & Autism	CYP
South East ICP											
Long Term Conditions		*	*	*	*	*					
Enhanced Health in Care Homes			*			*					
Covid Rehab											
Cancer and Diagnostics									*		
Elective Pathway Priorities			*		*						
CRIS Roll out			*								
Mental Health		*	*			*	*			*	*
North ICP											
Sustained focus on restoration and Recovery		*	*	*	*	*	*			*	*
Improved access to integrated Mental Health Services		*	*			*	*			*	*
Children and Young People			*			*	*	*		*	*
Long Term Conditions (incl Tier 3)		*	*	*	*	*					
Frail Elderly			*	*	*	*	*				
Asset based demand management		*	*		*	*	*			*	*
South West ICP											
Admission Avoidance Pathways			*								
Mental Health Pathways - Post Covid Mental Health &Wellbeing		*	*			*	*			*	*
Enhanced support to care homes			*			*					
Effective Referral Pathways for Planned Care (Triage and Treat)			*		*	*			*		
Long Term Condition Pathways		*	*	*	*	*					
Staying Well Pathway (Frailty)			*			*					

Provider Collaboratives

Provider Collaboratives

- Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS including the ICS (Shadow) Board and the System Strategy, Finance and Performance Committee.
- Provider CEO's have taken lead roles on the 5 system workstreams, agreed by the CEO Forum, as key areas for our development (slide 26).
- Long-term workforce planning across the system has taken an 'open book approach' through development of the FYDP and Phase 3 recovery plan. Arrangements for mutual aid have been have been utilised and effective during Covid-19.
- In order to build a compassionate and engaged workforce we have designed numerous initiatives which underpin the delivery of our system wide Local People Plan. We have developed programmes to support multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and developing an agile workforce.
- Whilst there is recognition that more can be done, provider collaborations within the STP are not new. Collaboration has been ongoing and our commitment to this will continue.
- Collaborations within the STP are structured as follows:
  - Horizontal Collaborations
    - Collaborations between acute providers on clinical services and / or clinical support & corporate functions. The majority of which are with partners external to the STP,
  - Vertical Integration
    - Collaborations between STP providers such as Social Care, Primary Care, Community Services and Mental Health,
  - Specialised Collaborations
    - These are in the early stages of development and are generally outside the STP and in support of developing safe and sustainable highly specialised tertiary services.
- University Hospital of North Midlands (UHNM) has on-going partnerships with a range of acute providers on a different footprint to our ICS boundaries but also within the ICS particularly with the 2 local mental health providers.
  - Clinical networks and specialist partnership arrangements are in place to support the delivery of the best possible outcomes for the population.
  - There are numerous opportunities for collaborative working and partnership/network arrangements available to explore in light of GIRFT network recommendations. UHNM is fully engaged with Specialised Commissioners to review these collaborative arrangements across wider geographies.
  - The Trust is part of the N8 pathology network that also includes Mid and East Cheshire and Shrewsbury and Telford Hospitals. From the 1st of December 2020 the Trust became the host of the North Midlands and Cheshire Pathology Service, providing services to the populations of Mid and East Cheshire, Staffordshire and Stoke-on-Trent.
  - Acute provider and Community Teams already work closely to ensure that for patients with Long Term conditions (LTCs) every opportunity is taken to ensure care can be provided close to home. All ICPs have identified LTCs as a priority which will strengthen that integration further.
  - Providers across Staffordshire are looking to work together in order to create Community Diagnostic hubs for the population of Staffordshire and Stoke-on-Trent. By reviewing both current provision and demand, data will be used to determine geographically where Diagnostic Hubs will have the most impact on patient pathways and access to healthcare.

Provider Collaboratives

Provider Collaboratives

- Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) are part of or lead on work within the Mental Health provider collaboratives.
    - Eating Disorders New Care Model - led by Midlands Partnership Foundation Trust
    - Child and Adolescent Mental Health services (CAMHS) New Care Model - led by Birmingham Women's and Children's Hospital.
    - Adult Low and Medium Secure Services - led by Birmingham & Solihull Mental Health NHS Foundation Trust (also work with St Andrew's Healthcare as part of the Reach Out).
- MPFT are leading on the deployment of long Covid clinics supporting rehabilitation of people that have had Covid-19. As a system we will use these clinics to profile the demand and data in order to shape a strategy that aligns to increases in acuity within general practice, primary care and community services. We plan to establish these clinics as part of our system resilience to support patients providing alternatives to hospital admission.
- MPFT and NSCHT are supporting the development of mental health surge plans. This has become one of four national models that form a community of practice and will influence surge planning into the new year. This data is being used locally within ICPs to understand the changes currently and build plans to support vulnerable people as the pandemic continues.
- At a PCN level, MPFT has signed contracts to deliver the DES including physical care and mental health. MPFT have worked collaboratively with general practice, to place workforce within practices, including occupational therapists, nurse prescribers for mental health to support the joint management of Serious Mental Illness (SMI), physiotherapists and extended hours which are all part of the DES and ultimately all part of hospital avoidance.
- The system continues to place a strong focus on admission avoidance and the work, which started twelve months ago, on the Community Rapid Intervention Service (CRIS) for North Staffordshire. The service is a joint partnership providing an integrated model across community, acute and social care services to provide sub-acute care in the community. Further detail on the work undertaken is explained in more detail in the Appendices of this development plan.
- Case studies in the Appendices also outline collaborative work on the NHS Continuing Healthcare Fast Track Pathway and The Staying Well Service (SWS) which was co-designed with partner organisations.
- NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN). The CN is a collective of around 20 plus voluntary organisations coming together with public bodies, chaired by the Chief Executive of the YMCA. The agenda is focussed on cross-cutting themes such as loneliness and economic prosperity to understand the linkages across all providers and better coordinate our resources.
- NSCHT has a small number of key voluntary sector bodies that are part of the supply chain of provision for services such as Community Drug & Alcohol Services and IAPT.
- Each ICP has been established with an inclusive governance model that sets a core membership of statutory partners but also allows sufficient local flexibility for ICPs to work with those voluntary/third sector partners which might be relevant in their local geographies.
- The North Staffordshire ICP model has active representation from both VAST and Support Staffordshire to represent the voluntary sector (VS) more generally but there is specific representation from larger VS partners in the Northern geography as well.
- ICP priorities developed in the summer were approved by ICP Stakeholder Group including VS representation. Subsequent working groups all have VS representation on them to ensure we make connections across the whole pathway of care
- Work will continue on our provider collaborative arrangements alongside any changes in legislation and as part of our development plan.

Strategic Commissioner Development

- Effective commissioning at the right level across the ICS is vital to create an environment in which our system is focussed on outcomes, our places and neighbourhoods are able to flourish and the benefits of integrated care can be realised.
- The vision is
    - A strategy agreed once for the whole system
    - Clinicians working in ICPs to agree the care pathways that work in that local context
    - Delivery in the neighbourhoods where primary care are empowered to work on the implementation of pathways
- The Strategic Commissioner Development work and ICP (Place) Development work are very closely connected. The leads from each area are working closely together to ensure that the interdependences are mapped across and to ensure that key milestones and decisions complement the other work stream.

Planning and Delivery

- A detailed plan has been developed to support achievement of the critical path of Strategic Commissioner Function, built around the core milestones of-
    - Population health management
    - Health and care outcomes framework
    - Health inequalities
    - LA & CCG integrated commissioning development
    - Devolvement of tactical commissioning resource into ICPs
    - CCG merger
- The Executive lead accountable for this development priority is Marcus Warnes (CCG Accountable Officer).

Specialised Commissioning Planning and Delivery

- We will build on the opportunities provided by our transition to an ICS by ensuring specialised services are planned and delivered as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.
- We will work with Specialised Commissioning to plan specialised services alongside locally commissioned services, providing the opportunity to transform and improve clinical engagement across integrated whole system pathways and positively influence health outcomes.
- The end-to-end integration of pathways will deliver benefits to patient outcomes and experience, reduce unwarranted variation and improve value for money. Where required and appropriate, services will be redesigned at a system or broader level to maximise clinical efficiency and financial resources.

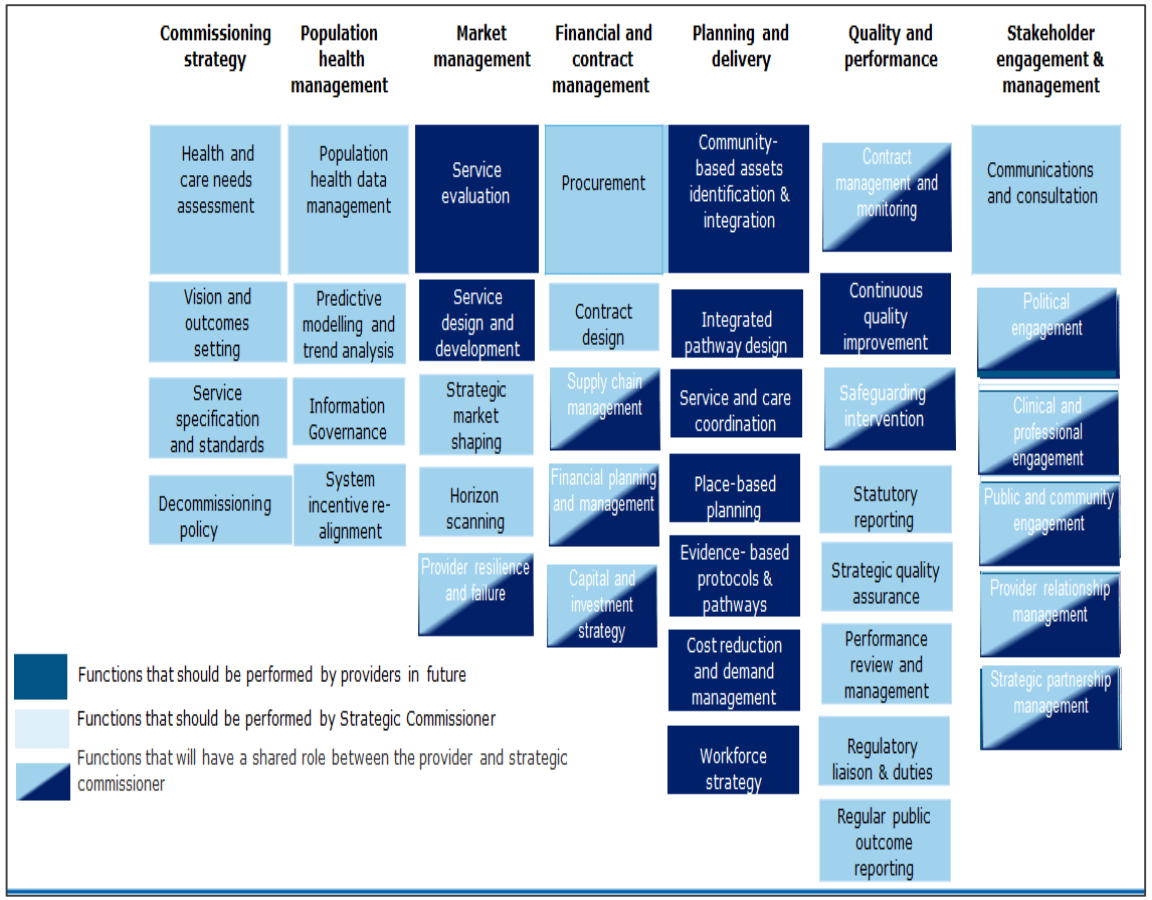
Engagement and Partnership Working

- The CCGs participate in the two Health and Wellbeing Boards (HWBBs), part of their role in this board is to ensure that the ICS Development Plan is aligned with the two Health and Well-being Strategies.
- We will work together with the two local authorities to align the ICS Plan with their respective corporate plans and provide regular updates to the HWBBs on progress of implementation.
- The CCG Clinical Chairs and Accountable Officer have been in detailed dialogue with NHSE/I regarding the CCG merger roadmap and timelines. This programme of work is underpinned by a more detailed plan which should be read as an accompanying piece to the ICS development plan.

Strategic Commissioner Blueprint

Strategic Commissioner Development

- The diagram below sets out the blueprint for the overarching functions that need to be delivered through the strategic commissioning work plan.



The Strategic Commissioner will:

- Ensure an in depth understanding of the health needs of the population in the System with a data driven population health management and a risk stratified approach;
- Identify and agree with all interested parties the priorities, which emerge from the above. This will involve aligning priorities, outcomes and resources with the two Local Authorities including the joint commissioning of services wherever possible;
- Develop and put in place outcome-based approaches for the delivery of priorities by all providers including ICPs;
- Take responsibility for allocating resources to ICPs and other providers to encourage local commissioning and delivery ownership;
- Ensure ongoing dialogue with patients and citizens so their views can contribute to the development of priorities and outcomes; and,
- Responsibility for public consultation over major service changes (including the PCBC)

Progress to Date

- We have taken the blueprint and added detail behind the functions in line with the vision for a Strategic Commissioner and place based care through the ICPs. These are split into determining the 'what' and delivering the 'how' and are outlined on the next slides.
- A communications plan underpins the work to ensure that the approach is supportive, managed internally with CCG staff and socialised with system partners.
- A HR plan underpins the function mapping in order to support the workforce through the transition of alignment of posts to Strategic Commissioning or ICPs.
- We have worked across the ICS work streams to co ordinate the approach linking to the ICP development and financial framework in particular;
- Clinical chairs, directors and lay members have been involved in the work to sense check functions.
- There are a number of functions that will need to sit centrally as part of an ICS and for the purpose of the splits, they have been aligned to Strategic Commissioning. If legislation changes in the future, there is a potential that a number of areas could move into the ICPs for delivery.
- The 6 CCG Governing Bodies in Common have previously agreed to the establishment of 3 Locality Commissioning Boards (LCBs) as a sub Committee of the Governing Bodies covering each of the Integrated Care Partnership (ICP) footprints. The Terms of Reference of the LCBs have been developed and agreed by the Governing Bodies in Common.

Functions Mapped

Strategic Commissioner Development

Strategic Commissioning		ICP	
Vision and outcomes setting	Strategic market shaping	Service evaluation	Service design and development
Health and Social Care Integration - Strategic planning	Whole system procurement	Health and Social Care Integration - local delivery	Local procurement
Consultation and engagement - whole service change	Contract design	Provider resilience and failure	Community - based assets identification & integration
System incentive re- alignment	Financial planning & management	Integrated pathway design	Service and care coordination
Capital and investment strategy	Contract management and monitoring - ICP and services commissioned across more than one ICP	Place-based planning	Evidence - based protocols & pathways
Provider relationship management	Strategic Partnership Management	Contract management and monitoring - local sub contracting	Financial monitoring - delegated budgets
Population health data management	Horizon scanning	Cost reduction and demand management	Engagement – Political / Clinical / Professional / Public / Community
Predictive modelling and trend analysis	EPRR	Outcome based service specifications	Management of delegated budgets
CPAG/IFR	Primary Care Strategy and Contracting	Local quality monitoring and delivery	Primary Care development and commissioning
Safeguarding and statutory quality functions	Strategic Urgent Care - 111/WMAS/OOH	Management of Urgent care performance and remedial actions	Medicines Optimisation
Corporate services - complaints, exec administration, FOIs, MP letters	Continuing Healthcare	Administration aligned to the ICPs	

Examples of Functions Mapped and Next Steps

Strategic Commissioner Development

Strategic Commissioning	ICP
Consultation and engagement -whole service change • CCGs will remain the statutory body and therefore responsible for consulting on material service changes (subject to change following the national engagement proposals around ICS's being placed on a statutory footing). • ICPs will feed the areas of consultation and engagement will be taken at a local level via the ICPs feeding into the formal process which will sit within strategic commissioning (to be determined as part of the new Health and Care Bill.).	**Engagement –Political / Clinical / Professional / Public / Community** • Engagement across multiple stakeholders to be undertaken through the ICPs in determining service and pathway changes. This will be both informal and formal. • ICPs will determine the methods and types of engagement working with the communications team in Strategic Commissioning to ensure legal requirements are met. • Relationships with MPs and Councillors including attendance at OSCs • Other public sector provision -fire and police etc.
Vision and outcomes setting • Taking the PHM data and information and develop strategies and outcome frameworks to define the 'what'. • Set the strategic priorities for delivery through the ICPs. • Work in partnership with ICP leads to define the outcomes.	**Service design and development and Integrated Pathway Redesign** • ICPs to take the required outcomes co-produced with strategic commissioning to design integrated services to meet the needs of the local population -'the how'. • Clinically led process aligned with the available financial envelope. • Lead provider arrangements to be identified and financial movements co ordinated. • QIPP/CIP/system savings to be considered in all redesign. • Care co-ordination and integration. • Consideration given to cross border commissioning by ICPs where appropriate and decided at ICP level. • Providers and commissioners across health, social care and the voluntary sector to take the co- produced required outcomes and develop integrated pathways. • Agreement of any financial realignment between providers. • Agree appropriate use of facilities and technology identifying efficiencies. • Development of CIP/QIPP programmes/system savings. • Identification of lead provider and mechanisms to hold to account through the ICP.

- The table shows an example of the detail of the "what" and "how" that sits within each function mapped.

Next Steps

- There is further work to be undertaken in breaking down the CSU functions into Strategic Commissioning or ICPs. Once the CSU work has been completed, this will then allow a breakdown of the ICP resource across the three ICPs and a gap analysis to be undertaken in terms of capacity and/or capability gaps to deliver against the functions.
- In quarter 4 discussions will commence with staff regarding alignment of posts to Strategic Commissioning or ICPs based upon the functions mapping.
- The functions mapping is a starting point and the way in which we work will evolve and change as we move forwards and the relationships and arrangements mature.
- The final version of the functions work (recognising that this is an iterative process), and structures will continue to be socialised with system partners as part of the ICS and ICP development work. This will enable provider partners to wrap staff around the functions to ensure that there is capacity and capability in place to deliver the requirements.

Health Inequalities and Prevention

Strategic Commissioner Development

- The FYDP outlined the ambitions and priorities to work collaboratively to increase the scale and pace of progress of reducing health inequalities. This now includes protecting the most vulnerable from Covid-19, with our system Phase 3 recovery plan setting out a clear commitment to tackling inequalities. The work programme identified and PHM approach will support ensuring that inequalities are mainstream activity, core to, and not peripheral to, our work across the system.

Leadership and Governance Progress to Date

- An inequalities strategic oversight group has been established, involving clinical and public health expertise, aiming to bring together the inequalities and prevention work streams. This now needs to set out clearly its plans and ambitions and for these to be agreed by the ICS Board
- An Executive Director is in place providing senior leadership and acting as SRO for this programme of work.
- A Public Health Consultant in the CCGs is leading delivery of the development and of population health management across the system.
- An integrated intelligence group in place undertaking population modelling around Covid-19.
- Progress on both health inequalities and the population health management approaches that support it will be reported via the ICS partnership board.
- A Health inequality champion at board level within each organisation and a system inequalities lead will be identified as a priority
- We are working collaboratively and engaging with local communities through existing assets such as community groups, peer support groups and work undertaken by the voluntary sector to aid place based approaches.
- The Health and Care Senate which will be used to ensure that inequalities are a key issue for clinical and professional leadership groups and are represented in clinical prioritisation decisions.
- Work will continue with LA public health leads to ensure that the Phase 3 recovery plan health inequalities priorities are linked to the wider health inequalities and prevention agenda, via the Health and Wellbeing Boards as they begin to meet again.

Planned work programme -

- The system inequalities and prevention programme is based on a practical and pragmatic view of what can be achieved and where the most impact can be gained.
- The Strategic Oversight Group will present its work plan to the ICSPB in January 2021 and will set out its approach to PHM
- Key areas of work around health inequalities will cover four main programmes outlined in the diagram below.

Reduce the risk of worsening inequalities

A clinical prioritisation framework;
Linking clinical and population data;
Equality Impact Assessment (EIA) and
Quality Impact Assessments

Provide an improved understanding of the population risks

(Population Health Management)

Integrated System Intelligence Hub;
Population segmentation and risk stratification;
Core performance monitoring of service use and outcomes
STP level metrics
Vulnerable population

Accelerate preventative programmes, which proactively reduce inequalities and support the recovery of services in the community.

Address significant ongoing inequalities that are in the long term plan

Population Health Management: Providing an improved understanding of the population

- While every person will have their own unique requirements and circumstances, when working at scale across a whole population, groups with similar needs and characteristics can be identified. By understanding these groups, we can plan and deliver services in the most appropriate way and in the most convenient locations for their population.
- Population Health Management (PHM) is one of the key ways that we are working to develop effective and efficient system integration.
- The city and county both have areas of high deprivation and the PHM approach will help us to focus on reducing inequalities and to work together across health and care to improve wellbeing for everyone.
- PHM requires partners across the system to come together in new ways and we are proud of what we have achieved together so far.

Progress to Date

Pre-Covid-19

- A PHM task group was set up and endorsed by the shadow ICS board
- Establishment of the Intelligence cell
- Increased recognition and drive in the system for collaborative, cross-organisational system wide PHM approach

During Covid-19 response

- The Intelligence and Modelling cell have consolidated the analytical and intelligence skill set across the system.
- We have seen successful collaborative and system working with sharing of data, intelligence and resources.

Developing Clinically Led Strategies

- PHM will be a key tool utilised by the Health and Care Senate (H&CS) to generate evidence based strategy and prioritisation.
- The H&CS will deploy cross system population health analysis, in order to establish areas of need and priorities for targeting resource. The Health & Care Assemblies will have health, care and clinical representation at the local and PCN level. These smaller populations are well positioned to reflect local areas of needs at a granular level.



System:
How can we use population health analysis to decide how to allocate resources across providers?

Place:
How can we support people on multiple waiting lists in deprived areas?

Neighbourhood:
Which at-risk patients should our MDT proactively engage in preventive efforts?

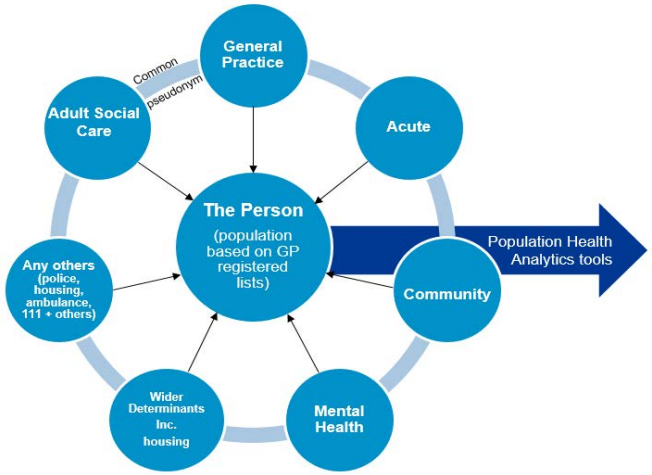
Person:
How can we leverage our neighbourhood assets to support this person who is at risk?

Resources = money, time, people, skill level, etc.

Strategic Commissioner Development

PHM Infrastructure

- Our Population Health Management (PHM) approach supports integrated teams at every level of a system with the 'person-based' analytics they need to drive better outcomes.



- The approach will support local teams to answer some of the questions they are faced with.
- By bringing together a linked data set that represents the total need of this population (Infrastructure), and providing advanced analytics that help professionals understand and prioritise risk, complexity and need (Intelligence), PHM supports these teams with the insights that can drive new proactive care models at scale (Interventions) at system, place and neighbourhood level.

Current action to support linked data sets

- Improving the recording of population data (ethnicity etc.) in clinical data
- Working with Upper Tier Local Authorities (UTLAs) to link clinical data to population testing data to support the management of outbreaks and understand and reduce the spread of infection in the community
- Working with UTLAs to link NHS data with LA data on vulnerable people to understand the impact of Covid-19 on health inequalities

Next steps include:

- Continuing to progress the infrastructure required for linked data sets
- Information Governance- SIRO, IG leads, data sharing agreements with system partners.

PHM Development Programme

- The system will benefit from the Wave 3 PHM development programme having been successful in the application to join.
- The programme aims to build capacity and capability by working with all tiers of the system to transform service delivery around key population groups.
- The intensive 22-week programme is designed to accelerate Integrated Care System (ICS) development through action learning sets, additional training and development

SYSTEM WORKSTREAM:

- 5 SME facilitated Action Learning Sets that **bring together all system stakeholders to develop a common understanding** and learn from international good practice
- Focus on **sharing learning across workstreams** and **collectively unblocking barriers** to scale PHM

PLACE & ICP WORKSTREAM:

- 3 Action Learning Sets with providers, Local Government and wider partners to **develop a scalable plan to restore services inclusively and address inequalities** by linking elective data with person level analysis

** 1 place funded through programme*

PCN WORKSTREAM:

- 5 Action Learning Sets with primary and secondary care partners, social care and third sector teams to **identify at risk groups and develop & deliver new holistic model of care**
- **Regular coaching** throughout the to key members of PCN MDTs

** 3-4 PCNs funded through programme depending on system footprint*

ANALYTICAL WORKSTREAM:

- 7 Action Learning Sets that bring together system analysts for **hands-on learning of PHM analytical techniques** and a facilitation to **create a sense of shared purpose** for system intelligence teams
- Local analyst community learns to directly **support MDTs designing intelligence-based care models** within the programme

FINANCE & CONTRACTING WORKSTREAM:

- 7 Action Learning Sets that bring together **finance and contracting leaders from commissioners and providers**
- Trained use of actuarial and predictive modelling to develop whole system demand models and drill down into a **new blended payment model based around a population cohort**

Strategic Commissioner Development

Population Health Management: Providing an improved understanding of the population

PHM Intelligence

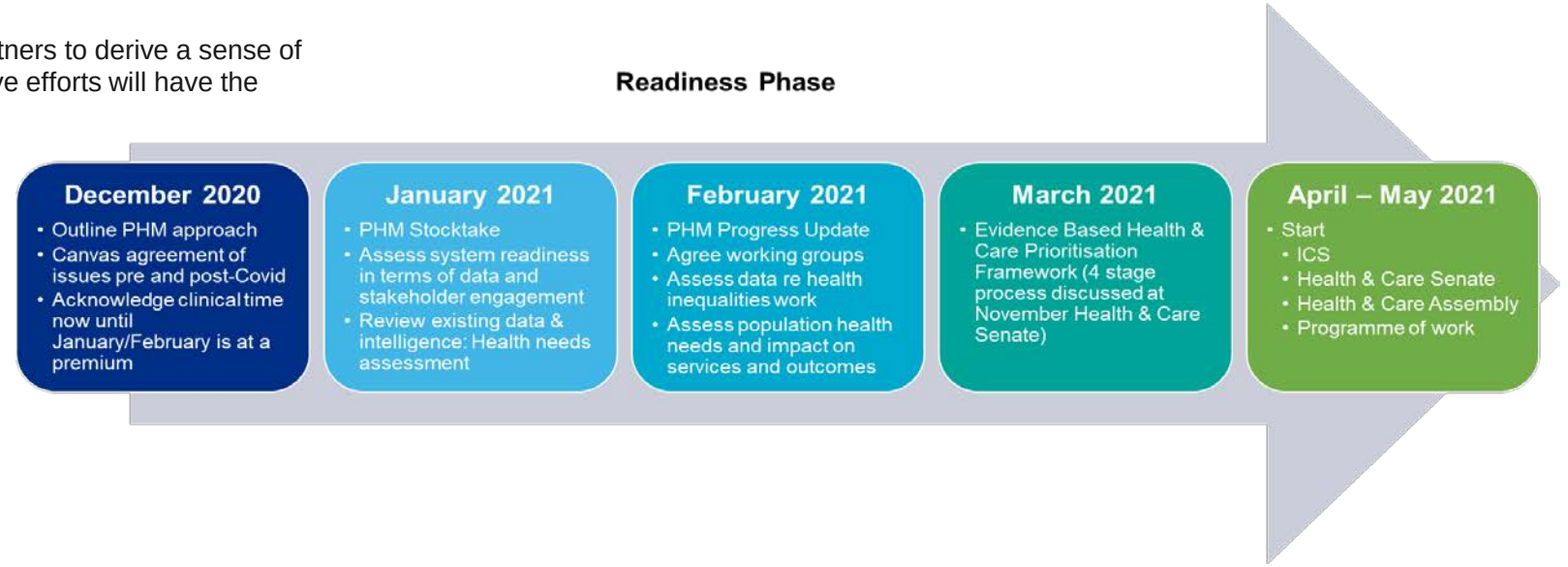
- Over the last nine months we have focussed on improving collaboration and sharing of data across the system and developing shared intelligence that is agreed collectively by all the organisations across the system.
- The H&CS is in a phase of readiness to use PHM intelligence to develop clinically led prioritisation and strategic development.

Next steps include working through the readiness phase to

- Undertake a pilot project using linked data sets to assess population health needs, prioritisation and using PHM analytics for developing appropriate interventions
- Work on Insights on how the use of linked datasets with integrated teams can support prioritisation and deliver change. e.g. interventions to reduce inequalities

Broader development and engagement in the system PHM approach will continue through delivery of:

- Development of core capabilities
- Stakeholder engagement by working with system partners to derive a sense of common purpose, priorities and agree where collective efforts will have the biggest impact



Governance and System Architecture

Model of Care

- Our overarching model of care and support is designed from the perspective of individual needs across an integrated pathway recognising that people will move both up and down the continuum of care in terms of the support and the intervention needed at specific points in their lives.
- Our approach to specific models of care is based on the application of a set of agreed design principles outlined below

1. Inpatient settings

- Reduced reliance on inpatient services
- Short-term support delivered as part of individual service designs including personalised risk and escalation plans

2. Entry intervention (de-escalation and management of crises)

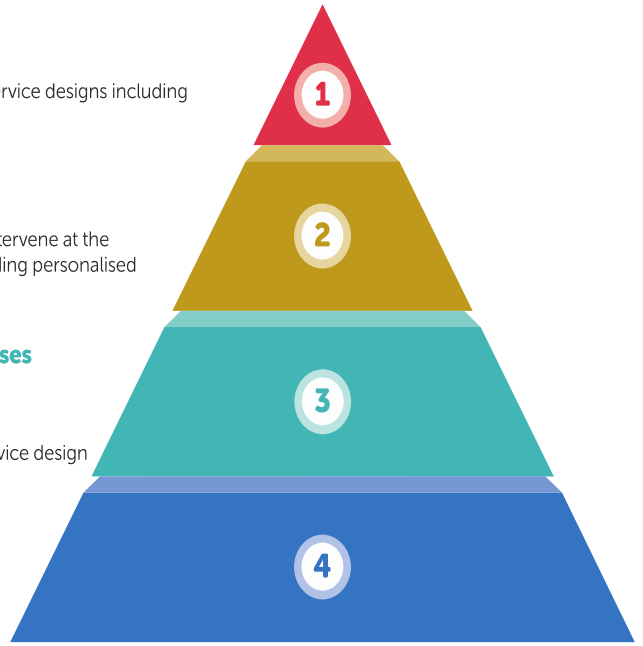
- Collaborative arrangements between partners to intervene at the right time based on individual service designs including personalised risk and escalation plans

3. Case management and prevention of crises

- Collaborative approach to care and support
- Early triggers and use of risk registers
- Flexibility of commissioning based on individual service design

4. Mainstream provision

- Public health prevention
- Primary care
- All services adapted to support



Delivered through

1. Integrated Care System (ICS)
2. Primary Care Networks (PCNs)
3. Integrated Care Providers (ICPs)
4. System leadership and governance
5. Population Health Management
6. Quality and safety
7. Involvement

Accessibility
People will receive the right care, in the right place, at the right time.

Quality
Services will meet the needs of the individual, are consistently high quality and cost effective.

Equality
Services will offer equitable care to our population.

Consistent service delivery
Services will developed to reduce variation in service provision and provide continuity of care.

Choice
People will be offered a person centred approach with more choice and control.

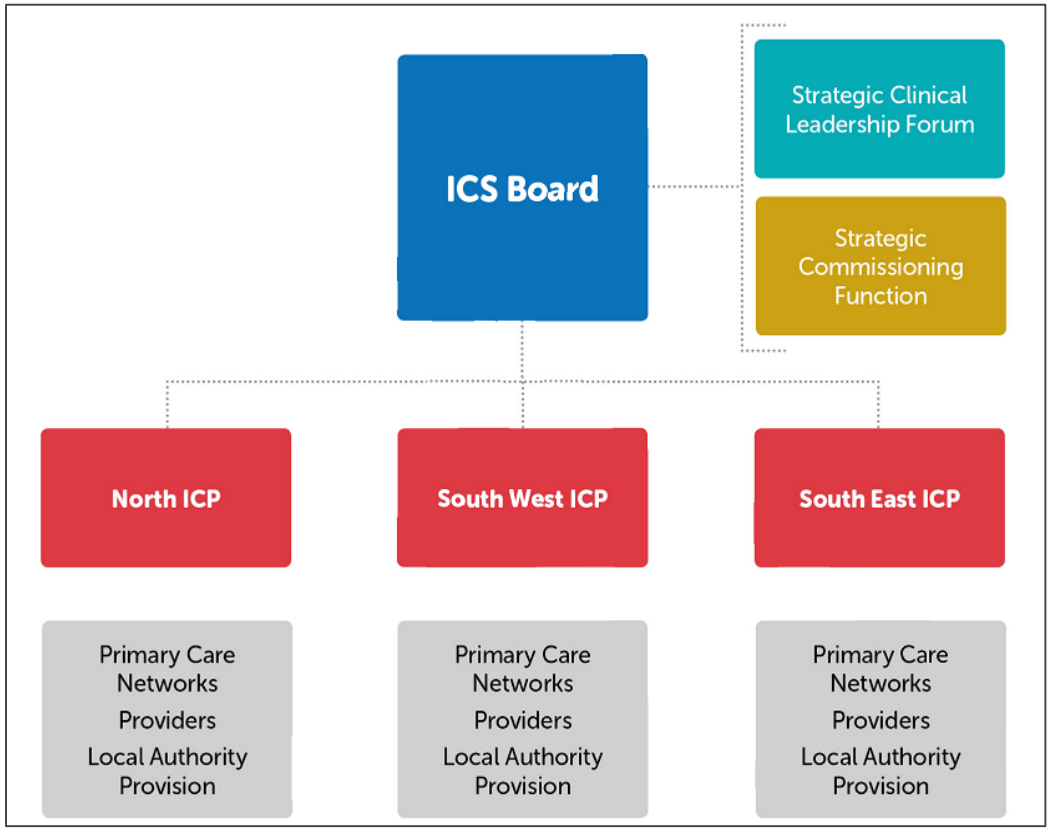
Parity of esteem
Services will be developed that value mental health equally with physical health.

Financial sustainability
System partners will spend resources wisely.

System, Place and Neighbourhood Functions

Governance and System Architecture

- The FYDP set out a commitment to establishing a new system architecture by April 2021.
- ICPs will adopt an inclusive approach to promote engagement from all health & care partners including NHS, LA, Primary Care, Third Sector and other partners (e.g. Universities) who can influence the delivery &/or transformation of services.
- At ICP level, the focus is likely to be centred around three key elements:
    - Operational liaison and local coordination
    - Delivery of transformation aligned to STP/ICS priorities
    - A clear focus on how we tackle health inequalities through PHM
- The simplified governance set out opposite shows the ambition that the system has in order to move to fully functioning ICS, that is built on the ICP (Place) based model of care.

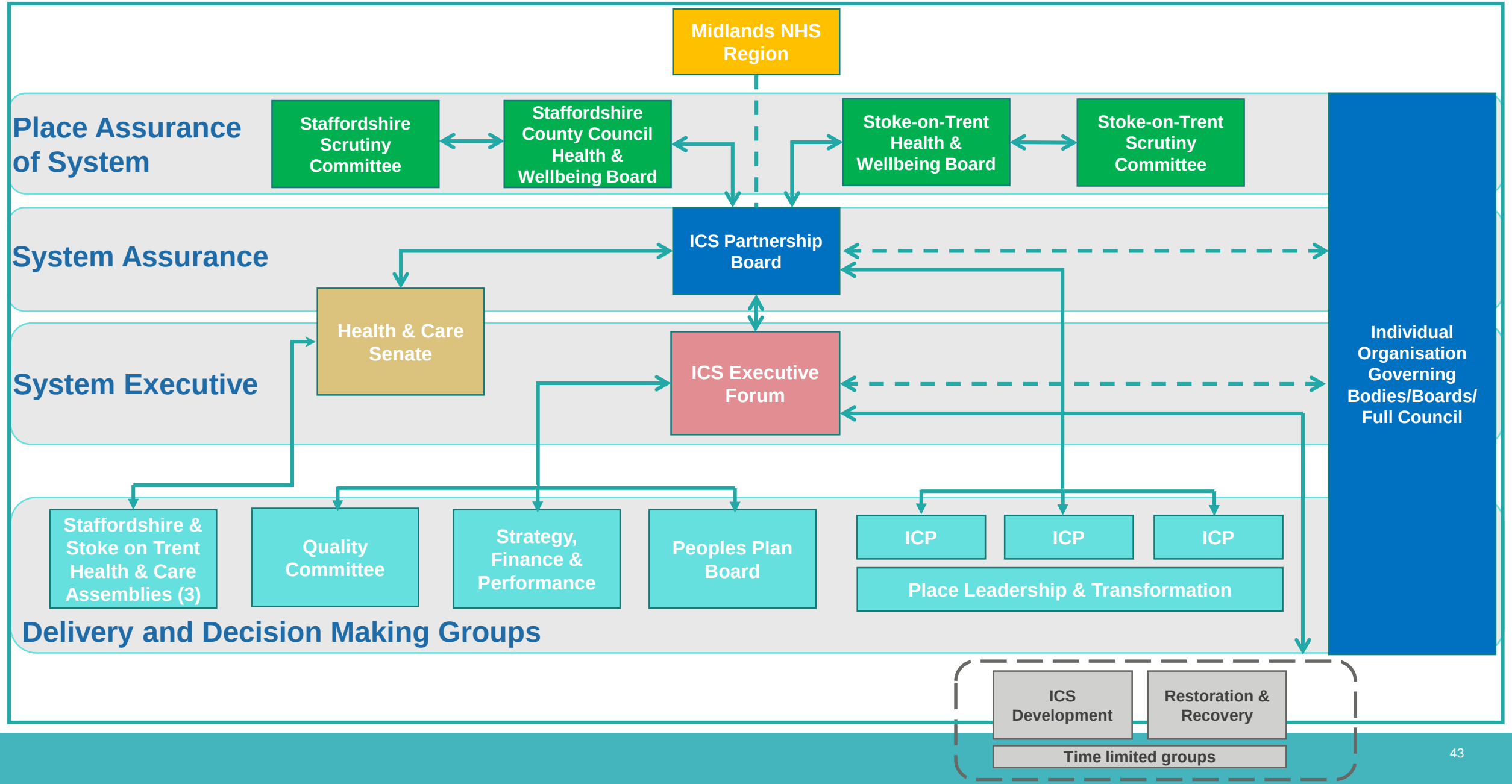


Draft (Interim) Governance Structure

Governance and System Architecture

- To support the ongoing partnership working an interim governance structure based on 'function' has been established and is shown in on the next page.
- The sub committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work.
- Central to the effectiveness of this structure is the tripartite relationship between the ICSPB, the Executive forum and the H&CS. These functions are are already established and will act as the vehicle to help facilitate ICS maturity development.
- This approach will continue to evolve but is focussed on-
  - Clarity of roles and responsibilities
  - Effective and simplified decision making
  - Recognising statutory organisations and their respective responsibilities and accountabilities
  - ICS & ICP development
  - Enabling the 'System by Default' Operating Model
- Progress continues to be made in regards to supporting decision making at the appropriate level – the principle of subsidiarity is applied in everything that we do
- The next stage of this work is to work through the functional requirements of an ICS and look to set them out at each level. This will require partner input and ownership and is an essential step to support the place (ICP) agenda.
- The functional analysis work will subsequently support the review of decision making. This will require legal support and input to ensure that any schemes of delegation are lawful and well understood. Partners are clear of the importance of getting this right but have not underestimated the scale of this task.
- The ICSPB will receive regular updates from the main standing committees to detail progress against the agreed objectives. These will be system based reports and will build from individual partner performance. The Board will rely on the Executive Forum to execute delivery and monitor implementation.
- We have a robust and well-functioning Mental Health (MH), Learning Disability and Autism Programme Board (MHPB) which will continue to operate within the ICS governance structure. There is appropriate representation from NHS partners within the STP and oversees deliverables in the FYDP. The MHPB will continue to oversee a transparent investment process of the Mental Health Investment Standard (MHIS) into priority programmes. More recently the MHPB have overseen the response and sign off of the submission in relation to the additional 2020/21 winter funding for post-discharge support for mental health patients.

Draft (Interim) Governance Structure



Place Assurance of System

Governance and System Architecture

- It is clear that there is still work to do to evolve and develop the governance to support effective system working. The recent publication from NHSE/I on the next steps for integration and the statutory establishment of ICS's provides an outline framework for us to work to but we anticipate that as further detail is provided that we will need to reflect this in our local approach.

Scrutiny Committees

- There are already strong relationships with both scrutiny committees and regular engagement enables a constructive and transparent process of scrutiny to function.
- We are clear that we expect this to continue as we move forward. However, there will be a need to consider how and who will have the statutory responsibility for any formal consultation that the system wishes to undertake. This will be dependent on the national legislation.
- Equally the role of the scrutiny committee in relation to the local place agenda will be an area that will need to be developed. It is likely that there will be a significant amount of local flexibility around the governance that is put in place and there is a strong local commitment

Better Care Fund

- The proposal for 2021/22 is to roll forward the Better Care Fund agreement as currently agreed. This is aligned to the national directive but the system will review this if that guidance changes as part for the Operational Planning Guidance for 2020/21. In future years it is likely that there will need to be a review of this budget as part of the budget setting process for the place based agenda. The future process for sign off will be revisited if the statutory responsibilities change as part of the ICS establishment.

Health and Well-Being Boards

- The 2012 Health and Social Care Act established Health & Well-being Board's (HWBBs) as committees of the Council. They were given statutory responsibility for producing the JSNA and for building a collective momentum in tackling the health inequalities in the local area. Each upper tier local authority is required to have a H&WBB.
- Locally there are two HWBB's (one for each LA) and system partners are represented on both. They have an important role to play given their responsibility for the JSNA. AS our ICPs develop and become more mature, there will be a need for much closer working.
- It remains unclear as to whether the proposed legislative changes will consider the purpose or need for HWBBs.

Involvement

Governance and System Architecture

- We have a strong track record in involving staff, service users and the voluntary sector in developing our priorities and plans. Understanding the views of our population helps to explore ideas such as the smarter use of technology, providing care in different settings closer to home and supporting the STP to seek ways to reduce health inequalities.

Existing feedback

- Over 12 weeks during the summer of 2019, we worked with health and care professionals, partners and the public to understand their priorities for local health and care services. Their feedback helped inform our FYDP and priorities.
- During summer/autumn 2020 we did further engagement with local community groups, to understand people's experiences during Covid-19, including future priorities. Working with our Healthwatch partners a wider public survey was carried out. This feedback will be considered by the restoration and recovery programmes and the ICSPB to inform future priorities and the approach to wave two.

Future communications and involvement activity at a system level, will include:

- Delivery of the Winter C&E plan and response to Covid-19 (2020-21)
- Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21)
- Publication of Long Term Plan and support for the local People Plan
- Systemwide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23)
- Significant mental health transformation programme over three years (2020-23)
- Supporting the equality programme, with a focus on reaching seldom heard groups

Approach to Communications and Involvement

- We have robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level.
- Healthwatch and voluntary sector partners are involved at a board level
- Integrated approach to C&E with a shared Director of Communications across the CCGs and ICSPB footprints, with a seat at the ICSPB
- Investment in a central STP C&E resource, led by the Director, that supports system transformation and co-ordination
- C&E leaders across providers/CCGs lead on specific priorities, using their individual expertise and report to the system group
- A C&E system group, with members from all partners, including local authorities, Healthwatch and the voluntary sector meets monthly chaired by the Vice Chair of the ICSPB
- The LRF C&E group meets weekly (during Covid-19) to co-ordinate the C&E response
- Aligned patient networks to support systemwide conversations, including the digital People's Panel and the face to face local representatives group. These are then supported with face to face groups at an ICP level.
- At an ICP level we are working to strengthen local networks with the voluntary and community sector, to inform future engagement activity
- Plans to strengthen our Local Equality Advisory Forum, working at a system level to listen to seldom heard groups
- Regular reporting on engagement activity into the PPI lay member committee within the CCGs (future Strategic Commissioner function) and the ICSPB to inform priorities
- Good relationships with the Overview and Scrutiny Committees to inform approach to involvement.

Quality, Performance and Finance

Quality

- Our underpinning philosophy is that quality should permeate everything we do, from the way we jointly plan and commission and deliver care, to the way we work collaboratively to drive improvement and innovation.
- To enable us to provide outstanding quality services for all our shared vision and underpinning quality framework will not only focus on quality assurance but also quality improvement.
- Fundamental elements of the quality framework are Quality Improvement and Quality Assurance.

Quality Improvement Elements

- Deploy a shared QI approach and methodology to support system wide change projects in line with system priorities, in particular and with initial focus on those priorities identified in the Phase 3 recovery plan response which broadly include:
  - Acceleration or preventative programmes which proactively engage those at greatest risk of poor health outcomes
  - Programmes to support those who suffer mental ill health
  - Action to address health inequalities
  - Restoration of services
- Establishment of a system QI steering group to prioritise and coordinate QI programmes
- Ensure all improvement programmes put the service user and carers right at the centre, and staff in the driving seat of change
- Establish a cohort or trained QI leaders able to work in partnership across boundaries
- Deploy a shared system and approach for report out of QI work programmes at key milestones
- Ensuring that we recognise and reward achievement

Quality Assurance Elements

- A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement
- Setting standards for what outstanding quality care looks like.
- Improving patient and carer experience through the development of ICS wide customer service culture
- Take findings from CQC Provider Collaboration Review and work together across the system to embed the learning both from examples of best practice and areas for improvement
- Embed a system wide Quality Impact Assessment process that ensures that system wide service development and changes do not put at risk the safety of our service users and their carers
- Establish a system wide mortality review process to better understand, measure and review patient mortality with the longer-term aim of reducing health inequalities
- Establish a system wide approach to harm reviews in line with the serious incident framework and national guidance on learning from deaths.

- The response to Covid-19 has seen dramatic changes in how health and care services are delivered and used. In the **Appendices** of this delivery plan we have outlined case examples of how the system has already worked together to overcome challenges in respect of the quality and safety agenda.

Performance, Improvement and Assurance

Quality, Performance and Finance

- One of the key roles of the ICS is to manage our own system performance and improvement process, taking on some of NHS England and Improvement's regulatory role, to ensure the best achievement of constitutional standards and of the commitments in the Long Term Plan.
- In the past this process has at times been characterised by a lengthy process that covers all areas of interest to regional, national and local leads that can absorb considerable resource and not always achieve a clear performance improvement.
- Our aim is that this becomes a more focused and supportive process taking a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues. We want to use the same principles that have worked through Covid-19 to underpin our work on future performance challenges. Assurance will be a dialogue of equals focused on improvement for the population, system and organisation.
- The focus will be on improvement, supporting the spread and adoption of innovation and best practice between partners. The ICS are committed to delivering assurance that is based on partnerships for improvement.
- There is a well established system Strategy, Finance and Performance Committee (SFP) which responsible for agreeing the messages on performance. It will define the issues and actions that need to be taken to deliver the plan and will break these actions down into individuals / organisations and ensure that the action plan is coordinated across organisations.
- The SFP has the correct membership and intelligence to support discussion of the main issues, decision making and challenge on system performance.
- Where consensus on the actions or decisions can not be reached in the meeting there is a clear route of escalation through to the CEO forum.
- A System Performance and Assurance Working Group (SPAWG) was formed in July 2020 to support the remit of the SFP.
- The purpose of the SPAWG is to support an approach to gain shared understanding of system performance and intelligence in advance of the SFP and regulator system review meetings. The aim is that system partners collectively own and are sighted on the key issues and actions to improve performance. Partners are all involved in developing a jointly owned System Performance and Assurance report.
- The outputs of the group feed in to the SFP Committee.

Progress To Date

- The SPAWG meets on a monthly basis prior to the SFP.
- The monthly meetings and report produced by the SPAWG are evolving and will continue to develop as required. Currently the initial provider data contained within the report has come from those organisations that sit within STP. Progress is being made with University Hospitals of Derby and Burton and the Royal Wolverhampton NHS Trust to expand the report to include their data and to develop data flows from non-acute settings including primary care, community and mental health.

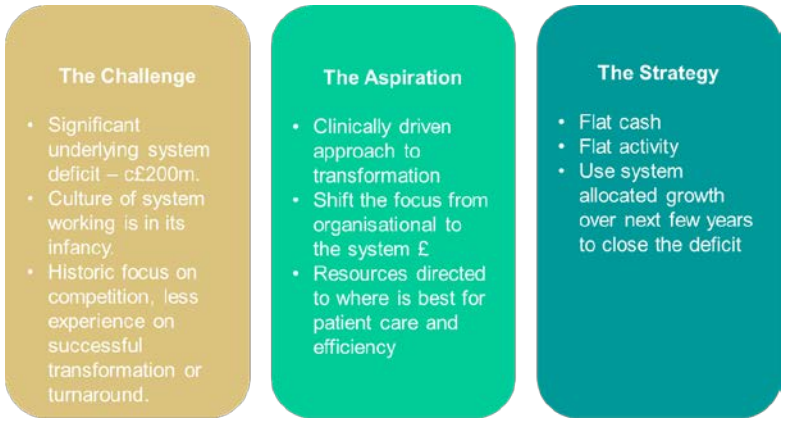
Finance

Quality, Performance and Finance

Financial Strategy

- The ICS will facilitate the development of a financial strategy that articulates how the system and the organisations within it will deliver the financial targets. It will define how the system will ensure that it is delivering the best healthcare for our population within the overall financial envelope.
- The strategy will define how the ICPs will deliver these outcomes. It will use evidence and data to define what can be done. It will define the expectations for the major drivers of the system financial position including provider productivity (system savings), investment in new services, funding, and managing activity growth, funding the delivery of system operational targets and managing financial risk.
- The pathway to a financial strategy was approved in October.
- Work on agreeing the principles of the financial strategy across the system has gone well, and all system partners understand the need for the strategy.

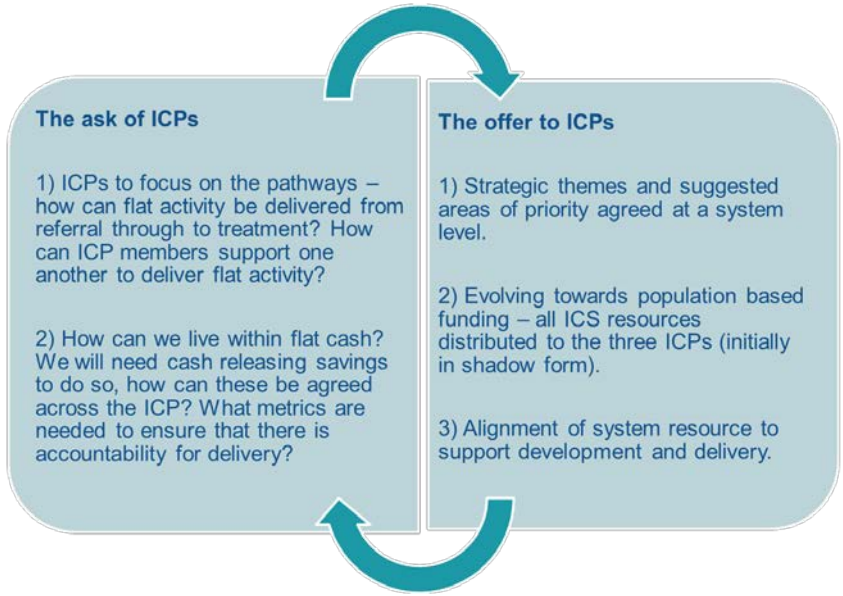
Financial Strategy on a Page



- The financial strategy principles recognise that, while there is a significant amount of uncertainty with respect to future ways of working and the financial regime, there are some key underlying assumptions and challenges that we can be confident of and start to shape our approach and response to.
- The strategy aims to strike a balance between what we do know and what we're waiting on confirmation of.

ICPs

- The approach proposed utilises the ICPs as the place where the work can be done across the system - to agree how flat cash and flat activity can be achieved.



- Once the more detailed arrangements for ICS and ICP is developed nationally we will continue to work flexibly to ensure that the analysis undertaken can accommodate all these views of the system's financial position

Finance

Quality, Performance and Finance

Opportunity Analysis

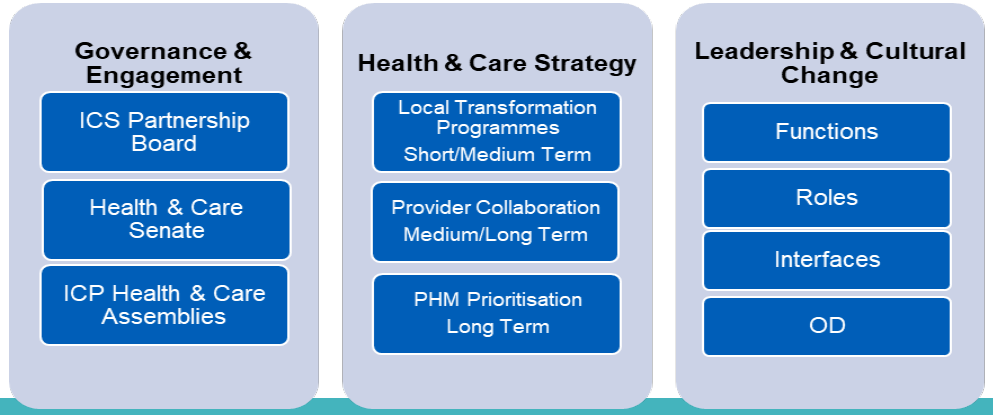
- The development of system opportunities was progressing throughout the late Winter and early Spring of 2020, however with the onset of the Covid pandemic this work was curtailed.
- Focus over the summer period has been the development of the restoration and recovery plan as well as the preparations for winter surge planning and the upturn in Covid. The next steps which sits alongside the development of the financial strategy roadmap is the preparation for the Phase 4 “Reset” plan. One of the key aspects of this will be the “refresh” of the FYDP priorities and opportunities as well as the consideration of the service developments implemented to respond to Covid-19.

The Intelligent Fixed Payment Approach

- The system is committed to evolving the Intelligent Fixed Payment (IFP) model to support the development of the ICS and ICPs. This will include the allocation of resources and the financial framework for ICPs, alongside supporting risk and gain share arrangements.
- The IFP represented a key step change in how we work together as a system to manage our financial positions. As we undertook 2020/21 planning, it was agreed that the IFP continue with similar arrangements before the Covid-19 central finance regime was put into place.
- The Finance Directors of the 4 statutory organisations oversee the management and development of the IFP and have agreed to establish a “shadow” IFP for ICP system in 2021/22 with a view to implanting it in full in 2021/22. This will allow partners to better understand the changes that are being proposed and not to destabilise individual organisation positions.
- Very early modelling of the 2021-22 baseline positions has been undertaken
- In the first instance, it is anticipated that the ICS holds the overall resource envelope for the system and is the level of aggregation that NHS England and NHS Improvement will hold the system to account for.
- Below this the 3 Integrated Care Providers would be delegated the CCG budgets which are relevant at a “Place” level – prescribing, continuing health care, and potentially delegated Primary Care.
- Providers would form “provider collaboratives” in both acute and community/mental health services to work with ICPs and each other in the best delivery of healthcare.
- In the first instance allocations would be made directly to the 5 NHS providers and 3 ICPs by the ICS. Risk and gain share arrangements would be agreed between each ICP and the 2 provider collaboratives to best manage care at a “place” level to improve patient pathways. Alternative risk and gain share agreements would be made between providers to manage risk and reduce competition.
- Whilst there is a significant amount of work to be done to establish this model, early modelling is now commencing. The financial allocations, and risk and gain share agreements, will need to be able to look at:
    - The organisational view;
    - The collaboration view; and
    - The place view.

Clinical and Professional Leadership

- Clinical and professional input for the ICS is provided by the Staffordshire and Stoke-on-Trent Health and Care Senate (H&CS) and its associated sub-groups, the Health and Care Assemblies. This will ensure strong clinical leadership at the centre of ICS decision-making.
- By working collaboratively with other system partners, strategic, evidence based, intelligence driven, health, care, clinical advice and leadership is at the heart of commissioning and service delivery. This will lead to improved provision of quality, safe and equitable health and social care resulting in improved outcomes for the population.
- The H&CS was established in 2019, by a group of health and care professionals who recognised the need for a concise system wide professional body, with representation from across the health and care sector. The structures support clinical and professional input from the front line of care, across Staffordshire and Stoke-on-Trent. This professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery.
- The Executive leads for this area of development are Dr John Oxtoby and Dr Rachel Gallyot.
- A detailed plan has been developed to support the provision of strong clinical leadership at the centre of ICS decision-making. The plan is built around 3 core areas of work:



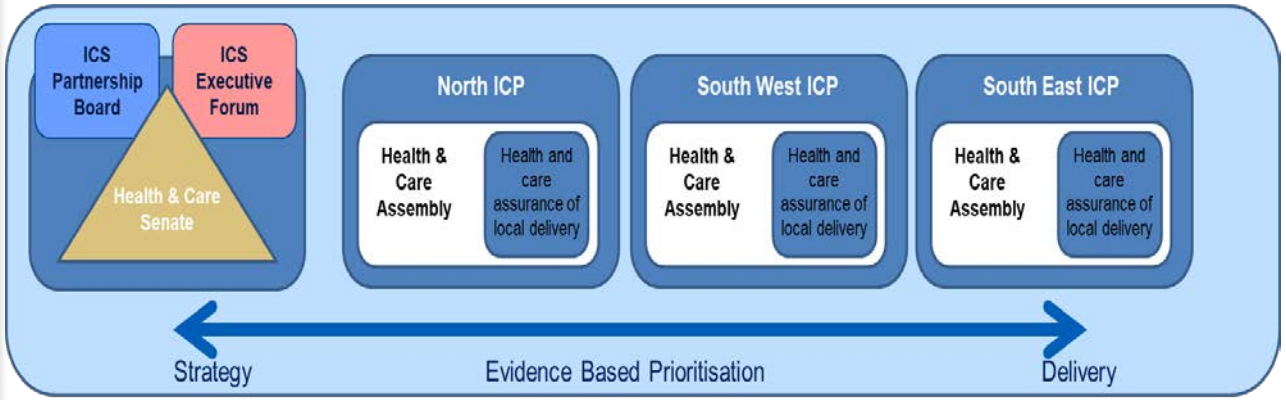
Engagement

- The H&CS is multi-disciplinary and inclusive of representation from across health and social care, comprising representatives from Social, Primary and Secondary care clinicians as well as representatives of Local Authorities and senior doctors and nurses. The H&CS meets monthly with the frequency of meetings having been increased in response to Covid-19; demonstrating the strength in working together across the system as health, care and clinical leaders
- The H&CS is supported by three affiliated, place based Health & Care Assemblies. Initially the vision was of a single sub-group Assembly for the system. With the development of the three ICPs, the reality is that each ICP will form a local Health & Care Assembly affiliated to the H&CS.
- Clear strategic direction and prioritisation by the H&CS will enable the local Assemblies to lead, support and deliver clinical decision making at ICP level. The Assemblies are inclusive of a wide-range of health, care and clinical professionals who can assure the local delivery against the system strategy a prioritisation that they are affiliated to.
- Primary, Secondary and Community Care, Mental Health and C&YP Networks are integral to the H&CS and Assembly structures. the H&CS will co-opt members of these assemblies to provide specific expertise to assist with its work.
- The H&CS and Assemblies are powerful forums for harnessing the energy and expertise of health, care and clinical professionals across the system.

The Role of the Health and Care Senate in the ICS Partnership Board

Clinical and Professional Leadership

- The relationship between the H&CS and the ICSPB is crucial and symbiotic. The H&CS is represented directly on the ICSPB by its Chair and Vice-Chair, with a defined system function in clinically supporting the Board.
- The H&CS will provide clinical scrutiny of proposed developments from the ICS and, in addition, a conduit, ensuring that the views of professionals from across the system are communicated and well represented.
- The Chair or Vice-Chair of the H&CS will provide clinical representation at the Executive forum.
- The H&CS provides a clear link to the ICPs, through each Health and Care Assembly.
- Engagement with the ICSPB, and the level of clinical influence and visible effect on strategy decisions, will sustain the full support and involvement of senior professionals. This input is vital to the ICS, in order to ensure that the right decisions are made early, and to satisfy the important requirement for health, care and clinical engagement.



- In order to ensure that this relationship is strong, the following points are key:-
  1. The Chair and Vice-Chair of the H&CS are co-opted onto the Executive Forum and ICSPB
  2. Any major area of strategic work undertaken will have health, care and clinical involvement with representation agreed via the H&CS and Assemblies with additional input as required. All final documents and/or developments before they are agreed by the ICS Partnership Board will go through the H&CS as a mandatory gateway process
  3. The H&CS has the delegation to refer clinical matters, which it deems significant, to the Executive Forum and ICSPB;
  4. The H&CS is used to provide reviews of services across the system, utilising expertise from within the Assemblies;
  5. The H&CS works with Executive Leaders across the system and is integral in the development of clinical strategy.
- The developing structures described are well defined, guaranteeing strong clinical and professional input. This provides a broad range of expertise and ensures strong linkage between health, care and clinical professionals and the ICSPB.

Clinical and Professional Leadership

Tackling Variation across the System through Clinically Led Strategy and Prioritisation

- The H&CS is responsible for the development of clinically led strategic developments that will inform the ICS strategic direction considering:
  - Standing Items: The H&CS discusses the current health, care and clinical positions of Primary, Secondary and Community Care, Mental Health, Children & Young People and other health and care professions, offering independent strategic and objective health and care advice that is based on evidence, best practice, data intelligence and robust understanding of population health needs
  - Emerging & Time Critical Issues: The H&CS is an essential forum to get quick health, care and clinical representation. This has proven invaluable during the Covid-19 pandemic in matters such as:
    - Discussion and agreement around the legality of End of Life care
    - Local trust clinical assessment of referrals and how these are prioritised
    - Urgent pathway reviews, i.e. paediatrics
  - Proactive Development of the System Agenda: The H&CS will lead on the most urgent and top clinical priorities across the health and social care system that are informed by population health management.

Leadership and Cultural Change

- The model of health, care and clinical professional leadership has the key enablers to provide broad and robust delivery for the system. The H&CS is already operational and will evolve with the development of the ICS.
- The structure provides strong and clear linkage between the health, care and clinical providers and the ICSPB. This provides real influence to a wide group of health and care professionals, which is a key requisite to ensuring their continued engagement. The governance structure is multidisciplinary, with engagement from all spheres of health and care as well as social care and clinical professionals
- There is ongoing leadership development of the health, care and professionals, to ensure these individuals are equipped with the skills to drive and lead the health, care and clinical strategy across the system.

Progress To Date

Governance & Engagement

- Resource to support the H&CS functions and work programme is confirmed and providing input. The levels of resource and skills required will continue to be reviewed to ensure that there is sufficient capacity in place.
- The H&CS Terms of Reference have been approved and the meeting format and a proposed annual business cycle developed.

Health & Care Strategy

- During Covid-19 the H&CS has already begun to provide an essential function to get quick health, care and clinical representation on emerging time critical issues.
- The evidence based prioritisation framework has been developed and agreed
- The readiness phase to receive PHM as a tool to develop strategy has commenced.
- The PHM readiness phase has been presented at the H&CS.

- The system approach to PHM is outlined further in the strategic commissioner development section.

Becoming a Mature H&CS

- The H&CS has utilised the format of the ICS maturity matrix to critically assess its current position. This has been used to plot and develop its path to becoming a mature H&CS for Staffordshire and Stoke-on-Trent.
- A self-assessment of the leadership state of maturity will be undertaken on a quarterly basis.

Integrated Care Record (One Health & Care) Summary

- Staffordshire and Stoke-on-Trent have a live Integrated Care Record Solution, which is already well populated with data from partner organisations and provides the foundation upon which to build integrated care tools and enhanced data to improve health and care for the local population.

- We are active members of the Local Health and Care Records Group across the West Midlands and accordingly are committed to sharing the data in the Integrated Care Record with partners across the region through the LHCR programme. Our close collaboration with Shropshire, Telford and Wrekin STP will see the Staffordshire and Stoke-on-Trent ICR shared to create a single integrated care record covering both regions, which will prove especially useful for MPFT who provide services in both areas.

- The requirement for an ICR was identified in our original Digital Roadmap submission in the autumn of 2016. The procurement process used the HSS framework and a contract award was made to Graphnet / System C in July 2019. An implementation project began in September 2019 and the ICR achieved full Go Live status in August 2020.

- All of the ICS provider Trusts, both Local Authorities, WMAS and all 150 GP practices are partners in the ICR resulting in a comprehensive health and care record.

- An outline roadmap has been developed which will see further datasets added, additional users from within the Health and Care Economy connected and a range of new and exciting features being made available.

- The diagram summarises the organisations and data that are presently live, the future datasets that are currently in development and further features to be implemented over the coming months. The roadmap is presently being prioritised by the Digital Clinical Advisory Group and the Digital Design Authority before being turned into defined work packages for delivery.



Shared Care Record (One Health & Care) Delivery Plans

- University Hospitals Derby and Burton have commenced their data-sharing project following delays due to resource issues around the response to Covid-19. These delays continue although data is expected to be integrated into the solution from January 2021.
- Social Care data for Children will commence in early 2021 as there are dependencies on Staffordshire County Council system upgrades
- Community Data: MPFT are dependent on system upgrades to enable data flows for Community data, which will follow in 2021 once the two community systems in MPFT have been merged.
- User access: All main partners (with the exception of UHDB) are enabled to access the Shared Care Record. Further developments access will be deployed in further care settings such as hospices, care homes and NHS111 provider.
- Personal Health Record: The project has agreed the scope for the Personal Health Record, which is a mobile app, and website, which will empower patients/service users to manage their conditions and support wellbeing. Features include viewing appointments, medication and correspondence. Individuals will be able to record information such as weight and mood; there is the ability to link smart devices to include heart rate etc. An initial version of the app is expected to go live in February 2021 accompanied by a roadmap detailing when additional functionality will be available.
- Care Planning and end of life: The project team are working with the RESPECT collaborative group to explore how the solution can support the national standard. Currently the information is paper based with various local processes, which uploads copies to partner organisation local system. The requirement is to make the most up to date information available to all those involved in the individuals Health and Care provision. Once the latest version of the RESPECT document is finalised by the Resuscitation Council this will be loaded into the solution and deployed.
- Business Intelligence Tool: The project team are working with UHNM Lung Screening Team to identify the initial cohort of patients who meet the criteria to be part of the screening programme to pilot the BI tools. The Project Team are exploring the wider use of the solution with Information Governance Colleague to ensure all aspects of secondary use of data is understood before a wider role out is planned.
- Regional Expansion: Staffordshire are working really closely with our neighbours to breakdown the digital boundaries of the Shared Care Record. Most advanced is in Shropshire, Telford and Wrekin where the current Shared Care Record will be expanded to include Health and Social Care partners from within this area. Black Country discussions are underway to establish the most appropriate way to share data into the record.
- Information Governance: The current IG articles will be expanded both the include a wider range of organisations into the agreement but include further uses of the data specifically the secondary use of data to support health analytics.

Detailed maturity self-assessment and development plan against the five domains



Introduction: Maturity Matrix Self-Assessment

- The system took part in an ICS development programme in July 2019. At that point the system completed the self-assessment against the ICS Maturity Matrix.
- An initial gap analysis was undertaken to map the current system position against the maturity matrix and the July 2019 assessment. This forms the basis of the development needs that have been identified by the system to ensure that there is progress made towards the 'Thriving ICS' ambition.
- A stock take of our current position demonstrates that good progress is being made against most elements of the maturity matrix.
- The system has demonstrated an improved ability to work collaboratively as part of the Covid-19 response. Being part of the region wide review on lessons learnt has facilitated the system undertaking its own review to help support the process.
- Further work is being undertaken to map these development needs against the 5 workstream areas to ensure that there is comprehensive coverage.
- The following section provides a description of the progress made in accordance with the maturity matrix along with development points, owner / resources and timelines.
- In contrast to the previous assessment all domains we have assessed our progress against against the "thriving" characteristics, with actions identified to achieve this level of maturity.



Domain 1: System Leadership, Partnership & Change Capability

Themes	Progress	Development Points	Owner / Resources	Timeline
Strong collaborative and inclusive system leadership and governance	• ICS Independent Chair appointed and in place. • H&CS established at ICS level mirrored at ICP level by Health and Care Assemblies. • Clinical and professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery. • A health inequality executive at board level within each organisation and a system inequalities lead. • Focus on inclusivity and diversity at senior level in our workforce is a priority of the system workforce group. • Established commitment to the three ICPs , each with leadership and governance in place which has been developed on inclusive basis, including key partners and stakeholders • CEO leadership to ICP development supported by an Executive programme lead. • System wide ICP Programme Board in place to coordinate activity to support ICS roadmap.	• Independent Chair to work with ICS leadership team to put in place ICS governance in order to transition from the shadow ICS Shadow Board. • The H&CS is currently revisiting its terms of reference, identifying the role of clinical and professional leadership and the senate at a system level; and the role of leadership and assemblies at the ICP/Place level and developing work programme. • An OD plan to support system and place clinical and professional leadership. • ICP Visioning Documents, Partnership Agreements and Delivery Plans to be signed off.	STP Exec Forum	Feb 2021
Shared system vision and objectives	• Overall ICS vision as set out in the FYDP. • The H&CS has agreed an approach to identify the system clinical priorities. • Developing outcomes frameworks at both the system and programme level • The FYDP and ICS Roadmap 2020 sets out commitment to an ICS supported by an ICP model of delivery. • Each ICP identified 6 priorities during Summer 2020 which have been shared with the ICSPB. The ICPs have been working to deliver these through their current governance arrangements.	• Refresh and reframe the Vision and System Objectives, overarching strategy and strategic priorities in the FYDP post Covid-19. • The PHM team will continue to work with the H&CS focusing the areas outlined in the FYDP into a set of priorities based on population need. This will then be used to develop a system level strategic and outcome framework and form the basis of the strategic commissioning framework.	STP Exec Forum	April 2021
System transformation partnership and engagement	• The system has captured the learning and service changes resulting from Covid-19 and are using this to understand the opportunities for transformation as part of recovery. • Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level • The system has actively engaged with the population and used focus groups for specific patient groups to understand how the changes during Covid-19 have impacted on our population. • The ICPs have developed on the basis of inclusivity and are supported by governance and servicing arrangements • Each ICP has an aligned Director of Strategy to provide the connection back to individual organisation and system wide transformation activity.	• Developing outline proposals for major service change as a result of Covid-19 and feeding those in to our transformation work. • ICP Delivery Plans will include a communication and engagement plan to support delivery. • At ICP level strengthen the involvement of patient and voluntary groups.	ICS Leads ICP Leads	April 2021 March 2021

Domain 1: System Leadership, Partnership & Change Capability

Themes	Progress	Development Points	Owner / Resources	Timeline

Capacity and system transformation change capability	• System performance and assurance report developed based on system strategic and recovery priorities.
	• A Transformation Delivery Unit is in place that supports our transformation agenda.
	  ◦ Projects are aligned to the FYDP and Phase 3 recovery plan
	  ◦ Standardisation has been applied to our programmes and projects including reporting and oversight
	  ◦ Project management discipline has been deployed against system priorities reporting into our system SFP and providing oversight on programme delivery
	• System:
	  ◦ Commitment to ICP model of delivery with oversight through the ICS Roadmap and CEO leadership to the 5 priority areas identified
	  ◦ ICP development has been co-designed with the strategic commissioner programme of work to ensure alignment of future models
	• Place:
	  ◦ Three ICPs established with defined geographical footprints
	  ◦ Cross- organisation work between health and social care partners delivered on ICP priorities identified throughout Summer 2020
	• Neighbourhood:
	  ◦ 25 PCNs in place
	  ◦ PCNs and Local Authority locality approaches have been critical to the development of the ICPs to date
		• Achieve a single CCG covering the STP footprint by April 2022.
		• Implement the plan to deliver a Strategic Commissioner function
		• Working to increase the provider level data from out of area acute providers, community care and primary care to improve the impact of the system assurance report
		• PHM work stream and programme work streams are working on developing outcome frameworks linked to the Phase 3 recovery plans and FYDP.
		• Development of ICP delivery plans which set out priorities for action
		• Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms
		• TDU capacity to be reframed and enhanced to support local ICP delivery and place based transformation – system wide PMO capacity and capability
		• Transformation projects to be rebased following refresh and reframe of the Vision and System Objectives, overarching strategy and strategic priorities post Covid-19
			Strategic Commissioner
			
			ICP / ICS Leads
			
			ICP Programme Lead / CCG CFO
				April 2022
				
				March 2021
				
				December 2020
				
				April 2021

System culture and talent management	• Increasing diversity in senior positions is a priority for the system workforce group • Leadership development programmes: High Potential Scheme pilot leading the way nationally in pilot programme. Winter Inclusion school guest speaker and programme of sessions agreed, Cultural Racial Inclusion development programmes • A range of Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes in place • A capability and capacity review of analytical/intelligence resource has been undertaken in the system to support development of PHM	• System workforce group co-ordinating across organisations to increase the diversity of workforce in senior posts • An integrated intelligence group to develop analytical and intelligence skills across the system	People Board	March 2021

Domain 2: System Architecture and Strong Financial Management and Planning

Themes	Progress	Development Points	Owner / Resources	Timeline
System architecture and oversight	• An interim governance structure based on 'function' has been established. • Sub-committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work. • System Performance and Assurance Working Group (SPAWG) set up to bring together an integrated provider and system view of performance and the key issues and actions for the system. • ICPs have been established and have been operational for several months working to deliver self-identified priority areas.	• Increase the provider level data from out of area acute providers, community care and primary care to improve the impact of the system assurance report. • System integrated Intelligence group and the SPAWG are working on the development of a system level dashboard and outcomes framework. • Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS.	CCG DoS ICP SRO	March 2021 March 2021

Streamlined commissioning arrangements	• A confirmed and finalised CCG merger timeline and roadmap.
	• A detailed plan to support delivery of the Strategic Commissioner Development particularly in relation to
	  • the functions delivered at system level by the strategic commissioner.
	  • a work programme on how current commissioning functions are part of ICP functions.
		• Developing a programme for further expansion of integrated commissioning with the Local Authority.
		• IFR and the funding arrangements utilised during Covid-19 are being used to reconsider the future role of commissioning.
		• Collaboration between ICP and strategic commissioning functions to determine nature and scale of locality commissioning support to enable ICP delivery.
		• Develop an approach for planning and delivery of specialised services as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.
			Strategic Commissioner	September 2021
				
				March 2021

System control totals, operating plans and financial risk sharing	• Implementation of Intelligent Fixed Payment (IFP) arrangements in 2019/20, and agreed these in shadow form in 2020/21 prior to the Covid-19 financial regime. • A System Capital Prioritisation Group, to review and prioritise capital plans across the system. • A system approach to developing plans (Phase 3, FYDP, system savings plans etc.) that involve strategy, finance and operational directors.	• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets taking on board the learning from Covid-19. • Directors of Strategy to take the leadership on development of the system wide plans (eg Phase 3, operating plans) • Development of the system/provider capacity/demand models to prioritise system actions and resource allocation. • Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms.	ICP Programme Lead / CCG CFO / System DoS	March 2021
System wide financial governance and cross-cutting strategies	• A System Strategy, Finance and Performance group in place ensuring collective overview and ownership of current system position and plans. • A System Finance Director Group , with supporting infrastructure in place. • TDU established to support system efficiency opportunities.	• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets taking on board the learning from Covid-19. • Development of system approaches to system savings. • Delivery programmes are in place but will need rebasing.	System DoFs	March 2021

Domain 3: Integrated Care Models

Themes	Progress	Development Points	Owner / Resources	Timeline

Population health management	• Developed an integrated intelligence function during Covid-19 that includes involvement from all organisations this has supported:
	  • Development of Covid-19 population models
	  • Capacity and demand modelling
	  • Population data on outbreaks and on the demographic distribution of Covid-19 admissions
	• An established system H&CS which has health inequalities and PHM as one of it's core priorities ensuring that inequalities are a key issue for wider clinical leadership groups.
	• A process for PHM based prioritisation at the system and place level
	• An initial work plan for the next six months.
	• Supporting the system understanding on health inequalities and the development of the inequalities work streams.
	• Active involvement with the NHS England regional team and PHM programme, and use of external experts Milliman, which supports the development of PHM capacity and capability across the system.
		• Population health management tools that can be used at system and place level.
		• Digital and PHM work streams continue to collectively work on data sharing protocols
		• Working with the H&CS and the system PHM group on developing a PHM Strategy and work programme for 2021/22.
		• Developing work on understanding the use and impact of CCGs inequalities funding on health inequalities.
		• Develop a plan to address the deficits identified as part of the Capability and Capacity review of functions.
		• Working with the integrated intelligence group on single population/clinical data sets for use at system and place level.
		• Work starting to develop primary care intelligence and PHM programme.
		• Development of system PHM infrastructure that can support ICP level needs analysis.
			ICP Programme Lead / CCG Director of Strategy	March 2021

Long term plan - care models and service changes	• Covid-19 has resulted in cross organisational system working on:
	  • Care homes
	  • Community care models
	  • Discharge and admission avoidance
	• All service changes as a result of Covid-19 have been captured, have QIAs and EIAs and are being used to inform the FYDP service change models/opportunities
	• There is an agreed overarching model of care and support outlined in the FYDP.
		• Consider which service changes made as a result of the response to Covid-19 need to be built into the FYDP service change models
		• For 2021/22 partners will be reinvigorating the System Objectives, overarching strategy and strategic priorities in the FYDP post Covid-19.
			Directors of Strategy	March 2021

Redesigning outpatient services and using new technologies and digital advances	• Rapid uptake of digital consultation in primary care – including video consultations. • Radical transformation to none face to face consultations across all sectors. • All system partners have deployed virtual technology during Covid-19.	• Embedding of change in practice and exploiting further opportunities for transformation e.g. patient initiated follow up.	Planned Care Cell Digital Board	March 2021

Domain 3: Integrated Care Models Continued

Themes	Progress	Development Points	Owner / Resources	Timeline
Development of Primary Care Networks	• ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS. • An agreed Primary Care Strategy is in place. • 25 PCNS in place each with Clinical Directors.	• CCG Primary Care support to PCN Development to include link to ICP development to support PCN CDs to contribute at wider system level. • PCNs currently working on the Delivery of Enhanced services specification. • The CCG is refreshing the GP strategy post Covid-19, focusing on embedding the primary care operating model, continuing to support an expansion of the workforce, focussing in on cutting bureaucracy, refocusing QOF, and making more funding available. • Deliver development plan with PCNs: this is currently being refreshed and relates to the leadership and development of PCNs.	ICP Programme Lead / CCG Director of Primary Care	March 2021
The prevention agenda and addressing health inequalities	• Our system Phase 3 recovery plan set out a clear commitment to tackling inequalities including population analysis of Covid-19 admissions. • Development of a system prevention group and work programme. • An inequalities strategic oversight group has been established in the STP, involving clinical and public health expertise to bring together the inequalities and prevention work streams. • A health inequalities expert group. • Inequalities identified as a key priority and work programme by the H&CS • ICPs progressing delivery of 6 areas of priority, including a focus on reducing health inequalities and promoting the prevention agenda. • A bid is under consideration by the regional Health Equality Partnership Programme.	• A system inequalities and prevention programme of work focussing on actions that mitigate the impact of inequalities and help take pressure off services by supporting people and communities. • Work to be undertaken to improve healthcare recording of demographic and inequalities data • Work on understanding the use and impact of CCGs inequalities funding on health inequalities • Work with LAs and Voluntary sector on community approaches to prevention • Developing the social prescribing/interventions within PCNs. • Developing risk stratification approaches to identify pathways where health inequalities are important. • Development of inequalities metrics as part of the system outcomes framework • Continue work with LA public health leads to ensure that the Phase 3 and FYDP prevention agenda is linked to the wider health inequalities and prevention agenda via the Health and Wellbeing Boards. • Develop the system level strategic framework and system operating plan to include clear objectives around health inequalities. • Development of system wide PHM infrastructure that can support ICP level needs analysis.	ICP Programme Lead / CCG DoS	March 2021
Workforce models	• Long-term workforce planning across the system has taken an ‘open book approach’ through development of the FYDP and Phase 3 recovery plan, with all providers engaged in the process and sharing their workforce projections across the system. • Arrangements for mutual aid in place and effective during Covid-19	• Review of integrated workforce models post Covid-19, with opportunities for new roles and ways of working to be embedded.	People Board	March 2021
Personalised care models	• System partners are working with local authorities to deliver personalised care.	• Continued development of the long-term conditions pathways and specific operational areas such as wheelchairs, continuing healthcare. • Work with local authority to implement an integrated PHB offer.	Joint Commissioning Board	March 2021

Domain 4: Track Record of Delivery

Themes	Progress	Development Points	Owner / Resources	Timeline
Evidencing delivery of LTP priorities and service changes	• The system Phase 3 recovery plan was built on and around our FYDP priorities. • During summer/autumn 2020 further engagement was undertaken with local community groups, to understand their experiences during Covid-19, including discussion of future priorities. • All of the Covid-19 service changes have been reviewed against the FYDP ICP priorities have been cross referenced against the FYDP. • Delivery of priorities designed, developed and delivered through individual ICPs to support maturity and build tangible evidence base for added value enabled through ICPs.	• Use learning to inform transformation against an agreed methodology to consider whether in accord with the FYDP areas should be developed further as permanent service changes. • Continue the work with the H&CS to develop the clinical priorities supporting the FYDP. • Maintain focus on main priorities in the Phase 3 recovery plan. • Further development through ICP Delivery Plans which will include assessment of alignment to FYDP including evidence base of case for change.	ICS / ICP Leads	March 2021
Delivery of constitutional standards	• Strong system delivery of mental health standards. • A system assurance framework. • Recognition of areas e.g. urgent care where the system have struggled to meet emergency care standards. • Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited. • Extensive data validation has reduced the number of patients waiting for elective care. • Good use of the independent sector with system wide plans for utilisation from January 2021.	• Focus on delivery on of the trajectories in the Phase 3 recovery plan. • Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards.	ICS and ICP leads	March 2021
System operating plans	• An agreed FYDP that was determined ready to publish pre Covid-19. • For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan.	• Directors of Strategy to support the development of the system operating plan in conjunction with ICP leads and the H&CS. • ICPs will become the 'engine rooms' of delivery for transformation and integration of health care pathways that harness expertise of Providers in translating plans into action	ICS and ICP Leads	March 2021
Challenging systemic issues	• Improved relationships through previous winters and in response to Covid-19 has given system partners the opportunity to work collaboratively to address systemic challenges • Significant evidence of co-production and co-delivery e.g. Care Homes • Covid-19 has focused the system to work collaboratively in providing joined up care. • As part of the our EPRR response a daily call is in place for leaders to address emerging issues in responding to Covid-19	• Confirm ICS role in developing provider relationships and alliances to system wide models of care (end to end pathways.) • Improved intelligence to support real-time demand and capacity modelling	ICP SRO	December 2020

Domain 5: Meaningful Geographical Footprint

Themes	Progress	Development Points	Owner / Resources	Timeline
Do you have a meaningful geographical footprint that respects patient flows and, where possible, is contiguous with local authority boundaries or have clear arrangements for working across local authority boundaries?	• Whilst geographical boundaries of the ICS do not respect patient flows the footprint of the ICP's create a closer alignment. • ICS and ICP boundaries reflect local authority boundaries with good engagement at all levels of the ICS and ICPs, including opportunities for District and Borough Councils to engage at ICP level. • ICPs cross local authority boundaries, though this is recognised, with clear arrangements in place for cross boundary working. • The upper tier Local Authority boundaries are coterminous with the boundary of the proposed ICS • The proposed single merged CCG boundary coterminous with the ICS boundary	• Engagement with major out of area acute providers and neighbouring STPs to ensure inclusion in system and ICP development work • Developing partnerships with Staffordshire County Council and Stoke-on-Trent City Council, and the VCSE sector.	ICS Lead	December 2020 Ongoing

Summary

- This plan sets out the work that has taken place in order to support the ICS development across Staffordshire and Stoke-on-Trent and progress against key operating requirements.
- The ICS development plan does not exist in isolation though. It is essential that this document is read in conjunction with-
    - The Five-Year Delivery Plan for Staffordshire and Stoke-on-Trent
    - The Phase 3 Recovery Plan
    - CCG Merger Project Plan
- As such, this plan helps to facilitate and support a change to the way that the system works to meet the changing needs of the population. Simply, it is not an end in itself.
- Equally there has been considerable learning from how partners responded to the initial impact of Covid-19 and the subsequent ongoing response. This plan looks to capture and build on this learning in order to find ways to embed the improved ways of working and collaboration.
- As system partners we demonstrated that during the Covid-19 we could respond by implementing and executing plans quickly and effectively. We need to carry this forward into our approach to delivering transformation.
- There is an exciting opportunity emerging around the approach towards truly integrated place-based care and the development of our ICPs. It remains early days with some of this work but there is a strong commitment from all partners to make this happen and for it to change how we deliver care to the population that we serve.
- In recognising the positive steps that have been made, there is a clear and coherent view on the next steps and the associated key risks. In producing this development plan, it has highlighted a number of areas where there is further work required if we are to deliver on the benefits of being an ICS.
- The ICS Partnership Board will have oversight of this process and the small steering group will progress the agreed actions. This will report through into the Exec Forum, but each CEO is expected to keep their own organisation fully informed of the progress being made and the associated risks.

Appendices

Case Studies and Patient Stories



Case Study: What is different about an ICP? Developing an Asset Based Approach

- The transition to an Integrated Care Partnership approach provides a fundamental opportunity to place a new emphasis on the strengths and assets of our communities and open up new ways of thinking about improving health.

- By adopting an 'asset based' approach, the ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups. Working with patients and community groups, the ICP will empower people with the confidence to look after themselves and take control of their own health and care needs, thus help to prevent or delay ill-health in the longer term.

- We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme

- The CLS programme involves selected local authorities and health and social care partnerships implementing a new way of delivering community support. It brings innovation to how services are delivered; designed and driven by practitioners along with local partners and members of the community they are serving.

- There are a number of key principles that have been recognised as guiding this work;
  - Co-production brings people and organisations together around a shared vision
  - There is a focus on communities and each will be different
  - People can get support and advice when they need it so that crises are prevented
  - The culture becomes based on trust and empowerment
  - People are treated as equals, their strengths and gifts built on
  - Bureaucracy is the absolute minimum it has to be
  - The system is responsive, proportionate and delivers good outcomes

- The programme also provides access to a strong national network to enable sites to share experiences, learning, tools and ideas and address common challenges.

Community Led Support Programme Progress

- The programme is coordinated through the Assistant Director of Adult Social Care and offers a tangible commitment of the ICP to work in true collaboration across Local Authority and NHS boundaries.

- To date 20 community conversations with over 100 groups have been held to shift the emphasis away from 'what is the matter with you' to 'what matters to you'. A clear area of priority emerging through the conversations was a CLS approach to redesigning 'front doors' of service access including acute hospital, community and social care

- Learning from experience of introducing CLS change elsewhere, the focus will initially be on two 'innovation centres' within Stoke-on-Trent to mobilise CLS change at locality/neighbourhood level

- A focus on Community Wellbeing Teams and redesign of the Front Door utilising Social Care First Contact Teams and Social Care Community Teams based in community venues alongside partners to drive contact and communication with residents in the community. Establish a Community Front Door in order for residents to access help through the community as a method of supporting early and intervening with appropriate support.

- Good progress has been made in a short space of time and the next steps include:
  - Innovation Team to meet prior to Christmas break
  - Communication content to be agreed and distributed
  - Local Community Organisations contact to be made and a community meeting pulled together for the new year.
  - The geographical boundary is currently being developed and will be ready for the new year.
  - Planning for Change and Signs for Change workshops have been scheduled week commencing 11th January 2021.

Case Study: NHS Continuing Healthcare Fast Track Pathway - Integrated Working with Partners

- As of the 1st September 2020, the NHS Continuing Health Care (CHC) Framework restarted, including the reintroduction of NHS CHC Fast Track. To support this, the sourcing of Fast Track packages at home transferred to the CHC Team within the Midlands and Lancashire Commissioning Support Unit from 24th August 2020.
- Guidance mandates that the CCGs should consider the delivery of end of life care in the context of the *Hospital Discharge Service: Policy and Operating Model*. The guidance also defines the importance of the function of community referrals from a single point of access that retains responsibility for overseeing communication with the system.
- The guidance does not define the six week funding for any specific patient cohort or clinical need and therefore there was an opportunity to consider Fast Track/ End of Life Care Pathways, both in terms of admission avoidance and hospital discharge to ensure individual's needs are met safely, in a timely manner in their preferred place of care.
- There is recognition that to meet the national guidance current pathways require improvement.

Challenges

- Inconsistent wrap around provision across the Staffordshire and Stoke-on-Trent footprint for fast track patients to receive care and support to meet preferred place of care (home) in a timely manner.
- Delays/issues are experienced with timely identification of fast track patients leading to increased length of stay in hospital and deconditioning.
- The fast track process does not currently meet the requirements to support same day discharge as per the national discharge guidance.
- No current function in place to commence packages of care over a 7 day period.

Revised Pathway

- The overarching principle of this pathway is to support individuals who would ordinarily meet NHS Continuing Healthcare Fast Track criteria to receive care and support in a timely manner to prevent a hospital admission or facilitate hospital discharge. The pathway will provide
  - Rapid step down care for individuals who meet fast track criteria
  - The ability to support individuals who are in the community who require rapid intervention;
  - Standardisation & equity of care provision through a single point of access;
  - Building trust, up-skilling across organisations & strengthening of clinical expertise within the community;
  - Training and education;
  - Completion of care assessments at home and support patients to achieve their preferred place of care/ death.

Integrated Approach Across Partners

- Patients will be supported based on assessed need by Midlands Partnership NHS Foundation Trust (MPFT) community staff; this will include both personal and clinical care as required.
- Onward referral to other services such as Hospice at Home will be facilitated through the Palliative Care Co-ordination Centre and community services
- The Hospices (Douglas MacMillan, Compton and St Giles) have worked collaboratively with the CCGs and MPFT to enable them to provide an enhanced offer of provision and to support the implementation & mobilisation of this pathway.

Anticipated benefits

- Opportunity to work with Hospices to support future commissioning arrangements/ models of care.
- Quality and patient centred response.
- Reduced delays in discharge/prevention of unnecessary acute admission.
- Minimal hand off.
- Clear lines of responsibility and governance.
- 7 day working 9-8.
- Opportunity to undertake change management approach, learning as we go, developing the process as it is rolled out.

Case Study: Staying Well Service (SWS)

- Responding to Frailty is one of the key transformational elements which underpins delivery of the NHS long term plan. The ambition locally is to develop new services for older people to proactively manage frailty and associated system consequences.

- The Staying Well Service (SWS) was co-designed with partner organisations including CCGs, GP practices, mental health and community trust, acute trusts, voluntary sector and GP Federations. Extensive stakeholder engagement resulted in a 12 week pilot which was evaluated and learning was used to inform further roll out.

- The Staying Well pathway uses a proactive population health approach, utilising system partners to enable earlier detection and planned interventions to prevent or delay progression to severe frailty. It can help to identify undiagnosed disorders such as heart failure or potential impacts of Covid-19 (both physical and mental) as well as supporting social inclusion using local support networks, communities, and the voluntary sector.

- During the first phase of the pathway, the model involves primary care identification of patients with mild-moderate frailty, using a combination of risk stratification tools, in some areas the model also includes a multi-disciplinary team meeting between the GP Practice and a Staying Well Facilitator to discuss individuals identified by the practice.

- Patients identified are then referred to a single point of contact, within a community provider, who maps which services the patient is currently engaged with. A Staying Well Facilitator (SWF) follows this stage with a home visit or a booked telephone call to complete a holistic assessment of the patient's needs. The patient can then be:
    - Case managed by a SWF; and/or
    - Referred into a commissioned service as appropriate.

- The second phase of the pathway, includes referring the most vulnerable patients to a Staying Well Hub where a multi-disciplinary team, including a consultant, therapist (addressing occupational therapy and physical requirements), memory services, prescribing pharmacist and community connector (a voluntary sector role to address social isolation), decide which professionals needs to see/speak to the patient, contribute to the individuals assessment and co-produce an action plan.

- This will then be communicated to the patient, tracked after attendance to ensure delivery, and communicated back to primary care.

- The service is currently delivered in South East Staffordshire and Seisdon CCG, Stafford and Surrounds CCG and will be rolled out to Cannock Chase CCG

- The SWS enhances coordination of care for the population and working this way means:
    - More care in people's homes and in their local neighbourhoods
    - Person-centred care (holistic), organised in collaboration with the individual and their carers
    - Better experience of care for people and their carers
    - Coordinated care that is pro-active and preventative, rather than reactive and episodic
    - Better value care and support at home, with less reliance on care homes and hospital based care
    - Less duplication and 'hand-offs'
    - Stronger, more resilient communities

- Work with front line teams has ensured colleagues from partner organisations feel like one team despite being employed by different organisations. The model is continually improving and with a 6 monthly Plan Do Study Act cycle in place.

- The service aims to contribute to the following system benefits:
    - Shared skills, information knowledge, expertise, and resources
    - Building strong trusting relationships across sectors & organisational boundaries
    - Building local connected communities linking with 3rd sector
    - Improving Population Health with partners, moving towards ICS
    - Delivering system priorities, recovery and planned costs out
    - Improved patient pathways and better outcomes

- Findings and recommendations from the Service evaluation will enable focus on key success factors for working in collaboration in the future, ultimately contributing to building a sustainable dynamic health and social care system.

Staying Well Service (SWS): Patient Story

Background of Case

- Referral sent by GP practice to the Staying Well Service Single Point Of Contact.
- Patient contacted same day to arrange assessment.
- Holistic Assessment by Staying Well Facilitator

- Patient lives alone in sheltered accommodation has been there for 21 years. Previously had a very active social life and lots going on at accommodation when she moved in. Accommodation is now supported living no meetings or groups in the building, all friends have moved out and patient feels very isolated.
- Past Medical History: Hypertension, Cataracts, Anxiety,

Identified Issues

- Poor vision due to cataracts so struggles to go far alone. Does walk into hospital ground 3-4 times weekly to sit on bench and talk with people.
- Mobility is deteriorating and now uses own stick, this appeared too tall in height.
- Is struggling to use bathing facilities at home and is at risk of falling. No aids in situ. Is independent with other daily living activities.
- Patient reports that she is concerned that her memory is deteriorating and is worried about this. Is low in mood and very tearful about the fact that life has changed and isn't as it used to be. Does not attend any lunch clubs or befriending groups as feels too low in mood.
- Son in 70's and has commitments with Grandchildren so cannot visit patient very often, however does food shopping on weekly basis.

Actions:

- Referral to Emotional Wellbeing Clinic for anxiety.
- OT saw patient in clinic and agreed to do a follow up home visit to complete a bathing and mobility assessment in own home.
- Voluntary Agency to locate social groups.

What difference did it make to the patient, their independence and wellbeing?

6 Week Review:

- Patient reports feeling more positive has Emotional Wellbeing Clinic appointment in 1 week.
- OT assessment has been very positive now has bathing aids and grab rails so life much easier. Has new walking stick at correct height and feels more confident.
- Has made contact with an afternoon group for natter and tea and has attended 1 session to date.
- Patient states that she feels supported and listened to now and feels more positive about life.

Has intervention been preventative?

- Early intervention by Occupational Therapist reducing risk of falls/injury and admission to hospital.
- Emotional support and allowing patient time to talk may have given her the confidence to link in with afternoon group, reducing social isolation.
- All services have been provided within a rapid time scale from referral to Staying Well Facilitator Anxiety, clinic and follow up
- All services have been provided within the patient's own local community
- Joined up working by Community Provider, GP, Acute Hospital and voluntary services

Case Study: Community Rapid Intervention Service (CRIS)

The proposed service model set out 2 components of a future Attendance/Admission Avoidance service, to support residents of care homes, frail older people and people with multiple LTC's, through engagement with senior acute and community health and social care practitioners in the Staffordshire system:

- **Unscheduled Care Coordination Centre (UCCC):** A single point of access as a viable alternative to ED/hospital attendance. Offering real time access to a senior clinician who will take responsibility for patient care. Referrers are treated as trusted assessors with rapid transfer of care. One Stop Shop where coordinators liaise with planned care services and arrange care as required
- **Community Rapid Intervention Service (CRIS):** A service which provides a two hour rapid clinical response to patients within their own homes. Offering assessment, diagnostics, prescribe and administer treatment, and ongoing review as an alternative to ED. A medical consultant lead multi-disciplinary team that ensures individuals get the most appropriate care. Right care in the right place, every time.

Healthcare professionals worked together to identify **several principles** that would underpin a future model:

- Our aim is to have one integrated model across our entire system (Pan Staffordshire).
- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to improve patient outcomes and experience through the prevention of avoidable non-elective emergency admissions
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- Personalised and timely care delivered within their usual place of residence
- Staff across organisations work together (co-locating where appropriate) to champion the 'home first' ethos.
- And the result of all these points - more people will remain and live more independently in their own homes.

Working this way means:

- Reduced pressure on the Emergency Department and hospital inpatient beds
- Reduced unnecessary admissions and decrease Healthcare Acquired Functional Decline (HAFD)
- Reduced level of deconditioning and increased dependency on Primary Care
- Improved patient outcomes and better experience
- No wrong door for someone that needs help.

The CRIS sought to measurably deliver the following outcomes:

- Reduction in non-elective emergency admissions to hospital by 4,173 per annum
- Equivalent to 22 admissions per day across the UHNM footprint
- Achieve £1.3m in efficiency savings
- Reduce ambulance conveyance by 20-25 a day

The service is **on track** to deliver the following outcomes by March 2021:

- Receive over 12,000 calls into the UCCC
- Accept on average 80 referrals a week from WMAS
- Complete over 6,500 CRIS patient visits
- Signpost/Refer approximately 1400 patients onto other Community Services
- Offer Clinical advice and support with clinical decision making for over 4000 patients
- UCCC will have prevented over 10,000 possible ED attendances
- CRIS will have prevented around 5,950 unnecessary hospital attendances/admissions following a patient contact

Community Rapid Intervention Service (CRIS) Patient Story

Background of Case

Frail 87 year old male with extensive co-morbidities presented as unconscious to District Nurses (DNs) on a routine visit.

Identified Issue

GCS was 3, with apnoeic episodes of 30-40 seconds. Likely massive stroke. NACPR in-situ but no ReSPECT form/ceilings of care in place, no palliative diagnosis and not expected to die imminently. Son was in London holding Lasting Power of Attorney for Health & Welfare. He was understandably distressed and requesting his father be conveyed to A&E.

Actions

West Midlands Ambulance Service paramedics attended, performed a full assessment, gathering the views of wife, son, care staff and DNs. They decided that although this gentleman was not in cardiac arrest he was clearly end-of-life and it was in his best interests to be made comfortable at home, with arrangements made for his family to be at his bedside.

A CRIS referral was made by the attending paramedics, and after discussions with the gentleman's son, he agreed his dad ought to be made comfortable at home.

An Advanced Clinical Practitioner visited, affirming the assessment made. A ReSPECT document and anticipatory medication to control any end-of-life symptoms, were put in place.

The gentleman's wife was able to attend to be with him and his son drove up from London.

In situations such as this, the easiest solution with the least resistance would be to convey the patient to A&E where he would have potentially passed away on a trolley, potentially after burdensome and invasive investigations/treatments.

It was a bold and brave decision to refer into CRIS and manage the gentleman at home, especially in light of his son's initial thoughts.

What difference did it make to the patient, their independence and wellbeing?

As a result of the referral the CRIS were able to put into place a clear plan for the gentleman to be managed comfortably in his preferred place of care, get the family including son on board and enable him to spend his final hours/days surrounded by his loved ones in a familiar setting.

Case Studies: Overcoming Challenges in Quality and Safety

Case Study 1 – Tissue Viability (Quality Assurance)

University Hospitals North Midlands (UHNM) observed an increase in pressure ulcer incidents reported during a three month period.

This increase was mainly related to Deep Tissue Injury. In particular there were six cases with potential infection transferred from the community.

In response to this Midlands Partnership NHS Foundation Trust (MPFT) and UHNM worked collaboratively to review the incidents and identify any key learning.

As a result of this joint review the two organisations have established a joint weekly review process that has enhanced communication and ongoing care for patients being transferred from one health provider to another.

Additionally MPFT have developed a patient information poster regarding risk factors associated with the development of pressure ulcers that has been shared with UHNM so that this can now be provided to patients on discharge.

Case Study 2 – Musculoskeletal and Community Physiotherapy Access Redesign North Staffordshire (Quality Improvement)

This work was facilitated by MPFT Quality Improvement Team and involved participants from MPFT, CCG, UHNM, Primary care, North Staffordshire Combined Healthcare and Keele University. Key elements of the work included:

- An away day training all attendees on QI, identifying opportunities to improve and looking at prioritising the major improvement work
- Progressing one of the priority areas around reviewing Access into the services.
- The development of a current state and vision the future state of how access might look, the aim is to reduce the wait times, standardise the access routes and to improve the operating consistency with the services to release capacity back into the services for clinical delivery.

Case Study 3 – Respiratory Pathway Redesign (Quality Improvement)

This work was facilitated by the CCG with support from MPFT Quality Improvement Team and involved participants from MPFT, UHNM, CCG, Primary Care, Staffordshire County Council and the voluntary sector.

The event was aimed at unifying and understanding where the cross cutting opportunities for improvement were.

QI principles were used to help frame the activities within the workshop which included a waste/values mapping exercise. This work is ongoing but currently paused due to Covid-19.

NHS
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Forecasting future impacts of Mental Health via COVID-19

Staffordshire & Stoke-on-Trent ICP

19th October 2021

MPFT

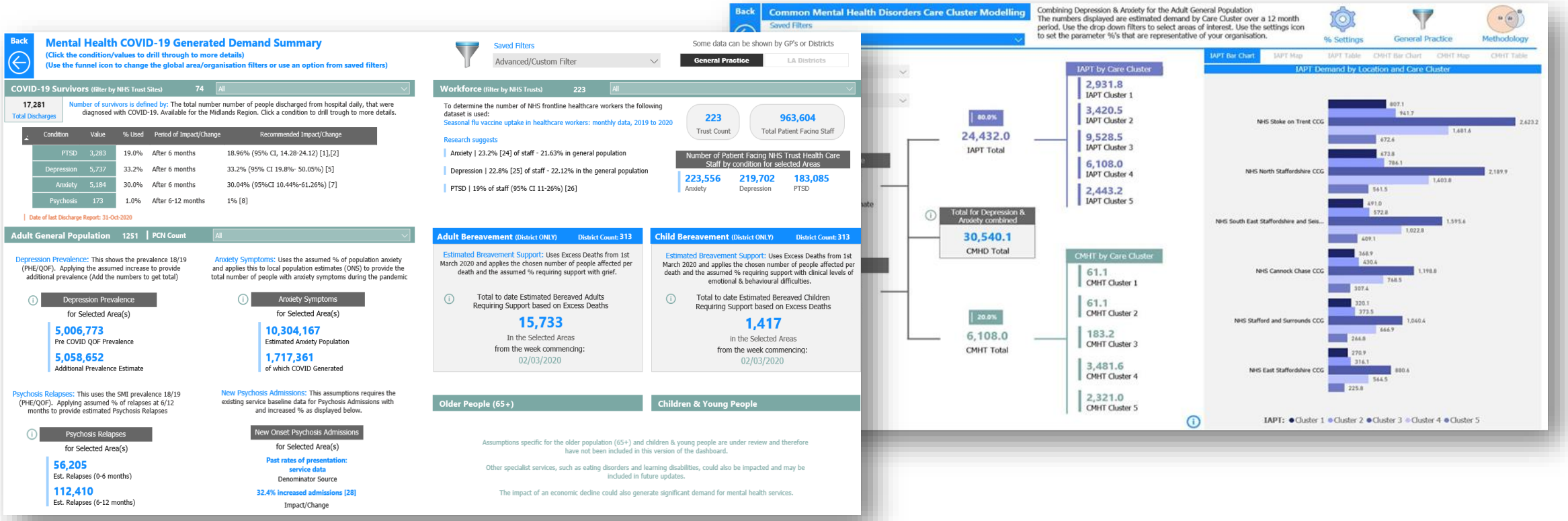
mpftnhs

@mpftnhs

Mental Health Dashboard

Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

MPFT's MH Dashboard is a strategic planning tool to support local planning decisions at Care Group level to help **predict the potential increase in new demand for our mental health services**. The dashboard includes the ability to expand the geographical and organisation structures to allow further filtering and drill down of data to GP/PCN/Trust level. The dashboard also shows estimated demand by Care Cluster over a 12 month period for the adult general population for common mental health disorders and the predicted increase in demand for our IAPT services – this can also be filtered by location.



Mental Health Dashboard

COVID-19 survivors in Staffordshire & Stoke-on-Trent ICP

NHS
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NHS Foundation Trust
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COVID-19 survivors is defined as patients who have been discharged from hospital following treatment for Covid-19.

As of 19th April 2021, **4,271** patients have been discharged from Staffordshire & Stoke-on-Trent ICP hospitals following treatment for COVID-19 since the start of the pandemic in March 2020.

Using evidence from studies relating to critical care patients and advice from consultant psychiatrists, we have modelled a number of patients that may develop certain mental health conditions following time spent in hospital with COVID-19. This has been applied to both non-critical care and critical care hospitalised patients.

- PTSD – **811** or **19%** patients after 6 months
- Depression – **1,418** or **33.2%** discharged patients after 6 months
- Anxiety – **1,281** or **30%** discharged patients after 6 months
- Psychosis – **43** or **1%** discharged patients after 6-12 months

Mental Health Dashboard

Midlands Partnership NHS Foundation Trust
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COVID-19 survivors SSOT – Depression & Anxiety

Weekly projected numbers per condition at 3/6 months from discharge

DEPRESSION	Estimated survivors with Depression	1,418

ANXIETY	Estimated survivors with Anxiety	1,281

COVID-19 Survivors (Depression)

Number of survivors is defined by: The total number number of people discharged from Hospital daily that were diagnosed with COVID-19.

Research suggests

Within the first 3 months 10.8 [3]-13.0% [4]

After 6 months 33.2% (95% CI 19.8%- 50.05%) [5]

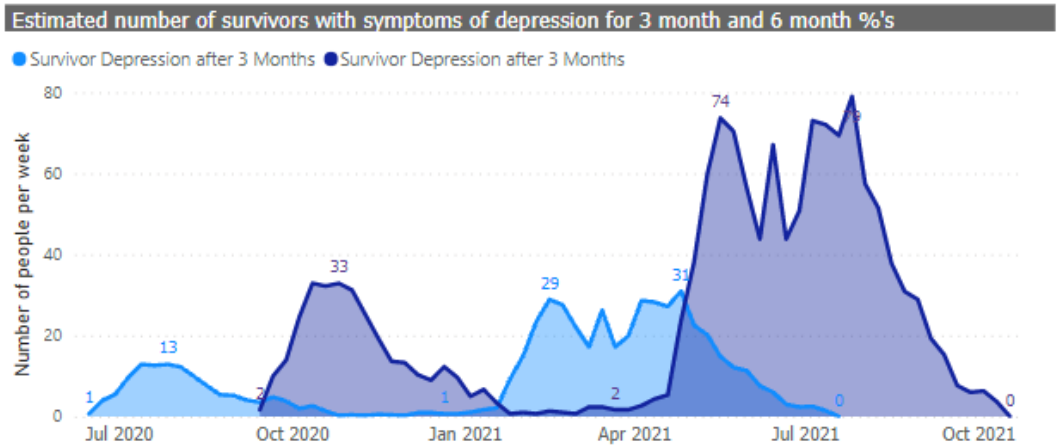
COVID-19 Survivors (Anxiety)

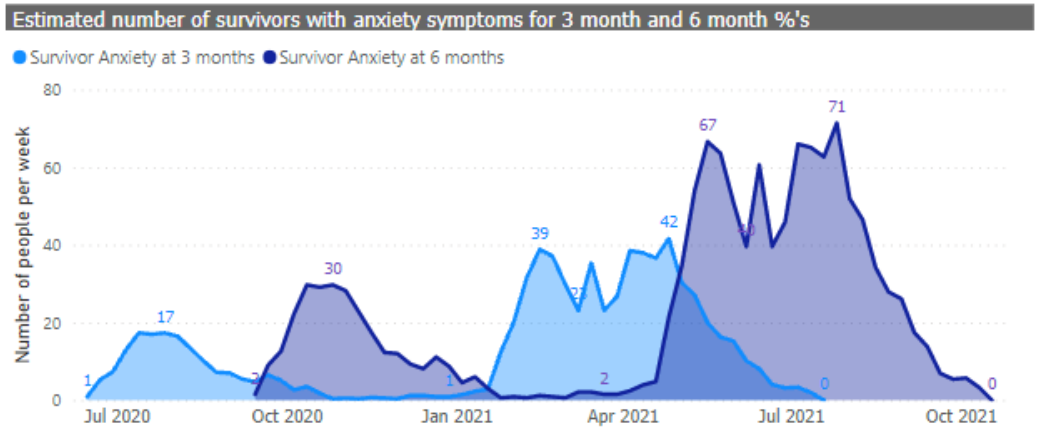
Number of survivors is defined by: The total number number of people discharged from Hospital daily that were diagnosed with COVID-19.

Research suggests

Within the first 3 months 13.5-17.5% [6]

After 6 months 30.04% (95%CI 10.44%-61.26%) [7]





Mental Health Dashboard

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COVID-19 survivors in SSOT – PTSD & Psychosis

Weekly projected numbers per condition at 6 months from discharge

PTSD	Estimated survivors with PTSD	811

COVID-19 Survivors (PTSD)

Number of survivors is defined by: The total number number of people discharged from Hospital daily that were diagnosed with COVID-19.

Research suggests

After 6 months 18.96% (95% CI, 14.28-24.12) [1],[2]

PSYCHOSIS	Estimated survivors with Psychosis	43

COVID-19 Survivors (New Psychosis)

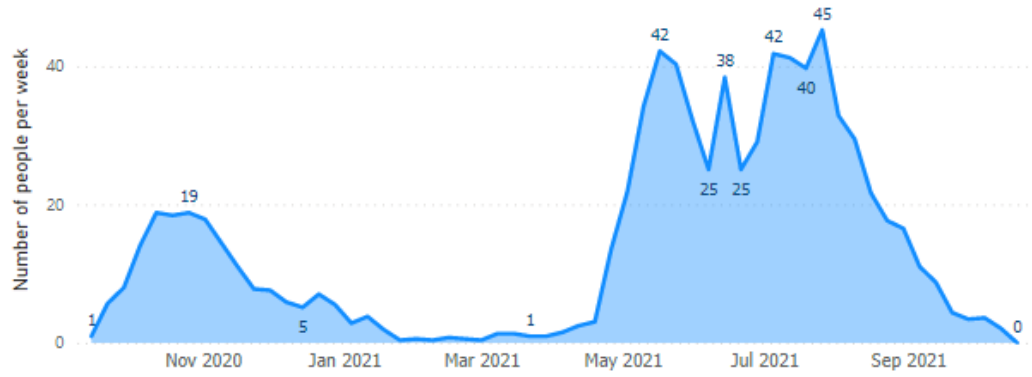
Number of survivors is defined by: The cummulative number number of people discharged from Hospital daily that were diagnosed with COVID-19.

Research suggests

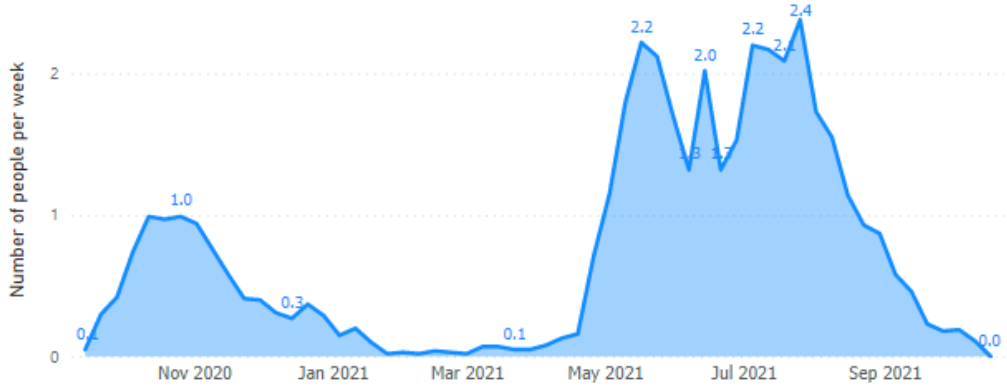
After 6-12 months 1% [8]

| Particularly scare evidence available, however, expert opinion is that 1% is reasonable.

Estimated weekly COVID-19 survivors with PTSD after 6 Months



Estimated weekly demand using the selected average time to present



Mental Health Dashboard

NHS
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Changes in mental health condition prevalence for the general adult population in Staffordshire & Stoke-on-Trent ICP

We have created a set of assumptions to model prevalence for Anxiety and Depression generated by the pandemic in the SSOT general adult population. This has been done using evidence from past viral epidemics, and emerging evidence from the current pandemic.

The assumptions suggest that there will be a significant increase in adults with anxiety and depression in Staffordshire & Stoke-on-Trent, however it is unclear how many and when these patients will present to mental health services. They also show significant potential relapses for known Psychosis patients.

The following slides show the breakdown of new prevalence for Anxiety and Depression, and Psychosis relapses, and how we've modelled the Anxiety and Depression prevalence into new presentations into SSOT mental health services.

Mental Health Dashboard

General/Mild Anxiety prevalence in Adult population

Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

Assumption: General Anxiety prevalence increased from **18%** pre-pandemic to **21.6%** for the duration of the pandemic.

The table below taken from the dashboard shows the new estimated prevalence in the area.

197,718 adults in Staffordshire & Stoke-on-Trent are now experiencing some general or mild anxiety.
This is an increase of **32,953** adults before the pandemic.

Location	% of Population 18+	Anxiety % During Pandemic	Estimated Total Population Anxiety	Generated Population Anxiety
ABOUT BETTER CARE (ABC) PCN (U93998)	76.7%	21.6%	6,815	1,136
BURNTWOOD PCN (U46695)	80.2%	21.6%	5,890	982
CANNOCK NORTH PCN (U12200)	79.7%	21.6%	7,212	1,202
CANNOCK VILLAGES PCN (U88414)	80.0%	21.6%	10,397	1,733
EAST STAFFORDSHIRE PCN (U57641)	78.4%	21.6%	23,155	3,859
HANLEY, BUCKNALL & BENTILEE PCN (U05734)	78.3%	21.6%	5,554	926
HIPC (HOLISTIC PATIENT CENTRED CARE) PCN (U06...	74.8%	21.6%	7,256	1,209
LEEK & BIDDULPH PCN (U12951)	80.9%	21.6%	8,766	1,461
LICHFIELD PCN (U64148)	80.3%	21.6%	7,488	1,248
MEIR PCN (U35724)	75.9%	21.6%	6,010	1,002
MERCIAN PCN (U79533)	78.9%	21.6%	15,265	2,544
MOORLANDS & RURAL PCN (U91937)	82.2%	21.6%	6,633	1,106
NEWCASTLE CENTRAL PCN (U36134)	80.8%	21.6%	7,051	1,175
NEWCASTLE NORTH PCN (U81818)	81.4%	21.6%	6,195	1,032
NEWCASTLE SOUTH PCN (U39113)	83.4%	21.6%	7,627	1,271
RUGELEY & GREAT HAYWOOD PCN (U16318)	80.2%	21.6%	7,117	1,186
SEISDON PCN (U56729)	80.8%	21.6%	8,760	1,460
SHELTON & HANLEY PCN (U87255)	76.8%	21.6%	5,377	896
SOUTH STOKE CENTRAL PCN (U85685)	78.9%	21.6%	8,419	1,403
SOUTH STOKE WEST PCN (U69072)	78.9%	21.6%	5,446	908
STAFFORD CENTRAL PCN (U08925)	79.4%	21.6%	6,649	1,108
STAFFORD NORTH PCN (U84263)	80.3%	21.6%	7,037	1,173
STAFFORD SOUTH PCN (U83494)	81.4%	21.6%	5,223	871
STONE & ECCLESHALL PCN (U04901)	81.1%	21.6%	5,747	958
WHITFIELD PCN (U36512)	78.9%	21.6%	6,629	1,105

Based on adult patient GP population totals from NHS Digital on 1st July 2020

Mental Health Dashboard

Depression prevalence in Adult population

Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

Assumption: General/mild depression increase of **99.2%** from a baseline of 2018/19 QOF depression prevalence.

The table below taken from the dashboard shows the new estimated prevalence in the area.

An additional **113,012** adults in Staffordshire & Stoke-on-Trent are now estimated to be experiencing some general or mild depression.

Location	Indicator Value	Eng Avg Comparison (Value Sort)	+/- Eng	Indicator Population (Pre-COVID)	New Estimated % Prevalence	Estimated Additional Prevalence
ABOUT BETTER CARE (ABC) PCN (U93998)	14.4%	↑	Higher	4,170	28.7%	4,466
BURNTWOOD PCN (U46695)	12.3%	↑	Higher	3,388	24.5%	3,324
CANNOCK NORTH PCN (U12200)	14.7%	↑	Higher	4,930	29.4%	4,891
CANNOCK VILLAGES PCN (U88414)	12.5%	↑	Higher	6,020	24.8%	5,955
EAST STAFFORDSHIRE PCN (U57641)	9.6%	↓	Lower	10,292	19.2%	10,230
HANLEY, BUCKNALL & BENTILEE PCN (U05734)	15.5%	↑	Higher	4,031	30.9%	3,959
HIPC (HOLISTIC PATIENT CENTRED CARE) PCN ...	15.3%	↑	Higher	5,032	30.4%	5,082
LEEK & BIDDULPH PCN (U12951)	12.4%	↑	Higher	5,080	24.6%	4,983
LICHFIELD PCN (U64148)	8.3%	↓	Lower	2,713	16.5%	2,906
MEIR PCN (U35724)	16.6%	↑	Higher	4,586	33.0%	4,603
MERCIAN PCN (U79533)	12.9%	↑	Higher	9,087	25.7%	9,035
MOORLANDS & RURAL PCN (U91937)	11.7%	↑	Higher	3,631	23.4%	3,579
NEWCASTLE CENTRAL PCN (U36134)	13.3%	↑	Higher	4,411	26.6%	4,332
NEWCASTLE NORTH PCN (U81818)	13.9%	↑	Higher	4,024	27.7%	3,961
NEWCASTLE SOUTH PCN (U39113)	13.3%	↑	Higher	4,784	26.6%	4,694
RUGELEY & GREAT HAYWOOD PCN (U16318)	10.4%	↓	Lower	3,411	20.6%	3,393
SEISDON PCN (U56729)	8.6%	↓	Lower	3,498	17.2%	3,473
SHELTON & HANLEY PCN (U87255)	13.3%	↑	Higher	3,252	26.4%	3,269
SOUTH STOKE CENTRAL PCN (U85685)	14.9%	↑	Higher	5,096	29.7%	5,840
SOUTH STOKE WEST PCN (U69072)	14.5%	↑	Higher	3,513	28.8%	3,559
STAFFORD CENTRAL PCN (U08925)	8.1%	↓	Lower	2,469	16.1%	2,474
STAFFORD NORTH PCN (U84263)	13.3%	↑	Higher	4,352	26.6%	4,332
STAFFORD SOUTH PCN (U83494)	9.1%	↓	Lower	2,216	18.1%	2,182
STONE & ECCLESHALL PCN (U04901)	12.1%	↑	Higher	3,259	24.2%	3,222
WHITFIELD PCN (U36512)	17.3%	↑	Higher	5,370	34.5%	5,268

Based on adult patient GP population totals from NHS Digital on 1st July 2020 and QOF depression prevalence 2018/19.

Mental Health Dashboard

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Modelling new common mental health disorders

Although we estimate significant increases in adults with anxiety and depression in Staffordshire & Stoke-on-Trent ICP, it is difficult to predict how many new patients will require support and when they would present to service. It is also worth noting that the wider effects of the pandemic on the public, i.e. social restrictions, economic impact, and bereavement, could be felt for the next few years.

We have created 3 scenarios based on the following assumptions:

- Combining generated Anxiety and Depression prevalence to create a single new prevalence for Common mental health disorders for SSOT.
- We also accounted for double counting by using a study based assumption:

  Cases when depression generated total is greater than generated Anxiety then the assumption is that approx. 72.3% of people with anxiety will have already been counted in the depression total;

  or

  Cases when Anxiety generated total is greater than generated Depression then the assumption is that approx. 80% of people with depression will have been counted in the anxiety total
- Every year 25% of new prevalence will have contact with Mental Health services.
- Three scenarios are based on different percentages of overall symptomatic adults seeking treatment:

  1. 25% 2. 50% 3. 75%
- 80% of patients to be seen by IAPT and 20% seen by other community mental health teams.

Mental Health Dashboard

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Modelling new common mental health disorders

Generated Depression & Anxiety Combined prevalence
122,140

Scenario 1: **25%** of new prevalence will present to service
Scenario 2: **50%** of new prevalence will present to service
Scenario 3: **75%** of new prevalence will present to service
Assuming 25% of each scenario will be seen each year

Scenario 1: 25%	Scenario 2: 50%	Scenario 3: 75%
6,107	12,214	18,321
IAPT Total	IAPT Total	IAPT Total
1,527	3,054	4,580
CMHT Total	CMHT Total	CMHT Total
7,634	15,268	22,901
Year Total	**Year Total**	**Year Total**

Mental Health Dashboard

Psychosis relapses in Adult population

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Assumption: 10% of known psychosis patients estimated to relapse in the first 6 months of the pandemic, rising to 20% during 6-12 months. *We have used the QOF SMI prevalence as a baseline for known psychosis patients.*

The table below taken from the dashboard shows the estimated number of psychosis relapses.

903 known psychosis patients in Staffordshire & Stoke-on-Trent will relapse in the first 6 months of the pandemic rising to **1,806** by 12 months.

Location	Indicator Value	Eng Avg Comparison (Value Sort)	+/- Eng	Indicator Population (Pre-COVID)	Estimated Relapses (0-6 months)	Estimated Relapses (6-12 months)
ABOUT BETTER CARE (ABC) PCN (U93998)	1.0%	↑	Higher	382	39	77
BURNTWOOD PCN (U46695)	0.8%	↓	Lower	278	28	56
CANNOCK NORTH PCN (U12200)	0.8%	↓	Lower	325	33	65
CANNOCK VILLAGES PCN (U88414)	0.7%	↓	Lower	407	41	82
EAST STAFFORDSHIRE PCN (U57641)	0.6%	↓	Lower	867	87	174
HANLEY, BUCKNALL & BENTILEE PCN (U05734)	1.1%	↑	Higher	361	37	73
HIPC (HOLISTIC PATIENT CENTRED CARE) PCN ...	1.1%	↑	Higher	501	51	101
LEEK & BIDDULPH PCN (U12951)	0.9%	↓	Lower	455	46	91
LICHFIELD PCN (U64148)	0.7%	↓	Lower	286	29	58
MEIR PCN (U35724)	1.0%	↑	Higher	362	37	73
MERCIAN PCN (U79533)	0.8%	↓	Lower	700	70	140
MOORLANDS & RURAL PCN (U91937)	0.7%	↓	Lower	274	28	55
NEWCASTLE CENTRAL PCN (U36134)	1.0%	↑	Higher	401	41	81
NEWCASTLE NORTH PCN (U81818)	0.7%	↓	Lower	262	27	53
NEWCASTLE SOUTH PCN (U39113)	0.8%	↓	Lower	336	34	68
RUGELEY & GREAT HAYWOOD PCN (U16318)	0.7%	↓	Lower	275	28	55
SEISDON PCN (U56729)	0.6%	↓	Lower	308	31	62
SHELTON & HANLEY PCN (U87255)	1.1%	↑	Higher	347	35	70
SOUTH STOKE CENTRAL PCN (U85685)	0.8%	↓	Lower	342	35	69
SOUTH STOKE WEST PCN (U69072)	0.8%	↓	Lower	253	26	51
STAFFORD CENTRAL PCN (U08925)	0.5%	↓	Lower	196	20	40
STAFFORD NORTH PCN (U84263)	1.0%	↑	Higher	409	41	82
STAFFORD SOUTH PCN (U83494)	0.7%	↓	Lower	201	21	41
STONE & ECCLESHALL PCN (U04901)	0.7%	↓	Lower	219	22	44
WHITFIELD PCN (U36512)	0.7%	↓	Lower	281	29	57

Based on adult patient GP population totals from NHS Digital on 1st July 2020 and QOF SMI prevalence 2018/19.

Mental Health Dashboard

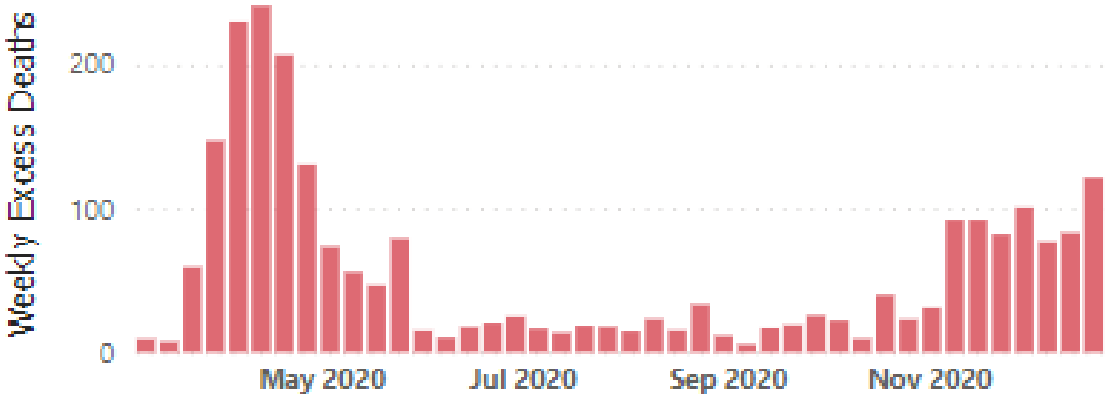
Bereaved Adults requiring support

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Assumption: 9.8% of bereaved adults will develop prolonged grief disorder beyond 6 months.

The denominator is calculated using number of excess deaths since the start of the pandemic multiplied by the average household size in each area.

Excess deaths from 2nd March to 21st December 2020



Local Authority District	Excess Deaths per 100,000 of Total Population	Total Excess Deaths	Affected Coefficient	Bereaved Adults Requiring Support
Cannock Chase	167	167	2.29	37
East Staffordshire	237	282	2.33	64
Lichfield	251	261	2.34	60
Newcastle-under-Lyme	220	285	2.25	63
South Staffordshire	205	230	2.31	52
Stafford	211	286	2.23	63
Staffordshire Moorlands	201	197	2.23	43
Stoke-on-Trent	197	503	2.30	113
Tamworth	224	172	2.34	40

535 bereaved adults in Staffordshire & Stoke-on-Trent will develop prolonged grief disorder.

Based on average household size from ONS projected to 2020, excess deaths compared with previous 5 year average.

Mental Health Dashboard

NHS trust frontline staff

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Patient facing Health Care Workers NHS Trusts

To determine the number of NHS frontline healthcare workers the following dataset is used: *Seasonal flu vaccine uptake in healthcare workers: monthly data, 2019 to 2020*

4
Trust Count

23,942
Total Patient Facing Staff

Research suggests

- Anxiety | 23.2% [24] of staff - 21.63% in general population
- Depression | 22.8% [25] of staff - 22.12% in the general population
- PTSD | 19% of staff (95% CI 11-26%) [26]

Number of Patient Facing NHS Trust Health Care Staff by condition for selected Areas

5,555	5,459	4,549
Anxiety	Depression	PTSD

Name	Code	Staff Count	Anxiety	Depression	PTSD
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	RRE	4,510	1,046	1,028	857
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	RLY	1,405	326	320	267
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	RTG	8,135	1,887	1,855	1,546
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	RJE	9,892	2,295	2,255	1,879

Mental Health Dashboard

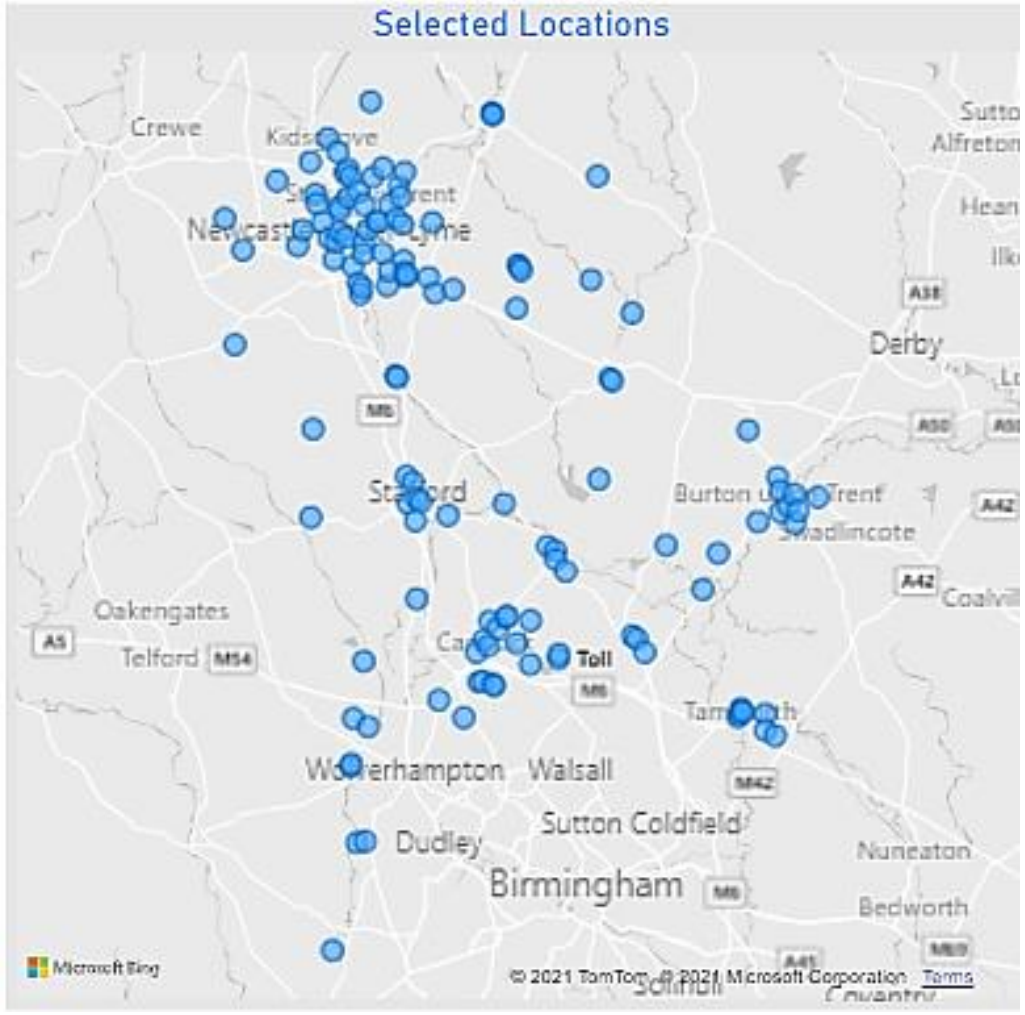
Appendix 1: GPs included in prevalence denominators

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<u>CCG's</u>

NHS Stoke on Trent CCG
NHS North Staffordshire CCG
NHS South East Staffordshire and Seisdon Peninsula CCG
NHS Cannock Chase CCG
NHS Stafford and Surrounds CCG
NHS East Staffordshire CCG

23 PCN's & 148 GP's

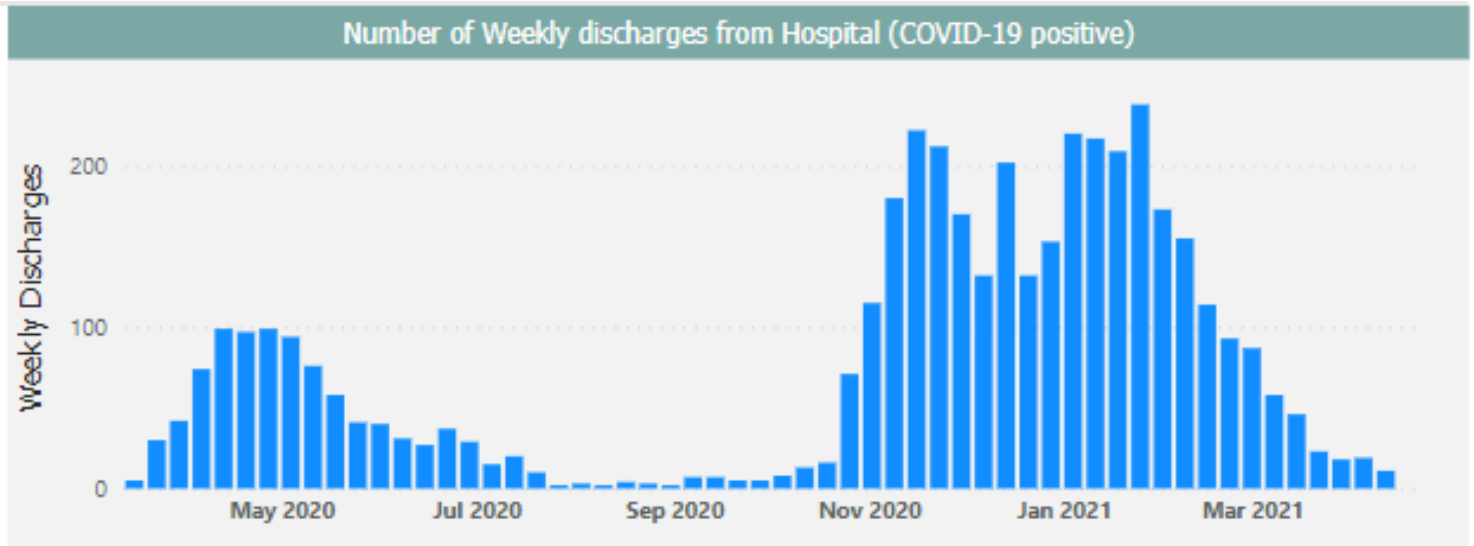


Mental Health Dashboard

Appendix 2: Covid-19 discharges from SSOT Hospitals

Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

DISCHARGES	COVID-19 discharges up to 14/04/2021	4,271



NHS Trusts included:

Midlands Partnership NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
University Hospitals of North Midlands NHS Trust
University Hopsitals of Derby and Burton NHS Foundation Trust *(Only Burton Hospital totals included for discharges)*

Benchmarking Network

Adult and Older People Mental Health Benchmarking

NHS Benchmarking Network

Inpatient and Community Mental Health Benchmarking



Weighted Report for MH181

Final November 2021





Adult and Older People Mental Health Benchmarking

Inpatient and Community Mental Health Benchmarking

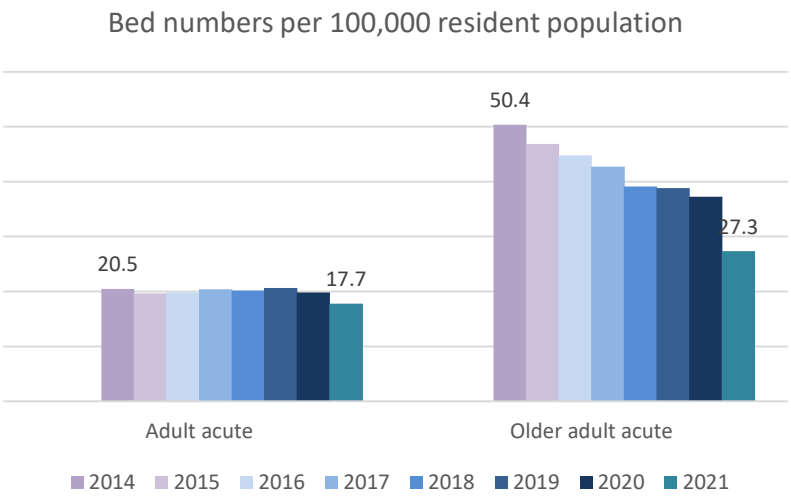
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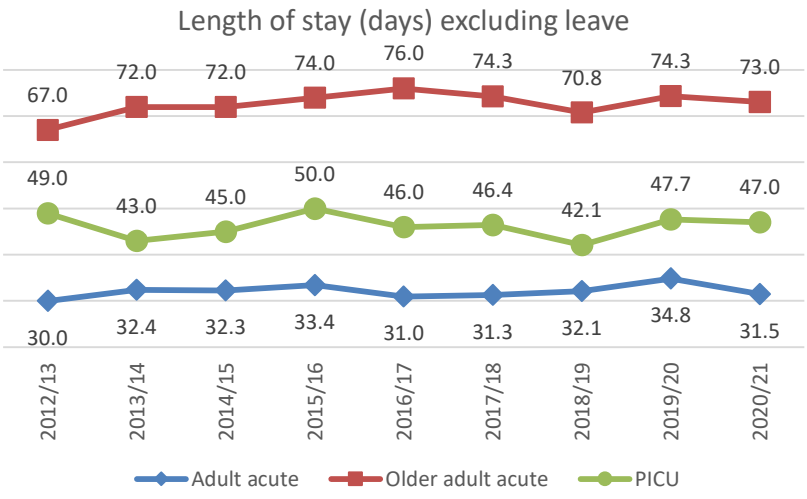
Benchmarking Network

Executive Summary

This report provides an overview of the findings from this year's NHS Benchmarking Network Mental Health project. The key findings are summarised on the following pages at UK level. This is then followed by a bespoke dashboard showing your organisation's unique position on key metrics. The metrics reported generally use two main milestones; either full year 2020/21 data, or the census position observed at 31st March 2021. Readers should note the impact of the Covid-19 pandemic on both of these positions with the significant disruption to services throughout the financial year. Readers should also note that the 2020/21 benchmarking report has been based on Office for National Statistics (ONS) populations which have been aggregated at Trust level. NHS BN's Mental Health Reference Group agreed to move away from GP registered population denominations due to the significant and ongoing list inflation issue evident in GP registers.



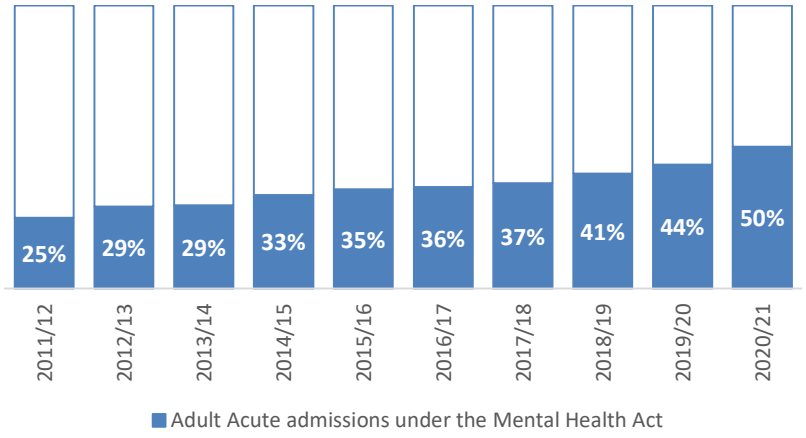
The number of adult acute and older adult acute beds has been declining in recent years. Adult acute beds showed a broadly stable position in 2020/21, whereas beds for older adults have continued the reductions evident in recent years.



Lengths of stay have decreased in older adult acute, adult acute and PICU services. The reductions are greater in the acute services, particularly evident in adult acute beds where there was a 3.3 days reduction when compared to 2019/20.

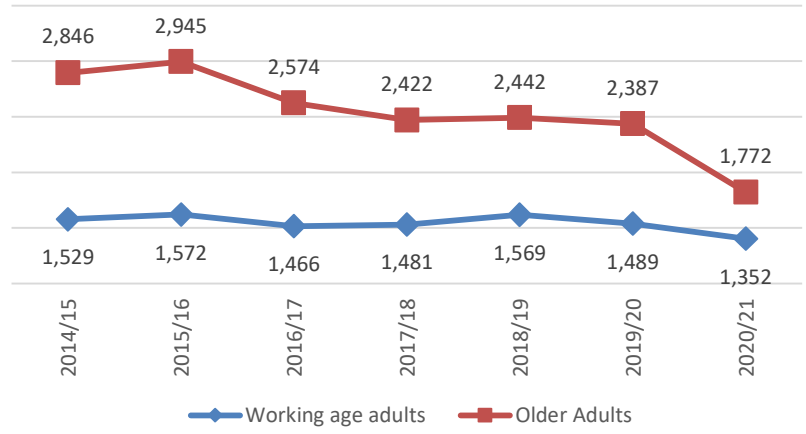
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Adult acute admissions detained at point of admission



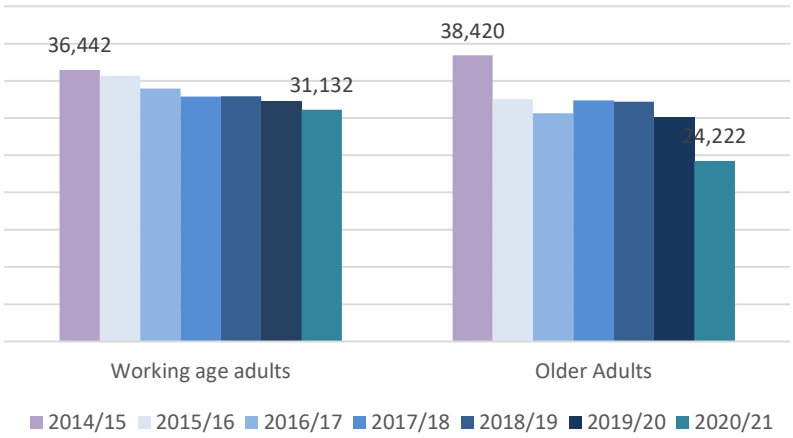
The proportion of adult acute admissions detained at the point of admissions has been increasing throughout the lifetime of the data collection. This year the rate has increased to 50.1%, meaning just over half of all admissions are now detained at the point of admission.

Community caseload per 100,000 resident population



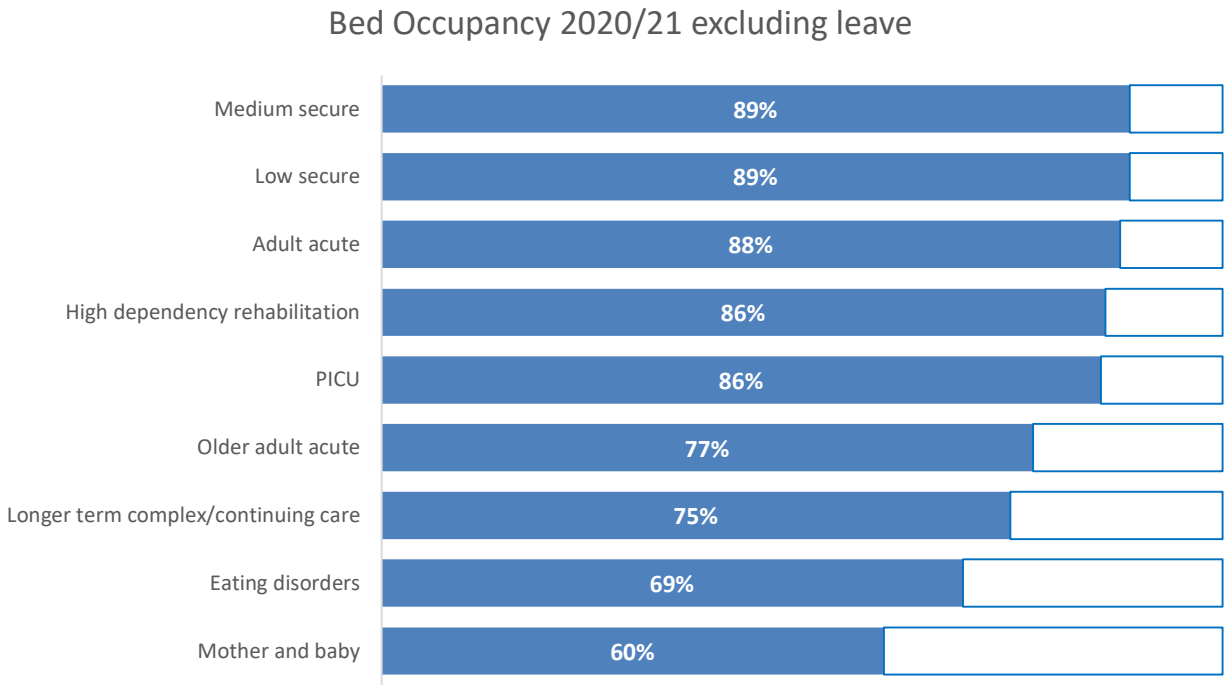
The older adult community caseload has continued to reduce in 2020/21. Whereas the community caseloads for working age people has increased after a period of relative stability.

Contacts delivered per 100,000 resident population



As with caseloads, the number of contacts for working age adults has increased in 2020/21. For older adults contacts have stabilised after many years of decline.

Bed occupancy



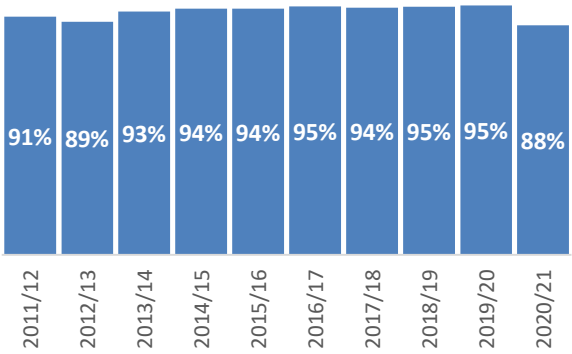
The Royal College of Psychiatrist's recommended bed occupancy level of 85% excluding leave remains challenging for many bed types. This is due to a combination of factors including demand, admission levels, length of stay and bed numbers. The highest bed occupancy rate are reported in Low and Medium secure services, where an average position of 89% was reported for both services during 2020/21.

The charts on the following page show that bed occupancy rates have reduced across all bed types. Longer term complex / continuing care and older adult beds saw the largest reductions in bed occupancies with an 11% reduction in each. Adult acute and eating disorder bed occupancies reported reductions of 7% to reach a record low due to the impact of the Covid-19 pandemic.

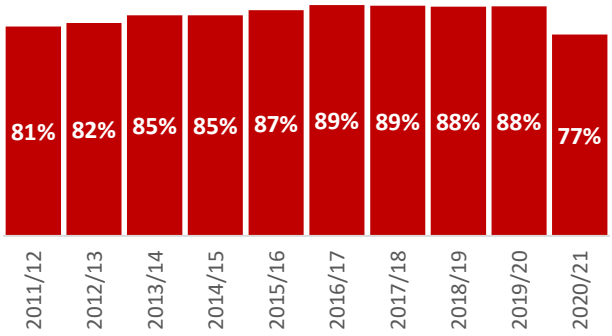
The pandemic brought about ward closures and increased distancing along with patient discharges which all impacted on bed occupancies.

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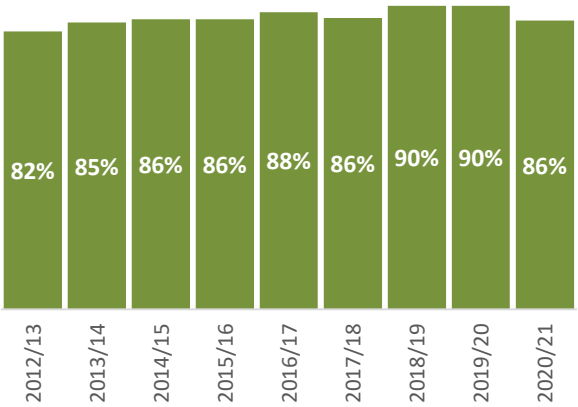
Adult acute bed occupancy excluding leave



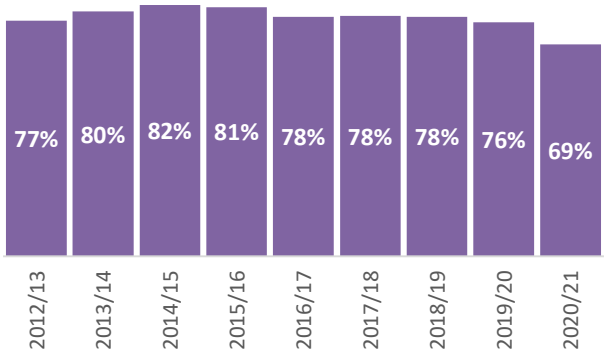
Older adult bed occupancy excluding leave



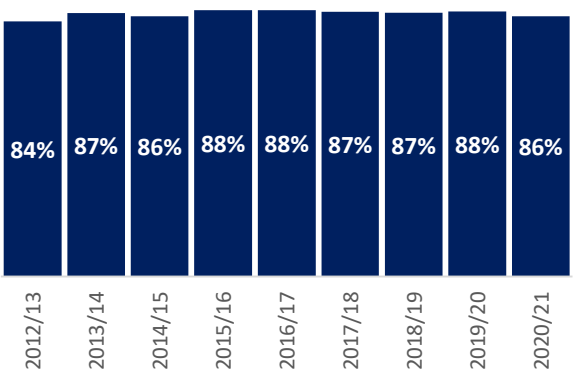
PICU bed occupancy excluding leave



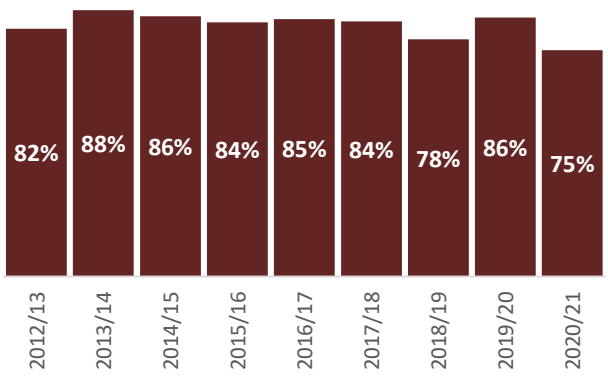
Eating disorder bed occupancy excluding leave



High dependency rehabilitation bed occupancy excluding leave

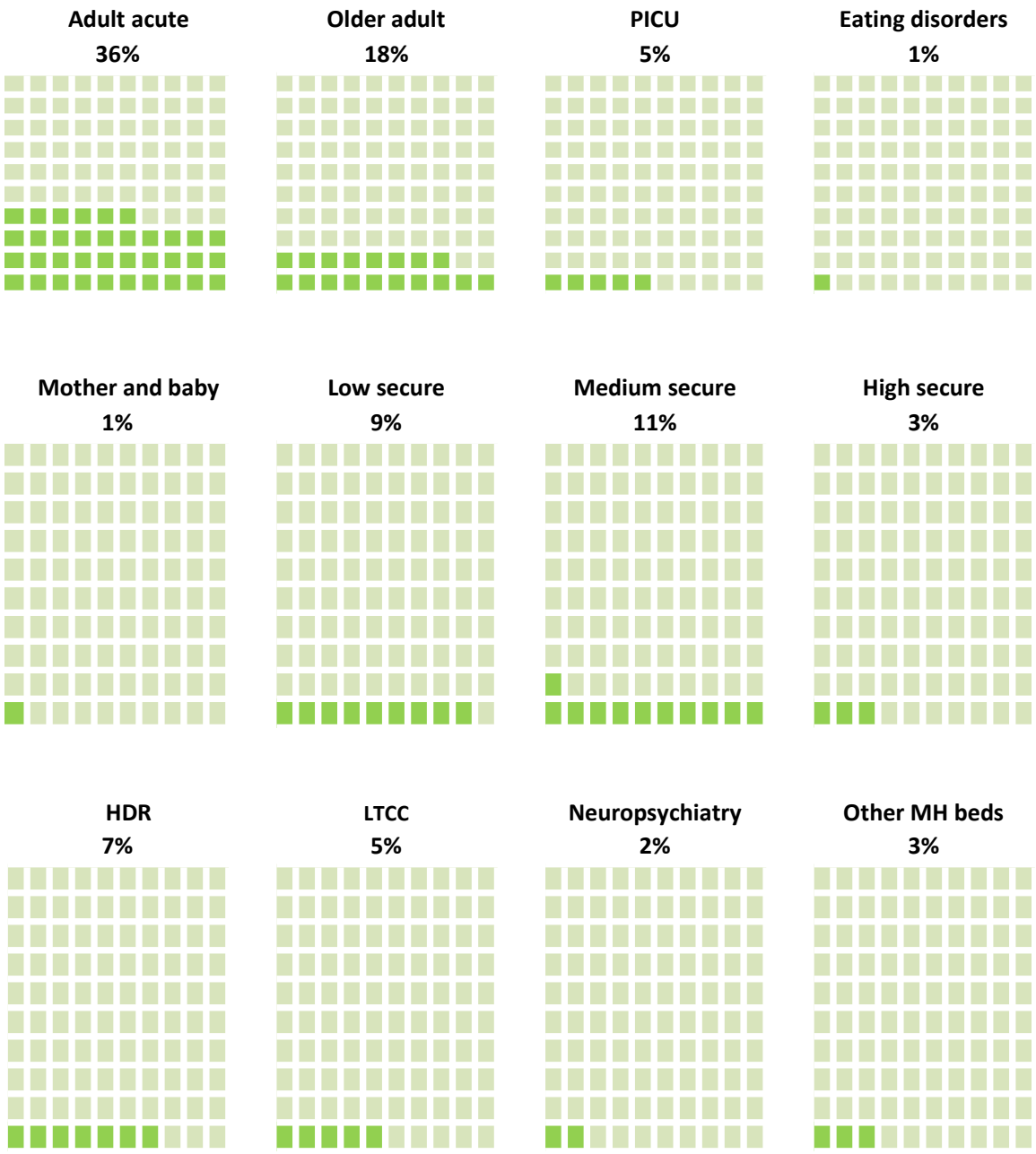


Longer term complex / continuing care bed occupancy excluding leave



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Bed Profile - national position of beds by specialty

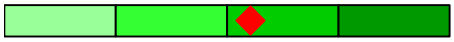
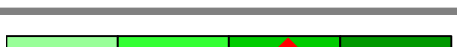
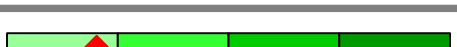


Acute admissions beds for adults and older adults together represent 54% of the total UK NHS mental health bed stock on 31st March 2021. This is a reduction of 4% on the previous year, with corresponding increases in beds for PICU, Low Secure, High Dependency, Long Term / Continuing Care and Neuropsychiatry. The change in bed profile is a consequence of the pandemic where reductions in beds were seen in general areas, but beds of a more specialist nature were less impacted (or increased in some specialties eg PICU). Just under a quarter (23%) of beds were in Low, Medium and High secure categories. However, this position is for NHS providers across the UK and does not include all independent sector providers who offer a range of specialist bed types including secure, eating disorder and rehabilitation.

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Dashboard

The following dashboard shows your organisation's position on key metrics included within this report, compared to other participants. It highlights which quartile your organisation's response falls into when all participants are ranked. It should be noted, however, than on some metrics the range is small and therefore being low or high is only relative to other responses, and may not signify a high or low outlying position.

Metric	Low – High	MH181	National Mean	National Median
Adult acute beds per 100,000 weighted population at 31st March 2021		12.8	18.2	17.7
Adult acute bed occupancy rates (excluding leave)		88%	87%	88%
Adult acute mean length of stay (excluding leave)		24	31	32
Adult acute admissions under the Mental Health Act		46%	50%	50%
Adult acute registered nurses per 10 beds		6.2	7.6	7.5
Adult acute WTE vacancies as % of staff in post		17%	12%	13%
Adult acute cost per bed		£147,315	£163,925	£160,692
Adult acute restraint per 10,000 occupied bed days		162	159	141
Adult acute prone restraint per 10,000 occupied bed days		6	23	18
Older adult beds per 100,000 weighted population at 31st March 2021		8.9	31.5	27.3
Older adult bed occupancy rates (excluding leave)		85%	76%	77%
Older adult mean length of stay (excluding leave)		47	73	69
Total community caseload per 100,000 weighted population at 31st March 2021		1,806	1,439	1,339
Total community contacts per 100,000 weighted population		32,307	28,951	28,544
Community total WTE per 100,000 weighted population (age 16+)		69.7	86.7	79.7
Generic CMHT cost per patient on caseload (Caseload at 31st March 2021)		£3,851	£4,077	£3,766



Introduction

This year is the 10th anniversary of the NHS Benchmarking Network providing comprehensive analytics to the UK mental health sector. The breadth and depth of data collected by NHSBN over this period allows for detailed time-series comparisons to be conducted as well as commenting authoritatively on the position of UK mental health services. The longitudinal analysis possible from the 10 years of data helps to develop a narrative on how NHS commissioned mental health services have evolved over time. Much of this narrative reinforces national policies such as the expansion of community based care, and wider strategies such as the commitment to quality and transparency evident in the current focus on reducing the use of restrictive practices in mental health services.

The annual NHSBN mental health benchmarking reports have become fixed points in understanding how the mental health sector is performing and how new policies and the financial framework impact on the size and shape of the sector. 2020/2021 has been a unique year with the impact of the Covid 19 pandemic emerging during March and the decision to impose UK national lockdowns at points throughout the year. The impact of Covid in terms of service disruption, recovery, and transformation is clearly outlined in the monthly reports that NHSBN have provided across mental health, learning disability and autism services across the UK. Almost all UK NHSBN member organisations are actively submitting data to our monthly Covid reporting project, and this work should be referred to in explicitly understanding the impact of Covid which is an evolving story containing ongoing uncertainty.

The impact of Covid-19 is evident in some of the 2020/21 benchmarking data with the recovery of services from the initial disruption. In inpatient services there is clear evidence of a reduction in length of stay and bed occupancy. This year marks the first year where the rate of adult acute admissions detained under the mental health act has increased above 50%, meaning over half of all admissions are now detained at the point of admission. Overall community caseloads and contacts have increased when compared to the previous year and with referrals increasing providers may need to prepare for increases in demand. Part of the Covid-19 response has been a switch to digital care in adult mental health services which helped to continue service access during extended periods of national lockdown and social isolation. The introduction of industrial scale telephone based care also helped maintain service contact rates although most providers acknowledge this as a short to medium term offer.

Detailed findings will be presented at this year's mental health benchmarking conference which will take place on Microsoft Teams at 2pm on Friday 8th October 2021.

The NHSBN team would like to extend our thanks to all member organisations for their contribution to the 2021 benchmarking cycle and wider work programme.

Julian Emms
Chief Executive
Berkshire Healthcare NHS Foundation Trust
and Chair, NHSBN Mental Health Reference Group

Stephen Watkins
Director
NHS Benchmarking Network



Populations

The use of population denominators is central to benchmarking in the NHS enabling a wide range of per capita comparisons to be produced. This is especially valuable where services are provided on a direct one to one relationship between providers and local populations and not disrupted by multi-provider models. Statutory NHS mental health services lend themselves well to this discipline and provide a reliable basis for benchmarking core services such as Adult Acute and Older Adult inpatient care, and community mental health services. Specialist services provided to wider or even national population footprints are not possible to benchmark reliably on a per capita basis.

Population denominators have been changed this year to be based on Office for National Statistics weighted populations after previously being based on GP registered populations. The populations have been compiled using weighted population footprints agreed with participant Trusts and Health Boards. Providers typically submit population profiles to NHSBN as part of the annual data collection process. Longitudinal trend data has been adjusted to reflect weighted populations to ensure like-for-like comparisons.

The shift to weighted populations was discussed and agreed with the Mental Health Reference Group and the change was made because of inaccuracies with the GP registered population data which had become significantly inflated over time in the NHS in England.

The last edition of the NHS England Exposition Book was published in 2015 and following this point reference was instead made to NHS England's published CCG population baseline data to help define NHS Trust mental health population catchments. This data was provided to member organisations each year so that members could refer to this source if necessary to help describe local population size. The source of NHS England's CCG baseline population data is NHS Digital's GP Practice registered populations which are aggregated to CCG level. Over the last 5 years these population totals have become increasingly over-stated due to the impact of GP list inflation. For example, by 2019 national mid-year population estimates for England published by the Office for National Statistics and Eurostat estimated England's population at 55.98 million.

However, the NHS Digital CCG registered population were above this level with 4 million additional people counted. The lack of veracity of the NHS Digital GP registered population position as a proxy for England's population size impacts on the source populations used by some providers as part of their benchmarking submission.

NHS England's Exposition Book also included calculations on a range of population mental health needs which formed the basis of weighted population totals which were subsequently used to issue needs adjusted weighted population benchmarking reports for English providers. These will continue to be used and applied to weighted population figures. Weighted population based benchmarking reports will be issued to English Trust providers in October 2021.

Data from Wales, Northern Ireland and Scotland is not prone to the risks outlined in using GP registered population totals as list inflation rates are much lower in these countries. However, weighted needs adjusted populations for these countries are not published so providers in these countries do not receive a weighted population report.



Reference Group

We would like to thank members of the Mental Health Reference Group who helped shape this year's collection and provided interpretation on findings.

Adrian Clarke	NHS Wales
Allan Fairlamb	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Andy Blaxill	Hertfordshire Partnership NHS Foundation Trust
Anna Foster	Northumberland, Tyne and Wear NHS Foundation Trust
Anne Thompson	Lancashire and South Cumbria NHS Foundation Trust
Annette Walliing	Surrey and Borders Partnership NHS Foundation Trust
Arokia Antonysamy	Cygnet Healthcare
Babs Dhillon	West London NHS Trust
Belinda Iringe-Koko	Central and North West London NHS Foundation Trust
Bernadette Chinnock	Avon and Wiltshire Mental Health Partnership NHS Trust
Bobby Mitik	National Collaborative Commissioning Unit NHS Wales
Caroline Brown	Coventry and Warwickshire Partnership NHS Trust
Caroline Winstone	NHS Wales Health Collaborative
Catherine Magee	Berkshire Healthcare NHS Foundation Trust
Charles Sant	Surrey and Borders Partnership NHS Foundation Trust
Chris Lanigan	Tees Esk and Wear Valleys NHS Foundation Trust
Chris Woon	Gloucestershire Health and Care NHS Foundation Trust
Dawn Painter	NHS Wales
Debbie Croft	Priory Group
Deborah Cundey	Sheffield Health & Social Care NHS Foundation Trust
Donna Hanson	Greater Manchester Mental Health NHS Foundation Trust
Doug Stewart	Surrey and Borders Partnership NHS Foundation Trust
Elaine Eannetta	Black Country Healthcare NHS Foundation Trust
Elspeth Clark	Central and North West London NHS Foundation Trust
Hamida Deemer	Pennine Care Foundation Tryst
Jagtar Singh	Coventry and Warwickshire Partnership NHS Trust
James Thackray	Hertfordshire Partnership NHS Foundation Trust
Janet Mcdonald	Mersey Care NHS Foundation Trust
Janette Leonard	Essex Partnership University NHS Foundation Trust
Jayne Flynn	Coventry and Warwickshire Partnership NHS Trust
Joanna Wood	Midlands Partnership NHS Foundation Trust
Julian Emms	Berkshire Healthcare NHS Foundation Trust
Keeley Twigg	NHS Wales
Kevin Wilkinson	Greater Manchester Mental Health NHS Foundation Trust
Lea Marsden	Betsi Cadwaladr University Health Board
Lee Cornell	Somerset Partnership NHS Foundation Trust



Lindsey White	Dorset Healthcare University NHS Foundation Trust
Louise Lloyd	Black Country Healthcare NHS Foundation Trust
Lyn Sansom	Gloucestershire Health and Care NHS Foundation Trust
Mandip Bal	Black Country Healthcare NHS Foundation Trust
Mark Polczyk-Przybyla	South London and Maudsley NHS Foundation Trust
Michelle Blackler	Avon and Wiltshire Mental Health Partnership NHS Trust
Mike Garnham	South West Yorkshire Partnership NHS Foundation Trust
Miranda Washington	Greater Manchester Mental Health NHS Foundation Trust
Mohit Venkataram	East London NHS Foundation Trust
Paul McCabe	Northern Health and Social Care
Philip Horner	Lancashire Care NHS Foundation Trust
Richard Morris	Public Health Wales
Richard Morton	South West London and St George's Mental Health NHS Trust
Rony Arafin	Devon Partnership NHS Trust
Sally Wilson	Hertfordshire Partnership NHS Foundation Trust
Sarah Meakin	Black Country Healthcare NHS Foundation Trust
Sarah Smith	Tees Esk and Wear Valleys NHS Foundation Trust
Sarah Stockham	Dorset Healthcare University NHS Foundation Trust
Shane Mills	NHS Wales
Sophie Trim	Dorset Healthcare University NHS Foundation Trust
Tania Hudson	Lancashire and South Cumbria NHS Foundation Trust
Toby Rickard	Avon and Wiltshire Mental Health Partnership NHS Trust
Tracey Reynolds	Dorset Healthcare University NHS Foundation Trust
Tracy White	Central and North West London NHS Foundation Trust
Vicki Bull	Oxford Health NHS Foundation Trust
Vicky Boswell	North Staffordshire Combined Healthcare NHS Trust
Wendy Harlow	Sussex Partnership NHS Foundation Trust
Yogita Dawda	Central and North West London NHS Foundation Trust



Participants

Participant organisations for 2021 are as follows:

England
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield and Haringey Mental Health Trust
Berkshire Healthcare NHS Foundation Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Black Country Healthcare NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Cheshire & Wirral Partnership NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Coventry & Warwickshire Partnership NHS Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership NHS Trust
Dorset HealthCare University NHS Foundation Trust
East London NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Gloucestershire Health and Care NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Hereford and Worcestershire Health and Care NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Humber Teaching NHS Foundation Trust
Isle of Wight NHS Trust
Kent and Medway NHS and Social Care Partnership Trust
Lancashire and South Cumbria NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Livewell South East
Mersey Care NHS Foundation Trust
Midlands Partnership NHS Foundation Trust
Navigo Health and Social Care CIC
Norfolk and Suffolk NHS Foundation Trust
North East London NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
North West Boroughs Healthcare NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust
Rotherham, Doncaster and South Humber NHS Foundation Trust



Sheffield Health and Social Care NHS Foundation Trust
Solent NHS Trust
Somerset Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South West London & St George's Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
West London NHS Trust

Wales
Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff & Vale University Health Board
Cwm Taf Morgannwg University Health Board
Hywel Dda University Health Board
Powys Teaching Health Board
Swansea Bay University Health Board

Scotland
NHS Greater Glasgow and Clyde

Northern Ireland
Belfast Health and Social Care Trust
Northern Health and Social Care Trust
South Eastern Health and Social Care Trust

Channel Islands
States of Jersey

Other
Cygnet Health Care
St Andrew's Healthcare

Cambridgeshire and Peterborough NHS Foundation Trust, Southern Health and Social Care Trust (NI) and Western Health and Social Care Trust (NI), were not able to update their data due to capacity issues relating to the Covid-19 pandemic.



Terms of Reference

The terms of reference for the project have been developed by the Mental Health Benchmarking Reference Group. They reflect the project's overall objectives and are reviewed by the reference group on an on going basis.

The terms of reference for the Mental Health benchmarking project are:

-To develop a specification for benchmarking mental health services
-To support members in collecting consistent data
-To process data and produce comparisons for member organisations
-To validate data and ensure comparisons are robust
-To produce detailed analysis reports for members
-To support a desktop benchmarking toolkit and other reporting formats for members
-To develop conclusions on the results of mental health benchmarking
-To help identify and share good practice amongst member organisations
-To support on going improvements within the mental health sector
-To facilitate networking and communications amongst member organisations

Wider objectives of contributing to continuous service improvement are taken forward by the NHS Benchmarking Network through the knowledge exchange and networking services provided by the Network.

Mental health is an important aspect of the NHS Benchmarking Network's wider work programme and will continue as an on going area of project work in future years. The commitment to enhance and develop the Network's mental health workstream in upcoming years provides an excellent platform for future service provision to members and engagement with the wider mental health community.

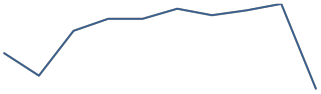
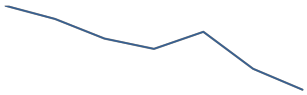
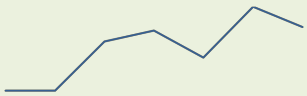
Members should also note that additional products are available to mental health providers that support further analysis on other aspects of services offered by many mental health providers. Examples include CYPMHS benchmarking and a range of bespoke projects undertaken with members, a survey of the IAPT workforce and the Covid-19 Monthly Tracker for Mental Health, Learning Disability and Autism.

Further projects of interest to mental health provider organisations include projects on learning disabilities, community physical healthcare services and pharmacy, which contain elements of relevance to many Trusts and Health Boards. All of these products can be accessed from the NHS Benchmarking Network's website.

www.nhsbenchmarking.nhs.uk

Benchmarking Network

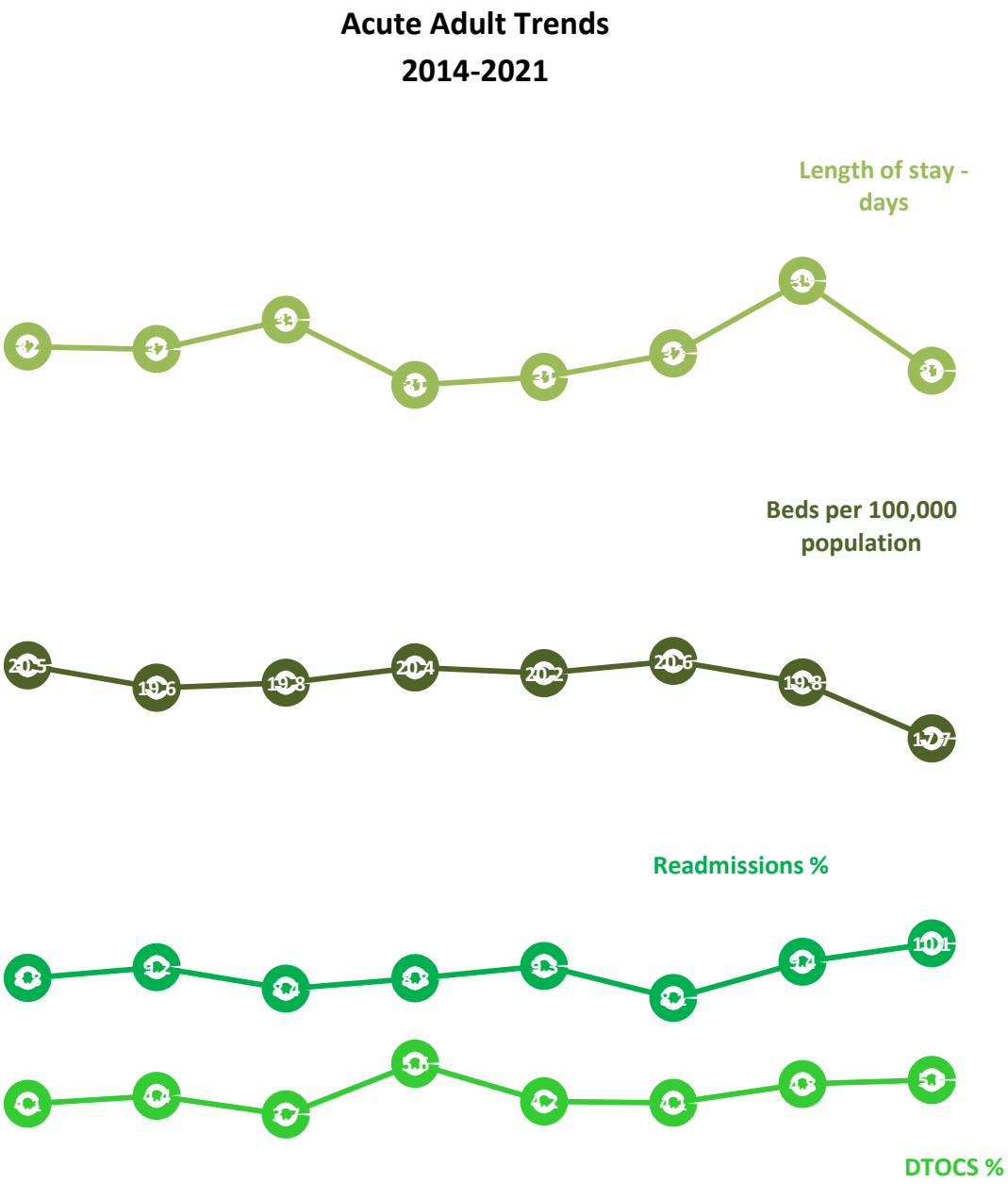
Adult Acute - Headlines and trends

	MH181	Mean	Median	National trend
Adult acute beds per 100,000 weighted population at 31st March 2021	12.8	18.2	17.7	
Adult acute bed occupancy rates (excluding leave)	88%	87%	88%	
Adult acute admissions per 100,000 weighted population	173	187	190	
Adult acute admissions - patients not previously known to services (as a % of all patients admitted)	23%	12%	9%	
Adult acute admissions - patients of no fixed abode (as a % of all patients admitted)	1%	3%	2%	
Adult acute mean length of stay (excluding leave)	24	31	32	
Adult acute admissions under the Mental Health Act	46%	50%	50%	
Adult acute admissions under the Mental Health Act per 100,000 weighted population	79	88	83	
Adult acute mean length of stay for Mental Health Act detentions	37	38	38	
Adult acute delayed transfers of care	8%	5%	5%	
Adult acute readmissions	10%	11%	10%	

Adult Acute Beds

There had been a clear reduction in bed numbers since the project's inception in 2012. Bed stocks have stabilised in recent years, and this year's participants reported a median position of 17.7 beds per 100,000 population which is a slight increase on the March 2020 position, however bed numbers in March 2020 had been impacted by the start of the pandemic measures. A pre-pandemic stocktake of Adult acute bed numbers was taken at 31st January 2020 and this reported 20.6 beds per 100,000 weighted population. Therefore the 2020/21 outturn position reflects a reduction on beds available immediately prior to the pandemic.

The mean length of stay recorded during 2020/21 was 31 days, a reduction on the previous year. Readmissions have continued to rise after a period of reduction, this year the average was 10.1%.



The largest bed type for most providers is adult acute. These beds form part of the core service offer of all NHS Trusts and Health Boards, and are predominantly designed to serve a working age (16-64) cohort. Older adult acute beds provide a similar function for older people (age 65 and over) and are discussed in the next section.

Adult acute beds support service users with a wide range of mental health conditions. This contrasts with specialist beds which may support a specific cohort of patients such as those with eating disorders or people on a forensic/criminal justice pathway. These specialist beds are profiled later in the report. In recent years, providers reported a reduction in adult acute bed numbers which then stabilised. This year the median average is 17.7 per 100,000 weighted population age 16-64, in comparison to the 19.8 per 100,000 weighted population reported at 31st March 2020.

The 31st March 2020 bed stock position was affected by the introduction of pandemic measures. The end of March 2020 saw significant disruption to NHS mental health services, due to the national focus on the management of Covid-19 patients and with new protocols introduced on how care could be provided.

The NHS Benchmarking Network has produced monthly reporting throughout the pandemic period. This has monitored the national disruption that brought changes to service demand and delivery with people less able to access services and services that had to adapt to limited in-person activity and social distancing. Bed availability was affected due to Covid restrictions on inpatient environments, community teams, staff sickness absence and the redeployment of staff and premises to support the Covid-19 response.

The following charts highlight the position as at 31st March 2021 compared to local and national peers. The map on the next page shows the geographical distribution of adult acute beds in the system. Regional variations are evident in the data.

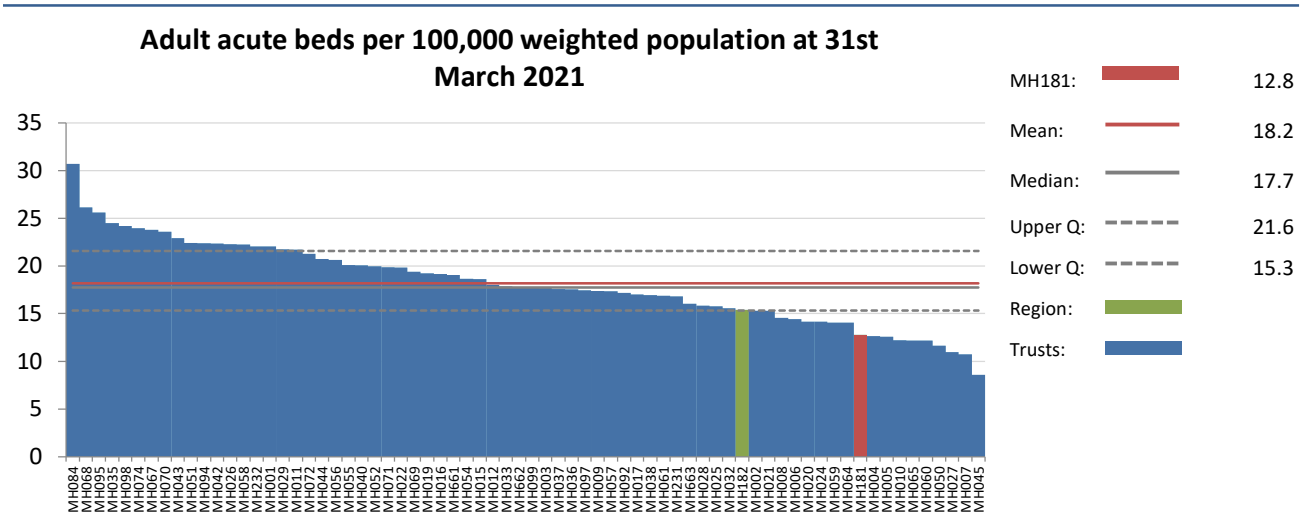
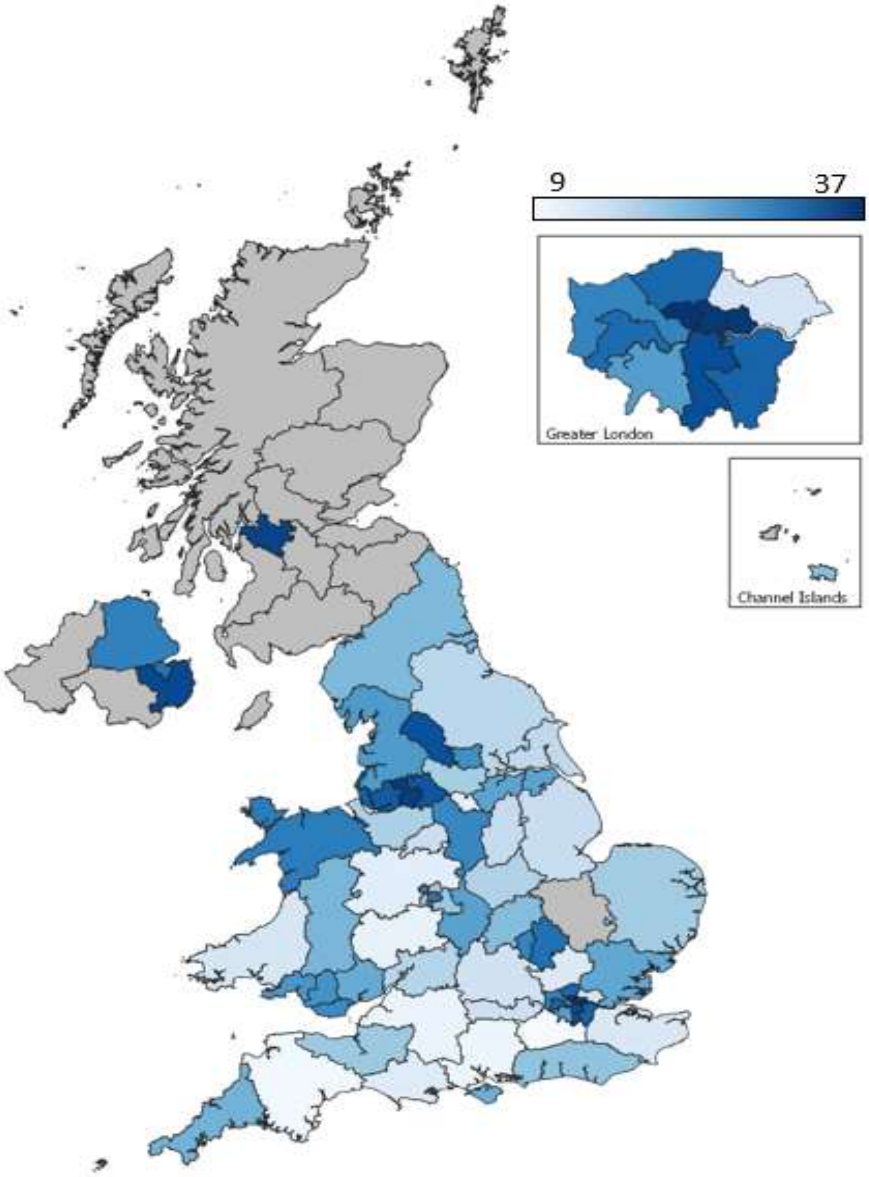


Figure 1

Benchmarking Network

Adult acute beds per 100,000 resident population at 31st March 2021



Benchmarking Network

Adult Acute Bed Occupancy

Bed occupancy figures show the number of days in a year that beds were occupied, as a proportion of all available bed days during that period, and make adjustments for beds that are temporarily closed. Bed occupancy excluding leave cannot exceed 100%, i.e. every bed being occupied every night of the year.

Participants have reported bed occupancy increasing in recent years, with average rates of 95% reported last year. This year's national median position of 87.8% is a significant reduction on the 2019/20 position and reflects the disruption to the services due to Covid-19. The monthly Covid-19 reporting showed that there was an immediate drop in bed occupancy rates in April 2020, however rates increased over the 2020 summer months. There was a reduction in bed occupancy rates coinciding with the second national lockdown in November, however occupancy (excluding leave) had risen to 89% during March 2021, a position 5% below historic rates.

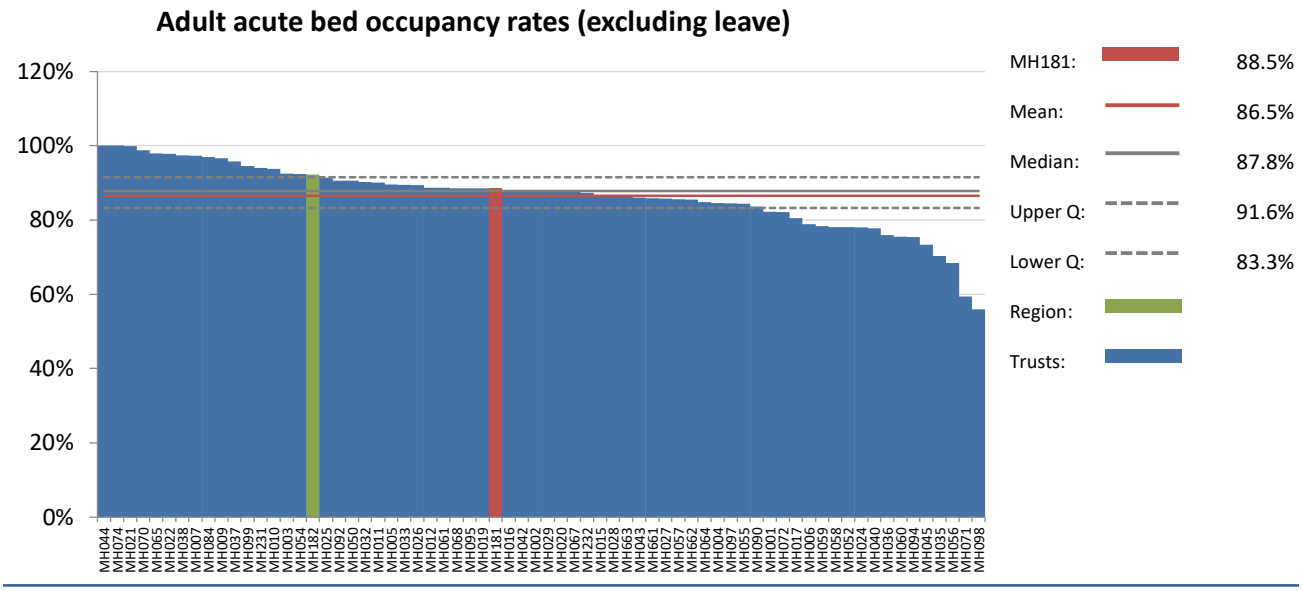


Figure 2

Adult Acute Admissions

Admission rates triangulate with bed numbers and length of stay to give an overall picture of an inpatient service. This year's national median position of 190 admissions per 100,000 population compares to the 206 per 100,000 weighted population in 2019/20.

Admissions are also profiled by patients not previously known to services. In this context, this means admissions for anyone who has not been admitted to a Trust or Health Board mental health bed before, and has not been on a community caseload. This year, admissions for this cohort accounted for 8.5% comparable with the 8.5% recorded last year.

Rates of admissions for patients of no fixed abode remain steady, with a mean position of 2.6% recorded this year.

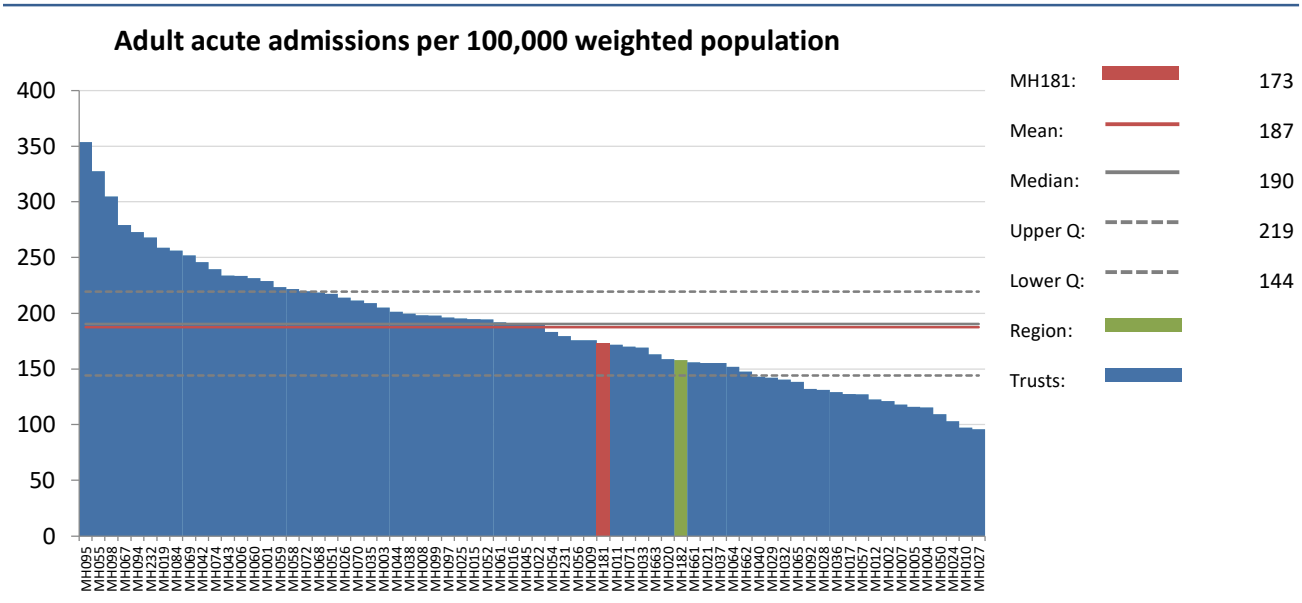


Figure 3

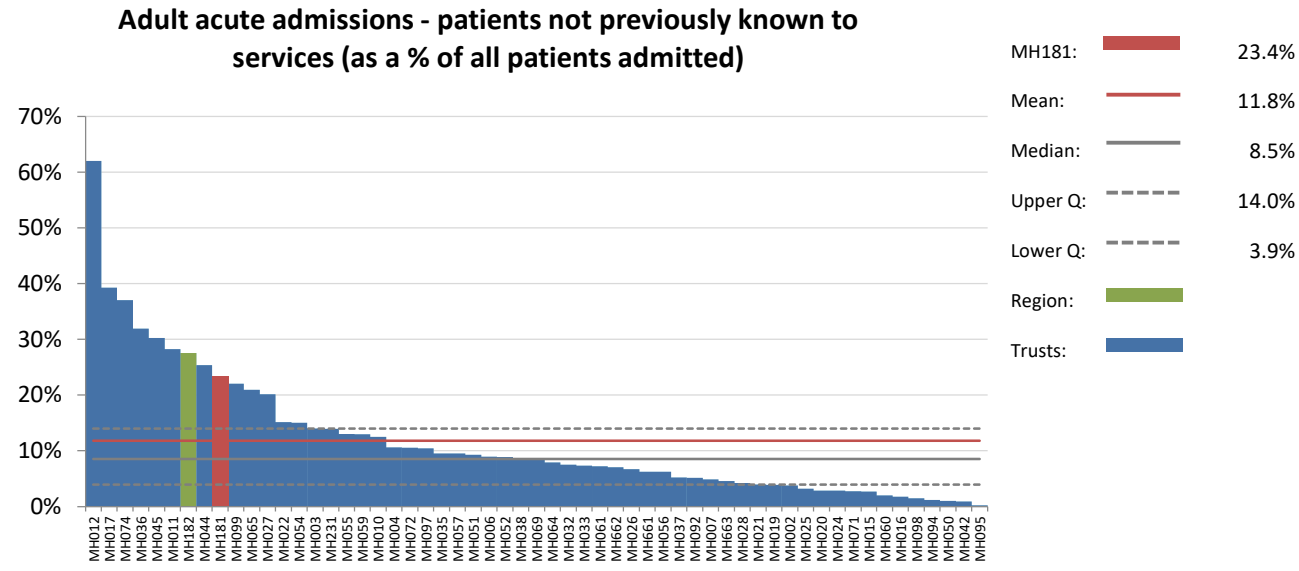


Figure 4

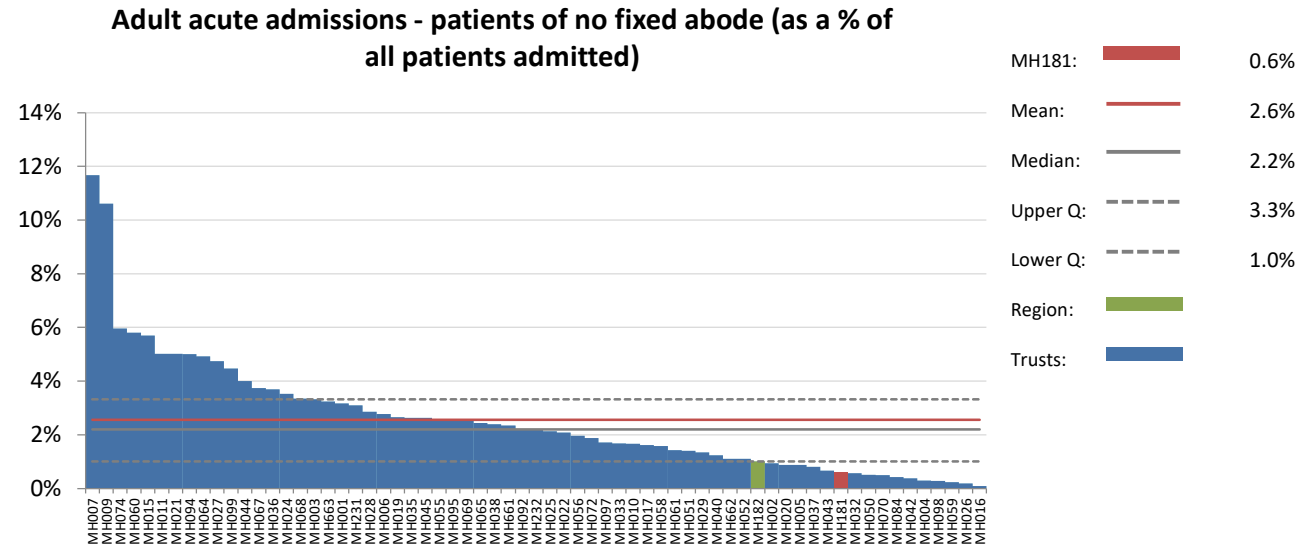


Figure 5

Adult Acute Length of Stay

Length of stay for adult acute beds sees variation on both a year to year basis and within year across different participants. This year's mean national position of 31 days is a reduction compared to the previous year and is a return to levels seen in 2018/19.

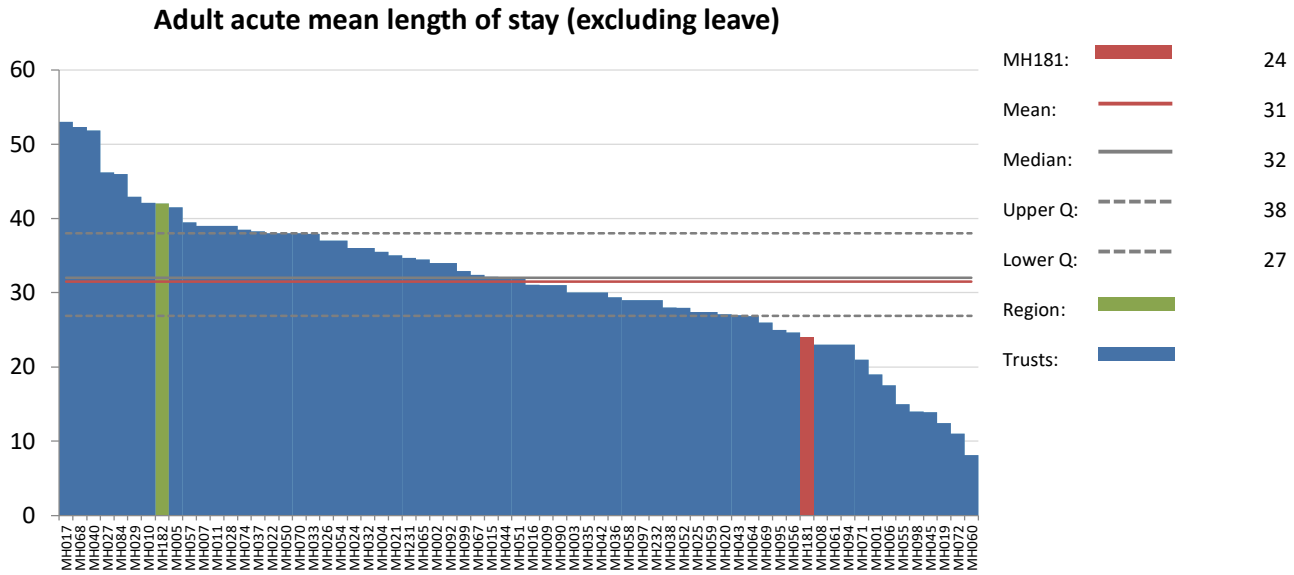


Figure 6

In addition to average length of stay across all admissions, it can be useful to consider the profile of patients in an individual provider. The table below shows national average positions for length of stay broken down by time period. The charts on the following page show individual participant positions on the proportion of patients with very short (0 - 3 days) and very long (90 days or over) stays.

Over time short stay admissions have shown a decrease with 44% of admissions during 2020/21 staying less than a fortnight, this is comparable with 2019/20, but a reduction on the position in 2017/18 (47%). During 2020/21 there was an increase in the discharges staying between 14-59 days.

National trend				
Length of stay	**2017/18**	**2018/19**	**2019/20**	**2020/21**
0 - 3 days	16%	15%	14%	14%
4 - 13 days	31%	30%	30%	30%
14 - 59 days	39%	40%	41%	42%
60 days or longer	14%	15%	15%	14%
* 60 - 89 days		7%	6%	6%
* 90 days or longer		8%	8%	7%

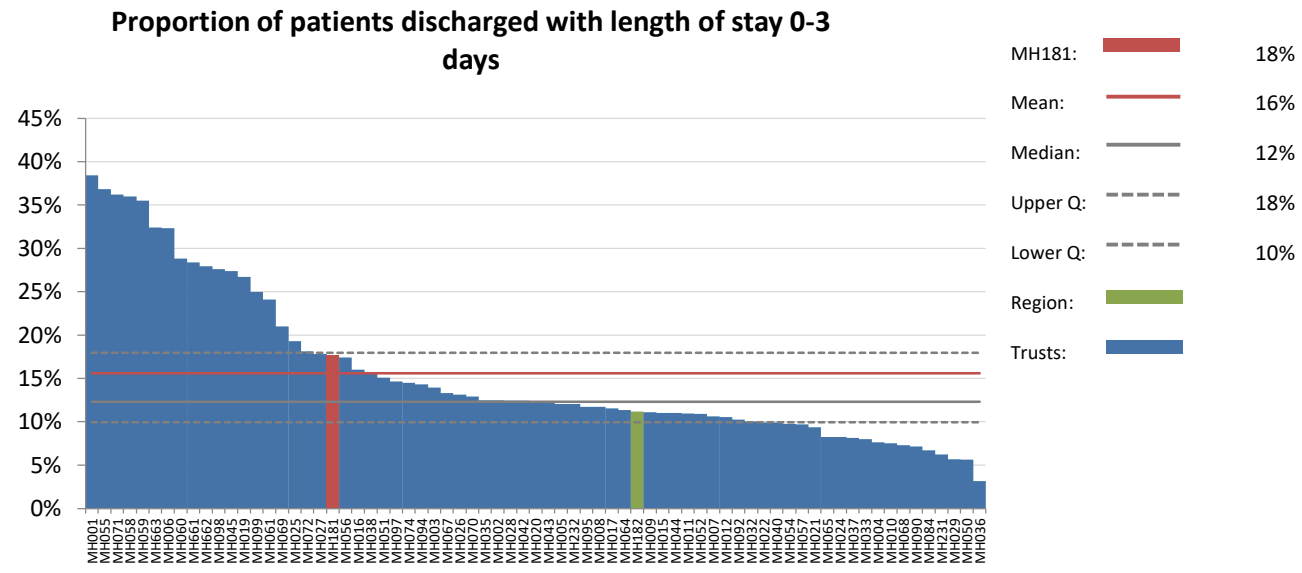


Figure 7

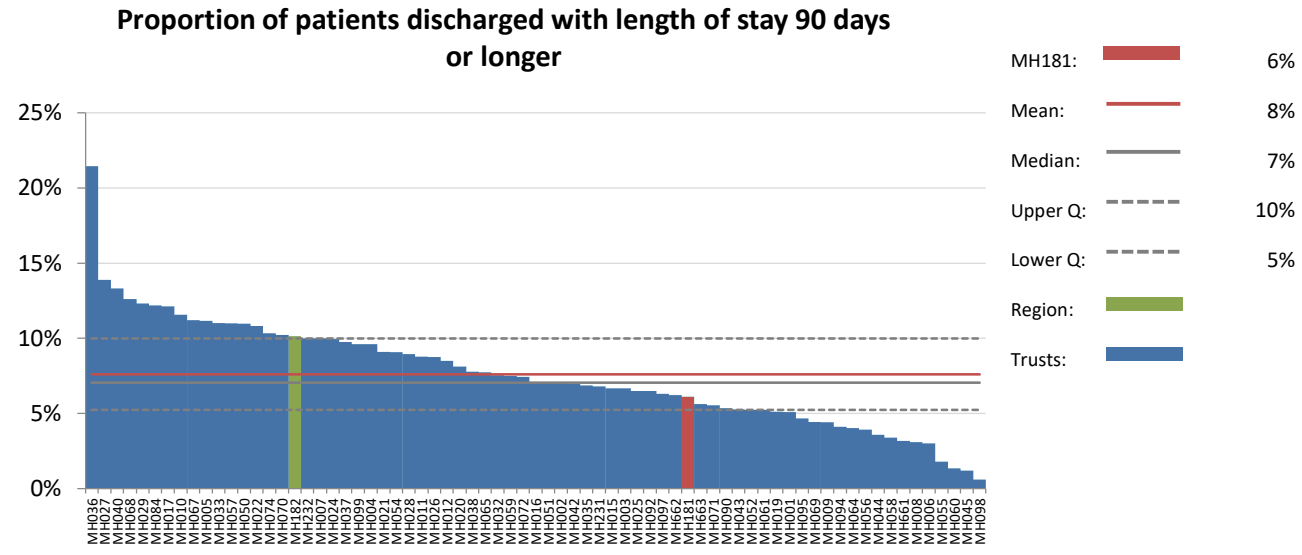
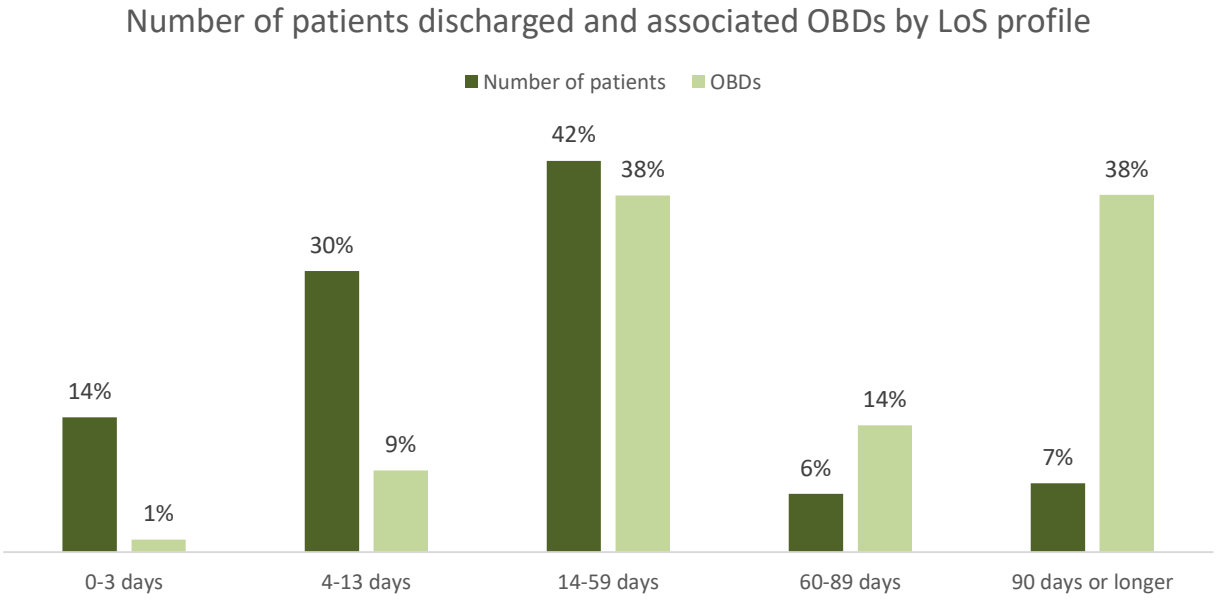


Figure 8

Occupied Bed Days

	MH181	Mean	Median	National trend
Proportion of OBDs (excluding leave) for patients discharged with length of stay 0-3 days	1%	1%	1%	
Proportion of OBDs (excluding leave) for patients discharged with length of stay 4-13 days	11%	10%	8%	
Proportion of OBDs (excluding leave) for patients discharged with length of stay 14-59 days	41%	39%	39%	
Proportion of OBDs (excluding leave) for patients discharged with length of stay 60-89 days	12%	14%	14%	
Proportion of OBDs (excluding leave) for patients discharged with length of stay 90 days or longer	35%	36%	36%	

Participants reported the proportion of their OBDs in adult acute beds that could be attributed to patients with different lengths of stay. Individual positions can be explored further in the Mental Health Benchmarking Toolkit. The chart below illustrates the comparison between proportion of patients discharged in each length of stay band and the proportion of OBDs each cohort occupied nationally. This shows that although 14% of patients are discharged within 0-3 days, they only occupy 1% of bed days. Meanwhile only 7% of patients stay 90 days or longer in adult acute beds, but this group occupy 38% of all bed days on adult acute wards. Patients that stay 60 days or more account for 13% of admissions but 52% of bed days.



Mental Health Act

Analysis of the use of the Mental Health Act shows that 50.1% of admissions to adult acute beds in 2020/21 were for patients who were detained at the point of their admission, an increase from the 43.7% recorded last year. In addition, some patients are admitted on a voluntary basis but then subject to detention during their episode of care. 2020/21 marks the first year that the percentage of admission detained at the point of admission has risen above the 50% threshold. During 2020/21 all mental health inpatient specialties demonstrated an increase in the use of the Mental Health Act.

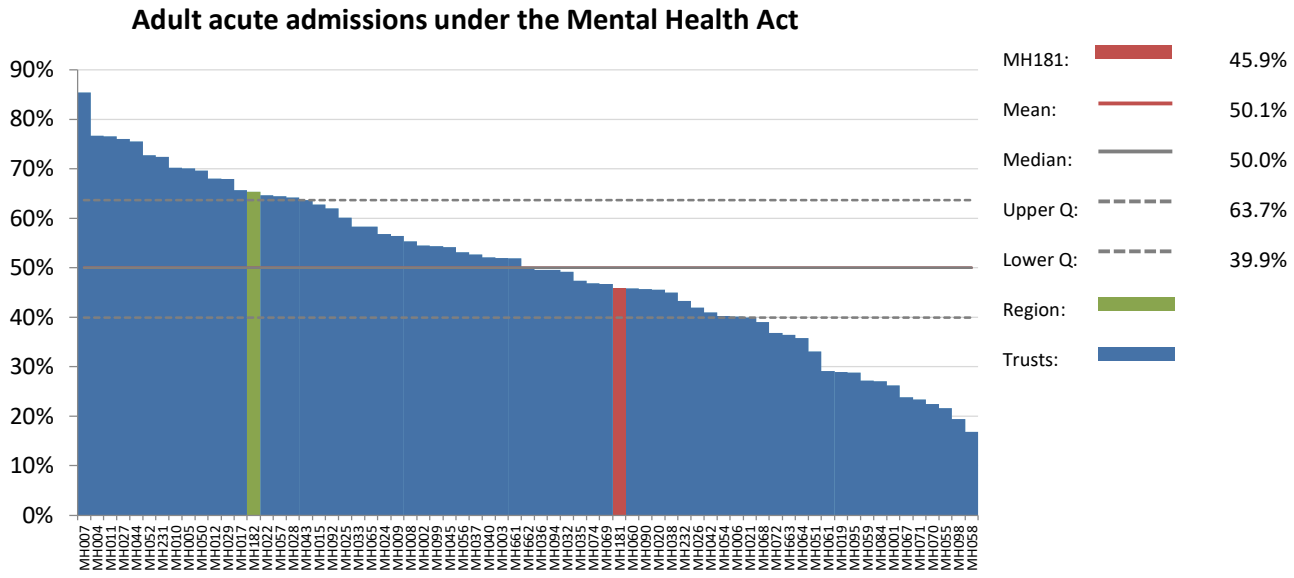


Figure 9

It is also useful to consider background detention rates, relative to population size. These figures are less influenced by bed numbers and admission rates. In 2020/21, there were 88.0 admissions to adult acute beds under the Mental Health Act, per 100,000 weighted population. A considerable increase on the 91.3 in 2019/20. The map on the following page explores the regional variation on this metric.

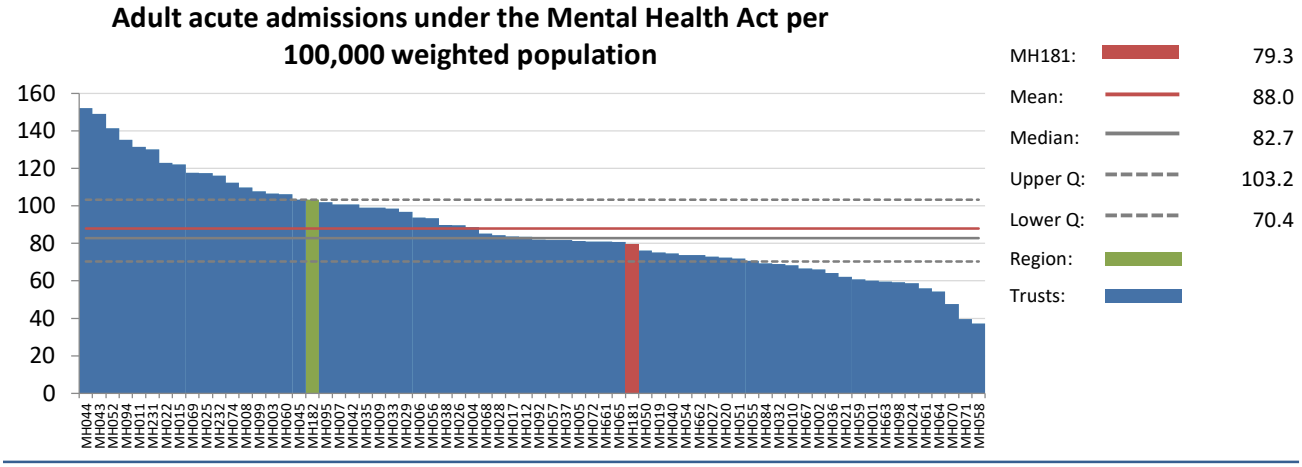
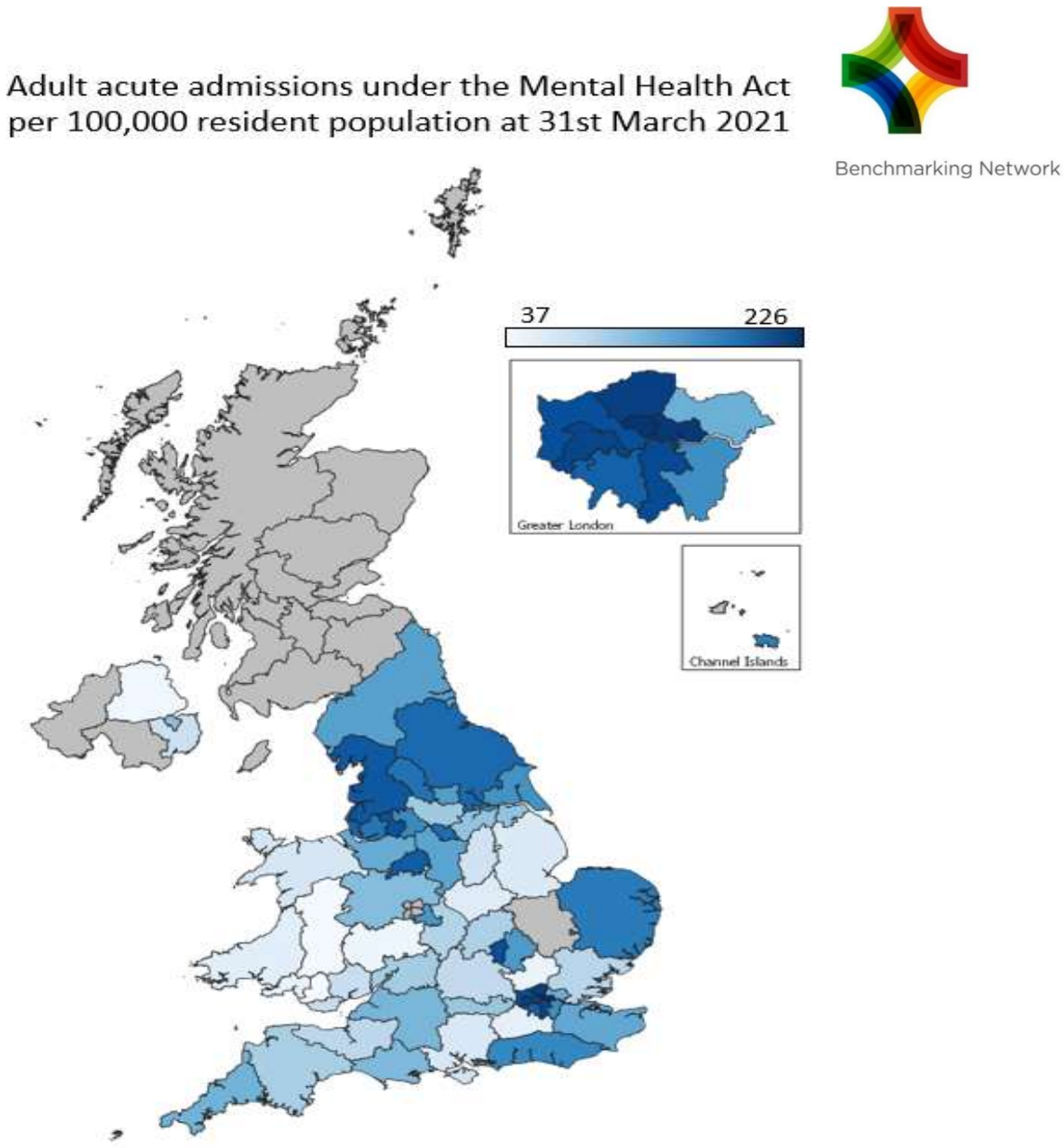


Figure 10



Patients admitted on an involuntary basis typically stay longer than those whose admissions are informal. In 2020/21 the average length of stay for people originally admitted under the Mental Health Act was 38 days, compared to 31 days across all adult acute admissions (both voluntary and involuntary).

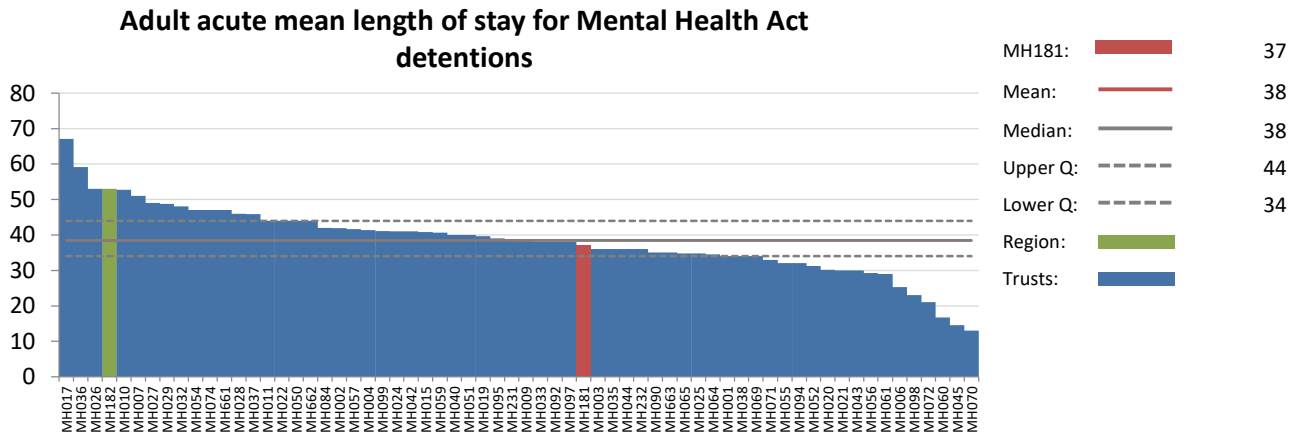


Figure 11

Adult Acute Delayed Transfers of Care

Participants continue to report inconsistencies in the measuring of delays, in particular the point at which a delay is formally acknowledged.

The chart below measures delayed transfers of care as a percentage of all occupied bed days. The 2020/21 average of 5.0% can be compared to 4.8% in 2019/20. The chart shows considerable variation which may be impacted by both the underlying service models and the wider health and social care provision on offer in the community. Both of these factors can impact patient flow. These variations may also be influenced by the clarity and consistency of reporting of delays.

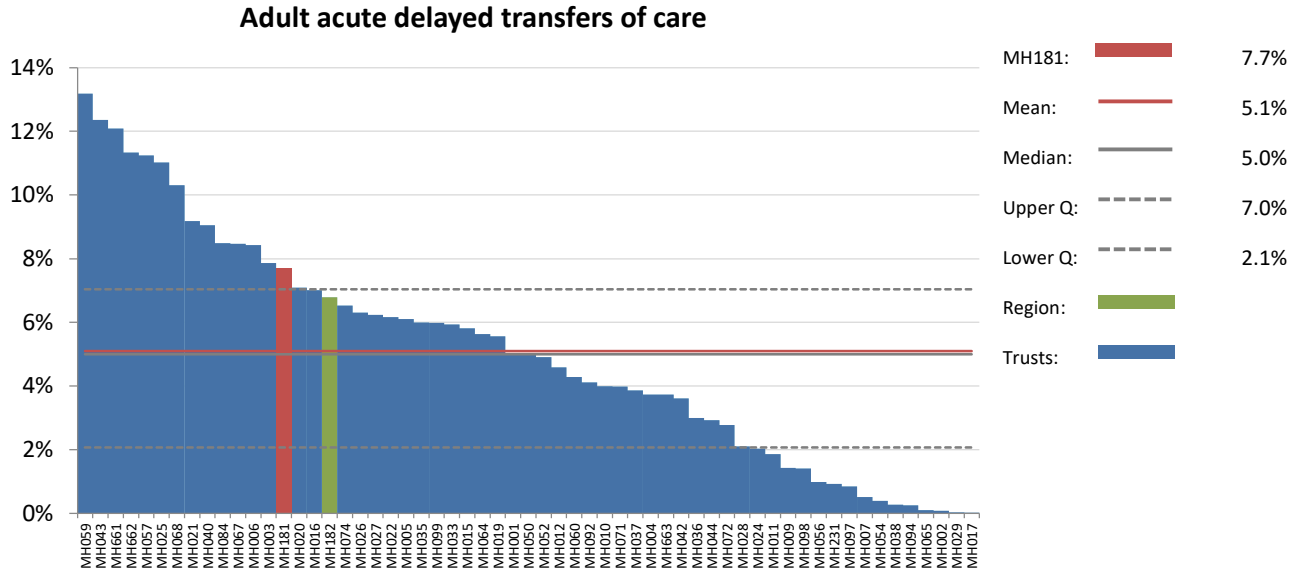


Figure 12

Adult Acute Readmissions

"Readmissions" refers to unplanned or unexpected readmissions to an adult acute bed of people discharged from an adult acute bed within the last 30 days. The figure is calculated as a percentage of overall admissions. This year, 10.1% of admissions to adult acute beds were readmissions for patients recently discharged. This metric has been between 8.1% and 10% of admissions in all nine previous years of this data collection, and therefore is just above the range for 2020/21.

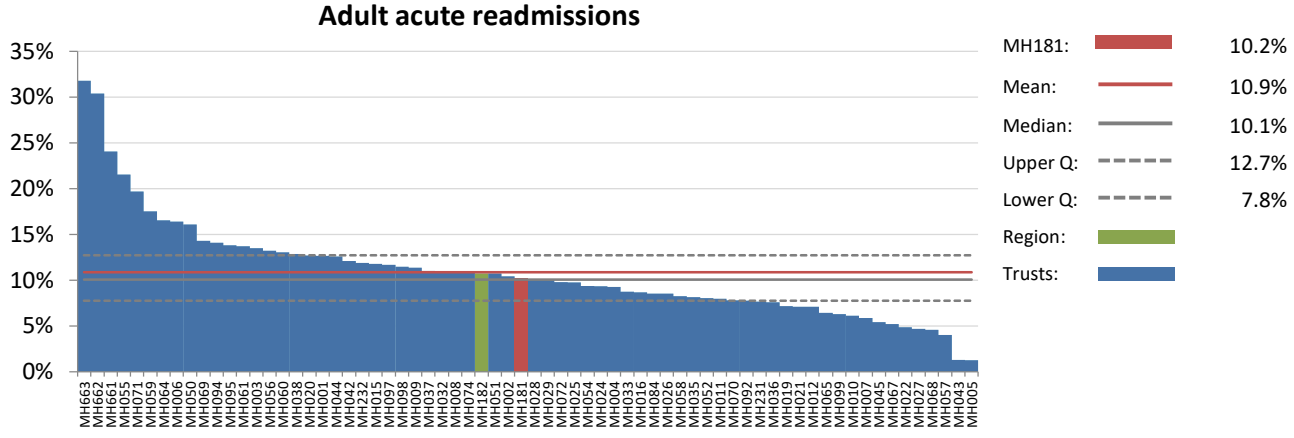
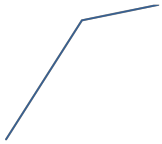


Figure 13

Follow Up Post Discharge

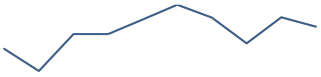
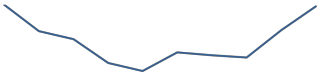
	MH181	Mean	Median	National trend
Percentage of patients having a first follow-up appointment within 3 days of discharge from in-patient care during 2020/21	91%	83%	86%	
Percentage of patients having a first follow-up appointment within 7 days of discharge from in-patient care during 2020/21	95%	92%	94%	

Metrics concerning follow up appointments for patients discharged from inpatient care were first collected in the 2018/19 project. The proportion of patients having a follow-up appointment within 3 days has increased to 83% from the 78% reported last year. Only a small proportion of patients are first followed up later in their first week post-discharge, i.e. in days 4 to 7.

Early follow up post discharge has been identified as a key safety issue by The National Confidential Inquiry into Suicide and Safety in Mental Health. The strong performance on 3-day follow up for the second year running is welcomed and confirms the commitment of many providers to reduce risks in the post-discharge period.

Participants can explore their individual positions on these metrics further using the NHS Benchmarking Network Mental Health Toolkit.

Older Adult

	MH181	Mean	Median	National Trend
Older adult beds per 100,000 weighted population at 31st March 2021	8.9	31.5	27.3	
Older adult bed occupancy rates (excluding leave)	85%	76%	77%	
Older adult admissions per 100,000 weighted population	45.3	120.5	115.2	
Older adult mean length of stay (excluding leave)	47.0	73.0	68.7	
Older adult delayed transfers of care	3%	8%	7%	
Older adult readmissions	8%	7%	5%	

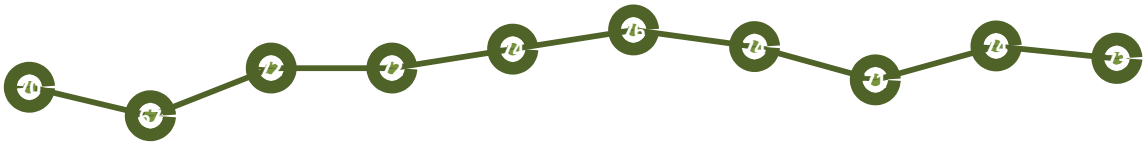
Similar to the position seen with the adult acute bed stock, inpatient capacity for older adults is the smallest since the benchmarking project began, at 27.3 per 100,000 weighted population as at 31st March 2021.

Also in line with the adult acute service, the length of stay saw a reduction, from 74 days last year to 73 days this year. DTOCs have reduced to 6.5% from 7.5% in the previous year. Readmissions have increased, but they are still lower than those seen in working age adult services. The findings from the older adult inpatient service should be read alongside the data from community based care which are described later in the report.

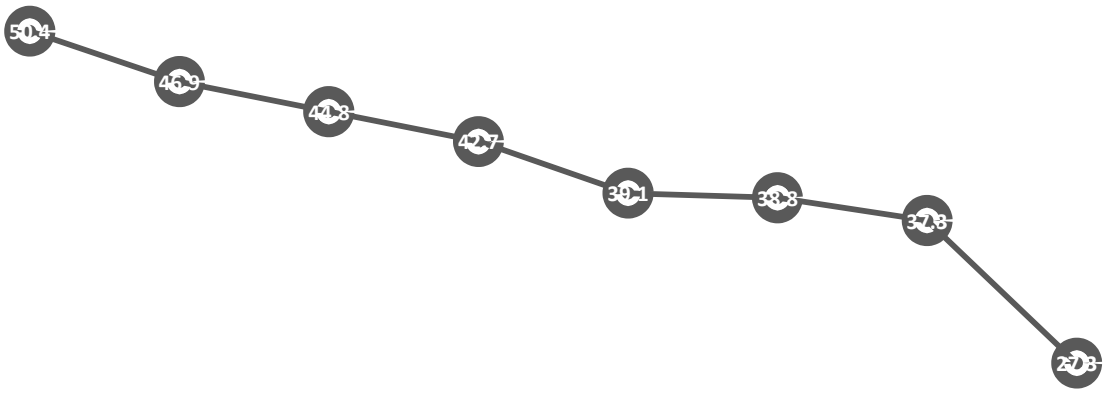
Benchmarking Network

Older Adult Trends
2012-2021

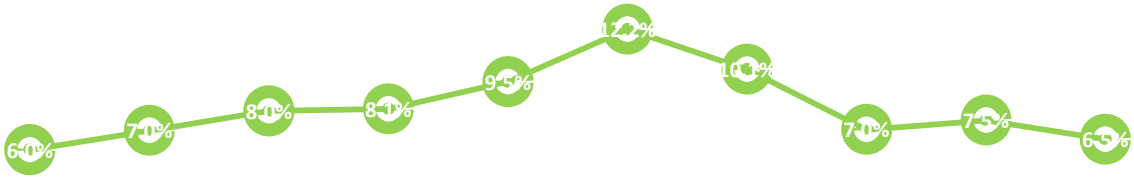
Length of stay - days



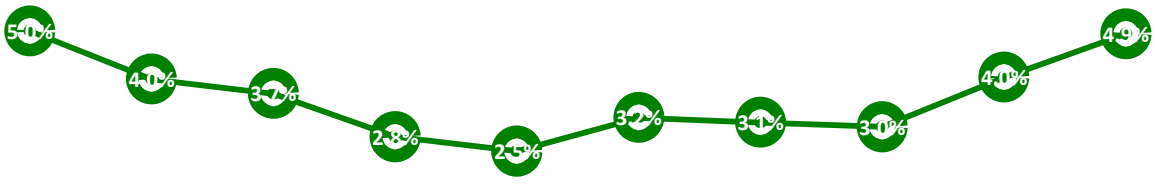
Beds per 100,000 population



DTOC %



Readmissions %



Older Adult Beds

Older adult beds have declined, though rates relative to population size are still much larger than for adult acute. Older adult services reported 27.3 beds per 100,000 population age 65 and older at 31st March 2021, in comparison to 17.7 adult acute beds per 100,000 population age 16 to 64.

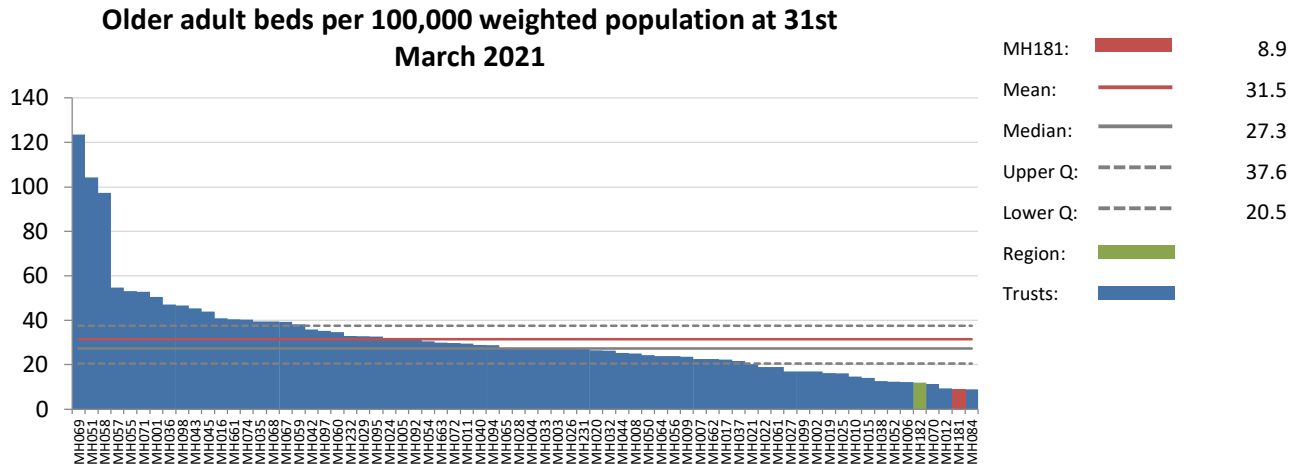


Figure 14

Older Adult Bed Occupancy

Bed occupancy for older adult beds should be seen in the context of higher rates of bed provision compared to adult acute services. This year, participants reported bed occupancy of 77.4% excluding leave in older adult services. This remains notably below the figure of 87.8% reported in adult acute services.

The 77.4% position reported in old age services is significantly below that reported over the last two years, confirming what the data from the monthly Covid-19 reports has highlighted that the recovery rates for bed occupancy in older adult beds has been slower than those in the adult acute beds.

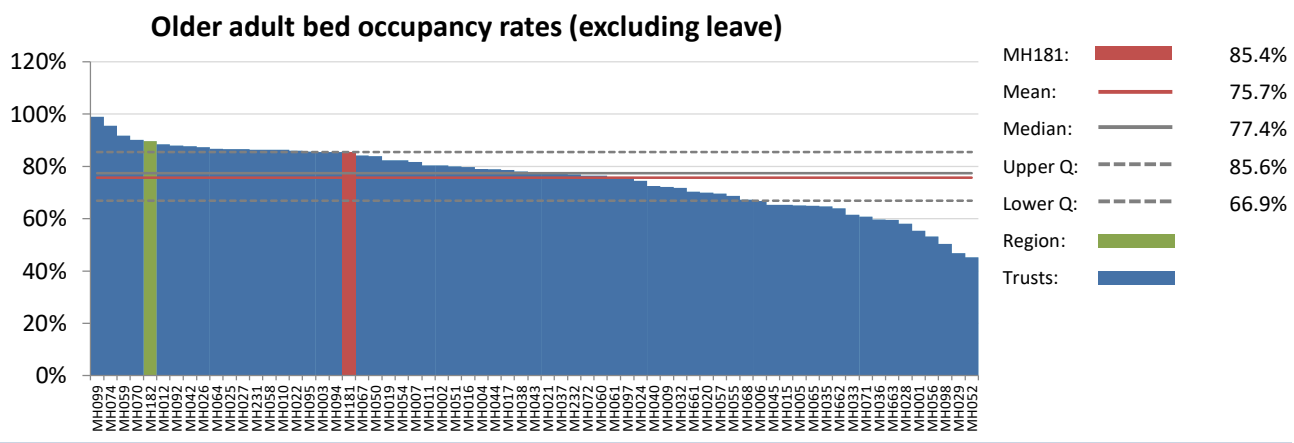


Figure 15

Older Adult Admissions

The decline observed in older adult admission rates reflects both diminishing bed availability and the rising lengths of stay reported in older adult services. This year's median position of 115 per 100,000 population shows an increase from the 142 per 100,000 population recorded in 2019/20.

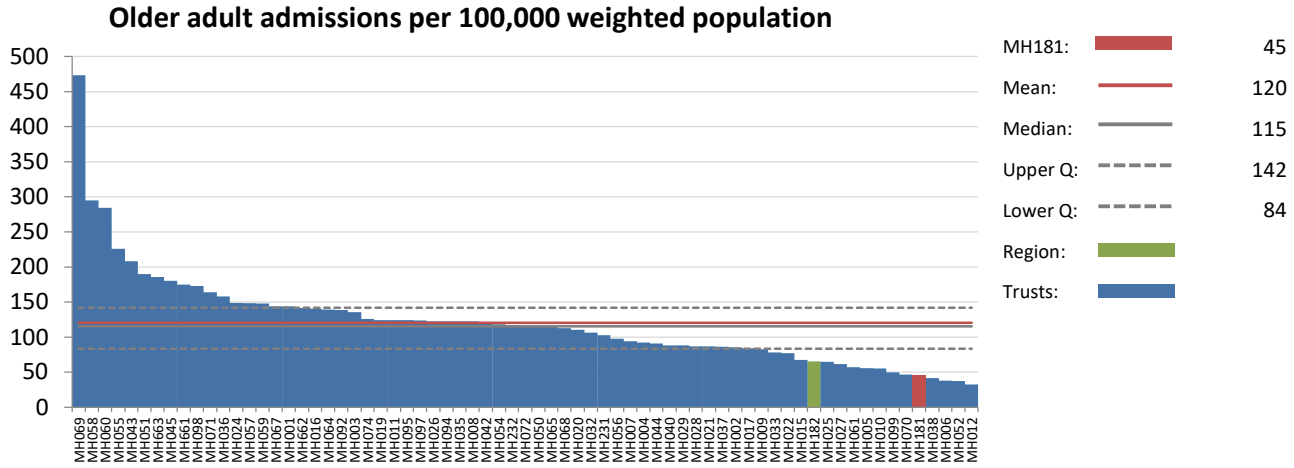


Figure 16

Older Adult Length of Stay

Length of stay in older adult beds continues to be more than twice the level seen in adult acute beds. In 2020/21, older adult length of stay was 73 days excluding leave, compared to 31 days in adult acute beds.

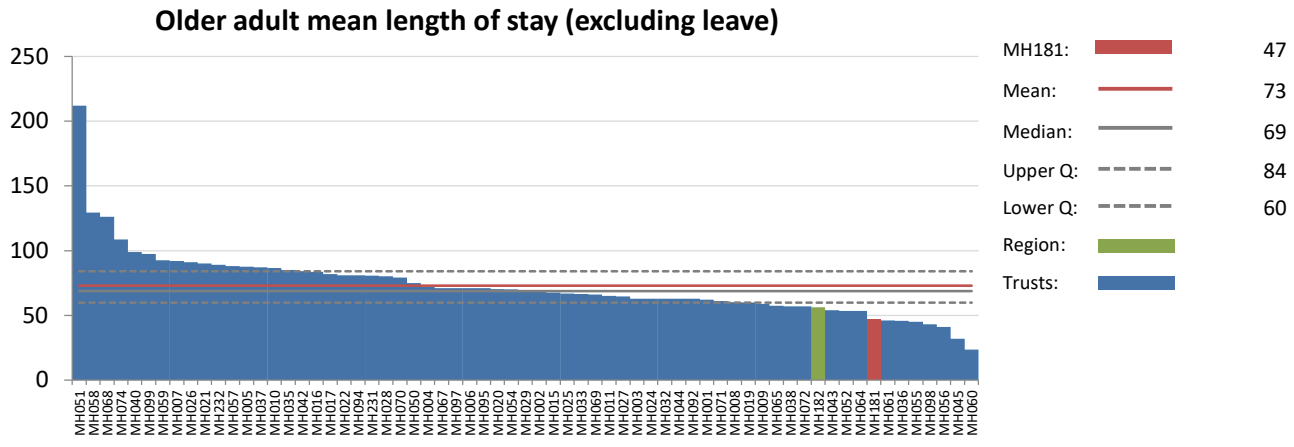


Figure 17

Older Adult Delayed Transfers of Care

Due to the complexity of discharge arrangements for some patients, delays in transfers of care occur much more frequently in older adult services than in services serving working age adults. This metric is calculated using the percentage of all occupied bed days that were attributed to delays. This year's figure of 6.5% for older adult beds compares to 5.0% for adult acute.

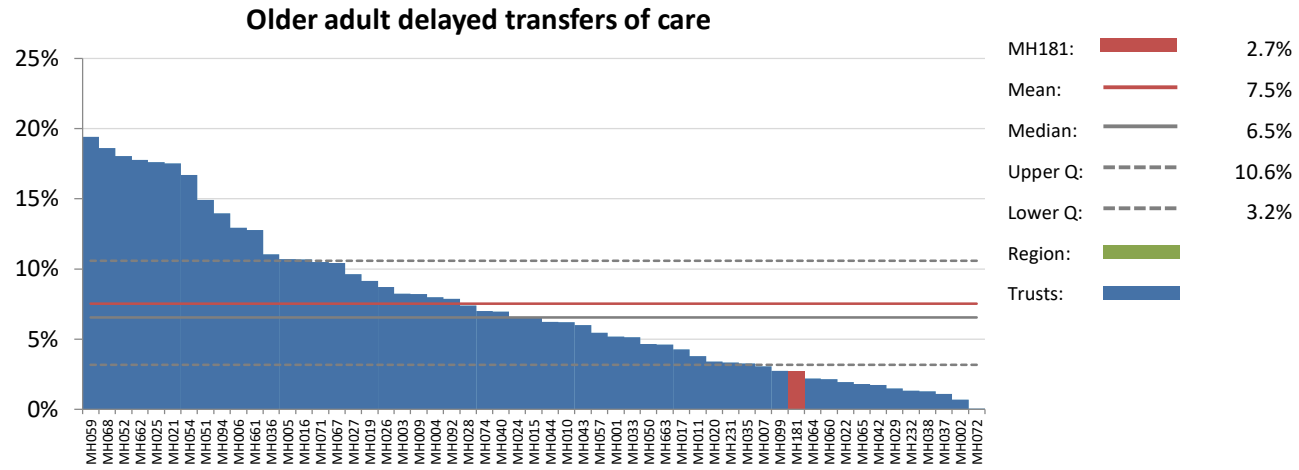


Figure 18

Older Adult Readmissions

Readmissions to older adult beds occur less frequently than in adult acute beds. This may be due to the higher level of post discharge support offered to this cohort, through ongoing packages of care and weightedial placements, which can help keep people well and reduce the risk of deterioration to the extent that a readmission is required. Other factors could include issues around co-morbid frailty, and a reluctance to readmit patients especially if discharged to care home settings.

Calculated as the percentage of all admissions that were readmissions in the immediate period after discharge, the median average position of 4.9% for older adults compares to 10.1% in adult acute beds.

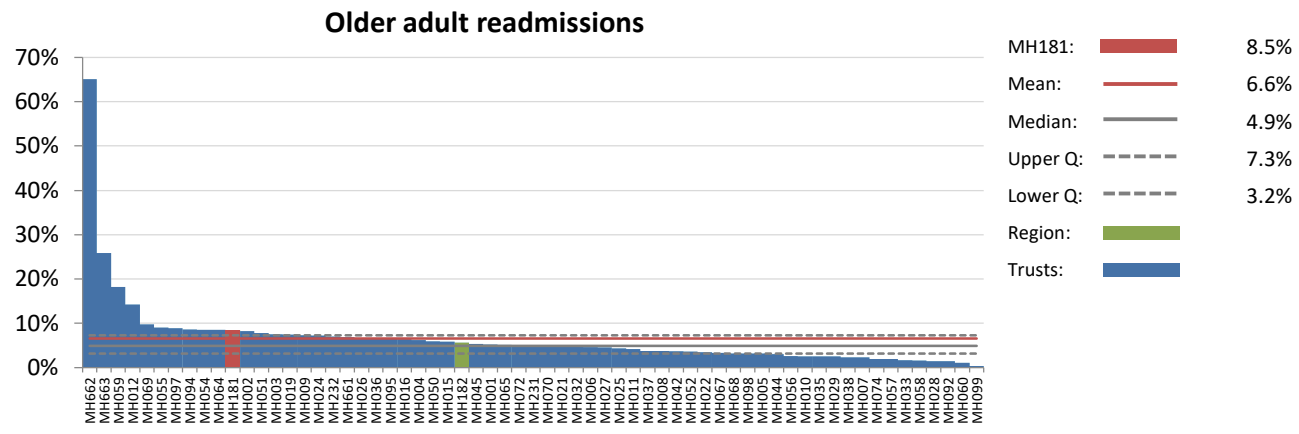


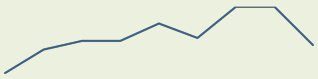
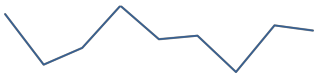
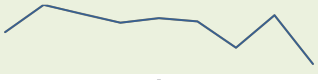
Figure 19

Specialist Beds

In this context, "Specialist beds" refers to all beds that are not for acute admission (adult acute and older adult acute). Some of these beds are linked to specific conditions (such as eating disorders) while others support patients on different pathways (such as low and medium secure beds for patients on a forensic/criminal justice pathway).

High secure beds are not included here due to the small number of national providers.

Benchmarks per 100,000 population are not used in this section, as population catchment footprints vary and are not mutually exclusive across providers.

	MH181	Mean	Median	National Trend
PICU bed occupancy (excluding leave)	...	84%	86%	
PICU length of stay (excluding leave)	...	47	40	
Eating Disorders bed occupancy (excluding leave)	...	72%	69%	
Eating Disorders length of stay (excluding leave)	...	91	85	
Low Secure bed occupancy (excluding leave)	...	89%	89%	
Low Secure length of stay (excluding leave)	...	707	535	
Medium Secure bed occupancy (excluding leave)	...	88%	89%	
Medium Secure length of stay (excluding leave)	...	730	658	
High Dependency Rehabilitation bed occupancy (excluding leave)	...	82%	86%	
High Dependency Rehabilitation length of stay (excluding leave)	...	401	347	
Longer Term Complex / Continuing Care bed occupancy (excluding leave)	...	75%	75%	
Longer Term Complex / Continuing Care length of stay (excluding leave)	...	451	307	
Mother and Baby bed occupancy (excluding leave)	...	62%	60%	
Mother and Baby length of stay (excluding leave)	...	36	36	Not available

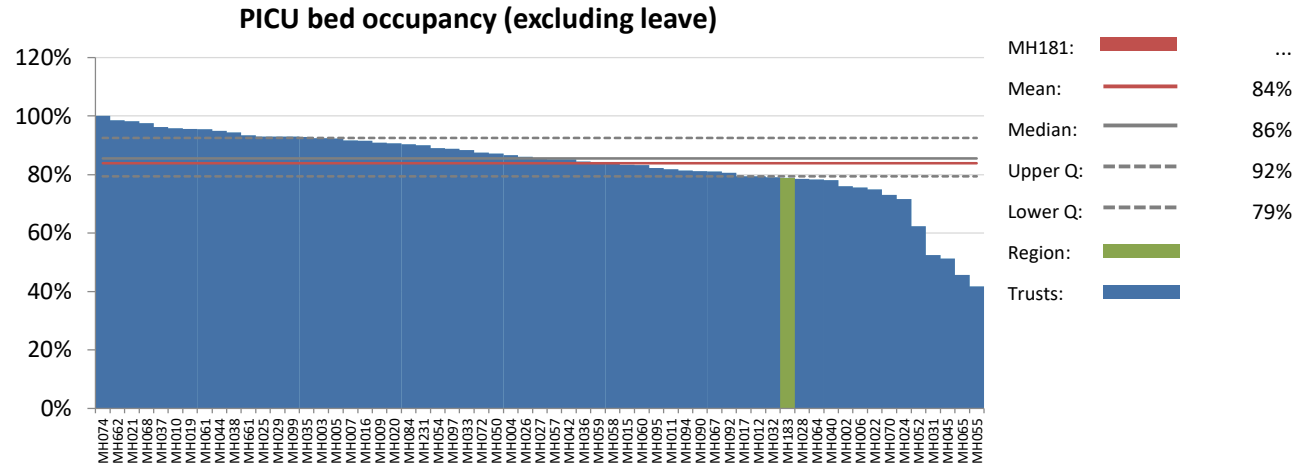


Figure 20

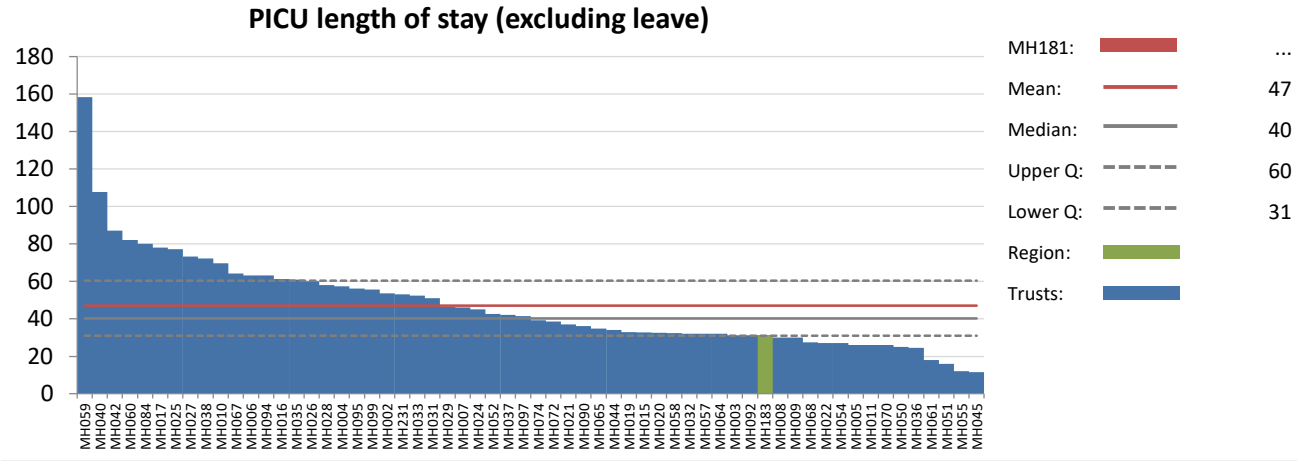


Figure 21

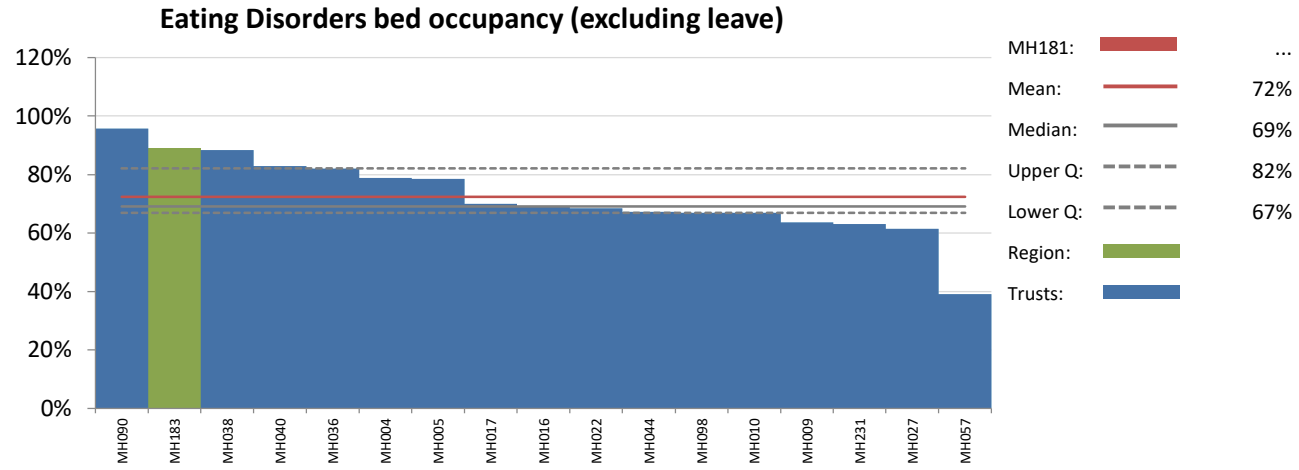


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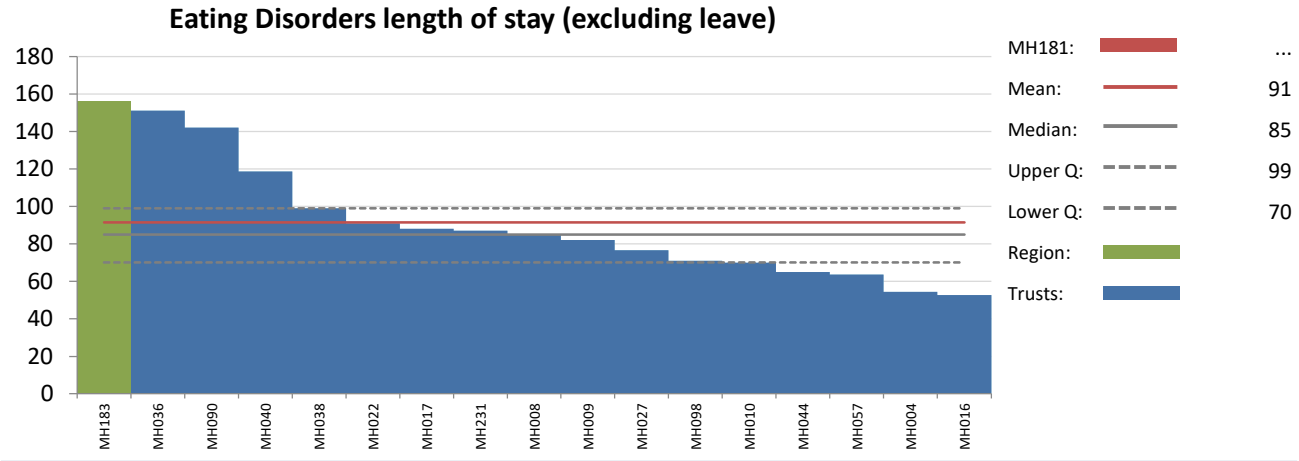


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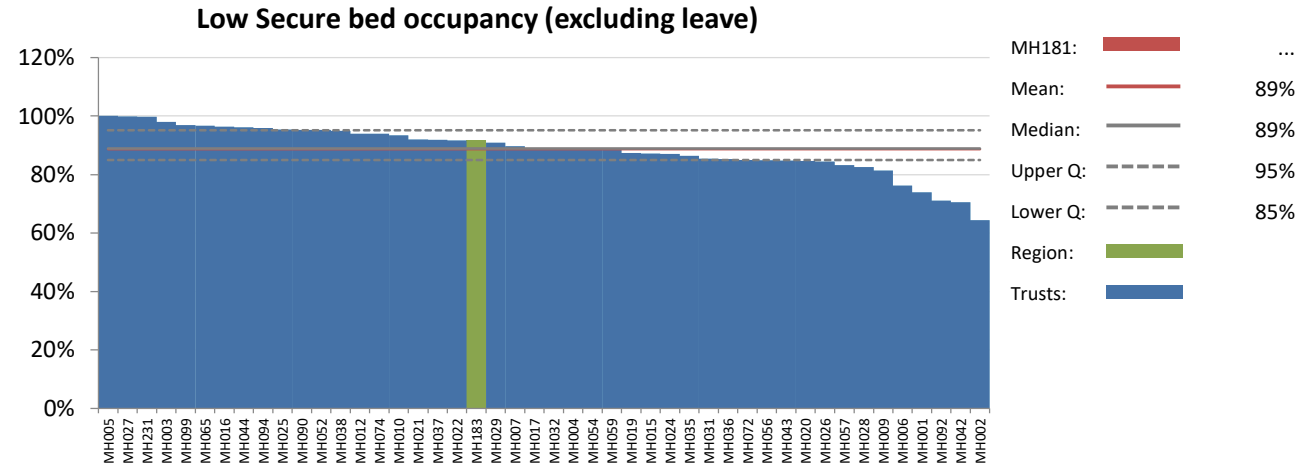


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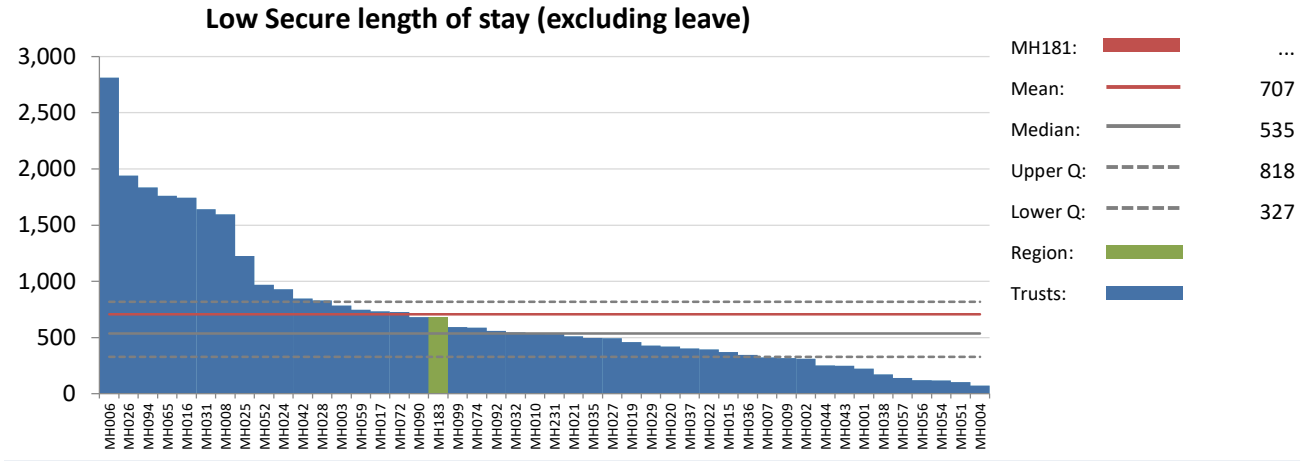


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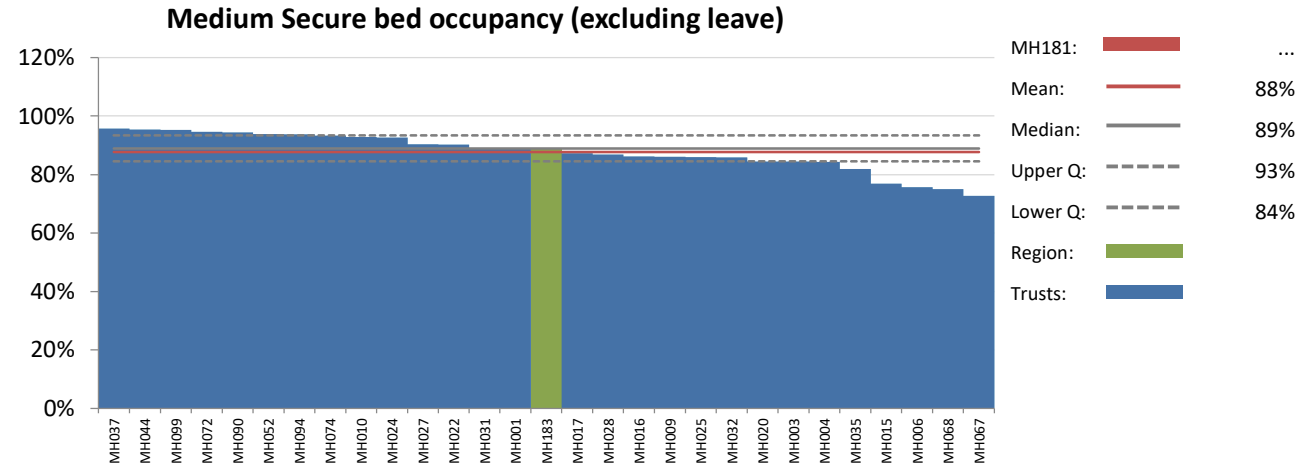


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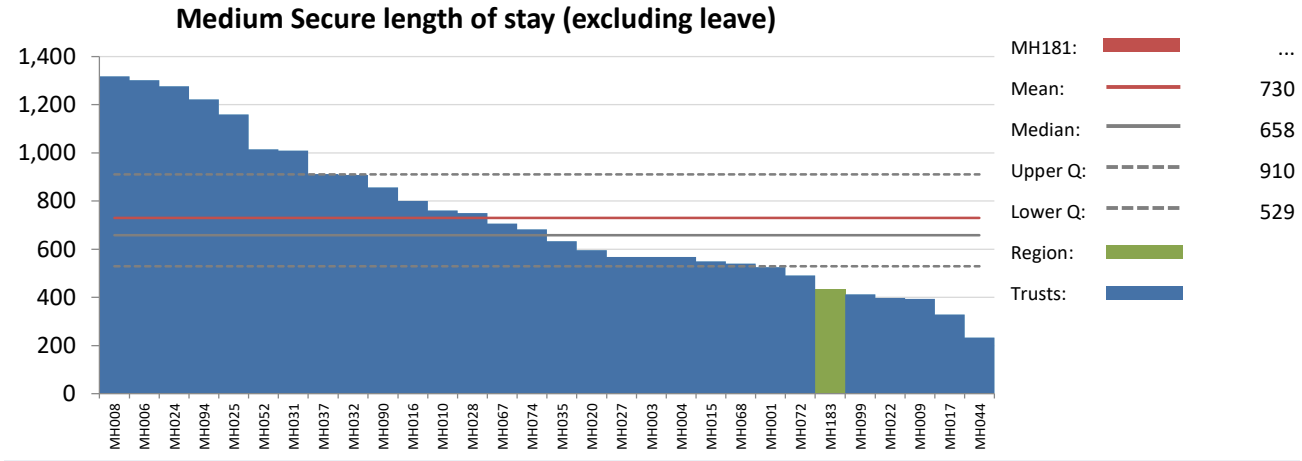


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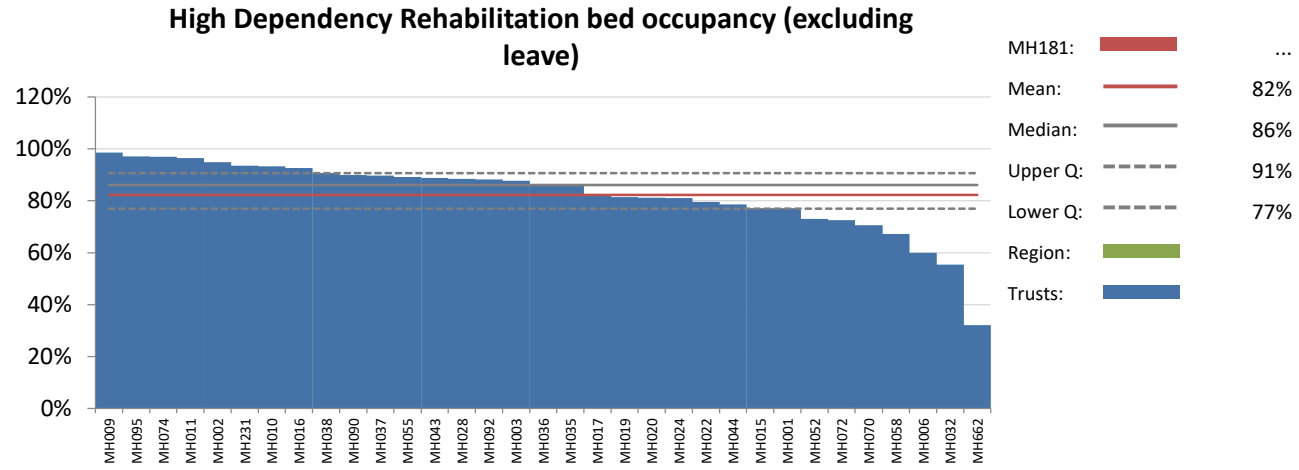


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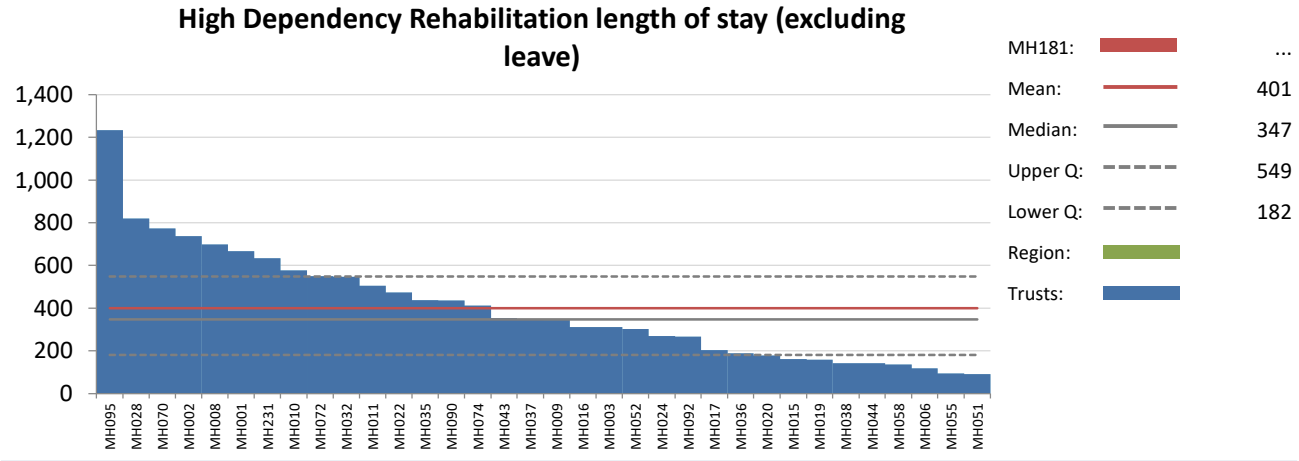


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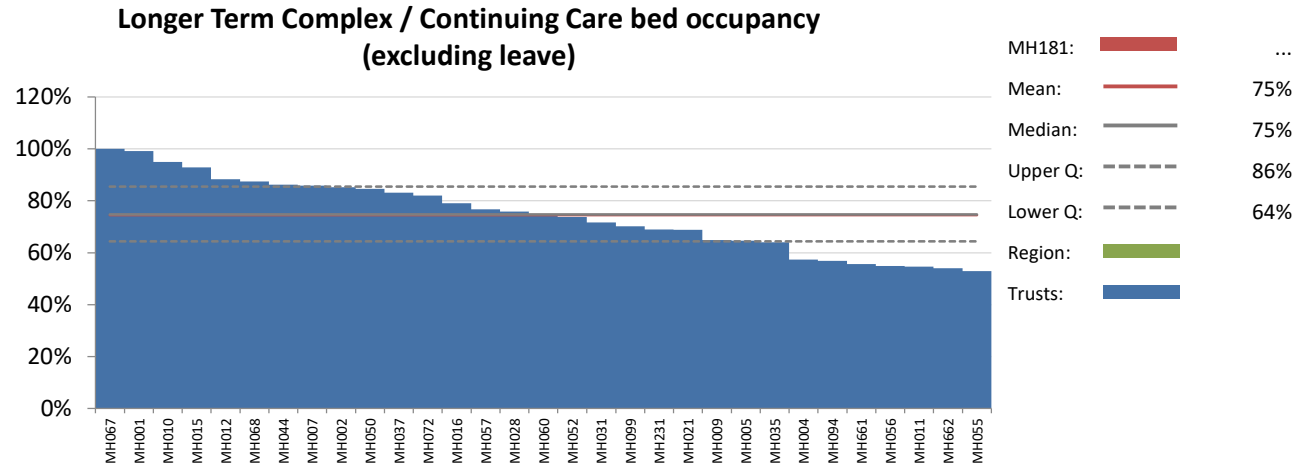


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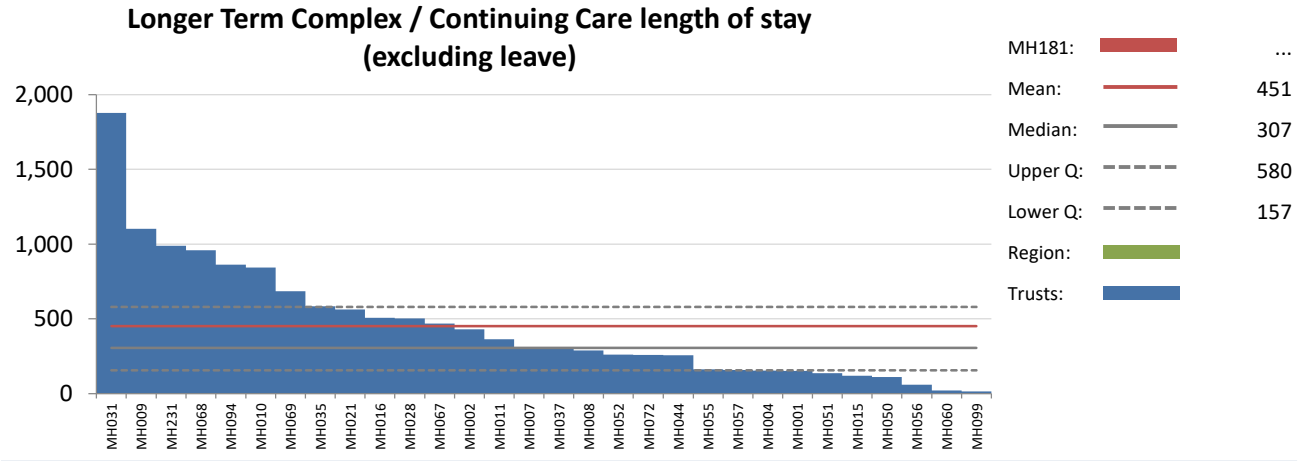


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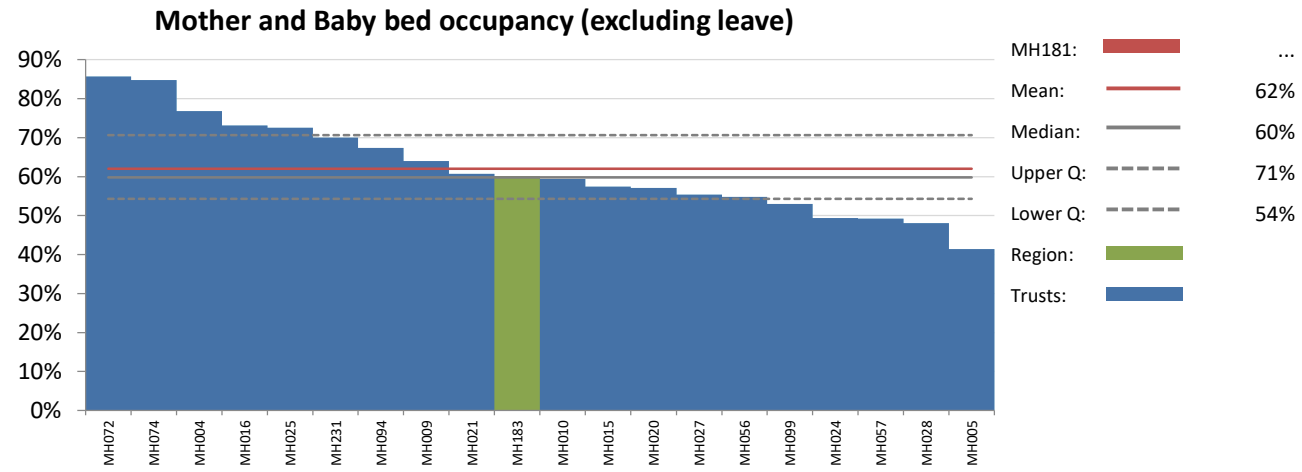


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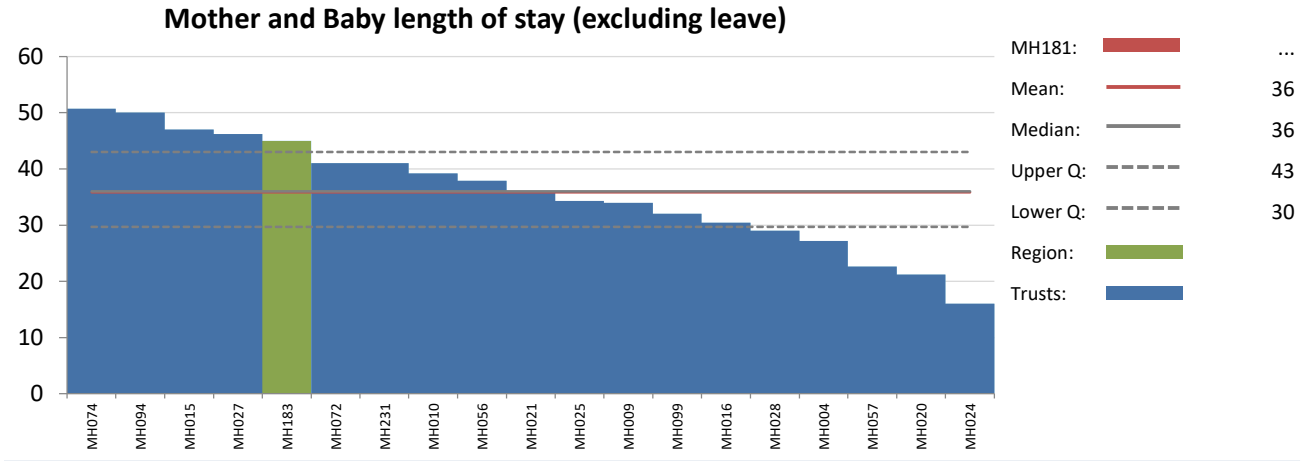


Figure 33

Benchmarking Network

Cluster Profiling

	MH181	Mean	Median	National Trend
Proportion of occupied bed days assigned to a cluster	99%	79%	86%	Not available
Of those assigned				
Occupied bed days - clusters 1-8	32%	24%	24%	
Occupied bed days - clusters 10-17	56%	65%	65%	
Occupied bed days - clusters 18-21	12%	10%	9%	

NHS England's Care Clusters for people who use specialist mental health services can be grouped into three main categories:

Non Psychosis
1 Common mental health problems (low severity)
2 Common mental health problems
3 Non psychotic (moderate severity)
4 Non psychotic (severe)
5 Non psychotic (very severe)
6 Non psychotic disorders of overvalued ideas
7 Enduring non psychotic disorders (high disability)
8 Non psychotic chaotic and challenging disorders

Psychosis
10 First episode in psychosis
11 Ongoing or recurrent psychosis (low symptoms)
12 Ongoing or recurrent psychosis (high disability)
13 Ongoing or recurrent psychosis (high symptom and disability)
14 Psychotic crisis
15 Severe psychotic depression
16 Dual diagnosis (substance abuse and mental illness)
17 Psychosis and affective disorder difficult to engage

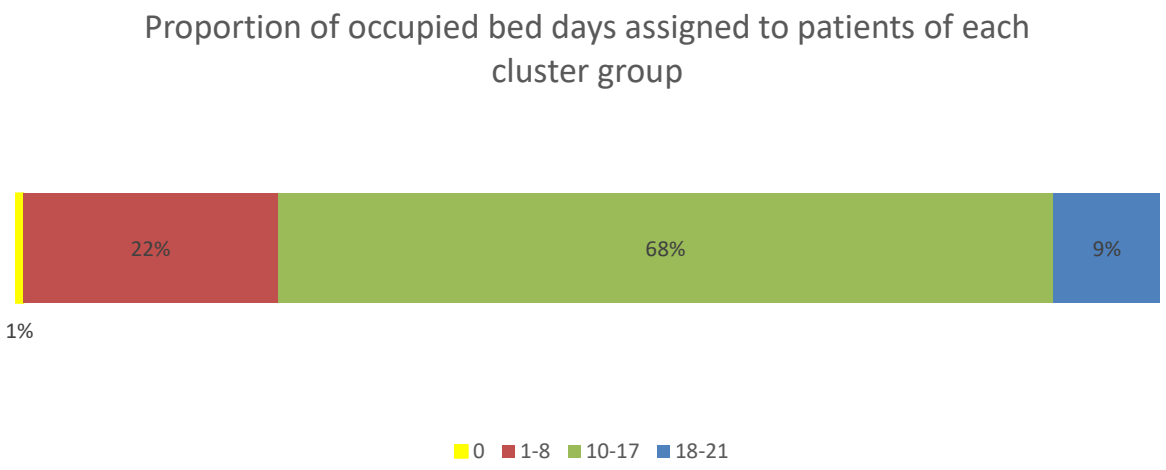
Organic
18 Cognitive impairment (low need)
19 Cognitive impairment or dementia (moderate need)
20 Cognitive impairment or dementia (high need)
21 Cognitive impairment or dementia (high physical or engagement)

Patients can also be assigned to cluster 0. Cluster 0 is for patients who require mental health care but cannot be adequately described by any of the descriptions in the above clusters.

Benchmarking Network

Inpatient activity is driven by bed availability, and the continued decline in older people's beds is reflected in the ongoing reduction in occupied bed days for patients whose episodes fall into clusters 18 to 21. This downward trend continued this year, with a slightly lower proportion of occupied bed days assigned to patients in clusters 18-21 than reported last year.

The chart below shows the breakdown of all occupied bed days nationally, split by patients assigned to each cluster group. Over two-thirds of all occupied bed days can be attributed to patients assigned to the psychosis cluster group and the trend shows that the proportion of occupied bed days assigned to this group is increasing.



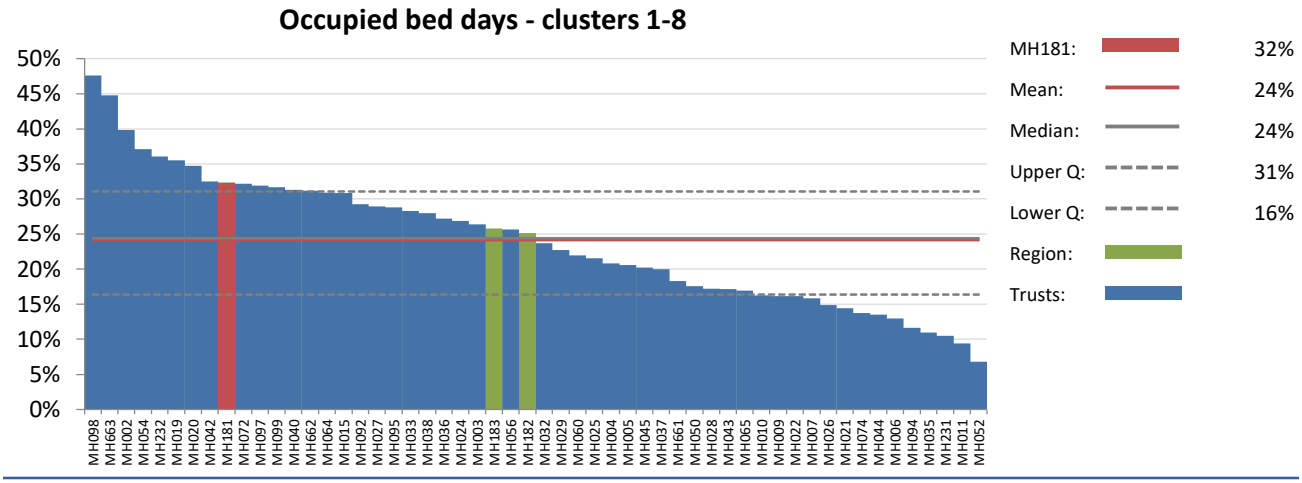


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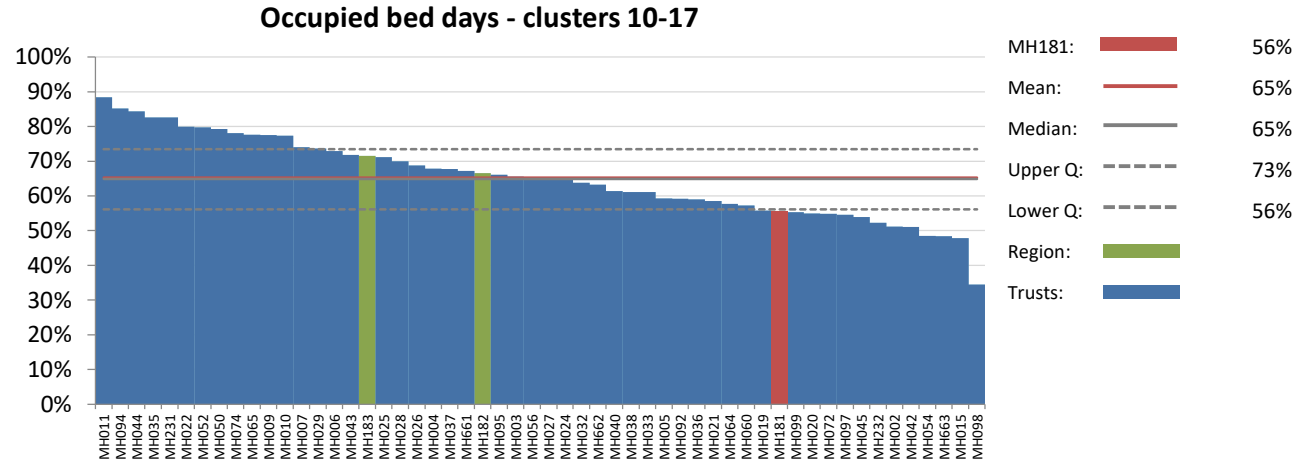


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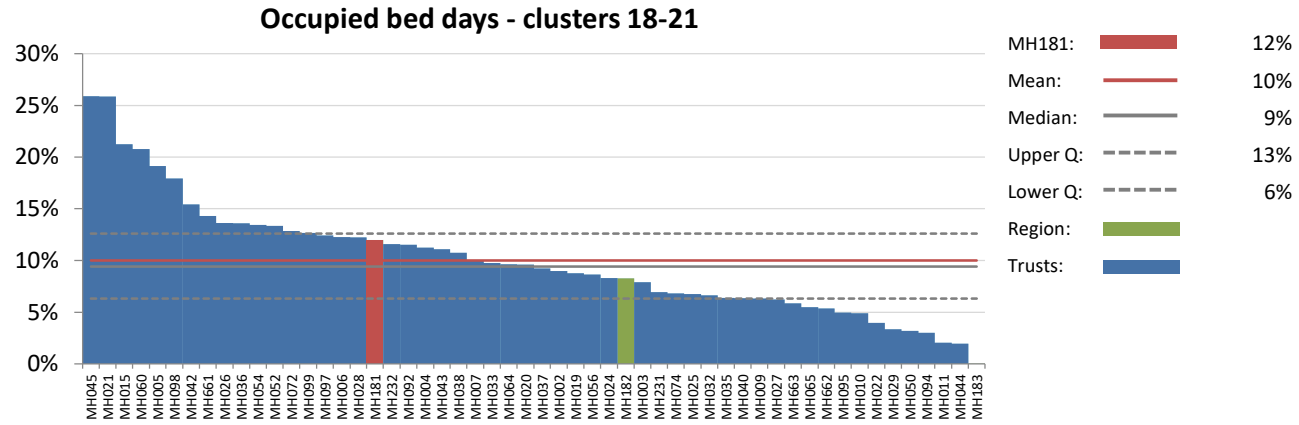


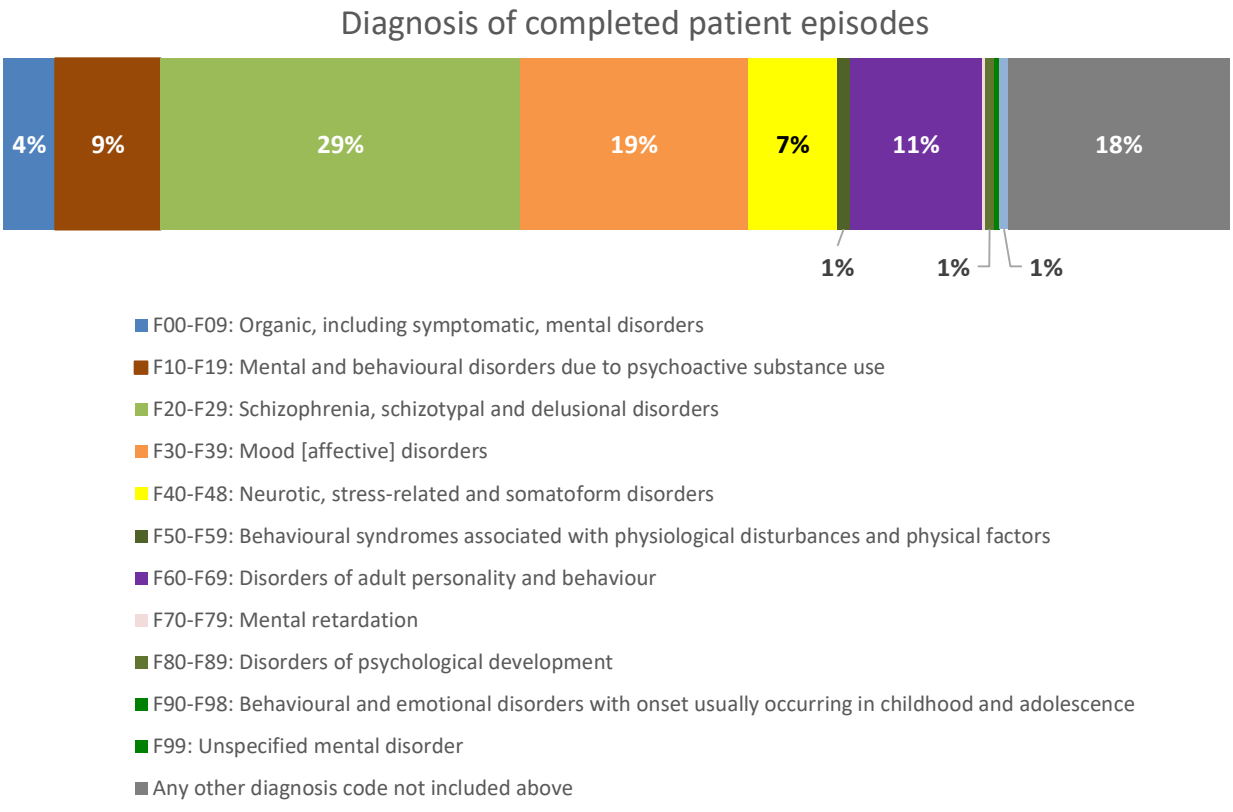
Figure 36

Diagnosis

The chart below shows that the primary ICD-10 diagnosis attributable to the largest proportion of completed patient episodes nationally was schizophrenia, followed by mood [affective] disorders.

The charts on the following page show the provider positions for Schizophrenia and Mood [affective] disorders. Participants can explore their positions for all other diagnosis categories in the NHS Benchmarking Network Mental Health Toolkit.

Some of the variation in diagnosis proportions between providers may be explained by the differences in bed types on offer.



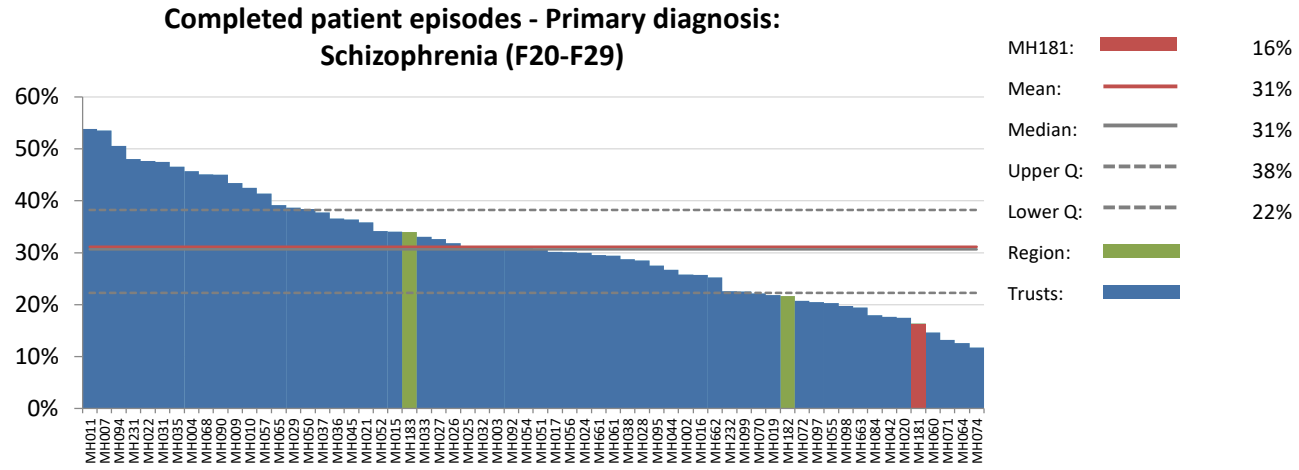


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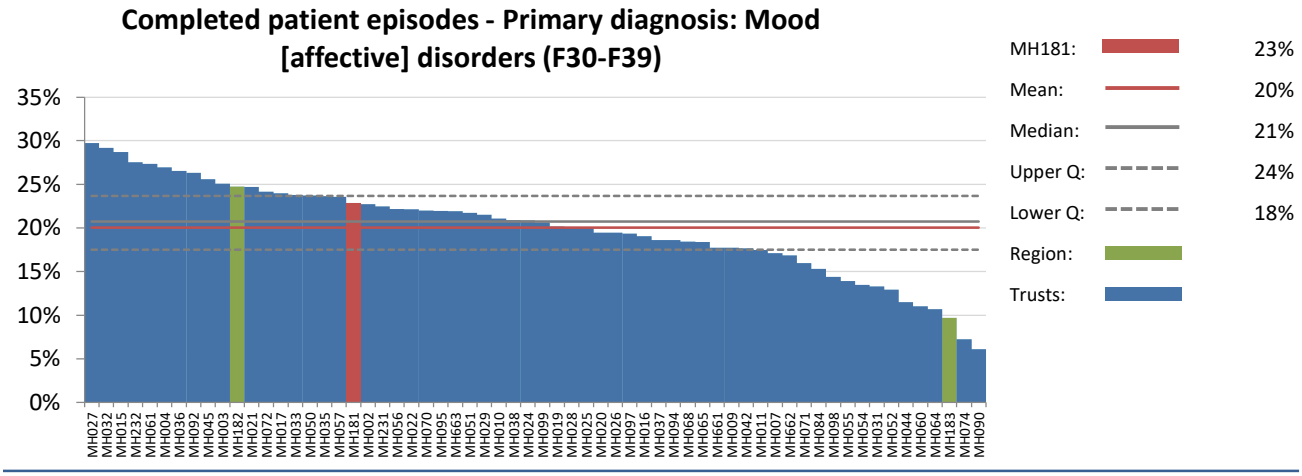


Figure 38

Demographics

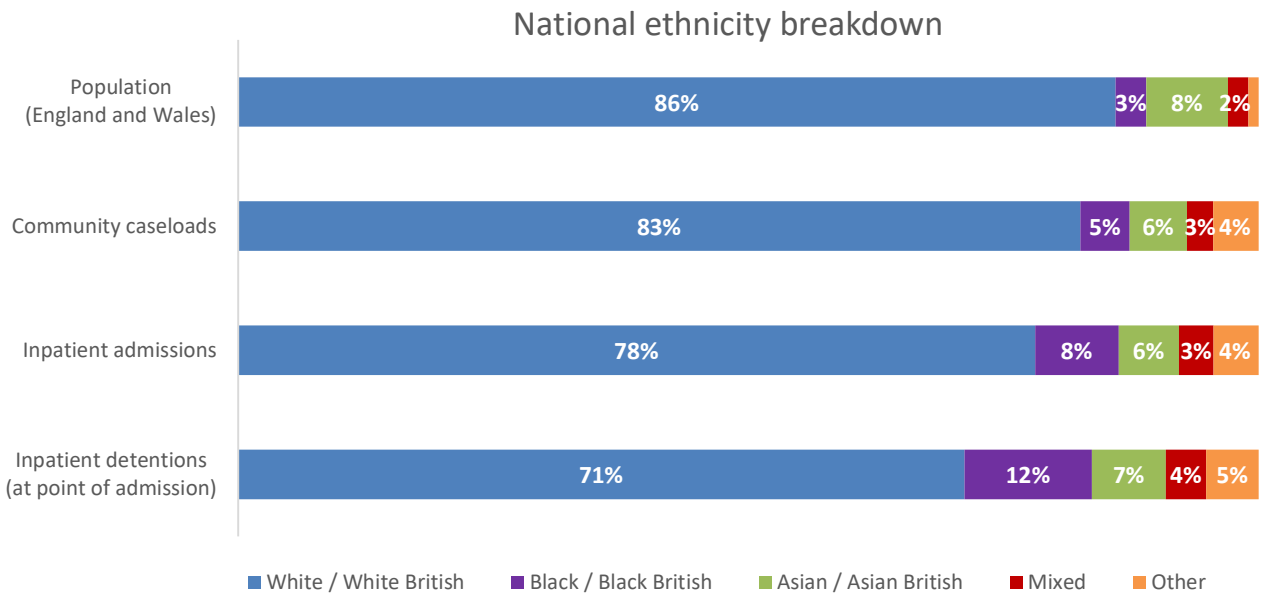
Ethnicity

The ethnicity of patients was included in the data collection for the second time this year. This field was collected for patients who were on community caseload, as well as patients who were both admitted and admitted via detention under the Mental Health Act.

The chart below shows the variations in proportion of patients of Black, Asian and Minority Ethnic (BAME) ethnicity in the various NHS provider cohorts alongside the general population for people aged 16 plus. With 14% of the UK population being of BAME ethnicity, these groups are overrepresented in both the admissions to mental health beds and admissions under detention in 2020/21. There are a similar proportion of BAME patients on community caseloads compared to the general population, but these proportions differ by each BAME ethnicity category.

When compared to the previous year the ethnicity profiles for service users has remained the similar to those reported in 2019/20.

The charts on the following page show individual provider breakdowns. The NHS Benchmarking Mental Health Toolkit allows users to explore the admission breakdown for each service type and by each ethnicity individually.



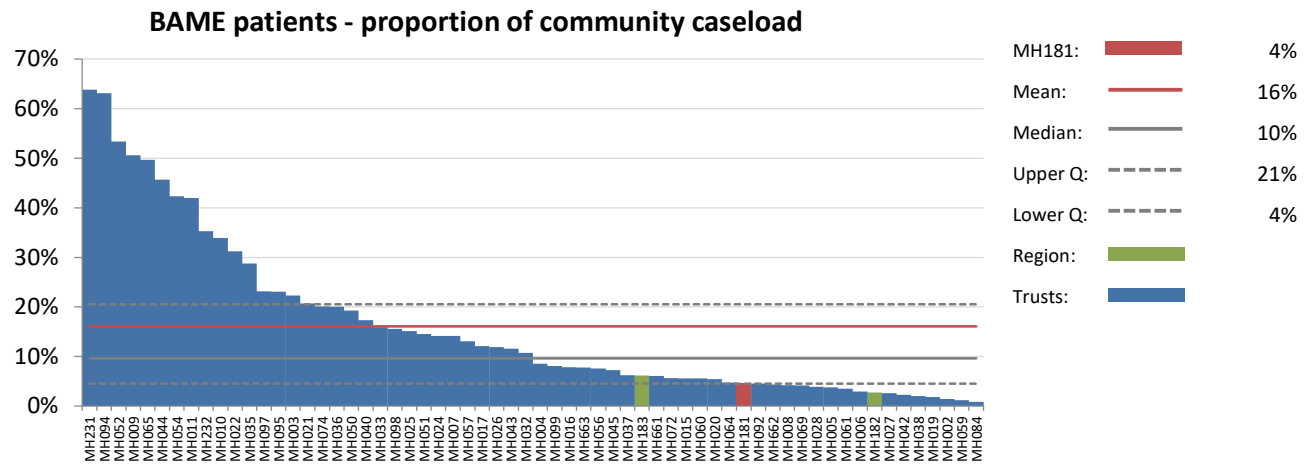


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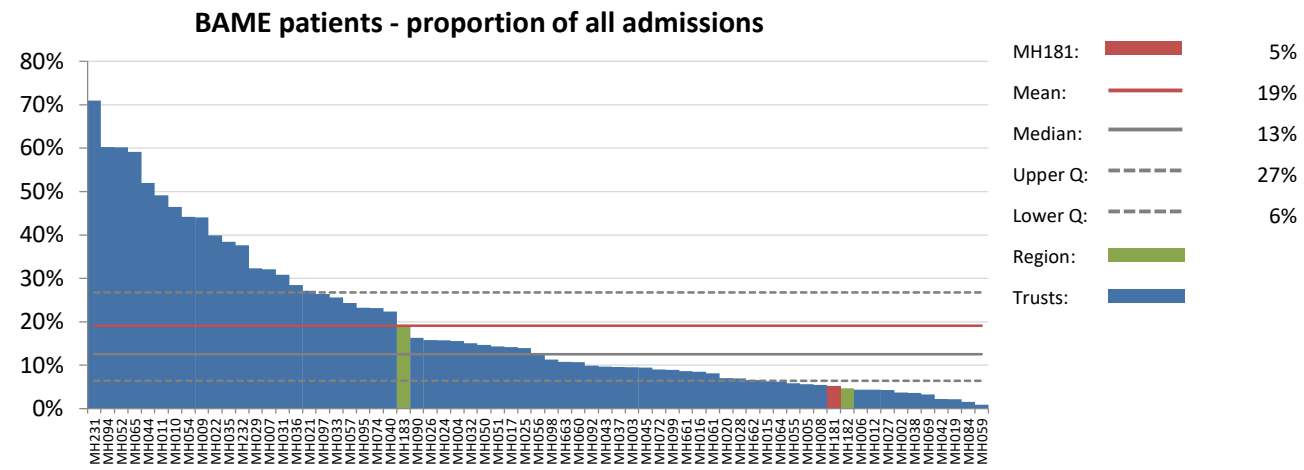


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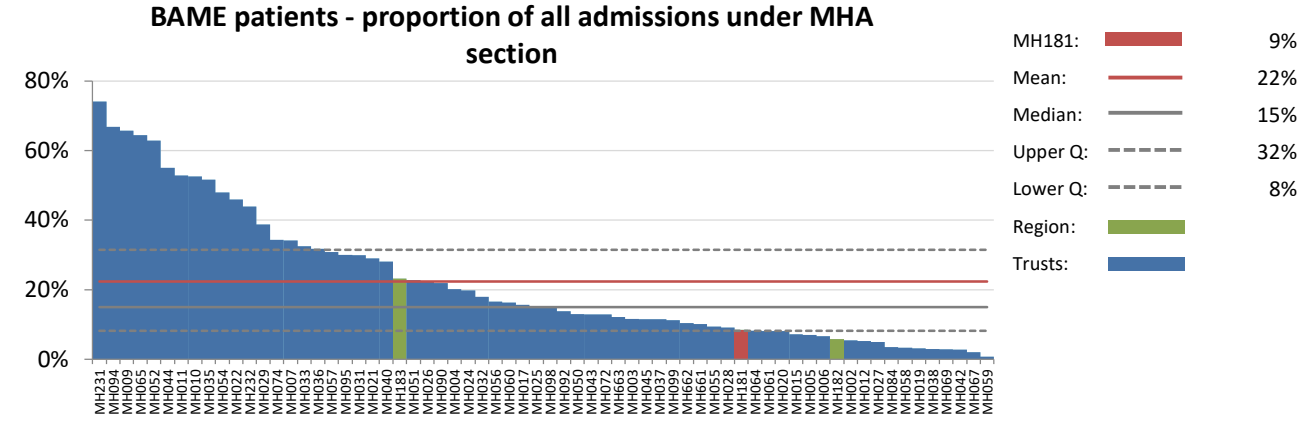


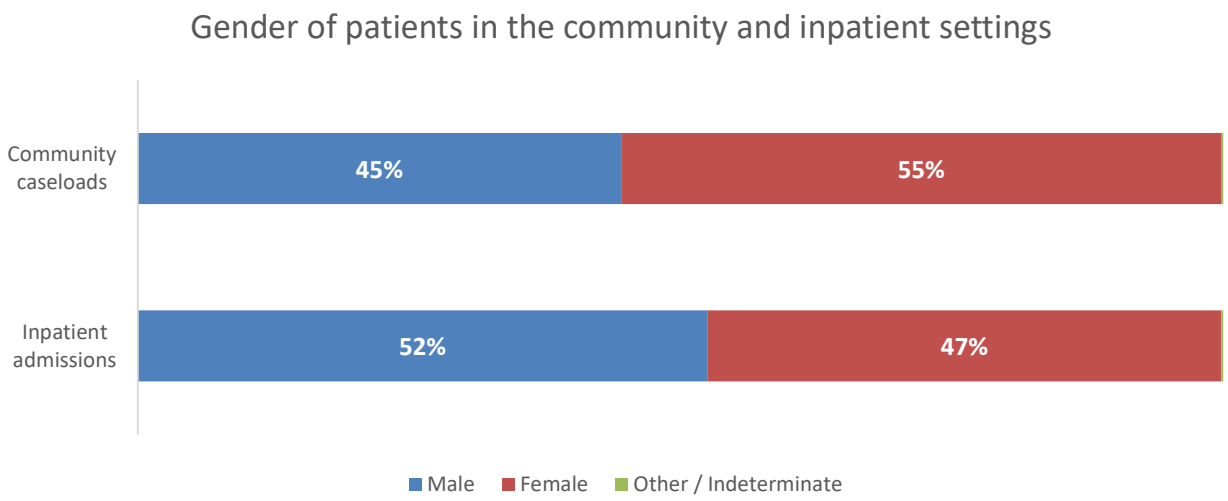
Figure 41

Gender

The gender of patients was continued to be collected this year, as it provides valuable context to the data. This field was collected for patients who were on community caseload and of those admitted to inpatient beds.

The chart below shows the gender split for patients on community caseloads and of those admitted to NHS provider inpatient beds across the UK. There were slightly more female patients on community caseloads than male patients, but there were slightly fewer female patients admitted to inpatient beds than male patients.

When compared to last year's collection the percentage of females accessing the services has increased by 1% in both the inpatient and community settings.



The following charts show that there is limited variation between providers on the gender splits of both the community caseload and admissions. Only a small proportion of providers had a community caseload with more male patients than females. The opposite was reported for admissions, with only a small proportion of providers having more female admissions than male admissions. Local bed provision may impact on this, for example larger providers of secure services or male PICU may have comparatively fewer admissions for females across their estate, due to more dedicated services for males.

The NHS Benchmarking Mental Health Toolkit allows you to explore the proportion of patients by gender for each community team and bed type.

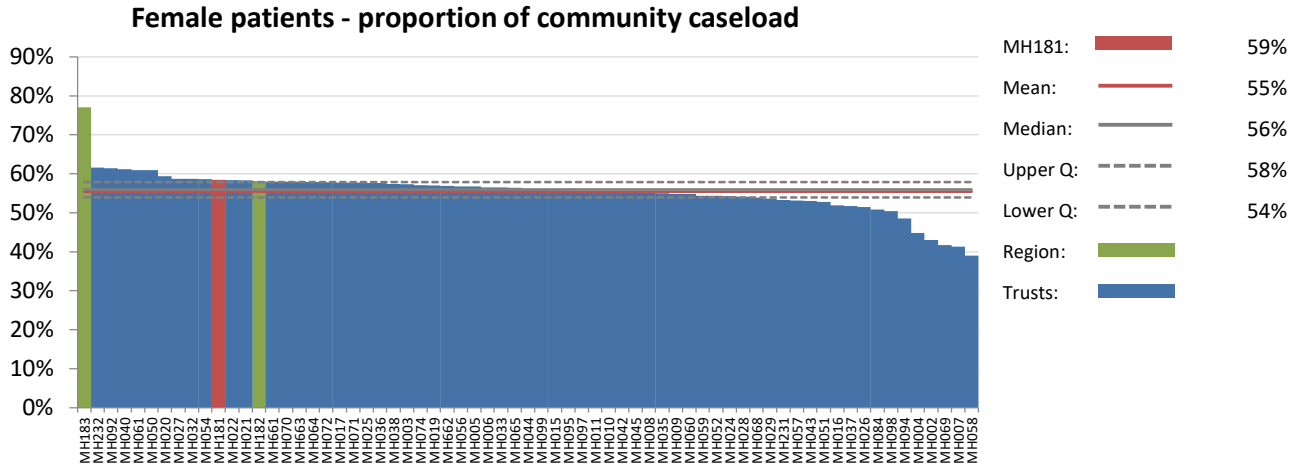


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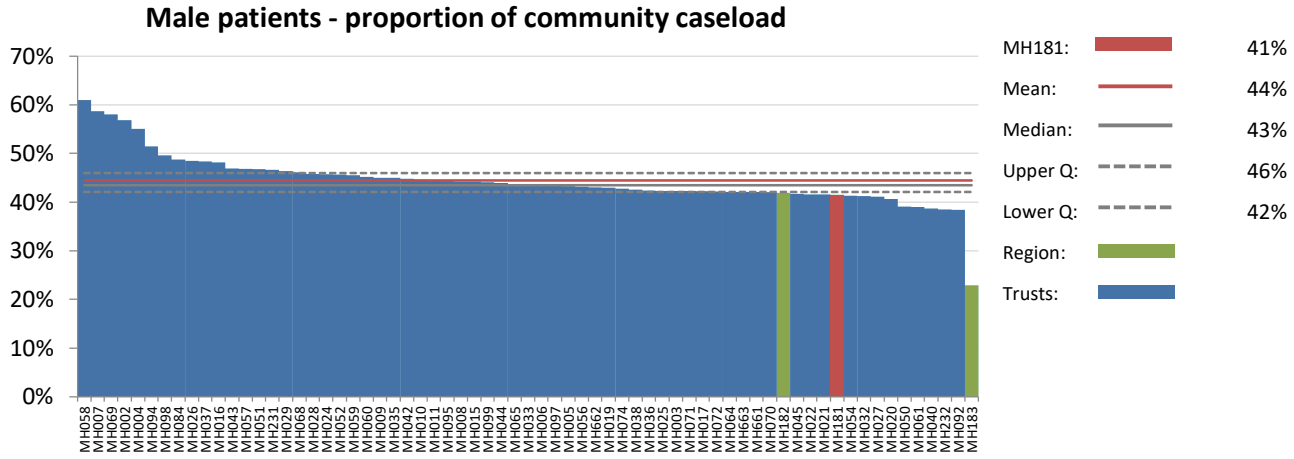


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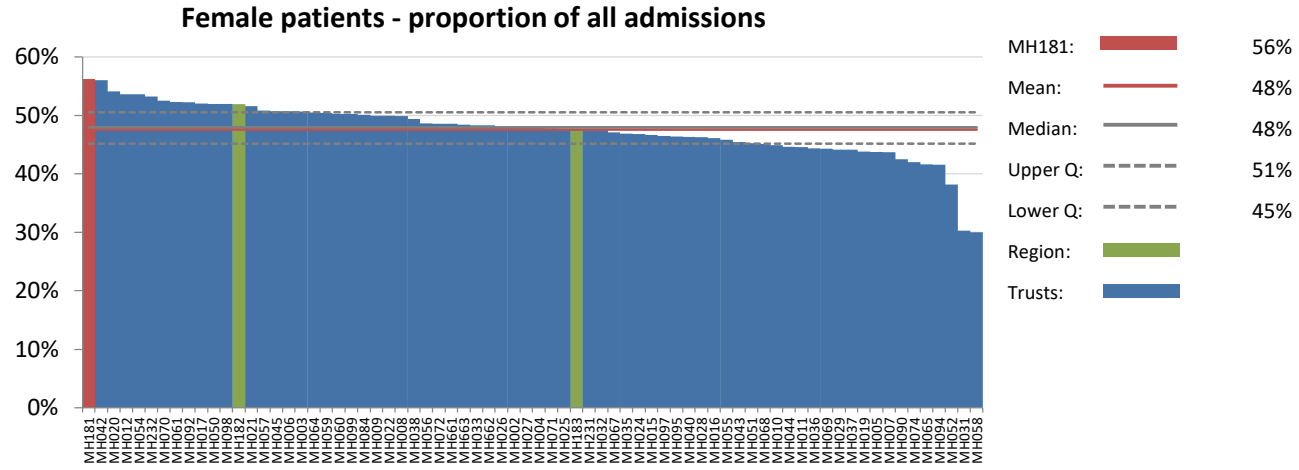


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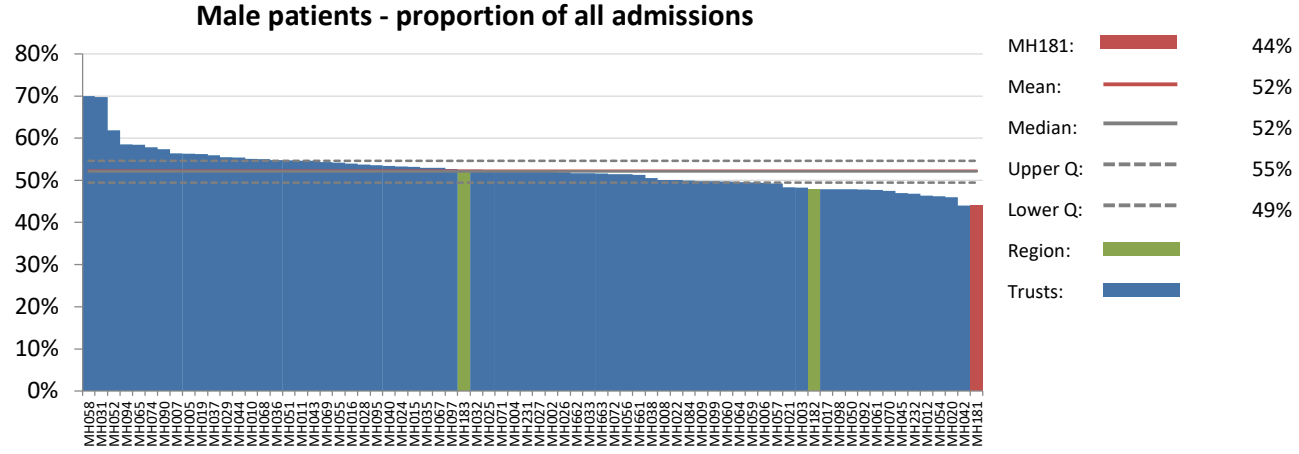


Figure 45



Benchmarking Network

Community Care

	MH181	Mean	Median	National Trend
Total community caseload per 100,000 weighted population at 31st March 2021	1,806	1,439	1,339	
Working age adult teams - community caseload per 100,000 weighted population at 31st March 2021	1,028	1,352	1,186	
Older adult teams - community caseload per 100,000 weighted population at 31st March 2021	3,554	1,772	1,510	
Total community contacts per 100,000 weighted population	32,307	28,951	28,544	
Working age adult teams - community contacts per 100,000 weighted population	25,654	31,132	30,500	
Older adult teams - community contacts per 100,000 weighted population	47,253	24,222	23,229	

Community based care is the most frequently accessed NHS specialist mental health service, serving around 800,000 people across the UK at 31st March 2021. The two key measures of community capacity are caseload and contacts.

The caseload snapshot was taken at 31st March 2021, following a year of significant disruption due to the Covid-19 pandemic. By 31st March 2021, the number of people on caseloads had recovered to a similar position to that as at 31st January 2020, the position immediately prior to the pandemic. During the period between the end of January 2020 and 31st March 2020, caseloads had reduced and the monthly data collected from April 2020 shows that they remained depressed throughout 2020. However, with referrals starting to increase providers can expect an increase in caseloads as patients move from assessment to treatment stages of pathway.

Contacts is a measure of the number of face to face and non face to face contacts delivered by a community team to patients on their caseload, and to those who are being assessed. The table above shows the number of contacts delivered in 2020/21.

Older adult community caseloads and contacts have seen a sustained reduction in recent years. In the working age community services caseloads started to increase in 2018/19 and contacts have seen increases since 2019/20. Caseloads and contacts for working age services are now the highest recorded in the lifetime of the project.

It should be noted that the definition of a patient being on a caseload was altered for the 2020/21 data collection after consultation with the Mental Health Reference Group. The new definition includes flexibility about non-face to face appointments being included in the '2 contacts' standard to access caseload.

Participants can explore their contacts and caseload positions for the individual team types in the NHS Benchmarking Mental Health Toolkit.

Community caseloads

Community services are reported here benchmarked per capita by caseload size and number of contacts delivered. The network, in conjunction with the Mental Health reference group have altered the definition of caseload for this data collection. For the purposes of this report, the following definition of caseload is applied, patients who have had two or more clinical contact appointments as part of the episode of care. This therefore excludes people who are still in the assessment phase, and may not enter treatment with a team.

Total community caseload shows the sum of all individual community team caseloads, against a population of those age 16 and older. Working age adult teams include all teams who predominantly serve this age group, against a population of age 16-64. Older adult teams include old age community teams and memory services, against a population of age 65+.

Total caseloads (for all community teams) averaged 1,439 per 100,000 weighted population on 31st March 2021, higher than the 1,672 per 100,000 weighted population reported as at 31st March 2020, as the UK went into its first national lockdown. There are differences in the trends for working age people and older people. In 2020/21 the caseload for working age people increased to 1,352 per 100,000 population from 1,489 in 2019/20, whereas the caseloads for older people have reduced to 1,772 per 100,000 population from 2,387 in 2019/20.

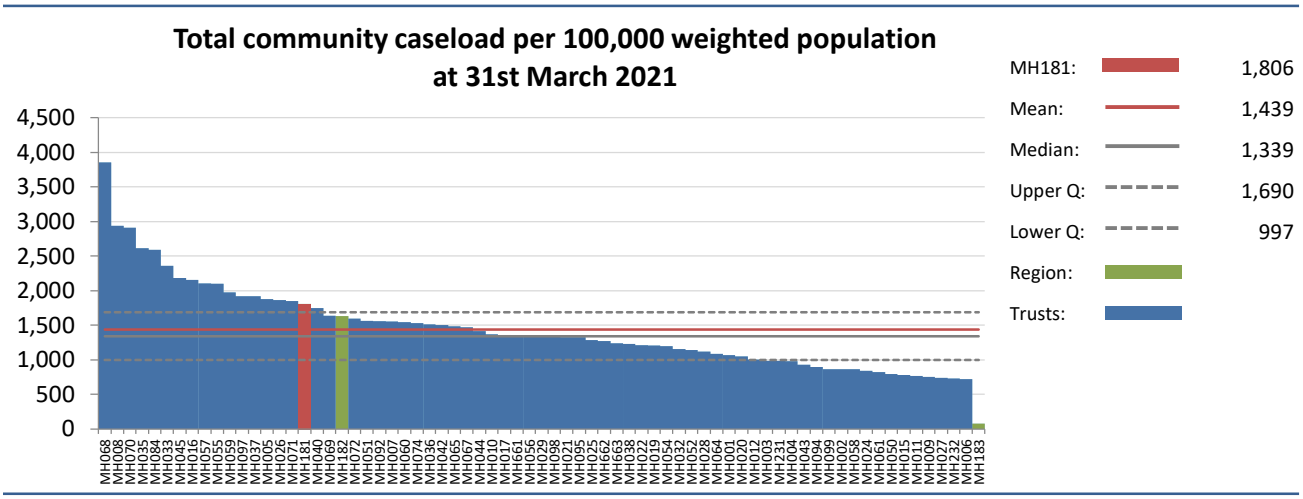


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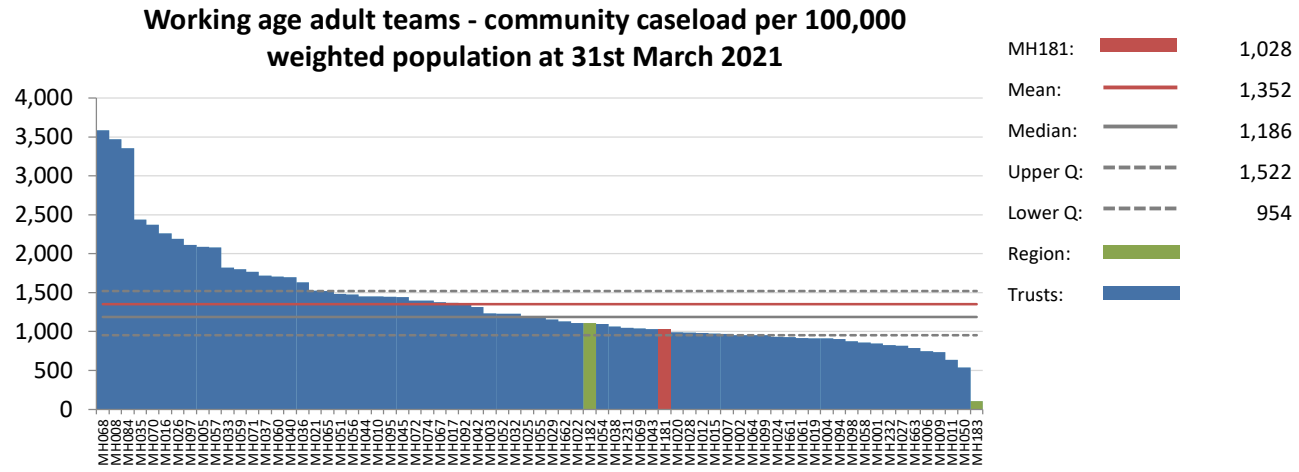


Figure 47

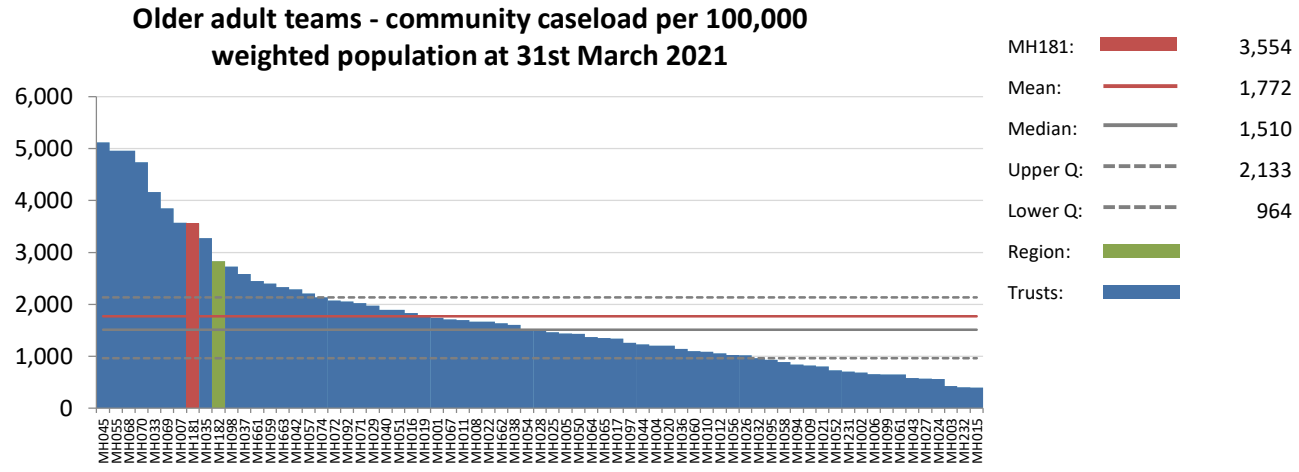
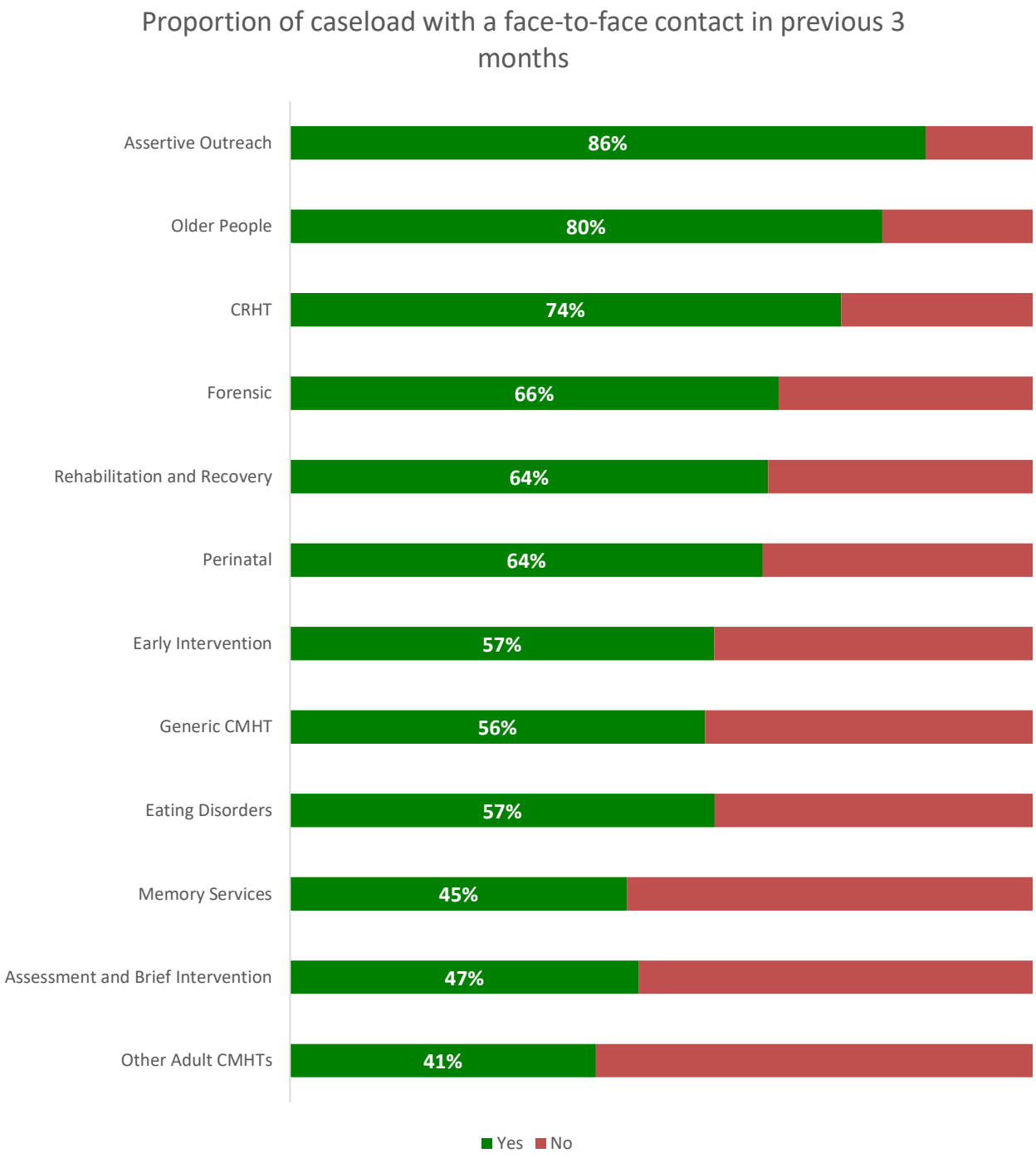


Figure 48

Benchmarking Network

Participants reported the proportion of their caseloads on 31st March 2021 who had been seen for a face to face appointment during the 3 months prior to that date (1st January- 31st March 2021). Although there is variation between team types, the typical experience appears to be that most patients will have had a face to face contact during that time.

The figure below shows national average positions, while the charts on the following page show individual participant positions for three key team types: Generic CMHT, Early Intervention in Psychosis, and Older People. Other team types can be explored in the toolkit.



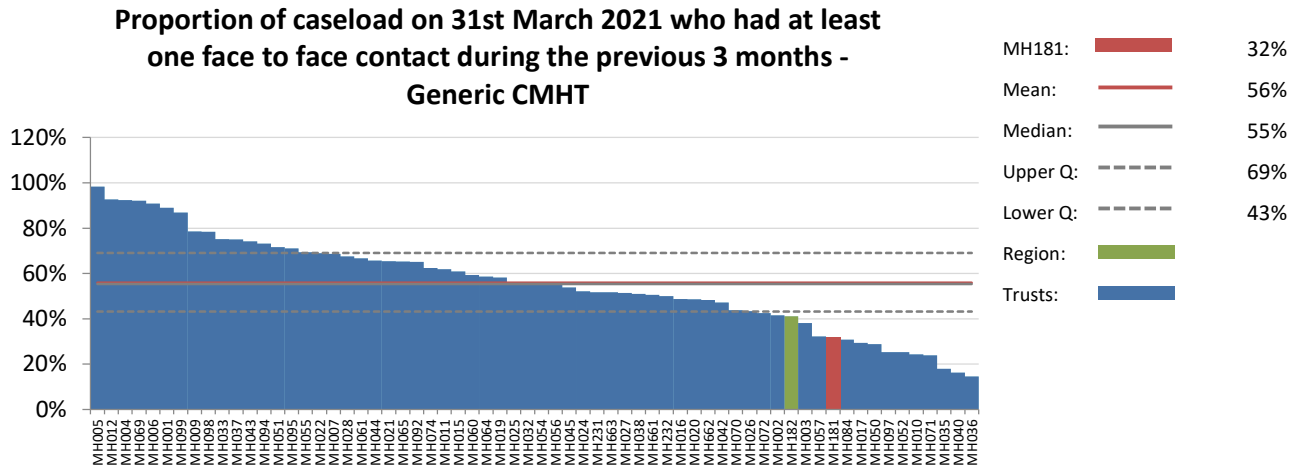


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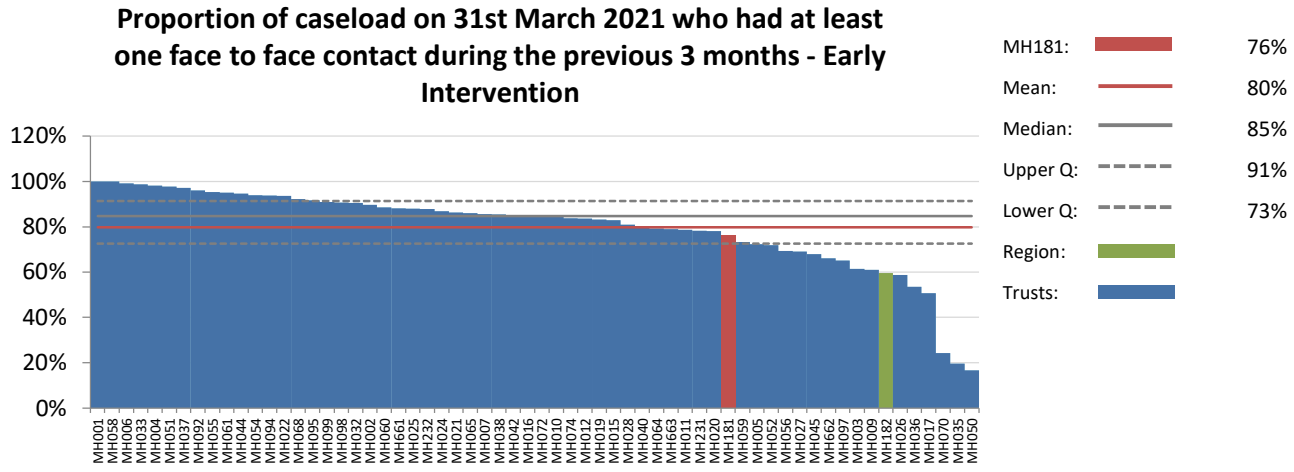


Figure 50

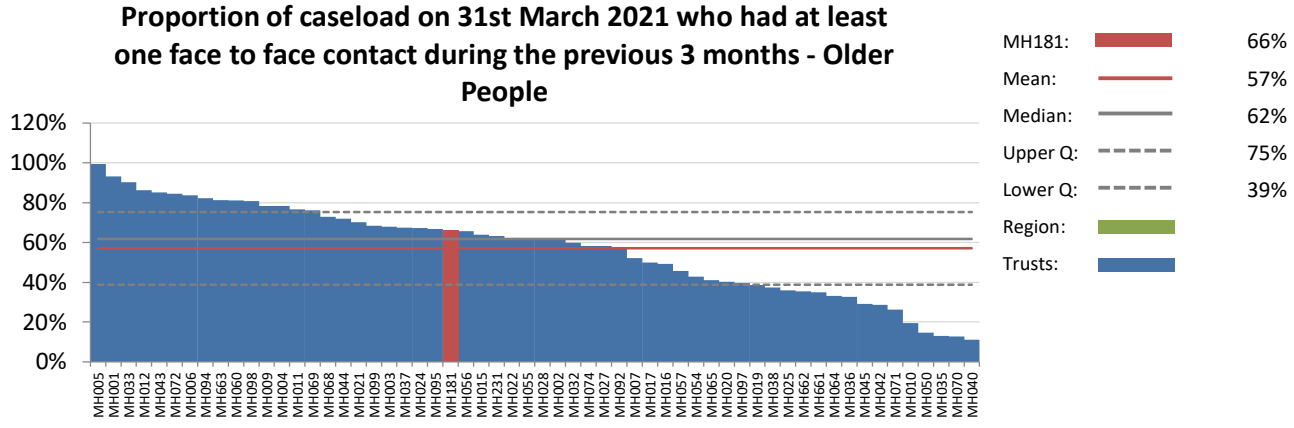


Figure 51

Community Contacts

Community contacts averaged 28,951 per 100,000 weighted population in 2020/21. This is higher than the 31,468 reported in 2019/20. When comparing this year's figure to that of previous years it is notable that although services have been significantly disrupted due to Covid-19 during the year, contact rates have recovered well following a drop in the first months of lockdown. Contacts include face to face, telephone and digital contacts.

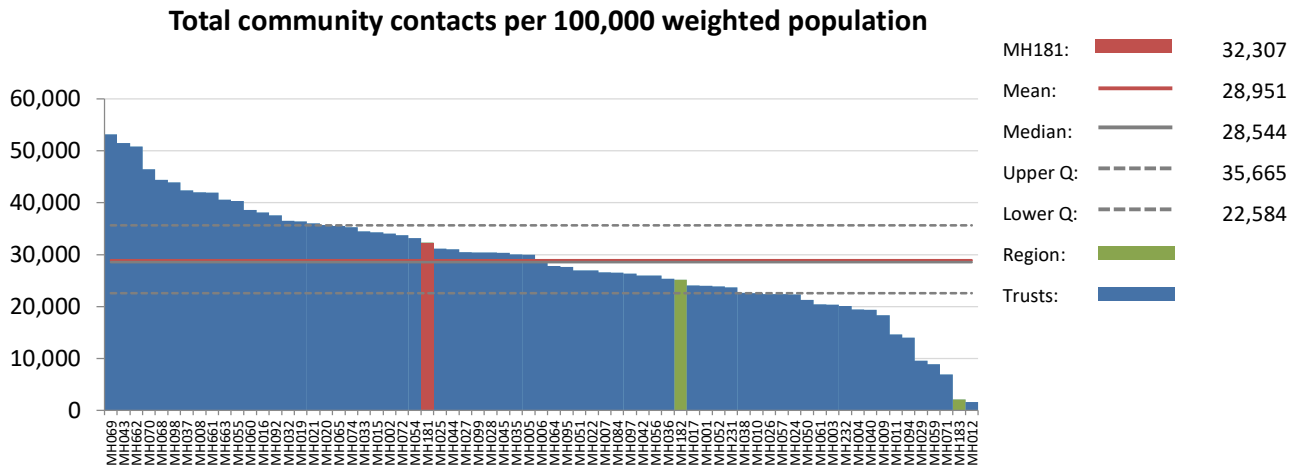


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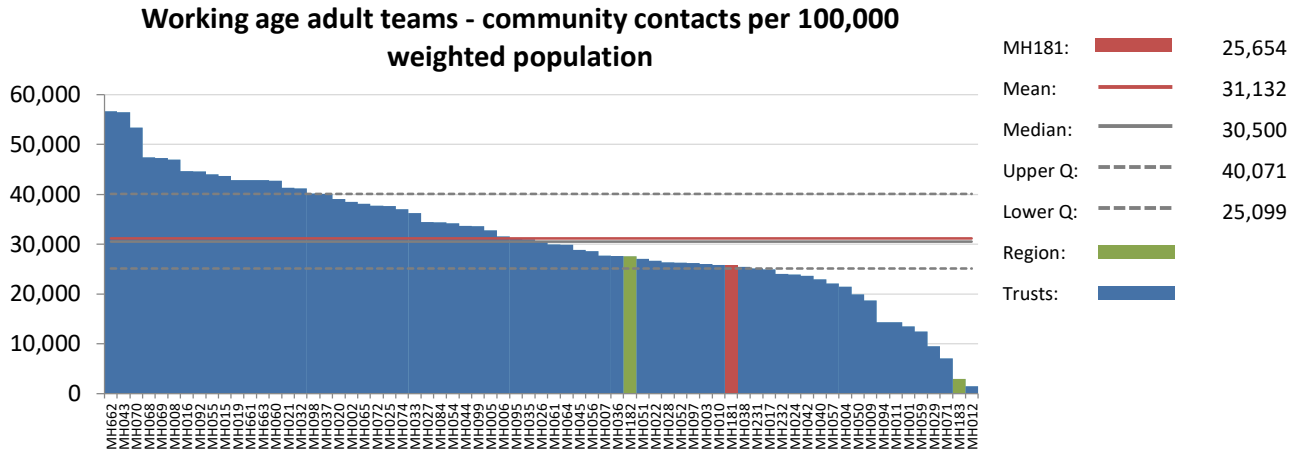


Figure 53

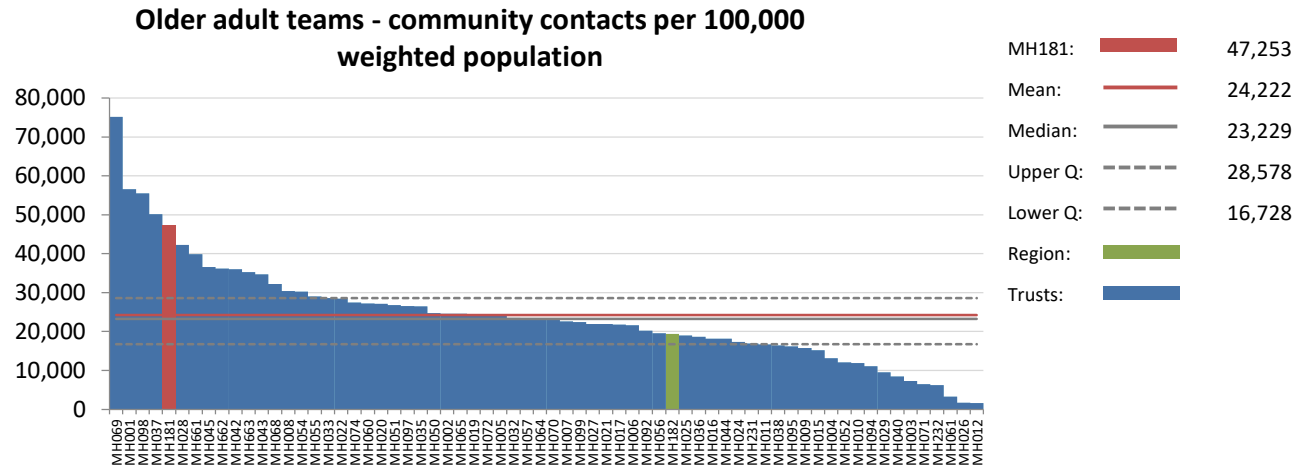
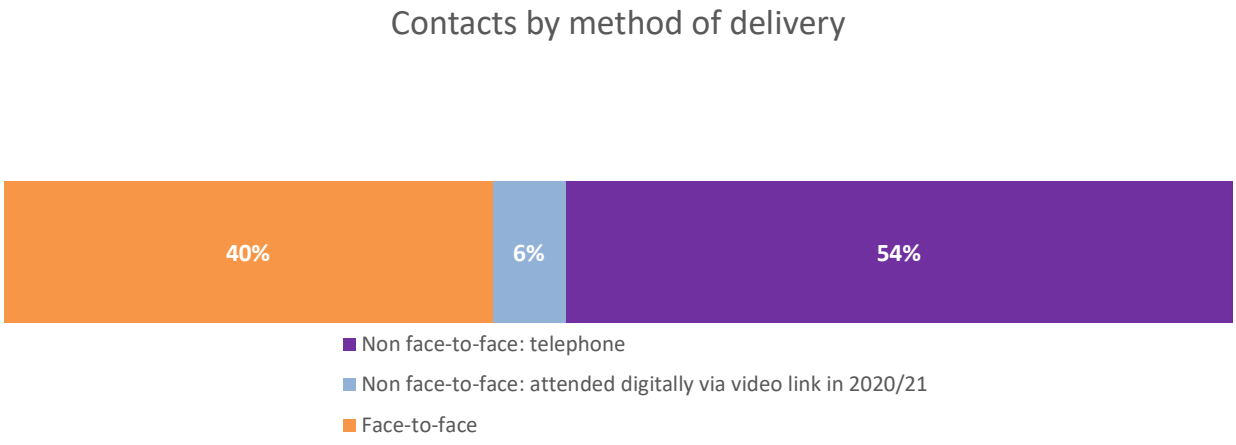


Figure 54

Non-face to face contacts delivered in 2020/21

The Covid-19 pandemic has seen substantial changes in the way community contacts have been delivered to patients. In previous years around a quarter of contacts were delivered in a non face-to-face manner, primarily by telephone. The pandemic has shifted the method of delivery considerably, with non-face to face contacts delivered by telephone or video link increasing to an average of 60%.



The chart shows that there is notable variation between providers in the proportion of contacts delivered in a non-face to face format in 2020/21.

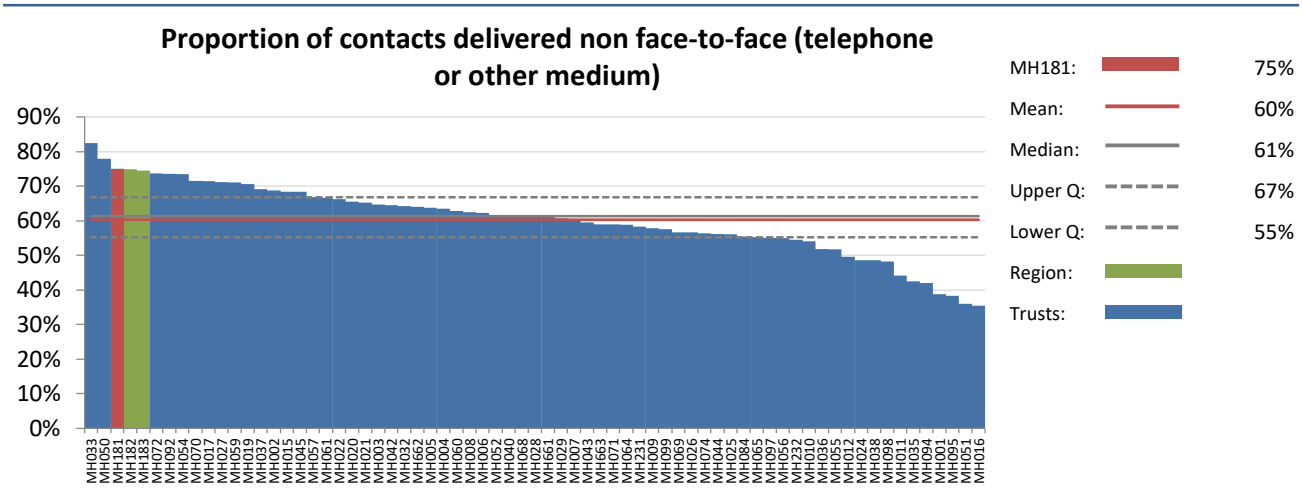


Figure 55

The chart below highlights an increase in the proportion of non-face to face contacts delivered digitally via video link, with increases in both the numbers of providers delivering via the method and increases in the digital average within non-face to face care from 7% in 2019/20 to 10% in 2020/21.

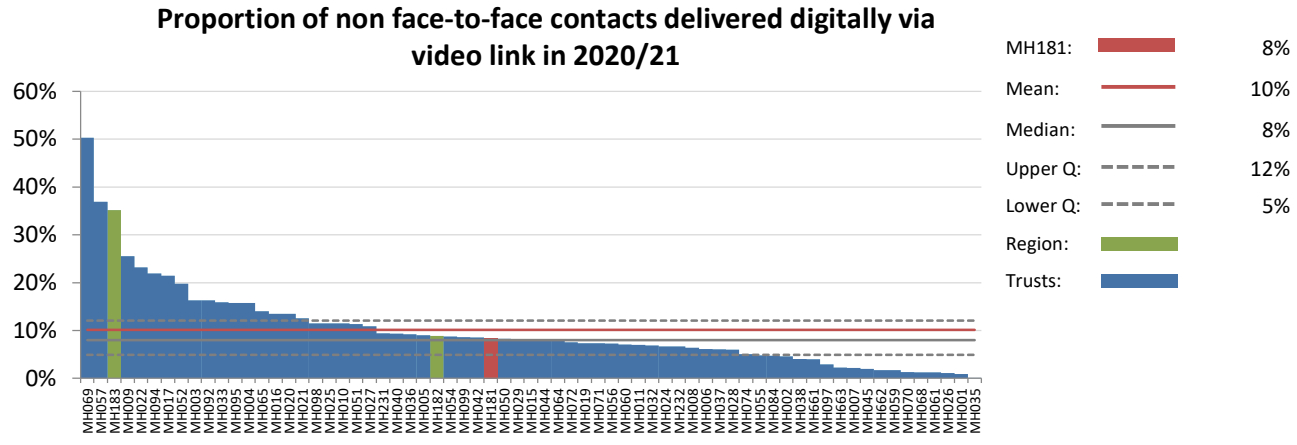
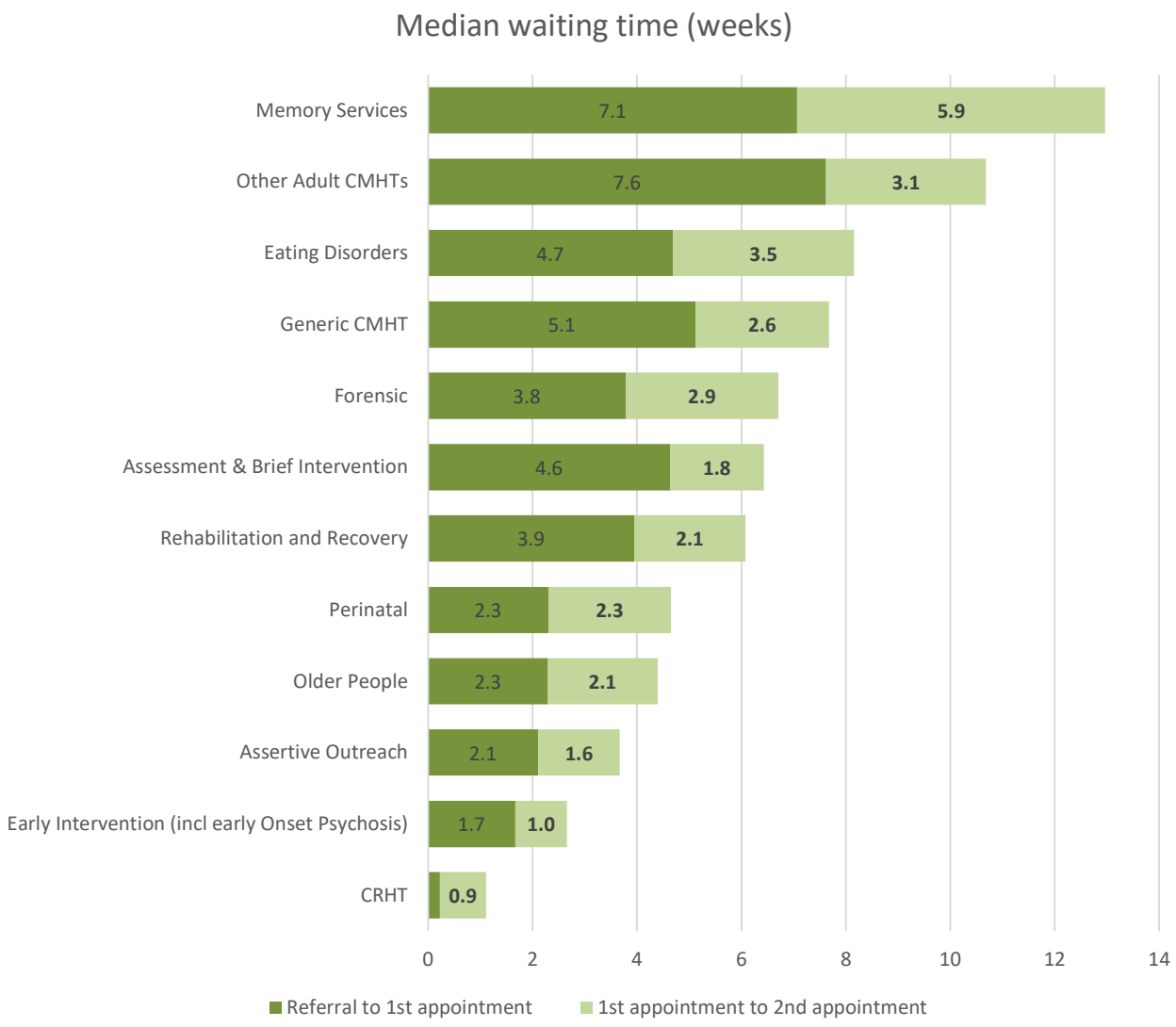


Figure 56

Waiting times

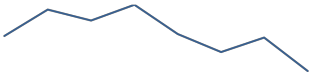
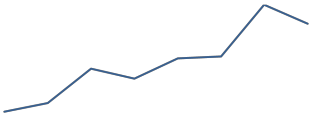


Waiting times show notable variation by team type. The above chart details national average positions for each team and shows that the shortest waits are reported for CRHT, followed by Early Intervention in Psychosis and Assertive Outreach teams. Early Intervention in Psychosis teams are the only community pathway currently subject to formal waiting time targets in England. Memory Services reported the longest waiting times closely followed by Other Adult CMHTs; Memory services reported waiting times just over 13 weeks, an increase on the previous year. The waiting time for Other Adult CMHTs was just over 10 weeks and this is a reduction on the waiting time in 2019/20.

Participants can explore their individual positions in detail in the NHS Benchmarking Mental Health Toolkit.

Benchmarking Network

Early Intervention

	MH181	Mean	Median	National trend
Early Intervention referrals received per 100,000 weighted population	63	70	68	
Early Intervention referral acceptance rate	48%	79%	83%	
Early Intervention caseload per 100,000 weighted population at 31st March 2021	40	62	58	
Total staff working in Early Intervention per 100,000 weighted population at 31st March 2021	6	7	7	
Early Intervention teams contacts per patient on the caseload (Caseload at 31st March 2021)	51	38	37	

As the only part of adult mental health services currently subject to formal national waiting time standards, there continues to be a focus on Early Intervention in Psychosis services.

This year has seen a reduction in referrals to 68 per 100,000 weighted population, from the 74 per 100,000 weighted population seen in 2019/20. This year's referral acceptance rate of 79% is just below the 80-83% range, which has been reported since 2013/14.

Staff working in Early Intervention in Psychosis services have ranged from 5.7 to 7.1 WTE per 100,000 population since 2013/14. This year's position of 7.2 WTE is above the range previously reported.

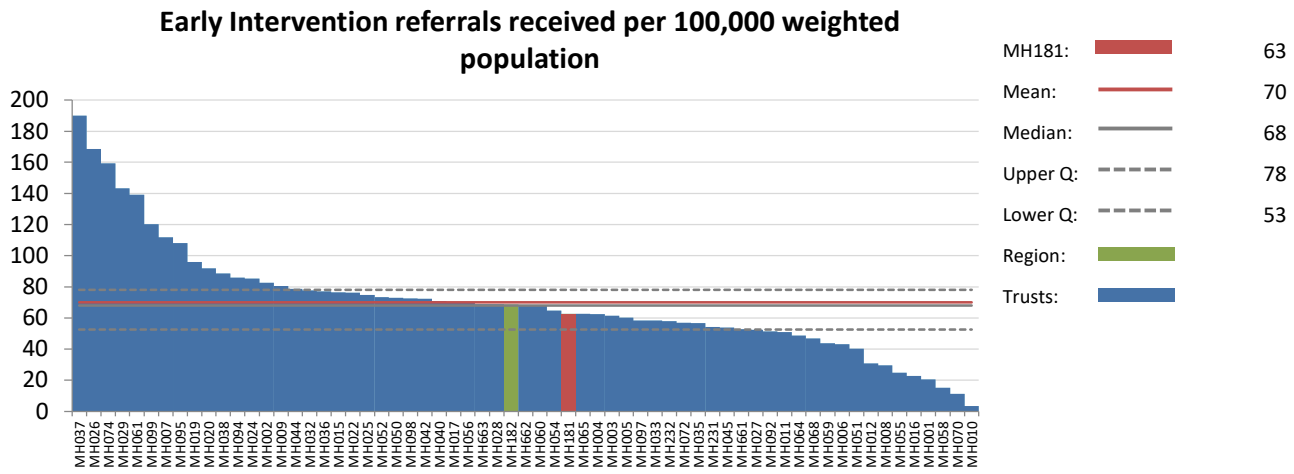


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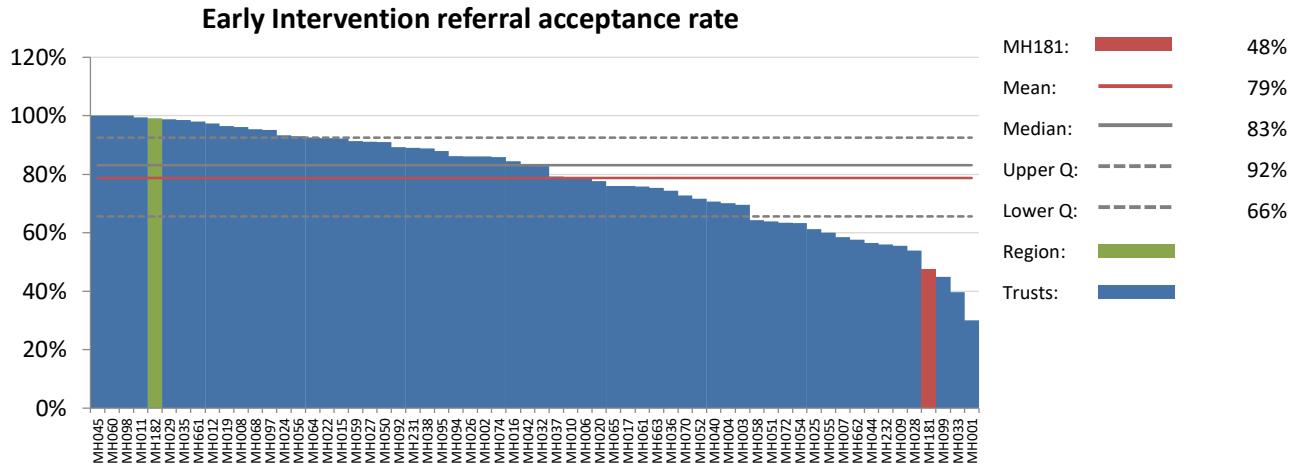


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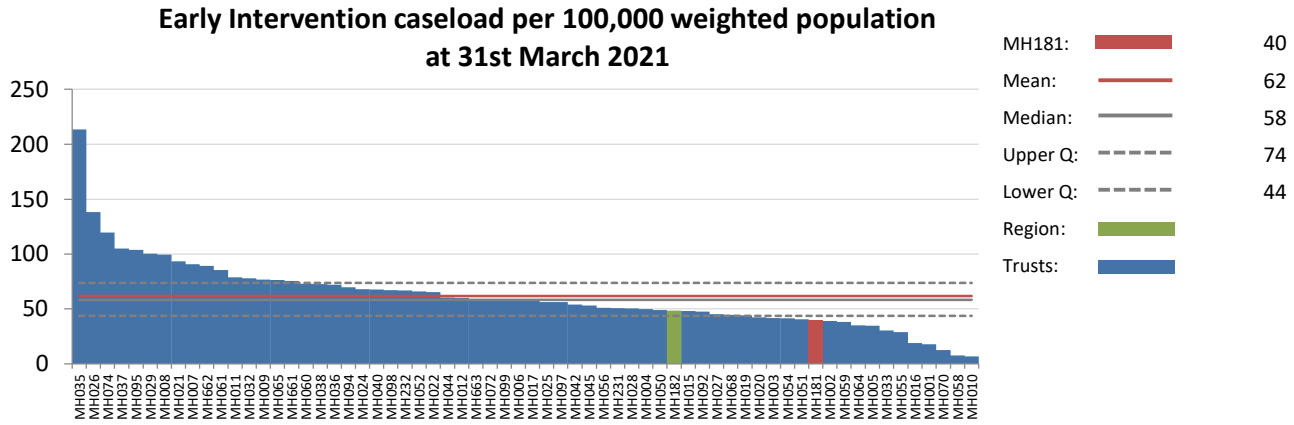


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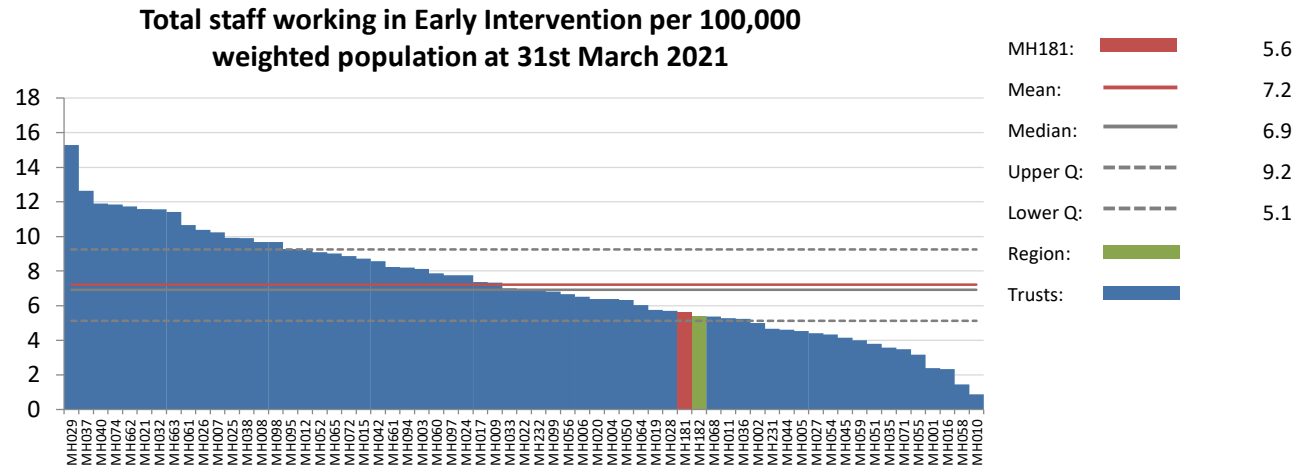


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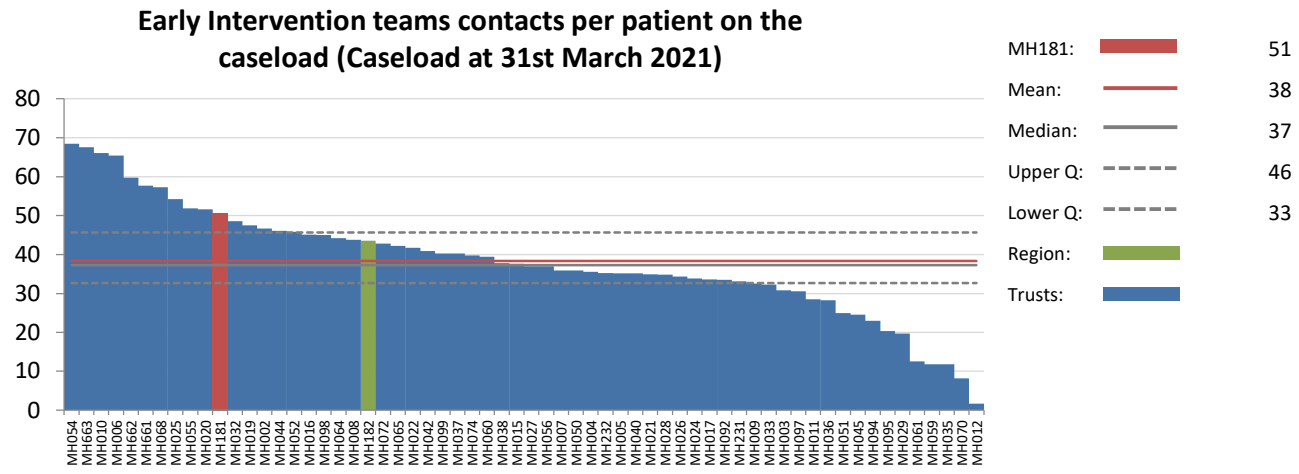


Figure 61

Crisis Care

	MH181	Mean	Median	National trend
CRHT face to face contacts per 100,000 weighted population	820	2,833	2,724	
Total staff working in CRHT teams per 100,000 weighted population at 31st March 2021	19	20	18	
Psychiatric liaison contacts per 100,000 weighted population	783	1,635	1,580	
Total staff working in psychiatric liaison per 100,000 weighted population at 31st March 2021	2	7	7	
Section 136 Assessments per 100,000 weighted population	64	89	89	

Continuing the upward trend in the number of Section 136 Assessments reported in recent years, this year's figure of 89 per 100,000 population is comparable with 2019/20 which was the highest recorded since the project began.

There have also been increases in the size of the workforce in both CRHT teams and psychiatric liaison settings. Contacts in these settings have reduced in comparison to 2019/20, but fluctuations are seen in the trend over the last few years. Face to face contacts in CRHT have shown a sharp decline in 2020/21 in common with other community team types.

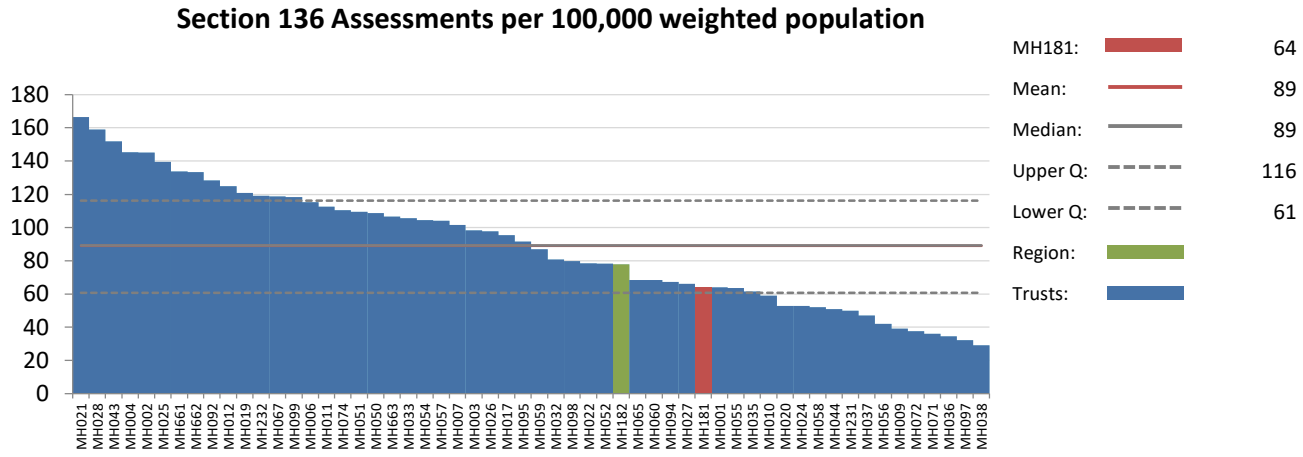


Figure 62

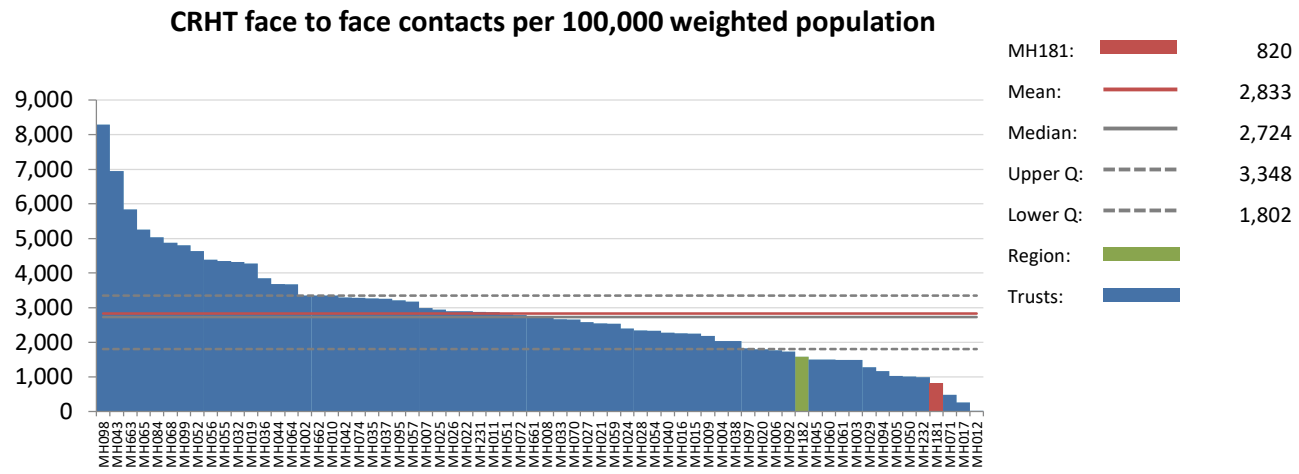


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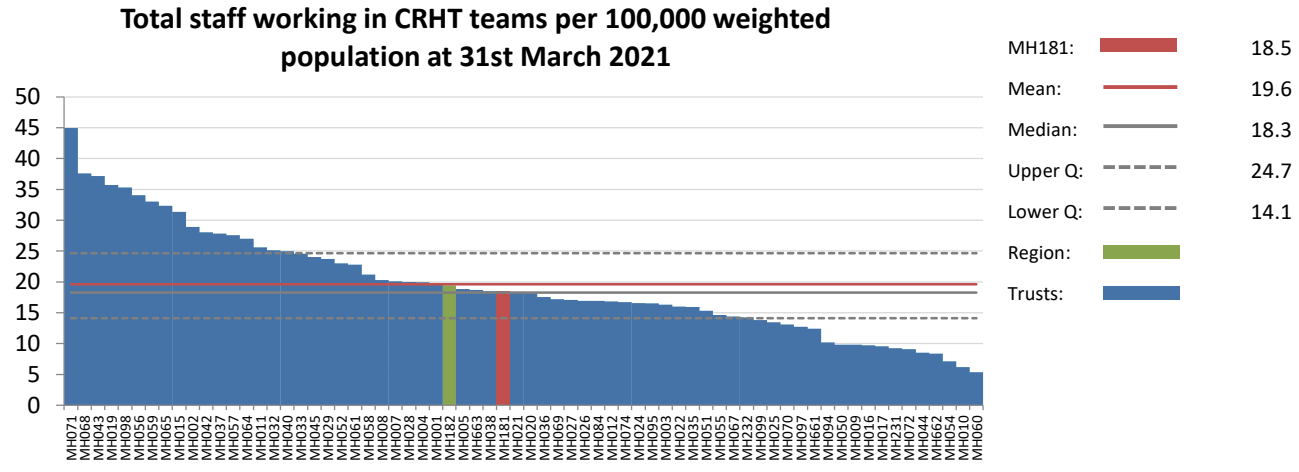


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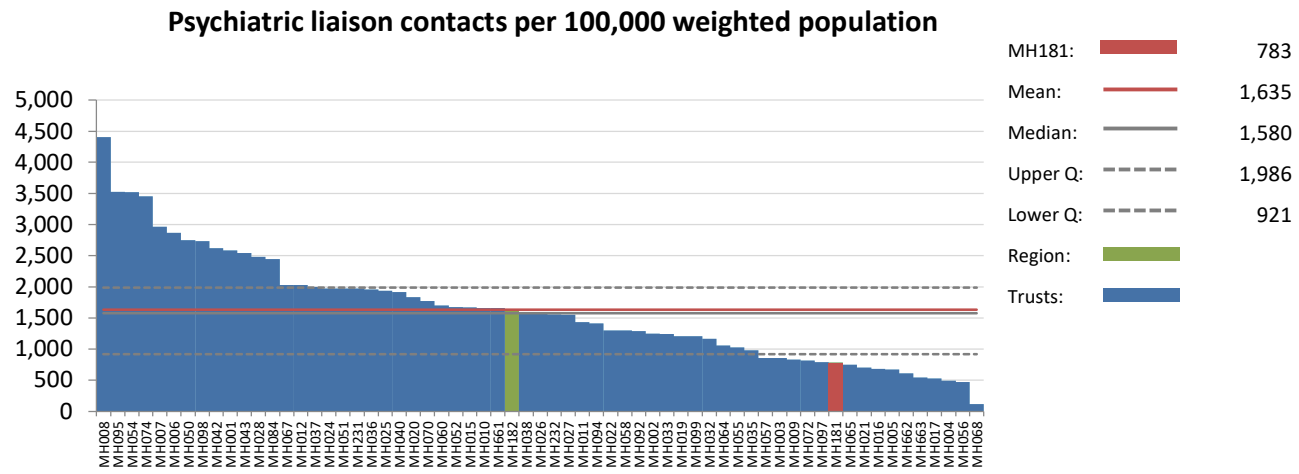


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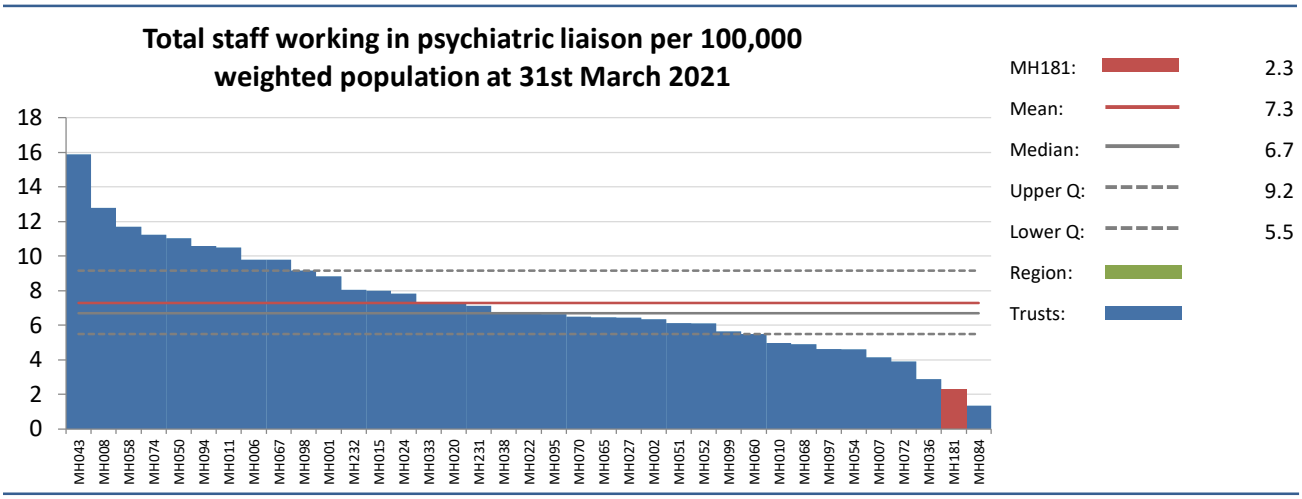
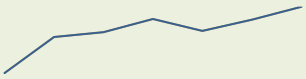
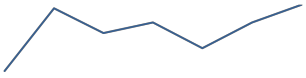
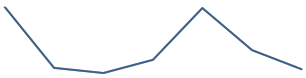


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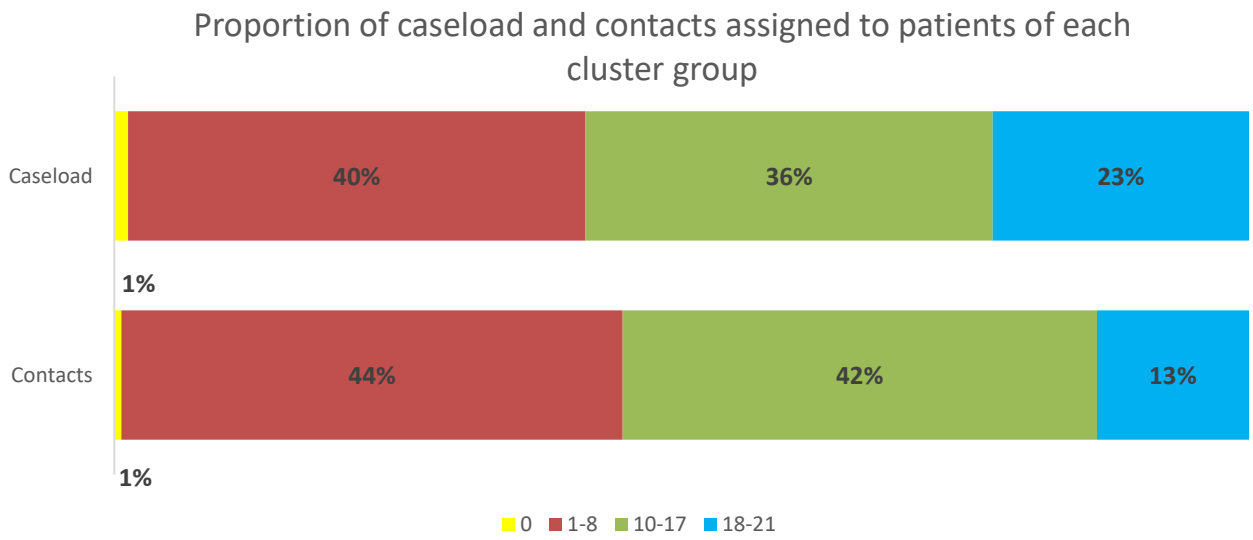
Benchmarking Network

Community Clustering

	MH181	Mean	Median	National trend
Proportion of caseload assigned to a cluster	95%	72%	76%	Not available
Of those assigned:				
Community caseload - clusters 1-8	26%	40%	42%	
Community contacts - clusters 1-8	35%	44%	42%	
Community caseload - clusters 10-17	16%	35%	34%	
Community contacts - clusters 10-17	27%	42%	41%	
Community caseload - clusters 18-21	56%	24%	22%	
Community contacts - clusters 18-21	37%	13%	11%	

There continues to be disparity between the proportion of caseload in each cluster and the intensity of provision (contact rates) to these cohorts. In particular, older people in organic clusters 18-21 represent just under a quarter of the people nationally on community caseload, but receive a notably smaller proportion of the community contacts delivered across the UK. The share of contacts delivered to patients in clusters 18-21 increased slightly last year, but this year has continued the general trend of decline.

Patients in psychosis clusters 10-17 receive the highest intensity treatment, with the largest uplift in proportion of contacts in relation to caseload.



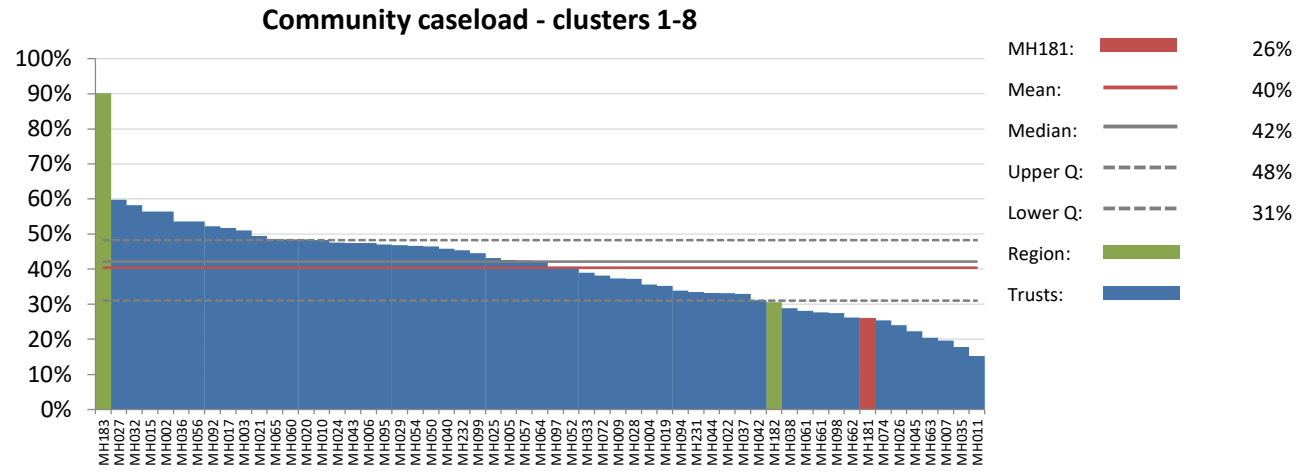


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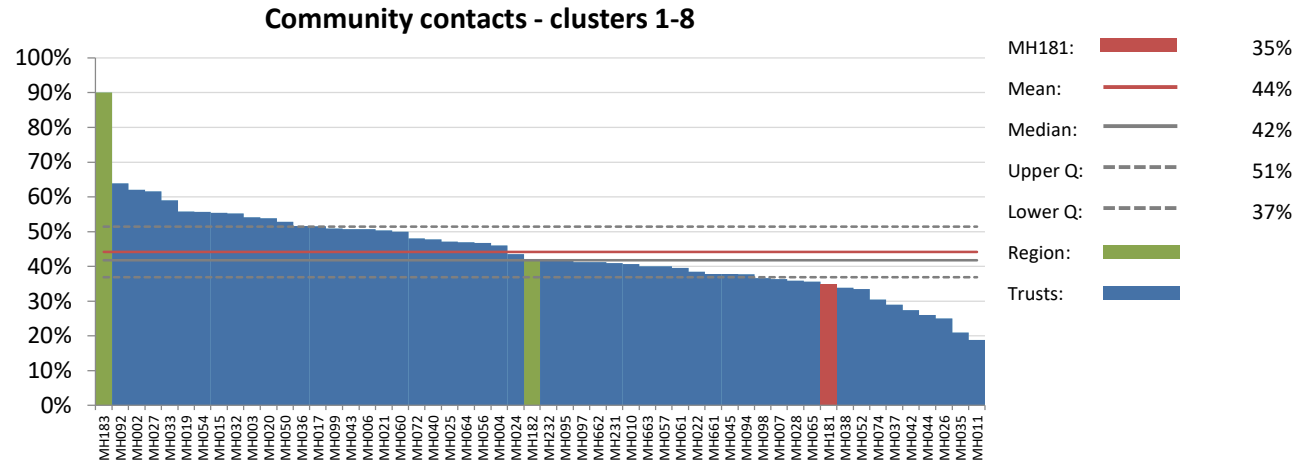


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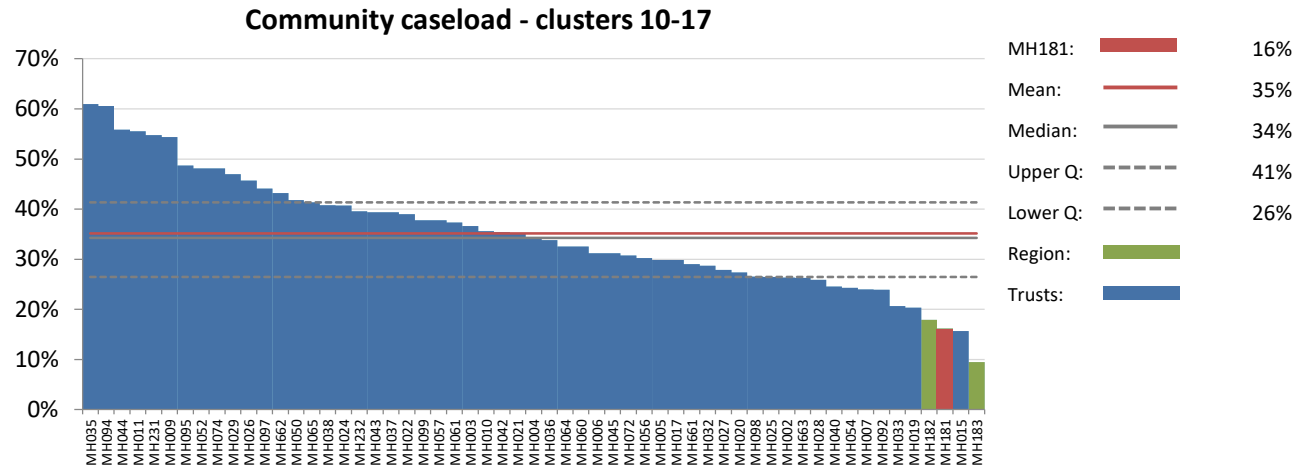


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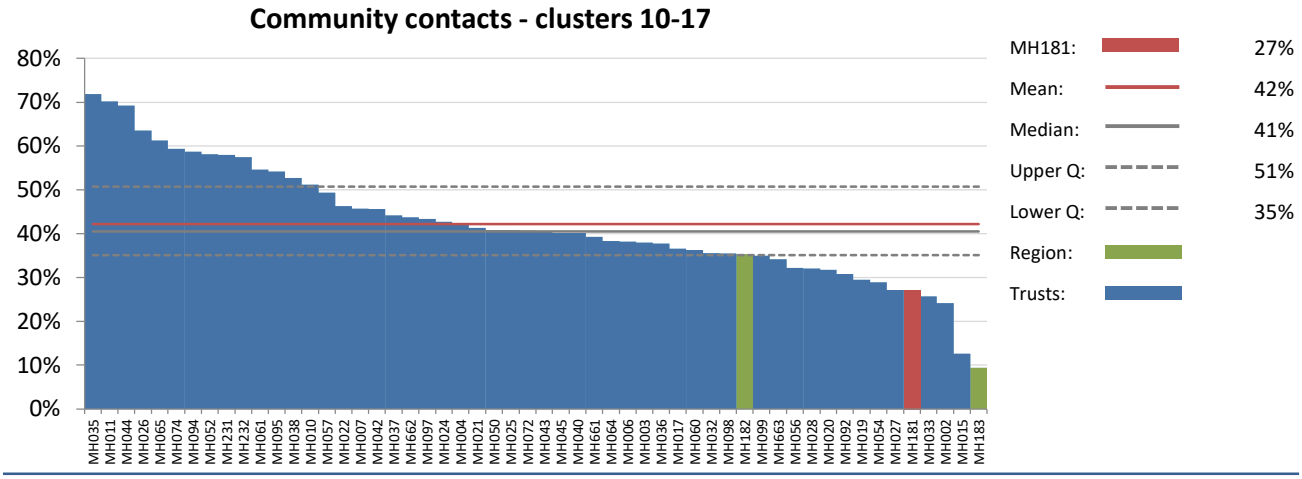


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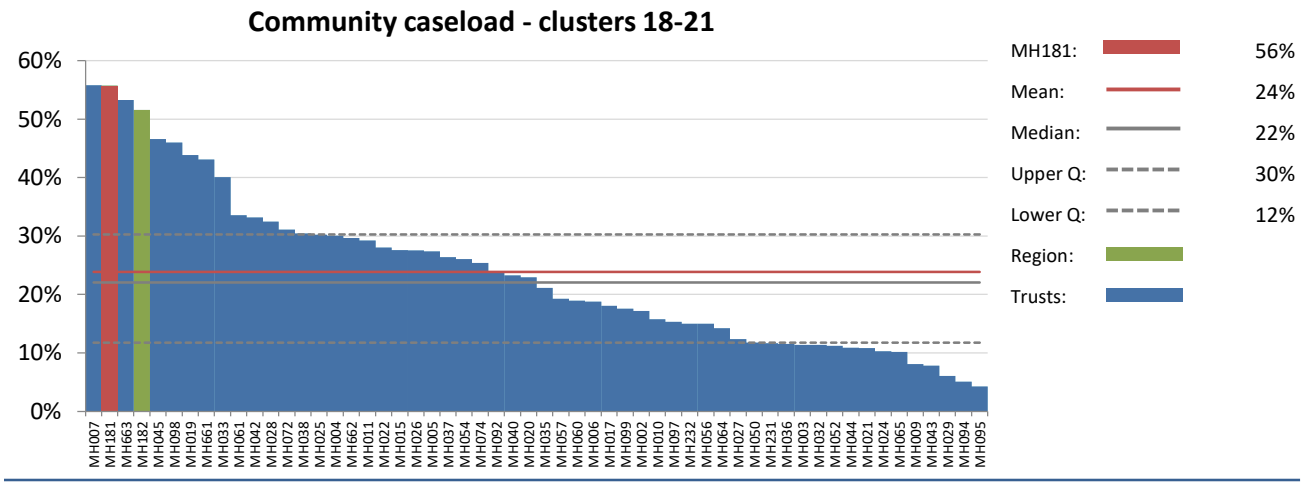


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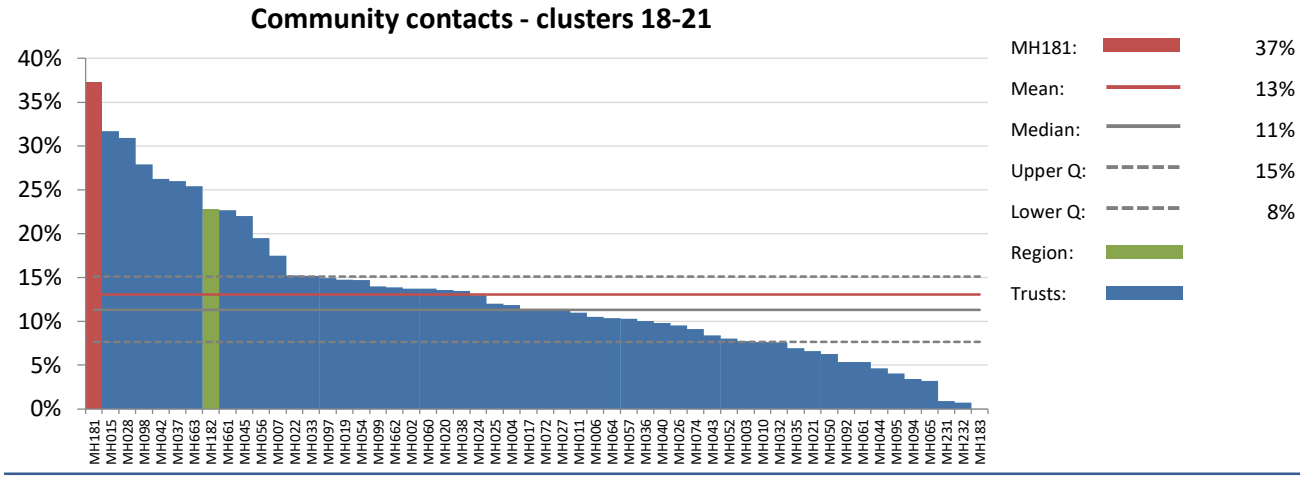


Figure 72



Benchmarking Network

Inpatient Workforce

	MH181	Mean	Median	National trend
Adult acute consultant psychiatrists per 10 beds	0.7	0.6	0.6	
Older adult acute consultant psychiatrists per 10 beds	0.7	0.6	0.5	
Adult acute registered nurses per 10 beds	6.2	7.6	7.5	
Older adult acute registered nurses per 10 beds	9.6	8.0	7.4	
Adult acute staff sickness / absence %	5%	7%	6%	
Adult acute staff turnover %	12%	12%	11%	
Adult acute WTE vacancies as % of staff in post	17%	12%	13%	
Adult acute spend on Bank and Agency (as a % of total spend on staffing)	29%	24%	24%	

Inpatient workforce rates continue to remain relatively stable. This year's rates are slightly higher than one consultant psychiatrist per ward (typically 18-22 beds), so around 0.6 WTE per 10 beds. This rate remains marginally higher in adult acute services than older adult acute services.

The staffing figures and bed stocks for this year's data collection were collected at 31st March, as in pre-pandemic data collections.

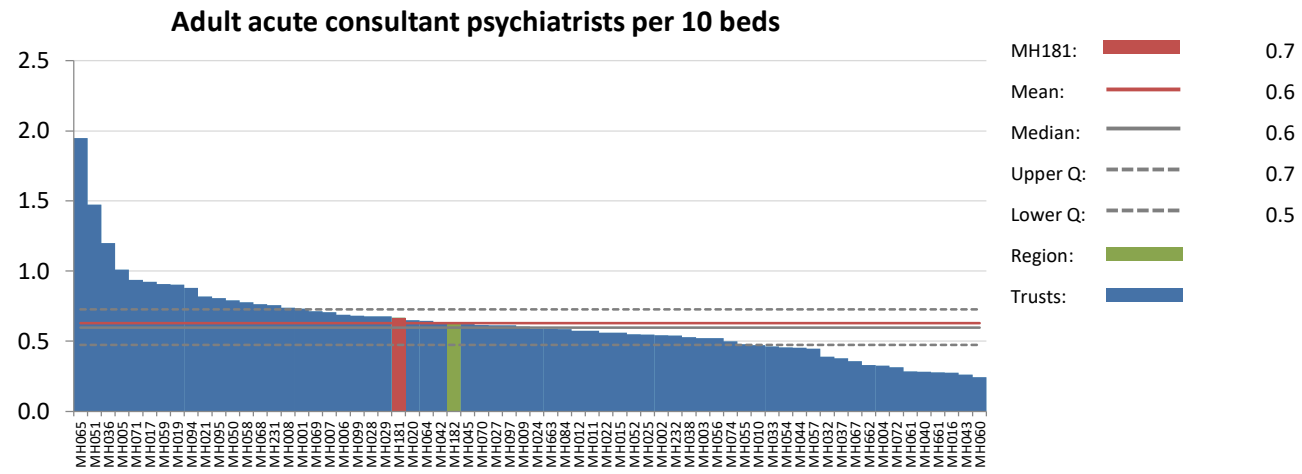


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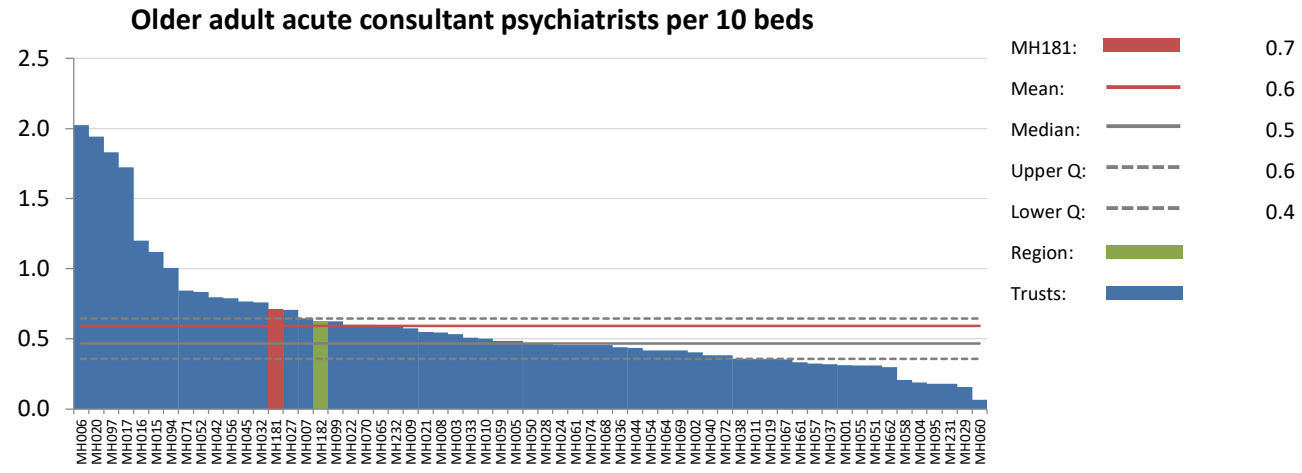


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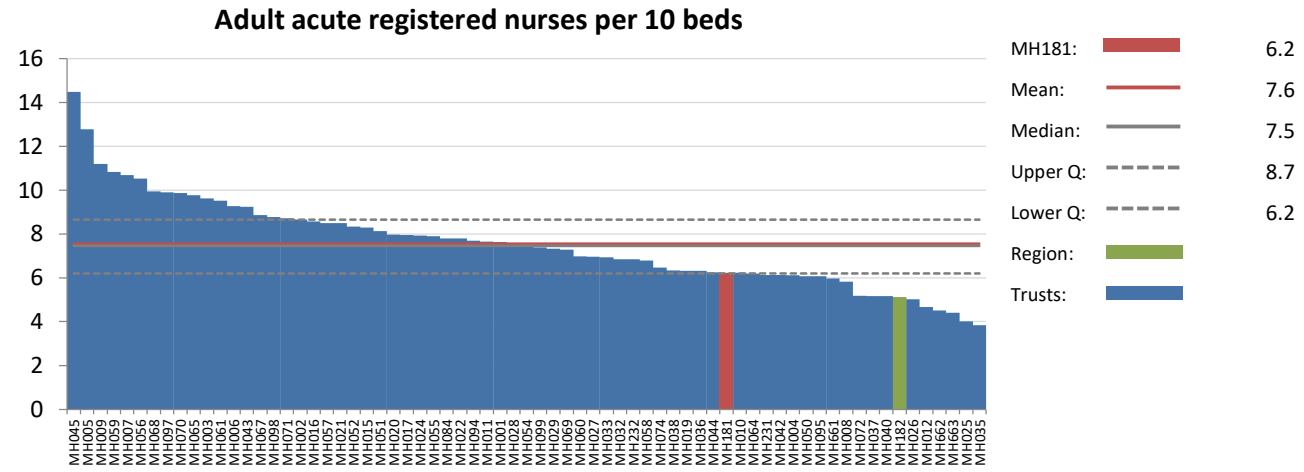


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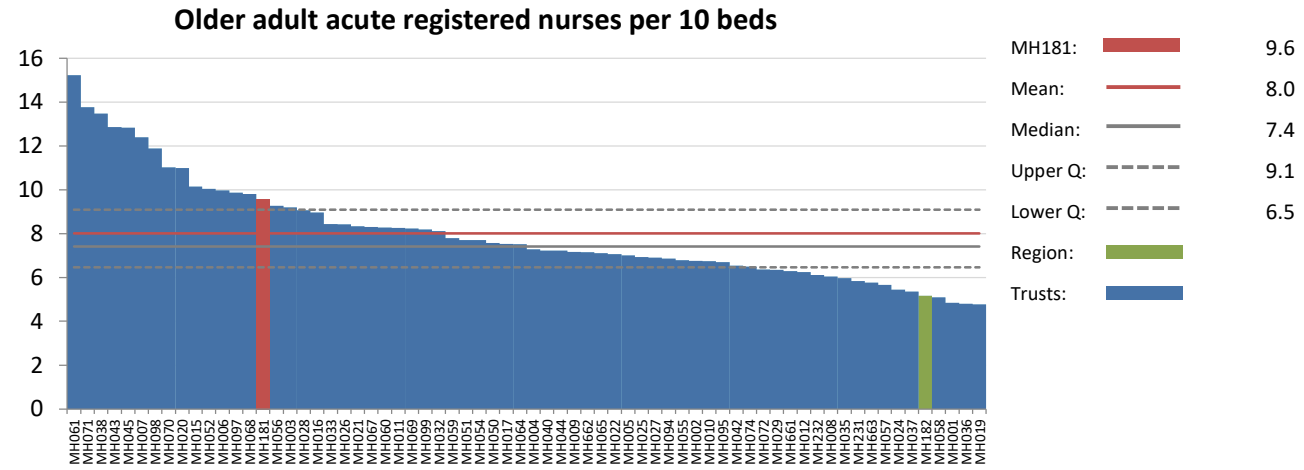


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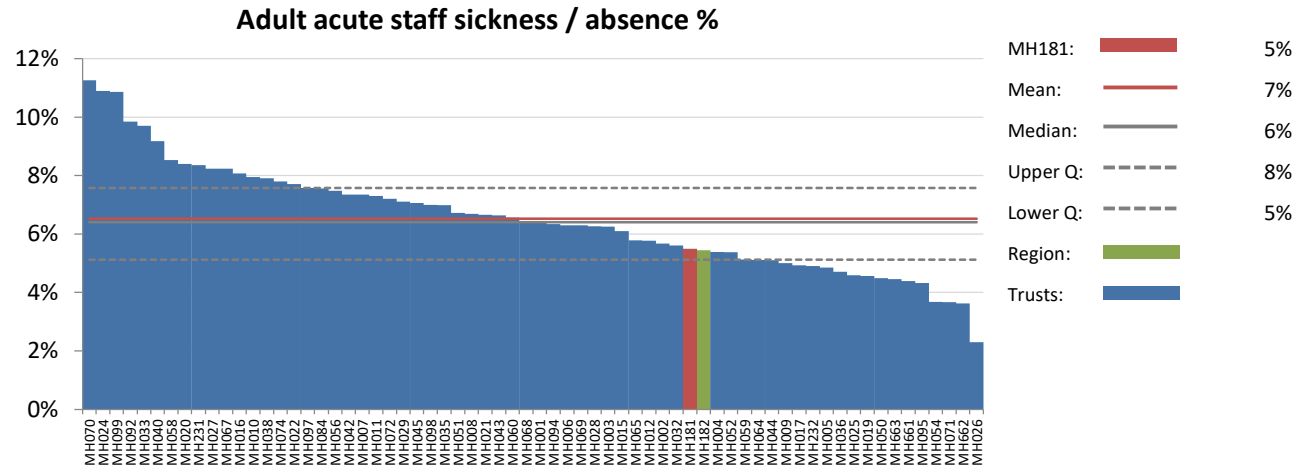


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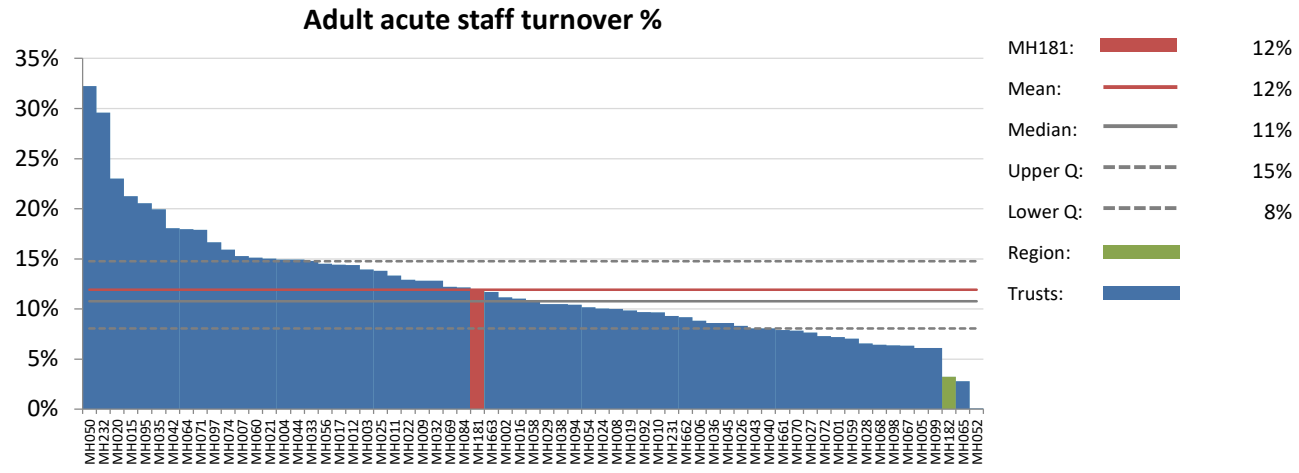


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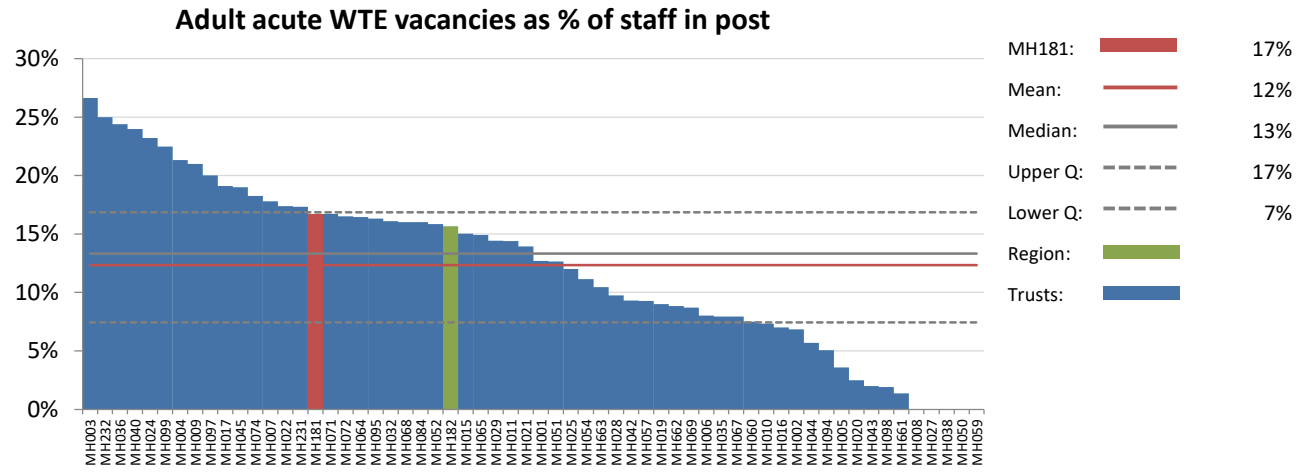


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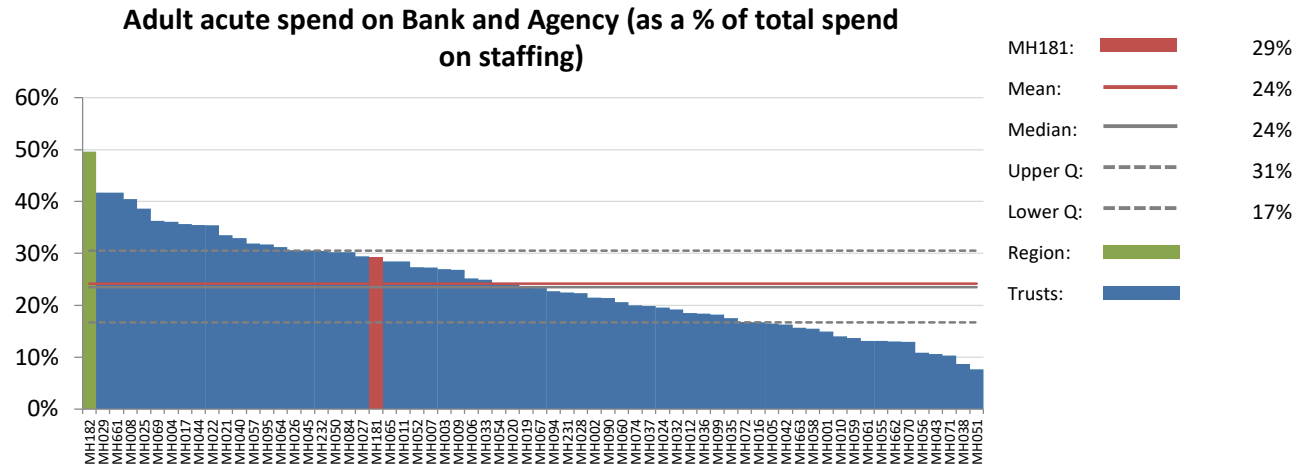


Figure 80

Community Workforce

	MH181	Mean	Median	National trend
Community total WTE per 100,000 weighted population (age 16+)	69.7	86.7	79.7	

The largest determining factor in how many people can be supported in the community is the size of the community workforce. The chart below shows the total community workforce across all team types, benchmarked per 100,000 weighted population aged 16+. This year's figure of 86.7 WTE per 100,000 weighted population suggests of an increase in capacity to that seen in 2019/20.

Similar to the inpatient workforce data, the community staffing figures for this year's data collection were collected at 31st March to be consistent with pre-pandemic data collections.

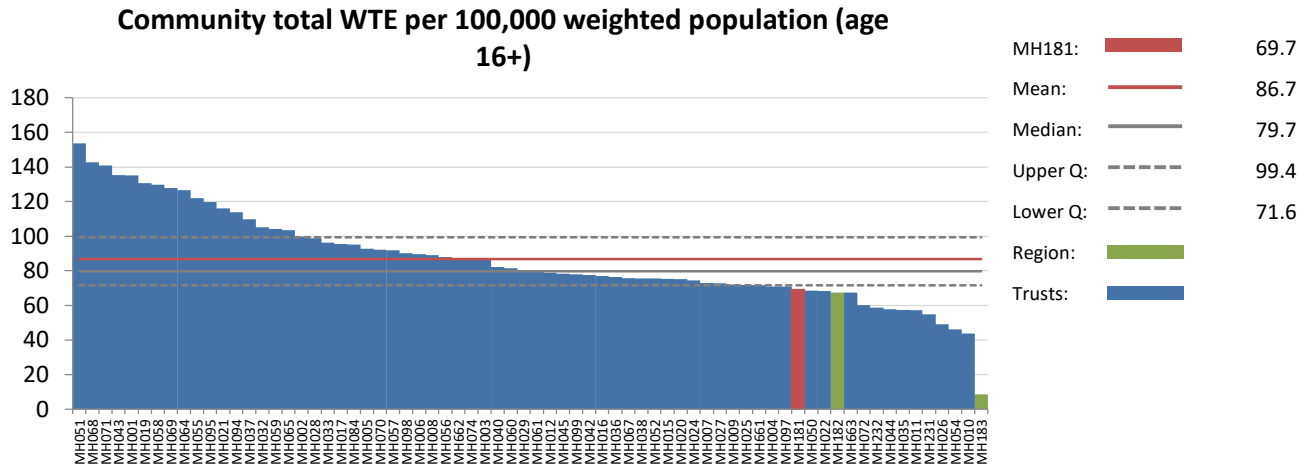


Figure 81



Finance

	MH181	Mean	Median	National trend
Adult acute cost per bed	£147,315	£163,925	£160,692	
Older adult cost per bed	£141,772	£178,080	£177,933	
Generic CMHT cost per patient on caseload (Caseload at 31st March 2021)	£3,851	£4,077	£3,766	

Average adult acute bed costs have risen steadily over the last 8 years, from £113,055 in 2012/13 to £144,929 in 2018/19, before a slight reduction in 2019/20. There is a sharp uptick in costs this year with additional costs related to the pandemic. This year's position is the highest it has been since the collection started, at £163,925 per adult acute bed, per annum.

Similarly, older adult bed costs have risen from £113,565 in 2012/13 to £158,008 in 2019/20. This year, the figure reached £178,080.

Factors contributing to increases in bed costs may include staffing levels, workforce pay increases and use of bank and agency staff, along with estate and other corporate costs and additional costs directly related to the pandemic, such as additional PPE.

Although community costs are lower, these too have seen a rise in recent years. Cost per patient on a Generic CMHT has risen from £2,702 in 2012/13 to £3,459 in 2019/20. This year's figure is £4,077.

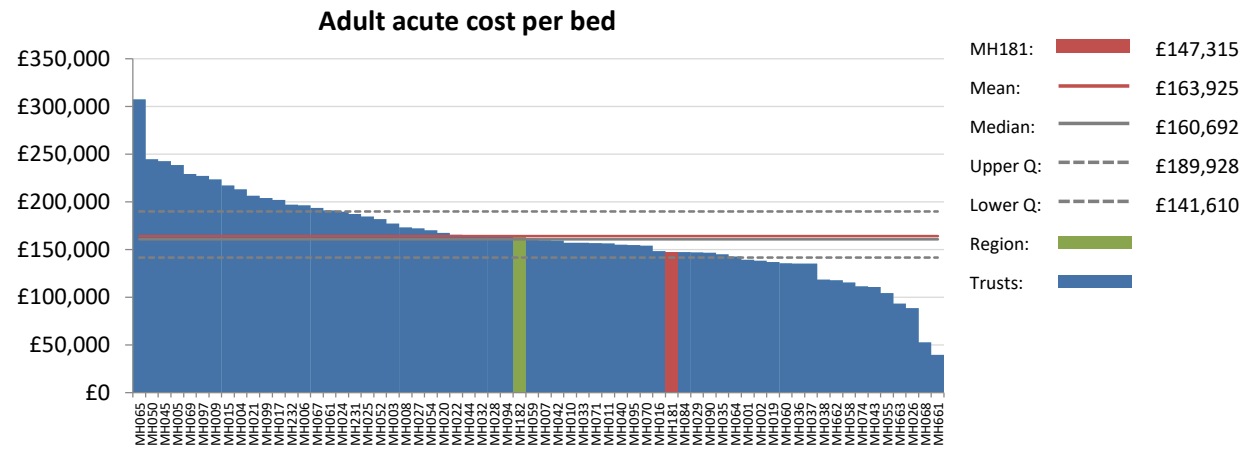


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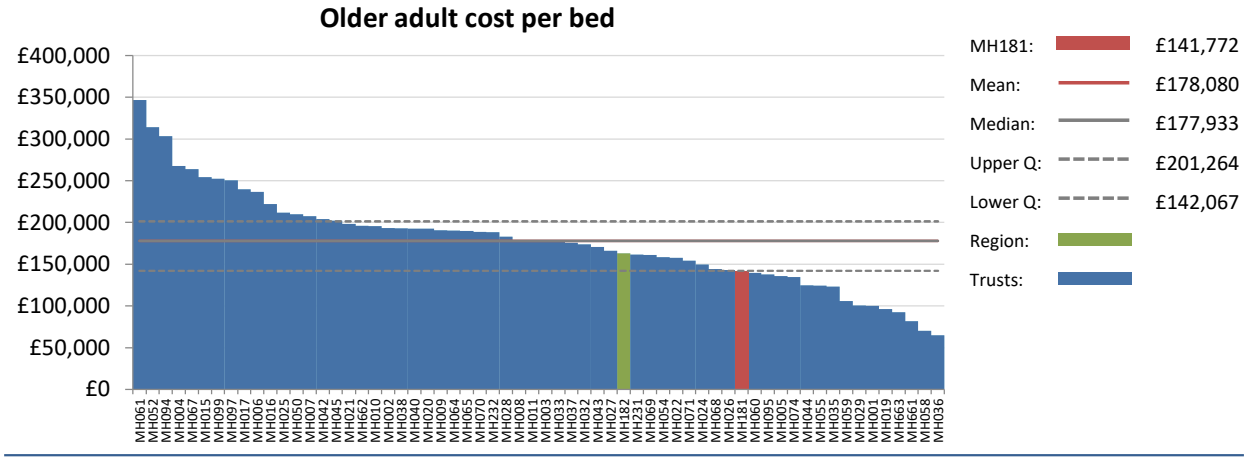


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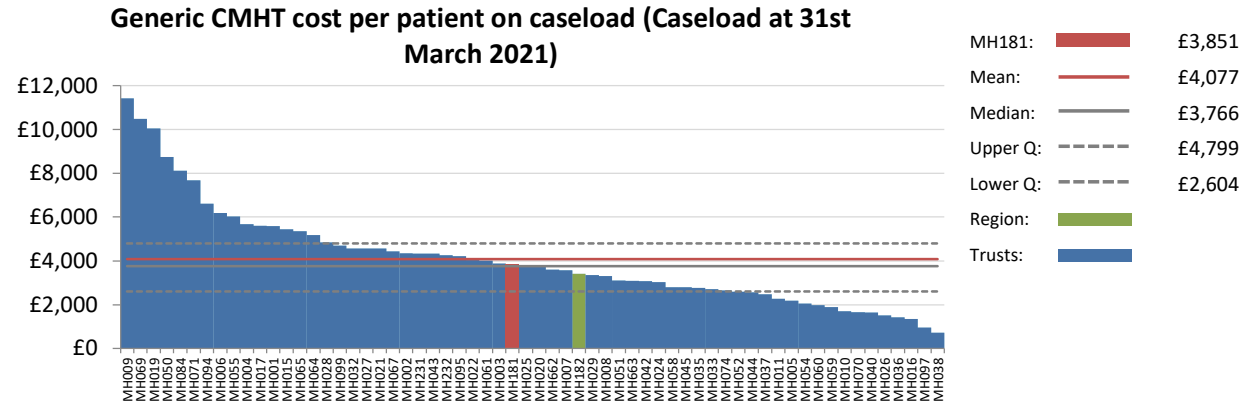


Figure 84

Quality

	MH181	Mean	Median	National Trend
Community Teams Patient Satisfaction Score	...	70%	70%	
NHS Friends and Family Test (FFT) Patient Satisfaction Score	...	89%	90%	

The CQC undertake surveys to explore the experience of people who receive care and treatment. One of these surveys covers community mental health teams and reports the proportion of people whose view was that overall they had a good experience of community mental health services. This year, comparable to last year, the average position recorded was 70.4%.

The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, and where improvements are needed. It includes a number of measures of satisfaction. The data shown for this metric relates to March 2021. The average position recorded was 88.9%.

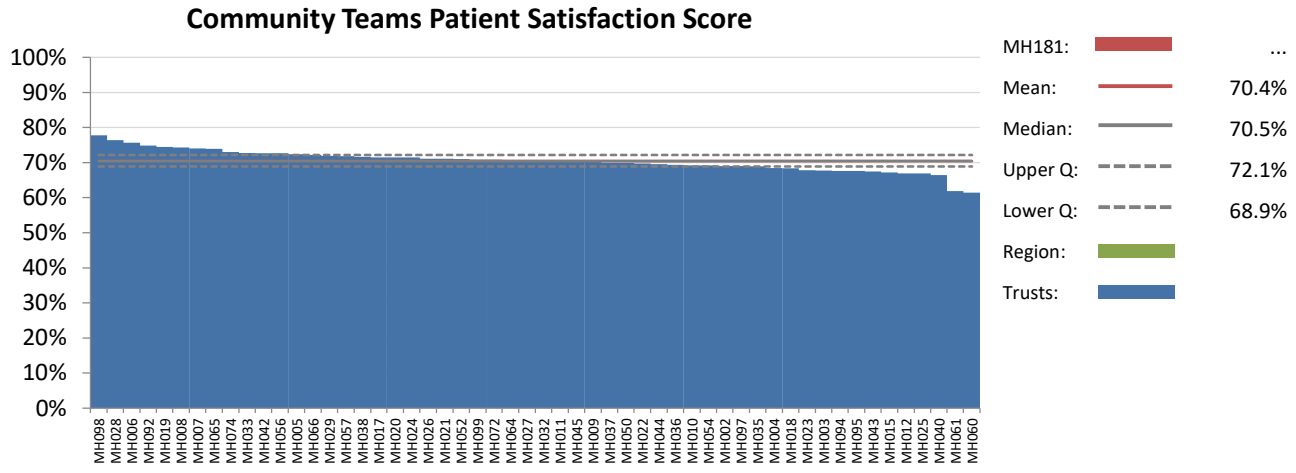


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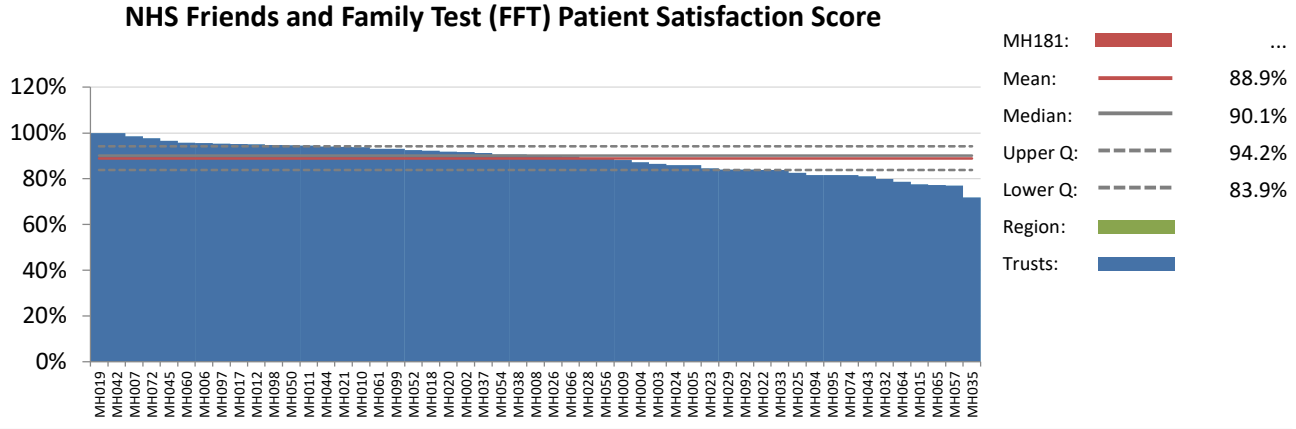


Figure 86

Incidents

	MH181	Mean	Median	National Trend
Adult acute restraint per 10,000 occupied bed days	162	159	141	
Adult acute prone restraint per 10,000 occupied bed days	6	23	18	
Older adult acute restraint per 10,000 occupied bed days	94	104	82	
Older adult acute prone restraint per 10,000 occupied bed days	5	5	2	
PICU restraint per 10,000 occupied bed days	...	572	485	
PICU prone restraint per 10,000 occupied bed days	...	103	76	

Incident rates provide another perspective on the quality of a service, by highlighting any areas of concern in an inpatient environment. This data is disaggregated to ward type to account for differences in patient cohort between services. The charts on the following pages show the positions for adult acute, older adult acute and PICU wards for providers who reported at least one incident of restraint/prone restraint for that bed type. Participants reported increases in both restraint and prone restraint for adult, older adult acute and PICU services in 2020/21.

Participants can explore their positions for all other bed types in the NHS Benchmarking Network Mental Health Toolkit.

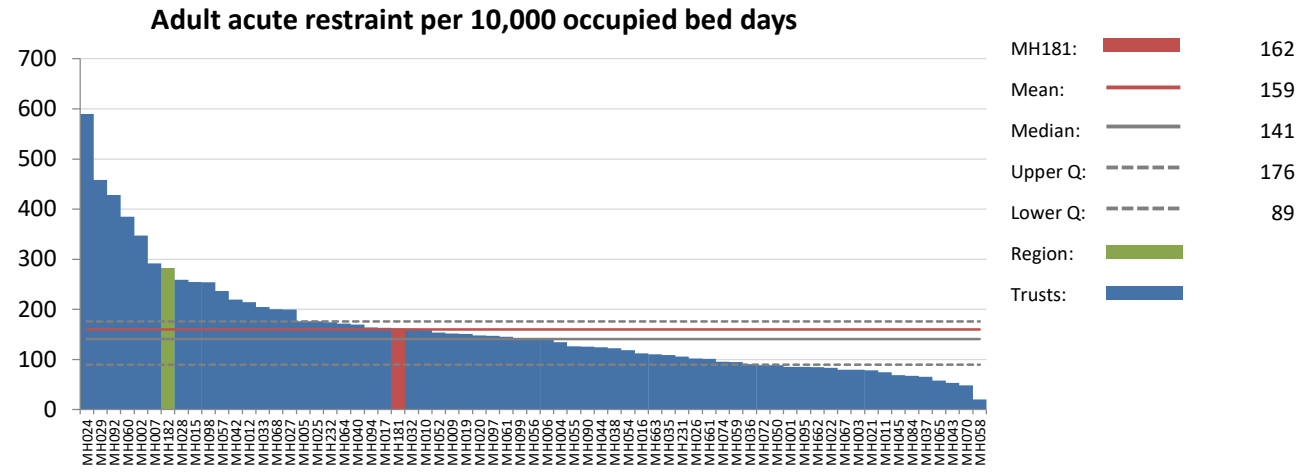


Figure 87

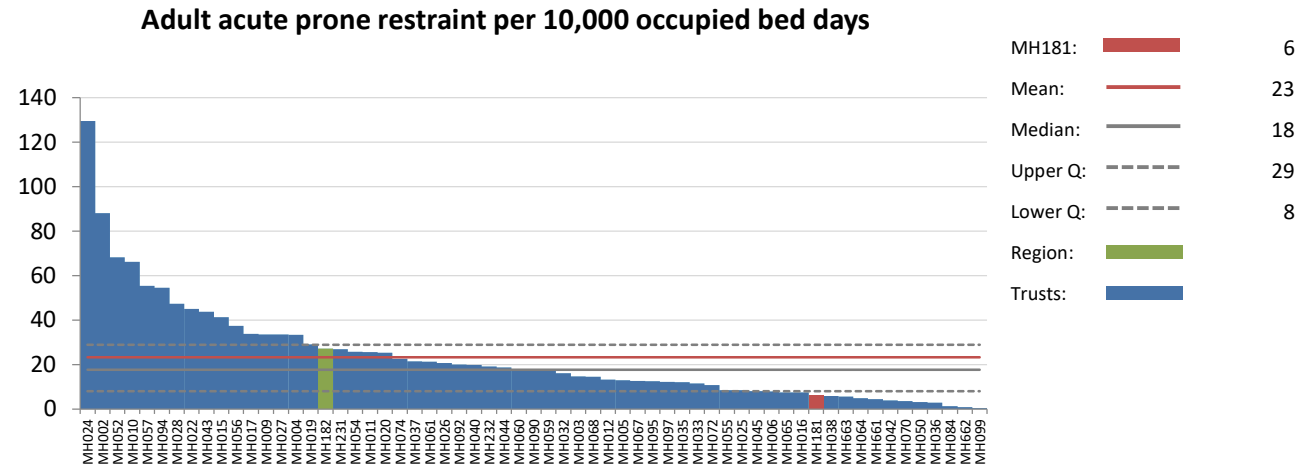


Figure 88

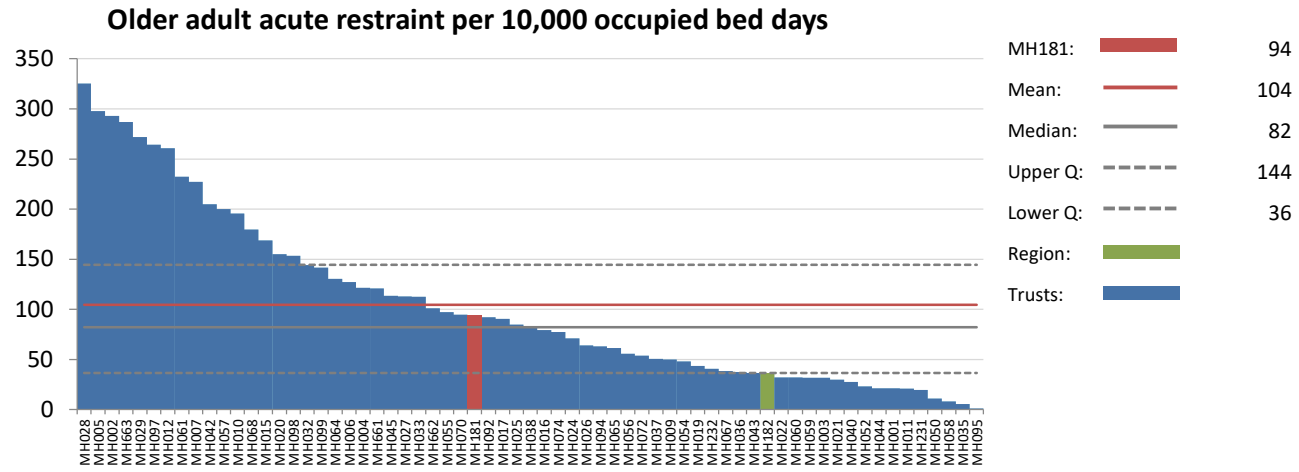


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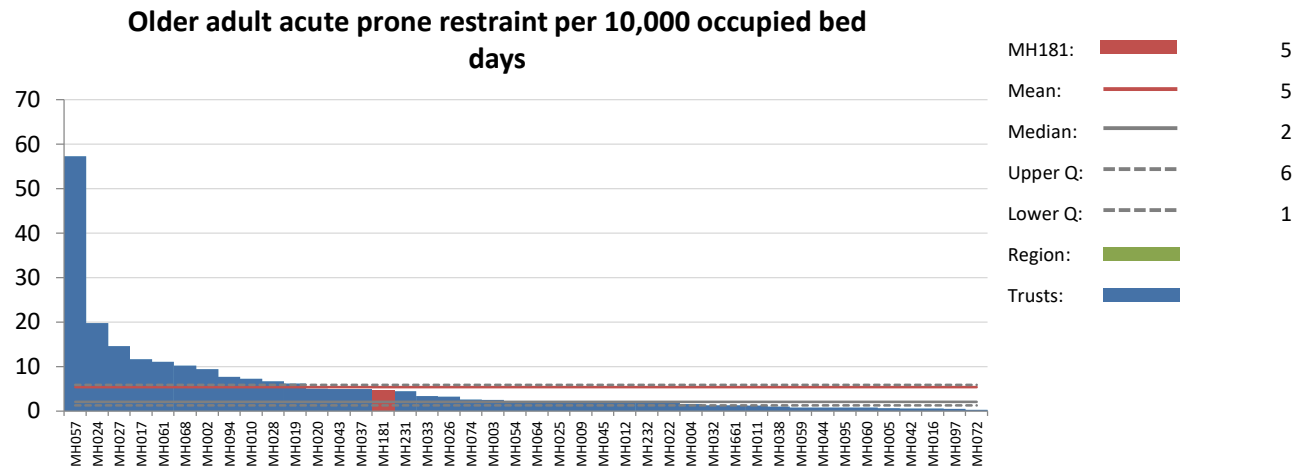


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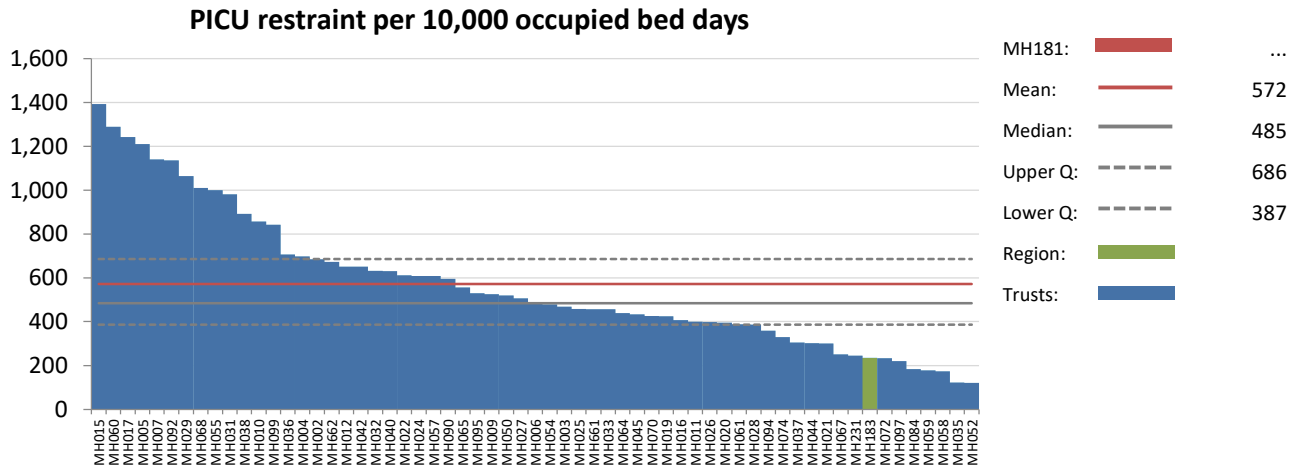


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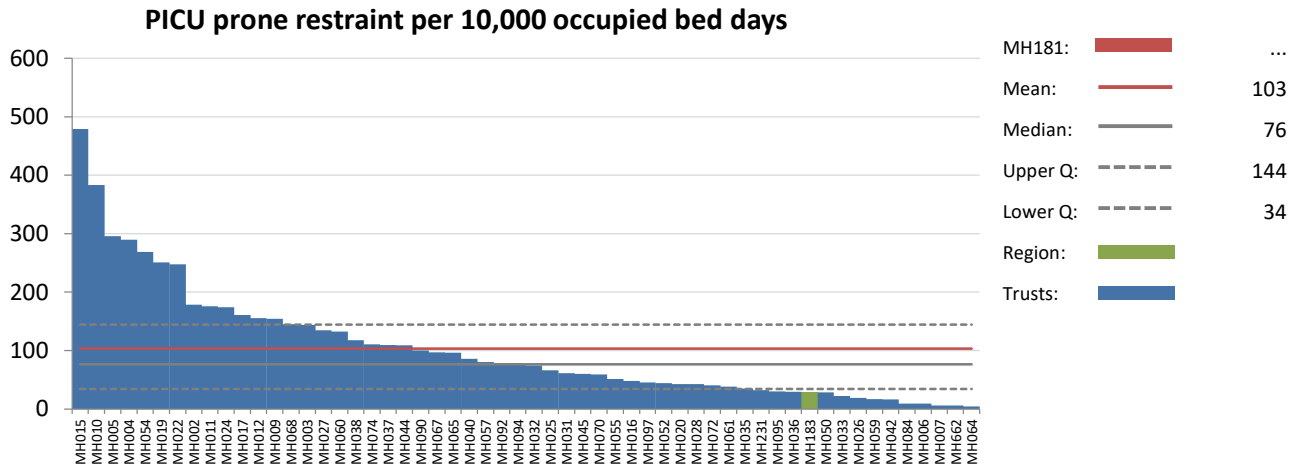


Figure 92

Balance of Care

This year's data shows some changes to the balance of care between inpatient and community services seen in previous years.

This year the spend on community services as a proportion of overall investment is 54%, similar to that seen last year. This proportion has been gradually increasing since 2013/14, when the figure was 51%.

The inpatient workforce as a proportion of overall workforce has seen an increase this year, at 46.5% in comparison to the 46% recorded last year. This is a return to previous year's levels which had seen this proportion gradually increasing, this was likely a result of safer staffing initiatives dictating minimum levels for inpatient environments.

The balance of activity levels shifted this year with a reduction in the proportions of activity taking place in the community. Community activity accounted for 84% of activity a reduction from 86% in 2019/20.

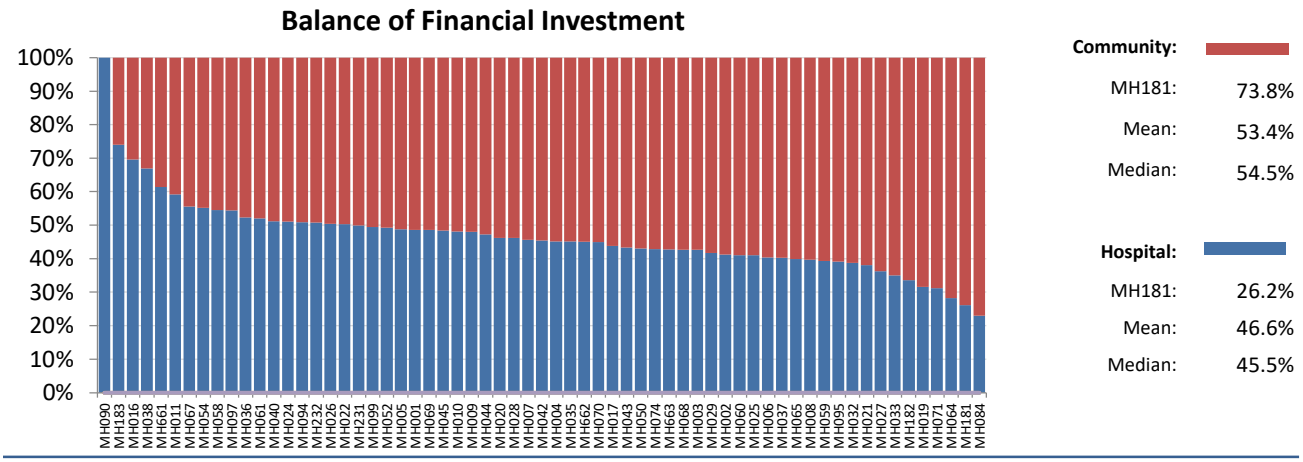


Figure 93

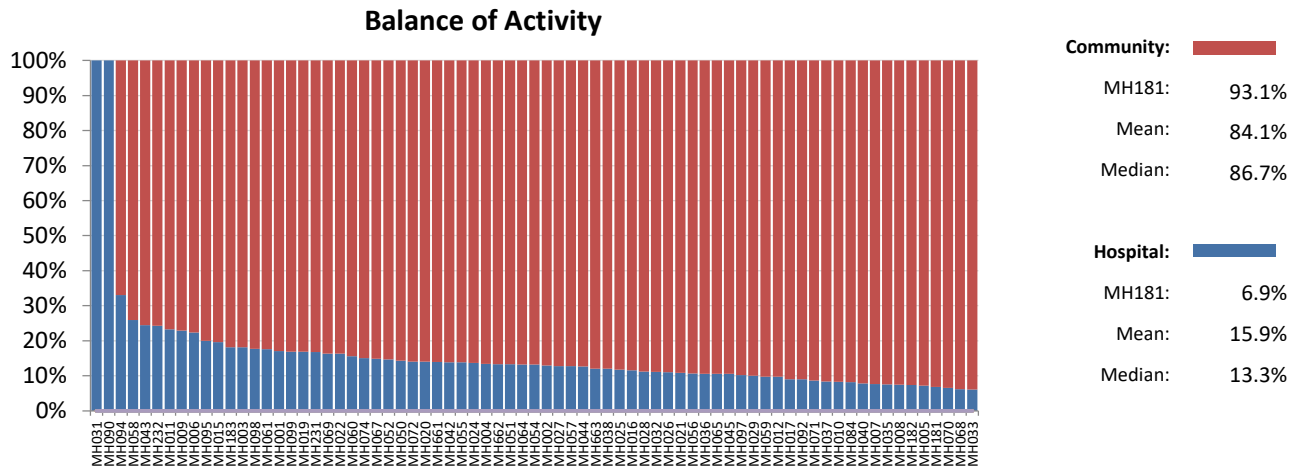


Figure 94

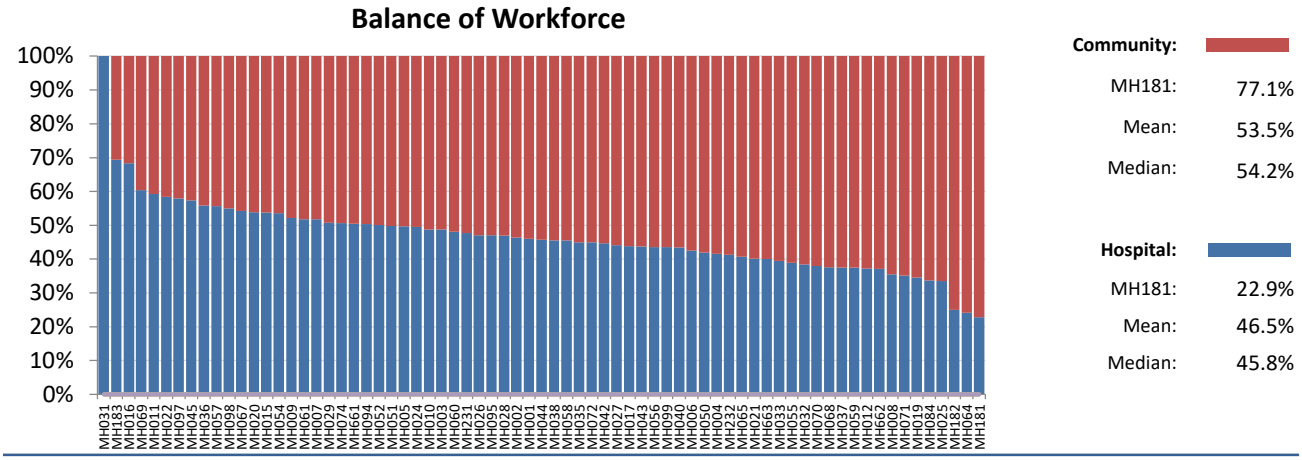


Figure 95



Conclusion

The NHS Benchmarking Network are pleased to publish the 2021 edition of our Inpatient and Community Mental Health Benchmarking report.

We would like to express our thanks to all contributors during what continues to be a challenging period for the NHS. The depth and breadth of the data provided allows us to generate confident comparisons, and the 10-year benchmarking history allows overall trends in service demand and provision to be explored across the UK.

The impact of Covid-19 is evident in some of the 2020/21 benchmarking data with the recovery of services from the initial disruption. In inpatient services there is clear evidence of a reduction in length of stay and bed occupancy. Overall community caseloads and contacts have increased when compared to the previous year and with referrals increasing providers may need to prepare for further increases in demand.

This year's project saw changes in some of the trends seen for acute inpatient care over recent years, with bed occupancy rates falling, along with average lengths of stays for adult and older adult acute bed types. Admission rates to adult acute services increased this year, following a sustained period of decline, whilst admissions to older adult beds continued to decline reflecting the reduction in capacity. The proportion of adult acute admissions that were for detained under the mental health act continued to increase and this year rose above 50% for the first time, meaning over half of all adult acute admissions were detained. Monthly Covid reports produced by the Network highlight the acceleration in detention levels from April 2020 onwards.

Bed occupancy rates fell across most inpatient bed types, although it remains high, with only Mother and Baby (60%), Eating disorders (69%), Longer term complex / continuing care (75%) and older adult acute (77%) beds averaging below the 85% target recommended by RCPsych.

Most service users receive their mental health care in the community. Overall caseload levels have increased, however this masks differences in community teams with working age community caseloads increasing whereas older people's teams reported a reduction in caseloads. It should be noted that the definition of a patient being on a caseload was altered for the 2020/21 data collection after consultation with the Mental Health Reference Group, the definition was amended to 'patients who have had two or more clinical contact appointments as part of the episode of care'. The number of community contacts increased in 2020/21, and as with caseloads, contacts for working age teams increased whilst contacts in older adult teams continued to decline.

The Covid-19 pandemic has seen substantial changes in the way community contacts have been delivered to patients. In previous years around a quarter of contacts were delivered in a non face-to-face manner, primarily by telephone. The pandemic has shifted the method of delivery considerably, with non-face to face contacts delivered by telephone or video link increasing to an average of 60% during 2020/21.



The proportion of contacts taking place digitally however saw a much slower increase, with the proportion of contacts delivered digitally rising from 7% in 2019/20 to 10% in 2020/21. This suggests a reticence in using digital contacts for core CMHT business, with telephone based care being the dominant approach.

The incident metrics data continues to show a commitment to transparency in reporting adverse incidents. Increases were recorded in both restraint and prone restraint in adult acute and PICU services. Older adult services reported an increase in the use of restraint but a slight decrease in prone restraint.

One of the central themes of the benchmarking work is to encourage providers to explore the balance of care between inpatient services and community care. Providers are encouraged to consider how best to ensure an appropriate balance of care between acute and community services. This year's data shows some similarities in the balance of care seen in previous years. However data on the deployment of the mental health workforce and associated investment continues to confirm an approximately equal split between bed and community based services. The ability to achieve an appropriate system balance can be tested in the benchmarking data by reference to key metrics including; waiting times to access community based care, scale of community offer, and perceptions of service quality and overall experience reported by service users and carers.

This year's benchmarking collection continued to report on BAME and gender equalities in mental health services and the Benchmarking Network is hosting a virtual conference on healthcare inequalities for the first time on 29th September 2021. Although there were a similar proportion of patients of BAME ethnicity on community caseloads to the proportion of the UK population who are of BAME ethnicity, these groups were overrepresented in both the admissions to mental health beds and admissions under detention in 2020/21. As a general rule, BAME patient over-representation increases as acuity and level of restriction of setting increases. It is important that providers explore their position for this metric in relation to the ethnicity of their catchment area, and use this data to implement the Long Term Plan commitment to advance Mental Health Equalities. Analysis of gender issues also reveals interesting variation between service types and providers.

We hope that this year's benchmarking process has been rewarding for members and has provided useful intelligence for local assurance and strategy development. We look forward to discussing this year's benchmarking findings with members at our annual mental health benchmarking conference which is taking place on Microsoft Teams at 2pm on 8th October 2021. The Covid-19 Monthly Tracker for Mental Health, Learning Disability and Autism will continue through the rest of 2021/22, to support members understand the impact of the Covid-19 pandemic on mental health services across the UK.

Further comments or questions on any aspect of this report should be addressed to either Stephen Watkins (s.watkins@nhs.net), Janet Heaton (j.heaton3@nhs.net).



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SOUTH EAST STAFFORDSHIRE STAKEHOLDER MAP

MPs Councillors & Councils

- Cannock Chase MP (Con) Amanda Milling
- Burton and Uttoxeter MP (Con) Kate Griffiths
- Tamworth MP (Con) Christopher Pincher
- South Staffordshire MP (Con) Gavin Williamson
- Stafford MP (Con) Theo Clarke
- Lichfield MP (Con) Michael Fabricant
- Cannock Chase District Council
- East Staffordshire Borough Council
- Lichfield District Council
- Stafford Borough Council
- Tamworth Borough Council
- Staffordshire Association of Local Councils
- Town/Parish Councils

Voluntary Sector

- Support Staffordshire

Regulators & Scrutiny

- NHS England
- Care Quality Commission
- Staffordshire Health and Wellbeing Board
- Staffordshire Health and Care Overview and Scrutiny Committee
- Secretary of State
- Local Clinical Assembly
- Local Government Ombudsman Board
- West Midlands Clinical Senate

Partners

Primary Care

- GP practices
- Staffordshire Doctors Urgent Care (SDUC)
- Local Medical Committee
- Local Pharmaceutical Committee
- Primary Care Networks
- Alliance Board South East
- Alliance Board South West

Independent

- Independent and voluntary providers

STP Partners

- University Hospitals of North Midlands
- North Staffordshire Combined Healthcare
- University Hospitals of Derby and Burton
- Staffordshire County Council PH and ASC
- West Midlands Ambulance Service

Decision authorities

- Midlands Partnership NHS Foundation Trust
- Staffordshire CCGs/ NHS Integrated Care Board

Patients & Service-users
Carers
Staff
Chairs
Chief Execs
Non Execs
Lay Members
Clinical Leaders
Directors of Public Health
Council Leaders
Cabinet members

Other Opinion Formers

- **Healthwatch** — Staffordshire
- **Patient Groups**
  - Patient Participation Groups
  - Patient Congress, Board and Council
  - Feedback Facilitators
- **Campaign Groups**
  - League of Friends Tamworth
  - Burntwood Action Group
  - Support Stafford Hospital
- **Trade unions**
  - Unison
  - Unite
  - HCSA
  - RCM
  - RCN
  - BMA
  - GMB
  - Other relevant specialist unions as issues are identified
- **Media**
  - Burton Mail
  - Staffordshire Newsletter
  - Tamworth Herald
  - Express and Star
  - Stone and Eccleshall Gazette
  - Tamworth Herald
  - Uttoxeter Echo
  - Advertiser
  - Cannock Chronicle
  - Lichfield Live
  - Uttoxeter and Cheadle Voice
  - Signal Radio and Capital Radio
  - Cannock Chase Radio
  - Radio Tamworth/ BaD
  - BBC Radio Stoke/DerbyWM
  - BBC and ITV News

Keep informed

- Neighbouring ICSs/ICBs
- Neighbouring trusts
- Police, Fire and Crime Commissioner
- Education

NHS
Midlands and Lancashire
Commissioning Support Unit

Mental health services and the George Bryan Centre Engagement Questionnaire

Introduction

Together We're Better is a partnership of NHS, local councils and voluntary sector groups that are working together to improve health and care services in Staffordshire and Stoke-on-Trent.

Our vision is to work with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work.

This questionnaire has been designed to gather your comments about mental health services in South East Staffordshire, provided by Midlands Partnership NHS Foundation Trust (MPFT).

The George Bryan Centre provided services to the residents of Burton upon Trent, Lichfield, Tamworth and the surrounding areas.

Early in 2019, one of two wings of the George Bryan Centre was destroyed by fire. The second wing was later temporarily closed on the grounds of safety.

Temporary arrangements were put in place, and we now want to design the long-term solution.

How we will use and manage your feedback and the information you provide

Staffordshire and Stoke-on-Trent CCGs and Midlands Partnership NHS Foundation Trust (MPFT) would like to understand your experience of using mental health services across Staffordshire and Stoke-on-Trent. The feedback will be used to help shape mental health services in the future.

Staffordshire and Stoke-on-Trent CCGs and Midlands Partnership NHS Foundation Trust (MPFT) have commissioned NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) to collect, handle and process the responses gathered for this consultation. MLCSU uses a tool called Snap which is owned by Snap Surveys Ltd, an organisation specialising in the delivery and management of questionnaires. Any information you provide will be added to Snap for analysis and handled in accordance with GDPR and the Data Protection Act 2018.

The questionnaire also asks respondents to provide their full postcode and demographic profiling data (age, gender, ethnicity, etc.). This information is used to ensure the responses are representative of the demographics of the whole local population. The postcode data will also be used to profile and segment those participating in this engagement This will be done using the Index of Multiple Deprivation (IMD) and Acorn Geosegmentation Profiler tool which enables the profiling of participants' health and wellbeing in comparison with the local population. The data will be available in its entirety to MLCSU, and the [name organisation] will be in receipt of some of the responses which will then be input into Snap. You do not have to provide this information to take part in the questionnaire.

Any reports published using the insights from the questionnaire will not contain any personal identifiable information and only show feedback in anonymous format. These anonymised results may be shared publicly, for example on NHS public facing websites or printed and distributed.

Your involvement is voluntary, and you are free to stop completing the questionnaire at any time and if you are completing this online you can do so by closing this webpage. Only submitted responses will be included in the analysis. You can also refuse to answer questions in this questionnaire, should you wish. All information collected via the questionnaire will be held for a period of five years from the date of questionnaire closure, in line with the Records Management Code of Practice for Health and Social Care 2016, which all NHS organisations work under.

If you have any queries about your involvement with this questionnaire, please email: mlcsu.involvement@nhs.net.

Q1 ◯ **Please tick to confirm you agree with the Data Protection statement. If you do not provide your consent then we will not be able to include your feedback in this consultation.**

N11 Who you are

Q2 **Are you responding as:**

- ◯ An individual
- ◯ A formal response from an organisation

N12 **Guidance:** If you wish to respond as an individual and also provide a formal response as an organisation, please complete the questionnaire twice – once as an individual and again as a formal response on behalf of the organisation.

Q3 **As an individual responding to this questionnaire, which of the following best applies to you?** *Please tick one only.*

- ◯ User of mental health services
- ◯ Other member of the public
- ◯ Carer
- ◯ NHS employee
- ◯ From another public sector organisation
- ◯ From a health-related group, charity or organisation
- ◯ From a non-health voluntary group, charity or organisation

Q4 **As an organisation responding to this questionnaire, which of the following best applies to you?** *Please tick one only.*

- ◯ Formal response on behalf of an NHS organisation
- ◯ Formal response on behalf of another public sector organisation
- ◯ Formal response on behalf of a health-related group, charity or organisation
- ◯ Formal response on behalf of a non-health voluntary group, charity or organisation
- ◯ Other

Q5 **Please provide the name of your organisation.** *Please note, if you are making a formal response on behalf of your organisation this question should be completed.*

Q6 **Have you ever worked at the George Bryan Centre?**

- ◯ Yes
- ◯ No

Q7 **Where do you work now?**

- ◯ I worked at the George Bryan Centre but now work at St George's
- ◯ I worked at the George Bryan Centre but now work in community mental health services
- ◯ Other, please specify

Q7 **Please specify:**

Q8 **Tell us your role or job title.** *Please complete even if you are completing this questionnaire as an individual or do voluntary (unpaid) work.*

N 13 Section one: Which mental health services have you used and what was your experience of using them?

Q9 **Which of the following mental healthcare services would you like to give feedback on?** *Tick all that apply.*

- ☐ George Bryan Centre
- ☐ St George's Hospital, Stafford
- ☐ Community mental health services
- ☐ None of the above

Q10 **In what capacity did you experience the George Bryan Centre which you have indicated that you would like to provide feedback on?**

- ◯ As a member of staff
- ◯ As a patient
- ◯ As a carer or support worker for a patient
- ◯ As a provider of a service to a patient

Q11 **Which wing were you in?**

- ◯ East (for over 65-year-olds)
- ◯ West (for under 65-year-olds)

Q12 **During which period would you like to provide feedback on?**

- ◯ After March 2019
- ◯ Before and during March 2019

Q13 **Rate your experience of using George Bryan Centre**

- ◯ Very good
- ◯ Good
- ◯ Neither good nor poor
- ◯ Poor
- ◯ Very poor

Q14 **Tell us about your experience of using George Bryan Centre. What do you feel went well and what challenges or issues did you face?**

Q15 **In what capacity did you experience St George's Hospital which you have indicated that you would like to provide feedback on?**

- ◯ As a member of staff
- ◯ As a patient
- ◯ As a carer or support worker for a patient
- ◯ As a provider of a service to a patient

Q16 **During which period would you like to provide feedback on?**

- ◯ After March 2019
- ◯ Before and during March 2019

Q17 **Rate your experience of using St George's Hospital**

- ◯ Very good
- ◯ Good
- ◯ Neither good nor poor
- ◯ Poor
- ◯ Very poor

Q18 Tell us about your experience of using St George's Hospital. What do you feel went well and what challenges or issues did you face?

Q19 **In what capacity did you experience community mental health services which you have indicated that you would like to provide feedback on?**

- ◯ As a member of staff
- ◯ As a patient
- ◯ As a carer or support worker for a patient
- ◯ As a provider of a service to a patient

Q20 **During which period would you like to provide feedback on?**

- ◯ After March 2019
- ◯ Before and during March 2019

Q21 **Rate your experience of using community mental health services**

- ◯ Very good
- ◯ Good
- ◯ Neither good nor poor
- ◯ Poor
- ◯ Very poor

Q22 **Tell us about your experience of using community mental health services. What do you feel went well and what challenges or issues did you face?**

N 14 Section two: Community mental health services in the future for South Staffordshire

N15 **Our model of mental health services for the future**

We have developed a new model for providing mental health services. Our vision is that by working together, we create mental health services that are inclusive, accessible, value people as they are, and are responsive to their needs. We will embrace innovation and new ways of working to remove traditional barriers, improve communication and training, and provide personalised support that enables people to live well and realise their full potential.

Click here to watch an animation from NHS England and Improvement explaining the national model.

The guiding principles are:

N16 • To improve and simplify access to care
• To use a Trusted Assessor Model – so you don't have to re-tell your story every time. For more information, please click here
• To have one digital plan which all services can access and update
• For you to have a named worker
• To provide flexible and personalised care that meets your needs
• To provide safe services for you, your carers and our staff
• For all partners to work closely together to join up our services
• To support your physical health needs.

Q23 **Thinking about the principles as a whole, to what extent do you agree or disagree with these principles?**

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither
- ◯ Disagree
- ◯ Strongly disagree

Q24 Tell us why you agree or disagree with these principles.

Q25 Do you have any other ideas or suggestions about how we could provide mental health services in the future which we can use to help shape this model?

N About you
17

N18 We would like to know a little more about you. The following questions will help us understand more about who has responded to this questionnaire. This will help us to ensure we have listened to as many different people as possible. You can leave this section blank if you wish.

Q26 **Please provide your full postcode.** *Providing your full postcode does not mean we will be able to identify you individually. It will help us to ensure we have gathered views from all areas.*

Q27 **What is your ethnic group?** *Choose one option that best describes your ethnic group or background.*

--Click Here--

- White: English/Welsh/Scottish/Northern Irish/British
- White: Irish
- White: Gypsy or Irish Traveller
- White: Any other White background (please specify below)
- Mixed/Multiple ethnic groups: White and Black Caribbean
- Mixed/Multiple ethnic groups: White and Black African
- Mixed/Multiple ethnic groups: White and Asian
- Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)
- Asian/Asian British: Indian
- Asian/Asian British: Pakistani
- Asian/Asian British: Bangladeshi
- Asian/Asian British: Chinese
- Asian/Asian British: Any other Asian background (please specify below)
- Black/African/Caribbean/Black British: African
- Black/African/Caribbean/Black British: Caribbean
- Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify below)
- Other ethnic group: Arab
- Any other ethnic group (please specify below)
- Prefer not to say

Q27 **Please specify:**

Q28 **What is your age category?**

--Click Here--

- 16 – 19
- 20 – 24
- 25 – 29
- 30 – 34
- 35 – 39
- 40 – 44
- 45 – 49
- 50 – 54
- 55 – 59
- 60 – 64
- 65 – 69
- 70 – 74
- 75 – 79
- 80 and over
- Prefer not to say

Q29 **What is your religion or belief?**

- ◯ No religion
- ◯ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ◯ Buddhist
- ◯ Hindu
- ◯ Jewish
- ◯ Muslim
- ◯ Sikh
- ◯ Any other religion (please specify)
- ◯ Prefer not to say

Q29 **Other religion - Please specify:**

Q30 **How do you identify?**

- ◯ Male
- ◯ Female
- ◯ Trans-Man
- ◯ Trans-Woman
- ◯ Non-binary
- ◯ Gender-non-conforming
- ◯ Other (please specify)
- ◯ Prefer not to say

Q30 **Other - Please specify:**

Q31 **What is your sexual orientation?**

- ◯ Heterosexual
- ◯ Lesbian
- ◯ Gay
- ◯ Bisexual
- ◯ Asexual
- ◯ Other (please specify)
- ◯ Prefer not to say

Q31 **Other sexual orientation - Please specify:**

Q32 **What is your relationship status?**

- ◯ Married
- ◯ Civil Partnership
- ◯ Single
- ◯ Divorced
- ◯ Lives with Partner
- ◯ Separated
- ◯ Widowed
- ◯ Other (please specify)
- ◯ Prefer not to say

Q32 **Other relationship status - Please specify:**

N19 The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period.

Q33 **Are you pregnant at this time?**

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

Q34 **Have you recently given birth?** *(within the last 26-week period)*

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

Q35 **Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?**

- ◯ Yes, limited a lot
- ◯ Yes, limited a little
- ◯ No
- ◯ Prefer not to say

Q36 **Do you consider yourself to have a disability?** *(The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long-term (12-month period or longer) or substantial adverse effects on their ability to carry out day-to-day activities).*

- [ ] Physical disability (please describe)
- [ ] Sensory disability e.g. Deaf, hard of hearing, Blind, visually impaired (please describe)
- [ ] Mental health condition
- [ ] Learning disability or difficulty
- [ ] Long-term illness (please describe)
- [ ] Other (please describe)
- [ ] Prefer not to say

Q36 **Please describe:**

Q37 **Do you provide care for someone?** *(tick as many as appropriate)*

- [ ] Yes – Care for young person(s) aged younger than 24 years of age
- [ ] Yes – Care for adult(s) aged 25 to 49 years of age
- [ ] Yes – Care for older person(s) aged over 50 years of age
- [ ] No
- [ ] Prefer not to say

Q38 **Have you ever served in the armed services?**

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

Thank you for taking the time to complete this survey.

Please click 'Submit' to send us your replies.

TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Mental health services and the George Bryan Centre Engagement

Demographic midpoint review

19 October 2021



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Response figures

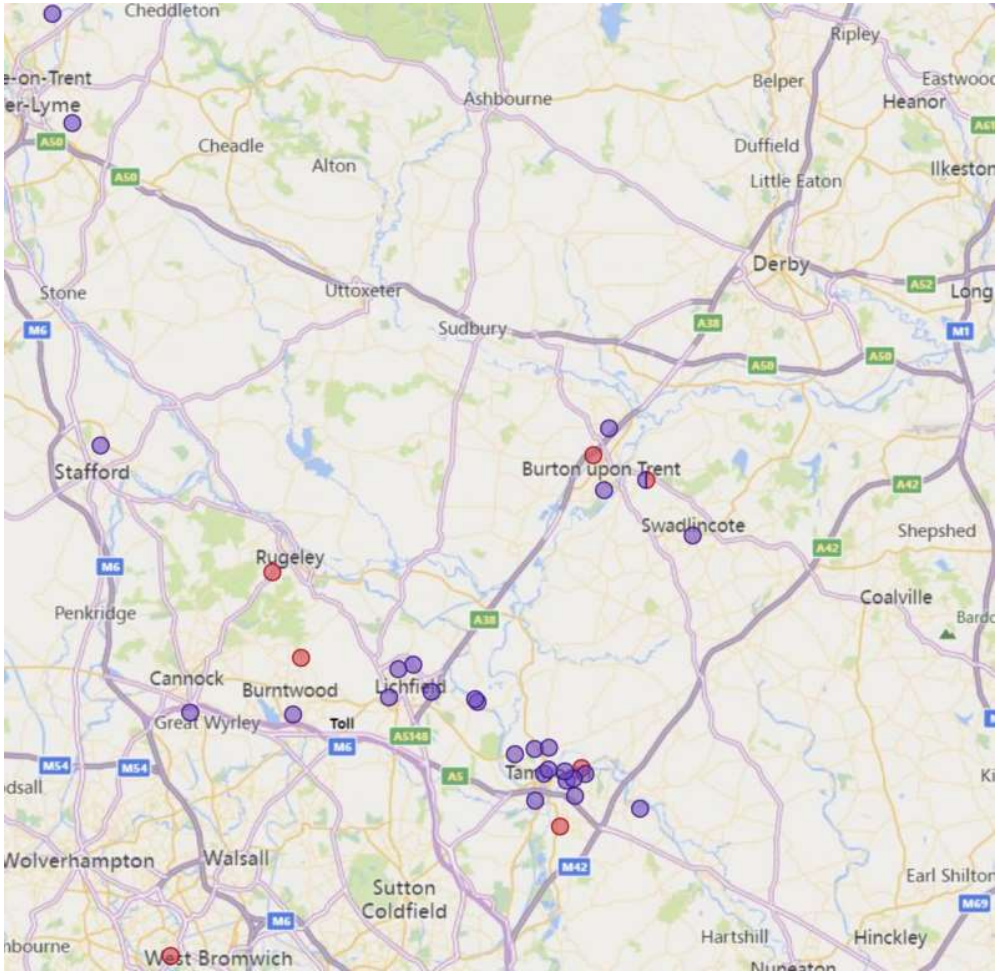


32
survey responses
as of 18.10.2021



9
responses to the event participant demographic profiling questionnaire as of 18.10.2021

Map of respondents



Key

- Event participant
- Survey respondent

TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Demographic profiling



Respondent type

Respondent type	Event		Survey		Total Engagement	
Other member of the public	-	-	13	46%	13	46%
User of mental health services	-	-	6	21%	6	21%
NHS employee	-	-	5	18%	5	18%
From a health-related group, charity or organisation	-	-	2	7%	2	7%
Carer	-	-	1	4%	1	4%
From other public sector organisation	-	-	1	4%	1	4%
Base	-		*28*		*28*	

Service usage

Mental health service usage	**Survey**	
George Bryan Centre	12	38%
Community mental health services	7	22%
St George's Hospital, Stafford	4	13%
None of the above	12	38%
Base	*32*	

Mental health service usage - capacity	**As a member of staff**		**As a patient**		**As a carer or support worker for a patent**		**As a provider of a service to a patient**		*Base*
George Bryan Centre	5	42%	1	8%	4	33%	2	17%	*12*
Community mental health services	1	14%	5	71%	-	-	1	14%	*7*
St George's Hospital, Stafford	1	25%	2	50%	1	25%	-	-	*4*

Mental health service usage – time period	**Before and during March 2019**		**After March 2019**		*Base*
George Bryan Centre	10	83%	2	17%	*12*
Community mental health services	-	-	1	100%	*1*
St George's Hospital, Stafford	1	100%	-	-	*1*

Ethnicity and religion

Ethnicity	Event		Survey		Total Engagement		Census
White	9	100%	30	96%	39	98%	94%
Asian	-	-	-	-	-	-	4%
Mixed	-	-	-	-	-	-	1%
Black	-	-	-	-	-	-	1%
Other	-	-	-	-	-	-	0.3%
Prefer not to say	-	-	1	3%	1	3%	-
Base	*9*		*31*		*40*		*1,097,497*

Ethnicity	Event		Survey		Total		Census
Christian	7	78%	14	44%	21	51%	67%
No religion	2	22%	14	44%	16	39%	23%
Religion not stated / prefer not to say	-	-	4	13%	4	10%	6%
Base	*9*		*32*		*41*		*1,097,497*

Source: 2011 census data downloaded from Nomis

Ethnicity

Ethnicity	Event		Survey		Total		Census
White: British	9	100%	28	90%	37	93%	92%
White: Irish	-	-	2	6%	2	5%	0.4%
White: Other White	-	-	-	-	-	-	2%
Asian/Asian British: Pakistani	-	-	-	-	-	-	2%
Asian/Asian British: Indian	-	-	-	-	-	-	1%
Asian/Asian British: Other Asian	-	-	-	-	-	-	1%
Mixed/multiple: White and Black Caribbean	-	-	-	-	-	-	1%
Black/Black British: African	-	-	-	-	-	-	0.4%
Mixed/multiple: White and Asian	-	-	-	-	-	-	0.4%
Asian/Asian British: Chinese	-	-	-	-	-	-	0.4%
Black/Black British: Caribbean	-	-	-	-	-	-	0.3%
Other ethnic group: Any other ethnic group	-	-	-	-	-	-	0.2%
Mixed/multiple: Other Mixed	-	-	-	-	-	-	0.2%
Asian/Asian British: Bangladeshi	-	-	-	-	-	-	0.2%
Mixed/multiple: White and Black African	-	-	-	-	-	-	0.1%
Black//Black British: Other Black	-	-	-	-	-	-	0.1%
Other ethnic group: Arab	-	-	-	-	-	-	0.1%
White: Gypsy or Irish Traveller	-	-	-	-	-	-	0.1%
Prefer not to say	-	-	1	3%	1	3%	-
Base	*9*		*31*		*40*		*1,097,497*

Source: 2011 census data downloaded from Nomis

Religion

Ethnicity	Event		Survey		Total		Census
Christian	7	78%	14	44%	21	51%	67%
Buddhist	-	-	-	-	-	-	0.3%
Hindu	-	-	-	-	-	-	0.4%
Jewish	-	-	-	-	-	-	0.03%
Muslim (Islam)	-	-	-	-	-	-	2%
Sikh	-	-	-	-	-	-	0.3%
Other religion	-	-	-	-	-	-	0.3%
No religion	2	22%	14	44%	16	39%	23%
Religion not stated / prefer not to say	-	-	4	13%	4	10%	6%
Base	*9*		*32*		*41*		*1,097,497*

Source: 2011 census data downloaded from Nomis

Age

Age	Event		Survey		Total	
16 - 19	-	-	-	-	-	-
20 - 24	1	11%	1	3%	2	5%
25 - 29	1	11%	4	13%	5	13%
30 - 34	1	11%	3	10%	4	10%
35 - 39	-	-	3	10%	3	8%
40 - 44	-	-	1	3%	1	3%
45 - 49	2	22%	1	3%	3	3%
50 - 54	2	22%	3	10%	5	13%
55 - 59	-	-	3	10%	3	8%
60 - 64	1	11%	5	17%	6	15%
65 - 69	1	11%	4	13%	5	13%
70 - 74	-	-	-	-	-	-
75 - 79	-	-	1	3%	1	3%
80 and over	-	-	-	-	-	-
Prefer not to say	-	-	1	3%	1	3%
Base	*9*		*30*		*39*	

Source: ONS data downloaded from Nomis

Disability or long-term condition

Disability or long-term condition	Event		Survey		Total		Census
Day-to-day activities limited a lot	2	22%	3	9%	5	12%	12%
Day-to-day activities limited a little	2	22%	5	16%	7	17%	11%
Day-to-day activities not limited	5	56%	24	75%	29	70%	77%
Base	*9*		*32*		*41*		*1,097,497*

Disability or long-term condition	Event		Survey		Total	
Physical disability	1	17%	3	12%	4	13%
Mental health need	3	50%	7	28%	10	32%
Long-term illness	2	33%	5	20%	7	23%
Sensory disability	-	-	1	4%	1	3%
Learning disability	1	17%	1	4%	2	6%
Other	-	-	1	4%	1	3%
Prefer not to say	1	17%	11	44%	12	39%
Base	*6*		*25*		*31*	

Source: 2011 census data downloaded from Nomis

Sex, gender reassignment, pregnancy and maternity

Sex	Event		Survey		Total	
Male	3	33%	6	19%	9	23%
Female	6	67%	22	71%	28	70%
Trans-Woman	-	-	-	-	-	-
Non-binary	-	-	-	-	-	-
Other	-	-	-	-	-	-
Prefer not to say	-	-	3	10%	3	8%
Base	*9*		*31*		*40*	

Pregnant at this time	Event		Survey		Total	
Yes	-	-	1	3%	1	2%
No	9	100%	29	91%	38	93%
Prefer not to say	-	-	2	6%	2	5%
Base	*9*		*32*		*41*	

Recently given birth	Event		Survey		Total	
Yes	-	-	1	3%	1	2%
No	9	100%	29	91%	38	93%
Prefer not to say	-	-	2	6%	2	5%
Base	*9*		*32*		*41*	

Sexual orientation and relationship status

Sexual orientation	Event		Survey		Total	
Heterosexual	8	89%	26	81%	34	83%
Bisexual	1	11%	-	-	1	2%
Gay	-	-	1	3%	1	2%
Lesbian	-	-	-	-	-	-
Other	-	-	-	-	-	-
Prefer not to say	-	-	5	16%	5	12%
Base	*9*		*32*		*41*	

Relationship status	Event		Survey		Total	
Married	5	56%	18	56%	23	56%
Single	1	11%	5	16%	6	15%
Lives with partner	3	33%	4	13%	7	17%
Divorced	-	-	1	3%	1	2%
Separated	-	-	1	3%	1	2%
Widowed	-	-	-	-	-	-
Other	-	-	-	-	-	-
Prefer not to say	-	-	3	9%	3	7%
Base	*9*		*32*		*41*	

Carer and armed forces

Carer	Event		Survey		Total	
Yes - person(s) aged under 24	1	11%	1	3%	2	5%
Yes - person(s) aged 25 to 49	-	-	2	6%	2	5%
Yes - older person(s) aged over 50	3	33%	3	10%	6	15%
No	5	56%	20	65%	25	63%
Prefer not to say	-	-	5	26%	5	13%
Base	*9*		*31*		*40*	

Armed forces	Event		Survey		Total	
Yes	2	22%	-	-	2	5%
No	7	78%	29	91%	36	88%
Prefer not to say	-	-	3	9%	3	7%
Base	*9*		*32*		*41*	

TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Location profiling



CCG

CCG	Event		Survey		Total	
NHS South East Staffordshire and Seisdon Peninsula CCG	4	44%	18	56%	22	54%
NHS East Staffordshire CCG	2	22%	3	9%	5	12%
NHS Cannock Chase CCG	1	11%	1	3%	2	5%
NHS Stoke on Trent CCG	-	-	2	6%	2	5%
NHS Stafford and Surrounds CCG	-	-	1	3%	1	2%
NHS Sandwell and West Birmingham CCG	1	11%	-	-	1	2%
NHS Derby and Derbyshire CCG	-	-	1	3%	1	2%
NHS Warwickshire North CCG	-	-	1	3%	1	2%
No postcode provided	1	11%	4	13%	5	12%
Unable to profile postcode	-	-	1	3%	1	2%
Total	*9*		*32*		*41*	

Local authority

Local authority	Event		Survey		Total	
Tamworth	3	33%	11	34%	14	34%
Lichfield	1	11%	7	22%	8	20%
East Staffordshire	2	22%	3	9%	5	12%
Stoke-on-Trent	-	-	2	6%	2	5%
Cannock Chase	1	11%	-	-	1	2%
South Staffordshire	-	-	1	3%	1	2%
Stafford	-	-	1	3%	1	2%
North Warwickshire	-	-	1	3%	1	2%
Sandwell	1	11%	-	-	1	2%
South Derbyshire	-	-	1	3%	1	2%
No postcode provided	1	11%	4	13%	5	12%
Unable to profile postcode	-	-	1	3%	1	2%
Grand Total	*9*		*32*		*41*	

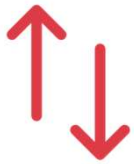
Comments and recommendations

- **Respondent type:** Most respondents engaged through the survey are members of the public (13 / 46%), however there is some representation from service users (6 / 21%) and NHS employees (5 / 18%). Also, there is some representation from carers, with 25% (10) of respondents stating they care for someone.
- **Service usage:** 72% (23) of survey respondents stated they have used mental health services. Of these the majority stated they used the George Bryan Centre before or during March 2019. Only one survey respondent stated they used the George Bryan Centre as a patient.
- **Location:** Most responses have been received from the Southeast of the county (Tamworth, Lichfield, East Staffordshire). There is little representation from other areas.
- **IMD:** Responses have been received from across all the IMD deciles. However, there was no participation in the events from those in the most deprived areas – coupled with the number of survey respondents from these areas, this could be an area to target.
- **Ethnicity:** The vast majority of respondents are white, with no representation from the other groups.
- **Age:** Responses have been received from most age groups, except the very young and very old, which could be potential cohorts to target.
- **Disability:** 29% (12) respondents engaged with stated their day-to-day activities are limited ('somewhat' and 'very' combined), which is in-line with census data (23%).

IMD

IMD	Event		Survey		Total	
1	-	-	1	3%	1	2%
2	-	-	3	9%	3	7%
3	-	-	1	3%	1	2%
4	-	-	2	6%	2	5%
5	1	11%	4	13%	5	12%
6	1	11%	5	16%	6	15%
7	1	11%	1	3%	2	5%
8	3	33%	3	9%	6	15%
9	1	11%	2	6%	3	7%
10	1	11%	5	16%	6	15%
No postcode provided	1	11%	4	13%	5	12%
Postcode unable to be profiled	-	-	1	3%	1	2%
Total	*9*		*32*		*41*	

Most deprived



Least deprived

Equality, Health Inequality Impact and Risk Assessment

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

Stafford &Cannock CCG

Current Status
Stage 2 Approved

Review Date
22/03/2022

Person Responsible
Helen Slater

Service
Transformation Programme

Service Area
Adult Mental Health Services

Project Lead

Name:	Whitfield, Kathryn
Email:	kathryn.whitfield@northstaffs.nhs.uk
Phone:	01782298252

Stage 1 has been Bypassed

Explanation

Until February 2019, the George Bryan Centre provided inpatient mental health services to people living in Burton upon Trent, Lichfield, Tamworth and the surrounding areas. The George Bryan Centre's West wing had 19 beds and provided inpatient care and treatment for adults aged 18–65 with a severe mental illness (SMI). The East wing had 12 beds and provided inpatient care and treatment for older people (65 and over). Most of these were people living with dementia. On 12 February 2019, a fire destroyed the West wing. Anyone in the West wing at the time of the fire was transferred to St George's Hospital as an emergency response. The Board of Midlands Partnership NHS Foundation Trust (MPFT) made the decision later in February to temporarily close the remaining East wing – which was enacted in April 2019 after patients were either discharged or transferred to the most appropriate care setting according to their needs, including home. Since the fire, anyone in the local area referred for mental health support has been treated in the community, through an enhanced community mental health service offer, or where clinically appropriate, admitted to an inpatient bed in St George's Hospital. Since July 2019, MPFT clinicians and staff have been working to find the long-term solution for the two inpatient services that the George Bryan Centre delivered.

Supplementary Files
No files uploaded

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Stage 2 Details

Equality Policies

No files uploaded

Equality Other

EIA George Bryan Centre_Final submitted.pdf (1191553 bytes) - *Attached below*

Human Rights

No files uploaded

Additional Files

No files uploaded

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Comments

Assessment Comment

This assessment is moving to a Stage 2 process. Dan Shackleston. MLCSU Equality and Inclusion Support Officer - 29/03/2022.
29/03/2022
Shackleston, Daniel

Approval Comment

This assessment is moving to a Stage 2 process. Dan Shackleston. MLCSU Equality and Inclusion Support Officer - 29/03/2022.
29/03/2022
Shackleston, Daniel

Stage 2 Comment

Hi Kathryn, Happy to approve and finish this assessment. Engagement has taken place and you have confirmed that comments from the 2019 involvement activity have been considered and have helped to inform proposals. Due to a delay because of Covid-19, there has also been a sense check in Autumn 2021 to see if anything has changed since 2019 that would need to be considered in the business case. You have stated in the assessment that young adults form part of the transformation of community services and that this includes the transition from CAMHS to Adult Mental Health Services. Consideration has also been given to those people who live in a rural location and/or have difficulties with transport, the enhanced community mental health offer for people who can be cared for without an admission will provide a service in that persons usual place of residence. Kind Regards, Dan Shackleston - MLCSU Equality and Inclusion Support Officer - 29/03/2022.
29/03/2022
Shackleston, Daniel

Last Activation Comment

No comment saved

Last Deactivation Comment

No comment saved

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Equality, Health Inequality Impact and Risk Assessment Stage 2

Template for Services, Policies and Function

Title of Service / Policy / Function:

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre



EQUALITY, HEALTH INEQUALITY IMPACT AND RISK ASSESSMENT – STAGE 2

Please complete all sections

Guidance documents available

Name of Organisation: Midlands Partnership NHS Foundation Trust (MPFT) and the Staffordshire and Stoke on Trent CCGs			
Assessment Lead: Kathryn Whitfield, Programme Manager, CCGs			
Responsible Director/CCG Board Member for the assessment: Jane Moore, Strategy, Planning and Performance			
Who is involved in undertaking this assessment: Kathryn Whitfield, Programme Manager, CCGs Upkar Jheeta, Head of Primary Care Development & MH Programme Lead (South Staffordshire), MPFT			
Start date: 15/12/2021	Completed date: 22/03/2022		
Who is impacted by the service / project / change?	**Yes**	**No**	**Indirectly / Possibly**
Patients, Service Users	x		
Carers or Family	x		
General Public			x
Staff	x		
Partner Organisations			x

Summary information of the service / policy / function being assessed:

Background

This paper is about mental health services in South East Staffordshire (Burton upon Trent, Lichfield, Tamworth and surrounding areas) for adults aged 18 plus and the inpatient bed provision at the George Bryan Centre, in particular.

Early in 2019, the West wing of the George Bryan Centre was destroyed by fire. People in the West Wing on the night of the fire were transferred to St George's Hospital to continue their treatment.

The East wing was temporarily closed for safety reasons in April 2019. The size and location of the ward made response to medical and psychiatric emergencies difficult, which put service users, visiting carers and staff at risk.

After the fire, temporary arrangements were put in place.

Anyone living in Burton upon Trent, Lichfield, Tamworth and surrounding areas who needed an inpatient stay was admitted to St George's Hospital in Stafford, and enhanced crisis and community mental health services provided support to enable people to stay in their own home.

This included:

- Enhanced crisis home treatments with skilled, experienced older adult specialists
- Addition of a nursing/therapy lead
- New clinical psychologist to focus on older adults
- A training plan for the team.

A series of engagement events took place in 2019 to understand people's views about the services and where improvements could be made to help shape the long-term solutions.

The report was published and is available on the Together We're Better website.

The MPFT Board received a report detailing the outcomes of an exercise MPFT had undertaken, and agreed to support the system-wide exercise to determine the long-term solution for those services.

The COVID-19 pandemic delayed further public engagement, but we have since held sense-check engagement events and are in the process of confirming the long-term solution for the George Bryan Centre.

Our model of mental health services for the future

Since the beginning of this year, we have been working with existing service users, carers and staff to find a way to realise locally, the national vision for a place-based community mental health model as set out in the NHS Long Term Plan.

Our vision is that by working together, we create mental health services that are inclusive, accessible, value people as they are and are responsive to their needs.

We will embrace innovation and new ways of working to remove traditional barriers, improve communication and training, and provide personalised support that enables people to live well and realise their full potential.

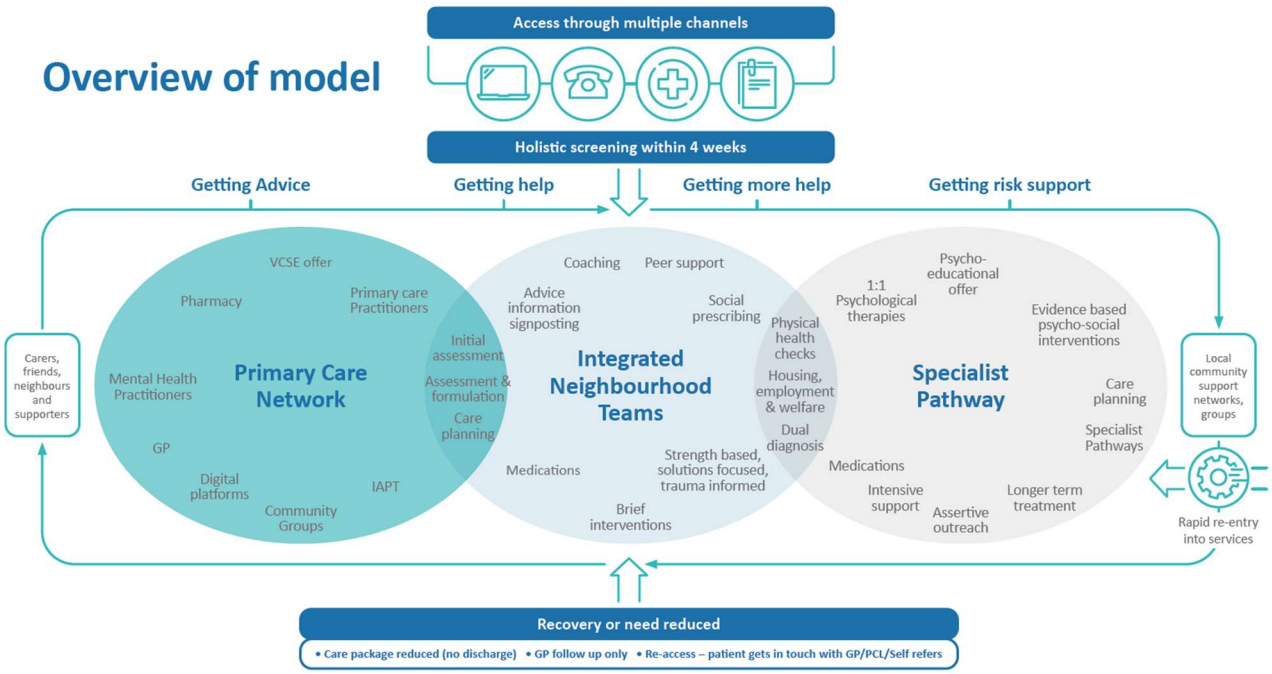
The guiding principles are:

- To improve and simplify access to care
- To use a Trusted Assessor Model – so you don't have to re-tell your story every time
- To have one digital plan which all services can access and update
- For you to have a named worker
- To provide flexible and personalised care that meets your needs
- To provide safe services for you, your carers and our staff
- For all partners to work closely together to join-up our services
- To support your physical health needs.

Mental health staff, doctors and nurses will work with local GP practices, social workers and local communities to offer services closer to home.

Adults would have access to a mental health crisis response service 24 hours a day, based in the local community.

Admission should only be considered when a person is so seriously ill as to require intensive medical supervision and treatment, and when their home circumstances mean this is impossible.



Service Provision – Pre-fire

The George Bryan Centre was purpose-built in 1995 to the standards required at the time.

It provided in-patient mental health services to people living in Burton upon Trent, Lichfield, Tamworth and the surrounding areas.

The West Wing provided 19 beds for people aged 18 and over with serious mental health needs.

The East Wing had 12 beds for people aged over 65.

Not all treatments and interventions were available to people staying in the George Bryan Centre and so some people who had severe mental health needs were admitted to St George's Hospital, in Stafford, because of the more intensive support that can be offered in a larger hospital.

Additional interventions that are available at St George's that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy.

St George's Hospital has 168 beds. Of these, 94 are for adults from Staffordshire with severe mental illness.

The number of admissions to the George Bryan Centre are below. One person may account for more than one admission.

Admissions April 2017-March 2019		
	2017/18	**2018/19**
Older adult ward (East wing)	52	50
Working age adult ward (West wing)	220	189

Service Provision – Post fire

Following the fire, people in the West wing were immediately transferred to St George's Hospital to continue their treatment. Anyone needing an inpatient stay after that was admitted to St George's Hospital.

The East wing was later temporarily closed for safety reasons. The size and location of the ward made response to medical and psychiatric emergencies difficult, which put service users, visiting carers and staff at risk. The fire damage was so severe that the West wing was demolished.

The existing community mental health teams were enhanced to provide support to enable people to stay in their own home. This model of care aligns with the long-term plan and is backed by robust evidence to demonstrate improved outcomes for care provided in the usual place of residence.

- The crisis home treatment service was enhanced with skilled and experienced older adult specialists
- A nursing / therapy lead was added
- A new clinical psychologist was added to focus on older adults and provided additional training for the team.

Aims and objectives of service / policy / function:

The service was commissioned to provide in-patient mental health services to people living in Burton upon Trent, Lichfield, Tamworth and the surrounding areas.

The West Wing provided 19 beds for people aged 18 and over with serious mental health needs.

The East Wing had 12 beds for people aged over 65.

Since the George Bryan Centre began providing services, the landscape of mental health services has changed significantly, particularly for older people living with dementia. Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can exacerbate the symptoms of dementia, permanently reduce independence and increase the likelihood of discharge to residential care and readmission to hospital. NICE guidelines (NG97, 2018)

request that, when considering admission to hospital for a person living with dementia, the value of keeping them in a familiar environment is considered.

If this assessment relates to a review / current service or policy, what are the main changes proposed and reason why:

Future Provision

At a technical event held in December 2021 a group comprising representatives of commissioners and providers including the deputy chief executive of MPFT, directors and/or leads for mental health services, continuous improvement, quality, strategic commissioning and finance, and the community outreach lead from Healthwatch, East Staffordshire and South East Staffordshire, examined the progress with the development of options so far with a view to confirming the options to take forward. The two proposals under consideration were:

1. Consolidation and centralisation of inpatient beds in St George's Hospital, Stafford
2. Provision of inpatient beds in South East Staffordshire for people aged 18+ with serious mental health needs

For both of these proposals, the provision of a transformed community mental health offer will be provided, which includes enhanced crisis home treatment with skilled older adult specialists, a nursing/ therapy lead and new clinical psychologist to focus on older adults.

The discussion centred around the new national clinical model for mental health which involves a move to providing services in the community wherever possible, coupled with the research showing that people with dementia thrive better if they remain in their home setting, meant that the beds provided in the East Wing no longer needed to be provided. Therefore, the level of provision of inpatient beds would change, as the enhanced community service would provide care for that cohort of patients in their usual place of residence.

It was then confirmed that provision of 19 inpatient beds for people with acute mental health needs in a separate facility from the central services provided at St George's was not safe on the grounds of staffing and remoteness.

The proposal agreed is as follows:

Consolidation and centralisation of inpatient beds in St George's Hospital, Stafford AND the provision of a transformed community mental health offer, which includes enhanced crisis home treatment with skilled older adult specialists, a nursing/ therapy lead and new clinical psychologist to focus on older adults.

Case for Change

Evidence based care - Since the George Bryan Centre began providing services, the landscape of mental health services has changed significantly, particularly for older people living with dementia.

Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can exacerbate the symptoms of dementia, permanently reduce independence and increase the likelihood of discharge to residential care and readmission to hospital. NICE guidelines (NG97, 2018) request that, when considering admission to hospital for a person living with dementia, the value of keeping them in a familiar environment is considered.

Strategic Planning / Accessibility –. In line with the aims set out in the LTP, national best practice in mental health has shifted from a bed-based model to a community-based model. Staffordshire and Stoke-on-Trent have secured funding to implement this national model, locally. Their transformation plans for mental health reflect this.

Safe staffing - Evidence shows that hospital-based care can be detrimental to people living with dementia, therefore, the proposal to re-provide the 12 beds that were previously in the East wing could not be taken forward as a viable option, as this would not support a quality service for this cohort of people. Without those 12 beds, the proposal for provision of beds in South East Staffordshire would be for people aged 18+ with serious mental health needs only. Providing care to one ward of people in a standalone centre makes responding to medical and psychiatric emergencies difficult, which put service users, visiting carers and staff at risk.

What engagement work is planned / or carried out and how will you involve people from equality groups to ensure that their views inform decision making:

Engagement activity in 2019

A series of engagement events took place in 2019 to establish what was good about the services and what needed improving. The Board of MPFT received a report detailing the outcomes of the engagement exercise on 30 January 2020.

Sense check engagement

The COVID-19 pandemic delayed any further engagement on the future of the services. The decision was made to re-start the process in Autumn 2021 to find the long-term solution for the services formerly provided at the George Bryan Centre.

Feedback was gathered by a survey and three events. The survey and events were promoted via the MPFT website and social media. Local stakeholders were contacted by email and telephone to encourage participation.

The survey was hosted online between Thursday 7 October and Sunday 31 October. Paper versions were available on request. **80 responses were received.**

Two online workshop events were held on 13 and 14 October. **There were 29 participants in total.**

The report of finding has been published and includes demographic information on respondents. https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement

Plan for reference group (March 2022)

- Targeted reference group to be recruited to inform the short-list/ business case
- Recruitment to start w/c 13 December
- Includes service users, staff, seldom heard groups, interest groups

- Aiming for a balanced room (as reasonably possible)
- Detailed information packs, including SWOT analysis/ data analysis, will be shared to ensure group is informed
- Group will review the viable proposals (agreed by the technical group) against the desirable criteria
- The feedback will be shared with the technical group in February to inform the business case

The aims of the engagement were to hear:

- From staff, patients and carers to understand experiences of mental health services since the fire
- Ideas and suggestions about how mental health services could be provided in the future

Does the proposal or change help to reduce health inequalities? YES

If yes, please summarise these:

Area	Proportion of people living in rurality (2017)	Proportion of people living in deprived areas (IMD 2015)	Households without a car (2011)
Cannock Chase	9.1%	13.8%	20.2%
East Staffordshire	21.7%	18.2%	21.4%
Lichfield	29.8%	3.9%	13.6%
Newcastle-under-Lyme	20.0%	11.5%	22.1%
South Staffordshire	40.1%	1.4%	13.2%
Stafford	32.4%	5.3%	17.5%
Staffordshire Moorlands	30.5%	4.7%	14.8%
Tamworth	0.0%	17.5%	20.6%
Staffordshire	24.2%	9.3%	18.0%
West Midlands	14.7%	29.8%	24.7%
England	17.0%	20.4%	25.8%

Key demographics of the most impacted areas are highlighted below.

Summary of key demographic characteristics in Staffordshire

Source: Indices of Deprivation 2015, Department for Communities and Local Government, 2017 mid-year population estimates, Office for National Statistics, Crown copyright. The Rural and Urban Classification 2011, Office for National Statistics, Crown copyright. 2011 census, Office for National Statistics, Crown copyright.

A cohort of patients and carers will be impacted by the requirement to travel further to visit a person who is admitted to a bed in St George's hospital in Stafford (approximately 26 miles from Tamworth). This could adversely impact those who live in rural areas without good transport links and those without households without a car.

Previously, there were two potential sites across south Staffordshire where a patient with a serious, acute mental health need could be admitted – St George's Hospital in Stafford and George Bryan Centre in Tamworth. However, not all treatments and interventions were available to people staying in the George Bryan Centre and so some people who had severe mental health needs were admitted to St George's Hospital, in Stafford, because of the more intensive support that can be offered in a larger hospital.

Additional interventions that are available at St George's that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy. This centralisation of bed provision will ensure equal access to these facilities based on need and will eliminate the need to transfer patients between these sites to access appropriate therapy.

For those people who live in a rural location and/ or have difficulties with transport, the enhanced community mental health offer for people who can be cared for without an admission, will provide a service in that person's usual place of residence.

Does the proposal relate to impacts due to COVID-19? NO

If yes, please summarise these:

Evidence section

What evidence have you considered within this assessment? (this can include NICE / research / engagement work / demographics)

- George Bryan Centre Report of Findings https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement
- NICE guidance (NG97, 2018) states that, when admission to hospital is considered for a person living with dementia, the value of keeping them in a familiar environment should be considered.
- NCCMH (2018) guidance on the dementia care pathway notes that hospital admissions can exacerbate symptoms of dementia, permanently reduce independence, and increase the likelihood of discharge to residential care and readmission to hospital.
- NHS Providers (2018) notes that treating patients as close to home as possible is better for patient care, with community services at the heart of provision.
- Community Mental Health Transformation programme details can be found at https://www.england.nhs.uk/mental-health/adults/cmhs/
- Quality impact assessment (in development and QIA panel booked for 30/03/22)

Summary of engagement work

In 2019, there was a process of involvement to understand people's views about the services and where improvements could be made to shape the long-term solutions. The involvement included a survey run by Together We're Better (the report of findings is on the Together We're Better website). Then, between September and October 2019, MPFT held five involvement events in south east Staffordshire.

The comments from the 2019 involvement activity have been considered and have helped to inform the proposals that were presented during the options appraisal process. However, the process had to be put on hold because of the COVID-19 pandemic.

In autumn 2021, there was sense-check involvement activity that aimed to find out whether anything had changed between 2019 and 2021 that would need to be considered in the business case. The full report of findings, and a summary report, can be found on the MPFT website: https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement

If this assessment relates to a policy / strategy, has an equality statement been added or planned to be added? **If no, please state why not:** Since the fire in early 2019, people who accessed mental health services from the George Bryan Centre have been provided with appropriate care, either through admission to the inpatient mental health beds at St George's hospital in Stafford or through the transformed community health teams.	No

IMPACT ASSESSMENT:

This section should record any known or potential impacts on equality groups and other groups at risk of poorer health outcomes. Impacts may be both negative and positive. Think about barriers to access and how different groups may be disproportionately impacted. You can copy and paste this tick: ✓

Age	**Positive effect**	**Negative effect**	**Neutral**
	✓		

Explanation:

Access to mental health services is needs-based, but for patients with dementia, (which impacts more people over 65 years), the transformed and enhanced community offer will ensure they can receive appropriate care, in their usual place of residence where possible.

Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can exacerbate the symptoms of dementia, permanently reduce independence and increase the likelihood of discharge to residential care and readmission to hospital. NICE guidelines (NG97, 2018) request that, when considering admission to hospital for a person living with dementia, the value of keeping them in a familiar environment is considered.

The enhancements to the community mental health teams includes enhanced crisis home treatment with skilled older adult specialists, a nursing/ therapy lead and new clinical psychologist to focus on older adults.

Young Adults form part the transformation of community services, this includes the transition from CAMHS to Adult Mental Health services. As part of this work, the Trust is developing a co-produced service model with young adults with lived experience. To progress this work at pace there is a task and finish group in place, made up of a range of professionals with a broad level of expertise (including a CAMHS Service Manager, Early Intervention Lead, Youth Participation Leads, Additional Roles Reimbursement Scheme (ARRS) Practitioner with a specific focus on the 18-25 agenda, Involvement and Co-production Officer/s).

Disability	**Positive effect**	**Negative effect**	**Neutral**
	✓		

Explanation:

For those people who live in a rural location and/ or have difficulties with transport, the enhanced community mental health offer will reduce admissions for a cohort of people who can be cared for at home, thus removing any barriers to access for the patient or carer.

For those patients who require admission to a centralised bed in St George's Hospital, additional interventions are available that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy. This centralisation of bed provision will ensure equal access to these facilities based on need and will eliminate the need to transfer patients between these sites to access appropriate therapy, leading to improved outcomes for these patients.

The service seeks to be inclusive through providing accessible information, this could include easy read, BSL or any other formats for people requiring additional communication support. MPFT have also produced a style guide to support health literacy issues.

Sexual Orientation	**Positive effect**	**Negative effect**	**Neutral**
			✓

Explanation:

Both inpatient and community mental health services support patients from the LGBT community.

Gender Reassignment	Positive effect	Negative effect	Neutral
	✓		

Explanation:

It would be expected that both inpatient and community mental health services support patients who have undergone gender reassignment. The provision of an enhanced community mental health services team increases the likelihood that the patients will be cared for in their usual place of residence and by clinicians who know them.

Sex	Positive effect	Negative effect	Neutral
			✓

Explanation:

Acute adult mental health wards are mixed sex at St George's, as they were at the George Bryan Centre. No change to service. All patients are allocated single rooms at St George's hospital. There have not been any specific complaints about mixed sex wards and there are female only day rooms on site. On occasions when for clinical need a single sex ward is required then MPFT do have access to male only beds on PICU and female only wards at Redwoods but these occasions are rare.

Race	Positive effect	Negative effect	Neutral
			✓

Explanation:

It would be expected that both inpatient and community mental health services support patients of any race. Staff would work under the values and behaviours of the Trust which promote service user inclusion, dignity and respect.

The service seeks to be inclusive through easy read, interpreter services, and materials in different languages.

Religion and Belief	Positive effect	Negative effect	Neutral
			✓

Explanation:

It would be expected that both inpatient and community mental health services support patients from all religions and/ or beliefs. Staff will support the cultural beliefs of patients and carers/families. Staff

would work under the values and behaviours of the Trust which promote service user inclusion, dignity and respect.

Pregnancy and Maternity	Positive effect	Negative effect	Neutral
			✓

Explanation:

Pregnant women will be supported throughout their in-patient stay at St George's hospital. There is no change to service provision between George Bryan Centre and St George's hospital. No concerns have been raised through the engagement/ patient feedback.

Marriage and Civil Partnership	Positive effect	Negative effect	Neutral
			✓

Explanation:

It would be expected that both inpatient and community mental health services support patients irrespective of marital status.

Other groups at risk of poorer health outcomes:

Carers	Positive effect	Negative effect	Neutral
		✓	

Explanation:

A cohort of patients and carers will be impacted by the requirement to travel further to visit a person who is admitted to a bed in St George's hospital in Stafford (approximately 26 miles from Tamworth). This could adversely impact those who live in rural areas without good transport links and those households without a car.

For those people who live in a rural location and/ or have difficulties with transport, the enhanced community mental health offer for people who can be cared for without an admission, will provide a service in that person's usual place of residence.

At the reference group held in March 2022, attendees were asked if they are able to suggest potential mitigations related to this impact on patients and carers. A full report will be produced based on the feedback received and MPFT will be exploring digital solutions for remote support in addition to other potential mitigations discussed.

Socio-economic deprivation	Positive effect	Negative effect	Neutral
			✓

Explanation:

A cohort of patients and carers will be impacted by the requirement to travel further to visit a person who is admitted to a bed in St George's hospital in Stafford (approximately 26 miles from Tamworth). This could adversely impact those who live in rural areas without good transport links, those households without a car and those on low incomes. For those people who live in a rural location and/ or have difficulties with transport, the enhanced community mental health offer for people who can be cared for without an admission, will provide a service in that person's usual place of residence.

At the reference group held in March 2022, attendees were asked if they are able to suggest potential mitigations related to this impact on patients and carers. This may include digital solutions for remote support from carers.

Other groups e.g. Asylum Seekers, Homeless, Sex Workers, Military Veterans, Rural communities – please state	**Positive effect**	**Negative effect**	**Neutral**
			✓

Explanation:

It would be expected that both inpatient and community mental health services support any patients based on need. MPFT are committed to working with groups that can struggle to access health care and an example of ongoing work is given below.

MPFT's discharge pathway is identifying a number of service users who have been admitted to an in-patient ward who do not have a fixed abode. These service users are referred to the council for housing support and the team:

- support them to obtain identification documents
- support them to access appropriate benefits
- discharge to emergency housing once confirmed by local authority
- arrange for food parcels to be delivered
- liaise with housing to resolve any issues that occur
- support them to complete housing assessment documents
- refer to lower-level supported accommodation, for example, rethink, league of friends
- employs recovery workers who can support people to get their own flat, to furnish the flat and support them with setting up paperwork

Equality Legal Duties – compliance

Has the CCG given due regard and given consideration for the following:

Eliminating unlawful discrimination, harassment, and victimisation	Yes

Unlawful discrimination takes place when people are treated 'less favourably' as a result of having a protected characteristic	
Advancing equality of opportunity between people who share a protected characteristic and those who do not *Making sure that people are treated fairly and given equal access to opportunities and resources*	Yes
Fostering good relations between people who share a protected characteristic and those who do not *Creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference*	Yes
Are there any potential Human Rights concerns If yes – please seek advice from the E&I team to discuss carrying out specific human rights assessment	No
Compliance to the NHS Contract In relation to Service Conditions (SC13) which includes Accessible Information Standard	Yes

Supporting narrative to support the above responses: *This section must be completed*

Access to mental health services, both in the community and for inpatient beds, are provided on the basis of need. The proposed centralisation of inpatient beds at St George's hospital site provides equity of provision for all patients requiring inpatient care. Previously, inpatients at George Bryan Centre did not have ready access to a range of therapeutic interventions or consultant level support. There is consultant support at St George's hospital and a wider range of service provision and staff.

Equality Related Risk Assessment Section

If you have identified an equality risk, please use the table below to work out the risk score. If you have a score of 9 and above you should escalate to risk management procedures.

	Level of risk				
Level of consequence	RARE: 1	UNLIKELY: 2	POSSIBLE: 3	LIKELY: 4	VERY LIKELY:5
1. Negligible	1	2	3	4	5
2.Minor	2	4	6	8	10
3.Moderate	3	6	9	12	15
4.Major	4	8	12	16	20
4.Catastrophic	5	10	15	20	25

If you have identified an equality risk: What is the consequence? 2	Risk Score = 8

What is the likelihood? 4 Risk score = consequence x likelihood	

Any narrative relating to risk score:

The risk score relates to the negative impact for the cohort of patients and carers impacted by the requirement to travel further to visit a person who is admitted to a bed in St George's hospital in Stafford.

Prior to the fire, some patients from South East Staffordshire were directly admitted to St George's hospital, as their severe mental health needs required the more intensive support offered in a larger hospital. In addition, the enhanced community offer makes it more likely that a person will be cared for in their usual place of residence, rather than being admitted to an inpatient bed.

People on low income who claim certain benefits can reclaim transport costs to hospital.

MPFT staff will signpost people to any voluntary car schemes that are in place at the time. Digital solutions will also be explored, following the successful use of technology throughout health and social care during the COVID-19 pandemic.

Equality Action Plan with target dates

Please include any related recommendations arising from this assessment. A target date is required for all actions

Action required	Lead person	Target date	Further comments

Date for this assessment to be shared with governance processes:

Within **MPFT**, the completed business case, with impact assessments included, will be presented at the following Committees/ Boards:

- Business Development & Investment Committee
- Financial Effectiveness Group

- Finance & Performance Committee
- MPFT Trust Board

Within the **CCG/ ICB**, the completed business case, with impact assessments included, will be presented at the following Committees/Boards:

- South East Place Based Partnership Board (for information)
- Mental Health Transformation Board
- ICS Transformation Programme Board
- Governing Body/ ICB Board

These meetings are scheduled to take place between **May-July 2022** (subject to NHSEI Assurance and Clinical Senate approval).

(All assessments should have governance oversight)

Final Section: Approval from Equality and Inclusion Team
Date received by E&I Team for assurance check: Friday 25 March 2022
Person completing the assessment template: Kathryn Whitfield, Programme Manager, CCGs
Date and E&I Team member completing assurance check: Tuesday 29 March 2022 - Dan Shackleston – MLCSU Equality and Inclusion Support Officer
What next?
1. Regularly review the action plan and update EHIIRA accordingly 2. Save a finalised copy for your records and share with your governance processes and the E&I Team / E&I Business Partner 3. Follow any internal advice from the E&I Team – if provided

Pre-consultation Business Case – inpatient services for mental health in south east Staffordshire

Section 6
6.5.4 Staff and clinical engagement

Comments from consultant psychiatrist

During late 2021 discussion took place with a consultant psychiatrist from MPFT who had been based at the West Wing in the George Bryan Centre about the impact on clinicians and staff of the temporary changes to the services at the George Bryan Centre which involved staff moving to St George's Hospital.

The psychiatrist said that the move to St George's Hospital was advantageous in terms of safety. As the George Bryan Centre was isolated, there was a limit to the type of patients they could care for safely because if something went wrong at the George Bryan Centre, there was only one other ward, whereas at the Milford Ward in St George's Hospital they can draw on wider sources of support. For example, at St George's Hospital the psychiatric intensive care unit is "*just two steps away*", one advantage of being in a centralised unit. Also, if patients became violent at the George Bryan Centre the police were sometimes called, whereas this is less necessary at St George's Hospital where there are more facilities to deal with patients who become violent. For the consultant psychiatrist, the work did not change, but the feeling of safety 'that you know the patients are safe and the staff are safe' was a great benefit.

A disadvantage was travel for patients from Tamworth, Lichfield or Burton upon Trent because visitors have to travel further and this has had a huge impact for some patients.

There can also be difficulties with scheduling home leave. As the journey between Stafford where St George's Hospital is and the other towns takes longer, the psychiatrist has to take into account the longer journey times, managing the risk against benefit when making this decision. This can mean that patients who live more locally to St George's Hospital have different opportunities for leave than patients who have to travel further. It can also mean that patients are given longer home leave to allow for their travel time, which may be an advantage to them.

Another consideration is the cost of travel, which is more if the patient or visitor needs to travel further. There is sometimes the possibility of transporting the patient in a ward car but this involves a member of staff spending perhaps six hours accompanying the patient, so there are staffing implications.

For staff, too, there was a travel impact. Those who lived near the George Bryan Centre who transferred to St George's Hospital after the fire now need to travel further. This could include needing to catch a train. The travel changes have had a huge impact for some staff.

When asked if they would return to the George Bryan Centre if it reopened tomorrow, the consultant psychiatrist said they would not if it was as it used to be. Their reasons were because of safety for both patients and staff.

The programme team met with two MPFT clinicians on 12 Nov 2021, to discuss the service provision pre and post fire, in order to develop the narrative to inform the business case.

Comments from healthcare assistant

In a one-to-one interview in March 2022, a healthcare assistant who had worked at the George Bryan Centre on the East Wing until the time of the fire shared their views.

They explained that at the time of the fire they helped evacuate the patients from the West Wing whilst three other staff cared for the patients in the East Wing.

When the East Wing was closed, they chose to move to work at St George's Hospital and then moved to a new role at St George's Hospital.

When working at the George Bryan Centre they liked the fact that it was only five minutes journey from home, but did not like the fact that it 'didn't feel safe'. It felt understaffed and when staff called the police unless they voiced that there was imminent danger, the police did not come.

After moving to St George's Hospital, they liked the fact that there was a bigger team, stronger rapport with colleagues, a bigger hospital, more staff in the event of an attack – if an alarm goes off, plenty of staff go to the alarm.

They explained that at the George Bryan Centre, because it was so close to home, people used to contact them out of hours, for example if they had left something, but now people never contact them at home and so they really leave the stress and the day behind when they go home.

Although there is a longer commute (an hour each way) this is not seen as a problem because of the perceived advantages of working at St George's Hospital.

When asked what impact the move to St George's Hospital had had on patients, the staff member said that as the East Wing patients were from Tamworth, the patients' relatives have struggled if they were admitted to St George's hospital, because of the journey. With regard to the acute beds, they are still there now, just in a different town.

When asked what they would like to happen in future with regard to the inpatient beds that were provided at the George Bryan Centre, the staff member said that it would be a 'win-win' if older patients that would have been in East Wing are kept in the community. Many relatives are in real crisis, but there is more support out there.

With regard to inpatient beds, with the new arrangement and the 18 beds now at Stafford, the staff member has never heard that there is a shortage of beds.

Appendix 10

Engagement with Health Overview and Scrutiny Committees about the future of inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia in south east Staffordshire

Staffordshire County Council Health and Care Overview and Scrutiny Committee

The Staffordshire CCGs have updated the Staffordshire County Council Health and Care Overview and Scrutiny Committee with information about the Together We're Better transformation programme, including mental health services in south east Staffordshire, providing details about the patient and public involvement, in line with Overview and Scrutiny Committee responsibilities outlined at the beginning of the business case.

15 July 2019 (Healthy Staffordshire Select Committee Meeting)

Lisa Agell, Head of Mental Health Services, Midlands Partnership NHS Foundation Trust and Nicola Harkness, Managing Director, South East Staffordshire CCG's, attended the meeting to present a report in relation to the engagement plans for the George Bryan Centre. The minutes[1] state:

> *"RESOLVED – That:- (a) The CCGs and Midlands Partnership Group be informed that the Committee felt that the 12 bed based facility, should remain in Tamworth. (b) Following the consultation, the CCG should bring detailed proposals to the Committee for consideration."*

28 October 2019 (Healthy Staffordshire Select Committee Meeting)

The minutes[2] of an item headed **Midlands Partnership NHS Foundation Trust: merger and quality accounts** state:

> *"Following the recent closure of the George Bryan Centre West Wing, due to fire damage, it had been considered that the East Wing had been too isolated to continue to operate and services had been temporarily moved into the community. There was a conversation /engagement taking place on the future model of provision for these services. The feedback from the engagement exercise so far included transport issues for both patients and family. It was reported that there were adequate numbers of beds available, but they may not be in convenient locations. More work was taking place into increasing community support to prevent hospital admissions. "*

[1] Printed minutes 15th-Jul-2019 14.00 Health and Care Overview and Scrutiny Committee.pdf (staffordshire.gov.uk)

[2] Minutes of the Healthy Staffordshire Select Committee Meeting, 28 October 2019

also

"RESOLVED: That the report be received, and that the following information be requested: .... d) The Committee be formally consulted on any proposed changes to the George Bryan Centre. "

26 October 2020 (Healthy Staffordshire Select Committee Meeting)

The minute[1] of an item headed **District/Borough Healthy Scrutiny Activity** state:

"With regard to Lichfield District Council's Community Housing and Health (Overview and Scrutiny) Committee, a Member stressed the urgent need for clarity regarding the long term future/re-opening of the George Bryan Centre which had provided mental health services until a serious fire at the site during 2019. In reply the Scrutiny and Support Manager referred to an update given to the Committee shortly after the fire. However, further information regarding the Centre was being sort from the local CCG and would be circulated to Members as soon as possible."

1 February 2021 (Healthy Staffordshire Select Committee Meeting)

The minute[2] for the item headed **District/Borough Health Scrutiny Activity** stated

During the discussion which ensued Members expressed their agreement with the Chairman's view that scrutiny of:- (i) Midlands Partnership NHS Foundation Trust in - 5 - respect of the George Bryan Centre, Lichfield and; (ii) Burntwood Health and Wellbeing Centre in respect of their temporary accommodation (as referred to in paragraph 8 of the report) were matters for Lichfield District Council's Community Housing and Health (Overview and Scrutiny Committee) under the agreed Code of Joint Working – Local Authorities…

RESOLVED – … (c) That the Chairman meets with the Member representative of Lichfield District Council in respect of their Community Housing and Health (Overview and Scrutiny) Committee's scrutiny of:- (i) Midlands Partnership NHS Foundation Trust's George Bryan Centre, Lichfield

9 August 2021

On 9 August 2021 NHS Staffordshire and Stoke-on-Trent CCGs presented an update[3] to Staffordshire County Council Health and Care Overview and Scrutiny Committee about the temporary closure of the George Bryan Centre.

Members of the committee were asked to note the report and to advise on any additional information that was required by members to feel that due process and sufficient involvement activity would be undertaken to inform the proposals in the business case.

[1] Minutes of the Healthy Staffordshire Select Committee Meeting held on 26 October 2020

[2] Minutes of the Healthy Staffordshire Select Committee Meeting held on 1 February 2021

[3] Staffordshire County Council, Health and Care Overview and Scrutiny Committee, Monday 9 August 2021

The report outlined the changes to services at the George Bryan Centre since the fire in February 2019 and explained the process of service change, stating "*the process for deciding the long-term solutions for the services formerly provided at the George Bryan Centre will be based on the best balance of clinical evidence and evidence".*

The report outlined previous engagement and the plans for the 'sense-check' engagement in the autumn.

The minutes from the committee's response (full minutes are available on the council's website[1]) state:

> ***21. George Bryan Centre***
>
> *The Committee considered the proposals for engagement events and the process for deciding the long-term solutions for mental health services which would be based on the best balance of clinical evidence and evidence gained through public involvement.*
>
> *The Committee noted that:*
>
> - *Since the fire, services had been provided at St George's hospital in Stafford or through community mental health services, which had been developed during the closure to expand expertise and provision in the community. Staff from GBC had been either redeployed or re-trained. Work was underway to determine the future of the mental health services through engagement events and an options appraisal.*
> - *Previous engagement had informed the business case alongside the clinical evaluation, further engagement events, and equality impact assessments. All information gathered through listening and engagement was used to develop the Clinical Service Model which would be evaluated, and services shaped.*
> - *The Clinical Service Model would also take into consideration the Integrated Care Strategy (ICS) programme for adult and older people's mental health services across Staffordshire and Stoke on Trent.*
>
> *The following comments and responses to Members questions were noted:*
>
> - *The GBC had been insured by the Midlands Partnership Foundation Trust (MPFT), detail of the insurance funding had been calculated on the damage extent and reasoning for the fire, this information was not available at the meeting but would be sent to Members.*
> - *MPFT consultation events included service users from GBC, other mental health services across Staffordshire and members of the workforce. A link to the survey was available on the website and would be shared with members alongside more detail on qualitative data requested.*
> - *It was confirmed that all service users were over 18 years old.*
> - *Members highlighted the need to hold face to face events to bring on board service users or carers who could reach out to people who had used or*

[1] Minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 9 August 2021 Printed minutes, 9 August 2021

intend to use services. They indicated that the information would bring perspectives to shape services to what people want and need, and in doing so people would feel included. MPFT welcomed the opportunity to talk with Staffordshire Healthwatch about the co-production group, to engage face to face with individuals who had experience of services.

- *There had been no significant increase in serious mental health incidents drawing on other services such as police and ambulance in the communities during the lockdown period. It was noted that the way services were delivered during this period was different and not comparable to other periods. A ward had been available at St George's hospital for short term stays and average length of stay during this period was 23 days, this benchmarked well across the country.*
- *Members requested further data about re-admissions to make a useful comparison and highlighted the importance of clinical evidence to inform the business case.*
- *Members thanked staff for work they had done in difficult circumstances.*
- *It was explained that people liked local services, but they were not always the best pathway for the individual based on clinical health outcomes.*
- *The Community Impact Assessment would identify issues such as transport and travel and mitigate against the impact on the individual. This would be part of the decision making process before a final decision was made.*
- *It was explained that this work aligned to the wider mental health programme.*

Resolved:

1. That the update report and presentation were noted.

2. That Committee requested the link to more detailed information from engagement feedback, data of re-admissions to ensure clinical evidence was included in the business case and confirmation of the insurance funding details.

3. That the final draft proposal be considered by the Committee at a future meeting.

15 March 2022

On 15 March 2022 NHS Staffordshire and Stoke-on-Trent CCGs presented an update[1] to Staffordshire County Council Health and Care Overview and Scrutiny Committee about the Together We're Better transformation programme.

This included an overview of the autumn 2021 engagement and a summary of the feedback.

The paper summarised the position with regard to the options appraisals process for the transformation programmes, including inpatient mental health services in south east Staffordshire.

[1] Minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 15 March 2022

It emphasised the continued involvement of staff, service users and other interested groups and detailed the development of reference groups including service users, workforce and members of protected characteristic groups.

It underlined that no decisions had yet been made, and confirmed that the CCGs would keep the committee informed of the progress in developing future business cases, and to inform their approach to any future involvement activity.

01 August 2022

On 01 August 2022 NHS Staffordshire and Stoke-on-Trent ICB presented[1] to Staffordshire County Council Health and Care Overview and Scrutiny Committee the draft business case to provide from St George's Hospital, Stafford the inpatient services in south east Staffordshire formerly provided by MPFT from the George Bryan Centre for adults with severe mental illness and older adults with severe mental illness or dementia.

The presentation introduced by Steve Grange, deputy chief executive at MPFT, and given by Paul Edmondson Jones, Chief Medical Officer SSOT ICB summarised the case for change and process to date.

Members asked questions of SSOT ICB and MPFT representatives and held a wide ranging discussion covering points including workforce safety on hospital sites and in the community; wider community safety; community mental health services; the reach of involvement to date; transport and service accessibility; the requirement for greater contractual commitment to services from commissioners; the insurance money from the fire at the George Bryan Centre and future use of the site; and the relationship with social care services.

The Chairman thanked presenters for providing a detailed and useful presentation and detailed analysis of the questions raised. The Chairman established that Committee was broadly in support of the principle to move towards Community Services and that further information would strengthen the proposal. Committee was in support of the principle to move people with dementia into community services if it benefitted those individuals.

The committee formally noted the report and set out the information it wishes to see when the matter is next raised for discussion.

[1] Draft minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 01 August 2022

Lichfield District Council and Tamworth Borough Council

Mental health services in south east Staffordshire were also discussed at scrutiny meetings of Lichfield District Council and Tamworth Borough Council.

Lichfield District Council Community Housing and Health (Overview and Scrutiny) Committee

25 March 2019

The minutes[1] note that:

> *"The five system priorities were discussed and there was some concern that not much work had been identified for mental health. Members agreed that care closer to home should be considered significantly for Lichfield especially with the temporary closure of George Bryan centre as that meant there was no mental health facility in the area. It was noted that any permanent plan for the George Bryan centre would be subject to consultation."*

26 June 2019

The agenda[2] includes:

> *'Engagement Plans for George Bryan Centre This presentation will be led by the Clinical Commissioning Group and supported by the Midlands Partnership NHS Foundation Trust.'*

This was a verbal presentation. No minutes are available.

Tamworth Borough Council Health and Wellbeing Scrutiny Committee

27 February 2019

The minutes[3] state:

> *Future of the George Bryan Centre*
>
> *County Councillor Oates reported that since the previous meeting of this Committee there had been a significant fire at the centre which had led to the need to move 18 residents of the centre, either to alternative residential centres or to alternative arrangements. Staffordshire County*

[1] Community Housing and Health (Overview and Scrutiny) Committee Agenda and Minutes- Monday, 25th March, 2019

[2] Lichfield Health (Overview and Scrutiny) Committee Agenda - Wednesday, 26th June 2019

[3] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes- Wednesday, 27th February 2019

Council were maintaining contact with the Midlands Partnership NHS Foundation Trust, however, there was no update which could be provided on future plans. The Committee sought clarification on any investigation into the fire. County Councillor Oates confirmed that he would seek clarification on what investigation would be undertaken.

23 July 2019

There was not an item on the agenda about the George Bryan Centre, but the minutes[1] state:

George Bryan Centre – there was significant discussion on this item at the Select Committee and County Councillor Clements remained concerned that there was insufficient mental health care capacity based within Tamworth. It was reported that there were two engagement events in Tamworth planned to ensure that Tamworth is heard in this area.

19 Sept 2019

The minutes[2] state:

The Chair updated the Committee on the following matters: • the Engagement Event regarding George Bryan Centre services – two sessions (afternoon and evening) on 16 October at Coton Green Church. The Chair reminded members that if they wanted to attend they needed to sign up to a session on the Eventbrite website.

15 October 2019

The minutes[3] state:

The Committee noted the request to invite in Midlands Partnership NHS Foundation Trust to talk about their approach to partnership working and to provide an update on the George Bryan centre.

There were also some comments relating to the engagement sessions.

26 November 2019

The minutes[4] state:

The Chair provided an update to the Committee on the relevant agenda items covered at the Healthy Staffordshire Select Committee held on 28 October 2019 and in particular: ...Midlands Partnership NHS Foundation Trust (MPFT) item, where an update was provided to the Healthy

[1] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - Tuesday 23rd July 2019
[2] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - 19 September 2019
[3] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - 15 October 2019
[4] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - 26 November 2019

Staffordshire Select Committee on the work undertaken to change the organisational culture and improve services in all areas. It was noted that the Healthy Staffordshire Select Committee had asked to be consulted on any proposed changes to the George Bryan Centre, as well as other matters. The Chair further reported that he, and several other members of this Committee, had attended an engagement event on the George Bryan Centre.

26 February 2020

This meeting received an update from a member of MPFT. This included:

- The Trust's approach to partnership working in Staffordshire
- The services provided by the Trust in Staffordshire and particularly Tamworth, and
- the George Bryan centre.

The minutes[1] state that the update on the George Bryan Centre described:

- The engagement undertaken regarding the George Bryan services, including five engagement events and the outcomes from such process which included support to re-build the centre like-for-like, suggestions for additional beds, the centre being used as a base for community services and potentially other health services as well as suggestions regarding the relationship of that centre with the Sir Robert Peel Hospital;
- The most common theme from the engagement process on the George Bryan centre was the distance of travel between Tamworth and Stafford and the importance of this in terms of visitors to patients. However, the engagement process also highlighted some differences in service available between Stafford and the George Bryan centre;
- The next steps to be followed, which was for the clinical commissioning groups to deliver a statutory consultation later this year which would determine the outcome.

Members asked for clarification about whether it was financial resourcing which was preventing the rebuild of the George Bryan centre and the extent to which any fundraising undertaken could assist.

23 September 2021

The minutes[2] state:

The Chair further reported that the Midlands Partnership Foundation Trust had restarted its engagement process on the services previously provided

[1] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - 26 February 2020

[2] Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - 23 September 2021

at the George Bryan Centre and the Chair encouraged members as well as members of the public to consider this.

NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust



Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

8 November 22

Information pack

This document is for members of the George Bryan Centre Reference Group meeting on 15 March 2022. It should not be shared with anyone else.

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 This document is for members of the George Bryan Centre Reference Group meeting on 15 March 2022. It should not be shared with anyone else.

1. Introduction

This information pack is for members of the reference group. Thank you for helping us with this latest stage of involvement. We are grateful for your views, insights and support.

The document contains the information you need to help you prepare for the meeting, so please read through it carefully.

2. Background to this project

Until February 2019, the George Bryan Centre provided **inpatient** mental health services to people living in Burton upon Trent, Lichfield, Tamworth and the surrounding areas.

The George Bryan Centre's West wing had 19 beds and provided inpatient care and treatment for adults aged 18–65 with a severe mental illness (SMI). The East wing had 12 beds and provided inpatient care and treatment for older people (65 and over). Most of these were people living with dementia.

On 12 February 2019, a fire destroyed the West wing. Anyone in the West wing at the time of the fire was transferred to St George's Hospital as an emergency response.

The Board of Midlands Partnership NHS Foundation Trust (MPFT) made the decision later in February to temporarily close the remaining East wing – which was enacted in April 2019 after patients were either discharged or transferred to the most appropriate care setting according to their needs, including home.

Since the fire, anyone in the local area referred for mental health support has been treated in the community, through an enhanced community mental health service offer, or where clinically appropriate, admitted to an inpatient bed in St George's Hospital.

Since July 2019, MPFT clinicians and staff have been working to find the long-term solution for the two inpatient services that the George Bryan Centre delivered.

You can see a timeline diagram of the process in section 5 (page 10).

An **inpatient** is a patient who stays in hospital for treatment and so needs a hospital bed. Treatment for a patient who stays in hospital can also be called **bed-based care**.

3. The case for change

In 2019, Together We're Better (the health and care partnership for Staffordshire and Stoke-on-Trent) developed a case for change, setting out the challenges for healthcare locally and explaining the local vision for a future clinical model that aims to improve outcomes for patients and the performance of our organisations across a wide range of services.

Our case for change highlighted many areas where the Staffordshire and Stoke-on-Trent system could improve, both in terms of outcomes for patients and performance of our organisations:

- Delivering services for our deprived population
- Responding to the needs of an ageing population
- The healthcare needs of the population are growing, with increasing levels of long-term conditions
- Improving life expectancy
- Mortality varies significantly across localities, and there is a high incidence of death from avoidable causes
- The quality of healthcare could be improved to better manage demand and address performance challenges
- The financial challenge is significant and will require efficiencies across all areas of the system.

More recently, we have reviewed the case for change to reflect service improvements introduced in response to the COVID-19 pandemic. These are changes that enhance the way we deliver care to our patients and their families – including digital consultations, telephone appointments and supporting people in crisis in their own homes.

The local case for change includes a section focused on mental health that builds on recommendations in the NHS Long Term Plan, published in 2019. This sets out a new national model for community mental health services, with an emphasis on shifting from a bed-based model to a community-based model.

The national model of mental health services for the future

For most people with severe mental health problems, their illness is not the only thing they need help with. They need mental health services that go beyond treating symptoms. The model is for holistic, person-centred care, with services that are joined up.

- Primary and secondary care need to work together – because joined-up services make it easier for people to get the care they need
- Healthcare and social care need to work together – because people's social needs can affect their mental health
- Mental healthcare and physical healthcare need to be looked at together.

The new model is inclusive and aims to ensure equality of access, experience and outcomes for people from all backgrounds. It also calls for a real shift in our culture, with service users and carers becoming much more involved in how care is designed and delivered.

In the new model, care is given at home and in the community wherever possible. Inpatient care is only used when essential – when a person is so unwell that they need intensive medical treatment and care that they can only get in hospital.

Implementing the national model locally

Up to 2019, while the George Bryan Centre was still open, our mental health services were operating in a way that depended more on bed-based care.

Since the George Bryan Centre closed, we have been making changes to how we deliver our community mental health services. You can read in more detail in Appendix 2 about the specific changes and improvements we've been making.

Our new enhanced services mean that we are in a different situation from 2019. Changes we have introduced – such as integrated neighbourhood teams, the hospital avoidance team for older adults, and more support for people after inpatient treatment – mean that we can now support more people in the community and avoid sending (or returning) people to hospital when this may not be in their best interests. This is in line with up-to-date clinical guidance (see section 4 below) and the new national model (see above), and we believe it provides better care for patients.

Our enhanced services are for all adults with mental health needs, but they include specific support for older adults with dementia and/or severe mental illness, whose needs may be particularly complex. New forms of support for these older adults include the hospital avoidance team and specialist staff helping early on, to make sure these patients find the care they need.

For patients who do need to be admitted to hospital, we want to make sure they get the right care for their needs, from on-site specialists who can provide the right interventions. This can help reduce the length of stay in hospital, giving people a better chance of regaining their independence.

In 2021, Together We're Better made a successful bid for funding to implement the national community mental health transformation locally.

This is revenue funding that will go towards paying for staff and services – not capital funding that would pay for buildings. We have started a three-year programme of work (2021–24) to ensure that people living in Staffordshire and Stoke-on-Trent receive the mental health support they need, when they need it. This programme will build on the work that we have already done to enhance community mental health services since 2019.

4. Planning and delivering service change: NHS requirements

Finding the long-term solution for the inpatient services previously provided by the George Bryan Centre is considered to be a service change and there is a nationally determined process we must follow.

The national guidance on planning, assuring and delivering service change for patients (PADS) is set out in a document from NHS England.

Commissioners and their local partners, including providers, need to develop clear, evidence-based proposals for service change. They must be able to show that they have considered the government's four tests of service change and NHS England's test for proposed bed closures. (These are explained below.)

What is service change?

The PADS guidance document describes service change as below:

> "Broadly speaking, this is any change in the way frontline health services are delivered. This usually involves a change to the range of services available and/or the location from which services are delivered.
>
> Commissioners and providers should work with the local authority's Overview and Scrutiny Committee (OSC) to determine whether the proposed change is substantial. If it is substantial, this will trigger the duty to consult with the local authority under the s.244 Regulations."

What are the tests of service change?

The government's four tests of service change are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support for proposals from clinical commissioners.

Since 1 April 2017, there has been an extra test. In any proposal that includes plans to significantly reduce hospital bed numbers, NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

i. Demonstrate that enough alternatives (such as increased GP or community services) are being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it
ii. Show that specific new treatments or therapies will reduce specific categories of admissions
iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

Clear clinical evidence base

One of the four tests of service change is whether there is a clear clinical evidence base. Here we present the clinical evidence case for change.

Treatment of patients with dementia

Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can:

- make the symptoms of dementia worse
- permanently reduce the person's independence
- make it more likely that the patient will be discharged into residential care and/or readmitted to hospital.

The dementia care pathway guidance says that, when a patient must go into hospital, the stay should be as short as possible. Care should focus on helping people to live as well as possible at home, with support from health and social care, local authorities and/or voluntary groups. It should be person-centred, and could include things like:

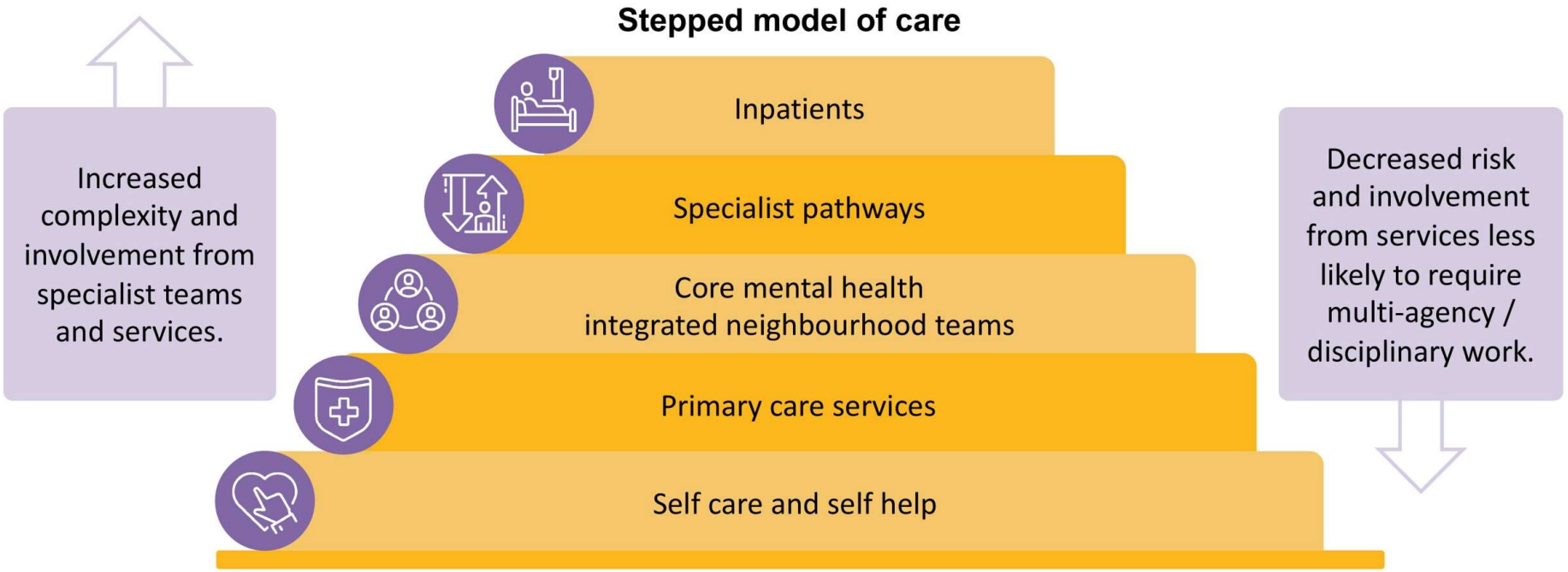
- extra-care housing and practical support, for example with transport
- help in maintaining relationships at home and in the wider community
- help to take part in meaningful daily activities.

NICE guidelines (NG97, 2018) request that, when considering admission to hospital for a person living with dementia, the value of keeping them in a familiar environment is considered.

Treatment of patients with severe mental illness

The national best practice for treating patients with severe mental illness (SMI) has moved from a **bed-based** model to a community-based model. Figure 1 shows this 'stepped' model of care, with most people living in the community and receiving different levels of care depending on their need.

Figure 1 The stepped model of care



NHS Providers (2018) notes that treating patients as close to home as possible is better for patient care and outcomes, with community services at the heart of provision.

The report Improving acute inpatient psychiatric care for adults in England (2015) made these points:

- If people are admitted for longer than clinically necessary, they can become **institutionalised**. This means they can find it harder to go back to normal life (they might have lost their job, benefits or a place to live)
- Recovery and **rehabilitation** need to happen as close as possible to where people live. Training people in 'activities of daily living' while in an inpatient setting does not prepare them to use these skills in the community.

However, there will be times when patients need intensive medical supervision and treatment that can only be provided in hospital. We will always still admit patients when this is the right course of action. Since the temporary closure of the George Bryan Centre, patients needing an inpatient stay have been admitted to St George's Hospital, Stafford.

For our proposals for future inpatient treatment, see section 6, page 12.

A **bed-based** model of care means the focus is on treating people as **inpatients** staying in hospital.

People can become **institutionalised** if they stay too long in a place like a hospital rather than living at home and in a community. They get used to being in the institution and find it hard to go back to normal life.

In mental health, **rehabilitation** means support with returning to normal life, for example living independently and going back to work.

5. The proposal development and options appraisal process

Since 2019, MPFT has been looking at the options for a long-term solution for the inpatient services previously provided by the George Bryan Centre. This process has included public involvement exercises that have informed what we call the 'technical' process of developing proposals. Figure 2 below shows the timeline of both the public involvement and the technical process.

The technical group was made up of clinicians and staff from MPFT, system partners and the clinical commissioning groups (CCGs), with Healthwatch as an observer at meetings. In a series of meetings between 2019 and 2021, the technical group looked at all the proposals that could potentially be developed. As part of this process, they looked at the national model and best practice for mental health services (see page 3) and the clinical evidence base (see page 5), and they defined the essential criteria that any proposals would need to meet in order to be **viable** (realistic and achievable). The essential criteria were:

- Clinical sustainability
- Strategic fit
- Meeting the needs of the population
- Demand and capacity
- Workforce sustainability
- Estates

This options appraisal process has helped take us to a recommendation of a **single viable proposal** (see page 12). We want to sense-check this recommendation at the event on 15 March.

Although we are recommending that there is a single viable proposal, no decision has been made and this recommendation may be subject to change, depending on the outcome of the reference group meeting on 15 March and the completion of the business case. For the business case, we still need to:

- hear your views on whether there is anything else we need to consider in the business case
- undertake the financial, data and travel analysis that are essential components of the business case.

We will only take a proposal forward to the decision-making bodies (see page 20) when the business case has been completed.

(Figure 2 below is also supplied for you in PDF format.)

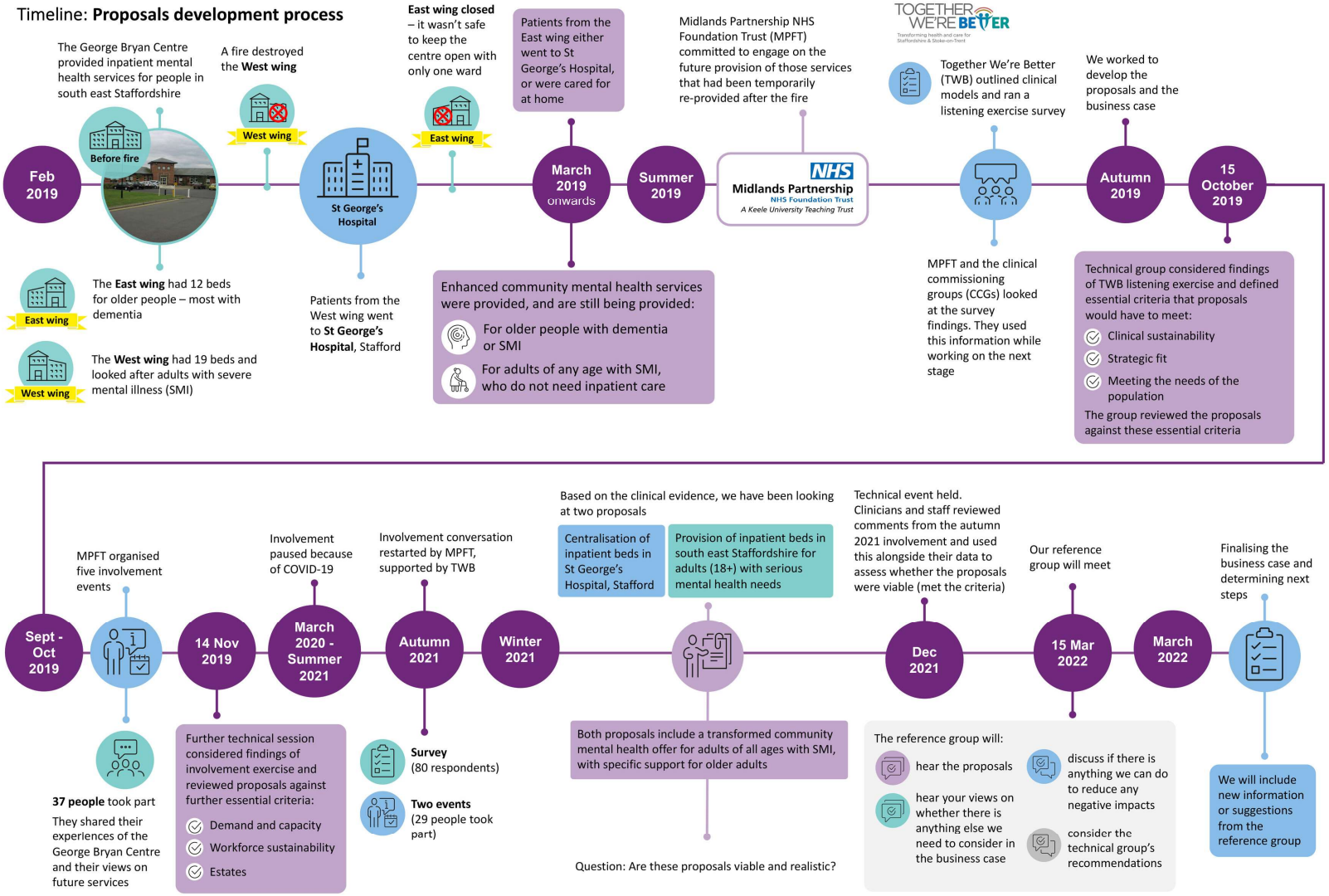


Figure 2 Proposals development process

2019 and 2021 involvement findings

The involvement findings have informed the proposal development process at each stage.

For more details, please see Appendix 1.

6. The proposals

Below we describe the proposals we have been considering.

Please note that BOTH proposals include enhanced community mental health services as a key element. The difference between the two proposals is the setting for inpatient care.

At this stage, no decisions have been made. However, at our technical event on 10 December 2021, our clinicians and managers recommended that there is only **one viable proposal – centralising inpatient treatment at St George's Hospital in Stafford** – and that this one proposal will be presented to the board of MPFT in the spring.

Proposal including centralising inpatient treatment at St George's Hospital in Stafford (recommended proposal)

This proposal would make permanent the solution that has been provided since the fire.

- Patients who need inpatient treatment are admitted to St George's Hospital in Stafford. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital.
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services.
- There are distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia, so that patients get the specialist support that they need.

Proposal including providing inpatient treatment in 18-bed unit on site of George Bryan Centre

- Provide a ward with 18 beds at the George Bryan Centre. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital.
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services.
- There are distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia, so that patients get the specialist support that they need.

7. Advantages and disadvantages of the proposals

Table 1 Proposals: advantages and disadvantages

Centralised beds at St George's Hospital		18-bed unit on site of George Bryan Centre	
Advantages	**Disadvantages**	**Advantages**	**Disadvantages**
Patient safety			
Timely access to intensive psychiatric care As a larger facility, now with 84 beds for adults with SMI, St George's Hospital has a wider range of staff including full-time consultants. This means the most unwell patients have faster access to intensive psychiatric care, without having to be transferred from another site.			**No on-site access to intensive psychiatric care** There were concerns in 2017 that the George Bryan Centre was a remote site with a small pool of staff. It did not have a full-time consultant or isolation facilities. If a patient became very unwell, they had to be transferred to St George's Hospital. A unit with 18 beds on the existing George Bryan site would have junior and middle-grade medical staff (as previously) but would still not have a full-time consultant – because of the lower number of patients there, with less complex needs.

Centralised beds at St George's Hospital		18-bed unit on site of George Bryan Centre	
			The most unwell patients would still have to be admitted to St George's Hospital. Some patients might need to be transferred from the 18-bed unit to St George's Hospital – which may create risks and cause disruption of care.
Staff cover for illness With more staff and a wider skill mix, it is easier at St George's Hospital to provide cover across different areas when colleagues are unwell.			**Reduced staff cover for illness** With a smaller pool of staff at the 18-bed unit, it would be harder to provide cover and maintain a high level of care.
Fewer emergency call-outs There have been fewer police call-outs since the centralisation of beds at St George's Hospital (nine in 2021) than at the George Bryan Centre before the fire, even though there are more patients. This reflects that a larger site with senior clinical back-up, more staff, and intensive			**More emergency call-outs** The number of police call-outs to the George Bryan Centre West wing before the fire was high (32 in 2017, 44 in 2018). This reflects that in a smaller, remote unit without a full-time consultant and with fewer staff to support other areas during absences, it is harder to manage crises when they happen.

Centralised beds at St George's Hospital		18-bed unit on site of George Bryan Centre	
psychiatric care facilities, can manage crises more effectively.			
Duty of quality			
Meeting a wider range of needs A bigger staff, with a wider skill mix, at St George's Hospital means that patients can be looked after by staff with a wider range of skills and specialisms. This means staff can meet a wider range of needs. (Examples: perinatal mental health – around pregnancy and childbirth – and eating disorders). Additional interventions available at St George's Hospital that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy.	**Greater risk of health inequalities** Evidence shows that being in touch with family, carers and friends is beneficial to patients with SMI. Some patients and carers will have to travel further to visit a person who is admitted to St George's Hospital in Stafford. This could have an impact on people living in rural areas without good transport links, those households without a car and those on low incomes – with a risk of greater risk of health inequalities for some patients.	**Lower risk of health inequalities** If inpatient services were re-provided on the existing George Bryan site, carers, friends and family of patients from the local area would face fewer difficulties in terms of travel.	**Less able to meet a wide range of needs** Not all treatments and interventions were available to people staying in the George Bryan Centre and so some people who had severe mental health needs were admitted to St George's Hospital because of the more intensive support that can be offered in a larger hospital. Staff who provide therapeutic interventions are skilled and specialist, so it can be difficult to recruit and keep these staff. It would be particularly hard to recruit to a smaller, isolated site. In a bigger hospital, they would work across wards as required.

Centralised beds at St George's Hospital		18-bed unit on site of George Bryan Centre	
Patient experience			
Location Involvement comments have suggested that St George's location is an advantage – patients have access to activities outside hospital.	**Travel impacts** Some patients and carers will be impacted by having to travel further to visit a person who is admitted to a bed in St George's Hospital in Stafford. This could affect those who live in rural areas without good transport links, those households without a car and those on low incomes. Travel was a major concern raised in both the 2019 and 2021 public involvement sessions	**Easier travel** Visiting and being involved in care will be easier for carers/families in south east Staffordshire if a loved one is admitted to a local inpatient unit.	**Location** Location of 18-bed unit at the existing George Bryan site may have negative impacts on inpatient experience if fewer activities are available (because there will be fewer staff in the smaller, remote unit).
Clinical effectiveness			
More consistent care provision More consistent care provision in a centralised centre, as no need for disruptive transfer to intensive psychiatric care or to access therapeutic interventions.	**Travel impacts** Centralisation of beds at St George's Hospital would impact on travel for some carers and there is evidence that family / carer visits improve outcomes.	**Positive clinical impact of easier travel** As noted, evidence shows that being in touch with family, carers and friends is	**Less consistent care provision** Some patients needed transfer to St George's Hospital for either access to a higher acuity bed (psychiatric intensive care unit, for example) or for therapeutic interventions unavailable at the George Bryan Centre. This

Centralised beds at St George's Hospital		18-bed unit on site of George Bryan Centre	
		beneficial to patients with a severe mental illness.	reduced consistency of care for a cohort of people previously, and the same problems would be likely if services were provided in the same location.
Fewer emergency call-outs Fewer police call-outs since the centralisation of beds at St George's Hospital (nine in 2021) than at the George Bryan Centre before the fire. This reflects that a larger site with senior clinical back-up, more staff, and intensive psychiatric care facilities, can manage crises more effectively.			**More emergency call-outs** The number of police call-outs to the George Bryan Centre West wing before the fire was high (32 in 2017, 44 in 2018). This reflects that in a smaller, remote unit without a full-time consultant and with fewer staff to support other areas during absences, it is harder to manage crises when they happen.

Other factors to consider

Most effective use of resources

An 18-bed unit at the existing George Bryan Centre site would have more staff than before, to meet safe staffing requirements (although it would still not have a full-time consultant). It's projected that there would be the equivalent of 46.2 full-time staff – the same number previously needed to support 31 beds at the George Bryan Centre. While this would provide safe staffing levels, it could have an adverse impact on other services.

It would be likely to affect the services at St George's Hospital as some staff would have to work across two sites. It could also affect our enhanced community mental health services if staff have to move from community roles into inpatient roles.

We need to manage our available resources carefully and use them where the clinical evidence suggests they can achieve the best outcomes. As the clinical evidence and the new national model for mental healthcare emphasise the advantages of community-based care, we need to make sure that our community mental health services have the resources they need. Locally, since 2019, our hospital avoidance team (working with older people) and our crisis resolution home treatment teams have been doing good work to support people at home and reduce unnecessary hospital stays. We want them to keep doing this, and we also want to expand and improve our community mental health services for the future.

8. Purpose of the event on 15 March 2022

At the reference group event on 15 March, we want to:

- present the proposals to date
- hear your views on whether there is anything else we need to consider in the business case
- consider the recommendations that the technical group has made
- discuss anything we can do to reduce any potential negative impacts.

You may feel that the proposal we are presenting to the MPFT board could have a negative impact on a service user or their family. If so, please tell us in the reference group if there is something we could do to make things easier. We have already received the following suggestions from the 2019 and 2021 involvement activity:

- Financial support for transport
- A hospital bus that picks up from the train station
- Group of volunteers to visit patients who may not see their relatives because of the distance they have to travel
- Need to ensure appointments for people who use public transport are booked after 10am (so they can make use of free bus travel)
- Extend the times of the bus from Tamworth to Stafford (and back)
- Pre-book transport to coincide with visiting times.

We would like to hear any other suggestions you may have for improvements. These will be included in the business case.

The reference group is part of the continuous involvement process, in which we listen to your views and suggestions and make sure that they are brought into our decision-making.

9. Next steps

We now need to finalise the business case for the proposal.

What is a business case?

There are lots of things to think about when the NHS wants or needs to make a change to a service. It's important that background information and evidence about the effect of the change are clearly set out for decision makers to consider – this is what a business case does.

A business case includes:

- the background and history of the issue
- information about the people who live in the area and what their needs are
- information about the service that will be changed
- evidence about the effect of the change for patients and staff
- information about how patients and local people have been involved in the process

- information on how much the change will cost or save
- the process for making the decision.

What stage has our business case reached, and what happens next?

We are close to completing the business case. We will include new information or suggestions that you give us in the reference group. We will also undertake full analysis of finance, equality, quality and travel impact, which are essential components of the final business case.

When the business case is complete, we will send it to the decision-making bodies that need to agree to the proposed change – this is likely to be in the late spring of 2022. These bodies are:

- the board of MPFT (the organisation that provides the service)
- the governing body of Staffordshire and Stoke-on-Trent CCGs (these are the commissioners of the services – they plan and pay for the services).

After this, the business case will:

- be reviewed by NHS England
- be reviewed by independent senior doctors and other clinicians
- and then go back to the MPFT and CCG boards for a decision

The boards will decide what further public involvement is needed before they make a decision. We will continue to liaise with the local overview and scrutiny committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

Appendix 1: Findings from 2019 and 2021 involvement events

2019 findings

In 2019, there was a process of involvement to understand people's views about the services and where improvements could be made to shape the long-term solutions. The involvement included a survey run by Together We're Better (the report of findings is on the Together We're Better website). Then, between September and October 2019, MPFT held five involvement events in south east Staffordshire.

The themes from that exercise included:

1. Support to rebuild the George Bryan Centre like for like
2. Additional beds
3. Using the centre as a base for community-based services (including young people and all types of mental health support). Some extended this to other health services and the voluntary sector
4. The greater range of services in Stafford was mentioned – art, music and occupational therapy
5. Travel was the most common theme – distance, cost and accessibility of public transport.

The comments from the 2019 involvement activity have been considered, and have helped to inform the proposals that were presented during the options appraisal process. However, the process had to be put on hold because of the COVID-19 pandemic.

The MPFT board received a report of the outcomes of the 2019 involvement activity. You can find the report on the MPFT website: https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement

2021 findings (survey and events)

This was a sense-check involvement that aimed to find out whether anything had changed between 2019 and 2021 that would need to be considered in the business case. The full report of findings, and a summary report, can be found on the MPFT website: https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement

2021 events

The events findings show a mixture of views about different services, with both positive and negative comments about community mental health services and the George Bryan Centre.

The 2021 events produced similar comments to those listed above from 2019. Specifically, the themes numbered 1, 3 and 5 above were repeated.

There was continuing support for the George Bryan Centre to be kept, to meet local needs.

Travelling was still the most prominent concern – relating to access to services, and families and carers being able to stay in touch and be involved.

- "Travel shouldn't be an issue if you need to access services"
- "Travel to and from is costly if you don't have much money, and we had two young children too which made commuting every day difficult"
- "Resident of Burtonwood – to get to Stafford is a nightmare. Three bus journeys to get there."

New themes in the 2021 events were:

Need for improved communication	"We need a pathway – people need to know where to go to get help"
Reports of difficulties during COVID-19 pandemic	"Access to diagnosis for people with dementia was difficult during pandemic"
Need for earlier intervention and preventative services	"With things in place people would not get to the point where they need admission"

At the events, people were also asked to comment on the new model of care.

The themes that emerged included:

Ensure integration and collaborative working	"Services across the patch are not aware of each other and their services. GB should be bringing all these services together"
Need for communication and information (like about how to access services)	"Make the pathway available to everyone so they are aware"
Need to implement the new model effectively	"Proposal sounds great in theory. It's the practice that counts. Remove barriers and expand access"

2021 survey

Experience of the George Bryan Centre (29 respondents)

- Experience was good / very good: more than 3 in 4
- Experience was poor / very poor: nearly 1 in 5

"Superb care of a very close friend. The GB team were beyond perfect"

"No communication from staff. Unsafe premises for patients. Layout very poor. communal areas poor and activities non existent."

Experience of St George's Hospital (12 respondents)

- Experience was good / very good: 2 in 5
- Experience was poor / very poor: 1 in 3

"I haven't even talked to any of the nurses there when I was a patient suffering major depression. They were always too busy. I know that as a NHS nurse, it could get overwhelming and very busy but they really don't talk to patients. They were like robots."

"Staff were unhelpful. Place was dirty. I understand it was due to covid restrictions, but had to isolate in 1 room for 5 days limited contact."

Experience of community mental health services (29 respondents)

- Experience was good / very good: nearly 2 in 5
- Experience was poor / very poor: nearly 1 in 3

"Very difficult to access the services and often little continuity of care"

"After the fire at George Bryan Centre the lack of a local inpatient facility put pressures on staff, patients and relatives. The combined area of Staffordshire is too big to assist people with mental health challenges. It

The new model of community mental health care (50 respondents)

- Agree or strongly agree with the new model: more than 4 in 5
- Disagree or strongly disagree with the new model: nearly 1 in 20

"All of the above has got to be an advantage and benefit to the service user. However, placing all this on a piece of paper does not achieve the final objectives in the Tamworth area. The objective must be to 'walk the walk' and not simply 'talk the talk'."

Appendix 2: Enhanced community mental health services for people in the local area

Since the George Bryan Centre closed, we have been making changes to how we deliver our community mental health services – so that we can support people to recover and stay well in their home and community, avoiding hospital admissions that could take them away from support networks and risk loss of independence.

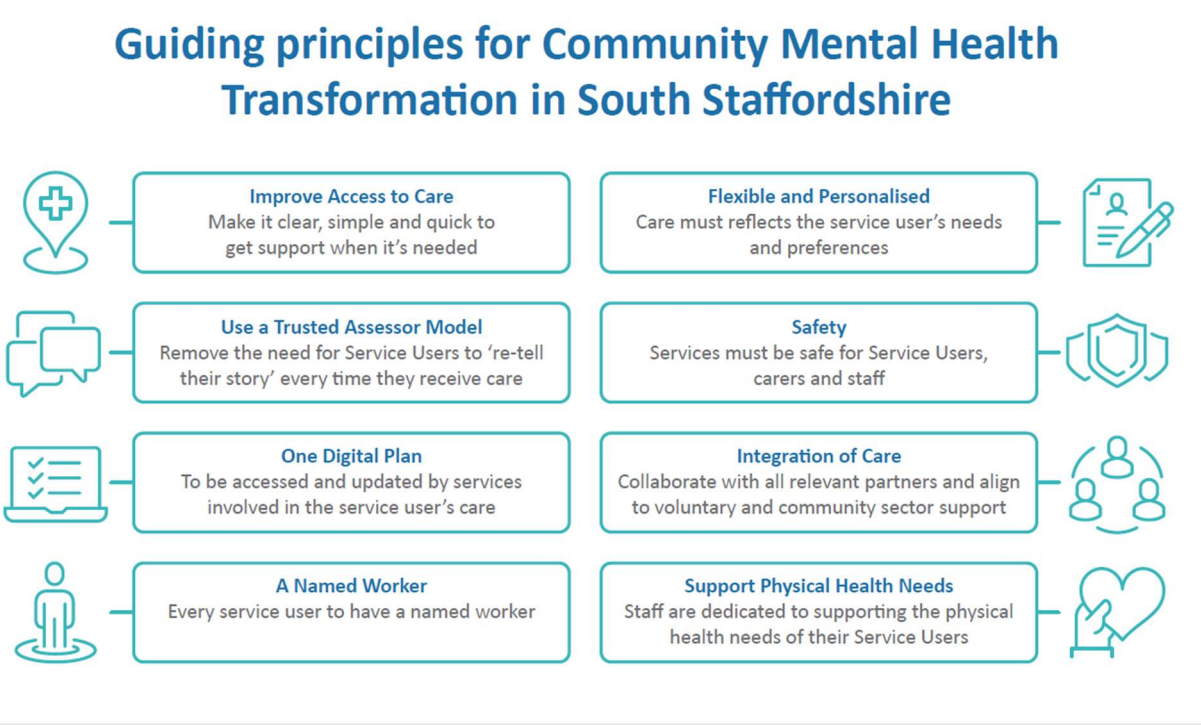
This section explains some of the specific changes and improvements we have already made. We also explain some of the new services we are developing.

Guiding principles

We want older people, adults and young adults in Staffordshire to feel supported, whether they find themselves in crisis, or simply want to maintain their day-to-day mental health and wellbeing.

The service changes we have been making are based around the guiding principles shown in Figure 3.

Figure 3 Guiding principles for local community mental health transformation



Integrated neighbourhood teams

We have introduced integrated neighbourhood teams – core mental health teams that sit at the heart of the community. These new teams work with local voluntary sector organisations to give more support to people using our services. The teams include professionals like nurses, medics, healthcare support workers, occupational therapists and pharmacists, and also social workers.

The aim is to join up services, to give better continuity of care and reduce the risk of patients 'falling through the gaps' between services.

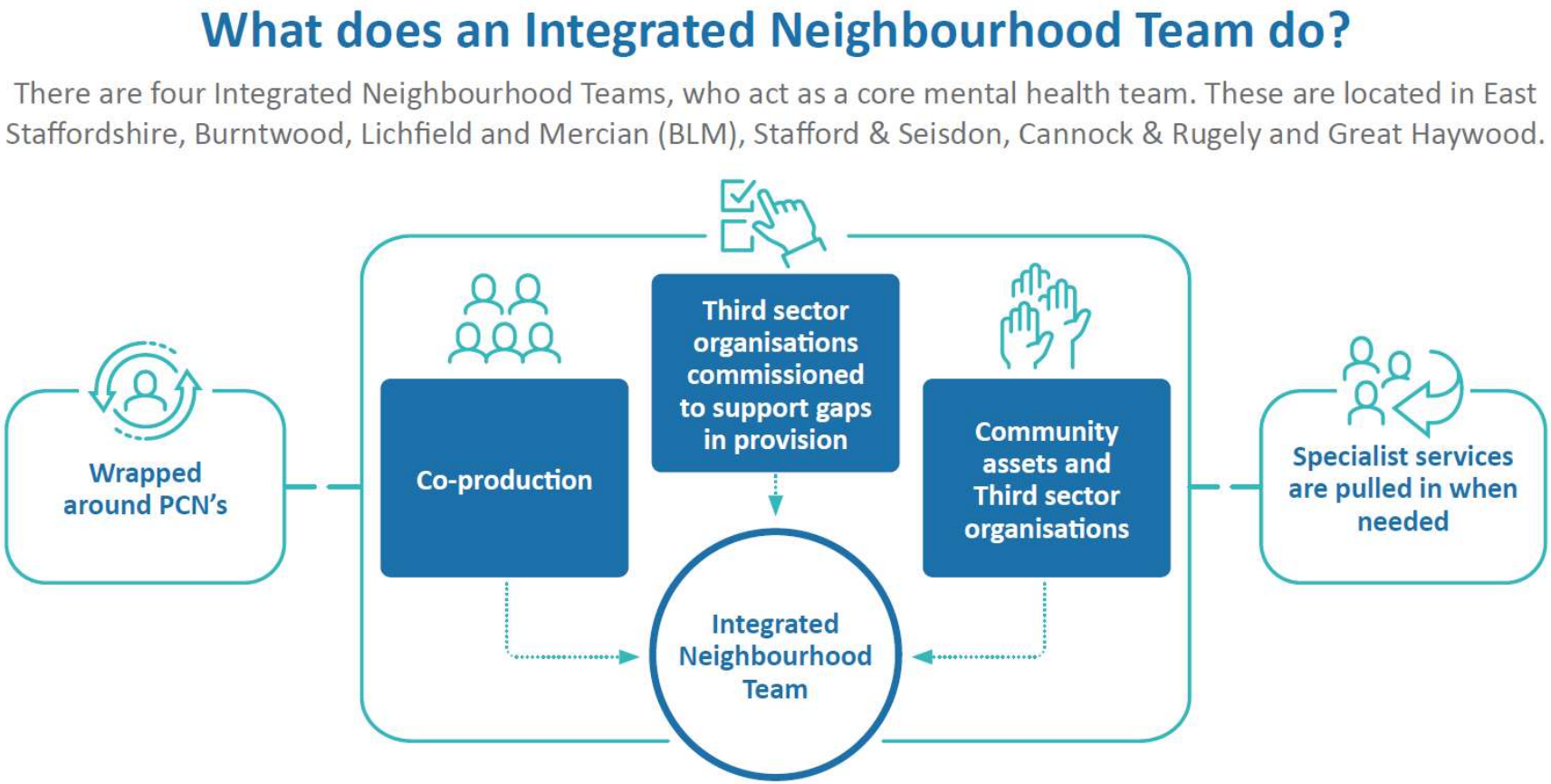
For example, in the past, mental health professionals might have recognised that social issues, like problems with housing, employment, benefits, or addictions, were affecting people's mental health, but they had little influence over this. This was because they had to refer their patients to different services – which could cause delays, mean that patients had to keep on repeating their story, or that people 'got lost' between services.

Integrated working by neighbourhood teams will help resolve these problems. For the patient, there will be more holistic care that looks at their physical health and personal circumstances alongside their mental health.

Our integrated teams will also make sure that people get specialist help when they need it. This could be from teams dealing with eating disorders, personality disorders, or substance abuse, or with teams that support people with learning disabilities, autism, or women who are affected by pregnancy or childbirth. If people need support from different specialists, the integrated teams will work to achieve this.

There are already four integrated neighbourhood teams in place, as Figure 4 below shows.

Figure 4 What does an integrated neighbourhood team do?



Co-production – involving service users

Co-production means that patients, and their carers or family, work with the person co-ordinating their care to make decisions about the best kind of care for them. This is a new way of working that's in line with the national guidance, and we are building it into our integrated teams.

Help to stay at home and get better quicker

Our crisis resolution home treatment teams work 24/7 and respond within 4 hours when someone needs urgent help. They work to get people the help they need within the community, avoiding unnecessary stays in hospital which might not be in a person's best interest.

We have a single local phone number, available 24/7, on which anyone can contact us to ask for help with their mental health needs.

Discharge pathway and Future Focus pathway

The discharge pathway supports people after they leave hospital. This can be a very difficult time, and the discharge pathway gives people help to take the important first steps, such as leaving the house, going shopping and getting involved in social activities.

The Future Focus pathway, which begins in April 2022, will give similar support to people who have been getting treatment in the community. Even when people haven't been in hospital, they might need this kind of support to help them stay well and stay at home.

Support in the community for older people with dementia or SMI

In the past, our crisis teams have mainly worked with younger people. Since March 2019, we have introduced new support for older people. This includes older people who are living with dementia, or who have a severe mental illness, or both.

Hospital avoidance team

The hospital avoidance team works in the same way as the crisis resolution home treatment team but focuses on older adults. The team includes experienced older adult specialists with the knowledge and skills to help older adults who may have very complex needs, including frailty, in addition to their mental health needs.

Help with getting the right services

We know that older adults sometimes need support in getting access to the right services, which understand issues such as frailty and co-existing physical health conditions. So, we have specialist staff who can get involved at an early stage to make sure that people get the help they need, whether it's social care, physical care or mental healthcare.

Out of hours home sitting service

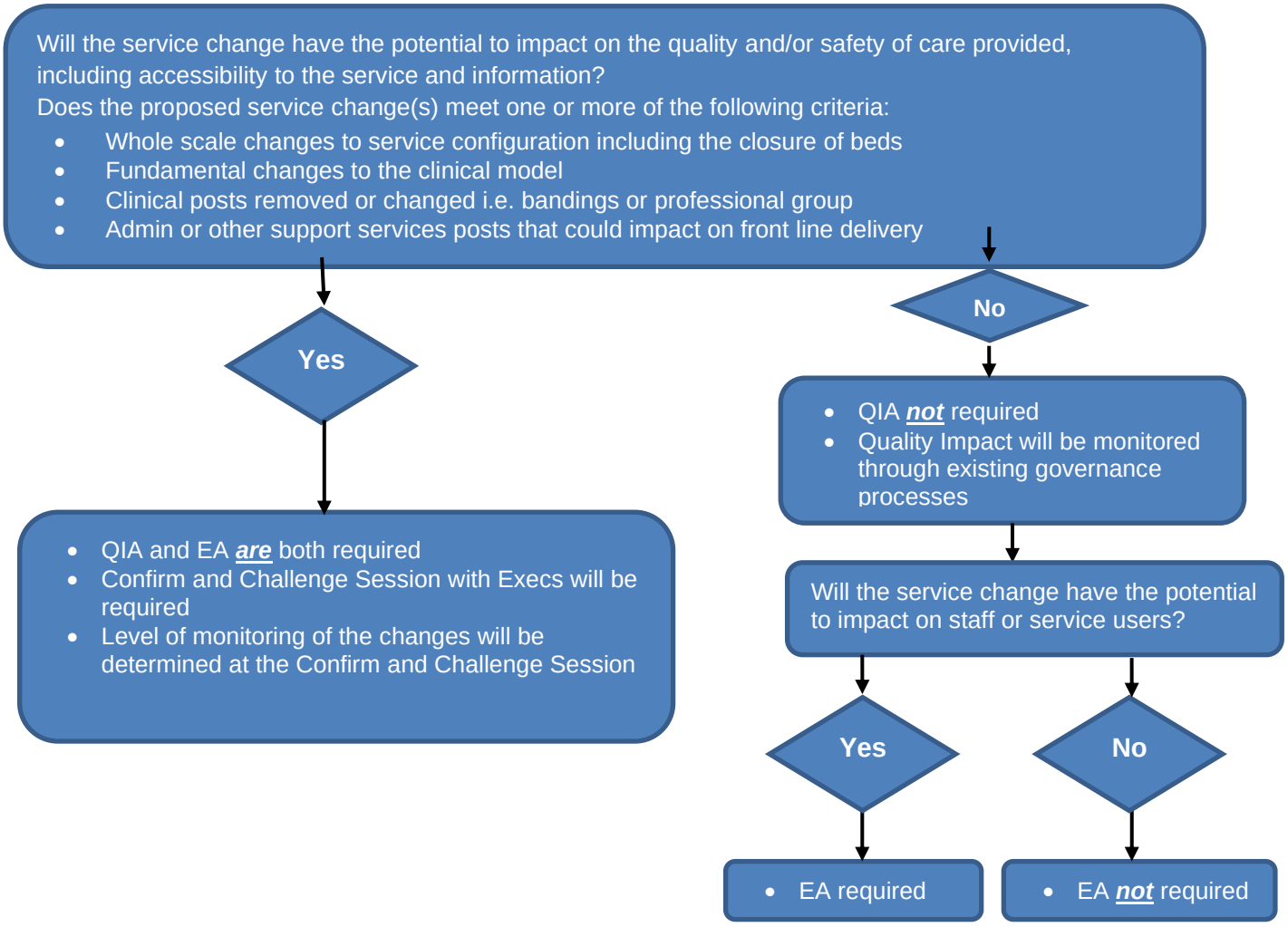
We also want to support carers, whose health and wellbeing may also be at risk. We are developing a new home sitting service, which aims to give carers some respite. This would be provided by non-medical, but appropriately qualified, support staff.

Joint Impact Assessment Tool (Equality Analysis (EA) and & Quality Impact Assessment (QIA)

Service Change:	**George Bryan Centre** (George Bryan Centre – Older Adult ward closure and implementation of enhanced community offer)
Saving Plan Reference Number:	N/A
Care Group/Directorate:	Staffordshire and Stoke on Trent
Service Change Lead:	Lisa Agell
Anticipated Service Change Start Date:	
Clinical Director 'Sign Off'	Emma Lambert

Section 1 - Screening - is an Impact Assessment Required?

When is a QIA required to be completed?
QIAs will normally be completed by care groups where service changes may impact on the quality and safety of care of service users. However, a QIA may also be appropriate for a service change proposed by a corporate service if the proposed change will affect a service user facing service element and there is a risk the change may impact on the quality and safety of care.
When is an EA required to be completed?
The specific duties set out with the Equality Duty 2010 requires public organisations to publish evidence of the Equality Analysis that have been undertaken to establish whether their policies or practices (this includes projects, proposals for service improvement / re-design, strategies, CIP plans etc.) would further or have furthered the aims of the Equality Act and duty. This includes the details of the information that has been considered and details of engagement undertaken when doing the Equality Analysis.



Section 2 – For consideration prior to proceeding with the Impact Assessment process

Before completing Section 3 and 4 of the tool, please ensure you can answer "yes" to the following general questions:

Question	Yes/No	Outcome/ Comments *Related to EA consultation (Step 4)
The Care Group has agreement for proposing this service change from the Clinical Director, in consultation with the relevant clinical and professional leads.	Yes	
The Care Group has completed a detailed assessment of financial impact of the service change in line with Finance Department guidance.	Yes	
*The Care Group has sought bottom-up ideas from front-line staff on how services could be delivered differently.	Yes	Staff have been engaged on the proposed closure and the model.
*The Care Group has sought opinions from service user and carer representatives.	Yes	Public Involvement Events. Online Events held throughout October 2021 for public to feedback. Online survey available up to October 31st 2021. People with lived experience, carers and representatives from the local communities have been invited to join the George Bryan Centre Reference Group to ensure that local people are involved at every step of the journey. The members of the reference group will use their lived experience and knowledge of local services and communities to provide their views and consider the proposals.
*The Care Group has an agreed process for responding to concerns expressed by staff, service users or carers, or other stakeholders.	Yes	Staff have been engaged on the proposed closure and the model. Service user and stakeholders will be done as part of the

		public involvement and 1-2-1 semi-structured interviews.
*The Care Group has developed a process with key stakeholders to monitor impacts regularly post implementation.	Yes	MPFT will use current governance processes to monitor impacts including the established CQRMs.
*If the service change is likely to lead to a service closure or significant contractual change, discussions have taken place between the Care Group and commissioners about whose responsibility it is to consult with stakeholders.	Yes	
*Will the proposed service change potentially impact upon the effectiveness of the overall care pathway where the delivery of the care pathway crosses organisational boundaries?	Yes	Positive impact

Section 3 - Impact Assessment of a Scheme

Background Information (Equality Analysis Step 1)
Please provide some descriptive background to the proposed service changes, outlining: • What are the changes trying to achieve? Describe the aims and objectives of the service redesign/change/CIP for example; if it is a change to skill mix, please identify changes in hours, banding and capacity as appropriate. • Explain how the changes relate to the Trust's wider Strategic and Equality Objectives?
This JIA supports the 2021/22 options appraisal on the proposed centralisation of Inpatient beds to the St George's site supported by enhanced community services. The scheme covers the case for closing older adult beds at the George Bryan Centre, Tamworth. The 12 older adult beds were closed following a fire in April 2019 with and enhanced community pathway developed to support older adults by Older Adult Services/Care Team in the community August/September 2019. The aim of an effective acute care pathway for people with a functional mental illness is that as service users become more unwell, intensive community support both enables them to recover without requiring acute inpatient admission and facilitates early discharge. Community support includes: • Enhanced crisis home treatments with skilled, experienced older adult specialists and Hospital Avoidance Team • Addition of a nursing/therapy lead • New clinical psychologist to focus on older adults • A training plan for the team, including Equality training and Dementia training. The Trust is in the process of commissioning cultural sensitivity training and demographic information collection training. If unavoidable, admission remains an option, but only for a short period and a small minority of service users. The aim of an effective acute care pathway for people with dementia is that there is a range of community support services able to respond to individual's needs.

The options appraisal process presented two options:

Option One the provision of 18 beds in SES and the transformed community offer.

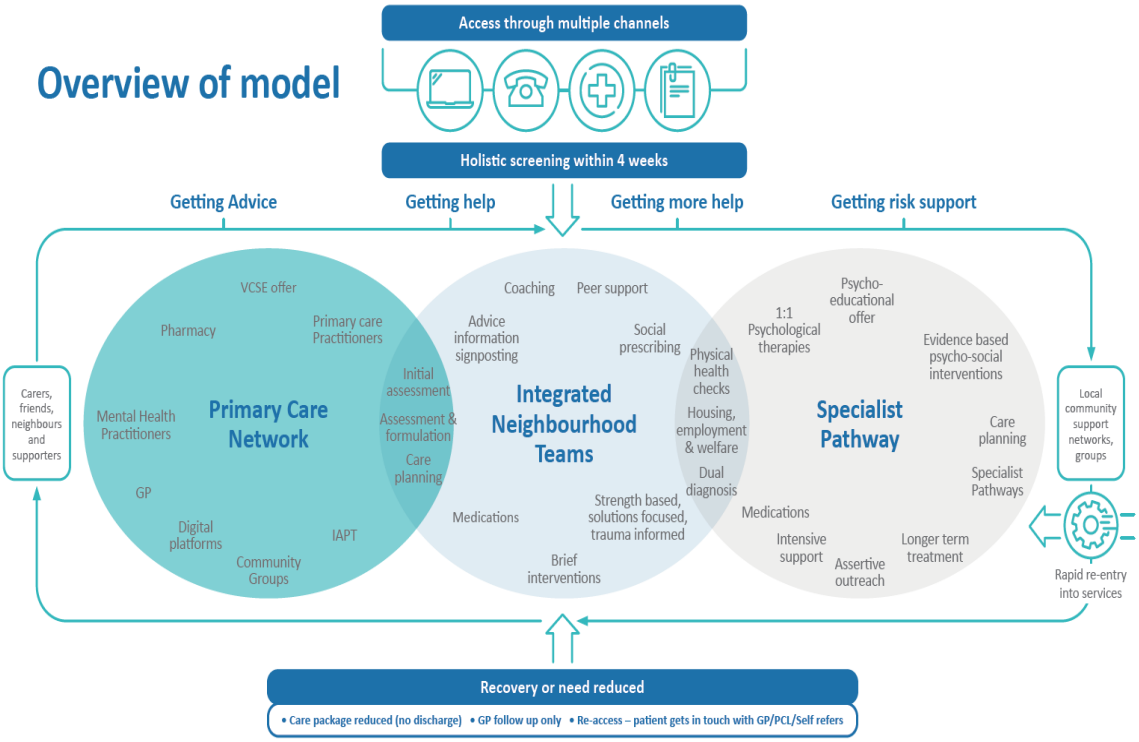
Option Two is the consolidation and re-affirming of the current transformed community service pathway and inpatient facilities.

Option One was deemed unviable due to CQC concerns around patient safety, safer levels of staffing.

Option Two can evidence two years of the successful delivery of patient care and support, demonstrating the current arrangements are working successfully.

Supporting Documents:

- *George Bryan Centre Factsheet (invite to the community to join the reference group)*
- *Literature review available for reference: 'Literature Search Results: Dementia and inpatient facilities' November2021*
- *George Bryan Project Risk Register*



Section 3a – Quality Impact Assessment (QIA)

Assessment	Yes/No	Please explain the rational/reasoning behind the answer and how any negative impacts will be addressed	Risk Register Ref. Number
Safety			
Did you identify any risks to clinical, patient or staff safety? (Safe)	Yes	There are two sites for inpatient mental health care in South Staffordshire the quality of the environments on these sites varies considerably. The George Bryan Centre inpatient site required significant building works to provide a clinically safe environment, observation and layout was difficult. The CQC inspected the George Bryan Centre in July/August 2013 visiting West Wing (adult acute ward) alongside East Wing (an older adult acute psychiatric ward). They inspected the two wards together and made judgements made about the hospital as a whole. "We found that the safety and suitability of premises to be below the required standard. The concerns were that the ward did not provide suitably segregated accommodation for men and women. They also identified the outside spaces that they considered unreasonable. On our inspection of West Wing at the George Bryan Centre, we identified a number of potential ligature risks. The most significant of which was new and was not covered in the ligature risk assessment for the ward" (CQC report, September 2017). The trust has made some improvements to the environment, in particular the ligature risks, however to fully enhance the environment to meet standards it would require significant rebuild. The unit is remote from other sites therefore making response to medical and psychiatric emergencies difficult. The greater number of inpatient sites the more is spent on administrative and other support services and the less efficient	

		the Trust is overall. The clinical evidence suggests that older adults are better served in the community than an admission to hospital. *Literature review available for reference: 'Literature Search Results: Dementia and inpatient facilities' November2021* There are risks associated with SU and Carer Experience – about people's perceptions of the changes and the possible damage to the Trust's reputation. There have been public Involvement events to explore options. The involvement process that we have to follow stipulates a number of engagement sessions with service users, carers and the local population. We have developed a risk register with include reputational risks which have been mitigated by our communications team. *George Bryan Project Risk Register*	
Will you be able to maintain compliance with CQC's Fundamental Standards? (All)	Yes	We would maintain standards within community teams.	
Will you stay on track for delivering services within policies and procedures? (Safe)	Yes	Yes, the relocation and closure did not and will not impact on the Service's ability to adhere to policies and procedures.	
Will this increase any entry on your group risk register to 15 or above? (Safe)	No	The older adult ward at George Bryan centre has been closed following the fire, the enhanced community offer delivered in the community will reduce the requirement on beds and therefore mitigating any risks identified at GBC.	
Will the changes introduce any specific environmental risks/considerations? Following the changes, will the environment be fit for purpose? (Safe)	N/A	The ward was closed following the fire	
Effectiveness			
Will this impact on the maintenance of the multidisciplinary skills base? (Safe)	Yes	The Trusts priority following the fire was to redeploy staff into suitable alternative posts. Some staff filled roles within	

		community teams (as part of increasing the enhanced community offer). The re-deployment took into account individuals' skills, experience and location. Appropriate clinical training would be required and was carried out to support staff in the transition from working in an acute to community setting. Where possible and appropriate some staff were relocated to Stafford with mileage protection in accordance with Agenda for Change. For any staff displaced, redeployment was sought within the Trust. There are no foreseen TUPE transfers as a result of this proposal.	
Will this impact on your delivery of national quality indicators? (Effective)	No	Supporting more people at home is in line with national quality indicators. The community teams have been enhanced to support increase in demand. *Literature review available for reference: 'Literature Search Results: Dementia and inpatient facilities' November2021*	
Will this impact on your delivery of contract quality measures & CQUINs?	No		
Will you be able to maintain delivery against all relevant NICE guidance? (Effective)	Yes	Yes, the NICE guidance for mental health in older people will be enhanced.	
Will this impact on clinical or care outcomes for service users? (Effective) (Complete equality considerations in section 3b.)	Yes	Advantages • Better support networks and easier access to a wider range of services • Increased number of patients and carers are supported in own home • Reducing lengths of stay for older adults by implementing a specific pathway Disadvantages • Reputational risks of service users and carers expressing concerns to the media - • Additional travel time and costs for families and carers • Where admission is required, there is potential difficulty for carers of elderly patients to be able to travel at all (no direct transport from some areas of Lichfield	

		/ Tamworth / East Staffs) - may impact on patient outcomes as visiting is known to promote recovery	
Will this impact on service user's ability to access the service? (Responsive)	Yes	Increased number of patients and carers are supported in own home. Access to acute care will still be available at the point of escalation/assessment of staff where the need has been identified.	
Will the proposed changes have a negative impact on the reputation of the service and Trust with service users?	Possible	Disadvantages: Reputational risks of service users and carers expressing concerns to the media. *Mitigations: George Bryan Project Risk Register*	

Overall Baseline Risk Assessment						
What is the likely overall impact of this service change on quality?	**Improves Quality**	✓	**Maintains Quality**	✓	**Reduces Quality**	
Please provide a narrative below that supports your assessment regarding the overall impact of the service changes on quality. *(Note: It is important to note that the impact of the service change may not always be a negative impact, the service changes may lead to no change or even an improvement in the quality/safety of the service. Therefore it is important that the measures selected in Section 4 of the Impact Assessment can help demonstrate what that impact has been and whether it is negative, neutral or positive.)*						
The service changes were initially discussed at a confirm and challenge session in August 2019, the discussion and outcome of this session are relevant to the current proposal which will be to re-affirm and consolidate the existing arrangements: The centralisation of beds onto the site and the roll out of the new community care pathway has been expedited due to the fire; however this work would still have been implemented just with a more phased approach. The Commissioners/CCGs are already sighted on the new pathway plans and the service will strengthen the communications relating to the reduction of inpatient beds. The new pathway work identified the skill mix required for working with frailty and older people and the service were able to bring staff with the required skills into the new pathway from the start of the roll out. There are also new elements to the pathway which enhance the community care and ensure the service is running safely: • Support at the access point – older people's nurse working in Access to capture the patients requiring this more specialised care, they will also go out to patient's homes to refer them to services. • The Crisis team work with the service to direct relevant patients to the new						

pathway, with a dedicated member of staff within the Crisis Team. All over 65 patients are screened, with the new pathway taking the more frail and complex patients. All patients can be referred to the new pathway at any stage if their circumstances change.
- An early identification pilot is ongoing in Lichfield at one of the clinics.

There have been public engagement events with the George Bryan family being involved. The family were not focussed on the building being an inpatient unit so long as it is a health based building serving the community.

Staff involvement in the transition –they were involved in the changes and through the redeployment process were enabled to choose which post they wished to move to. There are both East and West based services in new pathway and staff were able to state a preference to work as Band 5s in an inpatient setting as not all wished to work in community as Band 6.
All West and East staff have been redeployed

The service initiated and currently uses a variety of measure to monitor the quality of care.
Quantitative data measures:
RiO data – the older adult team is on RiO.
- Admission rates, checking if they are reducing.
- Length of stay, any reduction due to early discharge.
- Admission prevention analysed at patient level by the team.

Qualitative measures:
The outcome measure being utilised: SWEMWBS have been completed at the start and end of episodes by all professionals. Psychology colleagues have been doing this systematically, with only a few people who have been referred to psychology declining to complete these.

Psychologists have also been completing problem-specific outcomes with older people (again when they have consented), which may include The Geriatric Depression Scale, the Geriatric Anxiety Scale and individualised therapeutic goal achievement scales. The service have documented any outcomes that have been completed on service user clinical notes. Other professionals have been completing outcome measures on a case by case basis.

One of the psychology assistants is currently going through the Trust research team with regards to a service evaluation of the individual anxiety programme that was rolled out at the beginning of the pandemic and is still being provided to this day, the service now have circa two years of data that has already been collected and processed with some conclusions suggested.

Care cluster reviews are also being reviewed.

Direct links are in place with the “Staying Well Team” where staff from older adult / dementia services are now working to support those with chronic health conditions to receive mental health support in their stabilisation and to live well with their conditions.

ACCESS workers were put in place at the beginning of the enhanced pathway development to support older adults accessing community services. It is recognised that older adults often need support to ensure they get access to the appropriate service which recognises their individual circumstances and possible frailty or co-existing conditions. These workers worked directly alongside the Mental Health single point of

access and offer whatever approach is suitable for the individual to ensure they access the service they need wherever this may be delivered from: e.g. IAPT, Social Care, Physical care or Secondary MH Care. We have some initial data showing us that this has been effective in reducing the need for secondary MH care and supporting older people to access service such as IAPT or others at the point of need.

Risk score is a 6. There have been no Serious Incidents, untoward events or complaints reported to MPFT relating to the closure of the George Bryan Centre and introduction to the new pathway.

Update from 2022. Monitoring from the past two years has not highlighted negative impacts on quality.

An overall baseline risk assessment must also be completed here.	**Score**
Impact of the service changes on service quality (1-5), I =	2
Likelihood of above risk occurring (1-5), L =	3
Total baseline risk score (I x L) =	6

Section 3b – Equality Assessment (EA)

Equality Analysis – Step 2
Please explain how the proposed changes relate to the Trust's Equality Obligations? ((3 aims of the Public Sector Equality Duty: Equality Act 2010). (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it).
The EIA supports the 2021/22 options appraisal process on the proposed centralisation of Inpatient beds to the St George's site supported by enhanced community services The service changes were initially discussed at a confirm and challenge session in August 2019, the discussion and outcome of this session are relevant to the current proposal which will be to re-affirm and consolidate the existing arrangements. No negative impact has been identified since the changes in 2019. Staff would work under the values and behaviours of the Trust which promote service user inclusion, dignity and respect. All staff members maintain dignity and respect of service users and will always be inclusive of all abilities and disabilities, ages, genders, race, religion or beliefs, sexual orientation and caters for any differences that may exist.
Equality Analysis – Step 3
What information has been considered to inform this service redesign/change/CIP? • Will the activity impact on service users, patients, carers and wider community members? • Will the activity impact on staff? • Reference data sources/ reports. *(NB: this replaces the experience section of the QIA)*
Information considered:

The involvement process that we have to follow stipulates a number of engagement sessions with service users, carers and the local population. We have developed a risk register with include reputational risks which have been mitigated by our communications team

A series of engagement events took place during September – October 2019, across the South East of the County, to establish what was good about the services and what needed improving, to help shape the long-term solutions. A range of marketing material was used, which was designed by the service user, which included leaflets and posters together with usage on Facebook and Twitter, local newspapers and a dedicated page on the Trusts website 'getting involved. A report was submitted to MPFTs Board on the 30th January 2020 with the outcome of the findings. A copy of the report can be found on page 143 on the link below. https://www.mpft.nhs.uk/application/files/5115/8037/7994/MPFT_Trust_Board_Papers_20200130.pdf
Due to impact of COVID-19 there had been some delays in some engagement events, these were brought back on track in 2021 and online events were held throughout October 2021 to allow for public feedback. An online survey was available up to 31st October 2021 https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement The Trust will also hold a further event in February 2022 to gain a better understanding on how service users are currently feeling and how they feel about the future proposed model of care.

People with lived experience, carers and representatives from the local communities have been invited to join the George Bryan Centre Reference Group to ensure that local people are involved at every step of the journey. The members of the reference group will use their lived experience and knowledge of local services and communities to provide their views and consider the proposals. *Flyer – George Bryan Centre Factsheet.*

Relevant National Quality Indicators and NICE guidance - *Literature review available for reference: 'Literature Search Results: Dementia and inpatient facilities' November2021*

Positive impact on Staff as detailed in the QIA.

Equality Considerations: Assessment of Impact (Step 5)		
Assessment (consider the following protected characteristics in relation to the questions below: Age, disability, gender, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender reassignment/identity, sexual orientation, human rights)	**Response** Please include response for each identified/ affected protected characteristic.	**Risk Reg. Ref.**
General Impact		
Describe the likely impact of the activity on people because of their protected characteristic and how they may be affected.	Protected characteristics of age gender and disability most likely to be impacted – positive impact detailed in QIA as increased number of patients and carers are supported in own home. Also need to consider Gender and disability and potential impact on carers/families. May need to support cultural beliefs of patients and carers/families. All Service users will be treated with dignity and respect and safeguarding concerns will be dealt with appropriately.	

	The service seeks to be inclusive through easy read, interpreter services, and materials in different languages. The language used by team members and training provided to all staff to ensure high levels of care and knowledge across all of our services. Staff competencies/training to cover Equality training and Dementia training. The Trust is in the process of commissioning cultural sensitivity training and demographic information collection training. Service to work with data or information from the consultation feedback to support a positive impact. Learning from any Serious Incidents, PALs Complaints or Service User Feedback to be shared with the Service/Staff. Supporting the reduction of health inequalities by having care at home which is appropriately supported with access to the pathway being inclusive, supporting carers and families to maintain flexibility and some consistency to their usual activities of employment and education.	
How and why is this protected characteristic relevant to the proposed activity?	Age – is a relevant protected characteristic due to the age of service user that commonly requires the service. Services are for older adult mental health needs.	
How does the protected characteristic determine/shape the potential impact of the proposal?	Detailed in QIA.	
Is there a positive impact?	Improved outcomes for patients. Increased number of patients and carers are supported in own home.	
Risk of Negative Impact		
How likely will people from the protected characteristic be negatively affected?	Potential for additional travel time and costs for families and carers. Where admission is required, there is potential difficulty for carers of elderly patients to be able to travel at all (no direct transport from some areas of Lichfield / Tamworth / East Staffs) - may impact on patient outcomes as visiting is known to promote recovery.	
How great will that impact be on their well-being and health outcomes?	This will be an ongoing review and evaluation process.	
What will determine who will be negatively affected?	Business as usual monitoring of referrals and patients on the service caseload.	

For negative impacts, what mitigating actions can be taken to reduce or remove this impact?	Patients can claim depending on whether they receive benefits. In other circumstances any issues raised are going to be managed on a case by case basis through our Trust PALs and complaints process. (This provision was put in place when the Margaret Stanhope Centre closed with very little take up.)	
Is the Impact Understood?		
Is the impact on equality groups sufficiently understood? If not what actions will be taken to better understand the impact on equality groups?	This will be an ongoing review and evaluation process. Patient equality data will be reviewed on a quarterly basis and where we find patterns of under or over representation we will seek to engage with local services and voluntary/community sector groups to raise profile of service and better understand impact and accessibility of service pathway. The Trust is in the process of commissioning cultural sensitivity training and demographic information collection training. Concerns in the community related to closure of unit. Action in the EIA action plan to monitor and act on building community confidence of the service.	
Summarise why the groups not commented on in the section above are not relevant to the proposed activity.		
Inclusive of all groups. The service is open to all people regardless of any of these protected characteristics. There are no foreseen impacts at this time for these characteristics.		

Note: where a mitigation action is identified in sections 3a and 3b of the assessment this will need to be included in the 'Impact Analysis Action Plan' in section 4.2 below.

Section 4 – Impact and Action Plan Monitoring

4.1 Impact Monitoring Arrangement

The Care Group will need to determine the key measures it will need to monitor to determine whether a service change has an impact on the quality and safety and what that impact is. It is important to note that the impact of the service change may not always be a negative impact, the service changes may lead to no change or an improvement in the quality/safety of the service. Therefore it is important that the measures selected can help demonstrate what that impact has been and whether it is negative, neutral or positive.

The following list highlights the six key measures you must review for any service change, other measures should also be selected as appropriate.

These should be reported through your Care Group Quality Governance Sub-Committee. Where changes are identified in any of these, a review of your scheme/s risk assessment must take place and be updated on your risk register.

Safety

- Change in the numbers and/or type of serious and patient safety incidents
- Change in the evidence that the service is meeting the CQC Fundamental Standards

Effectiveness

- Changes in delivery of contract quality measures, CQUINs and quality related KPIs (including NICE compliance)
- Changes to staffing capacity e.g. increases in staff sickness absence rates, increase in staff vacancies

Experience

- Change in the numbers and/or type of feedback (e.g. PALs concerns, compliments or complaints, FFT results)
- Changes in access or waiting times (e.g. referral to treatment rates, referral to assessment rates, assessment to treatment rates)

Measures to be monitored

Please identify in the table below the measures you will be monitoring to assess the impact of the service change. Monitoring these measures should help you to assess what the impact of the service changes has been on the quality and safety of care and identify whether the change has had either a; negative, neutral or positive impact on the quality and safety of the service.

Measure	Data Source	Frequency	Baseline	Expected Outcome/Target
Gatekept Admissions – Older Adults with functional mental health difficulties	95% of admissions are gate kept according to gatekeeping SOP	Monthly	2019/20	No increase
Incident Review	There is a review of any incidents/ serious incidents, related to bed availability and care delivered through CRHT, conducted to monitor the impact of inpatient bed reduction and ensure appropriate responses are implemented	Monthly	2019/20	
Use of Out of Area Beds	RiO data	Monthly	2019/20	There is no utilisation of beds not provided by MPFT for South Staffordshire residents as a result of there being non-acute beds available

Review of Complaints/ PALS	Monthly report on issues raised related to bed availability and care delivered through Older Adult Service to identify trends and implement actions to respond	Monthly	2019/20	
Service User Experience	Audit of Service User Experience for CR/ HTT and bed availability issues on inpatient wards	Monthly		
Carer Experience	Audit of carer experience for CR/ HTT & Older adult team	Monthly		
Training in Older People specialist work	80% of qualified staff in CR/ HTT have received specific internal training in working with older people	3 monthly		

4.2 Impact Assessment Action Plan Arrangements

Impact Analysis Action Plan Give an outline of the key actions that need to be taken account of as a result of this impact analysis. Please base these on any gaps, challenges and opportunities you have identified during this analysis. These can include actions; - to improve the proposed activity - to address specific impact issues/data gaps - to address evidence/issues resulting from consultation - to address financial implications/resource implications such as staff training, staff backfill, interpretation costs			
IMPACT ANALYSIS ACTION PLAN - actions for mitigation			
Impact Analysis Finding	**Actions required to achieve better outcome/address identified issues**	**Completion Date**	**Officer Responsible & Service**
1. Potential for community to be concerned about closure of unit.	Monitor and act on building community confidence of the service if required.	On-going	

4.3 Governance arrangements:

If the proposal is required to go to a Confirm and Challenge Session please list who will be attending the session:	**Lisa Agell** - Operations Director-Unplanned Care & Mental Health, **Emma Lambert** – Clinical Director, **Upkar Jheeta** - Business Development & Service Improvement Manager, **Angela Upton**, Deputy Head of Operations (Mental Health) **Liz Lockett -** Executive Director of Quality & Clinical Performance, **Alison Bussey –** Chief Nurse**, Abid Khan –** Medical Director, **Baz Kaur -** Associate Director of Equality and Inclusion

Please state who will be responsible for monitoring the service change risks, performance measures and actions plans within existing Care Group governance arrangements:

Monthly:	SSoT Care Group – Mental Health Performance and Quality Forum
Quarterly:	SSoT Care Group – Mental Health Performance and Quality Forum

All completed QIA and EA documents together with any associated documents should be submitted to your designated Performance Development Manager or to the generic inbox: pdt@mpft.nhs.uk

If only the EA part of the assessment has been completed please submit this to: equalityanalysis@mpft.nhs.uk

Quality Impact Assessment Tool (QIA) – CIP/QIPP/Other Schemes

Scheme Name:	George Bryan Centre – Older Adult ward closure and implementation enhanced community offer
Saving Plan Reference Number:	1819MHST3
Scheme Lead:	Lisa Agell
Anticipated Scheme Start Date:	August 2019 – enhanced community offer
Is an Equality Impact Assessment required?	Yes – this will completed as part of the public consultation
Clinical Director 'Sign Off'	Insert signature/sign here

For Guidance on Completing the QIA see page 3 of this document or click here

Section 1 – Screening

Before completing Section 2 and 3 of the tool, please ensure you can answer "yes" to the following general questions:

Question	Yes/No
The directorate has agreement for proposing this scheme by the clinical director, and/or the clinical leads and professional leads	Yes
The directorate has completed a detailed assessment of financial impact of the scheme in line with finance department guidance	Yes
The directorate has sought bottom-up ideas from front-line staff on how services could be delivered differently.	Yes
The directorate has sought opinions from service users and carer's representatives.	This will be done as part of the public consultation
The directorate has an agreed process for responding to concerns expressed by staff, service users or carers, or other stakeholders.	Staff have been consulted on the closure and the model. Service user and stakeholders will be done as part of the public consultation
The directorate has developed a process with key stakeholders (Commissioners, Staff, Patients, Carers, Public) to monitor impacts regularly post implementation?	This will be done as part of the public consultation
If the scheme is likely to lead to a service closure or significant contract change, have discussions taken place between the directorate and commissioners about whose responsibility it is to consult with stakeholders?	Yes

Section 2 - Quality Impact of Scheme, Detailed Risk Assessment and Mitigants

An overall baseline risk assessment must be completed for all schemes at the bottom of this sheet.

Assessment	Yes/No	Please explain the rational/reasoning behind the answer and how any negative impacts will be addressed	Risk Register Ref. Number
Background			
Please provide some descriptive background to the scheme, outlining what it is and how it will aim to make the identified saving, for example if it is a skill mix please identify change in hours, banding and capacity as appropriate.	N/A	The scheme covers the case for closing older adult beds at the George Bryan Centre, Tamworth. The 12 older adult beds were closed following a fire in April 2019 with and enhanced community pathway developed to support older adults by Older adult teams in the community August/September 2019. The aim of an effective acute care pathway for people with a functional mental illness is that as service users become more ill, intensive community support both enables them to recover without requiring acute inpatient admission and if this is unavoidable, facilitates early discharge. Admission remains an option, but only for a short period and a small minority of service users. The aim of an effective acute care pathway for people with dementia is that there is a range of community support services able to respond to individuals needs.	1170
Safety			
Did you identify any risks to clinical or staff safety?	Yes	There are two sites for inpatient mental health care in South Staffordshire the quality of the environments on these sites varies considerably. The George Bryan Centre inpatient site requires significant building works to provide a clinically safe environment, observation and layout is made difficult. The CQC inspected the George Bryan Centre in July/August 2013 visiting West Wing (adult acute ward) alongside East Wing (an older adult acute psychiatric ward). They inspected the two wards together and made judgements made about the hospital as a whole. “We found that the safety and suitability of premises to be below the required standard. The concerns were that the ward did not provide suitably	382, 524

		segregated accommodation for men and women. They also identified the outside spaces that they considered unreasonable. On our inspection of West Wing at the George Bryan Centre, we identified a number of potential ligature risks. The most significant of which was new and was not covered in the ligature risk assessment for the ward" (CQC report, September 2017). The trust has made some improvements to the environment, in particular the ligature risks, however to fully enhance the environment to meet standards it would require significant rebuild. The unit is remote from other sites therefore making response to medical and psychiatric emergencies difficult. The greater number of inpatient sites the more is spent on administrative and other support services and the less efficient the Trust is overall. The clinical evidence suggests that older adults are better served in the community than an admission to hospital. There are risks associated with SU and Carer Experience – about people's perceptions of the changes and the possible damage to the Trust's reputation. We are liaising with the communication team to develop mitigants.	
Will you be able to maintain compliance with CQC's Fundamental Standards?	Yes	We would maintain standards within community teams.	
Will you stay on track for delivering services within policies and procedures?	Yes	Yes, the relocation and closure will not impact on the directorates ability to adhere to policies and procedures	
Will this increase any entry on your directorate risk register to 15 or above?	No	The older adult ward at George Bryan centre has been closed following the fire, the enhanced community offer delivered in the community will reduce the requirement on beds and therefore mitigating any risks identified at GBC	
Will the changes introduce any specific	N/A	The ward at GBC has been closed	

environmental risks/considerations? Following the changes, will the environment be fit for purpose?		following the fire	
Effectiveness			
Will this impact on the maintenance of the multidisciplinary skills base?	Yes	The Trusts priority following the fire was to redeploy staff into suitable alternative posts. Some staff filled roles within community teams (as part of increasing the enhanced community offer). The re-deployment had taken into account individuals' skills, experience and location. Appropriate clinical training would be required to support staff in the transition from working in an a acute to community setting. Where possible and appropriate some staff will be relocated to Stafford with mileage protection in accordance with Agenda for Change. For any staff displaced, redeployment will be sought within the Trust. Although this cannot be guaranteed no redundancies are anticipated as a result of this proposal. There are no foreseen TUPE transfers as a result of this proposal.	1276
Will this impact on your delivery of national quality indicators?	No	Supporting more people at home is in line with national quality indicators. The community teams have been enhanced to support increase in demand	
Will this impact on your delivery of contract quality measures & CQUINs?	No		
Will you be able to maintain delivery against all relevant NICE guidance?	Yes	Yes, the NICE guidance for older people will be enhanced	
Experience			
Will this impact on service users' and/or carers' experiences of service delivery?	Yes	Advantages • Better support networks and easier access to a wider range of services • Increased number of patients and carers are supported in own home • Reducing lengths of older adults by implementing a specific pathway Disadvantages • Reputational risks of service users and carers expressing concerns to the media	

Will this impact on your delivery of care within the most appropriate pathways?	No		

Overall Baseline Risk Assessment		
An overall baseline risk assessment must also be completed here.	**Score before**	**Score after**
Impact of CIP scheme on service quality (1-5), I =	4	2
Likelihood of above risk occurring (1-5),L =	4	3
Total baseline risk score (I x L) =	16	6

Section 3 – Risk Monitoring

3.1 Risk Monitoring Arrangement

The following list highlights the six key quality measures you must check on a monthly basis for any scheme. Where changes are identified in any of these, a review of your scheme/s risk assessment must take place and be updated on your risk register.

Safety

- Change in the numbers and/or type of serious incidents
- Change in the evidence the service is meeting the CQC Fundamental Standards

Effectiveness

- Changes in delivery of contract quality measures, CQUINs and quality related KPIs
- Change in the rate of sickness absence

Experience

- Change in the numbers and/or type of feedback e.g. on Meridian
- Changes in RTT, including to specialist elements of service

Moderate Risk Identified – Specific Measures to be monitored (Risk score of 6 or more)

Where a scheme is identified as presenting a moderate or high risk to the quality and safety of care (where the overall risk is assessed as 6 or over), specific measures should be identified and monitoring of the scheme must be put into place.

Quality Standard	Measure	Frequency	
Additional staff to enhance the Dementia & Memory Service, Community and Crisis Teams	Staff have taken up post	End October 2019	
Gatekept Admissions – Older Adults with functional mental health difficulties	95% of admissions are gate kept according to gatekeeping SOP	Monthly	
Incident Review	There is a review of any incidents/ serious incidents, related to bed availability and care delivered through CRHT, conducted to monitor the impact of inpatient bed reduction and ensure appropriate responses are implemented	Monthly	

Quality Standard	Measure	Frequency	
Use of Out of Area Beds	There is no utilisation of beds not provided by MPFT for South Staffordshire residents as a result of there being non-acute beds available	Monthly	
Review of Complaints/ PALS	Monthly report on issues raised related to bed availability and care delivered through Older Adult Service to identify trends and implement actions to respond	Monthly	
Service User Experience	Audit of Service User Experience for CR/ HTT and bed availability issues on inpatient wards	Monthly	
Carer Experience	Audit of carer experience for CR/ HTT & Older adult team	Monthly	
Training in Older People specialist work	80% of qualified staff in CR/ HTT have received specific internal training in working with older people	3 monthly	

A monthly report will be produced detailing the level of delivery against quality standards relevant to that period. Where an action plan is required to improve a standard this will be developed and available for scrutiny.

3.2 Governance arrangements:

If the proposal is required to go to a CIP Challenge Session please list who will be attending the session:	Lisa Agell, Upkar Jheeta & Angela Upton

Please state who will be responsible for monitoring your CIP scheme risks, within existing directorate governance arrangements:

Monthly:	Monthly via the Care Group Portfolio Meeting
Quarterly:	

Guidance for Completing the QIA

General

This tool combines both the screening and detailed risk assessment of any proposed CIP/QIPP/Other scheme. It must be completed for any scheme where money is being withdrawn from a service and there are potential risks to the quality of clinical care covering safety, clinical outcomes and patient experience. For further guidance on when a QIA needs to be completed please see the "Process for Agreeing and Monitoring CIP/QIPP/Other Schemes", which can be found at the following link: http://nww.intranet.sssft.nhs.uk/The-Knowledge-Bank/Sections/Directorates-and-Services/Performance.aspx

It is important that the QIA tool is completed and goes through the approval process before the scheme commences. Screening simply consists of answering “yes” or “no” to the questions in Section 1. An "Overall Baseline Risk Assessment" must be completed in Section 2, even if no further quality risks have been identified it is important to briefly explain the reasoning behind the answers. Where risks have been identified, their risk register reference numbers must be inserted in the box provided. Financial impact should be considered separately, in agreement with your Directorate Accountant.

Please complete the QIA tool (above) for each scheme considered. Where there are two or more small, but similar, schemes under consideration they must be grouped together to answer all questions as though they were one scheme. e.g. same type of posts (banding, discipline, location) being taken out in different, but similar or related, services. All questions require simple "yes-no" answers and links to your risk register where potential increases in risks to quality are identified. They have been designed to guide managers' thinking when putting schemes forward for consideration. All schemes must have the approval of clinical directors and/or leads where no clinical director is in place. An overall baseline risk assessment on the scheme is then required.

Section 2 – Quality impact of Scheme, Detailed Risk Assessment and Mitigants

Please reference your risk register entries for any answers which indicate a potential impact on quality (positive or negative). Risk mitigation plans should be prepared and monitored through your risk register in the usual way. You do not need a separate CIP/QIPP risk register. Score through any line where no increased risk, as a result of the scheme, has been identified as likely. When considering and assessing the risk of the scheme on the quality and safety of care. Please ensure the thinking and rationale when arriving at the risk score is transparent and clearly documented, as this will be the key focus of challenge from the Executive Directors.

Impact - Extreme – 5, Very High – 4, Medium – 3, Low – 2, Negligible – 1

Likelihood - Almost Certain – 5, Likely – 4, Possible – 3, Unlikely – 2, Rare - 1

For more guidance on the risk methodology see the Trust Risk Strategy which can be found at the following location: http://www.southstaffsandshropshealthcareft.nhs.uk/Work/Policies-Procedures-and-Strategies/Default/Corporate-Policies/Risk-Management-(also-see-Clinical-Risk-Management.aspx

Section 3 – Risk Monitoring

After a scheme is approved, you must ensure your plan is considered at least monthly by the Division’s management team during its regular governance focused meetings. If the scheme is identified as having an adverse risk to the quality and safety of care, then the Division is required to ensure specific monitoring of the impact of the scheme is in place once it is implemented. Your Performance Development Manager can assist you with identifying service specific measures.

If the scheme is assessed as not presenting an adverse risk to the quality and safety of care, then no specific monitoring of that scheme will be required, it should however be monitored as part of the regular ‘business as usual’ monitoring of risks and performance. However, final approval of which schemes require; specific monitoring is subject to agreement at both Divisional and Executive Challenge Forums/Sessions.

Risk Monitoring Arrangement

On a six monthly basis, the risk assessment must be updated, whether or not changes have occurred before then.

Appendix 14 – Governance process boards and committees

	Meeting	Chair	Paper/Author	Frequency
	Trust Board	Non-Executive Director	• **Trust Assurance Report, Quality and Clinical Performance** - author/presented by Executive Director of Quality and Clinical Performance • **Board Assurance Framework** – author/presented by Executive Director of Quality and Clinical Performance	Monthly
↑	**Trust Quality Governance Committee**	Non-Executive Director (attended by Executive Director of Quality and Clinical Performance)	• **Care Group Sub Quality Committee Summary Reports** – author/presented by Clinical Care Director for the Care Group • **Serious Incident; Never Event and Regulation 28 Report** – author/presented by Head of Safety and Risk Management • **Board Assurance Framework** – author/presented by Head of Safety and Risk Management • **Mental Health Act Legislation Report** – author/presented by Head of Mental Health Act and Mental Capacity Act	The Care Group summaries are bi-monthly, however Care Groups can take additional reports if required. Serious Incident Report and Board Assurance Framework Report – Monthly Mental Health Act Legislation Report - Quarterly
↑	**Staffordshire and Stoke on Trent Care Group Quality Governance Sub Committee**	Clinical Care Director for the Care Group	• **Portfolio and Professional Leads Update** – author/presented by Director of Operations and Professional Leads • **Quality and Clinical Performance Update Report** – author/presented by Deputy Director of Quality and Clinical Performance	Monthly

			• **Risk Management Report** – author/presented by Corporate Risk Team	
↑	**Performance and Quality Assurance Forum South Staffordshire Mental Health**	Director of Operations for Mental Health and Unplanned Care	• **Operational and Quality Reports** – author/presented by Operational and Service Leads • **Quality and Clinical Performance Directorate Corporate papers** covering Risk, Incident Reporting, Quality Assurance and Effectiveness, Patient Involvement and Experience, Regulatory Compliance – author/presented by the Corporate Quality and Clinical Performance teams.	Monthly

Cannock Chase Clinical Commissioning Group
East Staffs Clinical Commissioning Group
North Staffs Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

September 2020

STAGE 1. TEMPLATE

QUALITY IMPACT ASSESSMENT (QIA)

QIA Overview

Number of your QIA?	212
Title of the Scheme/Project	George Bryan Centre – Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre
Is this a QIPP?	No
QIPP No.	No
Project Lead	Head of Transformation and Acting Deputy Director of Strategy, Planning and Performance, Staffordshire and Stoke on Trent CCGs Executive Director for Strategy and strategic Transformation, MPFT
Executive Sponsor	Executive Director of Strategy, Planning and Performance
Clinical Lead	Clinical Director – Mental Health & Specialist Groups NHS Stoke on Trent & NHS North Staffs CCGs
Quality Lead for QIA	Head of Quality & Safety
Date QIA completed	23/03/22
QIA completed by	Quality Improvement Manager – CCGs, Transformation Programme Manager – CCGs, Interim Performance Development Team Manager, Midlands Partnership NHS Foundation Trust
CCGs covered by the scheme	Cannock Chase CCG South East Staffordshire and Seisdon Peninsula CCG East Staffordshire CCG Stafford and Surrounds CCG

Project Overview:

September 2020

Brief Description of the scheme (including proposed timescales):

FINAL

Methods to be used to monitor quality impact:

Monitoring of data will come from MPFT'sinternal systems such as: -

- Monthly CQRM reports
- RiO data – the older adult team is on RiO
- Friends and Family Test
- Admission prevention analysed at patient level by the team.
- Adhoc data analysis as and when requested by commissioners

Please describe the clinical engagement and sign-off process?

CCG Sign Off

The CCGs Quality Impact Assessment panel will have opportunity to review the proposal and identify any quality impact that have not been addressed/mitigated against. Clinical sign off will be made by a GP who is the CCGs lead for Mental Health SASCCGs CEO/Board. Signed off copy will be itemised at the Transformation Programme Board and ultimately the CCGs Governing Body**.**

What has been the patient and public involvement?

Quality Lead Comments (Required)	
Name	Kay Roberts
Date	23/03/22

FINAL

Comments	The proposed model of care is a positive initiative, intended to give patients/service users a better quality of care in a safe way in the most suitable environments for the patients' needs. Travel has been a main concern for service users/carers/family members as a result a travel impact analysis has been commissioned by the CCG and is discussed further in the patient experience section of the QIA.

Safeguarding Leads Comments	
Name	Lisa Bates
Date	23/03/22
Safeguarding Leads Comments	The model ensures there is a safe service and individuals are maintained in a safe environment. The provider is linked to both Adult and Child Safeguarding systems.
If Safeguarding is not be required explain WHY	

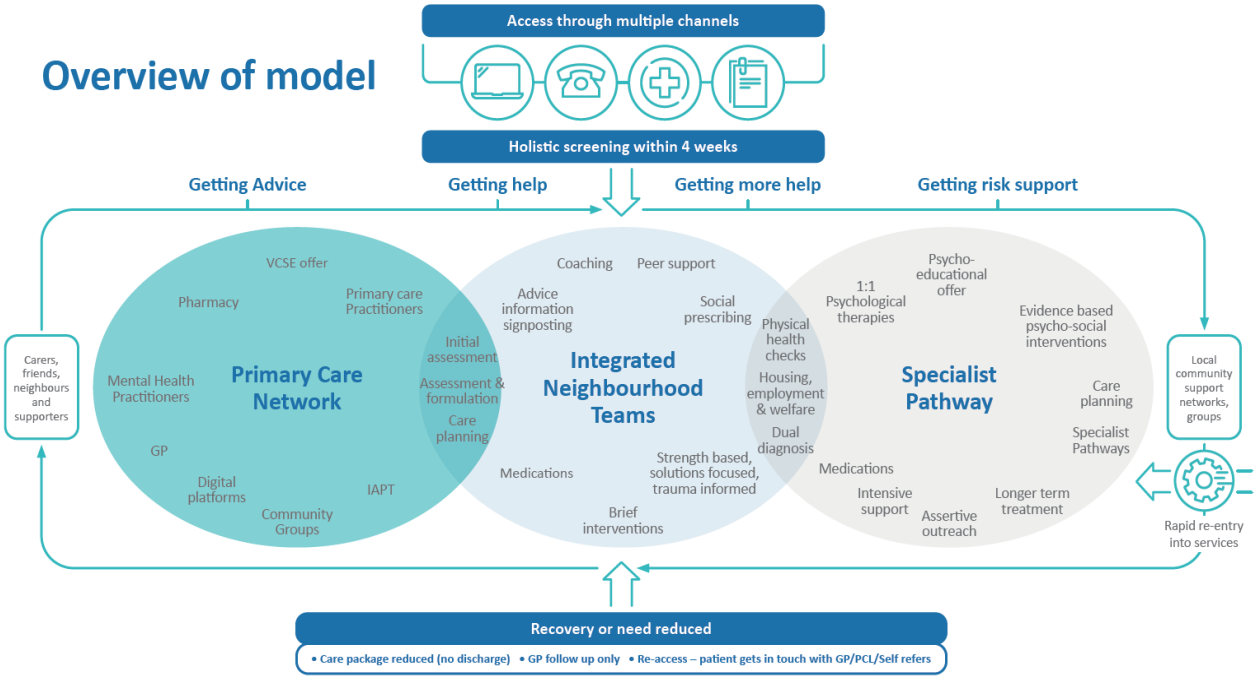
FINAL

PLEASE INSERT THE SERVICE REFERRAL PROCESS

Members of the QIA Sub Group have asked to see the process on how plans are for this service to work and how this links into the wider network. **The Panel would like you to complete a visual representation of the change required or service proposed**

For example a pathway flow chart, a process map, or service hierarchy (or section from your Project document visually representing the patient flow, or service flow).

FINAL


Overview of model
Access through multiple channels
Holistic screening within 4 weeks
Getting Advice
Getting help
Getting more help
Getting risk support
Carers, friends, neighbours and supporters
VCSE offer
Pharmacy
Primary care Practitioners
Mental Health Practitioners
Primary Care Network
GP
Digital platforms
IAPT
Community Groups
Initial assessment
Assessment & formulation
Care planning
Coaching
Peer support
Advice information signposting
Social prescribing
Integrated Neighbourhood Teams
Medications
Strength based, solutions focused, trauma informed
Brief interventions
Physical health checks
Housing, employment & welfare
Dual diagnosis
Psycho-educational offer
1:1 Psychological therapies
Specialist Pathway
Medications
Intensive support
Assertive outreach
Evidence based psycho-social interventions
Care planning
Specialist Pathways
Longer term treatment
Local community support networks, groups
Rapid re-entry into services
Recovery or need reduced
• Care package reduced (no discharge) • GP follow up only • Re-access – patient gets in touch with GP/PCL/Self refers

Cannock Chase Clinical Commissioning Group
East Staffs Clinical Commissioning Group
North Staffs Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

September 2020

QIA Stage 1 – Impact and Risk

PLEASE NOTE – If any domain has an overall risk score of 8 or above, a stage 2 QIA will be required.

PLEASE NOTE – The scoring must be from 1 – 6 on the scoring and there must not be a 0 included on any scoring.

<table>
<tr><th colspan="10">Patient Safety
Consider:
Any potential harm to patients
The potential for impact on incidents
Healthcare Associated Infections
Safeguarding of adults and children
Impact on children and Young People aged 0-25 with Special Educational needs and Disabilities (SEND)</th></tr>
<tr><th colspan="8">Positive Impact</th><th>Neutral Impact</th><th>Negative Impact</th></tr>
<tr><td colspan="8">SMI inpatient admissions

Fewer emergency call-outs
Fewer police call-outs since the centralisation of beds at St George’s Hospital than at the George Bryan Centre before the fire (outlined in the table below). This reflects that a larger site with senior clinical back-up, more staff, and intensive psychiatric care facilities, can manage crises more effectively. (*GBC West wing closed Feb 2019)

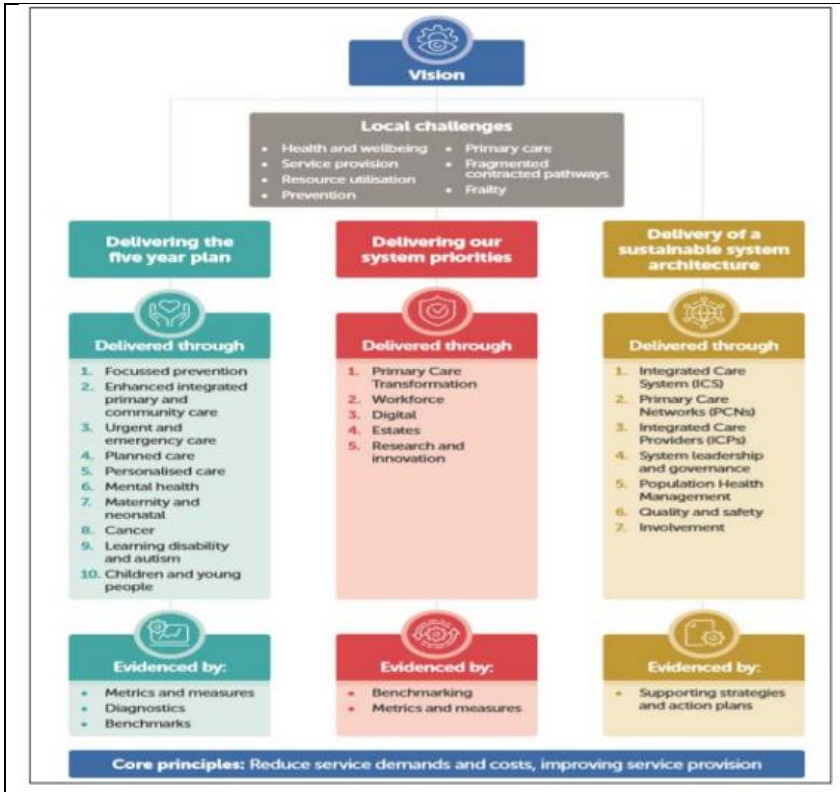
<table>
<tr><th>Site</th><th>Ward</th><th>2017</th><th>2018</th><th>2019*</th><th>2020</th><th>2021</th><th>Grand Total</th></tr>
</table>
</td><td>There have been no issues identified over the 2-year period that the model has been in situ.</td><td></td></tr>
</table>

St George's Hospital	**TOTAL (adult wards)**	**83**	**65**	**64**	**57**	**35**	**304**		
George Bryan Centre	**TOTAL**	**32**	**47**	**7**			**86**		
George Bryan Centre	West Wing	32	44	7			**83**		
George Bryan Centre	East Wing	0	3	0			**3**		
St George's Hospital	Chebsey House, SGH	42	26	13	15	5	**101**		
St George's Hospital	Brocton House, SGH	29	21	15	13	14	**92**		
St George's Hospital	Norbury House, SGH	11	16	12	11	6	**56**		
St George's Hospital	Milford House, SGH			22	18	9	**49**		
St George's Hospital	Bromley Ward, SGH	1	2	2		1	**6**		

Able to meet a wide range of needs Not all treatments and therapeutic interventions were available to people staying in the George Bryan Centre and so some people who had severe mental health needs were admitted directly to St George's Hospital, in Stafford, because of the more intensive support that can be offered in a larger hospital. The George Bryan Centre only had consultant cover during normal working hours, whereas, St. George's has 24/7 cover. Staff who provide therapeutic interventions are skilled and specialist, so it can be difficult to recruit and keep these staff. It would be particularly hard to recruit to a smaller, isolated site. In a bigger hospital, they would work across wards as required. Additional interventions that are available at St George's that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy. **More consistent care provision** More consistent care provision in a centralised centre, as no need for disruptive transfer to intensive psychiatric care or to access therapeutic interventions. **Timely access to intensive psychiatric care** As a larger facility, now with 84 beds for adults with SMI, St George's Hospital has a wider range of staff including full-time consultants. This means the most unwell patients have faster access to intensive psychiatric care, without having to be transferred from another site.		
Mitigation: for negative impact (include score below)		
Likelihood Score	Consequence Score	Overall Risk Score

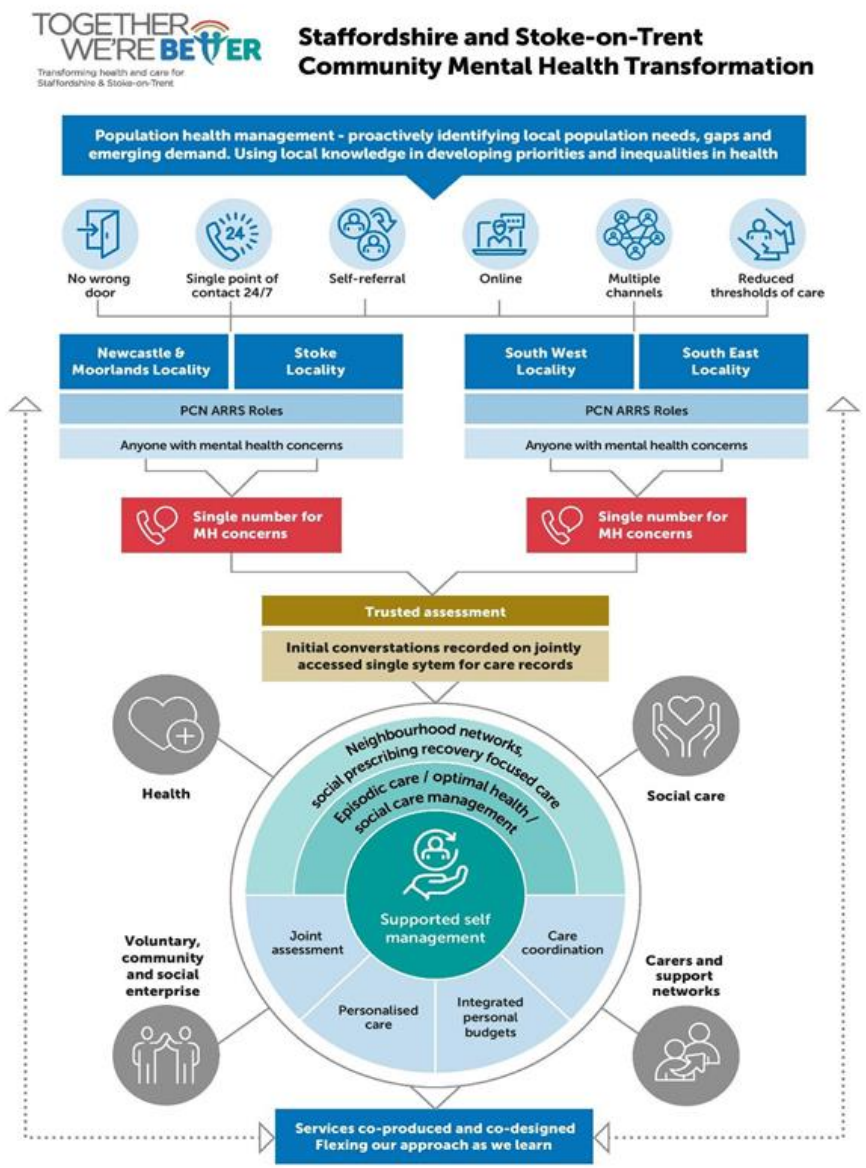
FINAL

2	1	2
Duty of Quality **Consider:** ***Continuous improvement*** ***The NHS Constitution*** ***Strategic partnerships*** ***Alignment to the STP*** ***Impact on the wider health economy*** ***Health inequalities*** ***Shared risk*** ***Children and Young People aged 0-25 with Special Educational needs and Disabilities (SEND)***		
Positive Impact	**Neutral Impact**	**Negative Impact**
Enhanced Community Service Offer for older adults with severe mental health illness, including dementia Community services are in the process of undergoing a transformation with additional funding, as outlined in -The Together We're Better Staffordshire and Stoke-on-Trent ICS Designation Development Plan PowerPoint Presentation (twbstaffsandstoke.org.uk) which outlines the response to the challenges to deliver the Long Term Plan; this includes the Strategic Framework and also summarises the delivery priorities which includes strong crisis response integrated into the community based offer, community transformation programme with all partners and alignment of community physical and mental health services around a Primary Care Network (PCN) to meet population needs. Within MPFT, community services were being developed prior to the fire, as this aligned with the national agenda and evidence, which supports provision of treatment in the usual place of residence and avoiding admission to an inpatient mental health bed unless necessary for safety reasons. MPFTs vision and model are set out below.	**SMI inpatient admissions** For the cohort of people with severe mental health needs, an admission directly to St George's Hospital, in Stafford, would have been made pre-fire, because of the more intensive support	**Greater risk of health inequalities** Evidence shows that being in touch with family, carers and friends is beneficial to patients with SMI.

		that can be offered in a larger hospital. **Impact on wider health economy** The 18 inpatient beds that were provided in the West Wing at George Bryan Centre are not being removed from the system. These are being provided at St George's Hospital in Stafford.	

Cannock Chase Clinical Commissioning Group
East Staffs Clinical Commissioning Group
North Staffs Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

September 2020



VAL

The enhanced community offer described above aligns with the strategic direction for more community-based care. Evidence demonstrates improved outcomes for patients who are cared for in their usual place of residence, rather than being admitted to an inpatient setting. This also provides more consistency of care from a known community team. Patients will also have a range of services and support available to them by use of a multi-disciplinary team which includes a wide range of specialities; this again will enable patients to stay in their preferred place of residence for a greater period of time. **Inpatient Beds for patients with severe mental illness** Compared to the George Bryan Centre, St. Georges Hospital offers a greater range of specialty services on one site. Therefore, patients are able to access a range of therapies on site, whereas if they were in an in-patient bed at the George Bryan Centre, they would need to travel for approximately 1 hour to St. Georges.		

Following the fire, the existing community pathway was developed and further enhanced to support older adults by Older Adult teams treating patients in home settings in the community; this now includes:

- Enhanced crisis home treatment with skilled, experienced older adult specialists and Hospital Avoidance Team
- Addition of a nursing/therapy lead to ensure interventions are evidenced-based and focussed on enabling individuals to maintain their independence at home
- New clinical psychologist to focus on older adults
- A training plan for the team, including equality and dementia training. This enhanced service model is in line with the national policy drivers including the national Community Mental Health transformation programme, which places emphasis on more care for mental health service users in the community rather than in hospital bed settings.

Mitigation: for negative impact (include score below)
Enhanced Community Service Offer for older adults with severe mental illness, including dementia

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The enhancements to the community services have been in place for over two years. During that time, there has not been any adverse incidents or complaints relating to the enhanced community provision. Providing care in the person's usual place of residence reduces the need for patients and carers to travel to access care.

Inpatient Beds for patients with severe mental illness

The Trust are looking at ways in which to mitigate against potential increased need to travel for a cohort of people from South East Staffordshire who do require admission to an inpatient mental health inpatient bed at St George's hospital in Stafford. The targeted reference group in March 2022, attended by a group of service users, staff, seldom heard groups and interest groups were asked to suggest ways in which any negative impact of the proposal can be mitigated. Previous suggestions from 2019 involvement events included financial support for transport, pre-booked transport and volunteer visitors. Digital solutions will also be explored, following the successful use of technology throughout health and social care during the COVID-19 pandemic.

Likelihood Score	Consequence Score	Overall Risk Score
2	2	4

Patient Experience

Consider:

Patient / service user experience (complaints / PALS/ Surveys etc.)
Hard to reach groups
Consent and confidentiality
Informed choice and care planning
Compassionate and personalised care
Quality of the physical environment
Involvement of patients and carers in the project
Whether previous patient experience has informed the new scheme
Accessibility of services
Travel arrangements - access to transport, car parking etc.

Cannock Chase Clinical Commissioning Group
East Staffs Clinical Commissioning Group
North Staffs Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

September 2020

Children and Young People aged 0-25 with Special Educational needs and Disabilities (SEND)		
Positive Impact	**Neutral Impact**	**Negative Impact**

FINAL

A series of engagement events took place during September – October 2019, across South East Staffordshire , to establish what was good about the services and what needed improving and to help shape the long-term solutions. A range of marketing material was used, which was designed by the service user, which included leaflets and posters together with usage on Facebook and Twitter, local newspapers and a dedicated page on the Trusts website 'getting involved. Excluding MPFT staff, 37 people attended these events. A report was submitted to MPFTs Board on the 30th January 2020 with the outcome of the findings. A copy of the report can be found on page 143 on the link below. https://www.mpft.nhs.uk/application/files/5115/8037/7994/MPFT_Trust_Board_Papers_20200130.pdf The themes from that exercise included: 1. Support to rebuild the George Bryan Centre like for like 2. Additional beds 3. Using the centre as a base for community-based services (including young people and all types of mental health support). Some extended this to other health services and the voluntary sector 4. The greater range of services in Stafford was mentioned – art, music and occupational therapy 5. Travel was the most common theme – distance, cost and accessibility of public transport. The COVID-19 pandemic delayed further public engagement in 2019/20 and therefore a sense check engagement exercise (online events and a survey) was undertaken in Autumn 2021 to understand people's experiences since the fire.		**Location** The cost of additional travel to St. Georges for service users and carers. This may adversely affect those on low income or do not have easy access to transport. **Patient experience** Some patients gave positive feedback about GBC

An online survey was available up to 31st October 2021 https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement. Across the two events, there were 29 participants, and 783 stakeholders were engaged with, 2014 emails sent, and 85 telephone calls placed to support the survey. MPFT held a targeted reference group in March 2022 to enable a group of service users, staff, seldom heard groups and interest groups to review the viable proposal to inform the business case. There were 14 participants. The report of findings from this event is in development.

The events findings show a mixture of views about different services, with both positive and negative comments about community mental health services and the George Bryan Centre.

The 2021 events produced similar comments to those listed above from 2019. Specifically, the themes numbered 1, 3 and 5 above were repeated.

There was continuing support for the George Bryan Centre to be kept, to meet local needs.

Travelling was still the most prominent concern – relating to access to services, and families and carers being able to stay in touch and be involved.

- "Travel shouldn't be an issue if you need to access services"
- "Travel to and from is costly if you don't have much money, and we had two young children too which made commuting every day difficult"
- "Resident of Burtonwood – to get to Stafford is a nightmare. Three bus journeys to get there."

New themes in the 2021 events were:

Need for improved communication	"We need a pathway – people need to know where to go to get help"
Reports of difficulties during COVID-19 pandemic	"Access to diagnosis for people with dementia was difficult during pandemic"

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Need for earlier intervention and preventative services	"With things in place people would not get to the point where they need admission"		

At the events, people were also asked to comment on the new model of care.
The themes that emerged included:

Ensure integration and collaborative working	"Services across the patch are not aware of each other and their services. GB should be bringing all these services together"		
Need for communication and information (like about how to access services)	"Make the pathway available to everyone so they are aware"		
Need to implement the new model effectively	"Proposal sounds great in theory. It's the practice that counts. Remove barriers and expand access"		

Accessibility of Services
This was a common theme of query from involvement activity.

MPFT have an access telephone number and helpline telephone number -which is clearly advertised on their website and also has been circulated to all GP practices across Staffordshire and to community settings. People can self-refer by contacting the helpline and will be referred into the access service if they require clinical support. From this access point, MPFT will complete an assessment and refer into appropriate services -this can be anything from an emergency admission to a place of safety, referral to crisis team who can admit to an inpatient mental health bed, to referral into community-based support teams.

This access number will be fully integrated with NHS111 in the future, to further simplify access across all health services.

Reports of difficulties during COVID-19 pandemic MPFT services have not been closed during the COVID-19 pandemic. For people who may have accessed services via their GP, access may have been impacted by COVID-19 pressures within primary care. **Early intervention and preventative services** The Community Mental Health transformation is a 3-year programme of change to be delivered, which has begun. This builds upon work that has already taken place to develop community teams with a focus on admission prevention and will integrate the community and voluntary sector. **Location** Involvement comments have suggested that St George's location is an advantage – patients have access to activities outside hospital. **Case study** The following summarised case study gives an indication of the level of care and support provided by the community home treatment service (MPFT) An 80-year-old lady from Tamworth was referred to memory services (by her GP via the MPFT ACCESS point) with suspected memory problems. This was a routine referral from GP and a diagnostic assessment was arranged. However, her family became concerned about her condition deteriorating and, on calling the number of the appointment letter, was contacted that day by the Dementia Duty Worker, to establish the level of risk. Her mother was disorientated and experiencing episodes of acute confusion, resulting in hostility and aggression towards family members. Her daughter reported that she had burnt food and stopped taking her medication correctly. Input from the Dementia Home Treatment Team was requested (this service is in place for when diagnosis is confirmed but can be flexible if deemed the appropriate service to respond.) Actions from this service included: • Community Mental Health Nurse (CMHN) allocated from the Home Treatment team		

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• Home Visit within 2 days, with assessment completed at service users' home with daughter present • Noted a possible leg ulcer infection, urgent GP review requested due to confusion and possible infection - antibiotics prescribed and leg dressed by District nurse, brief hospital visit required due to severity of infection • Contact with daughter maintained (calls and visits) to support in caring for mother • Involved an Occupational Therapist (OT) to complete functional assessments given the risks within the kitchen and Activities of Daily Living (ADL). • Consultant Psychiatrist assessment completed (requested by CMHN) within 4 weeks post discharge from acute hospital and dementia diagnosis reached - treatment and intervention plan agreed. • Treatment plans monitored over visits with community team and OT • Daughter feels huge improvement (within 5-6 months of initial contact) in mother's quality of life now. Anti-dementia drugs being utilised at stable dose • Support from the team is ongoing but frequency reduced. • Once diagnosed, the lady remains on caseload at MPFT as part of the "non-discharge" pathway. Reviews completed every 3 months. • CMHN referred to partner provider "The Alzheimer's Society Dementia Advisers" who are supporting daughter and service user post diagnosis. This includes carers support, housing and benefit support. • CMHN also referred to Social Services via Staffordshire Cares to assess care at home as daughter feels more support is needed with mothers ADL and personal hygiene needs. Social Care completed assessment with CMHN in attendance to support – care package agreed. **Community service provision based on previous patient experience** MPFT have developed a range of support services that meet the needs of the local population and have been implemented based on identified gaps in service provision which impact on mental health.		

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While these differ from clinical community mental health services, they all share a similar aim – of enabling and supporting people with mental health illness to remain safe and well in their community, avoiding the need for inpatient admission where this can be avoided. The main aim of these services is to address the social determinants of mental health which cause or exacerbate a service users experience of mental health The Lifestyle services for SMI aims to connect people to opportunities to remain healthy in their local area, to be motivated to maintain a healthy lifestyle and manage their weight and to educate service users so that they can enjoy being healthy. The service will deliver a range of meaningful and purposeful activities which support services users in their recovery journey and aim to reduce social isolation. Future focus support services aims to support people to stay well in their recovery journey, with a person centred and flexible approach to providing that support. The service aims to connect the service user to resources and services in their local community to reduce social isolation. This support is offer alongside clinical interventions and continues to support them for up 12-18months post completion of clinical interventions Housing support services provides a range of housing related support, supporting services users to access and navigate housing allocations processes and maximise opportunities to live in areas that support their ongoing mental health needs or provide support to enable individuals to sustain their tenancies. The service offers practical advice on a range of issues, including welfare benefits and personal finance skills, to promote independence. Financial wellbeing management and support for mental health services provides advice on a wide range of issues including debt prevention, consumer rights, bankruptcy, budget support and income maximisation. The service directly link with MPFTs community mental health teams. The out of hours home sitting service is newly commissioned, as MPFT recognised a gap in provision for those patients or carers who are potentially experiencing an exacerbation of their illness or breakdown in carer arrangements, which could result in an admission to an inpatient bed. This service aims to ensure service users		

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can safely remain at home, or an alternative environment and provides support and respite to carers/ relatives out of hours.		

Mitigation: for negative impact (include score below)

The CCG commissioned a travel time analysis to quantify the impact of proposals for mental health services for people across South Staffordshire. This analysis found that, before the fire in 2019, approximately 25% of total adult mental health inpatient admissions from Stafford, Cannock Chase, East Staffordshire, Lichfield, South Staffordshire and Tamworth districts were admitted to George Bryan Centre. From this cohort, there will be a number of people who will still require an inpatient admission and their family/carers would need to travel to St George's hospital in Stafford to visit. However, a number of them will benefit from the enhanced community service offer, which aims to provide care at the usual place of residence and avoid an inpatient admission unless necessary. Where an inpatient admission is required, the aim is to keep the length of stay as short as possible.

The analysis indicated that current public transport routes are poor from several areas within south east Staffordshire, and this applied to the George Bryan Centre too. Patients from Lichfield and Tamworth requiring inpatient care will have the greatest increase in travel time.

The enhanced community model will prevent unnecessary admissions and there will be a cohort of patients who were previously admitted to a bed who will now have care provision in their usual place of residence.

Likelihood Score	Consequence Score	Overall Risk Score
2	*2*	4

Clinical Effectiveness

Consider:
Evidence based practice
The Clinical leadership and engagement
Impact on consistency of care
NICE compliant treatment / care
Potential re-admission rates to inpatient facilities

Positive Impact	Neutral Impact	Negative Impact
Clinical Evidence Base The case for change for mental health services was developed through the TWB transformation programme, and was clinically led and aligns with the national model to provide: • Holistic, person-centred care, with services that are joined up ➢ Primary and secondary care ➢ Healthcare and social care ➢ Mental healthcare and physical healthcare • Patients and carers more directly involved in decisions • Easier to access the right service • Care given at home and in the community wherever possible • Inpatient care only when it's really needed **Treatment of patients with dementia** Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can: • make the symptoms of dementia worse • permanently reduce the person's independence • make it more likely that the patient will be discharged into residential care and/or re-admitted to hospital. The dementia care pathway guidance says that, when a patient has to go into hospital, the stay should be as short as possible. Care should focus on helping people to live as well as possible at home, with support from health and social care, local authorities and/or voluntary groups. It should be person-centred, and could include things like:		**Greater risk of health inequalities** Evidence shows that being in touch with family, carers and friends is beneficial to patients with SMI, therefore any difficulties they experience in visiting could impact on patient outcomes.

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- extra-care housing and practical support, for example with transport
- help in maintaining relationships at home and in the wider community
- help to take part in meaningful daily activities.

NICE guidelines (NG97, 2018) request that, when considering admission to hospital for a person living with dementia, the value of keeping them in a familiar environment is considered.

Treatment of patients with serious mental illness

The national best practice for treating patients with serious mental illness (SMI) has moved from a **bed-based** model to a community-based model. Figure 1 shows this 'stepped' model of care, with most people living in the community and receiving different levels of care depending on their need.

However, there will be times when patients need intensive medical supervision and treatment that can only be provided in hospital. MPFT will continue to admit patients when this is the right course of action. Since the temporary closure of the George Bryan Centre, patients needing an inpatient stay have been admitted to St George's Hospital, Stafford. The data shows us that there have been less patients admitted to St. Georges with dementia.

Timeline and details of Clinical Engagement

Date	Meeting	Notes
2018/19	STP MH Programme Board	Mental Health case for change developed through the Board, building on the NHS Long Term Plan
May 2019	West Midlands Clinical Senate	Case for change presented to the Senate. The Clinical Senate was of the view that the STP articulated a credible case for change and the aspirational principles of the programme of work were in keeping

		with the needs of the population, and general NHS national policies and guidance.			
June 2019	NHSEI Assurance	Case for change presented to NHSEI			
Summer 2019	Listening Exercise (12wk)	Case for change articulated to the public			
Summer - Autumn 2019	Clinical Advisory Group	Throughout this period of public involvement, the Clinical Advisory Group (CAG) met to develop the clinical model, based upon the case for change. The CAG membership included clinicians from across the system, including GPs and Public Health colleagues.			
15 October 2019	PCBC Workshop #1	Discussed the two options under consideration and agreed that both should remain on the medium list			
14 October 2019	Public Event	Clinical model shared at public event			
14 November 2019	PCBC Workshop #2	Re-capped on medium list. The membership for this workshop included clinicians from across the system, in addition to workforce, estates, quality and communications representatives. The medium list for GBC remained unchanged.			
3 March 2020	PCBC workshop	Developing desirable criteria			
October 2021	Sense-check engagement events and survey	Following programme pause (due to the pandemic) the public were engaged, in order to re-cap the point reached in the options appraisal process and to ask if anything had changed or if there was anything new to consider			
10 Dec 2021	Technical Event	Meeting to receive the report of findings from the sense check engagement and to review the two existing proposals in light of the evidence and feedback.			

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		It was agreed at this event that proposal two (re-establish beds at GBC site) was not viable and therefore one viable proposal remains. The main issue identified was around safe staffing of 18 beds in a standalone unit, and the risks associated with remote service provision.		

Delivery of national quality indicators will not be affected, MPFT will be able to support more people in their own homes in line with the national quality indicators. NICE guidance for mental health in older people will be enhanced.

Preventing readmissions
It is recognised that a patient being discharged from an inpatient mental health bed is at risk of re-admission. MPFT have a dedicated discharge pathway, which provides intensive community support for 4 weeks post-discharge. This is a person centred approach can include home visits, home cleaning/ repairs, support with food and utilities.

For older people with dementia, they are on a non-discharge pathway, therefore can access more intensive support if required from the from a specialist hospital avoidance team to support discharge and prevent admissions.

Mitigation: for negative impact (include score below)
The CCG commissioned a travel time analysis to quantify the impact of proposals for mental health services for people across South Staffordshire. This analysis found that, before the fire in 2019, approximately 25% of total adult mental health inpatient admissions from Stafford, Cannock Chase, East Staffordshire, Lichfield, South Staffordshire and Tamworth districts were admitted to George Bryan Centre. From this cohort, there will be a number of people who will still require an inpatient admission and their family/carers would need to travel to St George's hospital in Stafford to visit. However, a

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number of them will benefit from the enhanced community service offer, which aims to provide care at the usual place of residence and avoid an inpatient admission unless necessary. Where an inpatient admission is required, the aim is to keep the length of stay as short as possible.

The analysis indicated that current public transport routes are poor from several areas within south east Staffordshire from, and this applied to the George Bryan Centre too. Patients from Lichfield and Tamworth requiring inpatient care will have the greatest increase in travel time.

The enhanced community model will prevent unnecessary admissions and there will be a cohort of patients who were previously admitted to a bed who will now have care provision in their usual place of residence.

Likelihood Score	Consequence Score	Overall Risk Score
2	*2*	4

Productivity and Innovation

Consider:
Eliminating waste and inefficiency
Reducing emissions and supporting low carbon pathways
Improved provider performance
Improved care pathways
Promotion of self care

Positive Impact	Neutral Impact	Negative Impact
There is a more efficient and robust staffing model when inpatient beds are centralised on one site. The reduction in police call outs at St George's hospital, compared to those at the George Bryan Centre indicate improved management of crisis and an improved experience for patients. MPFT is an award winning Trust Awards :: Midlands Partnership Foundation Trust (mpft.nhs.uk) who provide excellent patient care at St George's hospital adult mental health wards Innovative Ward Staff Recognised for Excellent Service :: Midlands Partnership Foundation Trust (mpft.nhs.uk) and use innovative ideas to provide a safe environment for patients High tech sensors enhance safety on mental health wards :: Midlands Partnership Foundation Trust (mpft.nhs.uk)		*No negative impact*

Service user involvement in developing the new model of care, which will also encourage promotion of self-care. There have been no untoward incidents/events or complaints relating to the closure of the George Bryan Centre and introduction to the new pathway. Community services are in the process of undergoing a transformation with additional funding, as outlined in the NH Long term plan and the Together We're Better health and care partnership for Staffordshire and Stoke on Trent. Some patients/service users have stated that they prefer St. George's due to the fact that they have access to walks such as going into Stafford Town. Have arts and crafts and a wider range of activities that were not available at the George Bryan Centre.		
Mitigation: for negative impact (include score below)		
Likelihood Score	Consequence Score	Overall Risk Score
2	*1*	2
Prevention **Consider:** ***promoting people to stay well*** ***promoting self-care for long term conditions*** ***reduction of health inequalities*** ***prevention of people dying prematurely***		
Positive Impact	**Neutral Impact**	**Negative Impact**
Community services are in the process of undergoing a transformation with additional funding, as outlined in the NHS Long term plan https://www.longtermplan.nhs.uk/ and the Together we're Better health and care		

partnership for Staffordshire and Stoke on Trent. The enhanced community offer described above aligns with the strategic direction for more community-based care.https://www.twbstaffsandstoke.org.uk/about-us/our-work/mental-health Provision of care in the community by a small team provides more consistent care for an individual, as evidence demonstrates the negative impact of hospitalisations, particularly for the cohort of patients with confusion/ dementia. Community teams caring for patients in their usual place of residence would also be far more likely to involve carers / family present when attending, therefore could act on concerns from carers/ family before crisis reached. MPFT have said the most common reason for admission to an inpatient bed is carer breakdown. Patients who were admitted to inpatient beds at the George Bryan Centre were lower acuity (less seriously ill) than those who can be admitted to St Georges Hospital. This cohort of patients can be safely cared for in the community with an enhanced offer. This community offer provides care in the most realistic environment, the usual place of residence, to give patients/carers the tools to maintain home circumstances that allow them to remain safe at home and to access appropriate local community support. Of all the people from six South/South East council districts who required an inpatient admission when the George Bryan Centre was open, just 25% were admitted to the George Bryan Centre. This is likely due to the acuity of the illness and George Bryan Centre not being the best place for their assessment and treatment. As referenced earlier, there has been a reduction in police call outs, indicating that St George's hospital is able to provide more comprehensive and consistent care for higher acuity patients; reducing the need for disruptive transfers.		*No negative impact identified*
Mitigation: for negative impact (include score below)		

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Likelihood Score	Consequence Score	Overall Risk Score
2	1	2

Operational Impact

Consider:
Staff having relevant capability, skills and knowledge
Impact on violence/aggression experienced by patients or staff
Impact on targets such as waiting times
Staff engagement
Staff terms of conditions, base change, role change
Potential impact on other services / stakeholders such as primary care

Positive Impact	Neutral Impact	Negative Impact
MPFT's priority following the fire was to redeploy staff into suitable alternative posts. Some staff filled roles within community teams (as part of increasing the enhanced community offer). The re-deployment had taken into account individuals' skills, experience and location. Where possible and appropriate some staff have been relocated to Stafford with mileage protection in accordance with Agenda for Change. For any staff displaced, redeployment has been sought within the Trust. Although this cannot be guaranteed no redundancies are	There is less bed capacity in the system, however, evidence show that the cohort of older adults with dementia are better cared for in their usual place of residence. The community mental health team has been enhanced to provide this care. The beds are still available for patients with serious mental illness that cannot safely be managed in the community. .	**Travel** Once mileage protection expires there will be an increase in cost for those staff who transferred to St. Georges. This will continue to be reviewed in line with Agenda for Change terms and conditions. Most staff who worked at the GBC actually live closer to Stafford than Tamworth, therefore there is only a negative impact for a very small number of staff. Due to the cost-of-living crisis, MPFT are working to support people with enhanced payments and will review this on a case by case basis.

anticipated as a result of this proposal. There are no foreseen TUPE transfers as a result of this proposal. **Redeployment process** Staff were involved throughout the redeployment process and were enabled to choose which post they wished to move to. There are both East and West Staffordshire based services in the new pathway and staff were able to state a preference between inpatient and community settings. All West and East staff have been redeployed following the fire. During Quality Assurance visits, CCG colleagues have had the opportunity to speak to some of the staff who were transitioned into posts in Staffordshire and they reported that the outcome was extremely positive -they felt safer, more secure and supported in their new working environment. **Staff cover for illness** With more staff and a wider skill mix, it is easier at St George's Hospital to provide cover across different areas when colleagues are unwell.		

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Staff supported Staff more supported to successfully deal with patients in crisis- evidenced by police call out data. There is Consultant support on site at all times.		
Mitigation: for negative impact (include score below) Additional wards have been made available at St. Georges Hospital. Staff have been given excess travel costs to cover the additional mileage.		
Likelihood Score	Consequence Score	Overall Risk Score
2	2	4

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Staffordshire mental health inpatient access modelling

Quantifying the impact of proposals for community mental health inpatient services

Final report_v5_2022-05-06

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Background

Provision of community and non-acute services across Staffordshire are changing. Some of these are planned changes; some are as a result of measures introduced during the covid-19 pandemic and others, like this, are as a result of exceptional circumstances – a destructive fire.

In 2019 the George Bryan hospital wards on the Sir Robert Peel hospital site were destroyed or made hazardous by fire, were closed to patients and demolished where unsafe.

Since the fire and closure, the vast majority of patients requiring inpatient services have been admitted to wards at St. Georges (Stafford), Harplands (Stoke-on-Trent) or Redwoods (Shrewsbury) hospitals.

The system now wishes to understand better the potential implications of not re-instating a replacement inpatient unit on George Bryan site.

This report utilises activity data and travel times data to assess the potential impacts on access for this proposed change.

Methods for modelling journey times, activity data and other assumptions

We calculated journey times using the TRACC software and OS Highways integrated road networks alongside TrafficMaster [2] road speeds data for variable day and time periods of travel.

Public transport journeys are calculated using the most recent public transport schedules from the national PT dataset repository covering bus, train, coach and metro (where applicable). Walking to/from and in-between stops will use the road network and average walk-speed assumption of 4.8km per hour (3 miles per hour).

Using the output area* of patients' home address, we will ascertain the 'actual' travel times by private vehicle or public transport to the destination of treatment.

Modelled journeys to all other candidate destinations will be calculated using the same methodology and the nearest alternative chosen for the purpose of this analysis.

For mental health inpatient services we are assuming, based on previous survey work, that Public Transport is not a feasible choice for mode of travel for admitted patients, though maybe for others who wish to visit them during their stay.

* Output areas (OA's) are a static statistical geography covering an average 300 people of all ages. We will use individual postcodes weighted by the number of households to derive the average OA travel time against which to match patients' home OA from activity data (unit postcodes are not available to secondary users of healthcare data).

[2] The TRACC software, Trafficmaster and NPTDR data products are purchased under license from Basemap. https://www.basemap.co.uk/

As agreed with the client, the following modes of transport, days and time periods will be calculated and therefore summarised in the analysis for each element of care:

	Weekday AM peak	Weekday inter-peak	Weekend day
Car / Van	●	●	●
Public Transport	●	●	●

TrafficMaster (TM) GPS data defines travel periods as:

AM peak = 07:00 to 10:00

Inter-peak = 10:00 to 16:00

Weekend day = 10:00 to 16:00

For public transport, a start and end time window are required by TRACC software to ascertain accessibility. The same time windows defined by TM for cars above will be used for consistency.

Patient transfers or ambulance conveyances have not been explicitly analysed for this work, though some assumptions are given in the additional considerations section at the end of the report. A general assumption could be made that any blue light conveyances would be at the most favourable of our car travel windows though there is no hard evidence to support this.

Activity data inclusion criteria

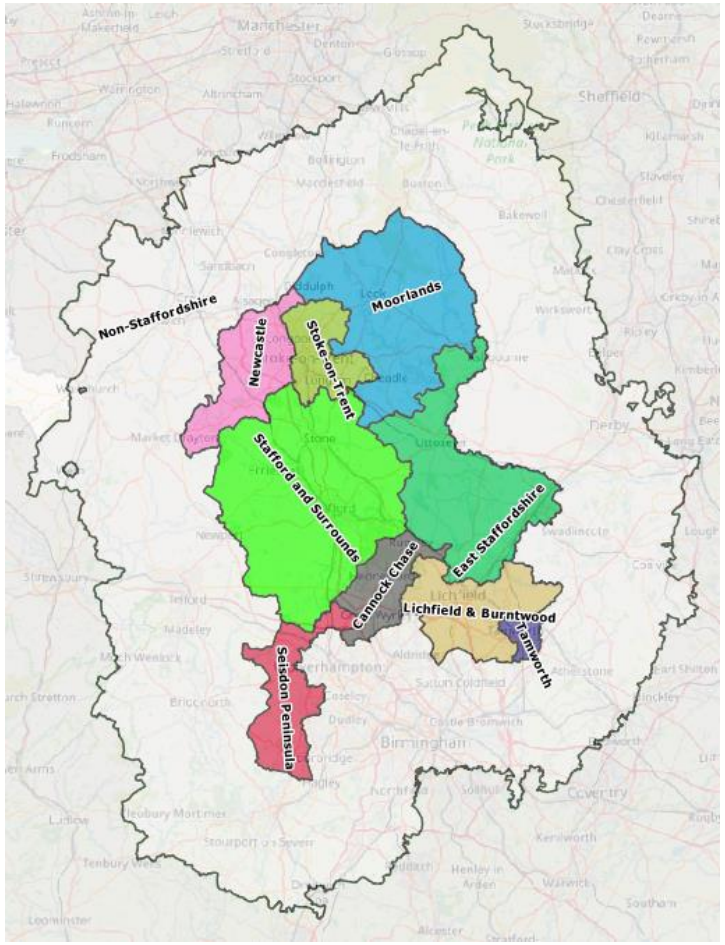
Admissions of adult patients (aged 18+) from 6 local authority district areas to wards with security level = 0 at St. George's (excluding Kinver and Mother & Baby Units), Redwoods and Harplands Hospital in the 24 months after closure have been included to assess the potential impacts on those patients of not re-opening a George Bryan site.

The rationale for exclusion of older adult patients is that the extended community mental health offer is intended to fully support them. Additionally, all future Dementia patient admissions would occur at St George's and not be an option for any new George Bryan unit replacement.

Additional notes and area of interest

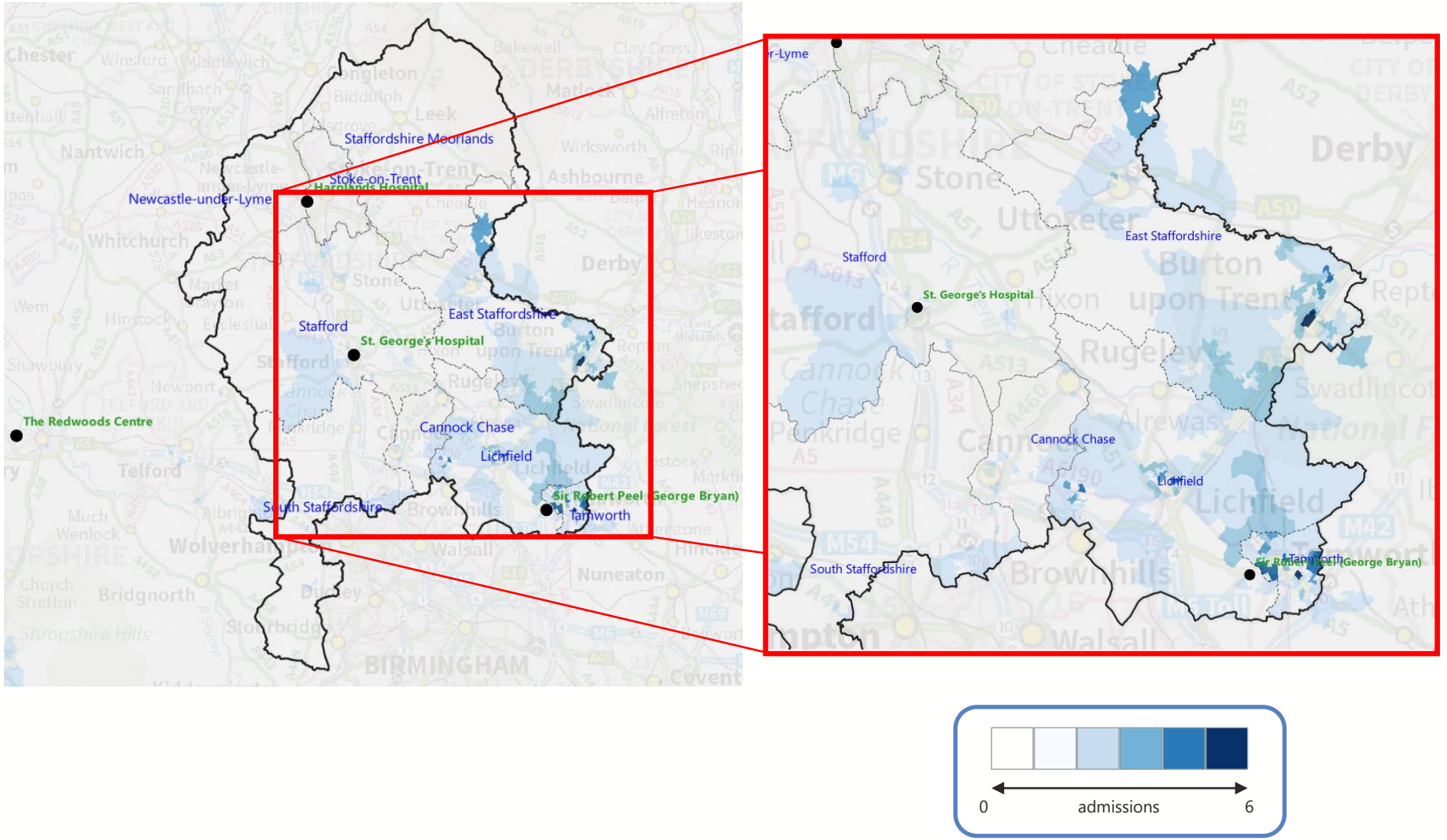
There are no data collected on mode of transport to inpatient settings in routine health and care data nor of any arrangements for visitors. As such, we will analyse all patient admissions by both modes from the output area of their usual residence to give a sense of relative impacts should either car or public transport be used.

The initial calculations cover 68,786 postcodes which were averaged to 9,689 output areas (OA) for matching with the lowest level of locality offered in the routine datasets.



Our travel time data covers the Staffordshire and Stoke-on-Trent STP area and a surrounding buffer of 10 miles although the 3 districts in the North (Newcastle-Under-Lyme, Stoke-on-Trent and Moorlands) are excluded from our analysis as outside of the pre-fire George Bryan catchment.

Home location of patients admitted to GB in 12 months pre-fire



There are a few hotspots or clusters where admissions came from in slightly higher volumes than other areas (all are small numbers < 7):

- Tamworth (Fazeley and Polesworth)
- Burton-on-Trent
- Lichfield
- Burntwood

A small number of patients appear to travel from further afield (Uttoxeter and Stafford). These may be due to bed availability and / or other clinical needs.

Assigning recent admissions to George Bryan for modelling

Before the fire forced closure of the unit, 24.9% of the total admissions from the 6 surrounding district areas went to George Bryan making up 95% of all admissions to the unit/s. Inversely, 75% of patients were already using other units.

To recreate that patient flow 'behaviour' and therefore measure potential impact for a set of patients we have assigned the subset of each district's admissions that is closest to George Bryan according to the volumes opposite.

The assumption therefore is that these suitable patients would have been admitted to George Bryan and there would be bed capacity at the unit to take them at the time of admission.

Tamworth – 51.5%
Lichfield – 47.1%
East Staffordshire – 44.2%
South Staffordshire – 10.4%
Stafford – 8.2%
Cannock Chase – 7.8%

For the period covering 2 years after the complete closure of the Unit, this equates to 173 non-transfer admissions.

An alternative method of assigning patients on a purely random basis within localities will likely produce spurious results as proximity tends to be a strong factor in bed assignment.

Overview of inpatients post-closure 'assigned' and pre-closure

There were 789 non-secure mental health inpatient admissions to St. George's (Stafford), Redwoods (Shrewsbury) or Harplands (Stoke) sites from the 6 Local Authority District areas in the 2 years after the fire, excluding activity that would not equate to services at George Bryan (e.g. Mother and Baby, Eating Disorders, Older Adults).

The socio-demographic make up of those patient that may have gone to George Bryan in the post-fire period is similar to those that used it prior to the closure, although with slightly higher levels of adults and females. Geographically, the groups are quite different which may reflect some changes in case-mix post fire.

	Pre-closure @ George Bryan		**Post-closure 'assigned' to GB**	
Variable	**% of activity**	**Avg. LoS**	**% of activity**	**Avg. LoS**
Gender - Male	57.8%	45.9	49.7%	52.7
Gender - Female	42.2%	51.7	50.2%	40.7
Age – CYP*	0.6%	0.0	0.9%	13.0
Age – Adults	**73.4%**	**48.4**	**78%**	**46.7**
Age – Older adults*	25.9%	285.4	21.6%	48.0
Cannock Chase	4.3%	12.0	16.6%	110.0
East Staffordshire	28.4%	79.7	18.4%	36.3
Lichfield	19.0%	25.2	15.2%	34.4
South Staffordshire	6.0%	13.4	13.6%	53.5
Stafford	7.8%	20.3	25.6%	47.7
Tamworth	27.6%	57.7	10.6%	66.0

* CYP and older adults included in this table for completeness, all other data and travel time analysis relates to working age adults only

	Pre-closure @ George Bryan		Post-closure 'assigned' to GB	
Variable	**% of activity**	**Avg. LoS**	**% of activity**	**Avg. LoS**
White - British	85.4%	48.5	81.5%	45.3
White - Irish	0.0%	-	0.9%	31.0
White - Any other White background	1.9%	53.7	2.5%	53.3
Mixed - White and Black Caribbean	0.6%	10.0	0.5%	12.0
Mixed - Any other mixed background	0.6%	62.0	0.5%	92.0
Asian or Asian British - Indian	0.6%	222.0	0.1%	-
Asian or Asian British - Pakistani	1.9%	7.0	0.9%	91.3
Asian or Asian British - Any other Asian background	0.6%	130.0	1.1%	125.7
Black or Black British - Caribbean	1.3%	20.2	0.8%	-
Black or Black British - African	0.0%	-	0.3%	28.0
Other Ethnic Groups - Any other ethnic group	0.6%	34.5	0.4%	9.0
Not stated/unknown	5.1%	48.4	10.5%	30.0

	Pre-closure @ George Bryan		Post-closure 'assigned' to GB	
Variable	**% of activity**	**Avg. LoS**	**% of activity**	**Avg. LoS**
IMD1 – most deprived	19.0%	32.3	17.6%	49.2
IMD2	20.7%	67.8	23.6%	67.0
IMD3	27.6%	45.1	20.7%	27.4
IMD4	18.1%	28.8	22.2%	37.2
IMD5 – least deprived	14.7%	72.2	16%	45.6

Whilst there are within-group differences in length of stay across the two time periods, these are likely due to variation in case mix. The overall length of stay for working-age adults – the comparable admissions – are very similar pre and post-fire for our modelled / assigned population.

Whole population access to sites

The following series of maps demonstrate the overall geographical (therefore population) effects on access by having or not having a George Bryan location on both car travel and public transport.

Residents of Tamworth, Lichfield and East Staffordshire will be further from an inpatient site if travelling by car. Residents from the Northern half of the county and the Seisdon peninsula will not see any changes in terms of access. Indirectly, they may however benefit from increased availability of beds at St. George's and Harplands if there are other facilities offered to residents from the South East of the county.

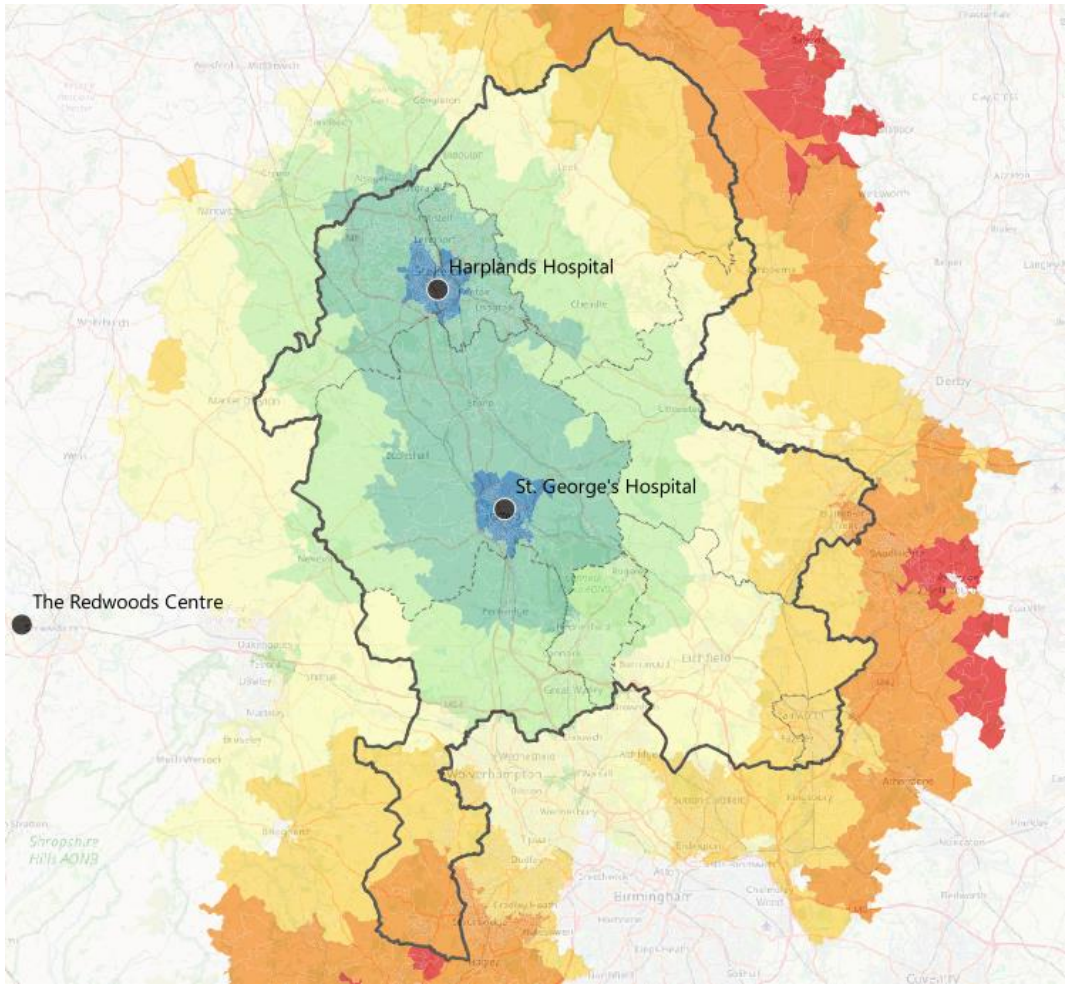
Given current public transport routes and schedules, there will only be a small geographical area for whom public transport access will be improved by re-instating a facility at the George Bryan site. This affects mainly Lichfield and Tamworth.

Some patients that previously would have admitted to George Bryan will be nearer to care.

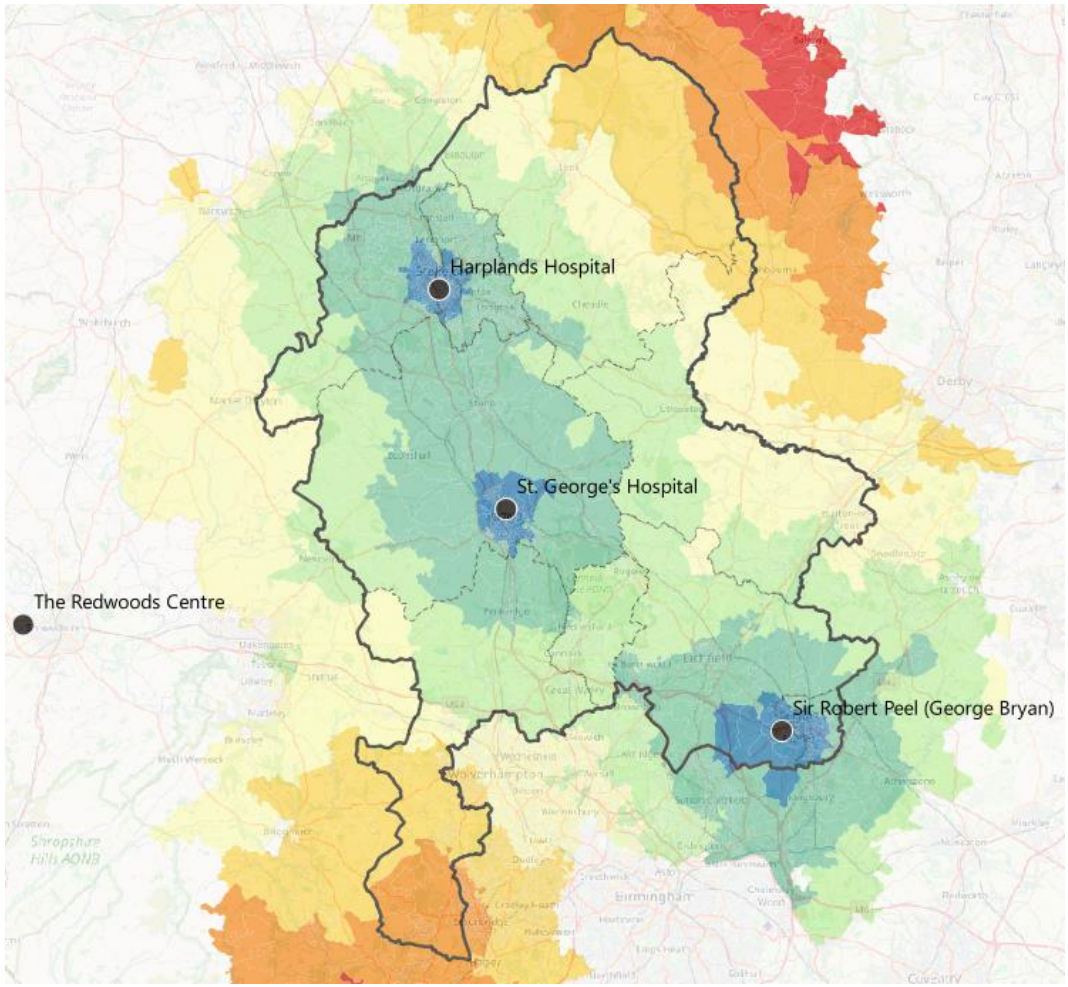
In general, public transport access to inpatient mental health facilities is poor with large areas being an hour or more away and some areas having no access at all.

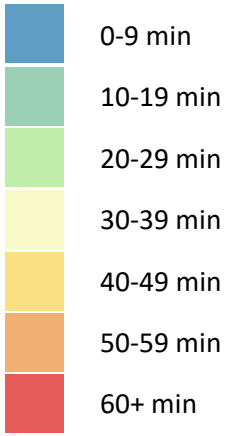
Car travel, peak weekdays

Current configuration



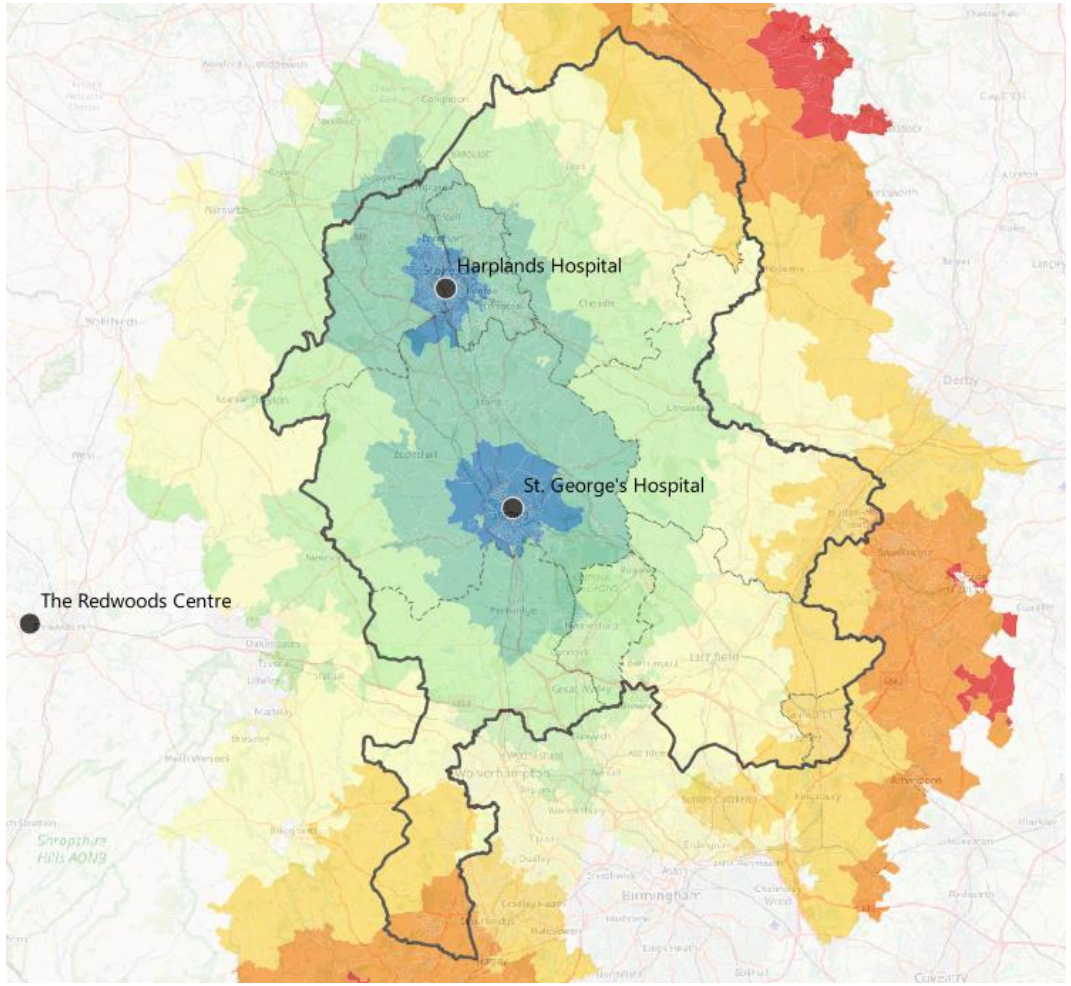
If George Bryan centre open



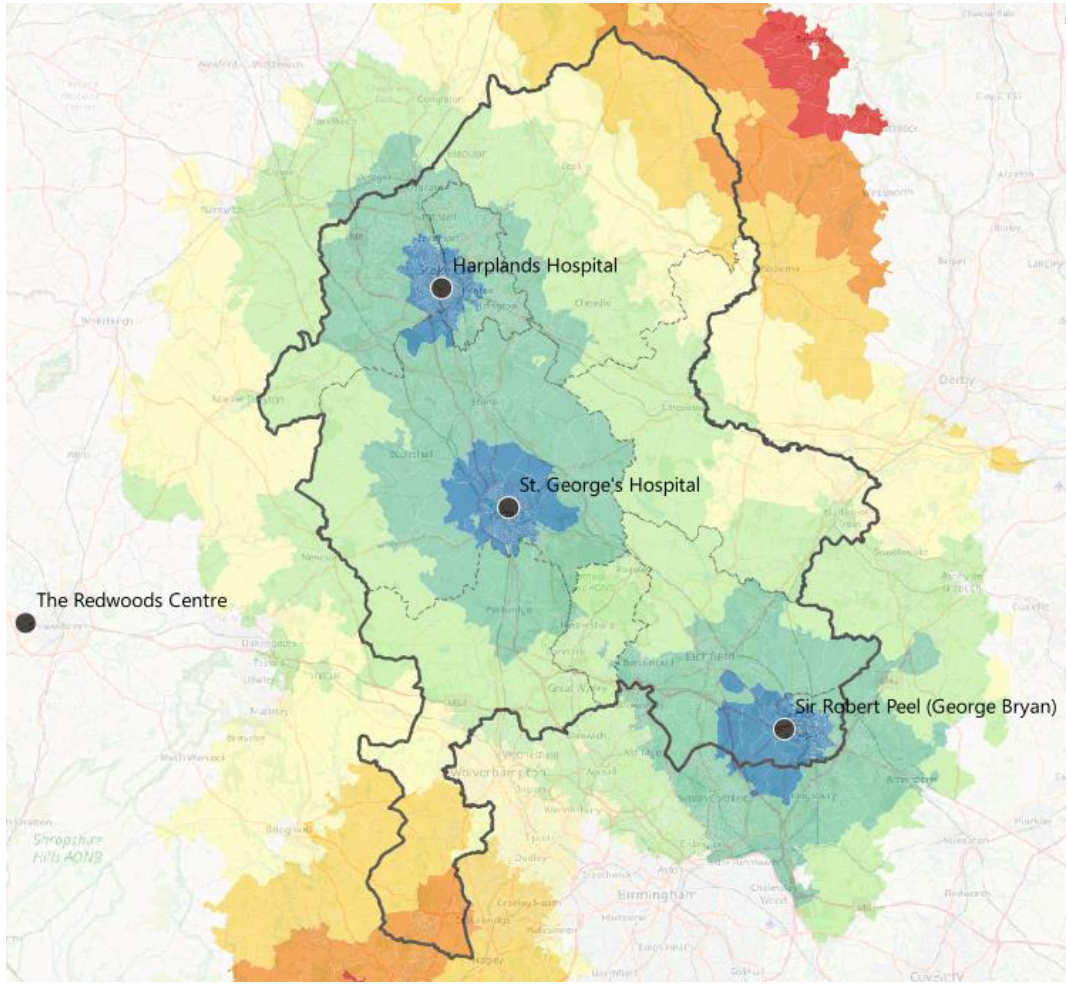


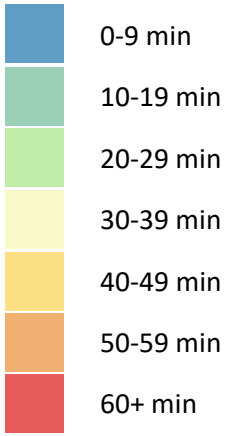
Car travel, weekends

Current configuration



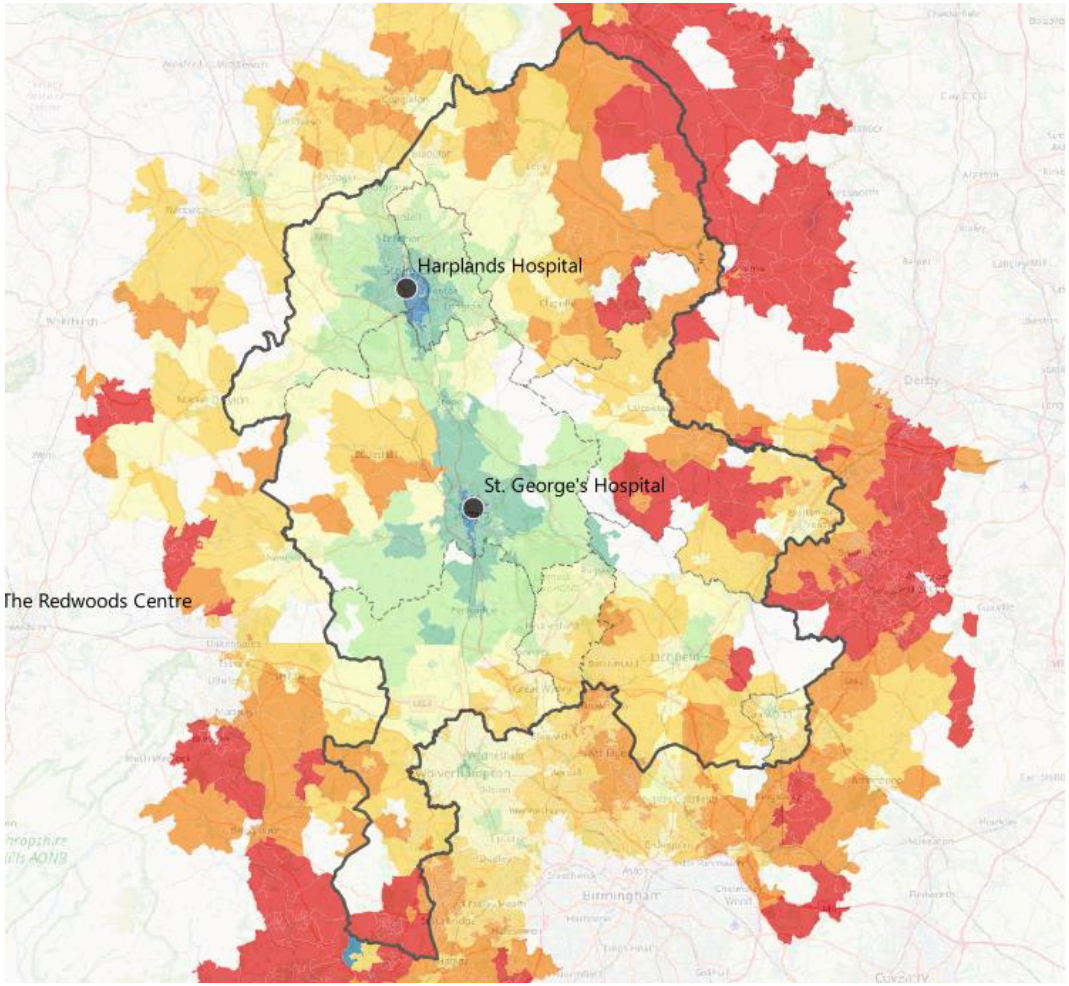
If George Bryan centre open



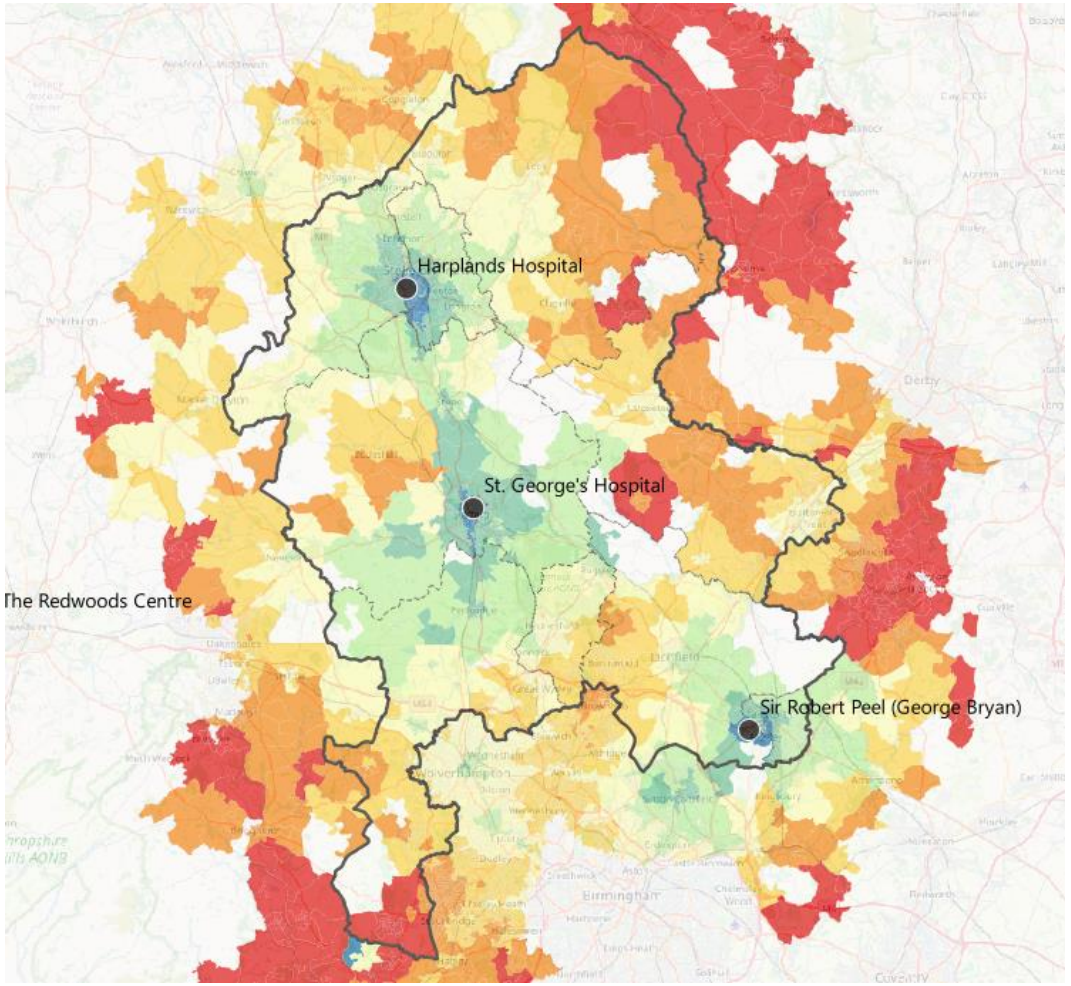


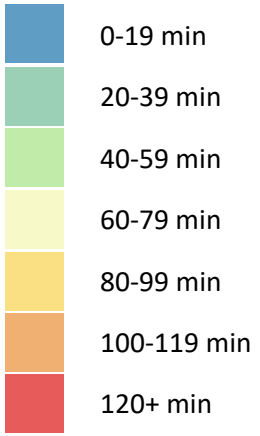
Public Transport travel, weekdays

Current configuration



If George Bryan centre open





Results

Overall access

The baseline scenario refers to the subset of patients from the 6 LA districts admitted post-closure and their estimated travel times to George Bryan based on home location and site of admission.

The times of their actual journeys to an inpatient unit at St George's, Harplands or Redwood can then be compared to see if shorter or longer.

There would likely be some worsening in access taking the whole population into account, however focus on the geographical areas most likely to be impacted suggest significant increases in travel times for them.

Average travel times (minutes) by scenario

	Scenario	Admissions	Weekday peak	Weekend	Public Transport (WD)
All admission	Baseline	789	26.6	24.8	68.3
	Keep GB closed		31.2	29.1	70.8
	difference		+4.6	+4.3	+2.5
Subset assigned to GB	Baseline	173	20.2	19.7	63.1
	Keep GB closed		41.1	38.7	74.5
	difference		+20.9	+19.7	+11.4

Overall access – key findings for sub-groups (car travel)

- Male residents could suffer significantly more from continued closure of George Bryan, in terms of additional and absolute travel times.
- All minority ethnic groups with the exception of White-Irish will have slightly smaller increases in travel time than the white population. Though the numbers of admissions from these groups are all very small.
- Patients from all IMD deciles will have experienced longer travel with no George Bryan unit. Those living in middle quantile areas (average deprived) will have the greatest sustained increases and those in quantile 2 areas (more deprived) the least impacts on travel.
- Unsurprisingly, patients living in Tamworth and Lichfield will have the greatest impacts on travel if George Bryan remains closed. A number of patients from Stafford area may have to travel less if St George's is the default option.

Overall access – key findings for sub-groups (public transport)

- Male public transport users could suffer significantly more from continued closure of George Bryan on the assumption these admissions are representative.
- There are very few admissions from diverse ethnic groups and the variation in public transport provision would seem to affect mixed groups and black groups less than the white population.
- Patients from the middle IMD quantile will suffer the most journey time increases by public transport if current provision persists. Those living in quantile 2 areas (more deprived) and using public transport appear to benefit on the whole from George Bryan being closed.
- Those patients and visitors from Stafford, Cannock Chase and South Staffs who would have admitted to George Bryan site benefit most from the current inpatient arrangements. Patients or visitors from Tamworth and Lichfield would spend an extra 30-45 minutes on buses or trains.

Access impacts by sub-group - gender

Car – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
Male	87	53	19.7	44.3	+24.6
Female	86	41	20.7	37.8	+17.1
Not stated	-	-	-	-	-

Public transport – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
Male	87	53	60.1	82.4	+22.4
Female	86	41	66.2	66.5	+0.3
Not stated	-	-	-	-	-

Car – weekend:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
Male	87	53	18.5	41.7	+23.2
Female	86	41	19.6	35.7	+16.1
Not stated	-	-	-	-	-

Access impacts by sub-group – ethnic group

Car – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
White - British	137	45	18.8	40.3	+21.5
White - Irish	2	31	6.6	56.2	+49.6
White - Any other White background	8	53	26.2	45.8	+19.6
Mixed - White and Black Caribbean	1	12	32.6	9.5	-23.1
Mixed - Any other mixed background	2	92	27.2	45.8	+18.5
Asian or Asian British - Indian	-	-			
Asian or Asian British - Pakistani	4	91	31.0	49.3	+18.3
Asian or Asian British - Any other Asian background	3	126	31.0	49.5	+18.5
Black or Black British - Caribbean	-	-			
Black or Black British - African	2	28	30.3	48.9	+18.6
Other Ethnic Groups - Any other ethnic group	1	9	30.9	47.5	+16.7

Car – weekend:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
White - British	137	45	17.8	37.9	+20.1
White - Irish	2	31	6.9	53.0	+46.1
White - Any other White background	8	53	24.1	43.4	+19.4
Mixed - White and Black Caribbean	1	12	31.8	8.5	-23.3
Mixed - Any other mixed background	2	92	24.8	44.0	+19.2
Asian or Asian British - Indian	-	-			
Asian or Asian British - Pakistani	4	91	28.3	45.6	+17.3
Asian or Asian British - Any other Asian background	3	126	28.5	46.4	+17.9
Black or Black British - Caribbean	-	-			
Black or Black British - African	2	28	27.6	46.7	+19.1
Other Ethnic Groups - Any other ethnic group	1	9	28.0	44.0	+16.0

Access impacts by sub-group – ethnic group

Public transport – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
White - British	137	45	62.0	74.3	+12.3
White - Irish	2	31	20.1	111.5	+91.3
White - Any other White background	8	53	65.5	72.5	+7.0
Mixed - White and Black Caribbean	1	12	101.4	20.2	-81.2
Mixed - Any other mixed background	2	92	92.5	74.7	-17.8
Asian or Asian British - Indian	-	-			
Asian or Asian British - Pakistani	4	91	68.0	88.1	+20.1
Asian or Asian British - Any other Asian background	3	126	62.9	76.3	+13.4
Black or Black British - Caribbean	-	-			
Black or Black British - African	2	28	75.3	70.7	-4.7
Other Ethnic Groups - Any other ethnic group	1	9	72.7	85.6	+12.9

Access impacts by sub-group – deprivation quintiles

Car – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
1 (most deprived)	52	49	24.6	43.7	+19.1
2	44	67	21.1	37.9	+16.8
3	37	27	16.7	43.9	+27.3
4	31	37	17.0	38.8	+21.8
5 (least deprived)	9	46	16.0	37.5	+21.5

Public transport – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
1 (most deprived)	52	49	60.9	72.0	+11.1
2	44	67	69.8	66.0	-3.8
3	37	27	57.5	87.7	+30.2
4	31	37	65.6	77.0	+11.4
5 (least deprived)	9	46	57.6	68.3	+10.7

Car – weekend:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
1 (most deprived)	52	49	23.1	41.0	+18.0
2	44	67	20.1	35.9	+15.9
3	37	27	15.9	41.3	+25.4
4	31	37	15.9	36.6	+20.7
5 (least deprived)	9	46	15.0	35.6	+20.6

Access impacts by sub-group – local authority districts

Car – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
Cannock Chase	5	110	21.1	25.0	+3.9
East Staffordshire	58	36	30.4	49.5	+19.1
Lichfield	46	34	13.8	40.4	+26.7
South Staffordshire	4	54	22.1	31.1	+9.0
Stafford	18	48	31.8	11.9	-19.9
Tamworth	42	66	8.0	45.6	+37.6

Car – weekend:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
Cannock Chase	5	110	20.3	23.0	+2.7
East Staffordshire	58	36	27.8	46.5	+18.7
Lichfield	46	34	12.9	37.9	+25.0
South Staffordshire	4	54	21.3	28.8	+7.5
Stafford	18	48	31.1	11.2	-19.9
Tamworth	42	66	8.2	43.4	+35.2

Public transport – weekday:

Group	Admissions	Avg. LoS (days)	Modelled time (m)	Actual time (m)	Difference (m)
Cannock Chase	5	110	126.4	68.2	-58.2
East Staffordshire	58	36	74.2	83.0	+8.8
Lichfield	46	34	50.7	80.1	+29.4
South Staffordshire	4	54	119.8	90.1	-29.7
Stafford	18	48	105.2	27.4	-77.8
Tamworth	42	66	30.4	76.2	+45.8

Additional considerations

Transfers:

- Given there are effectively fewer inpatient units without George Bryan there will likely be fewer transfers for specialist day care or for local repatriation. This may mean some patients are in beds further from home but fewer disruptive transfers will occur.
- Transfer would tend to have neutral (access) impacts on individual patients as transport would be via PTS, but could be disruptive and impact on carers or visitors.

Other potential activity to St. Georges:

In the 12 months pre-closure, approximately 5% of admissions to George Bryan came from outside the 6 nearest Staffordshire districts and all those from outside the county itself.

For our post-closure assigned patient group that could equate to a maximum of 9 additional admissions to St. Georges although in likelihood there may be nearer provision in Derbyshire, Birmingham or the Black Country.

Length of stay and visiting:

- The mean length of stay for those ‘assigned’ to George Bryan for our access analysis is 47 days, although this varies between 0 and >365 days
- Although not likely in all instances, family and friends would tend to travel from similar areas to the patients and therefore would benefit or suffer in similar ways in terms of access to their actual admissions sites in Stafford, Stoke or Shrewsbury.

Contact:

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Integrated Care Board

Board meeting in public

Thursday 18 August 2022







Meeting etiquette

- This meeting is being **recorded** and will be made available on our website. Please be aware of being ‘on camera’ during Board meetings. These are public recorded meetings and can be watched live and online indefinitely afterwards
- Turn **your camera off** and **mute your microphone**
- Please ensure your **mobile phone** is on silent
- If you **would like to ask a question,** please wait until the question-and-answer section and **raise your hand**. The Chair will introduce this, and it will be outlined on the agenda
- Please **introduce yourself** before expressing any input or views
- Ask questions, but try not to make statements in the chat
- If you see a question you like, give it a thumbs up

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre







Dr Paul Edmondson-Jones MBE MB ChB MSc FFPH
Chief Medical Officer
Staffordshire and Stoke-on-Trent ICB
18 August 2022

The George Bryan Centre: a recap

Provided inpatient mental health services to people living in Burton upon Trent, Lichfield, Tamworth and the surrounding areas:

- The West Wing had 19 beds for people aged 18 to 65 – for mental health inpatient care
- The East Wing had 12 beds for people aged over 65 – older care / dementia
- Early in 2019, the West Wing was destroyed by fire
- The East Wing was later temporarily closed for safety reasons.





The clinical case for change

New national model of mental health services supports community-based care wherever possible – backed by the clinical evidence

Since 2019, we have enhanced our community mental health services for adults with severe mental illness, with specific support for older adults

Strengths of St George's Hospital in terms of staffing levels, range of specialisms and expertise, range of interventions and therapies

Workforce – ensuring we use our staff appropriately, have a wide skill mix from different professions, and can ensure staff and patient safety

The clinical evidence

Severe mental illness

Treating patients as close to home as possible is better for care and outcomes, with community services at the heart of provision.

(NHS Providers, 2019)

Being in hospital for longer than necessary can make it harder for people to return to normal life.

(Improving acute inpatient psychiatric care for adults in England, 2015)

People living with dementia

Hospital admissions can:

- make the symptoms of dementia worse
- permanently reduce the person's independence
- make it more likely that the patient will be discharged into residential care and/or readmitted to hospital.
- *(Evidence from the Dementia Care Pathway, National Collaborating Centre for Mental Health, 2018)*

Milestone	Date
Listening exercises	Summer/Autumn 2019
Option appraisal process starts	**Autumn 2019**
COVID-19 pandemic: programme paused	March 2020 – August 2021
Sense check involvement with service users/staff	**October 2021**
Technical group of clinicians and staff meets to review feedback	10 December 2021
Public/patient reference group meets to review process	**15 March 2022**
Draft business case developed	April – June 2022
West Midlands Clinical Senate review	**10 June 2022**
MPFT internal governance process	28 June 2022
MPFT Board review business case	**30 June 2022**
Update to Health and Care OSC on process	1 August 2022
Integrated Care Board (ICB) to review business case	**18 August 2022**
NHS England assurance process	September 2022
Working closely with OSC on potential plans for involvement	**Autumn 2022**
ICB to decide whether to proceed with involvement	Autumn 2022
Potential involvement activity	**Autumn 2022**
Analysis of involvement activity	Winter 2022
Develop decision-making business case	**Winter/Spring 2023**

Two proposals were considered

Keep the beds at St George's

- Patients who need inpatient treatment are admitted to St George's Hospital in Stafford. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services
- Distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia.



Provide beds at George Bryan Centre site

- Provide a ward with 18 beds at the George Bryan Centre site. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services
- Distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia.



Recommendations from the technical group

- Each proposal was reviewed in detail by the technical group, made up of clinicians, staff and representative from Healthwatch
- Building on the learning from COVID-19 and the new ways of working
- The group considered the feedback from the sense check involvement activity undertaken in Autumn 2021
- Changing clinical guidance with enhanced community support – means no requirement for dementia beds (12 beds) as people seen at home/in community
- The technical group raised clinical safety and workforce concerns about developing a standalone site
- Recognition of limited numbers of specialist staff and no psychiatric intensive care at a standalone site
- Potential destabilisation of workforce at St George's Hospital if standalone site established
- For these reasons, in December 2021 the technical group recommended there is only one viable proposal. It is not safe to run an inpatient mental health unit with 18 beds as a standalone site, given the clear safety issues of remote service provision

Leaving a single viable proposal

Viable

Keep the beds at St George's Hospital

- Patients who need inpatient treatment are admitted to St George's Hospital in Stafford. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services
- Distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia.

Not viable

Provide beds at George Bryan Centre site

- Provide a ward with 18 beds at the George Bryan Centre site. This is for adults of any age experiencing a severe mental illness or dementia, who need intensive medical supervision and treatment in hospital
- Wherever possible, patients are treated at home, supported by the enhanced community mental health services
- Distinct enhanced services for adults of any age with a severe mental illness and for the population with dementia.

Understanding impact

Potential positive impact

- **National best practice, community care** – leading to fewer admissions helping people stay independent
- **Quality** inpatient mental health care – shorter stays
- **Clinical safety and quality** – 18-bed isolated wards are not sustainable
- **Better care** – patients have timely access to onsite specialist services at St George's Hospital – therapy (arts, speech), forensic mental health
- **Workforce** – a larger site provides cover for staff sickness and better multi-disciplinary working
- **Workforce** – a standalone site would impact on the number of staff available at St George's Hospital
- **Rapid support for crisis** – St George's Hospital has seclusion rooms and low restraint measures, not available at a standalone site.

Potential negative impact – travel

- Travel disadvantage for some families/patients - public transport, rurality, cost
- Providing care in the community could reduce length of stay and need for travel
- Evidence of shorter stays at St George's Hospital
- Successfully used digital technology during COVID-19/ temporary closure

MPFT are exploring:

- Digital solutions for relatives
- A travel policy to make it clear who is eligible for support

Business case development

- Following the technical group, and public reference group in March, MPFT undertook further detailed analysis to inform a comprehensive business case:
  - Workforce
  - Demand and activity
  - Impact analysis – equality and quality
  - Travel analysis
  - Separate financial analysis of both proposals (after clinical recommendations)
- 10 June 2022: The West Midlands Clinical Senate reviewed and supported the clinical case for change, following recommendations
- 30 June 2022: MPFT Board of Directors approved the business case to move to the next stage of development – ICB review. This does not represent a decision to implement the proposal.
- 01 August: MPFT and ICB presented presented the clinical model and business case to the Staffordshire Health Overview and Scrutiny Committee (OSC).

Next steps

Now: Integrated Care Board to review business case – to decide if further work needed / or if ready for NHS England assurance

September 2022: Potential NHS England assurance of business case

Autumn 2022: ICB to decide if further targeted involvement is needed to inform decision making process

Autumn 2022: Potential public, staff and service user involvement activity and analysis

2023: Decision making business case

Action required of the Board

The Integrated Care Board is asked to:

1. The Integrated Care Board is asked if they are assured by the process undertaken by MPFT in developing the business case and proposals to date.

2. The Integrated Care Board is asked if they approve for the business case to be passed to the NHS England assurance process.







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Questions







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Thank you

for attending our Board meeting in public







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Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

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Communications and Involvement Plan



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*NOTE: This document has been prepared to support the Pre-Consultation Business Case for Inpatient Mental Health Services previously provided at the George Bryan Centre. This document is in DRAFT form, setting out **potential activity** in the event further public involvement is required following the completion of the Business Case and the Assurance process.*

This document follows previous communications and engagement (C&E) plans for the inpatient mental health services previously provided by the George Bryan Centre in south east Staffordshire. The contents are subject to discussions following the assurance process – the document sets out two anticipated scenarios and will be updated to reflect the required activity once known.

Background

Following a fire in the West Wing of the George Bryan Centre, Tamworth, in February 2019 – inpatients of the West Wing were transferred to St George's Hospital in Stafford. The decision was also taken by the Midlands Partnership NHS Foundation Trust's (MPFT) Board that the 12 inpatient beds on the East Wing supporting older adults should also be temporarily closed due to clinical safety reasons.

This closure impacts on two services:

- Acute inpatient for functional mental health illness for working age residents (18+) – currently transferred to St George's Hospital in Stafford

- Inpatient beds for older patients (65+) (the majority of which had forms of dementia) – with a primary community model put in place to support their needs. If an inpatient stay were required, they would be transferred to St George's Hospital in Stafford.

It was recognised a long-term solution would need to be identified to provide acute mental health inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia who were previously supported at the George Bryan Centre.

In 2019, MPFT led a listening exercise to understand people's experiences of using the services before the fire occurred. They held five events in south east Staffordshire and received a range of correspondence. More details about this activity are available on the MPFT website.

This listening exercise was also held alongside a larger listening exercise by the Together We're Better Partnership in summer 2019, which gathered views on a range of services including mental health. More details about this activity are available on the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) website.

Information gathered during these activities was considered by MPFT's clinicians and staff to inform the development of proposals for the future of inpatient mental health services formerly provided by the George Bryan Centre.

The programme was paused in March 2020 to allow clinicians and staff to respond to the COVID-19 pandemic. It was restarted in 2021 with a sense-check involvement to understand any new considerations or experiences. The details of this work are available on the dedicated Integrated Care Board (ICB) website page for this programme.

Current position

This plan has been drafted to cover the period **after** the completion of the Business Case and the relevant corresponding governance steps required – it has been prepared in the event that any further formal involvement activity is necessary. Given the uncertainty, this plan includes two potential scenarios:

- Involvement to gather views before a decision is made
- Involvement to share information about a decision, after a decision has been made.

This **draft document** will support planning in the event that further involvement activity may be required to articulate the outputs of the activity since 2019, and to explain the latest position and proposed future of inpatient mental health services previously provided at the George Bryan Centre. Insight from our work in 2021 has identified a need to articulate the wrap-around services and community offer to ensure people are aware of the additional support available.

If required, any further involvement would include the service users, staff, the wider public, and other stakeholders.

Scope of this work

This involvement activity will inform the decision-making about the long-term solution to the inpatient services that have temporarily been suspended at the George Bryan Centre.

We recognise this work has connections with the involvement activity for the Community Mental Health Transformation Programme and the Mental Health Strategy for Staffordshire. Comments received will also be shared with these programmes to support the wider mental health vision.

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Aims and objectives

In the event that further involvement activity to gather views is required, the aims of this would be to:

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the single viable proposal identified through the options appraisal process and wider involvement activity since 2019
- understand views about the Business Case and the technical group's recommendation about the single viable proposal detailed within it
- review the views of the service users, carers, and carer representatives to date to inform our approach to involvement to articulate the current position and the single viable proposal for the future of inpatient mental health services previously provided at the George Bryan Centre
- inform decision-making, by listening to the views of:
    - people involved in the 2019 and 2021/22 engagement activity and others who were not to understand if there is anything new/additional that needs to be considered
    - service users and carers living in south east Staffordshire who have experienced the temporary arrangements between February 2019 and July 2021
    - other stakeholders with views about the provision of mental health services.

We will seek to understand people's views on the proposal, and in particular:

- if there are any ideas we have not considered
- if there is any positive or negative impact we need to plan for if we decide to go ahead with this proposal
- how we can support people if these changes are agreed, including how we can support people with travel.

The objectives of this work will be to gather any further information needed to inform the decision by decision-makers to meet our statutory duties.

In the event that further involvement activity to share information is required, the aims of this would be to:

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and outcome of the involvement activity since 2019 to identify long-term solutions for inpatient mental health services previously provided by the George Bryan Centre
- articulate the current position and the single viable proposal for the future of inpatient mental health services previously provided at the George Bryan Centre
- communicate the future solutions for inpatient mental health services previously provided by the George Bryan Centre.

Ongoing dialogue would continue with service users and other stakeholders through the usual and current channels during service delivery.

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Key messages

- We're committed to an open and transparent dialogue with service users, carers and carer representatives, staff, and partners
- Clinical evidence and best practice shows that a community-led model of mental health is better for the individual than admitting them to hospital
- When an inpatient stay is needed, we want it to be delivered by specialists, as short as possible and focussed on recovery
- We are investing in long-term community mental health services
- This exercise is focused on the services and when this is complete, we will look at the building

Key spokespeople

The following key spokespeople will be media trained and will act as spokespeople for the ICB and MPFT.

Clinical spokespeople:

- Paul Edmondson-Jones, Chief Medical Officer, ICB
- Mental health clinician at MPFT – to be identified.

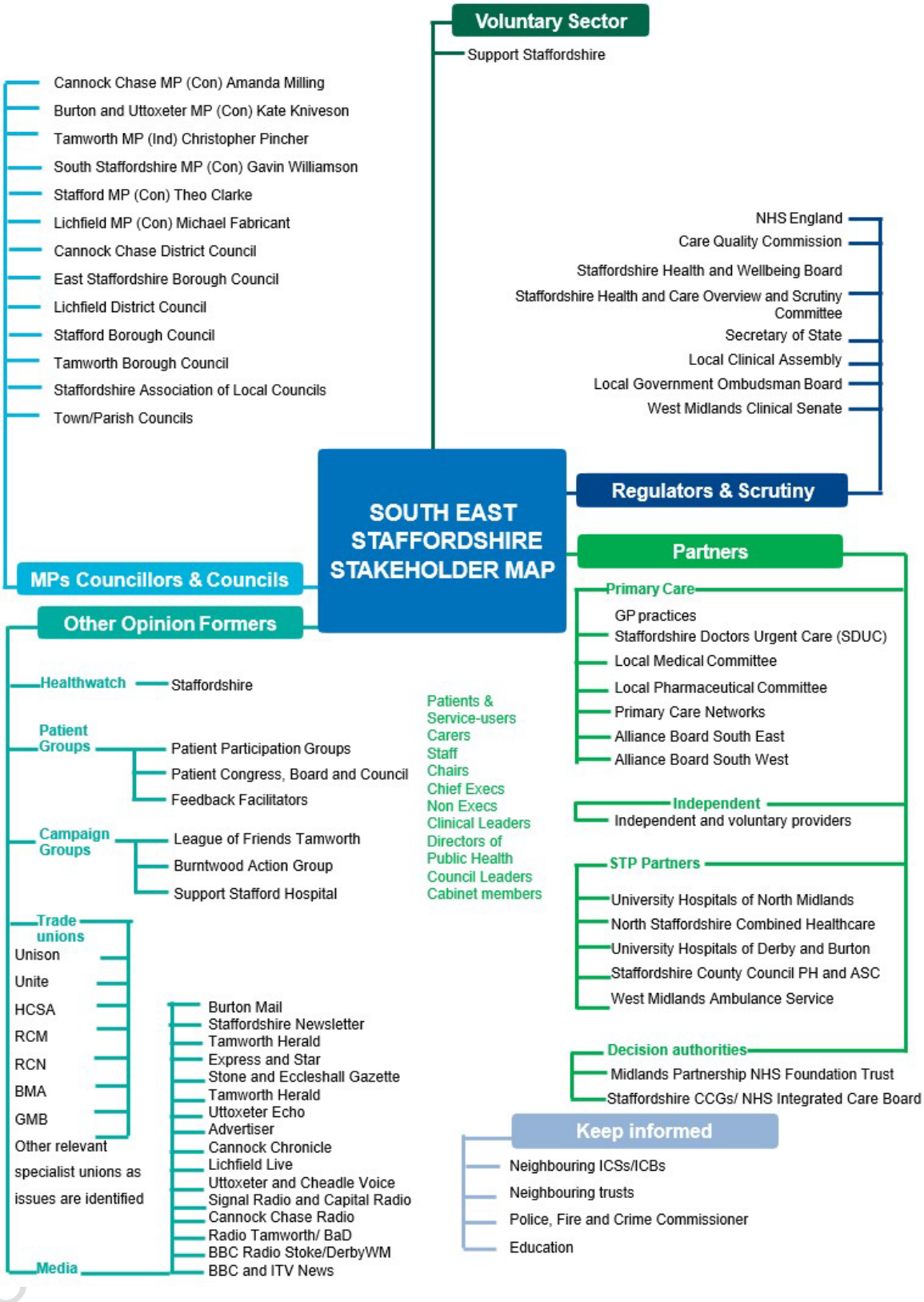
Executive spokespeople:

- Paul Edmondson-Jones, Chief Medical Officer, ICB
- Steve Grange, Deputy Chief Executive, MPFT

Key stakeholders

Our work to map stakeholders has been an iterative process throughout this programme of involvement activity and continues to be so. We have developed a comprehensive database of stakeholders. This is a live stakeholder management system which is updated as details change, and new or additional stakeholders are identified. This is the high-level stakeholder map:

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Approach to involvement

Recognising that this phase follows involvement activity in 2019 and 2021/22, we will seek to build on the relationships already established and previous conversations with stakeholders as well as giving people who have not participated so far, the opportunity to have their say.

We will involve the Staffordshire Health Overview and Scrutiny Committee (OSC) in developing our approach to involvement and information activity in autumn 2022. This plan is an iterative document and sets out our initial thinking, subject to the views of the OSC and the ICB Board.

We have reflected on all previous engagement activity and are recommending a six-week involvement period. We believe this will give sufficient time for people to participate and provide an informed response – but is balanced against the demand on our clinicians during winter and also the potential for 'involvement fatigue'. This timeline is subject to our discussions with the OSC and ICB Board. A midpoint review will guide whether there is a need to undertake more targeted activity with certain groups and whether there is a need to extend this timeline.

Face-to-face activity will be subject to COVID-19 Infection Prevention Control (IPC) requirements to ensure the public safety of staff and public who participate in events and discussions. We will also prepare for a **digital first** approach in the event national guidance or restrictions are in place. Should face-to-face events need to be replaced with online alternatives, this would be communicated at the earliest opportunity.

We would also be looking to launch a range of activities, including but not restricted to:

- **Survey** – To gather views about the proposal and understand if there is anything else that should be taken into consideration. The survey will also allow us to understand any potential impact of the proposal to retain the additional beds at St George's Hospital, Stafford, and the enhanced community-led model. We would also seek to understand if there are any alternative considerations to this proposal that are viable
    - **Traditional responses** – In addition to our online survey, people will be invited to phone our Involvement Team on X or to send a survey to our freepost address (add in) to be received by the closing date. People can request a paper copy of the survey or can request support in completing the survey by phoning X or emailing X
- **Offer a meeting with campaigners/campaign groups** – To seek their views on the proposal, the impacts and the mitigations
- **Online meetings** – Two meetings (one in working hours and one during an evening). These will include a presentation from the ICB and MPFT and a series of breakout sessions to seek views on the proposal
- **Drop-in roadshow events** – These would be face-to-face, subject to any Government guidance and organisational policy in place at the time in relation to COVID-19. Recognising this involvement activity is in the autumn or winter, we believe drop-in events will give the opportunity for face-to-face dialogue but will mitigate any risk of infection transmission. There will be a minimum of four roadshows, in the key towns of Tamworth, Lichfield and Burton, and at least one event each at Sir Robert Peel Hospital and at St. George's Hospital in Stafford. We will review the level of interest in and attendance at these events and organise more if appropriate. In selecting suitable venues, we will seek COVID-19 secure areas and areas of high. They will be promoted through traditional media, digital channels and through stakeholder channels.
- **Break-out rooms** – These would be provided at both face-to-face and online events and meetings to allow space for one-to-one discussions or to support people requiring time away from the main meeting
- **Targeted focus groups/one-to-one interviews** – We recognise that for some seldom heard groups, alternative channels may be needed. We will work closely with Healthwatch and the voluntary sector to identify existing community and voluntary groups that we can attend. These will be detailed in our action plan.

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Provisional timeline

Milestone	Anticipated Date/Timeline
NHS England Assurance Process	November 2022
Update to Staffordshire County Council Health and Care Overview and Scrutiny Committee (status of programme and potential plans for involvement)	January 2023
Integrated Care Board to decide whether to proceed with involvement	January 2023
Potential involvement activity launches	February 2023
Analysis of involvement activity	April- June 2023
Develop decision-making business case	Summer/Autumn 2023

Communication channels

We recognise there is a need to keep people informed throughout this journey to develop a long-term solution for the inpatient mental health services previously provided by the George Bryan Centre. We will use the following channels to keep people informed:

Channel	Stakeholder	Frequency/timeline
Newsletters / intranet / team meetings, and dedicated focus groups	Staff	Monthly
Stakeholder bulletin – using existing bulletins through ICS and MPFT	Partners/other health and care professionals	Monthly
One-to-one virtual briefings/correspondence	MPs/Council Leaders/OSC	As required
Website – the dedicated website page will be updated to provide the latest information about the programme	All (including service users and public	Ongoing
Media – we welcome the support of the media in helping us to deliver balanced information that will support patients to participate and share their	Media/public	At key milestones

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views. We commit to providing regular and timely press releases that are written in plain language and, where appropriate, giving advance notice to reporters. We will launch an ongoing dialogue through the local media, including press releases, social media posts and radio interviews. We will respond to media enquiries in a timely manner, recognising the deadlines that reporters operate within		
Social media – promotion of opportunities to have say.	All	At key milestones
In-depth interviews with representatives or and members of seldom heard groups to gather people's experiences and views as appropriate	Service users / interested public and seldom heard groups (targeted engagement)	Ongoing
Workshops to be organised to gather people's experiences and views (as appropriate)	Service users/ interested public/seldom heard groups	TBC
Survey tool to seek feedback from people who cannot attend events	All	TBC

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Communications and Engagement resources

We are developing a range of resources to support the planned involvement activity. The resources have been planned to support stakeholders who are interested in the subject matter and will be used as required and as appropriate.

Resources include, but are not restricted to:

Public Information Products:

- Integrated consultation document and survey – online. Including videos or animations where applicable

- Printed consultation document and survey. Links to online resources provided to facilitate access to videos/animations etc
- Summary consultation document
- Accessible consultation document and survey.

Promotional Information Products:

- Website content (including the Business Case and a range of case studies and further information)
- Handout flyer for events
- Poster to promote consultation and/or events. To include QR code to facilitate online access to materials. Translated posters to also be prepared
- Videos/animations
- Toolkit to support partners to promote on social media channels
- Press releases and media briefing
- Stakeholder updates (letters, emails and telephone scripts).

Event Products:

- Event registration form
- Event participation form, including demographic profiling questions
- Facilitator briefing notes and note-taking templates for events
- Presentations for deliberative online events
- Presentation for focus groups and voluntary sector events
- Voluntary sector collateral – presentation, facilitator booklet, and copies of printed promotional materials.

Supporting seldom heard groups

An Equality Impact Assessment (EIA) will be produced that outlines the approach to involving seldom heard groups. We will work closely with the ICS' Local Equality Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

We will ensure our communications are accessible by:

- Writing in plain language
- Using visuals (including diagrams, animations and accessible documents)
- Providing access to other languages, other document formats (large print, Braille, etc) and British Sign Language (BSL) interpretation when needed
- Arranging events to be at various times and days of the week to maximise attendance
- Asking people if there are any reasonable adjustments needed when attending virtual events and offering alternative ways for people to share their feedback (for example by phone)
- Providing reasonable adjustment and support, for example using interpreters or offering smaller focus groups with existing networks where appropriate.

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We will build on our relationships with the voluntary and community sector, to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, we will work with trusted advocates, for example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that is approachable and understandable.

Action Plan

The activity set out below is indicative of what would be included in the event future public involvement is required. This is a summary of the key milestones.

Task	Description	Stakeholder	Timeline
TCI review of involvement document	TCI advice on involvement document	TCI	August – September 2022
Business case taken to ICB Board meeting	Approval to go to NHS E assurance	Public meeting	22 September 2022
Internal briefing for staff	West Midlands Clinical Senate Report published	Staff	September 2022
Stakeholder letter including MP briefing	West Midlands Clinical Senate Report published	Stakeholders including MPs/Councillors	October 2022
Press release and offer for proactive interviews	West Midlands Clinical Senate Report published	Media	September 2022
NHS E assurance process	Assurance review meeting	Internal/ regulators	November 2022
User testing of involvement document	Small focus group of service users/clinicians	N/A	November 2022
TCI review of revised draft of involvement document	TCI advice on involvement document	TCI	November 2022
Ongoing development of a toolkit of public resources	See communications and involvement products	N/A	September – January 2022

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Monthly update in ICS newsletter/ internal channels	Regular (monthly update) on programme's progress	All	w/c 26/09/22 and ongoing thereafter as applicable
Health Overview and Scrutiny Committee	Involving the Committee in planning the approach for involvement activity	Scrutiny Committee	17 October 2022 January 2023
ICB Quality and Safety Committee	Update on programme and sharing draft involvement plan	Assurance	9 November 2022
MPFT Board meeting update	Update on programme	Board	27 October 2022
Media release and offer for proactive interviews	Update on the paper to ICB Board	Media	1 week before ICB meeting
Stakeholder update/ website update	Promotion of Board meeting and what will be discussed	Stakeholders including MPs/Councillors	1 week before ICB meeting
ICB Board meeting	Outcome of NHSE assurance and decision on whether to proceed to involvement, including plan and draft involvement document	ICB meeting	January 2023
Stakeholder update/ website update	Post Board update on next steps and potential involvement activity – include save the dates for events	Stakeholders including MPs/Councillors	After the ICB meeting
Media release and offer for proactive interviews	Post Board update on next steps and potential involvement activity – include save the date for events	Media	After the ICB meeting

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Finalise involvement document and materials, finalise events post Board	Final amendments post Board meeting Accessibility checks Printing	N/A	2 weeks after ICB meeting
Offer of phone call to MPs/Council Leaders pre-launch	Update on planned involvement activity	MPs/Council leaders	Week before launch
Website updated	Programme documentation, survey, involvement document, events, animation	All	Day 1
Staff promotion	Internal channels/posters on site	Staff	Day 1
Stakeholder letter	Letter to announce launch of involvement activity and promote ways to participate	All	Day 1
Media release and social media updates	Promotion of ways to participate and information e.g. animation/summary	Media	Day 1
Toolkit for partners	Promotional materials and key messages to cascade information across ICS channels	All	Day 1
Email to voluntary sector groups	Offering attendance at meetings seeking support for promotion	Seldom heard groups	Day 1
GP bulletin	Promotion to GPs through weekly bulletin	GPs	Week 1

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Launch of advertising	Social media adverts to target groups Potential newspaper adverts to promote drop in events	All	Week 1
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 1-2
Meeting with campaign group	Deliberative event to understand any views	Campaign Group	Week 1
Focus group for staff	Promotion of focus group for staff	Staff	Week 2
Existing service user focus group	Dedicated focus group	Service users	Week 2
1st Roadshow drop in event	See approach	All	Week 3
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 3-4
1st Online event	First online event	All	Week 4
2nd Roadshow drop in event	See approach	All	Week 4
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 3-4
Midpoint review	Review of activity at mid-point to understand efficacy of messaging, responses to information and ask of the activity and identification of any further activity which may be required as part of	Internal teams	Week 4

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	the overall action plan		
2nd Online event	See approach	All	Week 5
OSC meeting	Offer for update to OSC through involvement activity	Scrutiny Committee	TBC
3rd Roadshow drop in event	See approach	All	Week 5
4th Roadshow drop in event	See approach	All	Week 6
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 5-6
Staff message	Reminder of deadline for involvement and how to participate	Staff	Week 5
GP bulletin	Reminder of deadline for involvement and how to participate	GPs	Week 5
Press release	Reminder of deadline for involvement and how to participate	Media	Week 5
Stakeholder letter	Reminder of deadline for involvement and how to participate	Stakeholders	Week 5
Closure of survey on website	Website updated to thank people for participating and to explain next steps	Stakeholders	Midnight last day of survey Week 6
Analysis of findings	Report of findings and public summary to be developed to inform decision making process	N/A	Week 7-17 (depending on volume of responses)

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Next steps

A detailed analysis report will be produced by MLCSU on the comments from the involvement activity; this will include a thematic breakdown of comments received and demographic analysis from participants, subject to them sharing this information.

These reports will be shared with the programme team to conscientiously consider the findings to inform the next steps and any decision-making resulting from the findings.

The proposals will be reviewed by the relevant governance routes within MPFT and ICB (with statutory responsibility for decision making). The findings will be shared with the Staffordshire Health Overview and Scrutiny Committee for discussion. The full report of findings and a public summary will be published on our ICB website.

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Appendix one: What people have told us so far

2019 listening exercise:

- Listening exercise paper
- Summary listening exercise paper
- Report of findings
- Summary report of findings
- Public responses on general practice which should be read with the main report of findings.

2019 involvement activity (MPFT):

A series of engagement events took place in 2019 to establish what was good about the services and what needed improving, to help shape the long-term solutions. Feedback could also be submitted by email or by post.

The Board of MPFT received a report detailing the outcomes of the engagement exercise on 30 January 2020.

2021 listening exercise refresh:

- Listening exercise refresh issues paper
- Summary listening exercise refresh paper
- Report of findings
- Summary report of findings
- Reference Group report of findings

Appendix two: Our Communications and Involvement Charter

Our approach to communications and involvement includes:

- **Awareness** – we will provide clear and timely communications that help stakeholders to understand the complex case for change. We will ensure that the people involved have enough information to make an intelligent contribution and input into the discussion and any later process of options development. We will use multiple channels to help a wide range of stakeholders to understand and influence the issues
- **Discussion** – we will actively encourage two-way dialogue to understand the concerns, ideas, and solutions our stakeholders have. Our clinicians and decision makers will be proactively shaping and attending our public events to listen to feedback first-hand. We will utilise the knowledge, experience, and existing networks of patients, third sector and staff champions to involve as many people as reasonably possible
- **Inclusion** – we will support seldom heard groups to actively participate. Our communications will meet recognised accessibility standards and our activities will be designed to reach groups that may find it difficult to take part
- **Clinically-led** – we will listen to our workforce and clinicians as the experts in their field. We recognise how busy they are and will use the latest tools and technology to support

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them to participate in meaningful conversations. Our clinical leaders will encourage their peers to actively participate in clinically led workshops and debates

- **Collaboration and co-creation** – we will work in partnership, facilitating workshops with clinicians, service users and partners to design the right services based on local needs. During the listening exercise phase, we will work to gather information and insight, which we might use later to develop selection criteria
- **Openness and transparency** – we will be open minded and not pre-determine any decisions. We will assure our ICS, Healthwatch and Health Overview and Scrutiny partners, in their essential remit of providing critical challenge. We will provide regular updates and seek their views at every stage of the process
- **Compliance** – we will undertake a robust communications and involvement programme, following the latest best practice and legal guidance. We will adhere to the guidance and statutory duties of the regulators in designing our approach. We will work closely with the Consultation Institute to seek assurance on our approach
- **Feedback** – we will evidence how decision-makers have taken public opinion into account and provide feedback to those consulted.

Appendix four: Version control

Version	4b
Status	Draft
Name of originator / author	Communications and Engagement Team
Name of responsible committee	Transformation Programme Board
Date issued	17 May 2022
Last review	17 June 2022 – signed off by CT
Activity	26 September 2022 refreshed and shared with Programme leads 30 September 2022 26/09/22 Timeline updated following latest meeting with NHS England and shared with Board 09/11/22 Shared with ICB Quality and Safety Committee 10/11/22 Provisional timeline updated
Next review date	Live document
Target audience	Internal with the intention to become a public document

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Integrated Care Board

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

SAMPLE - NOT FOR DISTRIBUTION



Introduction



The NHS in Staffordshire and Stoke-on-Trent has been working with local patients, staff, interested groups and partners to redesign our mental health services.

Our priority is to deliver quality mental healthcare for patients in their own home or community whenever possible, rather than in hospital. This model of care is the national ambition set out in the NHS Long Term Plan. It is based on the latest clinical evidence, which shows that this approach gives the best outcomes for most patients with mental health problems, supporting their wellbeing and independence.

This is not new – we have been working with our partners and investing in our community mental health services for many years. We have enhanced our community teams and built better ways of working that help us meet the national goals – like making community services easier to access and giving people more choice and control over their treatment.

For the small number of patients who do need a hospital stay, we want to make sure that the right specialist staff are on hand to give them the best care.

Thank you to everyone who has joined in these conversations so far. Your contributions have helped us draw up a proposal for improving mental healthcare in the local area. This document sets out that proposal and explains how everyone can have their say.

Our proposal is about where we provide the inpatient (hospital bed) services that were previously provided at the George Bryan Centre. These are services for people living in south east Staffordshire: adults (aged 18–65) with severe mental illness, and older adults (aged 65 and over) with severe mental illness or dementia.

SAMPLE - NOT FOR DISTRIBUTION

Why are we reviewing our local mental health hospital services?

Following national best practice in mental healthcare

Community mental health teams support people in their own homes and communities. They help with different conditions, from mild levels of depression and anxiety to more severe mental illness. They also support older adults with dementia.

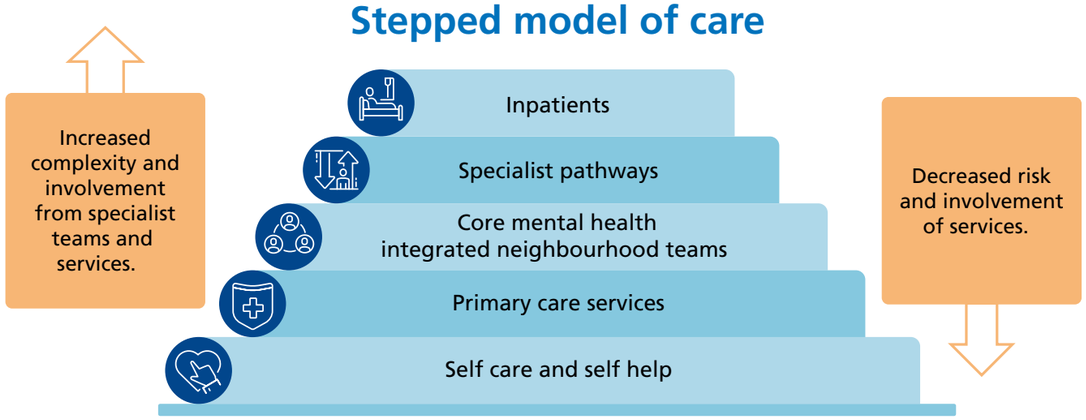
Clinical evidence shows that most patients get the best outcomes (the best experience and the best chance of recovery) if mental healthcare is provided in the community, rather than in a hospital. Getting the right support and treatment, while living in their usual home with loved ones close by, gives people the best chance to recover and stay well.

For older adults with dementia, clinical evidence suggests that hospital stays do not help. Instead, there is a big risk of losing their independence.

You can read some examples of this clinical evidence on **page 9**. You can find out more about the national guidance in 'The Community Mental Health Framework for Adults and Older Adults' (**www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf**), published by the NHS.

Of course, people sometimes become so unwell that they must go to hospital. But the national best practice is that hospital stays should be as short as possible – giving essential treatment and care until patients can safely go home, with continuing support in the community as needed.

The diagram shows our **'stepped model of care'**, with most patients being supported without the need for hospital stays.



Inpatient mental health services for people living in south east Staffordshire

The **George Bryan Centre** provided mental health beds for patients living in Burton upon Trent, Lichfield, Tamworth and the areas around those towns.

- The West Wing had 19 beds for adults aged 18 to 65 with severe mental illness – like mood disorders, psychosis, anxiety and depression
- The East Wing had 12 beds for older people (aged 65 and over) with dementia and/or other mental health problems.

There are different levels of severe mental illness. Although diagnosed with a severe mental illness, the patients who stayed at the George Bryan Centre usually had low-risk or less complex needs. Just one in four mental health patients from the district areas around the George Bryan Centre went there if they needed a stay in hospital.

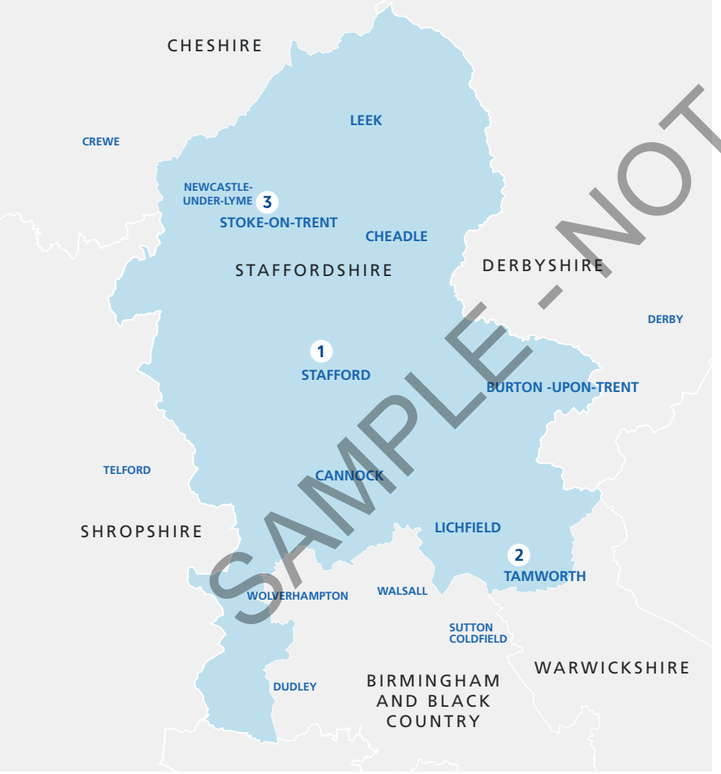
More seriously ill patients were admitted to **St George's Hospital** in Stafford, or other specialist settings. Sometimes, patients who were being cared for at the George Bryan Centre had to be transferred to St George's Hospital because it was better able to meet their needs.

In February 2019, a fire destroyed the West Wing of the George Bryan Centre. The patients in the West Wing were moved to St George's Hospital.

The board of Midlands Partnership NHS Foundation Trust (MPFT), which operated the George Bryan Centre, decided to temporarily close the East Wing, for safety reasons. Although the Sir Robert Peel Community Hospital was next door to the George Bryan Centre, it is not a mental health hospital, and so could not offer support.

Local inpatient mental health services

1. St George's Hospital (adults and specialist), Stafford
2. George Bryan Centre (adults and older adults), Tamworth
3. Harplands Hospital (adults), Stoke-on-Trent (serves North Staffordshire and Stoke-on-Trent)



SAMPLE - NOT FOR DISTRIBUTION

How have patients from the area been looked after since the temporary closure?

Since the George Bryan Centre temporarily closed, most of the patients from south east Staffordshire **who need a hospital stay** have been admitted to St George's Hospital in Stafford, with a small number going to different hospitals further away.

St George's Hospital is a specialist mental health hospital. Its facilities include a **psychiatric intensive care unit** for male patients. A range of specialist teams look after patients with eating disorders, and women with severe mental health problems linked to pregnancy and childbirth.

St George's Hospital has 168 beds in total. 84 are for adults with severe mental illness, and the rest are in the specialist wards.

When the George Bryan Centre patients were transferred to St George's Hospital in 2019, they moved into a ward that was kept for use during peaks in demand, like winter. Since then, this ward has been refurbished and provides 18 mental health beds.

Over the last three years, we have been investing in our local community mental health services and improving them – so they can offer earlier, more flexible support for patients **who do not need a hospital stay**.





We have been strengthening our services to provide better support for people experiencing crisis. As one example, we are opening a **crisis café** in Tamworth in spring 2023. This will support people in crisis with advice, information on the services that they can use, and a safe space with emotional support.

Our community mental health teams work closely with primary care (GPs), council staff (like social workers) and voluntary sector providers who are experts on particular issues – like drug and alcohol abuse, housing, or finance. We know that mental illness can be impacted by other problems in people's lives, from physical illnesses to money worries. By having our mental health teams work with these other services, we can offer more meaningful care that 'wraps around' a patient's needs.

Our **enhanced community services** mean that most patients who would previously have stayed at the George Bryan Centre can now be supported in the community, which is better for their long-term wellbeing and independence.

What is our proposal?

For a number of years, our mental health clinicians and staff have been working to find a long-term solution for the services that were based at the George Bryan Centre.

We have involved patients and carers, staff, mental health clinicians and the public throughout this journey. We have considered the findings from the public involvement, along with clinical evidence, while developing our proposal.

You can read in more detail about the process we have followed in developing the proposals and involving the public, starting on page 26.

Listening to your feedback, we have also looked at any potential impacts if we make the temporary changes permanent. We considered our workforce, clinical safety, health inequalities (fair care), and travelling times for family and carers.

We are recommending that there is one **viable** (realistic and achievable) proposal, which is to make permanent the changes we made in 2019.

In this consultation document, we explain how we have reached a recommendation to keep services at St George's Hospital. We will also explain the potential advantages and disadvantages of the proposal for local people.

In summary, evidence suggests that an isolated ward at the George Bryan Centre would not:

- be clinically safe
- be sustainable in terms of staffing
- provide the same high-quality care that patients could access at the specialist site at St George's Hospital.

No decision has been made yet about this proposal, and any decision about future service change will consider the findings from this consultation.

We will keep our enhanced community mental health services in place, which provide the right support for adults with mental health needs or dementia in their usual place of residence.

This means we do not need to re-open a ward for older adults with dementia at the George Bryan Centre site. National best practice is to care for people with dementia in their own home or community.

We will keep the 18 beds at St George's Hospital for people who need a hospital stay for high-risk andcomplex mental health needs. We will not re-open a ward at the George Bryan Centre site.

SAMPLE - NOT FOR DISTRIBUTION

What is consultation?

'Consultation' means the process for how we:

- give staff, patients, carers and other interested groups information about the work we have done so far, and our recommended single proposal
- gather the views of local people to inform the decisions that the Staffordshire and Stoke-on-Trent NHS Integrated Care Board will make.

By law, the NHS must involve the public and local organisations when developing services or considering big changes to the way they are provided. This legal duty is found in the NHS Act 2006, which was amended in the Health and Social Care Act 2012.

The Health and Care Act 2022 gives all health bodies a 'triple aim' duty. Together they must pursue:

- better care for all patients
- better health and wellbeing for everyone
- sustainable use of NHS resources.

Asking local people for their views is an important part of how we make decisions about local health and care services. Your views matter and will be considered alongside clinical, financial and operational factors.

The results of public consultation do not represent a vote or a referendum over any proposals for change.

Who is conducting this consultation?

The Staffordshire and Stoke-on-Trent NHS Integrated Care Board is legally responsible for this consultation. Integrated care boards are the organisations that commission NHS services in their local area, from the NHS trusts and other bodies that provide them.



Who will we consult?

We have developed a consultation plan based on our Equality Impact Assessment and what we know about our local people. You can find these documents on our website: **www.staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire**.

We have developed a database of stakeholders (people who may be interested), and we will continue to add to this. We would especially like to hear from the people listed below. However, anyone who is interested can take part in this consultation – you do not need to be in one of these groups.

- patients who have stayed at the George Bryan Centre
- patients who have stayed at St George's Hospital
- people who use or have used our community mental health services
- the family and carers of people who have used any of these services.

We will encourage NHS and partner staff, clinicians, providers of health services and politicians to take part in this consultation. We will engage with Healthwatch Staffordshire, and provide many opportunities to respond to the consultation.

Having your say in this consultation

We want to hear your views on this recommendation to help inform our final decision. We want to know:

- if there are any other ideas we have not considered
- if there is any positive or negative impact we need to plan for, if we decide to go ahead with this proposal
- how we can support people if these changes are agreed, including how we can support people with travel.

It is important to take the time to read this consultation document carefully before you answer the questions. It explains our proposal, which may affect you, your family, your friends or the people you care for.

To help you understand our proposals and give your views, we have a range of information available on our website: www.staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire



Understanding the clinical evidence

By clinical evidence, we mean the best available evidence about what works and doesn't work in healthcare. It shows that most patients get the best outcomes (best experience and chance of recovery) when mental healthcare and support are provided by community teams, avoiding the need for hospital stays.

For older adults with dementia, clinical evidence suggests that it is best for them not to go into hospital. It can make things worse, by moving patients into unfamiliar settings, which may increase their confusion. It also makes it more likely for someone who was independent before their hospital stay to need residential care sooner. Below are some examples of clinical evidence considered by our technical team of clinicians and experts.

For adults with severe mental illness

"If people are admitted for longer than clinically necessary, they can become **institutionalised**, finding it harder to resume normal life (including loss or difficulty of finding work, benefits and a place to live).

"Recovery and **rehabilitation** need to occur as close as possible to where people live – for example, training people in 'activities of daily living' while in acute inpatient settings does not adequately equip them to use these skills in the community."[1]

"It is better for patient care, better for performance outcomes, and better for the NHS budget to treat as many patients as close to home as possible, with community services once again at the heart of provision."[2]

"In conclusion, CRTs [community-based crisis resolution teams] have proven to be an acceptable alternative to hospitalization for psychiatric patients in acute crisis."[3]

For older adults with dementia

NICE guidance is that when admission to hospital is considered for a person living with dementia, the value of keeping them in a familiar environment should be considered.[1]

"Hospital admissions (especially when extended) can **exacerbate** the symptoms of dementia, permanently reduce independence, and increase the likelihood of discharge to residential care and readmission to hospital. It is estimated that people with dementia occupy 25% of hospital beds, often when the medical need is not acute, and their hospital stays tend to be on average 1 week longer than others. This results in poorer outcomes and notable costs."[2]

1. 'Improving acute inpatient psychiatric care for adults in England' (**www.media.wix.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf**), July 2015, The Commission to review the provision of acute inpatient psychiatric care for adults.
2. 'NHS community services: taking centre stage' (**www.nhsproviders.org/media/4885/state-of-the-provider-sector-0518.pdf**), NHS Providers, 2018.
3. 'Mobile Crisis Resolution Team Implementation Challenges' (**www.bit.ly/A_Rapid_Review**), Jan 2021, International Journal of Hospital Based Health Technology Assessment.
4. 'Dementia: assessment, management and support for people living with dementia and their carers' (**www.nice.org.uk/guidance/ng97/chapter/Recommendations**), June 2018, NICE guideline 97.
5. 'The dementia care pathway: full implementation guidance' (**www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/dementia/nccmh-dementia-care-pathway-full-implementation-guidance.pdf?sfvrsn=cdef189d_8**), 2018, National Collaborating Centre for Mental Health.

SAMPLE - NOT FOR DISTRIBUTION

How our local community mental health services are supporting patients and carers

The vast majority of people who have a mental health need are not admitted to our hospitals. Instead, they are supported in their own home or community. Most of our staff work in the community to help people stay in their usual routine and access a range of therapy services provided by the NHS and the voluntary sector.

Since 2019 we have been supporting more dementia patients to stay in their own home. When needed, we help them to move to a specialist residential home that will help provide the right care for their individual needs. Locally and nationally, our clinicians agree that a mental health hospital is not the best place for someone with dementia – they need specialist support from our enhanced community teams.

Only a small number of people will need a hospital stay. Although this consultation is about the future of services for people who need a hospital stay, we wanted to explain how we have enhanced our community services to support people to stay out of hospital and independent for longer.



SAMPLE - NOT FOR DISTRIBUTION

How we have been investing in our community services

Guiding principles for community mental health transformation in south east Staffordshire

1. **Improve access to care**
   Make it clear, simple and quick to get support when it is needed
2. **Use a trusted assessor model**
   Remove the need for patients to 're-tell their story' every time they receive care
3. **One digital plan**
   To be accessed and updated by services involved in the patient's care
4. **A named worker**
   Every patient to have a named worker
5. **Flexible and personalised**
   Care must reflect the patient's needs and preferences
6. **Safety**
   Services must be safe for patients, carers and staff
7. **Integration of care**
   Collaborate with all relevant partners and align to voluntary and community sector support
8. **Support physical health needs**
   Staff are dedicated to supporting the physical health needs of their patients

Before and since the fire, we have been enhancing services in south east Staffordshire (as well as in the other areas of Staffordshire).

Improving access to care, for faster treatment and support

- There is a free urgent mental health helpline providing telephone support, advice and triage to anyone living in South Staffordshire. Anyone can call **0808 196 3002** or email: **access.staffordshire@mpft.nhs.uk** 24 hours a day, seven days a week
- Patients can self-refer into services like Improved Access to Psychological Therapies (IAPT), rather than waiting to be referred (call **0300 303 0923** or self-refer online at: **www.staffsandstokewellbeing.nhs.uk**)

Integrated neighbourhood teams

'Joined-up' mental health teams bring together mental health professionals, GPs, social workers and other teams. By getting these professionals to work more closely together in teams, we can:

- co-ordinate care better, including sharing the right information
- cut out delays that can happen when a person's care moves from one team to another.

Case study

John has suffered from severe obsessive compulsive disorder (OCD) for more than 25 years. This disorder causes him to spend hours every day washing and cleaning. This means he struggles to stay in a job and do everyday activities that most people take for granted. He won't throw things out, and rubbish has gathered in his garden, so he has been in trouble with the Council.

In the past, John has found Cognitive Behavioural Therapy (CBT) useful, but sometimes it took too long to arrange. This was because the professionals helping him worked in separate teams. There were sometimes delays with sharing information, and John's problems got worse while he was waiting for help from the Improved Access to Psychological Therapies (IAPT) team.

Now, our integrated teams bring together staff from IAPT and the community mental health teams. John can start CBT quickly with an IAPT therapist. This therapist will also be his key worker and co-ordinate John's care with the other professionals who need to be involved – like a social worker and a psychiatrist.

This way of working will help get John the **psychological therapy, medical input and social support** he needs to get better and live well.

Better crisis support

We want to offer better community-based support to anyone experiencing a mental health crisis – helping to avoid a hospital admission unless it is really needed.

- Our **Crisis Resolution Home Treatment (CRHT) team**, set up since the George Bryan Centre closed, works 24/7 and responds within four hours if someone needs urgent help
- A new crisis café will be opening in Tamworth. Crisis cafés can offer emotional support, information on other services, and advice on the skills that can help someone cope in a future crisis.

Working in partnership with the voluntary sector

We now have arrangements with some voluntary organisations to provide some services for us. These are **non-clinical services** (not medical), covering issues that can affect people's mental wellbeing – like housing, money matters and having social contact.

Physical wellbeing affects mental health, so our voluntary sector partners also provide services around weight management, healthy eating and advice on getting good sleep.

This new way of working with voluntary sector partners helps us provide the 'wrap-around' care that the national guidance recommends. Here are some examples:

- Brighter Futures (**brighter-futures.org.uk**) help deliver the mental health helpline
- The Citizens Advice Bureau (**citizensadvice.org.uk**) give financial advice
- Humankind (**humankindcharity.org.uk**) deliver specialist support on substance misuse.

SAMPLE - NOT FOR DISTRIBUTION

Community venues for mental health services

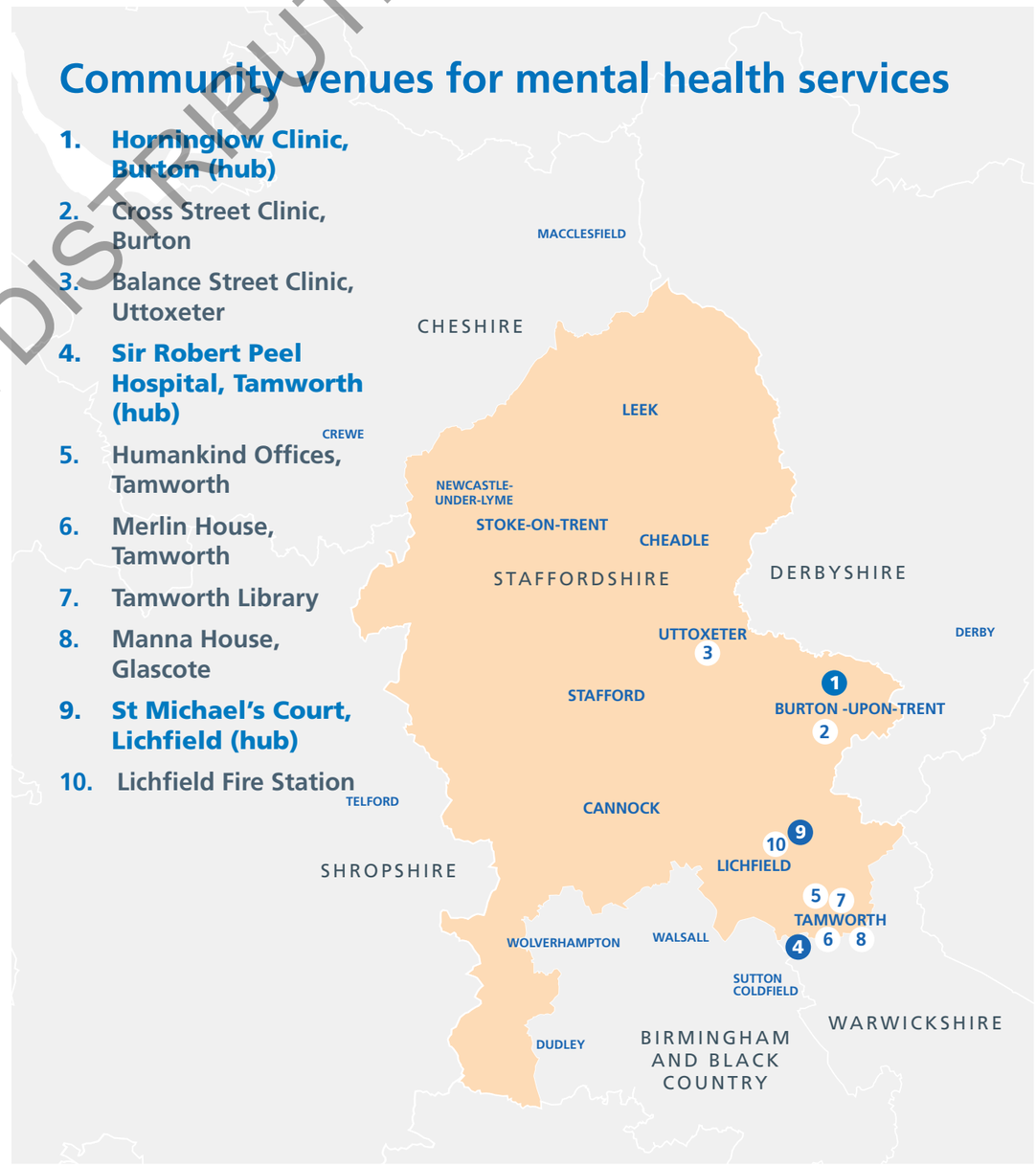
People can visit convenient local venues for a range of services, like group therapy sessions, memory clinics, and the clinics that carry out important physical health checks for people with mental health problems.

There are lots of community venues across south east Staffordshire, with the 'hubs' (those offering the most services) shown in bold on the map below.

MPFT is working to reinstate Cherry Orchard House in Tamworth as another community venue once refurbishment works are complete.

Community venues for mental health services

1. **Horninglow Clinic, Burton (hub)**
2. Cross Street Clinic, Burton
3. Balance Street Clinic, Uttoxeter
4. **Sir Robert Peel Hospital, Tamworth (hub)**
5. Humankind Offices, Tamworth
6. Merlin House, Tamworth
7. Tamworth Library
8. Manna House, Glascote
9. **St Michael's Court, Lichfield (hub)**
10. Lichfield Fire Station



How we are supporting older adults with dementia and/or severe mental illness

Improving access to care

Older adults can have complex needs. Without the right help, it could be challenging to find all the support that's needed.

Since the George Bryan Centre closed, an **older adult specialist** is now involved when a patient or carer first gets in touch to ask for help. They help to get the right teams in place for each patient, and to speed up the process.

Crisis support and avoiding hospital admission

The **Hospital Avoidance team** (HAT) does the same job as the crisis team but works with older adults. The team provides support at home to help older people stay out of hospital. It includes older adult specialists who understand the complex needs older people can have, including frailty. The team offers phone calls and home visits, and carers can call for help in a crisis.

Support for carers

We are developing a new **home sitting service** to support carers who need a break during the evening or at weekends. The crisis team will refer patients to this service, which will give carers some much-needed time to themselves, while their loved one is looked after in their own home.

Support from the voluntary sector

Our voluntary sector partners supporting older adults include:

- Alzheimer's Society dementia advisers (**www.alzheimers.org.uk/get-support/your-support-services/dementia-advice**) supporting patients at home
- Mental Health Matters (**www.mhm.org.uk**), who are supporting older adults after a hospital stay and connecting them with community groups that can offer ongoing support
- Mase Group (**www.themasegroup.org**) (Monthly Alzheimer's Support Evening) in Stafford providing dementia support
- Burton Mind (**www.burtonmind.co.uk**) providing the home sitting service mentioned above.



Case study

Janet is 81 and lives alone in the Lichfield area. About 18 months ago, her daughter, Kate, noticed that her mum's memory didn't seem so good, and that she was sometimes confused. Janet's personality seemed different, and she got angry when Kate suggested she ask for help.

Janet had a fall at home after taking an overdose of a prescription medication and was taken to A&E. While staying in hospital for treatment for the fall, she was assessed by a consultant psychiatrist, because there were concerns about her mental health. She was diagnosed with early dementia. A community mental health nurse met with Janet and Kate to discuss the help that could be put in place.

When Janet came back home, she had daily phone calls or home visits from the community nurse and a healthcare support worker.

The support worker looked for community groups for Janet to get involved with, and she was stabilised on medication for mood.

The nurse knew that things were difficult at weekends, and that Kate could not always be there to help her mum. So she asked the Hospital Avoidance team (HAT) to support Janet and Kate out of hours and at weekends.

The community nurse contacted social care to arrange a carer's assessment. Janet now has a care package in place, which includes a carer visiting to help her with washing and dressing.

You can read more case studies on our website: **staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire**.



SAMPLE - NOT FOR DISTRIBUTION

Mental healthcare for patients who need a hospital stay

Our vision for care in hospital

We want to deliver the best care in hospitals we can, to provide:

- quick and timely access to the right clinicians
- access to a range of staff who can support patients' complex needs, for example dieticians, drug and alcohol experts, and therapists
- facilities like seclusion rooms for patients when they are angry or at risk of harming themselves or others
- a calm and supportive environment
- continuity of carer, with a team that is big enough to adapt to staff sickness, but is known and trusted by the patient
- shorter hospital stays, to help you maintain your independence.

St George's Hospital

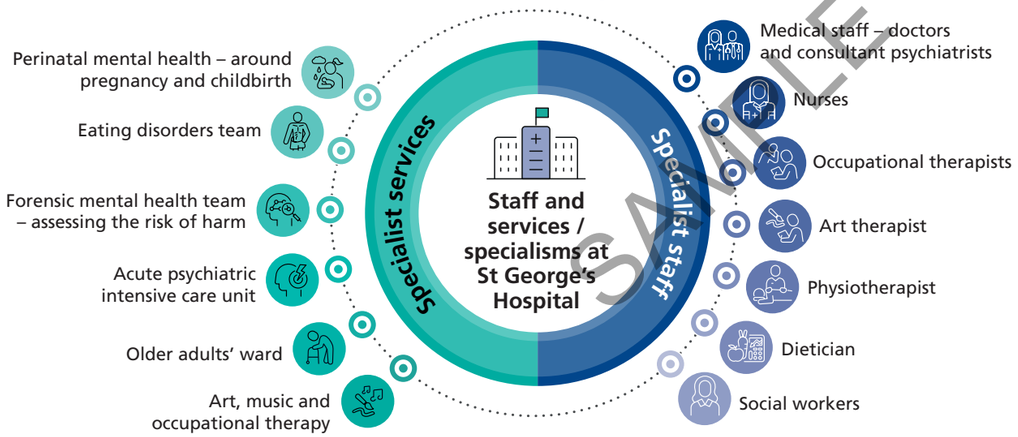
St George's Hospital, where we propose keeping the 18 beds, has a range of highly trained staff who give treatment and care to patients with severe mental illness during an inpatient stay.

There is a national and local shortage of these skilled staff, so they need to work in larger, specialist centres to offer support to more patients.

This diagram below shows the specialist staff, teams and facilities at St George's Hospital.

Sometimes it can be necessary to travel further from home for specialist treatment – for mental healthcare as well as physical healthcare. Although some families would experience difficulties with the additional costs and travel time needed to visit loved ones at St George's Hospital, this may be balanced by the advantages for patients in terms of the specialist treatment they can receive there.

Staff and services / specialisms at St George's Hospital

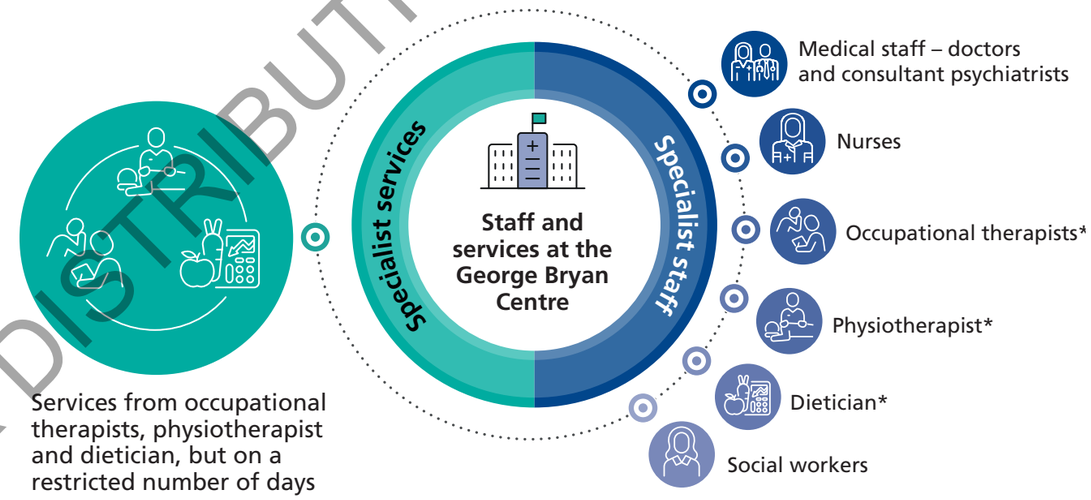


George Bryan Centre

The George Bryan Centre was a small, standalone unit with two wards. The diagram below shows the staff and services at the centre.

If we reinstated beds at the site, it would have only one ward, for patients with severe mental illness. We would not re-open a ward for older adults with dementia, because the national best practice is to care for people with dementia in their own home or community.

Staff and services at George Byran Centre



*visiting on a certain number of days only



SAMPLE - NOT FOR DISTRIBUTION

The proposal: a summary

Our clinicians and experts have recommended that we make the changes we made in 2019 permanent. This means keeping the 18 mental health beds at St George's Hospital.

Our clinicians and staff also considered a proposal to reinstate 18 beds for patients with severe mental illness on the George Bryan Centre site. However, the evidence considered by our clinicians and managers shows that an isolated ward at the George Bryan Centre would not:

- be clinically safe
- be sustainable in terms of staffing
- provide the same high-quality care that patients could access at the specialist site at St George's Hospital.

We give information to help explain each of these points in the next two pages. You can find more detailed information in our business case and appendices on our **website [add link]**

Having a sustainable workforce – being able to recruit and keep staff

There is a serious national shortage of:

- mental health nurses
- allied health professionals (AHPs – like dieticians, occupational therapists, and art and music therapists).

With these important roles in short supply, we need to plan for how we can recruit staff and keep them with us.

It is easier to recruit staff to bigger hospitals, where teams are larger and have a wider mix of skills. Staff benefit from working in bigger hospitals because they can learn more and gain wider experience. They become more skilled, which is good for patient care.

Data about job vacancies at the George Bryan Centre at the end of 2018 (its last full year), shows that it had a higher rate of job vacancies compared with St George's Hospital in December 2021:

Unit	St George's Hospital	George Bryan Centre
Date	End December 2021	End December 2018
Job vacancies	**21.23** (whole-time equivalent)	**12.43** (whole-time equivalent)
Vacancy rate	About **1 in 10 jobs** needed to be filled	About **2 in 10 jobs** needed to be filled

SAMPLE - NOT FOR DISTRIBUTION

Having a sustainable workforce – being able to recruit and keep staff

	Under the proposal (keeping the 18 beds at St George's Hospital)	If 18 beds were reinstated at the George Bryan Centre
Recruiting and keeping staff	Lower vacancy rates at St George's Hospital suggest it will be easier to recruit and keep staff here compared with the small, standalone site	Higher vacancy rates at the George Bryan Centre when it was open may be repeated in future. It is harder to recruit staff to work in smaller, isolated units. There are fewer opportunities for staff to gain wider experience and skills when working in small units compared to bigger specialist sites. If not enough permanent staff can be recruited, there could be additional costs in paying agency staff.
Impact on staffing at the main mental health hospital	No impact	Some staff would have to transfer there from St George's Hospital, impacting on patient care at the bigger site Extra travel time for specialist staff visiting the George Bryan Centre to provide the full range of services – a less efficient use of the workforce.



High quality of care

	Under the proposal (keeping the 18 beds at St George's Hospital)	If 18 beds were reinstated at the George Bryan Centre
Outcomes for patients are better when they have access to a wider range of treatments, therapies and activities, provided by specialist staff.	Larger staff, with a broader range of skills, at St George's Hospital means patients benefit from: • more specialist medical care • therapies such as art and music therapy provided by on-site specialists. Location makes it easy for patients with approved leave to go into Stafford town centre, which supports their recovery and independence.	There would be no on-site specialists to provide art and music therapy
National best practice is for hospital stays for severe mental illness to be kept as short as possible. For example, the NHS Long Term Plan (**www.longtermplan.nhs.uk**) promised to work with units where the typical length of stay was longer than the national average.	Average length of stay for patients at St George's Hospital since 2019: **22.94 days** (12 Feb 2019 – 23 Nov 2021)	Average length of stay for patients at the George Bryan Centre: **30.62 days** (11 Feb 2017 – 11 Feb 2019)

"The panel heard how lengths of stay for patients at St George's are now reduced compared with 2019 and earlier, and [are] one of the lowest in the country. This has been achieved through safe centralised care on a single site now being far more resilient and efficient, with very few patients requiring out of area care."

West Midlands Clinical Senate, 'Report of the Independent Clinical Senate Review Panel' (**www.midlandssenates.nhs.uk/wm-senate/wm-work-programmes/wm-clinical-reviews-recent**), July 2022.

Patient and staff safety

When the George Bryan Centre was open, it did not have a psychiatric intensive care unit or seclusion rooms. Patients who suddenly became more unwell often needed transfer to St George's Hospital. Transfers could take up to six hours because secure transport was needed. This was not good for the patients' care.

With fewer staff at the centre, the numbers of police call-outs was high compared to St George's Hospital, given the lower number of patients at St George's Hospital. (See section 2.5.3 of the business case on our **website**.)

	Under the proposal (keeping the 18 beds at St George's Hospital)	If 18 beds were reinstated at the George Bryan Centre
Psychiatric intensive care units and seclusion rooms are important for keeping everyone safe when a patient with a severe mental illness has a crisis. Psychiatric intensive care units are more secure and have higher staffing levels than ordinary wards, as well as offering intensive treatment. Seclusion rooms are used for short periods to keep patients in crisis, and other patients and staff, safe.	Facilities and specialisms at St George's Hospital: • Psychiatric intensive care unit for male patients • Seclusion rooms • Forensic psychiatry specialists who assess the risk of patients harming themselves or others.	There would still not be a psychiatric intensive care unit or seclusion rooms – because this would be a small unit with only one ward. The centre would be remote from the larger St George's Hospital site so staff from St George's would not be able to get there quickly to offer support. There would still be fewer staff to support each other in an emergency.
In bigger hospitals, staff can move between wards and provide cover when colleagues are absent. This makes things safer for patients and staff, especially in an emergency.	St George's Hospital has: • Two wards for older adults • Six wards for adults with severe mental illness • Other specialist wards • More staff to support in case of emergency (182 WTE) • Staff, particularly support workers, can move between wards as needed.	At the George Bryan Centre, there would only be one ward.

SAMPLE - NOT FOR DISTRIBUTION

Disadvantage of the proposal: travel for visitors

From listening to patients and carers, we have heard that your biggest worry is around travelling to visit loved ones at St George's Hospital in Stafford, compared with visiting at the George Bryan Centre.

You have told us how hard it can be if you depend on public transport.

- We know that public transport does not cover all areas in Staffordshire, which means people need to walk to their local public transport connection
- Lack of direct services can mean getting two or three buses each way. This is especially difficult for older carers or family members
- Buses don't run all evening, so it is hard for some family members to visit in the evenings. This could mean they can only make visits on their days off.

Because of rising fuel prices, you have also told us that you are worried about the cost of travel, whether by public transport or by car.



Weighing up travel difficulties against other considerations

We know that visits and support from family, friends and carers are very important to patients in hospital, and that they support their wellbeing and recovery.

In recommending that we keep the mental health beds at St George's Hospital, we have thought carefully about the potential disadvantage caused by travel difficulties for some patients and carers.

There are potential advantages of the proposal that may **mitigate** (make up for) the travel disadvantages.

- Better care through on-site access at St George's Hospital to a bigger range of mental health specialists, more treatment options and activities, and the safer care that the facilities help provide
- Getting the right specialist treatment means that hospital stays can be shorter and people are helped to stay independent
- Our community mental health services are giving better support to people with severe mental illness in the community, so that fewer people need to stay in hospital
- We are improving our services to offer better support for people in crisis.

We have carried out a travel analysis, which looked at admissions to mental health hospital beds after the fire (up to July 2022).

There were 1,155 admissions of 783 individual patients (because some patients had more than one hospital stay) who lived in south east Staffordshire.

The analysis found that, while the George Bryan Centre was still open, **75% of patients from the same areas went directly to St George's Hospital, rather than the George Bryan Centre**. For many of these patients, this was because their illness was too serious for them to be treated at the George Bryan Centre. They needed the specialist treatment they could receive at St George's Hospital.

Analysis suggests that only five patients per month from this area would have been admitted to the George Bryan Centre between February 2019 and July 2022.



Sometimes it is necessary to travel for specialist care

If you need a hospital stay, you should expect to receive the best care from our specialist mental health teams. They are used to dealing with the most complex and serious needs.

Like cancer, stroke, cardiology (heart) and other specialist services, these teams work in our major hospitals, as they need to maintain their skills by seeing larger numbers of patients. They are also in high demand, so we need to use them to the maximum benefit for everyone.

Like travelling for cancer treatment, it does potentially mean a longer journey for visitors. We recognise the important role visitors have for mental health patients, and we are balancing this against the need to deliver the best quality care.

How we can support patients, families and carers

We understand that visits are very important for patients, families and carers, and we are exploring ways to help manage any impact on this. The views and comments you give us during this consultation will help inform our travel policy.

During the COVID-19 pandemic, Midlands Partnership NHS Foundation Trust used digital devices, including tablets, so that people on their wards could speak to (and see) their loved ones at home. This was done through a video consultation platform called OneConsultation and Microsoft Teams. They will continue to do this so that people can keep in touch during hospital stays.

We want to hear your views as part of this consultation about how we can support patients and carers if we decide to make these changes permanent. We are open to hearing further suggestions.

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What the proposal means for you

These case studies show how care has changed since the George Bryan Centre closed.

Patients with dementia have better support in the community, with new teams like the Hospital Avoidance team, available seven days a week to help support people with dementia in crisis at home and prevent hospital admissions.

Patients with severe mental illness are more actively involved in planning their care with their key worker, who looks at the bigger picture of their needs. This helps ensure support with physical health needs, and social needs like connecting with other people and meaningful activity as well as help with problems like addiction.



Previous care: admission to the George Bryan Centre

Bettina is 83 and was diagnosed with dementia five years ago. In 2018, when she became increasingly aggressive, she had a stay at the George Bryan Centre's **East Wing**, which gave her husband, Joe, some respite. Although the staff were lovely, they always seemed very busy as there was a member of staff off sick.

The consultant psychiatrist mentioned that music classes might help Bettina, but they were not available at the George Bryan Centre. However, because the George Bryan Centre was near home, Joe was able to visit most days, which was good for Bettina.

Bettina had to stay in hospital for several weeks, and over time she became increasingly depressed and stopped eating.

This affected her physical health to the extent that she needed more treatment and was losing her independence.

Carolyn, now aged 58, had a stay in the George Bryan Centre's **West Wing** in 2018. Carolyn had been unwell for many years with more than one mental health condition, physical health problems, and addictions. She had lived in lots of different places, so had inconsistent care from different mental health teams. She was sometimes hostile to the people looking after her, believing that they were not 'on her side'.

One night during her stay in the West Wing she became violent – hitting staff. The police were called to help safely restrain her. In the end, Carolyn needed to go to St George's Hospital, but it took hours for the secure transport to arrive.



How it could work under our proposal

When **Bettina's** dementia made her angry and aggressive, it was difficult for Joe to cope. Apart from family, he wasn't sure where to turn for help. But his daughter contacted the mental health helpline. A nurse with specialist knowledge of older adult care offered advice over the phone and came to visit within 24 hours.

Bettina has a named care worker, who works with her GP and social care worker, and she has a care plan in place. The different teams in the community work together to give support, including the Hospital Avoidance team (HAT), who can help in the evenings and at weekends. For example, if Bettina gets aggressive around bedtime, Joe can call HAT, and they will visit if necessary.

Her healthcare support worker looked for community support groups that Bettina could join. She put Joe and Bettina in touch with the local carers group and music groups where they go once a week. Getting out during the day, having a routine and things to do, are all very helpful for Bettina. By the evening she is tired, and less likely to get frustrated and angry.

Carolyn has been getting help from the community mental health services. They have tried to involve her in planning her care, so she does not feel she is being forced into things. Her key worker co-ordinates her care and makes sure she has the right help for her physical health problems and addictions, as well as the medication and therapy she needs.

Carolyn feels at her best when she has company and plenty to do. So she has been supported to find fitness classes, a community choir, and voluntary work. She has needed a few visits from the Crisis Home Resolution Treatment team, who have helped her at home.

After three years without needing a hospital stay, Carolyn's condition worsened after a family member died. Her care worker met Carolyn and they agreed it would be best for her to be admitted voluntarily to St George's Hospital. A team of specialists were on site to help Carolyn manage her medication. One night she became upset and violent towards other patients, but the staff were able to help her safely and calmly recover.

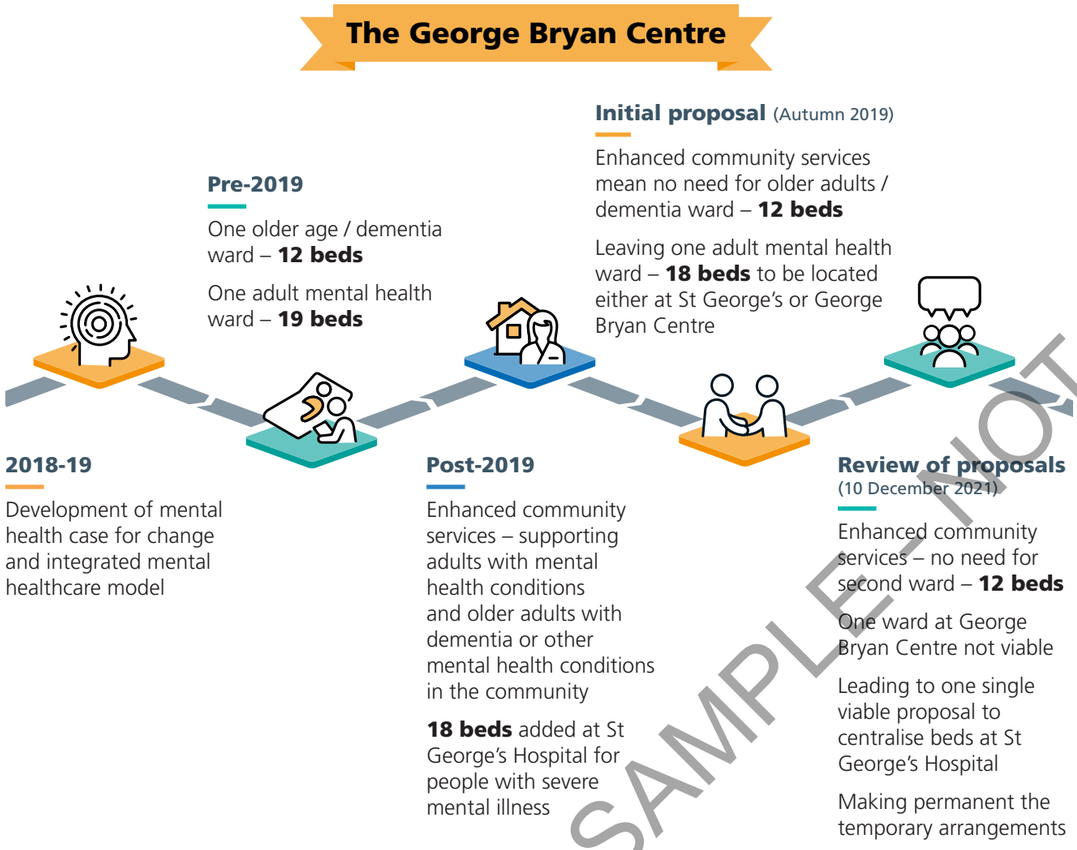
Two weeks later, Carolyn is back on her medication and has a care plan. She is now well enough to leave the hospital for walks to the local park and into town. She has regular calls on the iPad from her sister, who is able to reassure her and is looking forward to visiting her at the weekend. If all goes well, she will go back home in two weeks. The staff have already been working with the community teams and the voluntary sector to have meals waiting and support available.

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How did we reach this recommendation?

After listening to your views and completing a detailed analysis of all the data and information about what services people need, we designed our proposed model. This section describes how we developed our proposals.

This diagram shows the development of the proposal.



Listening to your views

We started our conversation with local people in 2019 to understand what worked well and what could be improved in our services. In autumn 2021, we held another listening exercise to understand any new experiences following the COVID-19 pandemic and sense-check our proposals in this 'new normal'.

We continue to listen to your views, and this consultation is the next stage in this conversation.

You can find out more about our involvement work to date on our website: www.staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire.

Actions we have taken after hearing your views

What you have told us:	What we have done, or will do:
You are worried about travelling to see a loved one at St George's Hospital.	We are asking your views on our travel policy as part of this consultation.
You are worried about how to keep in touch if travelling is not practically possible, or too expensive.	We will help you keep in touch through digital technology – we recognise some people may need equipment and support to use these tools. MPFT's website has a page offering support and guidance with digital skills: **www.mpft.nhs.uk/about-us/digital/training**.
You are worried about the lack of mental health services in your area to replace the George Bryan Centre.	We have enhanced our community mental health services. You can read more about these services on **pages 10-15**.
You are worried about lack of crisis support in your area.	A crisis café is opening in Tamworth in spring 2023, offering a safe space, emotional support and information.
More help should be available before someone reaches crisis point.	We have redesigned our community services to help people get support more quickly. For example, having your first appointment at your GP practice with a mental health nurse, instead of having to wait for your GP to refer you.
You have felt isolated and it has been difficult to find the help you needed.	We have been working to make services easier to find and access. For example: • a single phone number for the 24/7 helpline, which anyone can use to ask for help • for older adults, a specialist involved at an early stage to help find the right services and support for complex needs • more support for carers, for example the new out of hours home sitting service.

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From two proposals to one viable proposal

In 2019, two potential proposals were identified, as shown below. Under both proposals, our enhanced community mental health services would continue to look after the majority of patients, who do not need a hospital stay.

To keep the 18 beds at St George's Hospital

- Patients who need to stay in hospital for treatment would be admitted to St George's Hospital in Stafford
- The 18 beds would be for adults of any age experiencing a severe mental illness.

To provide beds at the George Bryan Centre site

- We would provide a ward with 18 beds at the George Bryan Centre site
- These beds are for adults of any age experiencing a severe mental illness
- We would not replace the 12-bed ward for patients with dementia, as it would not be needed. National best practice is to care for people with dementia in their own home or their community.



You can also view this animation [add link] which explains our journey so far.



Expert review of the proposals

Clinicians and staff from Midlands Partnership NHS Foundation Trust (MPFT) and the NHS clinical commissioning groups met as a technical group throughout this journey to develop proposals. (MPFT provides the services at St George's Hospital and previously provided the services at the George Bryan Centre.)

In autumn 2021, we ran two online events and a survey, to ask patients and interested groups if there was anything new we needed to consider since the COVID-19 pandemic.

After this involvement, our technical group met in December 2021 to examine all the evidence that had been gathered. A representative from Healthwatch Staffordshire was also at the technical group to champion the patient voice.

The group assessed whether both proposals were **viable** (realistic and achievable). They checked the proposals against the **essential criteria** agreed in 2019. Essential criteria set out the most important questions we need to answer about whether a proposal is going to work:

- **Clinical sustainability** (can we safely deliver services now and in the future)
- **Strategic fit** (does it fit with local and national strategies)
- **Meeting the needs of the population** (does it support local people who need our care).

The group also reviewed the proposals against three **additional criteria** (less important than essential criteria but still important):

- **Demand and capacity** (how much demand is there for the services, now and in the future, and can we meet it?)
- **Workforce sustainability** (can we keep enough trained staff over time?)
- **Estates** (buildings).

The group considered how our local community mental health services have been enhanced in line with the national guidance. This means that we do not need a ward for older adults with dementia, as they are looked after in their usual home.

They also looked at what we have learned from COVID-19, for example the use of devices to allow patients and family to keep in touch online.

They looked at potential problems if beds were reinstated in an isolated unit at the George Bryan Centre site:

- clinical safety, because there would be limited numbers of specialist staff and no psychiatric intensive care unit there
- potential destabilisation of workforce at St George's Hospital.

Based on these criteria and these considerations, our panel recommended that only one proposal was viable: to keep the beds at St George's Hospital in Stafford and maintain the enhanced community offer.

Testing this recommendation

Following the panel, we set up a reference group of patients, public, interested groups and the voluntary sector. Healthwatch Staffordshire also attended. The group met in March 2022 and reviewed the recommendations from our panel. We asked the group to:

- consider the recommendations
- discuss if there was anything else we should consider in the business case
- tell us about anything we could do to reduce negative impacts.

This group shared the concerns about the impact on travel time and cost for visitors. However, no other proposals were suggested that were viable.



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Further detailed analysis

Informed by the feedback shared at the reference group and the recommendations of the panel, we then carried out further analysis to inform our detailed business case. As well as workforce and data on demand, we developed:



Travel impact analysis (public transport and car ownership)

You can read about the proposal's impact on family and carers travelling to Stafford on **pages 22–23**. You can find more detailed information on our website (see link below).



Quality Impact Assessment (is our proposal clinically safe?)

MPFT carried out a Quality Impact Assessment (QIA). This looks at how MPFT monitors quality of care.

You can read the QIA in Appendix 2 of the business case on our website (see link below).



Equality Impact Assessment (who would be negatively impacted by the proposal?)

MPFT completed an Equality Impact Assessment (EIA) in March 2022. It found the proposal had positive impacts for most groups. It found a potential negative impact for those carers and family members who would need to travel further to visit a patient staying in St George's Hospital in Stafford.

You can read the full EIA in Appendix 14 of the business case on our website (see link below).



Financial analysis

Our priorities have been ensuring clinical safety and that we have enough well-trained staff for the long term. However, to ensure due diligence (proper approach), our finance teams completed a detailed financial analysis on both proposals in spring 2022.

This showed that the cost of rebuilding the George Bryan Centre would be £11.37 million. This proposal was discounted because it is not viable on the grounds of clinical safety and workforce.

You can read more about the financial analysis in section 3 of the business case on our website (see link below).

www.staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire

What is a business case?

A business case is an in-depth document which provides a lot of information before a service change is put in place. Our business case sets out the detail of our proposal, but this does not mean that a decision has been taken.

The views and information we gather in this consultation will help inform our **decision-making business case**.

We followed a tried and tested process to develop our recommendation. This includes making sure that it met the **five national tests** set out by NHS England:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support for proposals from clinical commissioners
- Satisfying the new patient care test for hospital bed closures, by:
  - Enough community provision in place alongside any bed closures
  - Workforce available to deliver the new model
  - Credible plan to improve performance without affecting patient care.

Assurance

The **West Midlands Clinical Senate** is an independent expert panel of clinicians (doctors and consultants). They considered our clinical model (plan), the proposals and the process we had been through to make sure we were not planning to do anything that would be unsafe and that we are delivering the best care for patients.

They made some recommendations that we have responded to in our business case, and supported our proposal.

You can read their final report on the West Midlands Clinical Senate's website: **www.midlandssenates.nhs.uk/wm-senate/wm-work-programmes/wm-clinical-reviews-recent**.

The business case was reviewed by both the Board of **Midlands Partnership NHS Foundation Trust** (30 June 2022) and the **Staffordshire and Stoke-on-Trent NHS Integrated Care Board** (18 August 2022).

We kept people updated about the process we were going through, by sending regular updates and publishing updates on our website.

NHS England has told us they are assured that our proposal meets the five tests for service change as well as other good practice tests.

We have also been advised by the Consultation Institute to make sure that we have followed best practice along the way.

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What happens next

This consultation will run for six weeks from Thursday 9 February 2023.

The responses received during the consultation will be analysed by Midlands and Lancashire Commissioning Support Unit and a report will be produced.

The report will be carefully considered by the Staffordshire Health Overview and Scrutiny Committee and the Staffordshire and Stoke-on-Trent NHS Integrated Care Board (ICB) who are legally responsible for making a decision. Their meeting about this will be held in public, and we will publish all the relevant documents on our website: **staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire**.

Once the ICB has made its decision, we will keep you informed.

We will continue to work with NHS England and the Consultation Institute who will monitor our decision-making process.

Ways to have your say

We welcome all responses to this consultation. The deadline for responses to the survey is [xx-xxxxx-xxxx]

Complete the survey:

- You can fill in the survey online on our website: **staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire**
- On our website you will also find details of upcoming consultation activities, background documents and more information about this consultation
- If you do not have access to the internet, you can complete the survey at the end of this document. Simply complete, tear off and send to:

  Freepost Plus RTAA-XTHA-LGGC
  Communications
  Heron House
  120 Grove Road
  Stoke-on-Trent
  ST4 4LX

  There is no need to use a stamp.

Take part in our events:

- Online event one (date TBC)
- Online event two (date TBC).

Come to our drop-in roadshows:

- Tamworth
- Lichfield
- Burton
- St George's Hospital.

If you would like regular updates on the development of the long-term solution, email us at **mlcsu.involvement@nhs.net** and we will add you to the mailing list.

If you would like printed copies of the documents, need documents in different formats or languages or need help to complete the survey, please phone us on **0333 150 3069**.

If you have additional feedback you would like to share, you are welcome to send this to us by email or through our Freepost address (**see above**).

We will also be carefully monitoring social media during the consultation:

Tweet us **@staffsstokeics**

Follow us on Facebook at **StaffsStokeICS**



Where to find more information

To help you to understand our proposals and give your views on them, we have a range of information available on our dedicated website: **staffsstoke.icb.nhs.uk/our-work/transformation/inpatient-mental-health-services-in-south-east-staffordshire**.

On the website you will find:

- a link to the online survey
- our business case, including our detailed analyses
- documents with more detailed background information and evidence, such as our case studies
- frequently asked questions.

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How we will use and manage your feedback and the information you provide

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) is the organisation legally responsible for this consultation and for making a decision. They would like to understand patient, public and wider stakeholders' views on their community model for severe mental illness, their community model for dementia care services and their proposal for delivering inpatient mental health services.

Staffordshire and Stoke-on-Trent ICB has commissioned NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) to collect, handle and process the responses gathered for this **consultation**. MLCSU uses a survey tool called Snap which is owned by Snap Surveys Ltd, an organisation specialising in the delivery and management of surveys. Any information you provide will be added to Snap for analysis and handled in accordance with GDPR and the Data Protection Act 2018.

The survey also asks respondents to provide their full postcode and demographic profiling data (age, gender, ethnicity etc.). This information is used to ensure the responses are representative of the demographics of the whole local population. The postcode data will also be used to profile and segment those participating in this **consultation**. This will be done using the Acorn Geodemographic segmentation tool which enables the profiling of participants' health and wellbeing in comparison with the local population. The postcode is also used to profile by UK Index of Multiple Deprivation (IMD) and the NHS index postcode directory which classifies postcodes by local authority, ward and ICB area.

The data will be available in its entirety to MLCSU, and **Staffordshire and Stoke-on-Trent ICB** will be in receipt of some of the responses which will then be inputted into Snap. You do not have to provide this information to take part in the survey.

Any reports published using the insights from the questionnaire will not contain any personal identifiable information and only show feedback in an anonymous format. These anonymised results may be shared publicly, for example on NHS public-facing websites or printed and distributed.

Your involvement is voluntary, and you are free to stop completing the questionnaire at any time. Only submitted responses will be included in the analysis. You can also refuse to answer questions in this survey, should you wish.

All information collected via the survey will be held for a period of five years from the date of survey closure, in line with the Records Management Code of Practice for Health and Social Care 2016, which all NHS organisations work under.

If you have any queries about your involvement with this questionnaire, please email: **mlcsu.involvement@nhs.net**.

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By proceeding, completing, and returning this survey you are agreeing with the Data Protection Statement and you consent for your answers to be included in our reports.

Tell us who you are and which mental health services you have experience of

1. Are you responding as:

- ☐ An individual
  Please complete question 2
- ☐ A formal response from an organisation
  Please go to question 3

Guidance: if you wish to respond as an individual and also provide a formal response as an organisation, please complete the survey twice – once as an individual and again as a formal response on behalf of the organisation.

2. As an individual responding to this survey, which of the following best applies to you? Please tick **one** only.

- ☐ User of mental health services
  Please go to question 5
- ☐ Another member of the public
  Please go to question 5
- ☐ Carer
  Please go to question 5
- ☐ NHS employee
  Please go to question 4 and then question 5
- ☐ From another public sector organisation
  Please go to question 4 and then question 5
- ☐ From a health-related group, charity or organisation
  Please go to question 4 and then question 5
- ☐ From a non-health voluntary group, charity ororganisation
  Please go to question 4 and then question 5

3. As an organisation responding to this survey, which of the following best applies to you? Please tick **one** only.

- ☐ Formal response on behalf of an NHS organisation
  Please go to question 4 and then skip to section 1: a community model for severe mental illness
- ☐ Formal response on behalf of another public sector organisation
  Please go to question 4 and then skip to section 1: a community model for severe mental illness
- ☐ Formal response on behalf of a health-related group, charity or organisation
  Please go to question 4 and then skip to section 1: a community model for severe mental illness
- ☐ Formal response on behalf of a non-health voluntary group, charity or organisation
  Please go to question 4 and then skip to section 1: a community model for severe mental illness
- ☐ Other
  Please go to question 4 and then skip to section 1: a community model for severe mental illness

4. Please provide the name of your organisation. Please note, if you are making a formal response on behalf of your organisation this question should be completed.

5. Which of the following mental healthcare services have you used or experienced? Tick all that apply.

- ☐ George Bryan Centre
  Please complete questions about the George Bryan Centre
- ☐ St George's Hospital, Stafford
  Please complete questions about St George's Hospital, Stafford
- ☐ Community mental health services
  Please complete questions about community health services
- ☐ None of the above
  Please skip to section one: a community model for severe mental illness

Questions about the George Bryan Centre

6. In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on?

- ☐ As a member of staff
  Please complete questions 8, 9 and 10
- ☐ As a patient
  Please complete questions 7, 8 and 9
- ☐ As a carer or support worker for a patient
  Please complete questions 8 and 9
- ☐ As a provider of a service to a patient
  Please complete questions 8 and 9

7. Which wing of the George Bryan Centre were you in?

- ☐ East (for people aged 65 and over)
- ☐ West (for people aged under 65)

8. Which period would you like to provide feedback on? Tick all that apply.

- ☐ Before and during March 2019
- ☐ After March 2019

9. Please tell us about your experience of the George Bryan Centre below.

10. Where do you work now?

- ☐ I worked at the George Bryan Centre but now work at St George's Hospital, Stafford
- ☐ I worked at the George Bryan Centre but now work in community mental health services
- ☐ Other, please specify

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Questions about St George's Hospital, Stafford

11. In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on?

- ☐ As a member of staff
- ☐ As a patient
- ☐ As a carer or support worker for a patient
- ☐ As a provider of a service to a patient

12. Which period would you like to provide feedback on? Tick all that apply.

- ☐ Before and during March 2019
- ☐ After March 2019

13. Please tell us about your experience of St George's Hospital, Stafford, below.

Questions about community mental health services

14. In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on?

- ☐ As a member of staff
- ☐ As a patient
- ☐ As a carer or support worker for a patient
- ☐ As a provider of a service to a patient

15. Which period would you like to provide feedback on? Tick all that apply.

- ☐ Before and during March 2019
- ☐ After March 2019

16. Please tell us about your experience of community mental health services below.

Section 1: a community model for severe mental illness

17. To what extent do you think the care model is a good one?

- ☐ 1 – Very good
- ☐ 2 – Good
- ☐ 3 – Neutral
- ☐ 4 – Poor
- ☐ 5 – Very poor

18. Please explain the reason for your rating. In your response, please explain what you like and what concerns you.

19. Are there any groups that you think may be disadvantaged by this model? If yes, please explain who and why.

20. Tell us if you think there are any better ways to provide these services.

Section 2: a community model for dementia healthcare services

21. To what extent do you think the care model is a good one?

- ☐ 1 – Very good
- ☐ 2 – Good
- ☐ 3 – Neutral
- ☐ 4 – Poor
- ☐ 5 – Very poor

22. Please explain the reason for your rating. In your response, please explain what you like and what concerns you.

23. Are there any groups that you think may be disadvantaged by this model? If yes, please explain who and why.

24. Tell us if you think there are any better ways to provide these services.

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Section 3: proposal for delivering inpatient mental health services

25. To what extent do you think this proposal is a good solution?

- ☐ 1 – Very good
- ☐ 2 – Good
- ☐ 3 – Neutral
- ☐ 4 – Poor
- ☐ 5 – Very poor

26. Please explain the reason for your rating. In your response, please explain what you like and what concerns you.

27. Are there any groups that you think may be disadvantaged by this proposal?
If yes, please explain who and why.

We would now like to understand your views on travel for visitors under this proposal.

28. To what extent are you concerned about travel for visitors under this proposal?
Where 1 is very unconcerned and 5 is very concerned.

- ☐ 1 – Very unconcerned
- ☐ 2 – Unconcerned
- ☐ 3 – Neither concerned nor unconcerned
- ☐ 4 – Concerned
- ☐ 5 – Very concerned

29. Please explain why you are concerned or unconcerned.

30. How do you think you will travel?

There are some parts of the proposal we would like your thoughts and ideas to develop. The following questions ask for your thoughts and ideas about how we support carers and visitors, and any other ideas you may have.

31. Do you have access to the internet?

- ☐ In your own home
- ☐ Another place
- ☐ No access

32. What type of device do you have? Please select all that apply.

- ☐ Mobile phone
- ☐ Laptop computer
- ☐ Desktop computer
- ☐ Tablet device
- ☐ I do not have any of these devices
  Please skip to question 35

33. Does the device have a camera you can use while using your device to make a call?

- ☐ Yes
- ☐ No
- ☐ Unsure

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34. Could you use the device to contact someone in hospital?

☐ Yes, easily ☐ Yes, with assistance ☐ No

35. What support, if any, would you require to use the internet device to contact someone in hospital?

36. In our proposals we are keen to include and develop support for travel for visitors. Tell us what support you think should be developed and provided for visitors. Please tell us if you think the support should be for a set period of time or up to a certain amount, e.g. money or support level.

37. Tell us if you think there are any better ways to deliver inpatient mental health services.

38. Finally, is there any other information you wish us to consider which you have not yet mentioned?

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About you

We would like to know a little more about you. The following questions will help us understand more about who has responded to this survey. This will help us to ensure we have listened to as many different people as possible. You can leave this section blank if you wish.

39. Please provide your full postcode.
Providing your full postcode does not mean we will be able to identify you individually. It will help us to ensure we have gathered views from all areas.

Enter your postcode here:

40. What is your ethnic group?

Choose one option that best describes your ethnic group or background

☐ Asian/Asian British: Indian
☐ Asian/Asian British: Pakistani
☐ Asian/Asian British: Bangladeshi
☐ Asian/Asian British: Chinese
☐ Asian/Asian British: Any other Asian background (please specify below)
☐ Black/African/Caribbean/Black British: African
☐ Black/African/Caribbean/Black British: Caribbean
☐ Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify below)
☐ Mixed/Multiple ethnic groups: White and Black Caribbean
☐ Mixed/Multiple ethnic groups: White and Black African
☐ Mixed/Multiple ethnic groups: White and Asian
☐ Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)
☐ White: English/Welsh/Scottish/Northern Irish/British
☐ White: Irish
☐ White: Gypsy or Irish Traveller
☐ White: Any other White background (please specify below)
☐ Other ethnic group: Arab
☐ Any other ethnic group (please specify below)
☐ Prefer not to say

41. **How old are you?**

- ☐ 16 - 19
- ☐ 20 - 24
- ☐ 25 - 29
- ☐ 30 - 34
- ☐ 35 - 39
- ☐ 40 - 44
- ☐ 45 - 49
- ☐ 50 - 54
- ☐ 55 - 59
- ☐ 60 - 64
- ☐ 65 - 69
- ☐ 70 - 74
- ☐ 75 - 79
- ☐ 80 and over
- ☐ Prefer not to say

42. **What is your religion or belief?**

- ☐ No religion
- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion (please specify)
- ☐ Prefer not to say

43. **How do you identify?**

- ☐ Male
- ☐ Female
- ☐ Trans-Man
- ☐ Trans-Woman
- ☐ Non-binary
- ☐ Gender-non-conforming
- ☐ Other (please specify)
- ☐ Prefer not to say

44. **What is your sexual orientation?**

- ☐ Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Asexual
- ☐ Other (please specify)
- ☐ Prefer not to say

45. **What is your relationship status?**

- ☐ Married
- ☐ Civil Partnership
- ☐ Single
- ☐ Divorced
- ☐ Lives with Partner
- ☐ Separated
- ☐ Widowed
- ☐ Other (please specify)
- ☐ Prefer not to say

46. **The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week (6-month) period.**

Are you pregnant at this time?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

47. **Have you recently given birth? (within the last 26-weeks (6-months))**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

48. **Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?**

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No

49. **Do you consider yourself to have a disability?**
(The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long-term (12 month period or longer) or substantial adverse effects on their ability to carry out day-to-day activities).

- ☐ No disability
- ☐ Physical disability (please describe)
- ☐ Sensory disability e.g. Deaf, hard of hearing, Blind, visually impaired (please describe)
- ☐ Mental health condition
- ☐ Learning disability or difficulty
- ☐ Long-term illness (please describe)
- ☐ Other (please describe)
- ☐ Prefer not to say

50. **Do you provide care for someone?**
A carer is defined as anyone who cares, unpaid, for a friend or family member who, due to illness, disability, a mental health problem or an addiction, cannot cope without their support. (Tick as many as appropriate.)

- ☐ Yes - Care for young person(s) aged under 25
- ☐ Yes - Care for adult(s) aged 25 to 49
- ☐ Yes - Care for older person(s) aged 50 or over
- ☐ No
- ☐ Prefer not to say

51. **Have you ever served in the armed services?**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

52. **Do you have access to a car?**

- ☐ Yes, and I drive
- ☐ Yes, but I don't drive
- ☐ No, I don't have access to a car

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Staying in touch

53. From time to time, we would like to send you information on future events and pieces of work conducted by our organisations. If you are happy for this to happen, please give your name, address and telephone number/email address here:

Name	
Address	
Telephone	
Email	

By providing your contact details you are giving us explicit consent to contact you. You can retract this agreement at any time by contacting **mlcsu.involvement@nhs.net**.

Thank you for taking the time to complete the survey. To return it, please tear off and send to:

Freepost Plus RTAA XTHA LGGC
Communications, Heron House, 120 Grove Road, Stoke-on-Trent ST4 4LX

There is no need to use a stamp.

Accessible formats

If you need printed copies of the documents, need documents in different formats or languages please call us on **01785 276926**.

আমরা স্টাফোর্ডশায়ার এবং স্টোক-অন-ট্রেন্টে স্বাস্থ্য ও যত্ন পরিষেবার বিষয়ে আপনার মতামত শুনতে চাই। আপনার নিজের ভাষায় এই তথ্য পেতে যদি আপনার সাহায্যের প্রয়োজন হয় তবে দয়া করে ফোন করুন এনাম্বারে 01785 276926

আরা স্টাফোর্ডশায়ার এবং স্টোক-অন-ট্রেন্ট এ স্বাস্থ্য এবং যত্ন অনর মতামত জনিবার লাই চাইদদি।

এই তথ্য অ্যাক্সেস করিবার লাই অনর নিজের ভাষায় সাহায্যের ফ্রয়জন হইলে, অনুগ্রহগরিয়ানে ফোন গজ্জুন 01785 276926।

અમે સ્ટાફફોર્ડશાયર અને સ્ટોક-ઑન-ટ્રેન્ટમાં આરોગ્ય અને સંભાળ સેવાઓ વિશે તમારા વિચારો જાણવા ઇચ્છીએ છીએ. જો તમને તમારી પોતાની ભાષામાં આ માહિતી ઍક્સેસ કરવા માટે સમર્થનની જરૂર હોય, તો કૃપા કરીને 01785 276926 પર ફોન કરો.

ਅਸੀਂ ਸਟੈਫ਼ਰਡਸ਼ਾਇਰ ਅਤੇ ਸਟੋਕ-ਆਨ-ਟ੍ਰੈਂਟ ਵਿਚਲੀਆਂ ਸਿਹਤ ਅਤੇ ਦੇਖਭਾਲ ਸੇਵਾਵਾਂ ਦੇ ਬਾਰੇ ਤੁਹਾਡੇ ਵਿਚਾਰ ਜਾਣਨੇ ਚਾਹੁੰਦੇ ਹਾਂ। ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਸਹਾਇਤਾ ਦੀ ਜ਼ਰੂਰਤ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 01785 276926 ਨੂੰ ਫ਼ੋਨ ਕਰੋ।

Chcemy poznać Pana/Pani opinie na temat usług zdrowotnych i opiekuńczych na terenie Staffordshire i Stoke-on-Trent. Pomoc w dostępie do niniejszych informacji w języku ojczystym można uzyskać pod numerem telefonu 01785 276926.

Note: translations will change this is to indicate how it will look

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