



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

June 2022

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Executive summary

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

Introduction

This business case is presented by Midlands Partnership NHS Foundation Trust (MPFT)/the Trust) to seek approval from Staffordshire NHS Commissioners to align commissioning arrangements for the provision of acute mental health inpatient services in south east Staffordshire with the established operational position.

The proposal is:

- Provision of 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 geographic area covered in this proposal includes Stafford, Tamworth, Lichfield and East Staffordshire including Burton upon Trent. The proposal takes account of safer staffing, clinical quality and national best practice. 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.

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.

This document has been developed by Midlands Partnership NHS Foundation Trust for discussion with Staffordshire and Stoke-on-Trent health commissioners, the wider Integrated Care System (ICS), NHS England and Improvement (NHSEI) and other partners.

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 business case.

Background

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 and supporting 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.

In line with national ambitions set out in the Five Year Forward View for Mental Health (2016), the NHS Long Term Plan (2019) and a case for change published in 2019 by the Staffordshire and Stoke-on-Trent Integrated Care System, work to transform community mental health services has been taking place across the MPFT footprint in south Staffordshire for more than three years. 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.

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.

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 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.

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. A number of listening exercises were 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.

The case for change

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 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 lengths 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 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.

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

- **The financial case for change**

Financial analysis provides assurance that the proposal 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 elsewhere in this section.

- **The workforce case**

Workforce planning and considerations underpinning the business case is detailed in Section four. Key points 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.

- **The safer staffing case**

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.

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.

Proposal development process

The timeline below shows the development of the proposal.

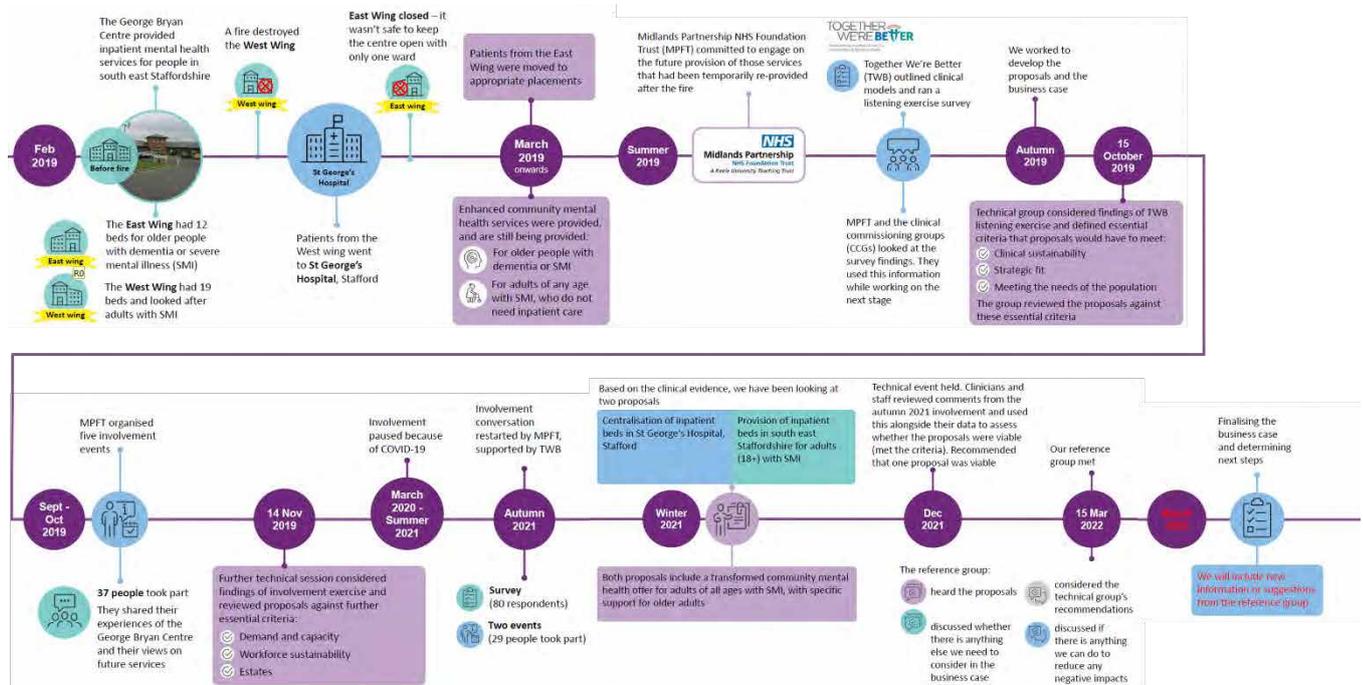


Figure 1 The timeline for the development of the proposal

In phases one and two (2019/20) the involvement of clinicians, stakeholders, patients and the public measured against the criteria:

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

led to two proposals:

- Centralisation of inpatient beds in St George's Hospital, Stafford
- Provision of inpatient beds in south east Staffordshire for adults (aged 18 plus) with serious mental health needs

In phase three (2021/22) further involvement taking into account the sense-check engagement led to the decision that one proposal was viable:

- 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.

Evaluation of proposal

The programme team is satisfied that the proposal meets the Government's 'four tests' applied to service change, and in addition, NHSEI's Patient Care (bed closure) Test.

A full Quality Impact Assessment and an Equality Impact Assessment are in place.

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.

MPFT employs a range of measures to measure the quality of care.

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.

Governance

The timeline for signing off the business case is as follows:

| Date (2022) | Committee/Board | Nature of meeting |
|-------------|--|--|
| 10 June | West Midlands Clinical Senate | Sign off |
| 23 June | ICS Mental Health Programme Board | For information |
| 28 June | MPFT Major Transactions Committee | Document sign off and Recommendation to MPFT Board |
| 30 June | MPFT Board | Formal decision |
| 11 July | Staffordshire Health Overview and Scrutiny Committee | For discussion |
| TBC | Integrated Care Board | Sign off |
| TBC | NHSE Assurance | Assurance |

If Staffordshire County Council Health Overview and Scrutiny Committee recommend a further round of involvement, it will go back to the MPFT and Clinical Commissioning Group (CCG) boards following that involvement for a decision. The boards will decide what further appropriate public involvement is needed before they make a decision.

There will be continued liaison with the local overview and scrutiny committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

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

A plan for any further involvement or a public consultation will be developed as appropriate.

1 Introduction

1.1 Introduction

This section provides an introduction to and an overview of:

- The service change proposal, including the scope
- The background to the service change proposal
- Current service delivery
- The vision and commitment and organisations involved
- The process and requirements covered in the business case

Organisations involved

This document has been developed by Midlands Partnership NHS Foundation Trust (MPFT / the Trust) for discussion with Staffordshire health commissioners, the wider Integrated Care System (ICS) and other partners.

1.2 The proposal

The scope of this business case is the inpatient services in south east Staffordshire formerly provided from the George Bryan Centre and by MPFT, for:

- Adults with severe mental illness
- Older adults with severe mental illness or dementia

Its purpose is to seek approval from Staffordshire NHS commissioners to align commissioning arrangements for those services with the operational position that has been in place since a fire destroyed the West Wing of the George Bryan Centre in February 2019 and that is in line with national policy on mental health services.

The proposal is:

- Provision of acute mental health inpatient services for south east Staffordshire on a single site: St George's Hospital, Stafford.

Those inpatient services are supported by enhanced community services commissioned in 2018 and 2019. The impact of this proposal is that inpatient mental health services would not be reinstated at the George Bryan Centre.

What is not in scope

Alongside this proposal sits a three-year programme to transform community services, which will continue beyond the timescale of this business case. This should be looked at alongside the proposal, as community support is a key factor in a decrease in the need for inpatient beds. Whilst the community support helps to provide the case for change, the delivery of the model of community services is not in scope of this business case.

Any decision about the future of the George Bryan Centre building will follow the decision about the services and is not in the scope of this business case.

Geographical context

The geographical area impacted includes parts of East Staffordshire including Burton upon Trent, Lichfield, Tamworth, Stafford and Cannock Chase. The George Bryan Centre is within the boundaries of Lichfield District Council.

Appendix 1 sets out a summary of the latest information relating to the local population, with a focus on its mental health, in order to provide background to this business case. It provides a particular focus on Lichfield, East Staffordshire (including Burton upon Trent) and Tamworth

Figure 2 below shows the home location of patients admitted to the George Bryan Centre in the 12 months before the fire in February 2019.

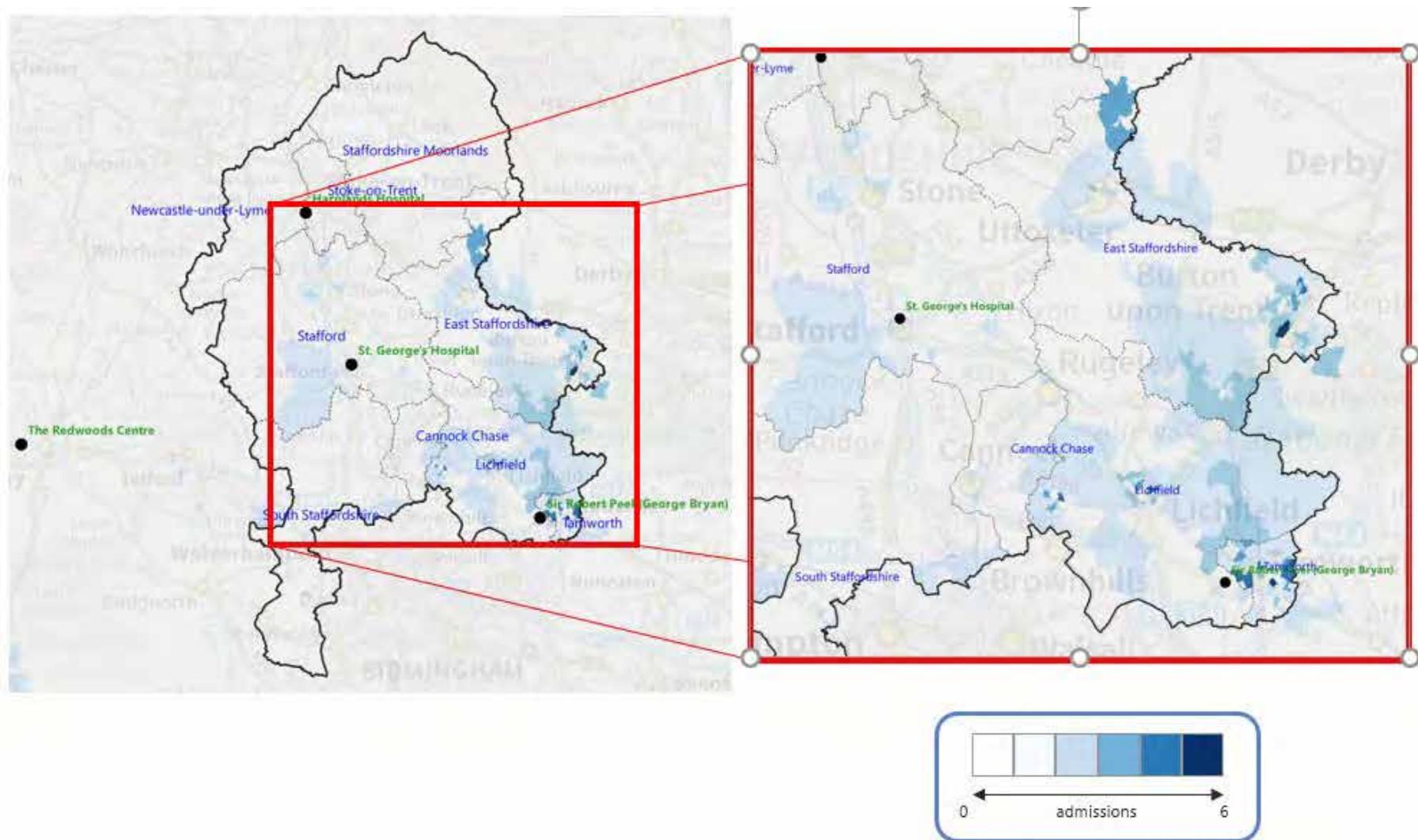


Figure 2 Home location of patients admitted to the George Bryan Centre in the 12 months pre-fire

1.3 Background to the service change proposal

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.
- The George Bryan Centre, just outside Tamworth in the boundary of Lichfield District Council.

St George's Hospital's offers services for up to 183 inpatients, comprising:

- Assessment and treatment for older people with severe mental illness and dementia at Baswich and Bromley wards with accommodation for 26 service users.
- Assessment and treatment services for 68 adults with severe mental illness at Brocton, Chebsey, Milford, and Norbury wards. These include six Ministry of Defence beds in Brocton Ward, and 11 psychiatric intensive care unit (PICU) beds for males in Norbury Ward.
- And specialist services including: 16 peri-natal beds, 12 eating disorder beds, and 61 specialist forensic beds

The enhanced facilities at St George's Hospital mean that it also provides a designated Place of Safety service for high acuity patients including those who, in severe crisis, have been detained under Section 136 of the Mental Health Act for their own safety and the safety of others. The service is available 24 hours a day, 365 days of the year. Assessments can take up to 72 hours and can lead to hospital admission on a voluntary or compulsory basis, or a discharge to the community with appropriate support.

The George Bryan Centre, a two-ward unit next to the Sir Robert Peel Community Hospital just outside Tamworth opened in 1995. At that time South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) was the Trust responsible, which became Midlands Partnership NHS Foundation Trust (MPFT) in 2018 following a merger of SSSFT with Staffordshire and Stoke-on-Trent Partnership NHS Trust. MPFT owned and still owns the centre. It provided services for the people of Tamworth, Lichfield, Burton upon Trent and surrounding areas.

These services were provided in:

- The West Wing - inpatient assessment, care and treatment services for up to 19 adults aged 18 plus with severe mental illness.
- The East Wing - inpatient assessment, care and treatment services for up to 12 older adults (over 65) with severe mental illness or dementia. Severe mental illness can include mood disorders, psychosis, anxiety and depression.

Patients were admitted to the George Bryan Centre if the severity of their illness was on the lower end of an acuity scale, but these wards did not support high acuity (very seriously ill) patients.

The Care Quality Commission (CQC) carried out a routine, unannounced inspection of the George Bryan Centre over two days in July and August 2013 and identified issues with the quality of care at the centre. Of the six standards assessed in the inspection, the

provider was assessed as having met four. The inspection team deemed that action was needed to meet the standards required for:

- Safeguarding people who use services from abuse; and
- Safety and suitability of premises.

The inspection team judged that the issues identified under both these headings had a minor impact on the people who use the service and told the provider to take action and report back. CQC checked that the necessary actions had been taken.

The CQC said in their report:

“We saw that in the communal areas and bedrooms some potential ligature points had not been removed... We saw that in both wards the physical environment did not lend itself to separation of male and female bedrooms. All bedrooms were single occupancy. However, we saw that each bedroom area within the wards had a mixture of male and female patients accommodated. Patients had to pass through opposite sex areas to reach their own facilities. Staff told us that it was difficult to ensure separate male and female areas because of the variation in the balance of genders occupying each ward. The published guidance on eliminating mixed sex accommodation states that all sleeping areas (bedrooms and bed bays) must be segregated, and members of one sex should not have to walk through an area occupied by the other sex to reach toilets or bedrooms. (CQC report, September 2013)”

MPFT’s forerunner (SSSFT) made some improvements to the environment and noted that to fully enhance the environment to meet standards it would require significant rebuild.

In 2017, SSSFT described¹ the quality of the environment at the George Bryan Centre as requiring significant building works to provide a clinically safe environment. It described the centre as remote from other sites, citing the challenges that this creates in responding to medical and psychiatric emergencies and the risks this creates for service users, visiting carers and staff.

At the same time, it was becoming clear that the services provided from the George Bryan Centre were not aligned with the developing national mental health strategy for services to be provided in the community and people’s homes wherever possible. These factors led to internal discussions about possible changes to the configuration of services, including the development of a business case on creating the capacity to consolidate mental health inpatient services at St George’s Hospital.

Increasing capacity at St George’s Hospital

In November 2021 MPFT completed the refurbishment and extension of Milford Ward, which had been a long-held ambition. First approved in June 2018, the project was initially delayed by using the ward as part of the system response to winter pressures in

¹ PM14 – SSSFT Business case for the interim solution for the centralisation of beds for adult Mental Health Services in Stafford (SSSFT Nov 17)

2018/19. The period of the works was then extended to allow for the ward to be occupied while work was carried out.

Milford House at St George's Hospital was MPFT's mental health contingency ward for some time. In June 2018, MPFT's finance and performance committee approved a case to increase capacity at St George's Hospital by refurbishing, upgrading and extending Milford House.

The use of Milford House for winter pressures, as a contribution to the system bed numbers for acute patients, delayed that programme. And in February 2019 the ward was used in its contingency role to accommodate patients relocated on the night of the fire at the George Bryan Centre. Plans for the works were revisited and improved with the Trust Care Group and enhanced to take account of updated guidance on planning and designing adult acute mental health units in England (HBN03-01)¹. The improvement works were rescheduled. In June 2020, the Trust approved plans and increased costs caused by the redesign and working in an occupied ward. In 2020-21 Milford House was extended, reconfigured and upgraded to provide up-to-date facilities and to increase capacity of adult acute beds on the St George's Hospital site. The number of inpatient beds increased from 12 to 18.

The refurbishment of Milford House provides additional, mixed-sex inpatient capacity at St George's Hospital.

How the fire at the George Bryan Centre impacted on the service change proposals

On 12 February 2019, a fire took hold in the West Wing of the George Bryan Centre.



Figure 3 Aerial view of the West Wing following the fire

¹ [HBN 03-01\) Adult mental health units: planning and design](#), August 2021

Following the fire, MPFT began what became a three-phase project to finalise the future of the services provided at the George Bryan Centre.

Phase 1 comprised the initial arrangements put in place after the fire alongside further deliberation about the overall future of mental health services.

Phase 2 was an involvement exercise in the latter part of 2019.

From spring 2020 there was a pause whilst the NHS concentrated on its response to the pandemic and the immediate needs.

Phase 3 began in 2021 when there was once again scope to look at transformation, including the transformation of mental health services in south east Staffordshire and to deliver on the MPFT board's commitment to engage on the future provision of those services.

Phase 1

At the time of the fire that destroyed the West Wing and in line with procedure, all the patients in the West Wing were evacuated to St George's Hospital in Stafford, 25 miles away. The patients in the East Wing were moved to communal areas for safety. An assessment was made about the safety of the East Wing. As a result of the assessment, the 12 beds for older adults with severe mental illness or dementia were temporarily closed on clinical safety grounds. The decision to close them was made at a confidential session of the Board of MPFT on 28 February and the patients were moved to an appropriate placement, the last patient leaving in April 2019.

At the time of the fire, the transformation of community mental health services in line with national guidance had already begun. A community model with a specialist team was already in place to care for patients with dementia. It was already having an impact on admissions as patients with dementia were more able to stay in the community rather than being admitted to hospital, in line with national guidance and clinical evidence. Consequently, when the West Wing burnt down, there were more older adults with severe mental illness in the East Wing than patients with dementia.

With support of commissioners MPFT took positive action in response to the loss of the facility at the George Bryan Centre to put in place enhanced community support for older adults with severe mental illness such as depression, anxiety and psychosis.

Phase 2

In June to August 2019 the Staffordshire and Stoke-on-Trent integrated health and care system, under the badge Together We're Better (TWB), published and held wide patient and public engagement on a Case for Change¹ document as part of its system-wide transformation plan for services across the area. This included mental health services.

MPFT carried out an engagement exercise in autumn 2019, the main objective of which was to capture people's experience of being an inpatient at both the George Bryan Centre and St George's Hospital in the two years preceding the fire. There were further

¹ [Together We're Better Case for Change](#), August 2019

workshops led by TWB looking at proposals for future services in autumn 2019 and January 2020.

COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent.

Phase 3

In 2021, there was once again scope to look at developments in health services, following the initial pressures of COVID-19.

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.

This business case refreshes, with more detail, the initial thinking about the future of the services previously provided at the George Bryan Centre and lays out a case for change for decision-makers to consider.

System partners across the Integrated Care System (ICS) are working together to identify interdependencies and to minimise risk.

Any decision about the future of the building on the site will follow the decision about the services and is not in the scope of this business case.

This business case is developed in line with the wider strategy for mental health services in Staffordshire and Stoke-on-Trent.

1.4 Current situation for those who might previously have been supported at the George Bryan Centre

Below we describe how patients previously served by the George Bryan Centre are now supported. The graphic below illustrates the timeline for the changes.

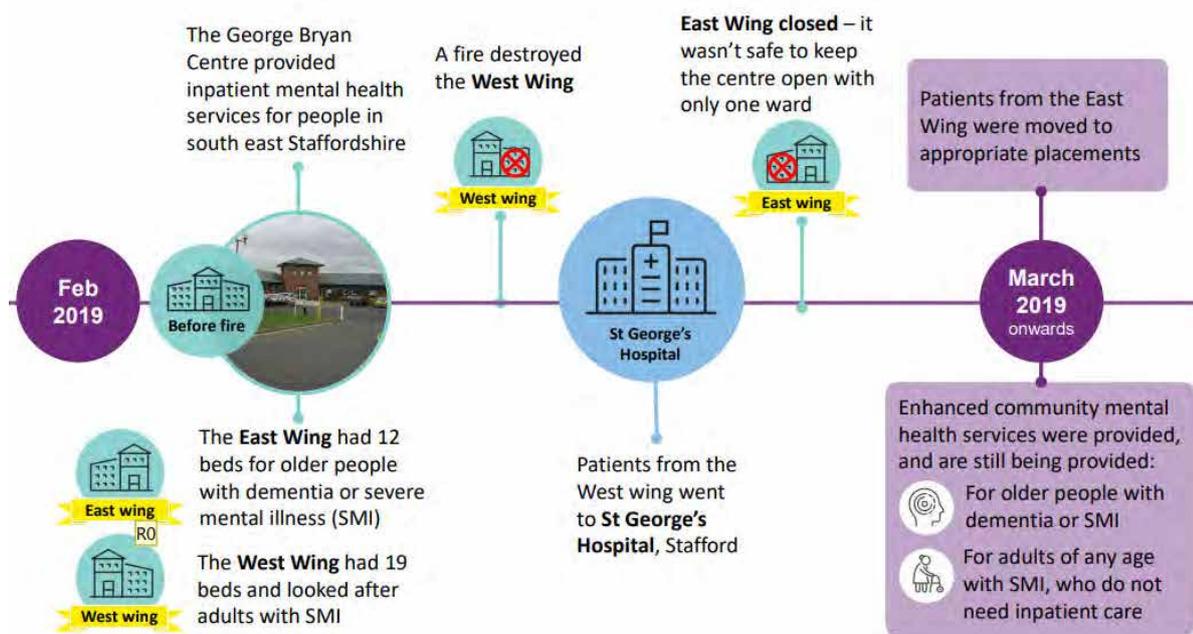


Figure 4 Changes following the fire

1.4.1 Adults (aged 18 plus) with severe mental illness

Since February 2019, anyone living in Burton upon Trent, Lichfield, Tamworth and surrounding areas who is experiencing severe mental illness is supported by the community teams. This is primarily, but not exclusively, those who would have been treated in the West Wing of the George Bryan Centre.

As they become more unwell, intensive community support enables them to recover without requiring acute inpatient admission and facilitates early discharge, if admission is required.

The community support in place includes:

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

The community support team includes a dedicated worker at a single point of access who could assess the requirements of each patient and recommend the appropriate care pathway.

If a patient needs an inpatient stay for assessment or for treatment, they are admitted to St George's Hospital in Stafford for a short period.

The acute inpatient service commissioned in April 2019 and reviewed as and when required includes the following statements:

- *Lengths of hospital admissions will be reduced through prompt, comprehensive assessments and multi-disciplinary working relative to identified needs.*

- *Care plans will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care.*
- *Service users will be discharged to accommodation appropriate to their needs, and where required accommodation providers will be active participants of care teams.*

This illustrates the move towards community-based care wherever possible.

1.4.2 Mental health assessment and treatment service for older adults (over 65) with dementia

With regard to older adults with dementia, a Quality Impact Assessment carried out in August 2019 [Appendix 2] for the interim closure of the East Wing explained that the Community Dementia Service provides a multi-disciplinary service to people with dementia and their carers who are affected by complex and challenging needs. This person-centred approach is delivered by teams based in the east and west of South Staffordshire and offers *a range of community support services able to respond to individuals' needs*. The approach has a strong evidence base on research on the management of challenging and complex behaviour in dementia.

The Community Dementia Service in south east and south west Staffordshire was commissioned in April 2019. It is reviewed as and when required by either commissioner or provider.

This illustrates that services for older adults with dementia had already moved or were moving to a community-based model of support.

The model for this enhanced service provision identified the skill mix required for working with frailty and older people and the service was 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 patients' homes to refer them to services.
- New clinical psychologist to focus on older adults.
- The Crisis Resolution Home Treatment Team (CRHTT) works with the service to direct relevant patients to the new pathway, with a dedicated member of staff within the 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.

1.4.3 Mental health assessment and treatment service for older adults (over 65) with severe mental illness

Older adults with severe mental illness often have additional needs that come with frailty and old age. Those needs are met by enhanced community services provided by the Older Adults Services/Care Teams.

This service was commissioned in April 2019 as part of the Adult Community Mental Health and Social Care Team Service (CMHTs) and is reviewed as and when required by commissioner or provider. The service specification states that its purpose includes providing a comprehensive community Mental Health Service to older people presenting with disorders such as depression, bi-polar disorder and psychosis.

The team provides an integrated whole-systems assessment and treatment service for individuals within the individual's home or a community setting close to home, including nursing and residential homes, that is person-centred and recovery-focused.

It had been recognised that the community offer in place for severe mental illness was the same for all adults aged 18 plus and that older adults often had additional needs because of physical frailty and the bereavements that come with old age. There was a period of two months before the East Wing beds were closed during which a plan was put in place for the enhanced community support from the Older Adults Services/Care Teams for older adults with severe mental illness.

This was in line with the policy drivers described in Section two of this business case, with the emphasis on more care for mental health service users in the community rather than in hospital bed settings.

As with the teams supporting older adults with dementia and adults with severe mental illness, the following are in place:

- Addition of a nursing/therapy lead to ensure interventions are evidenced-based and focussed on enabling individuals to maintain their independence at home.
- 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.

1.5 The vision and commitment

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

The overarching programme for transforming health and care services developed by the ICS, known as Together We're Better (TWB) has the following vision:

To work with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work. This means:

- *Helping you live well, for longer, and supporting you to be as independent as possible so we can be there when you need us;*

- *Delivering care as close to home as possible, ensuring that your experience of health and care is the best it can be; and*
- *Treating people rather than conditions and giving mental health equal priority to physical health.*

In May 2019 the Staffordshire and Stoke-on-Trent health and care system published and held wide patient and public engagement on a Case for Change¹ document as part of its service transformation plan for services across the area. It included mental health services and involved developing a completely different way of providing health and care support, making a critical shift of services and resources away from the hospital and bed-based traditional services towards a locality focussed model with a common standard of care across the whole of Staffordshire and Stoke-on-Trent.

The aims of the ICS detailed in the Staffordshire and Stoke-on-Trent ICS Designation Development Plan², 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 two 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 diagram below shows MPFT's model for mental health services.

¹ [Together We're Better Case for Change](#), August 2019

² [Staffordshire and Stoke-on-Trent ICS Designation Development Plan](#), Dec 2020

Overview of model

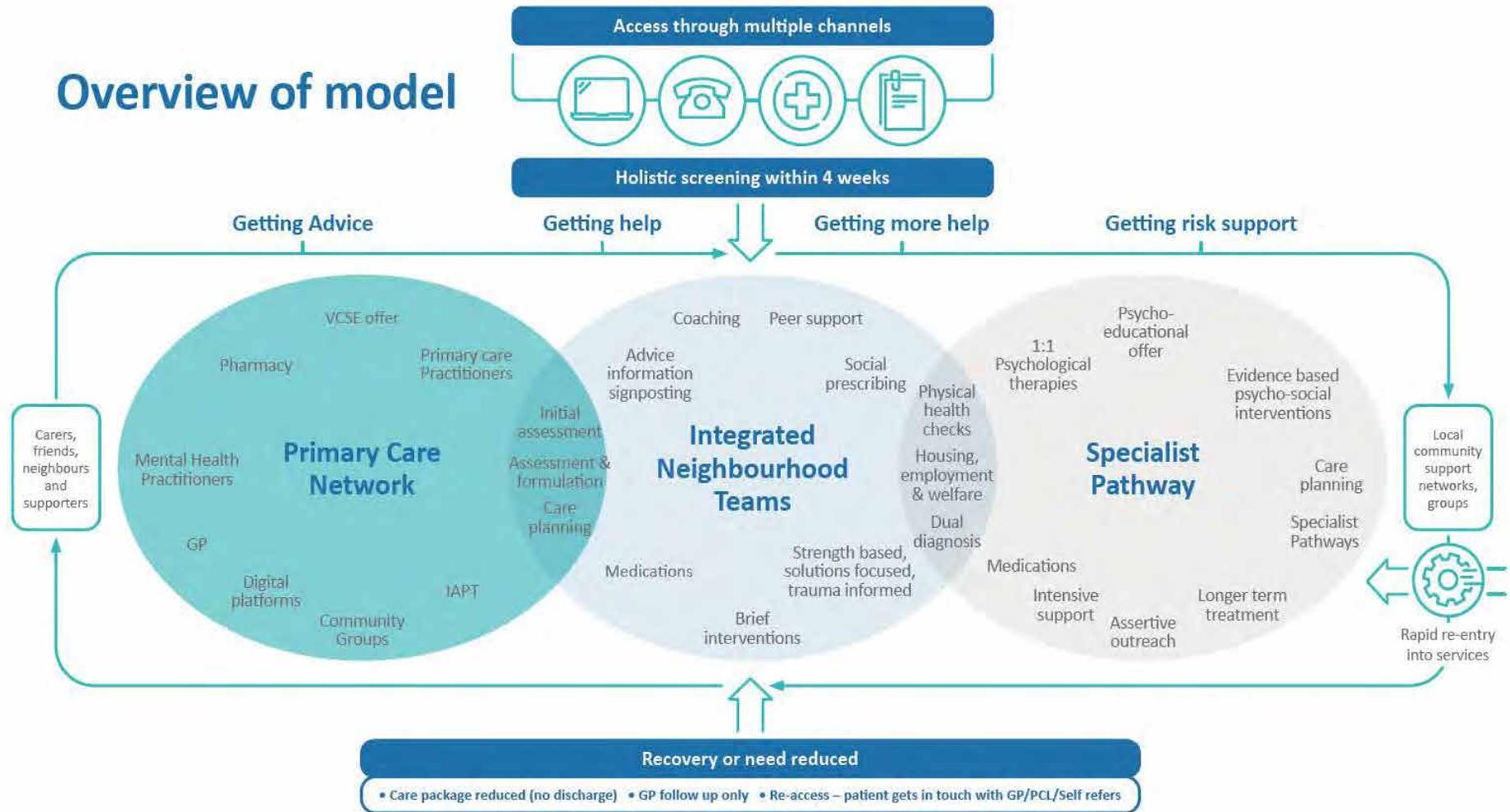


Figure 5 MPFT's model for mental health services

1.6 The process and requirements covered in the business case

NHS England describes service change as “*any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered*”.¹ Making changes to services is a complex, non-linear process.

The statutory requirements for service change are set out in *Legal duties for service change: A guide* (NHSEI 2020) [Appendix 3]. They include duties to promote equality of opportunity, reduce inequalities in health outcomes, involve patients and local people in the development and consideration of proposals for change, the four tests for service change plus the bed test, and consulting local authorities.

The regulatory requirements for service change are set out in *Planning, assuring and delivering service change for patients* (NHS England 2018)². Both have guided the development of the proposals in this business case and will inform the next steps in the decision-making process.

This document shows how the process so far meets these requirements and how the continuing process plans to meet them.

The project governance arrangements (described in Section eight) take account of the need to liaise with regional NHS England and NHS Improvement (NHSEI) teams and local authorities in the area of the change programme. Local authorities have multiple roles as critical stakeholders, partners in ICS, and have statutory scrutiny powers.

¹ p10, *Planning, assuring and delivering service change for patients*, NHS England 2018

² [Planning, assuring and delivering service change](#), April 2018

2 The case for change

2.1 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

2.2 The national policy picture

2.2.1 Long Term Plan

The NHS Long Term Plan¹ (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 View² (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 Plan³ 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”*³.

“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

³ [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 multidisciplinary 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 Act¹, 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.

2.2.2 National standards and aims

Following on from the LTP, the Community Mental Health Framework¹ 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 business case.

The 2017 review of the Mental Health Act and the government’s White Paper response to the review in 2021² 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 Health³ 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

2.3 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 Change¹ 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 [Together We're Better Case for Change](#), August 2019

2.3.1 ICS Designation Development Plan

In December 2020 the ICS published the Staffordshire and Stoke-on-Trent ICS Designation Development Plan¹.

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.”*

¹ [Staffordshire and Stoke-on-Trent ICS Designation Development Plan](#), Dec 2020

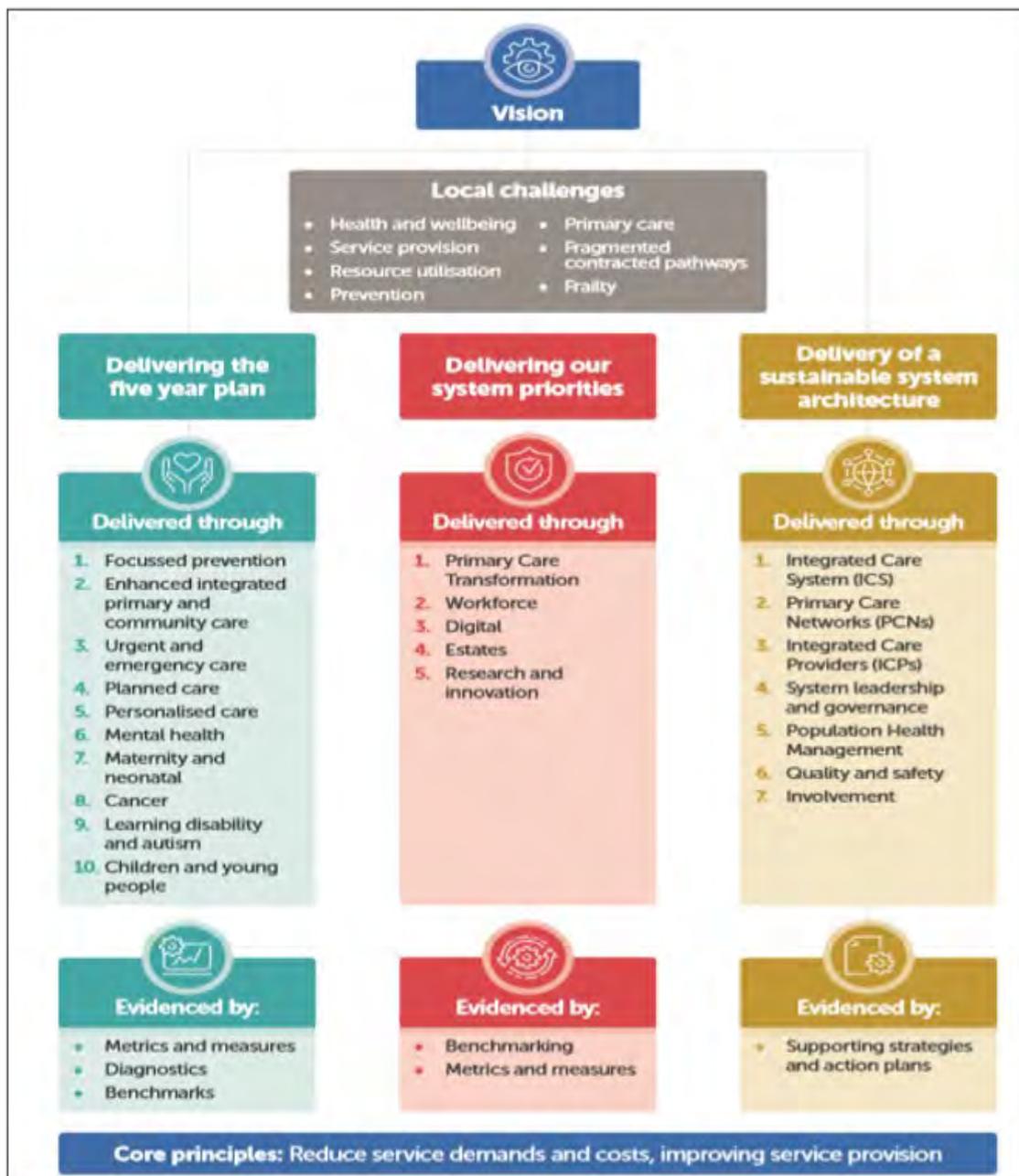


Figure 6 Strategic framework from the Staffordshire and Stoke-on-Trent ICS Designation Development Plan

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*

2.3.2 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 backdrop 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) [Appendix 4] on 19 October 2021 forecasting future impacts of mental health due to COVID-19 looked at potential changes in mental health condition 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 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

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

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.*

2.4 Operational case for change

2.4.1 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.

The Staffordshire NHS commissions inpatient services at two population levels: whole population and 500k.

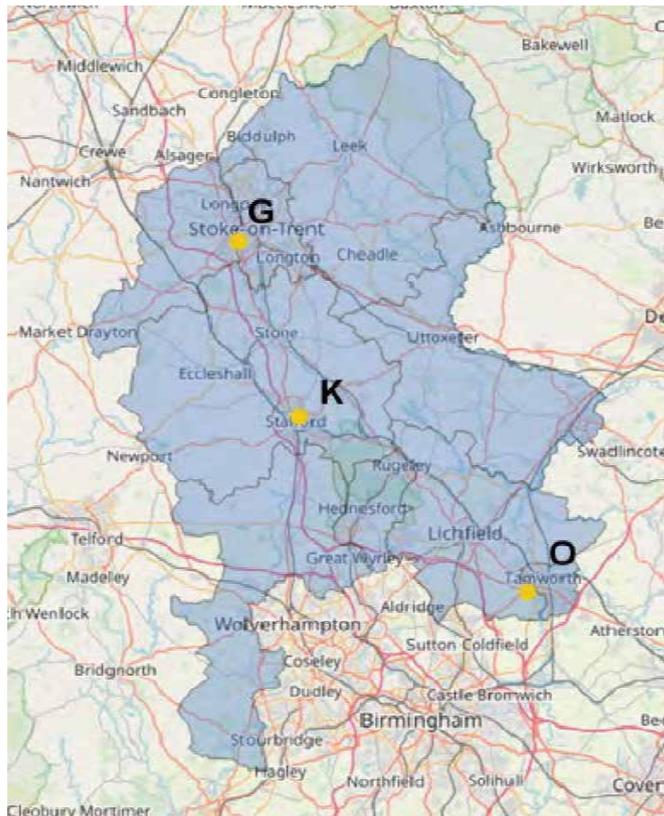


Figure 7 Care provided across the whole of the Staffordshire and Stoke-on-Trent system

The figure above shows the mental health care provided across the whole of the Staffordshire and Stoke-on-Trent system. In the figure, 'K' refers to St George's Hospital, Stafford and 'O' refers to the George Bryan Centre. Both serve south Staffordshire. 'G' 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 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 CCGs commission 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.



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% | |

Table 2 Comparing Staffordshire and Stoke-on-Trent's mental health services with those in the rest of the country

This table shows that compared to national figures, there are fewer adult acute beds per 100,000 weighted population, showing the commitment to more community-based care. The table also shows that the acute mean length of stay is lower than the national mean and median, an indicator that the move to community-based care is working well in Staffordshire.



Benchmarking Network

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% | |

Table 3 Demonstrating how Staffordshire has moved more quickly than average to move care into the community

Like the previous table, this table shows how Staffordshire has, more quickly than average, moved care away from inpatient beds and into the community. Where older adults are admitted, their length of stay is shorter than the national mean and median. Figures later in this document show the specific admissions for older adults with severe mental illness or dementia at St George’s Hospital and how they contribute to this overall figure.



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 | |

Table 4 Mental health support in the community

This table illustrates the mental health support in the community, showing a higher community caseload than the national mean or median and a higher number of community contacts per 100,000 weighted population.

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

Since 2021 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 diagram below gives an overarching view of community mental health that is developing and will operate across the whole of Staffordshire and Stoke-on-Trent.



Staffordshire and Stoke-on-Trent Community Mental Health Transformation

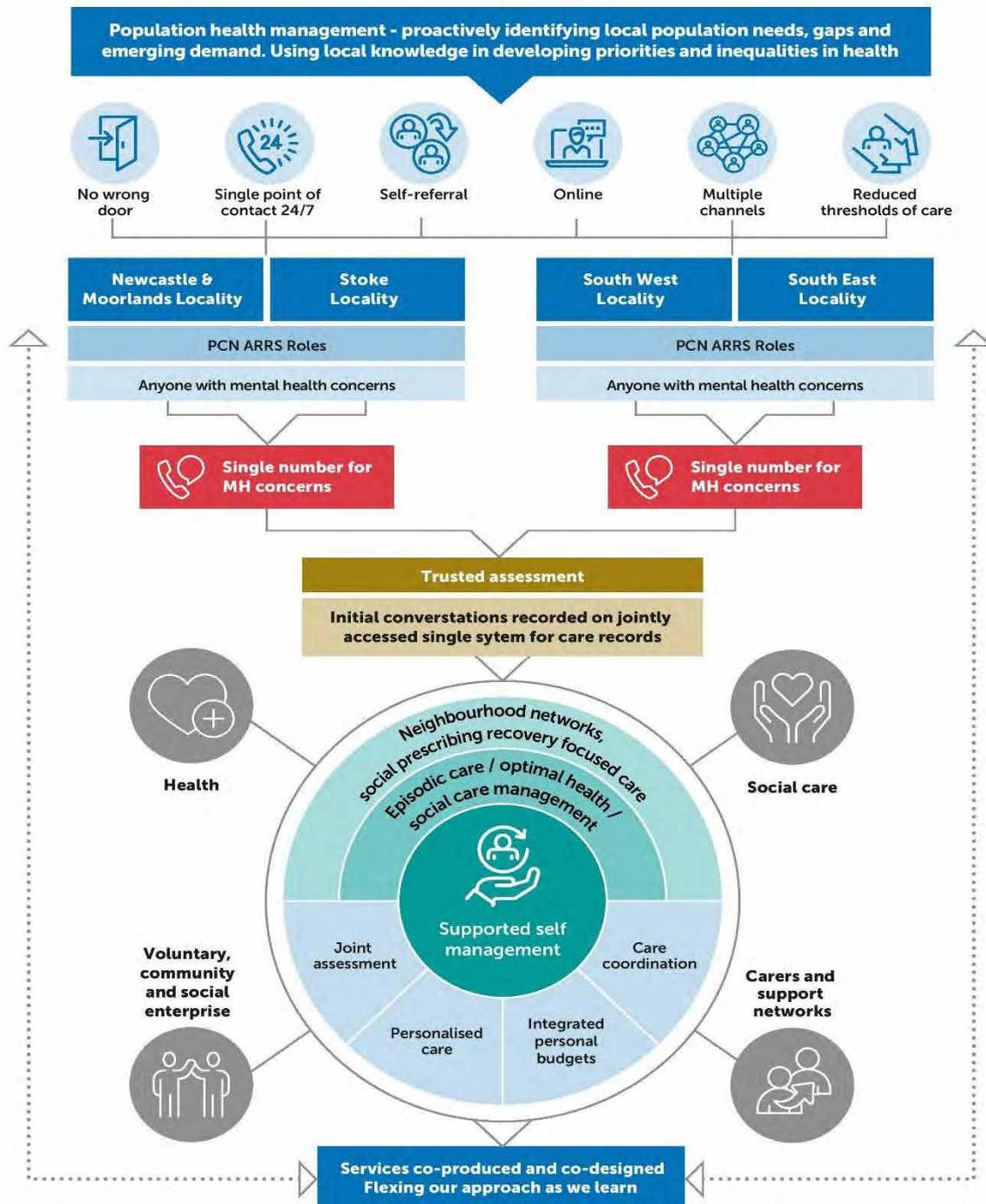


Figure 8 Staffordshire and Stoke-on-Trent community mental health transformation model

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, 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 | Expansion in the Improving Access to Psychological Therapies (IAPT) programme, particularly for people | 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 |

| | | | |
|---|--|--|---------------------------------|
| the promotion of wellbeing and recovery through self management | with long-term physical conditions | | 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 LTP and national best practice approaches.

2.4.3 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 8 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.

In 2018, North Staffordshire Combined Healthcare submitted a bid to the Sustainability and Transformation Partnership (STP) for capital funding to develop an Urgent Care Centre, a set of detoxification suites and four crisis cafés at various Staffordshire locations. The bid was prioritised and national money was awarded to support the schemes. Since the award of the money, an alternative solution has been developed and North Staffordshire Combined Healthcare Trust no longer require the capital funding. MPFT is progressing the approved schemes in South Staffordshire.

Following a change request in 2021, MPFT has been allowed to transfer £881,657.19 out of the original envelope of capital funding of £1.6m in order to fund a crisis café/safe haven in south Staffordshire. This will be located in Burton upon Trent and run by The Richmond Fellowship, a national mental health charity with experience in both developing and operating safe haven models. The Richmond Fellowship will recruit and manage the staff delivering the service under a service level agreement with the Trust. They are also commissioned to provide a Short Term Crisis Intervention service.

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 it has been demonstrated that low level interventions provided through Social Prescribing models, (e.g. a non-threatening environment with friendly faces where you can talk) provided by peer support networks and supported by Crisis and Substance Misuse Services has prevented the need for higher levels of support at NHS sites and hospitals.

The scheme is in line with the expectation in the 2019 LTP 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 mental health support groups in the form of Mental Health and Autism Peer Support groups (MAPS) and 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 detention under Section 136 of the Mental Health Act.

2.4.4 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). CCGs should broker agreement if needed. The entitlement is for 1 FTE in 2021/22 and will increase to 2 whole time equivalent (WTE) in 2022/23 and 3 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.

2.4.5 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.

A peer support service for individuals aged 18 plus with autism who are struggling with their mental health is also now in place. Clients accessing this service are supported by a Peer Support Worker who can draw on their own experiences to help clients navigate the uncertainty of a diagnosis, create a care plan and access broader services.

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 CCGs are working 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. They include, for example, help with provision of housing and food. 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.

2.4.6 The patient pathway

The first diagram below (Figure 9) shows how a patient with severe mental illness currently navigates the mental health system. It illustrates how wherever possible, the patient is cared for in community settings including their own home, with the help of a Hospital Avoidance Team, rather than in an inpatient setting, and how the care 'wraps around' them to provide not just clinical but social support.

The second diagram below (Figure 10) shows the voluntary sector provision for services to support mental health patients.

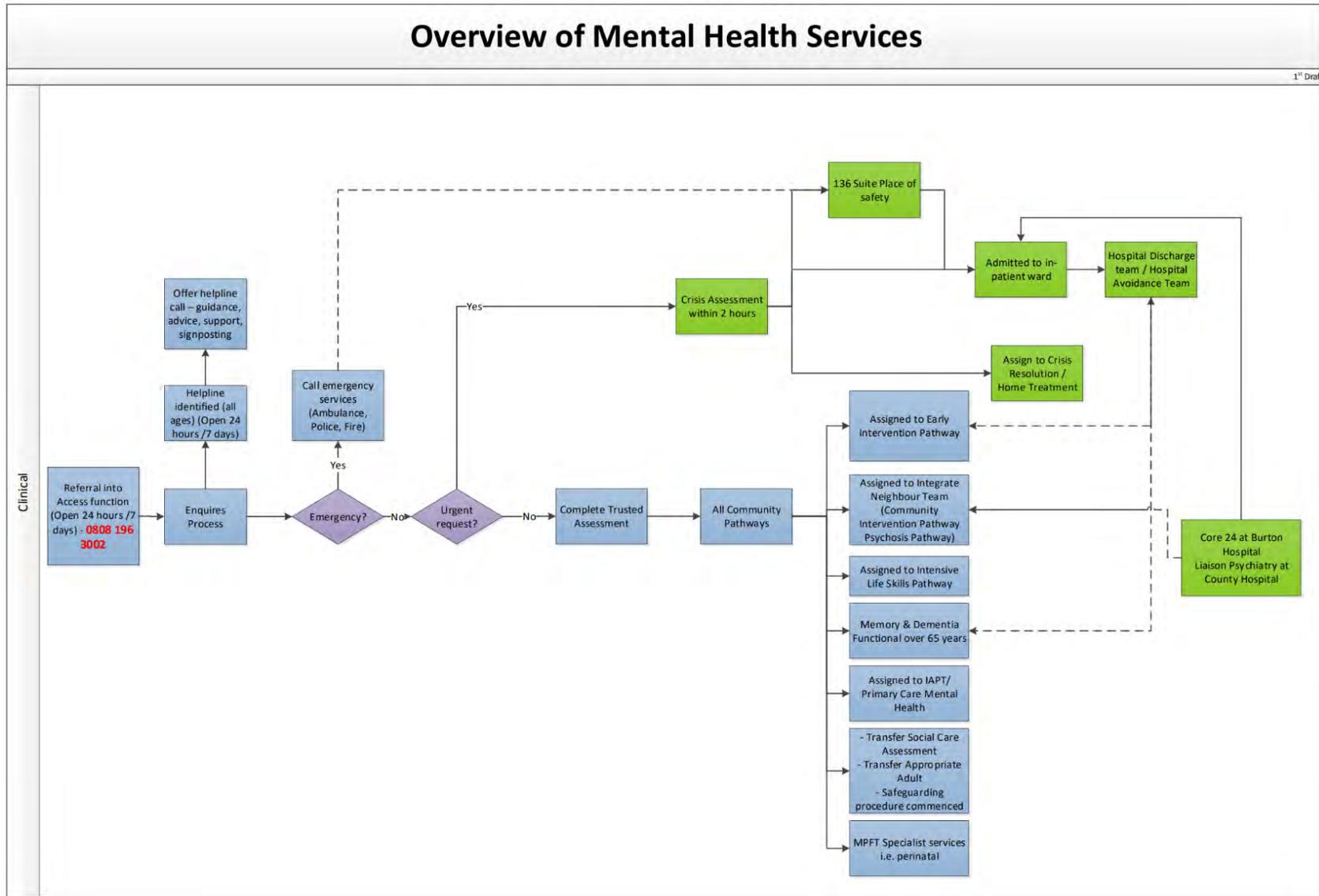


Figure 9 Overview of Mental Health Services

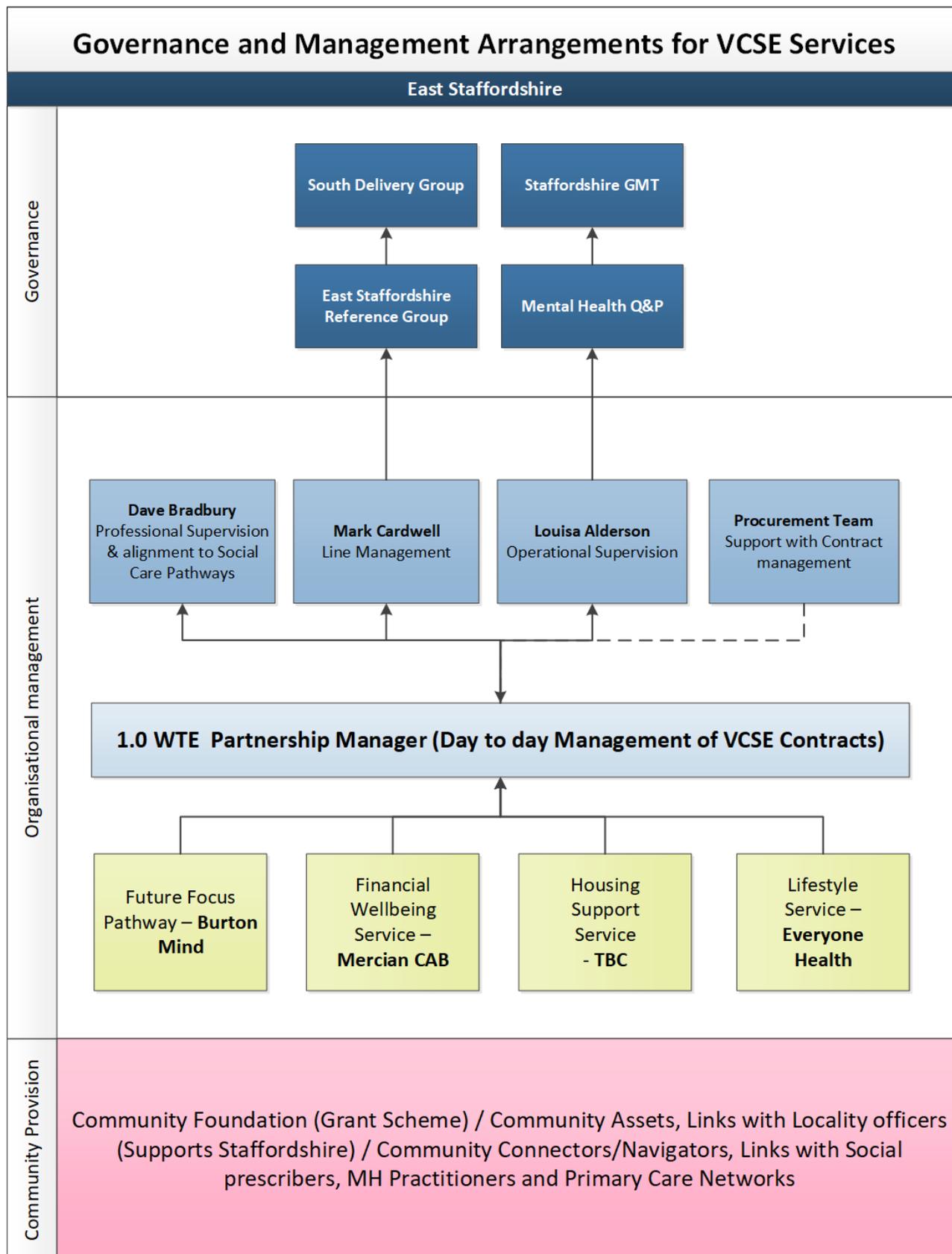


Figure 10 Governance and management arrangements for VCSE services

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 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 main contact.

2.5 Case for change for adults with severe mental illness

In this section we show the results of the change to inpatient services that has already happened as a result of the fire at the George Bryan Centre and the current situation in order to make the case that this change should become permanent.

2.5.1 Bed capacity

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 5 Configuration of beds before and after the fire

Since the fire at the George Bryan Centre, 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.

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 11 shows this ‘stepped’ model of care, with most people living in the community and receiving different levels of care depending on their need.



Figure 11 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 the fire, 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 drop 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 6 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. All other out of area acute admissions have been: the patient’s choice; 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 due to unavailability of bed is for psychiatric intensive care (PICU). MPFT does not provide female PICU services.

2.5.2 Range of services at St George’s Hospital

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 is an important element of this.

The size of the 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.

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 7 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.

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. There is more detail in the travel analysis in Section 7.5.2.

2.5.3 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 8 Number of staff safety incidents recorded at St George's Hospital until 2021 and at the George Bryan Centre pre-closure

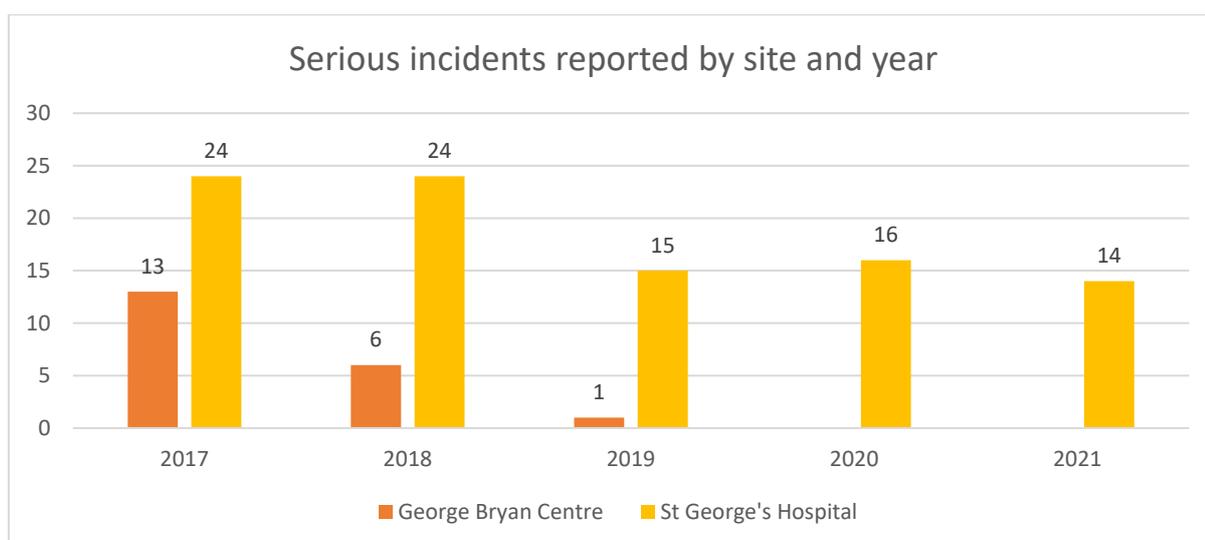


Figure 12 Number of serious incidents reported by site and year

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 drop 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 9 Number of police call outs to George Bryan Centre and St George's Hospital, Stafford

2.5.4 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 seven.

2.5.5 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.

| Centralised beds at St George's Hospital | | 18-bed unit on site of George Bryan Centre | |
|---|---------------|--|--|
| Advantages | Disadvantages | Advantages | Disadvantages |
| Patient safety | | | |
| <p>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.</p> | | | <p>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.</p> <p>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.</p> <p>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.</p> |
| <p>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.</p> | | | <p>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.</p> |

| Centralised beds at St George's Hospital | 18-bed unit on site of George Bryan Centre |
|---|---|
| <p>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.</p> | <p>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.</p> |

Table 10 Pros and cons of the two proposals as presented at the deliberative event on 15 March 2022

2.5.6 CQC inspection

The latest CQC inspection of MPFT¹ 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.

| Overall rating for this trust | | Good  |
|-------------------------------|--|--|
| Are services safe? | | Good  |
| Are services effective? | | Requires improvement  |
| Are services caring? | | Good  |
| Are services responsive? | | Good  |
| Are services well-led? | | Good  |

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Figure 13 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 as early as 2013, as discussed earlier.

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

The care of the patients who occupied the beds in the East Wing at the George Bryan Centre transferred to a community-based model following the fire in the West Wing. The diagram below shows how this model works for treating a variety of conditions.

¹ [CQC inspection report of MPFT](#), 2019

Overview of model

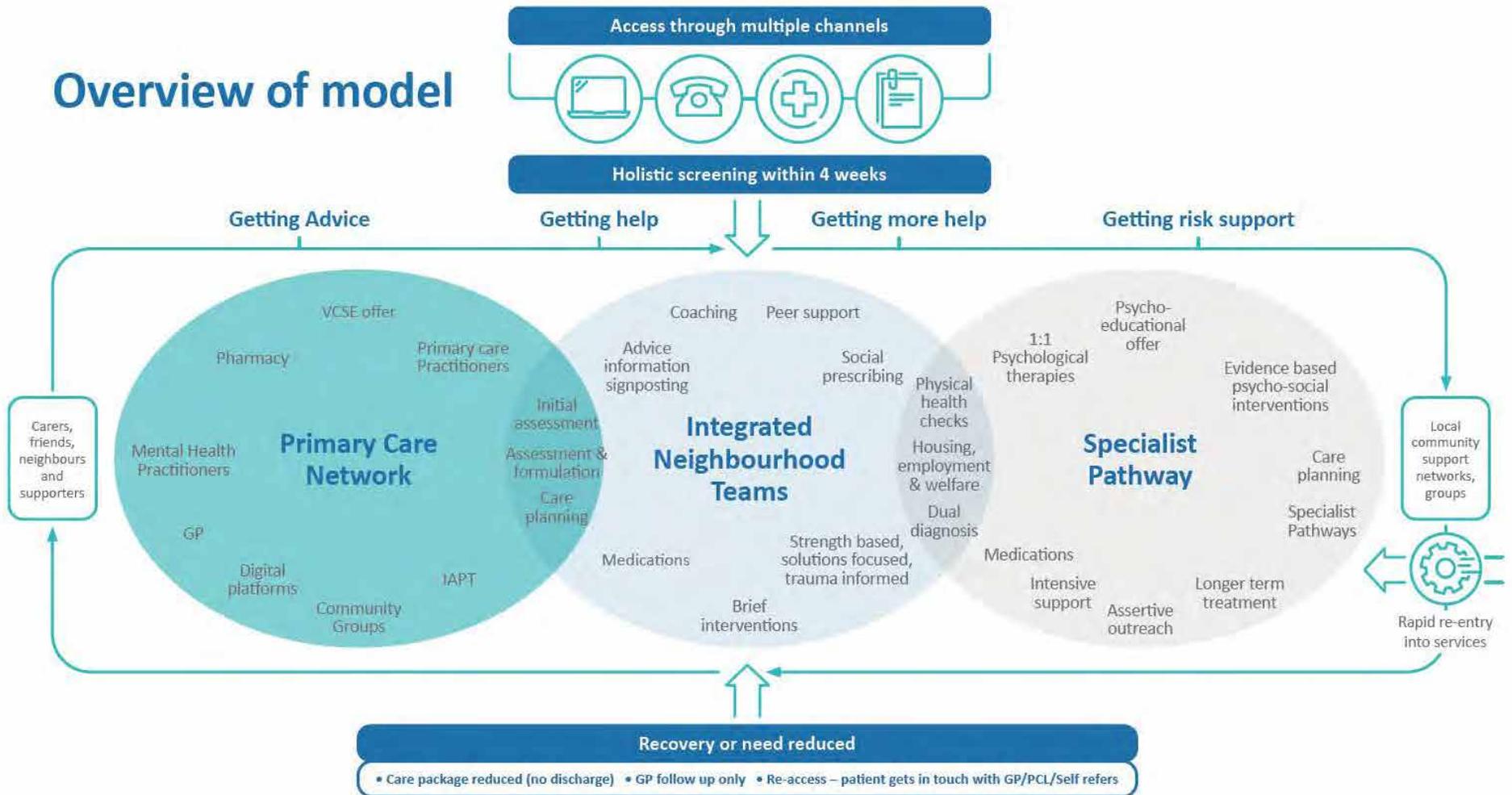


Figure 14 Community-based model of care

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. 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 worker 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.

Admissions for older adults (over 65) with severe mental illness or dementia to the George Bryan Centre from 2017 to 2019 when the fire took place 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 11 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 12 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. 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.

| Taken from the outline of 3-year delivery plan – Community Mental Health Transformation Framework | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|--|---------|---------|------------|------------|------------|
| 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 13 Funding for the Community Mental Health Transformation Framework

2.6.1 Clinical quality and safety

There is clear evidence that providing care to older adults through community teams produces better outcomes. For example:

- NICE guidance (NG97¹, 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 Pathway² 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 services³ states that overall, the strongest evidence supports the development of community multidisciplinary teams as a major service-delivery component.

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.

The latest CQC inspection of MPFT's community-based mental health services for older people in 2016 rated them outstanding.⁴

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

⁴ [Community-based mental health services for older people](#), MPFT inspection 2016

3 Financial case

3.1 Introduction

This section describes the financial impact of the proposal - the permanent re-provision of severe mental illness adult inpatient services formally 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:

- The 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.

3.2 Baseline

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 14 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.

3.3 Staffordshire ICB finances

The Staffordshire and Stoke-on-Trent ICS 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.

3.4 Impact on MPFT

The baseline costs of running services at the George Bryan Centre prior to the fire in 2019 have been summarised

The table below sets out both the workforce and inpatient bed structures for the George Bryan Centre and St George's Hospital respectively, pre- and post- the fire in 2019.

| | 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 15 Workforce and inpatient bed structures for the George Bryan Centre and St George's Hospital respectively, pre- and post- the fire in 2019

3.4.1 The changing service model

Earlier narrative has described in detail the changes to the service provision since the fire at the George Bryan Centre. Patients with severe mental illness who would formerly have been admitted to the George Bryan Centre are currently admitted to St George's Hospital. There are now additional beds at St George's Hospital following a refurbishment of Milford Ward, giving St George's Hospital more capacity.

As the table demonstrates, there are now 18 SMI beds at St George's Hospital on Milford Ward whilst there were 19 former beds at the George Bryan Centre for adults with severe mental illness. This is because when Milford Ward was refurbished it was established as a mixed sex ward rather than a single sex ward, with one of the bedrooms re-provided as a dedicated female lounge to comply with standards.

The 12 beds at the George Bryan Centre for older adults with SMI or dementia were replaced with community-based services.

3.4.2 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 14 with the current model that has evolved as described above, 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 16 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 14. 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.

3.5 Refurbishing Milford Ward

3.5.1 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 & 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.

3.5.2 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.

3.6 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 Delivery plan for 2022/23 reinforces the funding commitment and ambitions within the Mental Health Implementation plan (2019/20 – 2023/24) – the Five Year Forward View¹. 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 CCG baseline growth year on year.

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 for older adults with dementia, as well as community services which support adults, including older adults, with severe mental illness and are likely to lead to shorter inpatient stays.

The table below sets out the trajectory of additional funding into the CCG baseline over and above 2018/19 (Line 1), and the further earmarked transformation funding on top of that from 2021/22 (Line 2).

By 2023/24, community resources supporting SMI in the community will have grown by £16.6m per annum over the course of the 5 year forward plan.

¹ [NHS Five Year Forward View](#), March 2017

See line two in the table below:

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|--|---------------------------------------|---------------------------------------|--|-----------------|---------------|
| STP total of CCG baseline uplifts for community SMI care as per Analytical Tool (cumulative since 18/19; baseline of £0) | £1,786,407 | £5,030,599 | £5,312,130 | £6,241,960 | £10,133,917 |
| STP 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 |
| Minimum expectation of patient numbers to be seen within new models within your STP/ICS | <i>[early implementer sites only]</i> | <i>[early implementer sites only]</i> | 2,531 | 5,159 | 7,419 |
| Total number of PCNs within your STP/ICS | 25 | | | | |
| Total number of PCNs you plan your new model to cover (cumulative) | <i>[early implementer sites only]</i> | <i>[early implementer sites only]</i> | 8 | 16 | 25 |
| % of total PCNs in your STP/ICS that new model will cover (cumulative) | <i>[early implementer sites only]</i> | <i>[early implementer sites only]</i> | 42% | 75% | 100% |
| Total population of the PCNs you plan your new model to cover | | | 486,799 | 872,918 | 1,163,890 |
| Names of the PCNs you plan your new model to cover | <i>[early implementer sites only]</i> | <i>[early implementer sites only]</i> | Cannock North PCN Siesdon PCN East Staffordshire PCN Mercian PCN Leek and Biddulph PCN Newcastle North PCN Meir PCN Whitfield PCN | TBC via 2nd EOI | Full coverage |

Table 19 Outline of 3 year delivery plan

4 Workforce plans supporting the proposal

4.1 Introduction

This section of the 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 health 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 20 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 format of governance meetings follows a consistent agenda and has oversight of the mental health transformation work across the ICS. The ICS Mental Health programme Board receives highlight reports from delivery groups describing progress against the key deliverables and milestones. The reporting process ensures that the transformation programme is held to account for delivery and progress, including the escalation of risks and issues.

2020/21 saw a renewed focus on mental health services and the transformation requirements. The year 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 that a cross sector partnership of providers can wrap seamless and holistic support around individuals. The model is clinically-led only when necessary, and is built on the mutual respect of the skills and expertise all partners bring to the service.

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 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 and spreading the outcomes from this work will be identified and actioned as appropriate.

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 which enhance the workforce planning approach to recruit and retain the workforce, alongside robust organisational development approaches to engage the workforce and deliver new ways of working (including exploring the impact of transformation across professional roles).

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 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 two, 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 21 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.

At option 2, the table shows the total whole time equivalent (WTE) required for the George Bryan Centre as a standalone site, while meeting safe staffing requirements. The safe staffing requirements are calculated using the Mental Health Optimal Staffing Tool (MHOST).

This should be considered alongside the difficulties recruiting staff to standalone establishments such as the George Bryan Centre.

Around 20 WTE staff are required to support the community offer for adults and older adults with severe mental illness or dementia. In the event of the need for additional staff to support a standalone unit such as the George Bryan Centre, this would create a staffing pressure. The workforce profiles below demonstrate the number of people over the age of 51. Many of these staff will 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.

4.3.2 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 22 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, and 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.

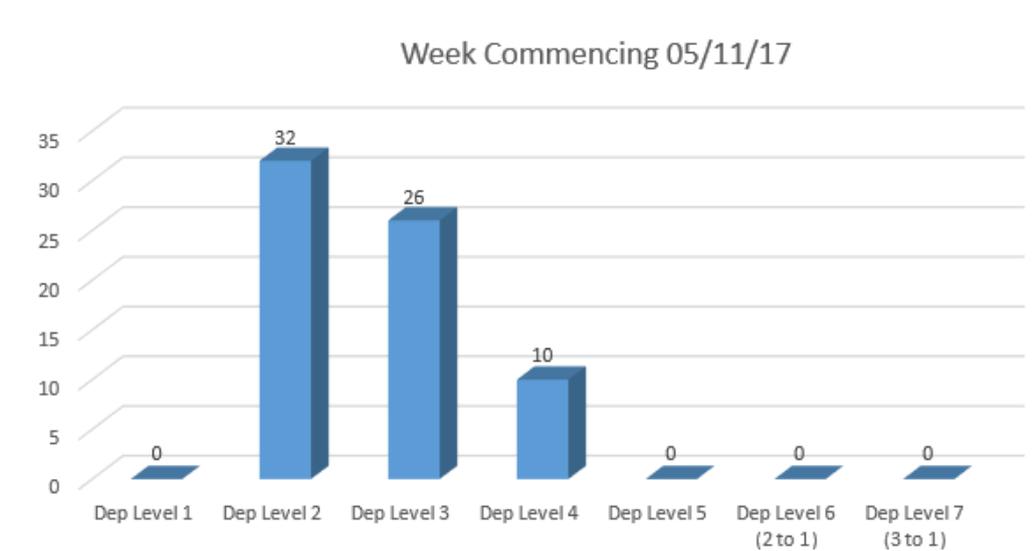


Figure 15 Acuity for the George Bryan Centre in November 2017

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.

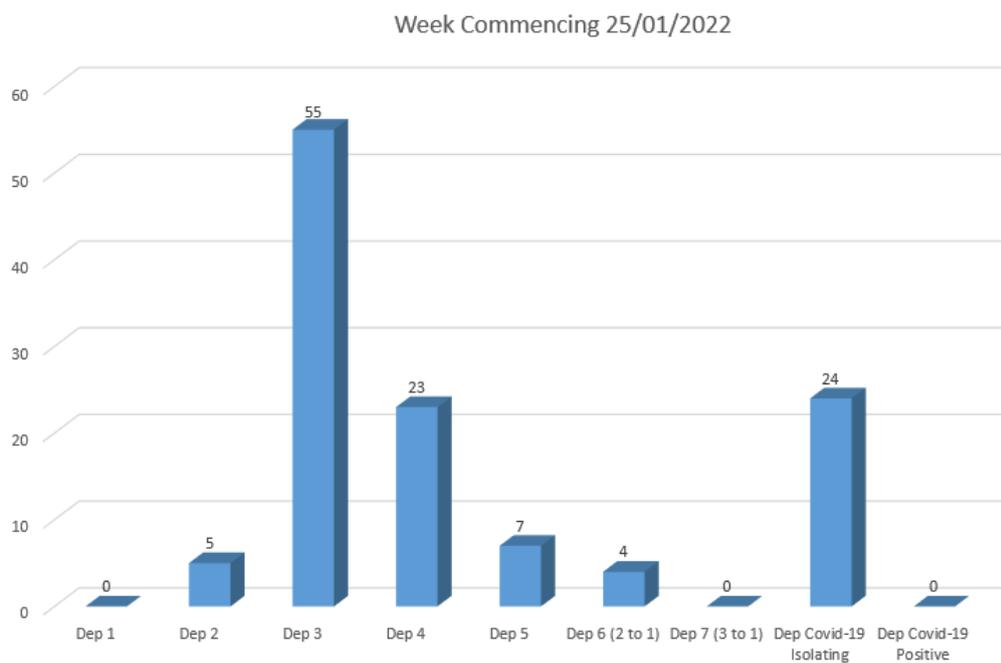


Figure 16 Acuity for Milford in January 2022

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.

4.3.3 Workforce profiles

The figures below illustrate the workforce age profile at the George Bryan Centre, together with the leavers profiles and the vacancy profile at the end of 2018.

4.3.3.1 George Bryan Centre workforce

George Bryan Centre - age profile

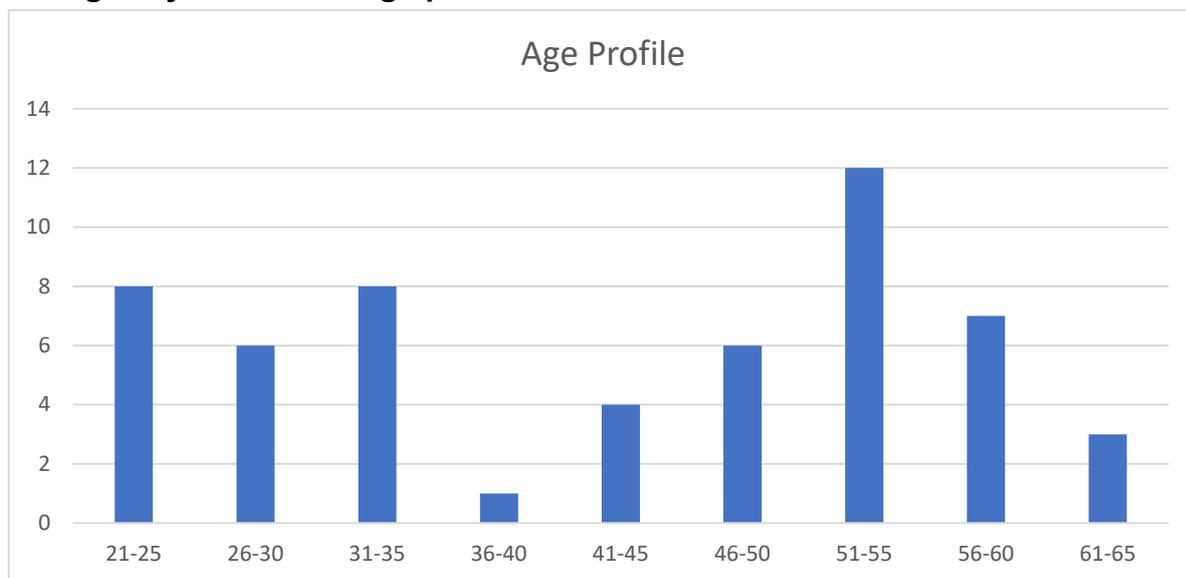


Figure 17 Age profile of the George Bryan Centre workforce at 31 December 2018

The figure above shows the age profile of the George Bryan Centre workforce as at 31 December 2018. The data shows that 40% of staff (headcount = 22) were aged 51 and over, with only 14.55% of the workforce (headcount = 8) below the age of 25.

Analysis of the nursing workforce highlights that 34.78% of staff were aged 51 and over; 33.33% of medical and dental staff fell within this age range. 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 challenges around staff shortages.

In the Allied Health Professional workforce, 33.33% of staff are aged 51 and over and 43.48% of clinical support staff were aged 51 and over.

George Bryan Centre – workforce leavers profile

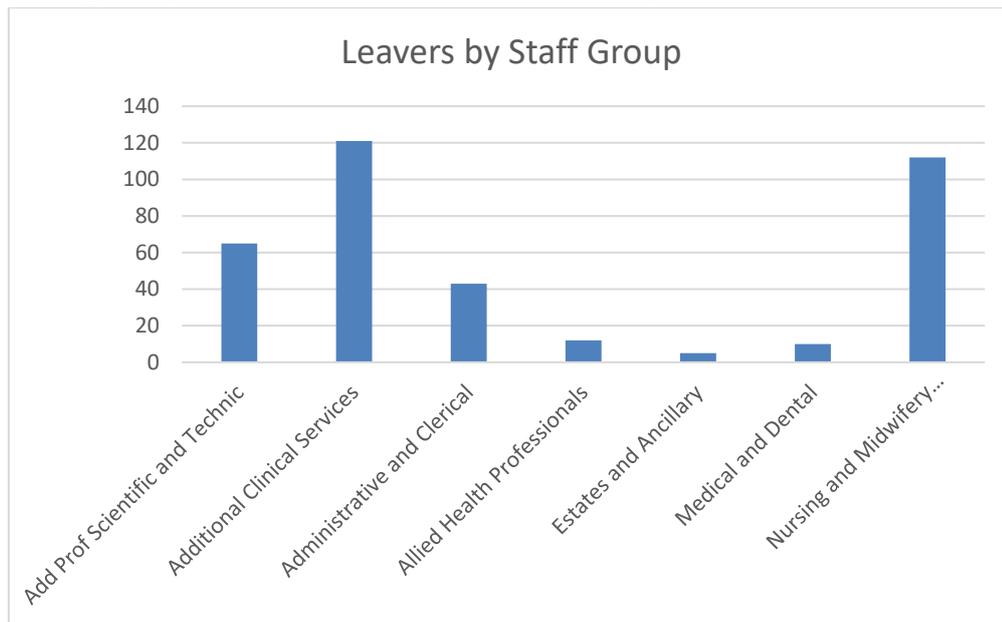


Figure 18 George Bryan Centre workforce leavers profile by staff group

The overall picture shows that over the 12 months ending 31 December 2019 the highest leaving reason from the George Bryan Centre was retirement (50% of leavers); 12.5% of leavers left for work life balance reasons and 12.5% due to promotion.

In terms of leavers by staff group, the highest number of leavers can be seen in the Additional Clinical Services staff group (62.5%), followed by Nursing and Midwifery Registered (12.5%) and Administrative and Clerical (12.5%).

George Bryan Centre – workforce vacancy profile

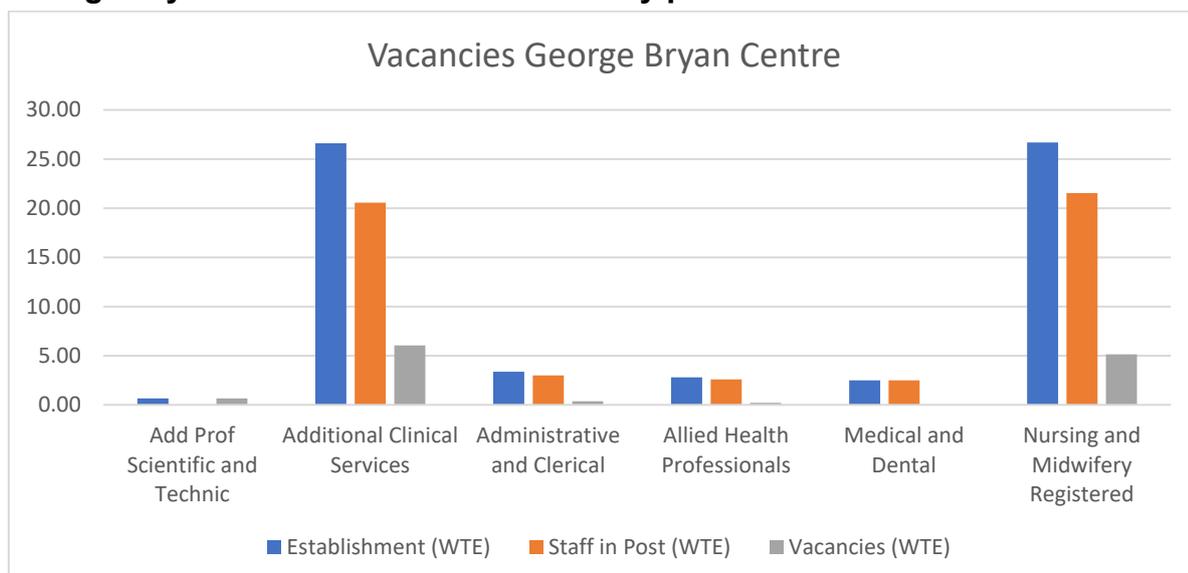


Figure 19 George Bryan Centre workforce vacancy profile

Whole time equivalent vacancies by staff group are shown in the table above. The overall number of vacancies across the George Bryan Centre at the end of December 2018 was 12.43 WTE, giving a vacancy rate of 19.84%.

In the Nursing and Midwifery Registered staff group there were 5.15 WTE vacancies giving a vacancy rate of 19.29% (this equates to 41.41% of all vacancies at the George Bryan Centre).

The vacancy rates in other staff groups are as follows; Medical and Dental 0% (0 WTE), Allied Health Professionals 7.14% (0.2 WTE), Additional Professional Scientific and Technical 100% (0.66 WTE), Administrative and Clerical 10.98% (0.37 WTE) and Additional Clinical Services 22.74% (6.05 WTE).

4.3.3.2 St George’s Hospital, Stafford

The figures below show the profiles of staff at St George’s Hospital at 31 December 2021. As patients who would have been admitted to the George Bryan Centre are admitted to several wards across the hospital depending on need and availability it is not possible to make a like-for-like comparison with staff, but these figures give a snapshot.

Inpatient Mental Health Wards - age profile

For context, the headcount at the end of December 2021 was 193 and 182.17 WTE.

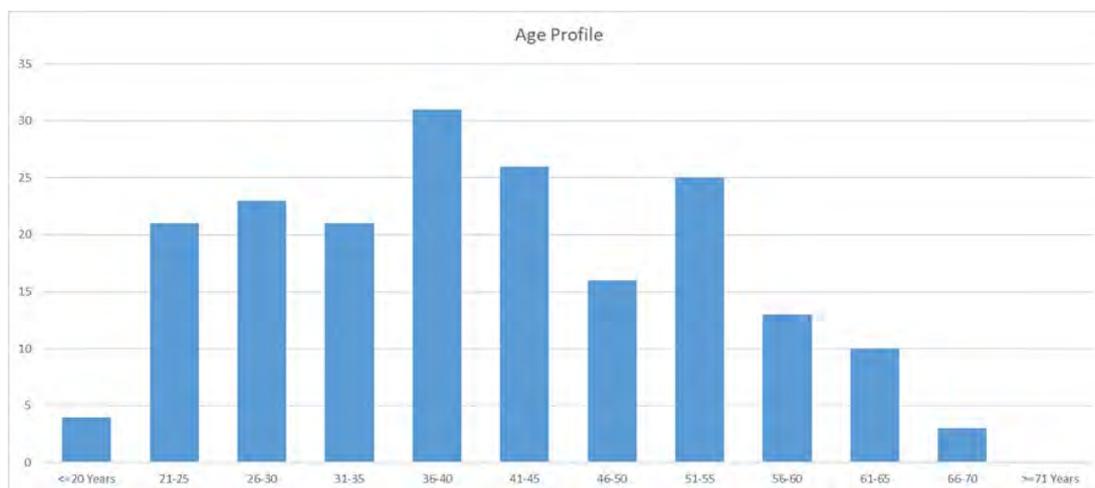


Figure 20 Age profile of the IAMH and ISFOP Wards workforce as at 31 December 2021

The figure above shows the age profile of the Inpatient Adult Mental Health (IAMH) and Inpatient Services for Older People (ISFOP) Wards workforce as at 31 December 2021. The data shows that 26.42% of staff (headcount = 51) were aged 51 and over, with only 12.95% of the workforce (headcount = 25) below the age of 25.

Analysis of the nursing workforce highlights that 21.62% of staff were aged 51 and over; 80% of medical and dental staff are within this age range. As described above, 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 challenges around staff shortages. In the Allied Health Professional (AHP) workforce, 20% of the staff are aged 51 and over and 30.39% of clinical support staff were aged 51 and over.

Inpatient Mental Health Wards - workforce leavers profile

For context, leaver data is based on 20 leavers during 2021.



Figure 21 Inpatient Mental Health Wards - workforce leavers profile

The overall picture however shows that over the 12 months ending 31 December 2021 the main leaving reasons were voluntary resignations 9 (45%), other reasons 7 (35%) and retirement 4 (20%).

In terms of leavers by staff group, 6 were in the Nursing and Midwifery Registered group and 14 were in Additional Clinical.

Inpatient Mental Health Wards - workforce vacancy profile

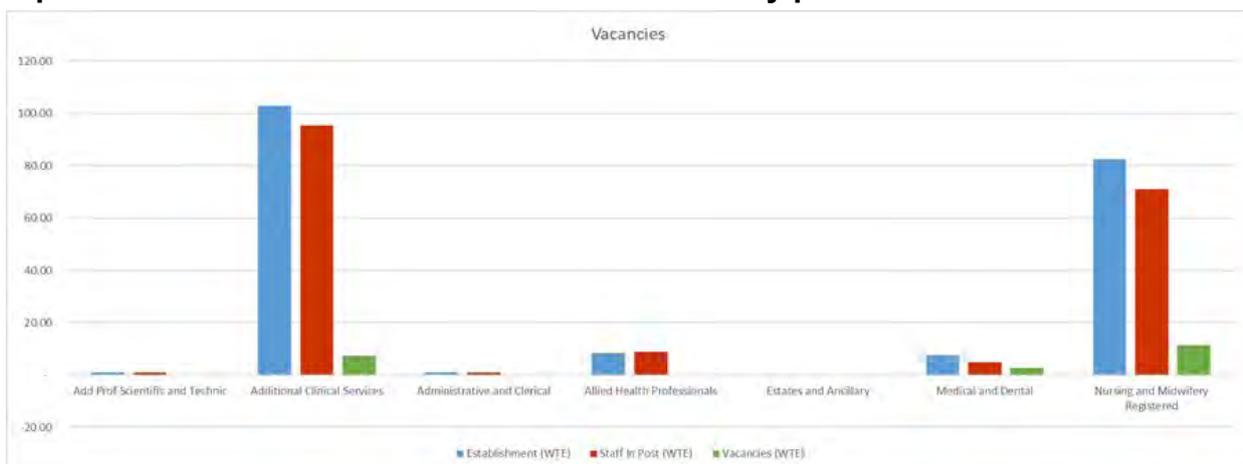


Figure 22 Inpatient Mental Health Wards - workforce vacancy profile

Whole time equivalent vacancies by staff group are shown in the figure above. The overall number of vacancies across the service at the end of December 2021 was 21.23 WTE, giving a vacancy rate of 10.44%.

In the Nursing and Midwifery Registered staff group there were 11.47 WTE vacancies giving a vacancy rate of 13.91% (this equates to 54.04% of all vacancies). The vacancy rates in other staff groups are as follows; Medical and Dental 34.98% (2.69 WTE), Allied Health Professionals 4.76% (over established by 0.40 WTE) and Additional Clinical Services 7.26% (7.47 WTE).

4.3.3.3 Staffordshire and Stoke-on-Trent Adult Community Mental Health - workforce profile

The data below illustrates the workforce profile for Staffordshire and Stoke-on-Trent, which includes community workforce in south Staffordshire.

Staffordshire and Stoke-on-Trent Adult Community Mental Health - age profile

For context, the headcount at the end of March 2022 was 396 and 363.03 WTE.

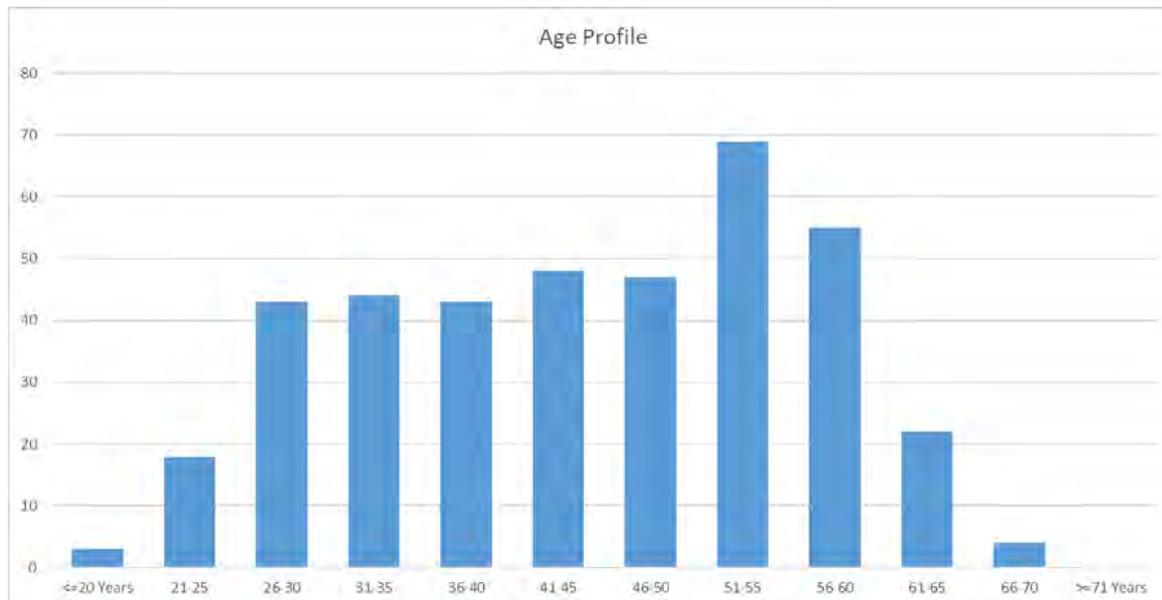


Figure 23 Staffordshire and Stoke-on-Trent Adult Community Mental Health - workforce age profile

The figure above shows the age profile of the Adult Community Mental Health workforce as at 31 March 2022. The data shows that 37.88% of staff (headcount = 150) were aged 51 and over, with only 5.30% of the workforce (headcount = 21) below the age of 25.

Analysis of the nursing workforce highlights that 35.16% of staff were aged 51 and over; there are 66.67% (headcount = 12) Medical and Dental staff within this age range. 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 challenges around staff shortages. In the Allied Health Professional (AHP) workforce, 11.54% of the staff are aged 51 and over and 48.21% of clinical support staff were aged 51 and over.

Staffordshire and Stoke-on-Trent Adult Community Mental Health - workforce leavers profile

For context, leaver data is based on 53 leavers during 2021/22.

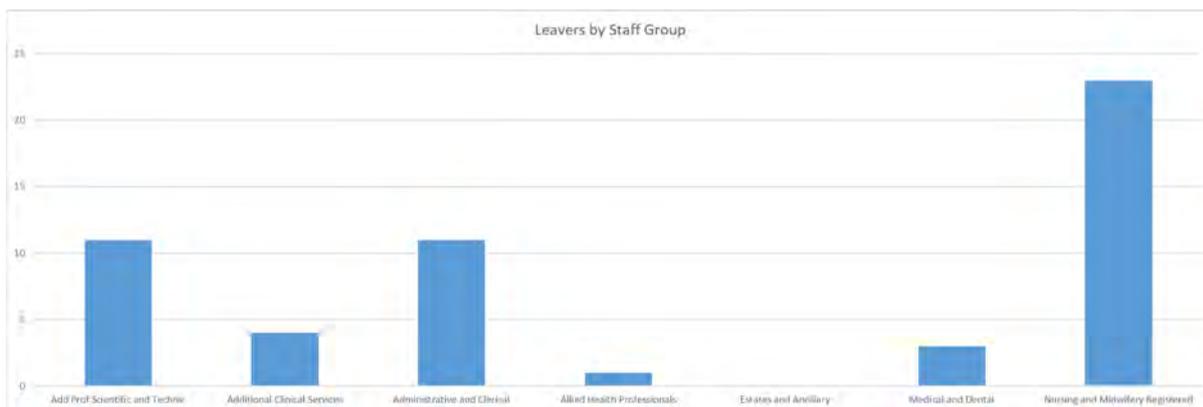


Figure 24 Staffordshire and Stoke-on-Trent Adult Community Mental Health - workforce leavers profile

The overall picture however shows that over the 12 months ending 31 March 2022 the main leaving reasons were 31 voluntary resignations, 16 retirements and 4 end of fixed terms contract. In terms of leavers by staff group, 23 'Nursing and Midwifery Registered' group, 11 were in the 'Additional Professional and Scientific' group and 11 were the 'Admin and Clerical' group.

Staffordshire and Stoke-on-Trent Adult Community Mental Health - workforce vacancy profile

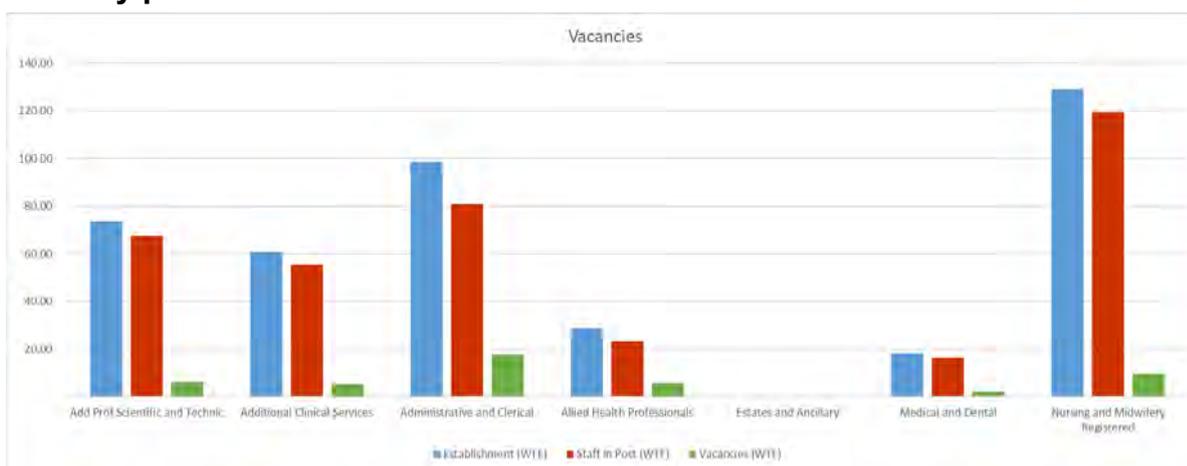


Figure 25 Staffordshire and Stoke-on-Trent Adult Community Mental Health - workforce vacancy profile

Whole time equivalent vacancies by staff group are shown in the figure above. The overall number of vacancies across the service at the end of March 2022 was 46.54 WTE, giving a vacancy rate of 11.36%.

In the Nursing and Midwifery Registered staff group there were 9.68 WTE vacancies giving a vacancy rate of 7.50% (this equates to 20.80% of all vacancies). The vacancy rates in other staff groups are as follows; Medical and Dental 11.61% (2.13 WTE), Allied Health Professionals 19.53% (5.65 WTE), Additional Professional and Scientific 8.32% (6.13 WTE), Additional Clinical Services 8.86% (5.40 WTE) and Admin and Clerical 17.80% (17.56 WTE).

4.3.3.4 Staffordshire and Stoke-on-Trent Adult Community Crisis - Workforce Profile

The data below illustrates the age profile of adult community crisis workforce in Staffordshire and Stoke-on-Trent, which includes south Staffordshire.

Staffordshire and Stoke-on-Trent Adult Community Crisis - age profile

For context, the headcount at the end of March 2022 was 60 and 59.56WTE.

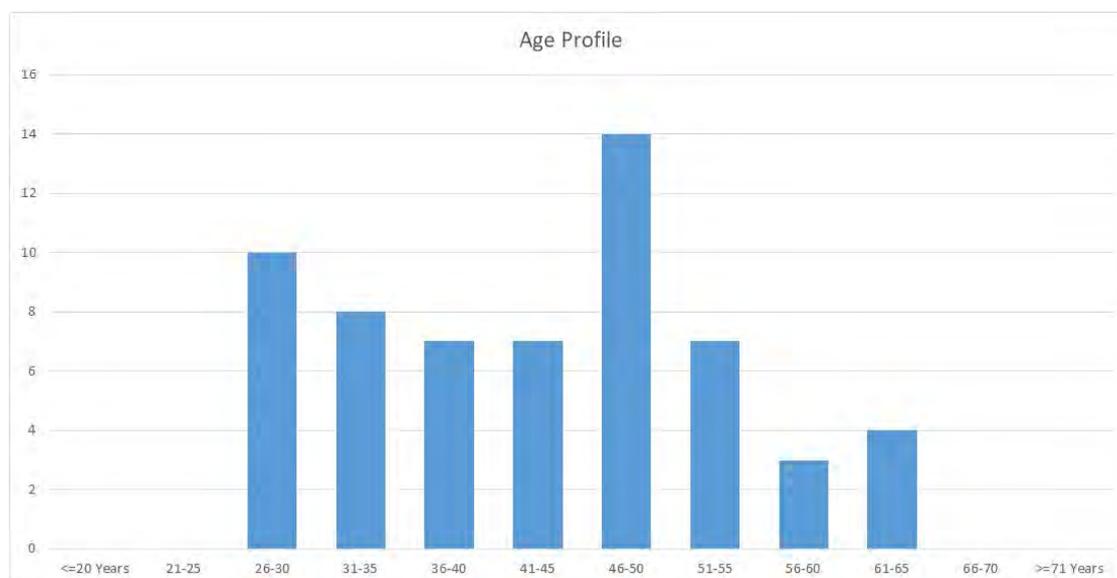


Figure 26 Staffordshire and Stoke-on-Trent Adult Community Crisis - age profile

The figure above shows the age profile of the Staffordshire and Stoke-on-Trent Adult Community Crisis workforce as at 31 March 2022. The data shows that 23.33% of staff (headcount = 14) were aged 51 and over, with 0% of the workforce below the age of 25.

Analysis of the nursing workforce highlights that 17.65% of staff were aged 51 and over; there are no Medical and Dental staff within this age range. With the opportunity for retirement at 55 with special class status for some staff there is a limited risk to workforce supply against demand which could further exacerbate challenges around staff shortages. In the Allied Health Professional (AHP) workforce, 0% of the staff are aged 51 and over and 25% of clinical support staff were aged 51 and over.

4.3.4 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.

4.4 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 also 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 also monitors training guidance on an ongoing basis, including NHSEI and NICE guidance and new developments and provide appropriate training as required. They are 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.

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.

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.

5 Public and patient, clinical and staff involvement

5.1 Introduction

This section of the 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 to understand people's views specifically of the services at the George Bryan Centre.
- Phase three – the further involvement after the project recommenced in 2021, following the pause caused by the pandemic, to sense-check previous feedback.
- The 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.

The description of engagement and involvement in this section includes both engagement and involvement activity in 2019 about a county-wide transformation programme including mental health services, and engagement and involvement carried out by MPFT in 2019 and more recently specifically about inpatient mental health services.

In summer 2019, the Staffordshire and Stoke-on-Trent health and care system conducted a large listening exercise to gather views on a range of services including mental health.

Following the fire at the George Bryan Centre there was a need to determine the long-term future of the services previously provided there. In September and October 2019 MPFT led a listening exercise to understand people's experiences of using the services at the George Bryan Centre. It held five events in south east Staffordshire and also received a range of correspondence. The events themselves were co-produced with lived experience representation throughout the planning and delivery phase. The MPFT Board received a report in January 2020 detailing the outcomes of the engagement exercise and agreed to support the system-wide exercise to determine the long-term solution for those services.

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

MPFT has used this collective feedback to inform the development of this business case and its proposal for the future of the services formerly provided at the George Bryan Centre.

5.2 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).

A 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 Change¹ 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.

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

TWB engagement 2019

A range of material was produced to inform stakeholders about the listening exercise in summer 2019 and to gather feedback.

This was distributed to GPs, libraries, council buildings and pharmacies, with electronic versions circulated across the partners of TWB, district and borough councils, as well as the voluntary and community sector.

A mix of communication channels was used to raise awareness about the listening exercise.

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.

Staff received information via the Clinical Commissioning Groups' Team Brief and the Information and News Intranet (IAN), and MPFT's "PEP Talk" newsletter.

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 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.

Staff were involved through internal communications and were able to complete questionnaires and attend both public and workforce events.

¹ [Together We're Better Case for Change](#), August 2019

Clinicians were also involved in the process. 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 six.

5.2.1 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.

A report of findings¹ 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 Staffordshire CCGs formally received the report on 7 November 2019. A summary, public facing report of findings² was published in February 2020.

5.3 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 lived experience representation.

5.3.1 Event dates and times - 2019 engagement

- 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.

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

² [Health and care in Staffordshire and Stoke-on-Trent Listening to your feedback](#) February 2020

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.

5.3.2 The outcome of the 2019 engagement

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 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 findings¹ from this engagement was published on 30 January 2020 as part of the Trust Board papers for the Board of Directors of MPFT.

There was a further workshop with service users and staff in January 2020 and at this workshop a set of desirable criteria for healthcare, including mental health, were developed.

5.4 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.

5.5 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 business case, and as this work has connections with the involvement activity for the Community Mental

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

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.

This slide shows a timetable for this continued engagement and involvement.

Continuing our ongoing conversation

Making Staffordshire and Stoke-on-Trent the healthiest places to live and work

- **Summer 2019:** public conversation to understand what is working well and what could be improved in health and care services
- **Autumn 2019:** capturing experience of mental health services, including George Bryan Centre
- **March 2020:** involvement work paused due to COVID-19
- **Autumn 2021:** transformation programme re-starts, with sense checks being undertaken in mental health, maternity services and urgent & emergency care
- **Winter 2021/22:** development of future proposals
- **2022:** public involvement in the proposals
- **2022/2023:** decisions made
- **2023:** implementation of decisions made



Figure 27 Timetable for engagement and involvement

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.

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.

5.5.1 Stakeholder map and engagement - 2021 engagement

Key stakeholders were identified for communication and engagement at each step of the journey. The stakeholder map is shown below.

Business Case - Inpatient services for mental health in South East Staffordshire

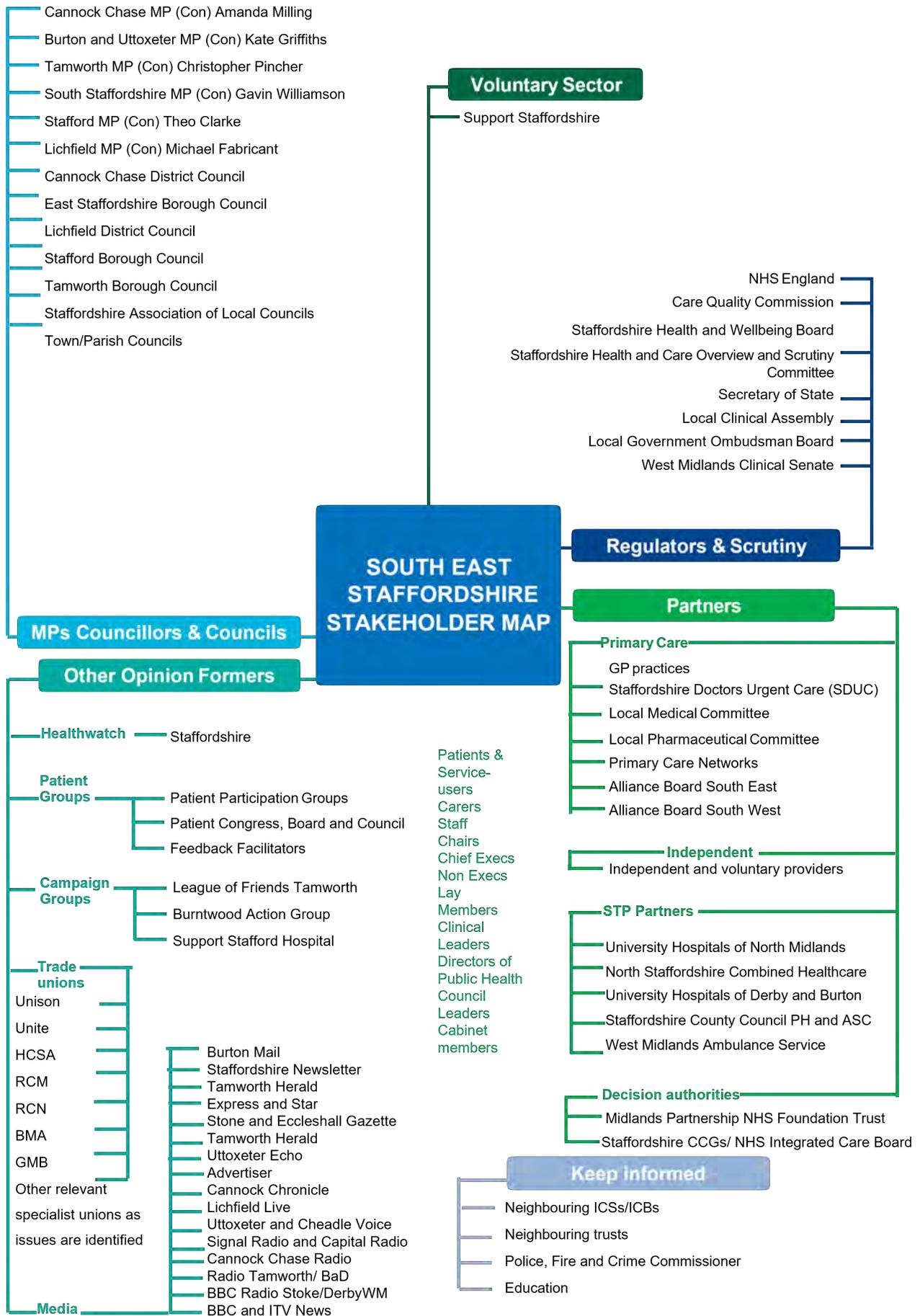


Figure 28 South east Staffordshire stakeholder map

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.

5.5.2 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 map shows the location of all those who responded to the question about location in the survey and at events.

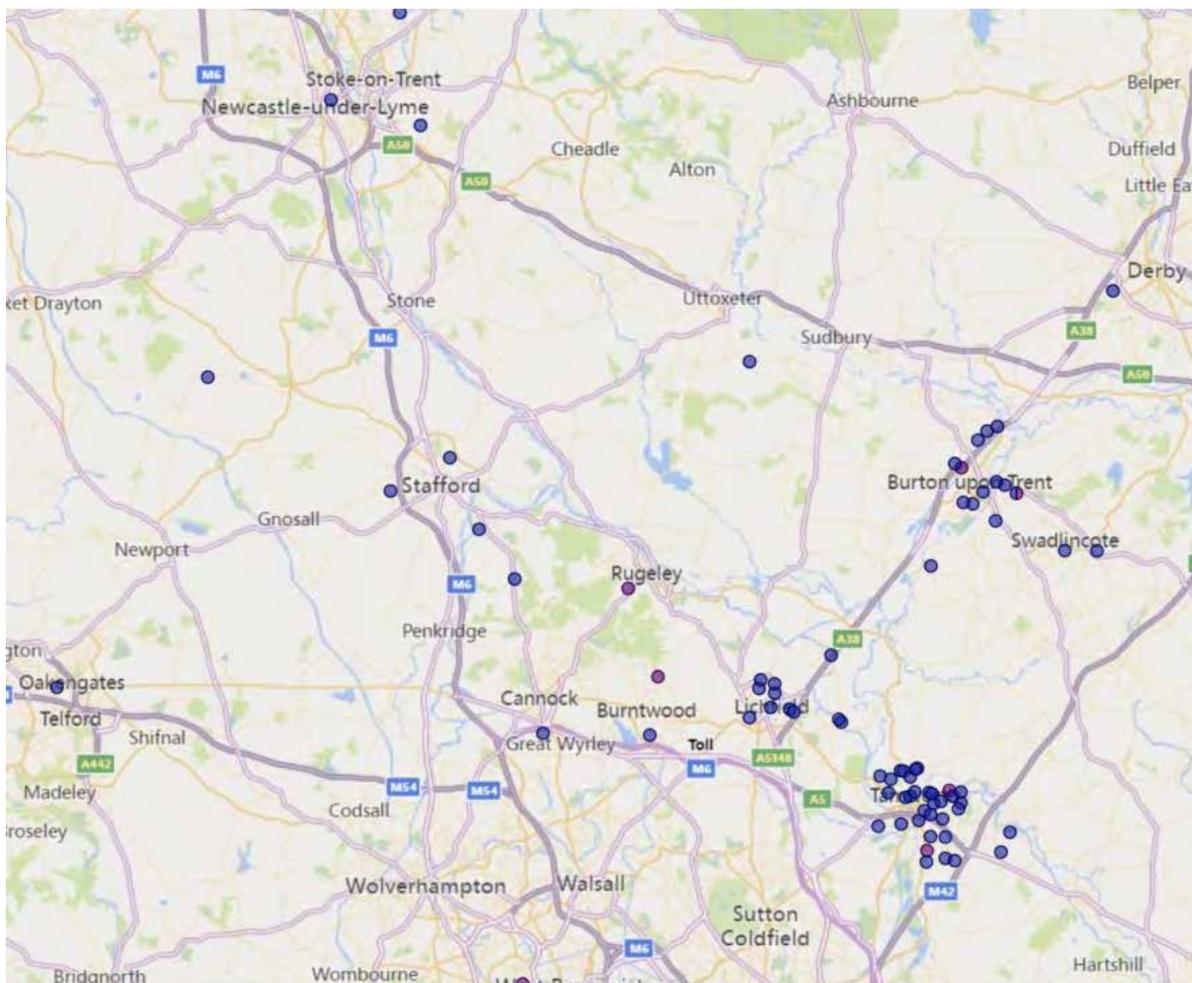


Figure 29 Map showing the location of respondents of the survey and events (when provided)

Those responding to the survey or attending events were asked whether they attended or responded as individuals or on behalf of organisations. The following organisations were represented:

| Survey | Events |
|---|---|
| Burton and District Mind | Combined Healthcare |
| Community Together CIC | Community Together CIC |
| Healthwatch Staffordshire | DPPG Cannock Chase |
| Midlands Partnership NHS Foundation Trust | East and South East Staffordshire CCG Patient Board |
| Sir Robert Peel Hospital | Healthwatch Staffordshire |
| The League of Friends of the Tamworth Hospitals | Lichfield District Council |
| The Rawlett School | Midlands Partnership NHS Foundation Trust |
| University Hospitals of Derby and Burton (UHDB) | South East Staffordshire and Seisdon Peninsula CCG |
| University of Birmingham | Tamworth Borough Council |

Table 23 List of organisations responding to the survey and participating at the events

A mid-point review of the engagement took place in October 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. The mid-point review is available at Appendix 6.

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 report¹ on the MPFT website.

The questionnaire is available at Appendix 7.

¹ [Summary of findings](#), Feb 022

5.5.3 Supporting seldom heard groups - 2021 engagement

An involvement Equality Impact Assessment (EIA) [Appendix 8] 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 at the engagement events (see below) and the questionnaire both included information about accessibility including a variety of opportunities to provide feedback.

0808 196 3002

Other ways to share your feedback



- Complete the survey at <https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement>
- Email for survey support & to provide feedback: mlcsu.involvement@nhs.net
- Phone: 0333 150 2155
- In writing: St George's Hospital, Corporation Street, Stafford. ST16 3SR



If you need printed copies of the documents, need documents in different formats or languages or need help to complete the questionnaire, please contact us.



Figure 30 Methods of feedback for the George Bryan Centre feedback

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.

5.5.4 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.

Clinicians were also involved in the process. As described earlier, 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, 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.

Clinical involvement has continued into the second phase of the project, and more information about this is detailed in Section six.

One-to-one interviews

Staff were offered one-to-one interviews to help share their feedback.

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.

5.6 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.

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 [Appendix 9] 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 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 business case.

Use of feedback

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

5.7 Engagement with Health Overview and Scrutiny Committees

Overview and Scrutiny Committee responsibilities are outlined at the beginning of the business case. The Staffordshire CCGs 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 minutes¹ 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 minutes² 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 minutes³ 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 business case.

The minutes from the committee’s response resolved⁴:

- “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 update⁵ 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.

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

⁵ [Health and Care Overview and Scrutiny Committee agenda and reports pack,](#) 15 March 2022

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 draft minutes¹ 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.
- In relation to difficult decisions, committee were assured that a consistent approach would be taken across Staffordshire for residents of all geographical areas. CCG gave assurance that national and local guidance was referred to and kept up-to-date to ensure prioritisation and clarity of key design criteria. It was confirmed that health inequalities and the equality duty were taken into account. There was consistency of approach in terms of service provision and being mindful in terms of access to services.

It was resolved:

- 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.

¹ [Minutes of the Health and Care Overview and Scrutiny Committee Meeting](#) held on Present: Jeremy 15 March 2022

6 Proposal development and shortlisting/selection process

6.1 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 NHS England and NHS Improvement (NHSEI), 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

Commissioners may need to provide information about discarded proposals⁴, if there is a requirement to consult on the proposals.

6.1.1 Current state description

The objective of this process is 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(Nettlehip) v NHS South Tyneside CCG and Sunderland CCG [2020] EWCA Civ 46

⁴ 28, Wilson LJ in R(Moseley) v London Borough of Haringey [2014] UKSC 56

- 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 five.

The timeline below illustrates the development of the proposals.

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

Business Case - Inpatient services for mental health in South East Staffordshire

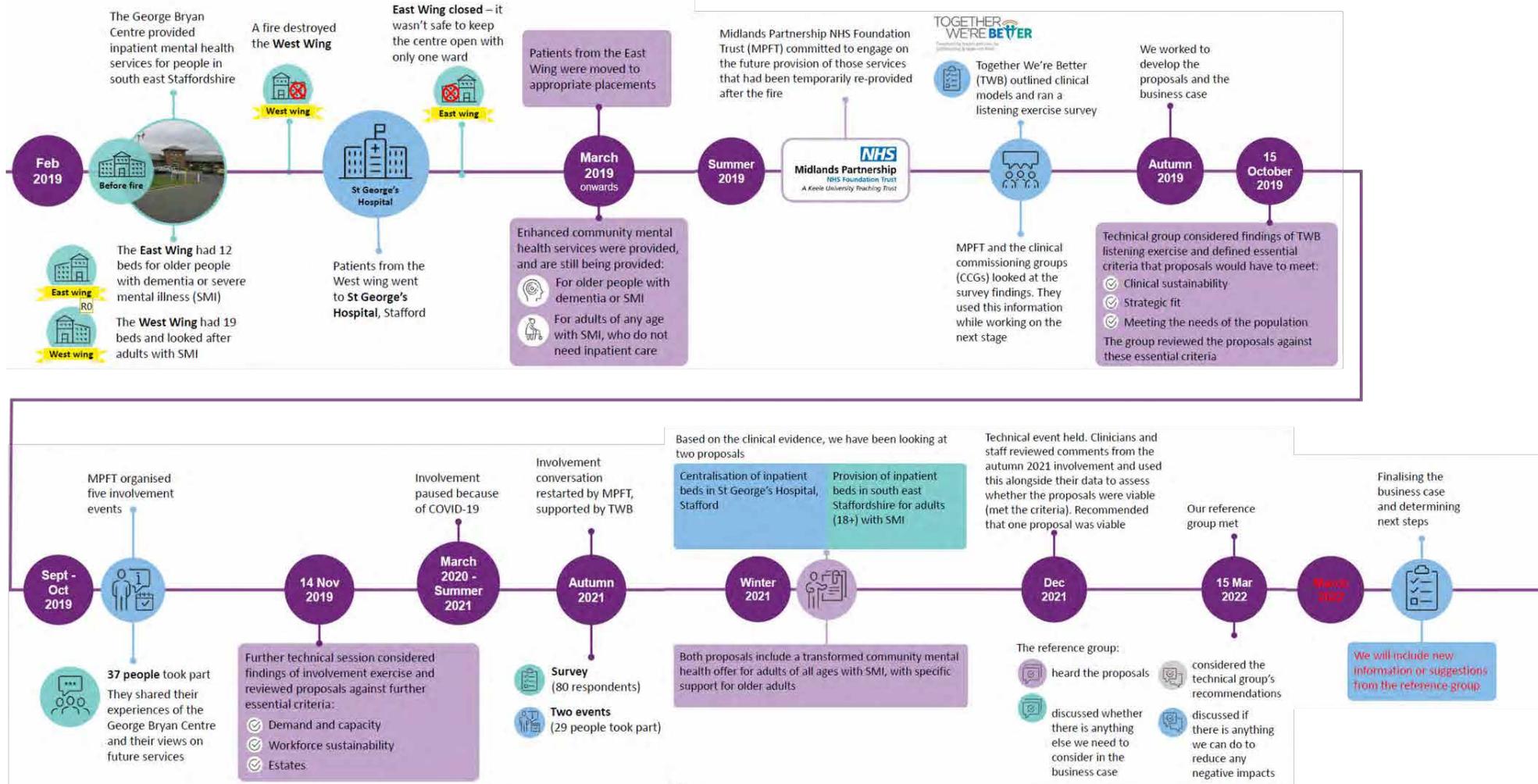


Figure 31 Timeline: Proposals development process

6.2 Proposal development phase 1

The Staffordshire and Stoke-on-Trent system-wide Case for Change¹ 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.

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 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 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.

6.2.1 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.

¹ [Together We're Better Case for Change](#), August 2019

- 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 health needs

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.

6.2.2 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.

6.2.3 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 desirable criteria and five service areas:

- Urgent and emergency care

- Integrated community services
- Mental health services
- Maternity care services
- Planned care services

Participants heard a summary of the feedback about mental health from earlier engagement. 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 were shown the clinical model for mental health services:

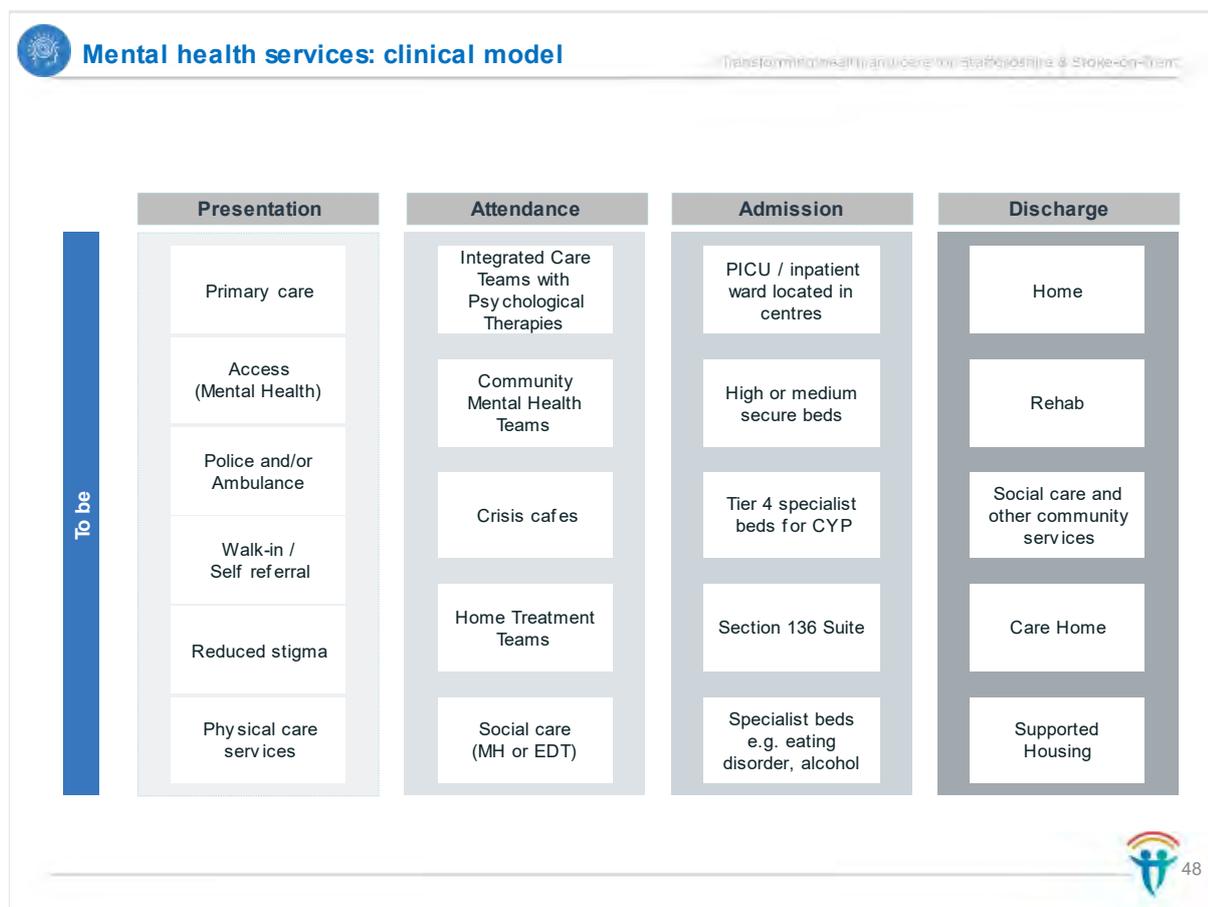


Figure 32 Clinical model for mental health services

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 which are presented here with the feedback received.

1. Are there any other ways to provide inpatient mental health beds in the South of the county?

Dementia care

- Consider the need for dementia centres

- Dementia provision should be separate to general mental health
- Consider support for care homes.

Location of services

- Consider capacity at St George's Hospital – may be beneficial for Tamworth residents
- Consider distance to travel for relatives
- Need more dispersed provision
- George Bryan Unit needs to be re-established.

Service provision

- Consider alternatives to inpatient care and the need for a range of services
- Need to consider crisis care.

Integration

- Links between child and adult services to manage transition
- Use outreach / voluntary services
- Consider support after discharge
- Consider utilisation of secondary care / children's facilities.

Other themes

- Consider the need for staff training around mental health
- Waiting times are too long.

2. Are there any essential services / locations missing in the area?

Location/Access

- Need for two locations to cover the south
- Consider services in Burton and Lichfield areas
- Consider capacity at St George's Hospital
- No services in South Staffordshire – patients go out of the area
- Need for treatment within other hospitals – not just mental health hospitals
- Look at travel arrangements.

Services

- Consider children's / young adults' facilities and services
- Need for immediate referrals and assessments in crisis situations
- Access required to supported accommodation
- Consider services for those with mental health and other needs
- Consider mental health services in prison services
- Need for greater mental health service provision
- Consider service provision within integrated care hubs.

Other considerations

- Need to consider demographics

- Consider links with education and children's services
- Consider integration of adult and children's services
- Consider role of police service
- Consider role of voluntary sector
- Consider the change in autism services.

3. Which services might people be prepared to travel further for?

- Specialist services
- Services need to be as close to home as possible
- Locations need to be community-based and familiar
- Need transport arrangements
- Patients may travel further for better quality care

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

6.2.4 Technical event 2

On 14 November 2019 there was a further technical session. The membership of this workshop included clinicians from across the system, in addition to workforce, estates, quality and communications representatives. They considered the findings of the involvement exercise and reviewed proposals against further essential criteria:

- Demand and capacity.
- Workforce sustainability.
- Estates.

It was agreed that both proposals should remain on the medium list.

In January 2020, technical events were held in relation to the other clinical areas subject to the TWB proposal appraisal process. 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.

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 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.

6.3 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 [Appendix 11]. More information is available in Section five.

6.3.1 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 comments from the autumn 2021 involvement and used this alongside their data 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 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 12 in Section two). 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 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 Core 24 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.

6.3.2 Our proposal

All 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 one).

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 two). 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.

6.3.3 Deliberative event

On 15 March 2022 a deliberative event took place to discuss the two proposals including the preferred option identified at the technical event. A targeted reference group was recruited.

The participants in the deliberative event included service users, carers, staff, seldom heard groups and interest groups.

Detailed information packs were shared to ensure the group was informed [Appendix 9].

The reference group were invited to:

- Hear the proposals.
- Consider the technical group's recommendations – they were given information about why one proposal was considered viable.
- Present their views on whether anything else needs to be considered in the business case.
- Discuss if there is anything that can be done to reduce any negative impact from the proposal.

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

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 33 Advantages and disadvantages for the St George's Hospital proposal

0808 196 3002

Recommendation – a single viable proposal

Viable

Centralise 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.



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Figure 34 Recommendation for one viable proposal

At the event, those participating gave feedback which was considered at a meeting of the Staffordshire and Stoke-on-Trent transformation steering group on 13 May 2022. The

steering group agreed that **‘one viable proposal – centralising inpatient treatment at St George’s Hospital in Stafford’** would go forward to this business case.

6.3.4 Impact assessment of proposals

MPFT conducted impact assessments as the operational model changed. A joint impact assessment [Appendix 12] has been conducted as part of the process to develop the business case.

7 Evaluation of scenarios / options

7.1 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.

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

NHS commissioners are required¹ 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
- 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)

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

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

7.2.1 Strong public and patient engagement

Section five explains 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 section details 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.

7.2.2 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 four. Data shows that a large percentage of adults with severe mental illness are cared for within Staffordshire with 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 two 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.

7.2.3 Clear, clinical evidence base

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

7.2.4 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 Change¹ sets out the needs of a 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 five and six, including clinical involvement in technical events evaluating the proposals.

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

7.2.5 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.

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.

7.2.6 Beds for older adults

As described earlier in the 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

¹ [Together We're Better Case for Change](#), August 2019

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 two of this 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’ | n/a | n/a/ | £2,170,703 | £5,281,898 | £6,534,610 |

| | | | | | |
|---|--|--|--|--|--|
| transformation funding allocation as per Analytical Tool (non-cumulative) | | | | | |
|---|--|--|--|--|--|

Table 24 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.

7.2.7 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.

7.3 Quality, safety and clinical sustainability

A Quality Impact Assessment has been completed for this service change and is available at Appendix 2.

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 13 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.

7.4 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 two shows the advantages of the new arrangement, and the report of engagement in Section five 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 five 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. 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 three) 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.

7.5 Equality and health inequalities

7.5.1 Equality Impact Assessment including health inequalities

An Equality Impact Assessment (EIA) was completed in March 2022 [Appendix 14]. 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 will also be explored, following the successful use of technology throughout health and social care during the COVID-19 pandemic.

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% |
| 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 25 Key demographics of the most impacted areas

The full Equality Impact Assessment is available as part of the overall impact assessment at Appendix 14.

7.5.2 Travel analysis

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 15, 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 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.

8 Management and governance

8.1 Introduction

This section of the 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.

8.2 Next steps and timeline

This business case will be reviewed by MPFT, the provider NHS Trust, and by Staffordshire Integrated Care Board. It will also be reviewed by NHS England and NHS Improvement (NHSEI) and senior clinicians as part of the West Midlands Clinical Senate.

The timeline is as follows:

| Date (2022) | Committee/Board | Nature of meeting |
|-------------|--|--|
| 10 June | West Midlands Clinical Senate | Sign off |
| 23 June | ICS Mental Health Programme Board | For information |
| 28 June | MPFT Major Transactions Committee | Document sign off and Recommendation to MPFT Board |
| 30 June | MPFT Board | Formal decision |
| 11 July | Staffordshire Health Overview and Scrutiny Committee | For discussion |
| tbc | Integrate Care Board | Sign off |
| tbc | NHSE Assurance | Assurance |

If further involvement is required, the outputs of that involvement will be considered by MPFT and the ICS ahead of any decision on the proposal.

There will be continued liaison with the local overview and scrutiny committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

8.3 Risk management

The programme has created a risk register, with appropriate mitigations.

| George Bryan Project RISK REGISTER | | | | | | | | | | | | | |
|------------------------------------|------------------|--|----------------------|---|--------------|-----------------|-------------|-----------------|------------------|-------------|-------------|--------|--------------|
| ID | Rating (Initial) | Risk Description (Inc. Ref. No. of existing Corporate Risk Register - CRR - where known) | Risk Type | Assurances | Action Owner | Action due date | Target Date | Rating (Target) | Rating (current) | Risk owners | Directorate | Trend | CCG - Staffs |
| 1 | 12 | Development of the business case and engagement activity will increase demands on the already stretched capacity of MPFT clinicians/staff who are currently dealing with the major incident/COVID-19 response and winter pressures | Operational | Recognition of the challenges and project support and additional C&E support has been commissioned by CCGs. Ongoing work planning meetings to discuss the risks. As far as possible events will be co-ordinated around clinicians diaries | UJ | 30.09.21 | 31.03.22 | 6 | 9 | SG | | Closed | ALL 6 |
| 2 | 12 | Risk of challenge/ Judicial Review over the process to determine the long-term solution for the services formerly provided from the George Bryan Centre. | Reputation and Legal | Evidence that we are adhering to the PADS guidance. Consistent and robust messages in all associated documentation, internally and externally. | CCG/ CSU | 31.12.21 | 31.03.22 | 4 | 4 | SG | | New | ALL 6 |
| 3 | 12 | Risk of engagement activity in 2019 becoming outdated (TCI consider 2 years) | Reputation and Legal | Continued conversations with TCI. Sense check engagement activity completed Autumn 2021 to obtain views post COVID-19 pause. Consider involvement an ongoing activity. | CCG/ CSU | 31.12.21 | 31.03.22 | 4 | 4 | SG | | Closed | ALL 6 |
| 4 | 9 | Appropriate engagement - views may not be representative of demographic profile of the population | Operational | Ongoing work with CSU communication and engagement team to ensure that all efforts are made to appropriately target engagement/ involvement activity. This risk will be fully explored in the Equality Impact Assessment. | CSU | 31.12.21 | 31.03.22 | 4 | 9 | SG | | New | ALL 6 |

Figure 35 George Bryan Centre Project Risk Register

8.4 Plan for involvement/consultation

The draft communications and involvement plan for potential public involvement ahead of a decision being made about inpatient mental health services in south east Staffordshire follows previous communications and engagement plans for this programme. The contents of this document 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.

Current position

This plan has been drafted to cover the period *after* the completion of the relevant 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.

This proposed approach 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 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 previously provided 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.

Aims and objectives

Further involvement activity to gather views

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

- Inform decision-makers by gathering any further information; ensuring we meet our statutory duties.

We will seek out 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.

Further involvement activity to share information

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

Ongoing dialogue would continue with service users and other stakeholders through the usual and current channels.

Approach to involvement

Recognising that this phase follows involvement activity in 2019 and 2021, 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, and virtual workshops
- 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. The survey would be available on-line and in hard copy.

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 page 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 detailed analysis report will be produced by Midlands and Lancashire Commissioning Support Unit (MCSU) on the comments from the involvement activity; this will include a thematic breakdown of comments received and demographic analysis of participants, subject to them consenting to share 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 and any decision-making resulting from the findings.

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.

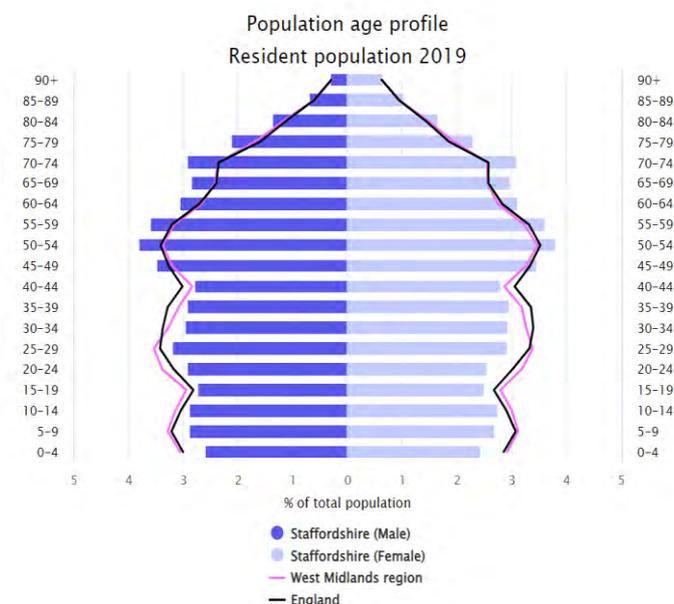


Figure 1 Age profile of the resident population of Staffordshire²

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 Pakistani². 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 2018/20⁶

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

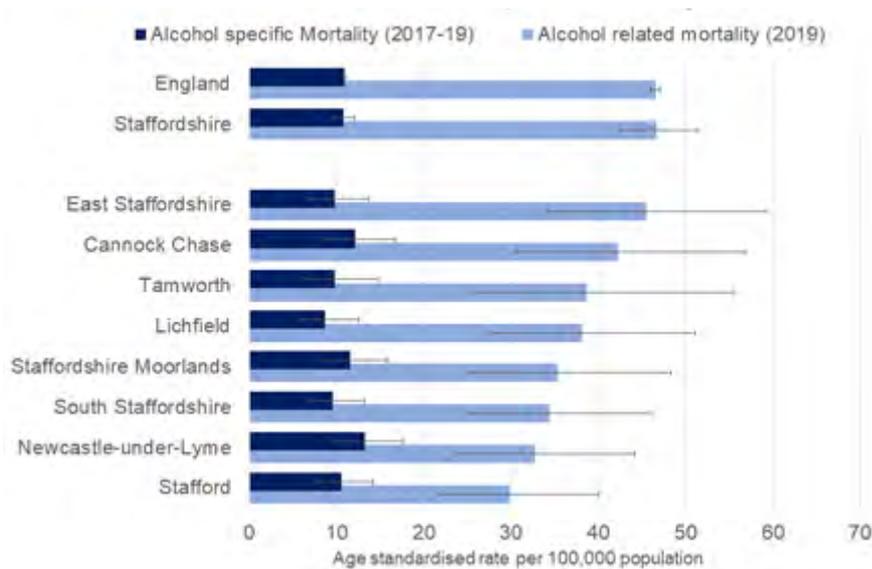


Figure 4 alcohol-specific and alcohol-related mortality in Staffordshire

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](#)

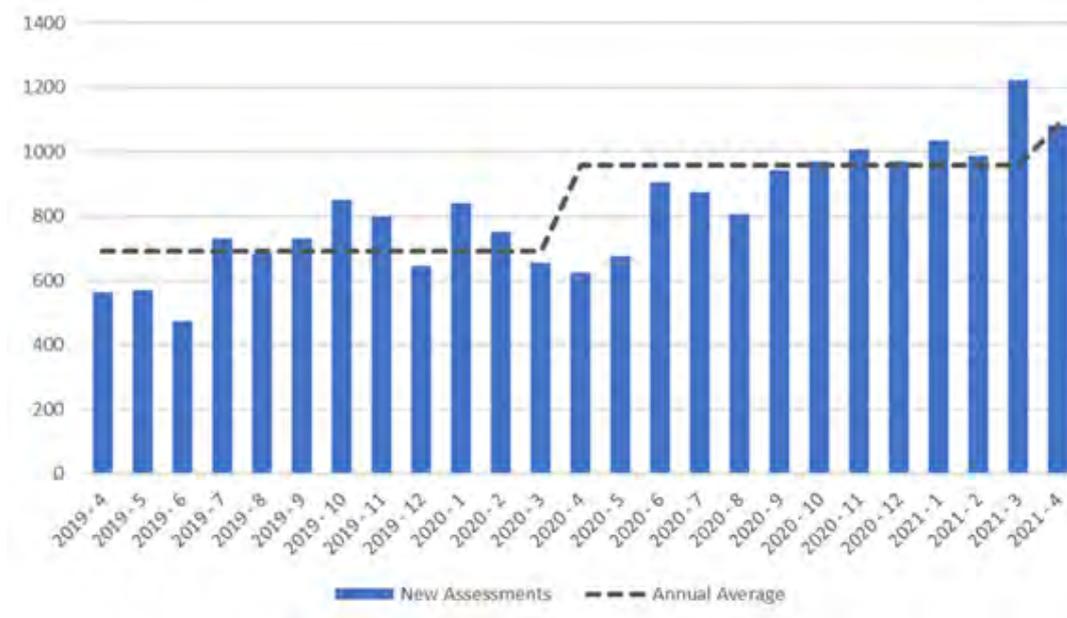


Figure 5 New assessments Staffordshire – April 2019 to April 2021¹

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](#)

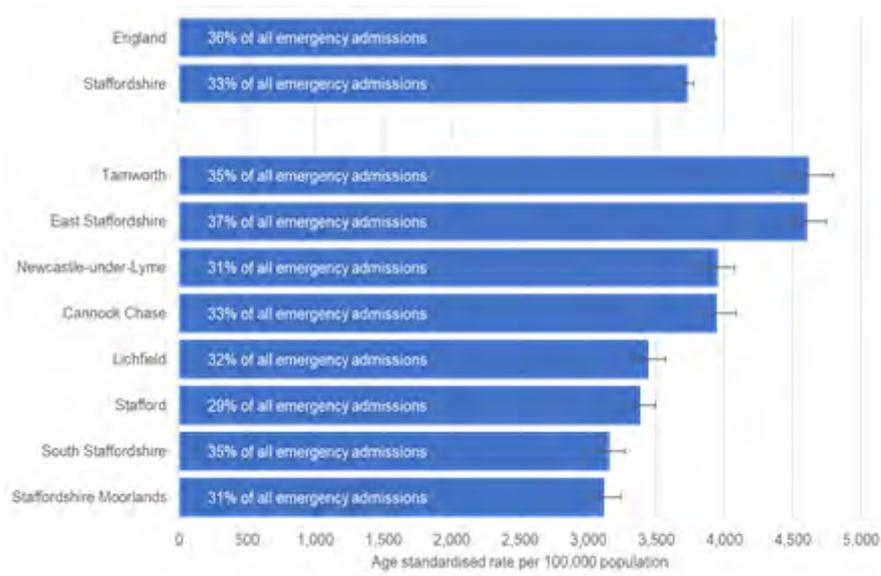


Figure 6 Emergency admissions to hospital for adults (age 20+) with a mental health diagnosis in any diagnosis field, 2020/21¹

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-19³

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](#)

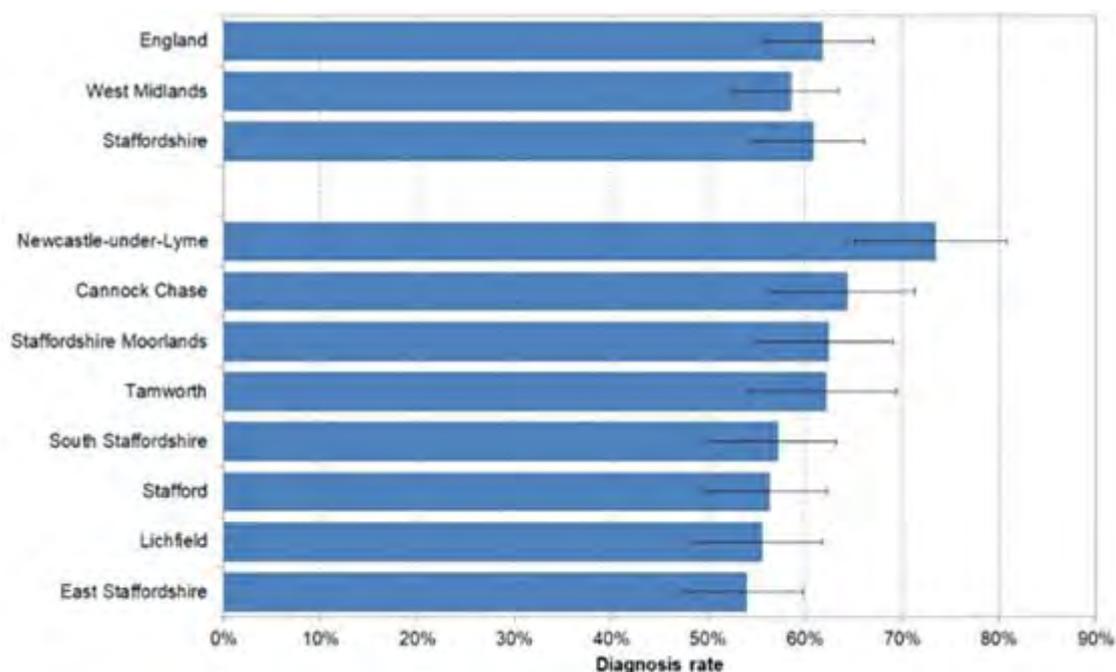


Figure 7 Dementia diagnosis rates, May 2021¹

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

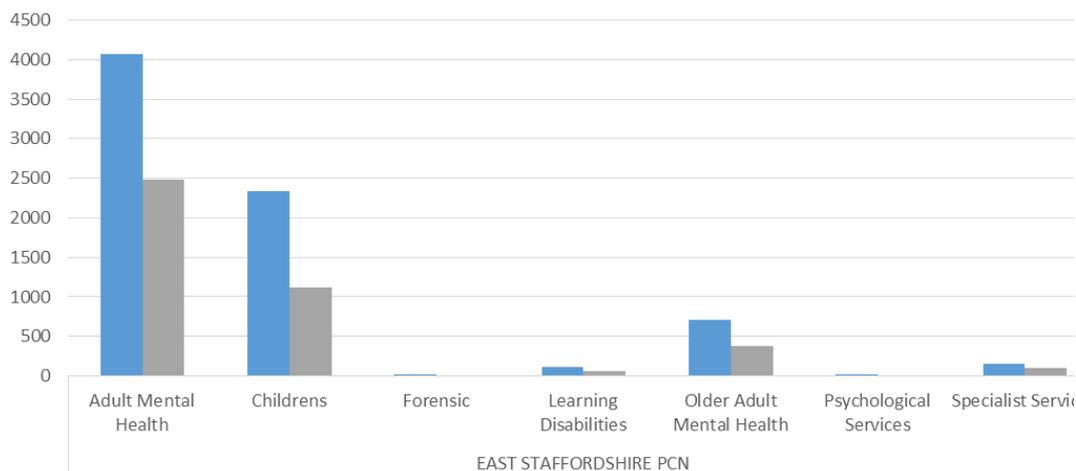


Figure 8 Referrals to Midland Partnership Foundation Trust in East Staffordshire by service³

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

Appendix 1 Communities we serve

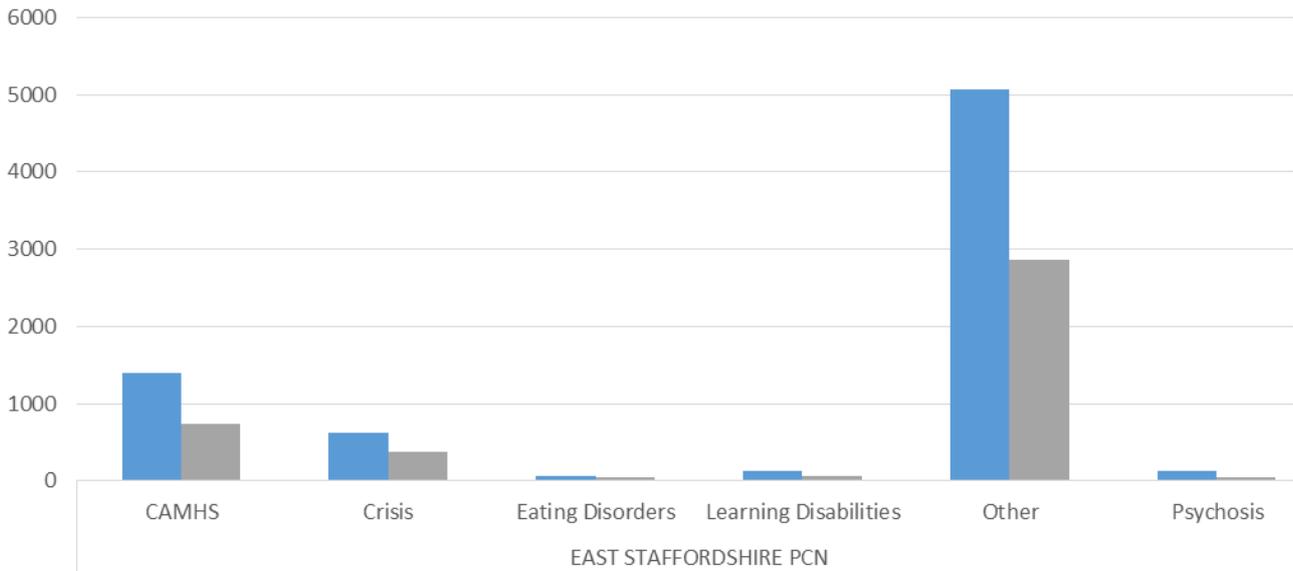


Figure 9 Referrals to Midland Partnership Foundation Trust in East Staffordshire by service *continued*¹

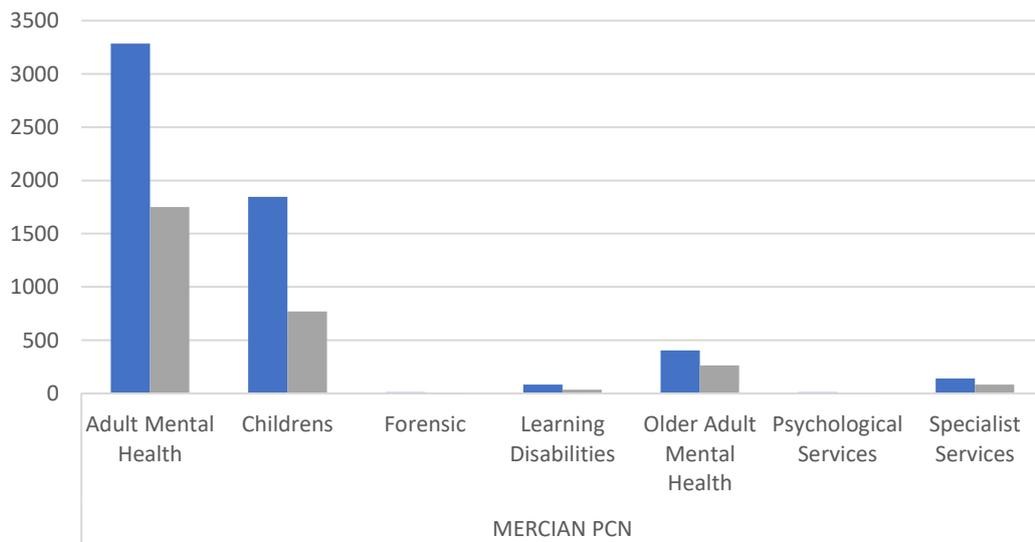


Figure 10 Referrals to Midland Partnership Foundation Trust in Mercian by service

¹ CMHF insight overview summary - East Staffordshire V2.2a

Appendix 1 Communities we serve

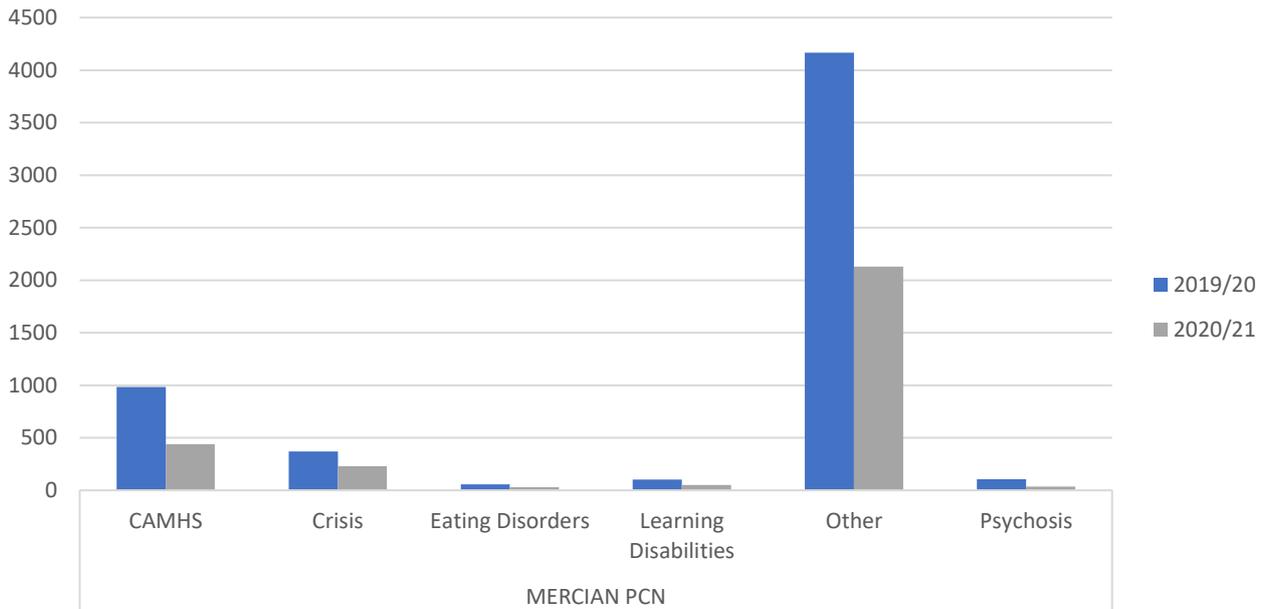


Figure 11 Referrals to Midland Partnership Foundation Trust from Mercian PCN by service continued¹

Mercian and East Staffordshire PCNs report that they have similar numbers of referrals to mental health services (not IAPT) in males and females.

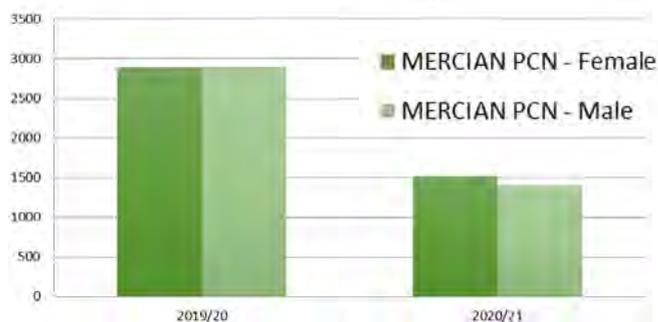


Figure 12 Numbers of referrals to mental health services (not IAPT**) in Mercian PCN by gender

¹ CMHF insight overview summary -Mercian V1.4b.pptx

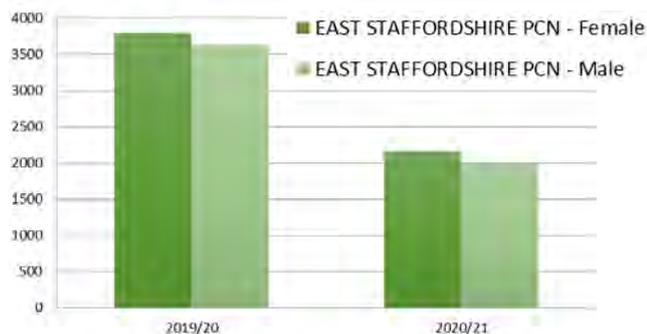


Figure 13 Numbers of referrals to mental health services (not IAPT**) in East Staffordshire PCN by gender

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 CCG³²

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](#)

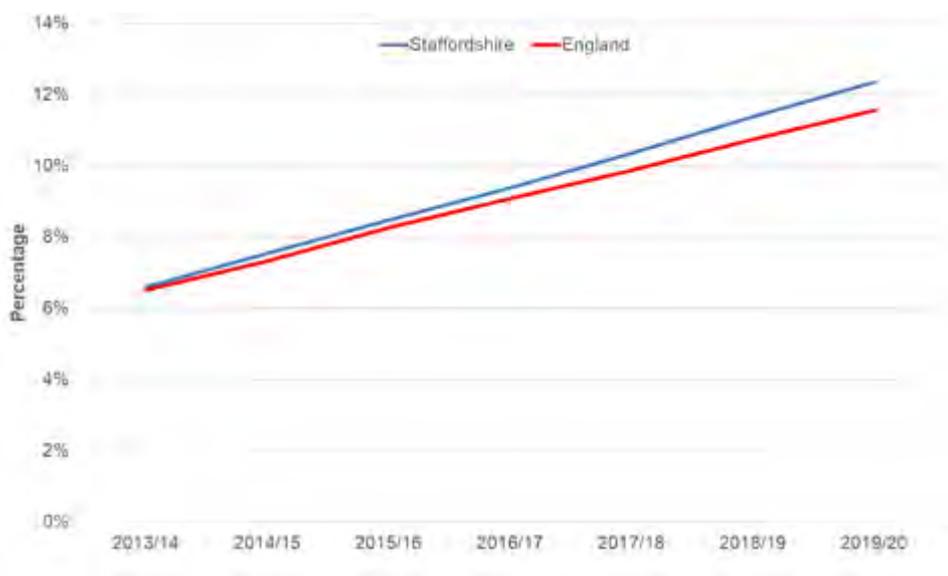


Figure 15 Trends in GP recorded depression¹

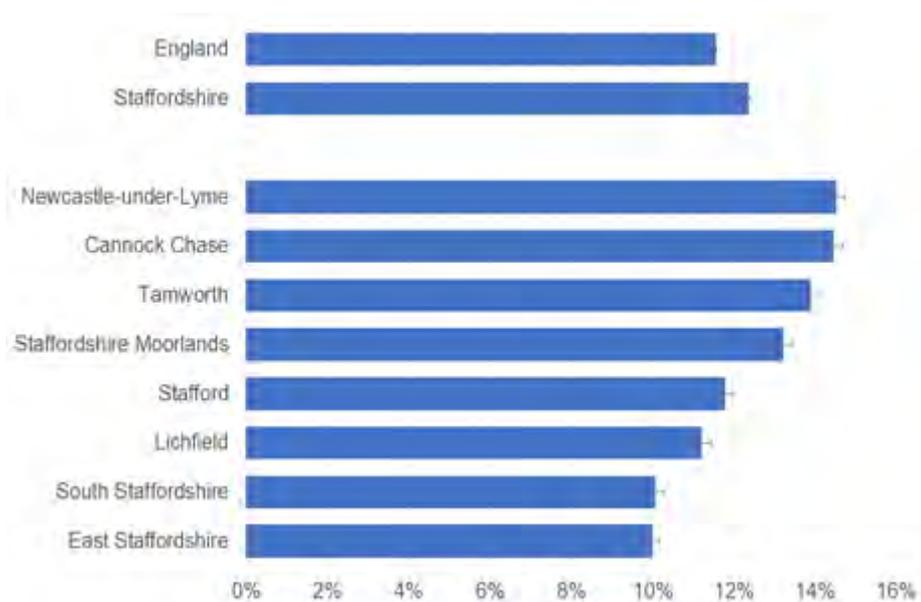


Figure 16 GP recorded depression in adults aged 18+ (2019/20)²

Note: High rates may indicate a high underlying pathology, but alternatively could be due to local recording practice.

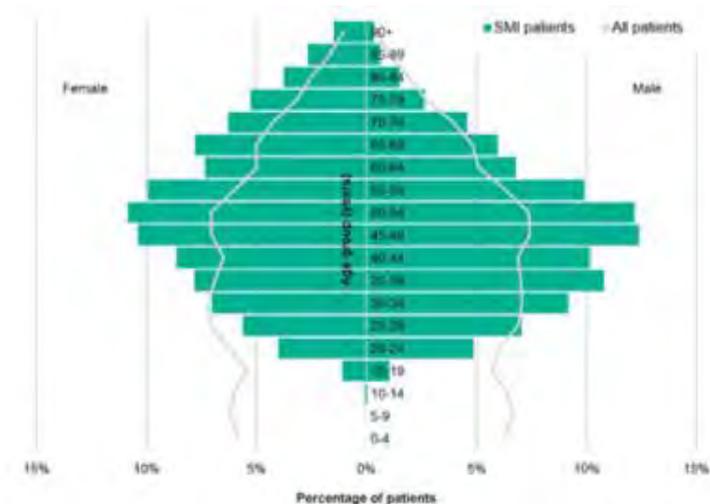
Severe mental illness

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 England¹

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

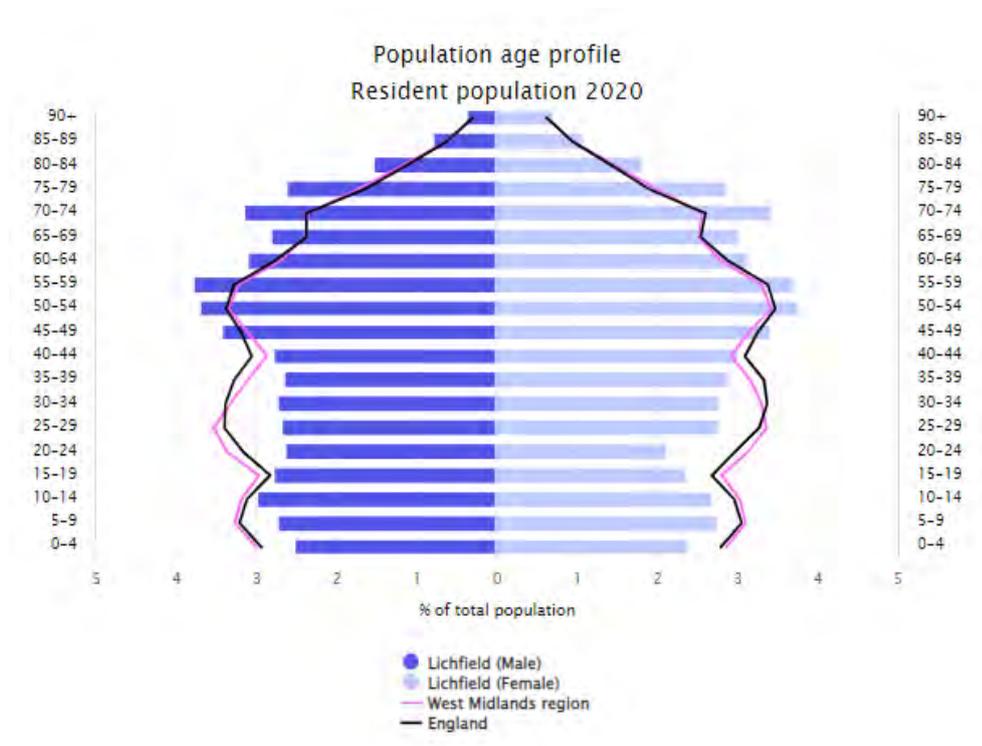


Figure 18 Age profile of the population of Lichfield in comparison to the West Midlands region and England 2020 ¹

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 England².

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

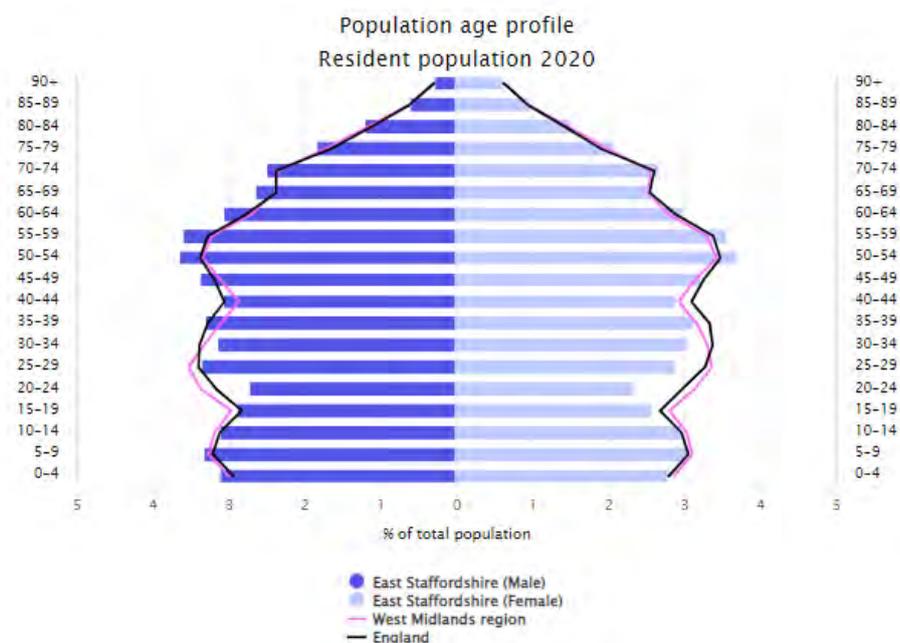


Figure 19 Age profile of the population of East Staffordshire in comparison to the West Midlands region and England 2020¹

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

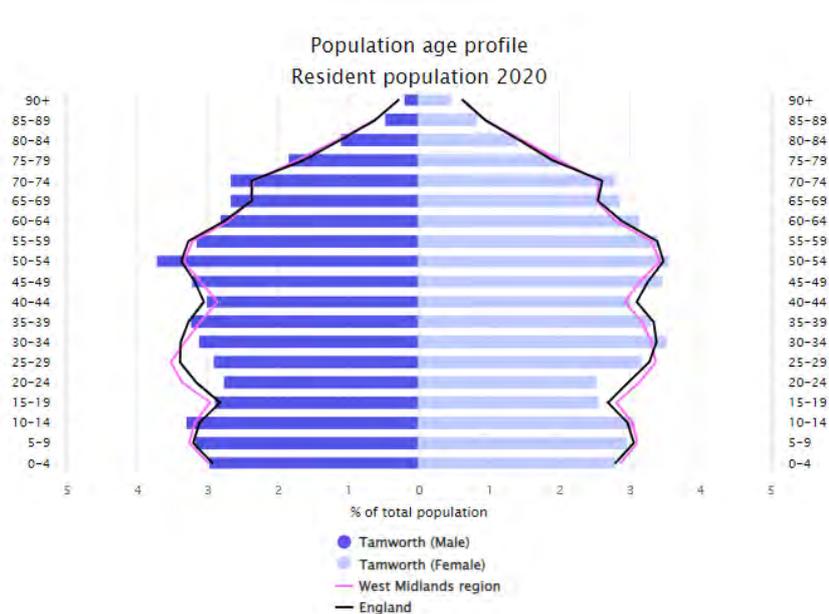


Figure 20 Age profile of the population of Tamworth in comparison to the West Midlands region and England 2020¹

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

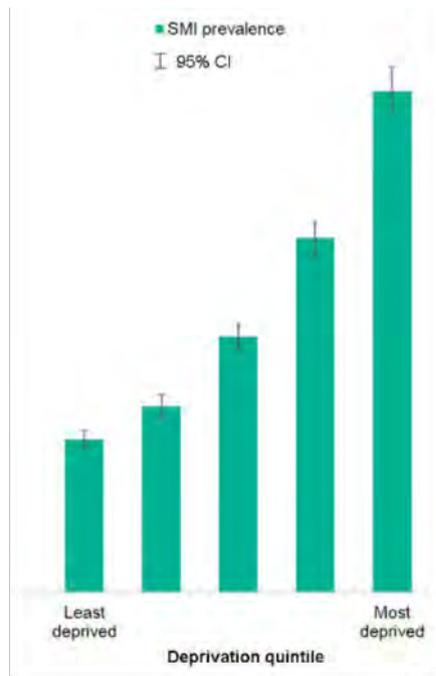
⁴ CMHF insight overview summary -Mercian V1.4b.pptx

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.

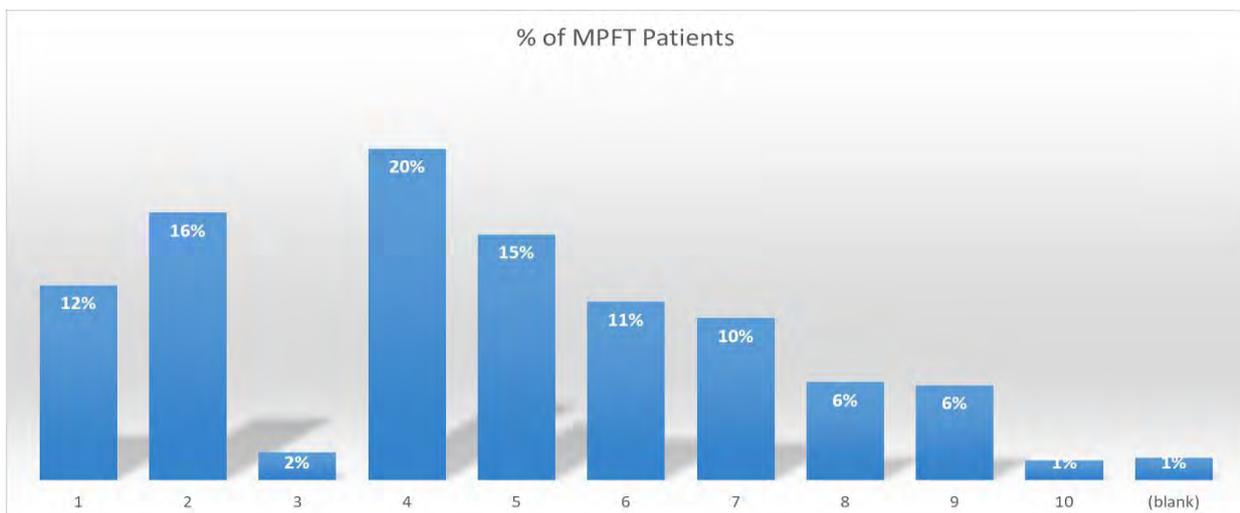


Figure 22 Mercian PCN IMD Profile of MPFT patient referrals in 2019-20¹

¹ CMHF insight overview summary - Mercian V1.4b.pptx

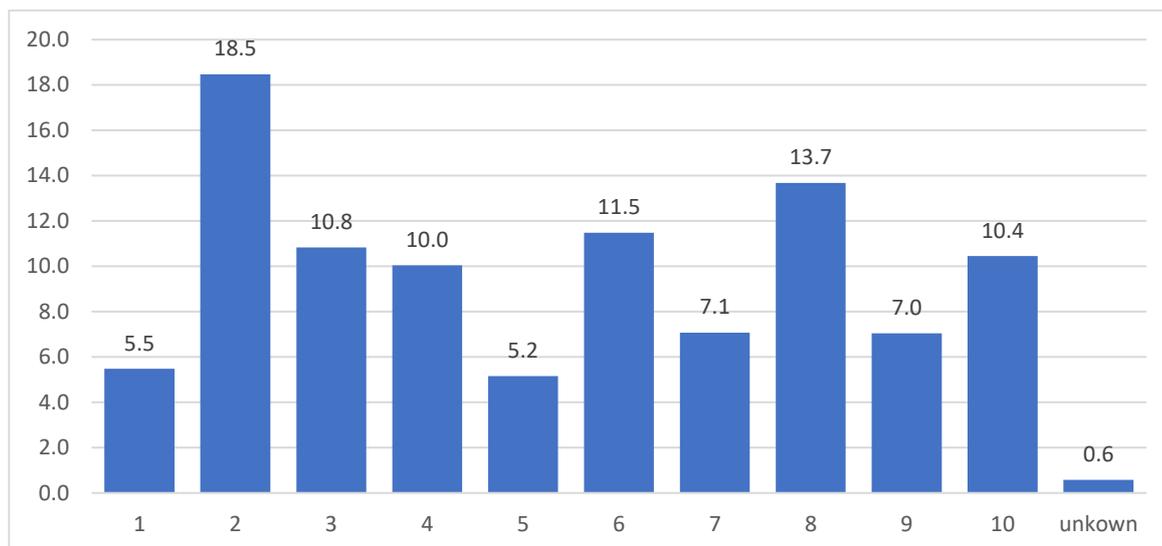


Figure 23 East Staffordshire PCN IMD Profile of MPFT patient referrals in 2019-20 in percentages¹

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 difference 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 2021⁴ 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](#)

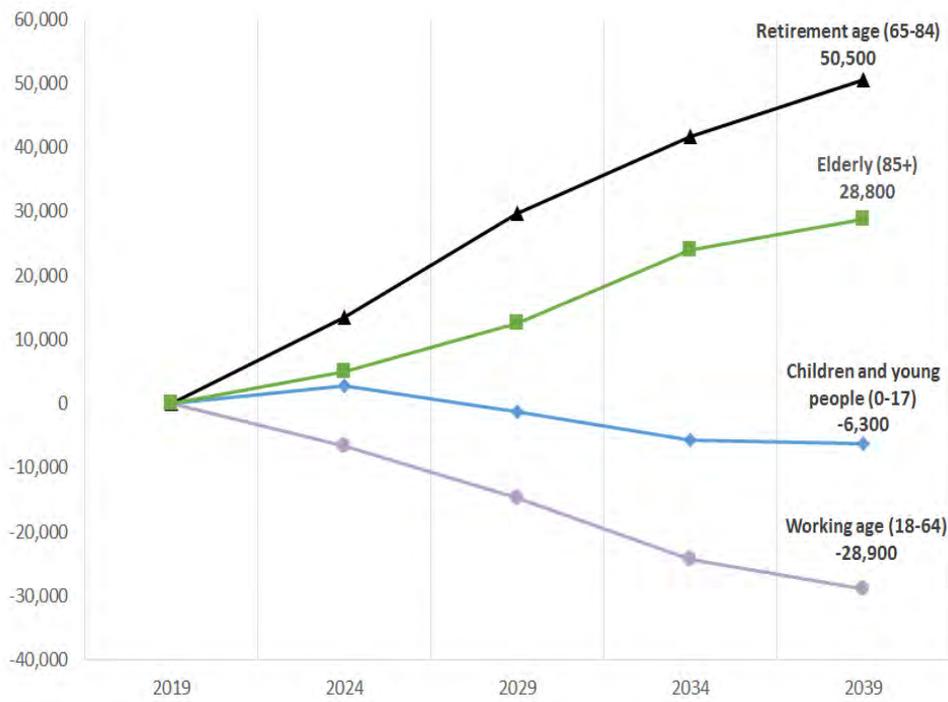


Figure 2: Projected changes in population structure 2019 to 2039¹

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 2028¹, having an impact on all aspects of the healthcare system in Staffordshire.

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 |

| | | | |
|--|-----|---|--|
| | | <p>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.</p> <p>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.</p> <p>The clinical evidence suggests that older adults are better served in the community than an admission to hospital.</p> <p>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.</p> | |
| 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 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 | <p>Advantages</p> <ul style="list-style-type: none"> 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 <p>Disadvantages</p> <ul style="list-style-type: none"> 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](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.

Legal duties for service change: a guide

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1 Introduction

1.1 Background and context

This is an introductory guide to legal obligations for NHS service change programmes in England. It can be costly and time-consuming when NHS bodies do not act on these obligations. Sometimes legal challenges can stop proposed service changes being implemented altogether. NHS colleagues involved in service change programmes say¹ they want more support to help them understand these requirements better. This guide has been written for that purpose.

This guide describes the current legal framework and the likely steps required to discharge legal duties when making changes to services. It does not set out an exhaustive list of requirements or offer guidance on how individual processes should be run. It does not replace the need for local legal advice. Each service change programme is different. Programme leaders should refer to further reading material and seek appropriate specialist legal input where necessary.

1.2 What is in this guide?

This guide sets out relevant legal considerations for NHS bodies in the process of changing services. Legislation is only one element in a complex picture that includes:

- **Legislation** – a law or a set of laws that have been passed by Parliament or on its behalf. For example, an Act of Parliament, or statutory instruments such as Regulations drafted using powers given to a Minister in an Act of Parliament.
- **Statutory guidance** – Guidance issued using powers given to NHSEI by primary legislation².
- **Policy and guidance** – Policy or guidance issued by a relevant body.
- **Public law** – the type of law governing the conduct of public bodies including the NHS which is derived from cases (sometimes known as common law).

This guide draws on these and other sources to introduce legal considerations for service change in context. It should be read alongside and does not replace or supersede³:

- *Planning, assuring and delivering service change for patients*, (NHS England, 2018)
- *Effective Service Change – A support and guidance toolkit*⁴

¹ NHSEI Research 2020 - <https://future.nhs.uk/reconfiguration/view?objectID=21336208>

² CCGs must have regard to guidance published by NHSEI (s14Z8, National Health Service Act 2006 as amended)

³ Every care has been taken to avoid the potential for ambiguity an additional document might create. Should such ambiguity arise, readers should refer to *Planning, assuring and delivering service change for patients*, NHS England 2018, as the primary document.

⁴ Available from NHSEI regional teams

In April 2020, NHS England and NHS Improvement came together as a single, operational organisation: NHS England and Improvement (NHSEI). This document refers to NHSEI whenever it cites a duty placed on either of the predecessor organisations.

1.3 Who is the guide for?

This guide has been developed for those considering, and involved in, NHS service change to help them navigate the common legal and policy issues from the very start of a service change programme through to decision-making. This includes NHS commissioners and providers, as well as Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP) leads and partners.

1.4 What is service change?

In this guide, service change is “any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.”⁵

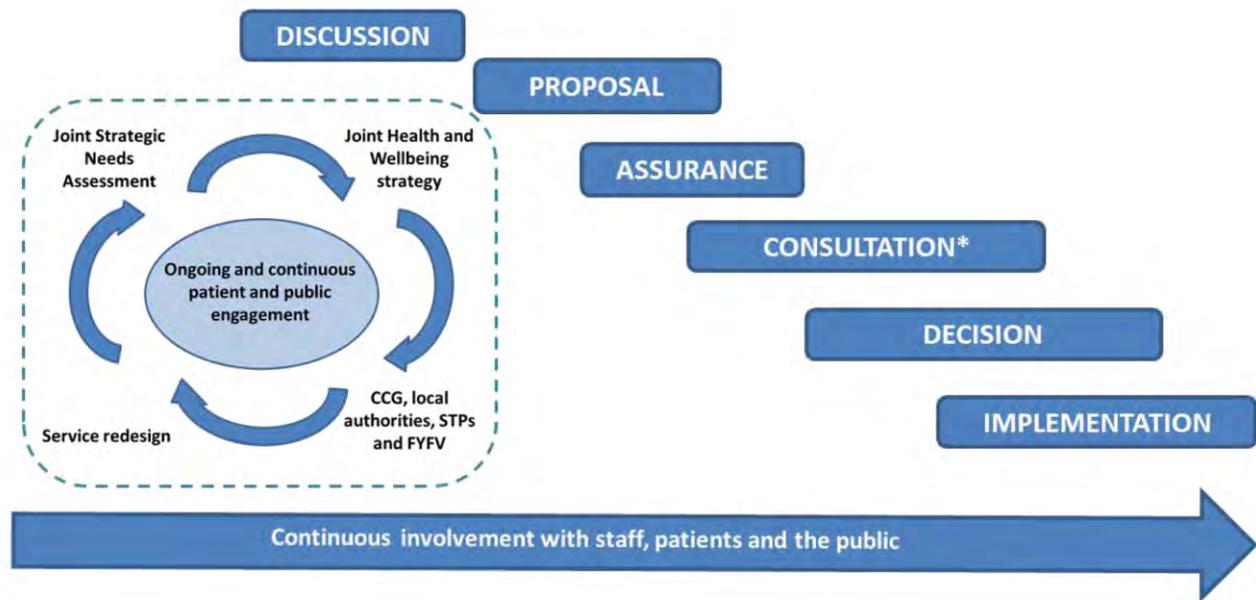
Service change usually involves a change in the range of services available or a change to the location from which particular services are delivered. Most of the legal duties apply to any change that meets this description. Some duties apply where there is any change to services from the perspective of patients. Other duties are triggered only where discussions with a local authority lead to service change proposals being deemed to be ‘substantial’. There is no single, generally accepted definition of service change and in particular no legal definition, so each case should be assessed on its specific attributes.

Service change is a complex, non-linear process. Many of the legal duties placed on NHS bodies take effect only at the decision-making point. Others have effect throughout. Preparing to discharge these duties requires regular assessment of when and how the duties are triggered and action at various planned points throughout a service change process.

Service change has several phases from setting the strategic context to implementation. *Planning, assuring and delivering service change for patients* illustrates a summary of these as⁶:

⁵ p 10, *Planning, assuring and delivering service change for patients*, NHS England 2018

⁶ p 9, *Planning, assuring and delivering service change for patients*, NHS England 2018; a footnote to the illustration states: “Public consultation may not be required in every case. A decision about whether public consultation is required should be made taking into account the views of the local authority.” For more information refer to [Section 6.2](#)



1.5 Why do we have legal requirements for service change?

Parliament sets out in legislation the things NHS bodies must consider and do when they are undertaking the work for which they were established. The aims of the duties vary and affect service change programmes in different ways. The overall aim is to secure the efficient functioning of the NHS across England in line with government policy and, where appropriate, the expectations of patients and the public.

1.6 Are there exceptions for urgent or temporary service changes?⁷

NHS bodies may decide to change a service without allowing time for consultation with the relevant local authority, where they are genuinely satisfied there is an imminent risk to the safety or welfare of patients or staff.⁸ This is the only specific exception to the statutory duties for urgent changes. Other duties will still apply and should be addressed appropriately. It is not acceptable for NHS bodies to delay addressing fragile service situations that might lead to such a risk occurring until they are so urgent that an imminent risk exists. The matter of whether a change is temporary or permanent is not addressed in legislation.

Where services need to be closed or suspended at short notice, NHS bodies and their partners should act in accordance with the *Joint Working Protocol*.⁹

⁷ [See section 5.4](#)

⁸ s23(2), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁹ [Joint Working Protocol: When a hospital, services or facility closes at short notice](#), NHS England, 2017

In all cases NHS bodies should act in accordance with their legal duties, including:

- keeping good records of the factors they consider in making these decisions;
- communicating the changes to affected people; and
- informing the local authorities in the areas affected about changes and reasons for not consulting them under the regulations.

1.7 What can happen if NHS bodies fail to discharge their legal duties?

NHS bodies must act in accordance with the law as it applies to them. The legal requirements are designed to make sure NHS bodies take all relevant factors into account in decisions to commission and provide the best services possible. If stakeholders are dissatisfied with a service change decision made by an NHS body, there are two formal ways in which the thinking and process behind the decision can be tested publicly:

1. **The matter may be referred to the Secretary of State for review¹⁰.** This avenue is open only to local authorities in the affected area using powers given under health scrutiny legislation.¹¹ The Secretary of State may take independent advice on the matter¹² and respond to the referring authority setting out the course of action to be followed.
2. **Anyone with an interest may bring a claim for Judicial Review¹³** if they consider that the NHS body has failed to act in accordance with the law. In this legal process a judge will review the facts of the case by examining programme documents and considering written witness statements. The court can quash¹⁴ decisions if a judge finds they have not been made in accordance with the law.

2 Programme leadership and governance arrangements

This section focuses on requirements that relate to governance and leadership on proposals for change.¹⁵ It covers:

- Strategic leadership
- The footprint for governance arrangements
- Independent scrutiny and assurance

2.1 Strategic leadership of change

¹⁰ See [Section 5.2](#)

¹¹ Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

¹² [How we advise the Secretary of State for Health and Social Care](#), IRP, 2020

¹³ <https://www.judiciary.uk/you-and-the-judiciary/judicial-review/>

¹⁴ Officially annul or void

¹⁵ For issues relating to decision-making, please refer to Section 6

All service change programmes need ownership, support and leadership from commissioners to make sure legal requirements are met.¹⁶ The Health and Social Care Act 2012 amended previous legislation to put clinicians at the heart of commissioning and give local NHS commissioners in England the strategic lead for deciding what health services should be provided and how they should be configured in their area.

Local NHS commissioners in England have the strategic lead for deciding what health services should be provided and how they should be configured in their area¹⁷. Service change programmes can be initiated by NHS commissioners, providers or other Sustainability and Transformation Partnership (STP) or Integrated Care System (ICS) partners. Decision-makers may begin service change programmes by investigating certain potential courses of action in response to identified challenges or opportunities. However, they must make sure other potential alternative approaches are explored in good faith and considered with an open mind.¹⁸

2.2 Governance arrangements

The governance arrangements for service change programmes must:

- Cover the geographic area impacted by the service change, using patient flows, not administrative boundaries to define that area¹⁹;
- take account of the range of services under consideration, and interdependencies between services;
- reflect and respect the legal powers and responsibilities vested in each partner organisation involved in the service change programme²⁰; and
- support decision-makers in keeping an open mind on proposals that might be subject to public consultation.²¹

NHSEI service change guidance requires that commissioners ensure that clinical ownership and leadership of plans is part of any governance arrangements.

Where the responsibilities of more than one commissioning organisation are the focus of a single change programme, Clinical Commissioning Groups (CCGs) have the power to form joint committees with other CCGs and NHSEI to exercise commissioning functions together.²² The focus on Integrated Care Systems (ICS) and Sustainability and Transformation Partnerships (STP) as the forum for service

¹⁶ p 16, *Planning, assuring and delivering service change for patients*, NHS England 2018

¹⁷ National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)

¹⁸ R (Royal Brompton Hospital) v Joint Committee of Primary Care Trusts [2011] EWHC 2986 (Admin) & [2012] EWCA Civ 472

¹⁹ The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

²⁰ National Health Service Act 2006 (as amended)

²¹ 29-30, R (Sardar) v Watford Borough Council [2006] EWHC 1590 (Admin)

²² The Legislative Reform (Clinical Commissioning Groups) Order 2014

planning make it increasingly important for statutory decision-makers to be satisfied that they have properly delegated their relevant functions to joint committees.

Where proposals for change raise questions of what services are delivered or which provider should deliver them, change programme leaders must be mindful of their duties in relation to procurement and patient choice.²³ Commissioners may not be required to undertake a formal procurement process in situations where there is only one possible provider.

2.3 Independent scrutiny and assurance of service change

NHSEI requires service change programmes to integrate regulatory assurance checkpoints into the programme timeline.

Governance arrangements must take account of the need to liaise with regional NHSEI teams and local authorities in the area of the change programme. Note that local authorities have multiple roles as critical stakeholders, partners in STP/ICS, and have statutory scrutiny powers.²⁴

In establishing governance arrangements for service change programmes, NHS bodies should take into account the need to meet the public law expectation that accurate records should be kept by public bodies when discharging statutory functions.

²³ [The Public Contracts Regulations \(2015\)](#); and The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

²⁴ See [Section 5.2](#)

3 Developing a case for change and early discussion

This section focuses on requirements that relate to developing a case for change. It covers:

- The starting point for developing a case for change
- Duty to consider Joint Strategic Needs Assessments (JSNA) and Health and Wellbeing Strategies (HWBS)
- Duty to consult on and publish a commissioning plan
- Public Sector Equality Duty
- Duty as to reducing health inequalities
- The case for change

The development of a case for change should be:

- overseen by clinical commissioners and be driven by clinicians including medical directors and heads of clinical services;
- based on the best available evidence;²⁵ and
- informed by the learnings from continuous patient involvement.²⁶

3.1 Strategic starting point

Clinical Commissioning Groups (CCGs) have statutory duties to:

- consider relevant Joint Strategic Needs Assessments (JSNAs) and Joint Health & Wellbeing Board Strategies (JHWSs);²⁷ and
- publish before the start of each financial period a plan that sets out how it will discharge its functions.

In developing or revising this plan, each CCG must:

- consult people who it is responsible for;
- consult each relevant Health and Wellbeing Board;
- publish a summary of the views gathered;
- publish a summary of how it took those views into account; and
- include in the published plan a statement of each relevant Health and Wellbeing Board's final opinion on the plan.²⁸

Combined, these duties mean a range of stakeholders (including local authorities, Health and Wellbeing Boards, Health Overview and Scrutiny Committees, local voluntary, community and third sector organisations, CCG Member Practices, service providers and participants in local consultative arrangements) will be aware

²⁵ p 17, *Planning, assuring and delivering service change for patients*, NHS England 2018

²⁶ s 13Q, 14Z2 and 242, National Health Service Act 2006 as amended.

²⁷ s 116B, Local Government and Public Involvement in Health Act 2007

²⁸ s 14Z11-13 National Health Service Act 2006

of the potential for change and early discussions on the need for specific service change will be well-founded.

Early involvement with diverse communities, local Healthwatch organisations, patient groups and other local organisations is essential, as well as engaging NHSEI where appropriate. This will give early warning of issues likely to raise concerns in local communities and gives commissioners time to work on the best solutions to meet those needs.²⁹

3.2 Equality and health inequality duties

The duties placed on NHS bodies by equality legislation permeate all stages of the service change process from early discussion through to decision-making and on to implementation. NHSEI has made available specific guidance for NHS bodies on discharging equality and health inequality legal duties.³⁰ Reflecting these duties and for reasons both of fairness and improvement in overall outcomes, the NHS Long Term Plan sets out commitments to take a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.³¹

3.3 The Equality Act

The Equality Act (2010) places NHS bodies under a continuing duty “in the exercise of their functions” to “have due regard to the need to:

- eliminate discrimination, harassment, victimisation and other prohibited conduct; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.”³²

The relevant protected characteristics are:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.³³

²⁹ p17 & 18, *Planning, assuring and delivering service change for patients*, NHS England 2018

³⁰ [Guidance for NHS commissioners on equality and health inequalities legal duties](#), NHSE 2015

³¹ 2.23 *The NHS Long Term Plan*, NHS England 2019

³² s149 (1), Equality Act 2010

³³ s149 (7), Equality Act 2010

This important duty, known as the Public Sector Equality Duty, is concerned with process. Public bodies must take appropriate steps to “be properly informed before taking a decision. If the relevant material is not available, there will be a duty to acquire it.”³⁴ The courts have recognised that discharging this duty and ensuring evidence is available to demonstrate it has been discharged “imposes a heavy burden upon public authorities”³⁵ and has made clear that a “realistic and proportionate approach” must be taken in evidencing compliance.³⁶

NHS bodies must avoid discrimination, harassment and victimisation and, where necessary, make reasonable adjustments for disabled people when undertaking activity that supports and informs decision-making and their other functions.³⁷

3.4 Duty as to reducing health inequalities

The Health and Social Care Act 2012 amended the National Health Service Act 2006 to place on clinical commissioners’ duties “in the exercise of their functions [to] have regard to the need to:

- a) reduce inequalities between patients with respect to their ability to access health services, and
- b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.”³⁸

Commissioners should consistently have regard to the need to reduce inequalities when exercising their functions.³⁹

³⁴ LJ Elias in *Hurley and Moore v Secretary of State for BIS* 2012 EWHC 201, cited by LJ McCombe in *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, MoJ 2013

³⁵ p60, LJ McCombe in *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, MoJ 2013

³⁶ p313 *R(SG) v Secretary of State for the Home Department* [2016] EWHC (Admin) 19

³⁷ p10, [Equality Act 2010: Summary Guidance on Services, Public Functions and Associations](#), EHRC 2014

³⁸ s13G & s14T National Health Service Act 2006 as amended Health and Social Care Act 2012

³⁹ p13, [Guidance for NHS commissioners on equality and health inequalities legal duties](#), NHSE 2015

4 Developing proposals for service change and a pre-consultation business case (PCBC)

This section focuses on requirements that relate to the development of service change proposals and a PCBC. It covers:

- Developing proposals
- Duty to involve service users
- The NHSEI Assurance process
- The five tests for service change proposals

4.1 Developing proposals

The way in which proposals for change have been arrived at will, if they progress, be exposed to scrutiny by NHSEI, by local authority health overview and scrutiny committees, by patients, the public and other stakeholders, possibly by the courts and possibly by the Independent Reconfiguration Panel after a referral to the Secretary of State.⁴⁰

Development of proposals should be started by seeking a comprehensive range of perspectives to identify the full range of service change solutions that could meet the stated objectives of the programme within available resources.⁴¹ Programme leaders must make sure good records are kept as potential proposals are whittled down to a shortlist.⁴²

There is no duty to carry forward to public consultation, where it is required, proposals that in the view of the commissioners are unrealistic, unviable or unsustainable.⁴³ Commissioners may need to provide information about discarded proposals⁴⁴, if there is a requirement to consult on the proposals.⁴⁵

4.2 Duty to involve service users

NHS commissioners have a statutory duty to secure 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].”⁴⁶

⁴⁰ See [Section 1.7](#)

⁴¹ p25, *Planning, assuring and delivering service change for patients*, NHS England 2018

⁴² See [Section 2.2](#)

⁴³ *R(Nettleship) v NHS South Tyneside CCG and Sunderland CCG* [2020] EWCA Civ 46

⁴⁴ 28, *Wilson LJ in R(Moseley) v London Borough of Haringey* [2014] UKSC 56

⁴⁵ [See section 6.2](#)

⁴⁶ S13Q & 14Z2 National Health Service Act 2006 as amended Health and Social Care Act 2012

The legislation states service users may be involved by “being consulted or provided with information or in other ways”.

NHS providers are subject to similar duties.⁴⁷

NHSEI guidance recognises that “A separate public involvement exercise is not required at every step, so long as existing arrangements are sufficient to secure the necessary public involvement in the commissioning process.”⁴⁸

NHSEI has set out in statutory guidance a three-step process for assessing whether the legal duty to involve applies.⁴⁹ NHSEI staff must document their assessment⁵⁰ and Clinical Commissioning Groups should ensure adequate records are kept of their decisions about the extent and nature of engagement they will undertake. Where commissioners rely on the outputs of patient and public participation activity undertaken by provider organisations, they should satisfy themselves that activity is sufficient to meet their statutory obligations.

4.3 NHSEI assurance process

NHSEI has set out a two-stage independent assurance process.⁵¹ Stage 1 involves a strategic sense check of the case for change normally conducted before the detailed process of developing proposals is started. Stage 2 requires commissioners to produce a pre-consultation business case (PCBC) for the purposes of testing and assessing the robustness of the proposals before they proceed to consultation where required. Preparing for and completing stage 2 assurance will assist NHS bodies in meeting their statutory obligations. At stage 2, NHSEI will decide if additional assurance is needed prior to decision-making.

4.4 The five tests of service change

NHS commissioners are required⁵² to apply the tests of service change.⁵³ 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.

⁴⁷ s242, National Health Service Act 2006 as amended

⁴⁸ p18, *Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England*, NHS England 2017

⁴⁹ p19, *Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England*, NHS England 2017

⁵⁰ NHS England staff acting as commissioners (e.g. for specialised services) should document their assessment using the public involvement assessment and planning form available on the NHS England intranet.

⁵¹ p18-23, *Planning, assuring and delivering service change for patients*, NHS England 2018

⁵² 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)

⁵³ p13, *Planning, assuring and delivering service change for patients*, NHS England 2018

- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test

It is for NHSEI to decide if the Patient Care Test has been met.⁵⁴ The assessment of proposals against the tests will likely need to be reviewed to include updated information and evidence prior to decision-making.

⁵⁴ p103-125 in R (Hinsull) v NHS Dorset Clinical Commissioning Group [2018] EWHC 2331 (Admin)

5 Local authority health scrutiny

This section focuses on legal requirements to formally consult local authorities on proposals for service change. It covers:

- Duty to consult local authorities
- Local authority scrutiny powers
- The duty to seek agreement
- Urgent service changes

5.1 Consulting local authorities

The 2013 Health Scrutiny Regulations⁵⁵ place on NHS commissioners a statutory duty⁵⁶ to formally consult a local authority where the NHS (commissioner or provider) has under consideration any proposal for a substantial development of the health service in the area of that local authority, or for a substantial variation in the provision of such a service. ‘Substantial’ is not defined in the Regulations and should be jointly agreed by the NHS and the local authority⁵⁷ taking note of locally agreed protocols and working arrangements where they exist.

Consulting local authorities on proposals for changes to NHS services is highly complex and requires a high level of preparation, co-operation and exchange of information.⁵⁸ Strong relationships and awareness of the issues underpinning the proposals are often critical to success. This can be developed through information-sharing and discussion at the points described in the preceding sections of this document.

Where an NHS body consults a local authority on a proposal under the regulations, it should state it is consulting under the regulations⁵⁹ and must give the authority two dates:

- the date by which the local authority must respond to the proposal; and
- the date by which the NHS body intends to decide whether to proceed with the proposal.

The NHS body must publish these dates and any changes to them.⁶⁰

5.2 Local authority scrutiny powers

The Regulations give local authorities statutory powers to:

⁵⁵ The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁵⁶ Regulation 23 (1) and 23 (12) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁵⁷ IRP Stoke-on-Trent referral advice, DoHSC 2017

⁵⁸ IRP Horton2 referral advice, DOHSC 2018

⁵⁹ 15, R (Juttla & Ors) v Hertfordshire Valleys Clinical Commissioning Group & Ors [2018] EWHC 267 (Admin)

⁶⁰ Regulation 23(1b), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

- require the relevant NHS body to provide information on matters it is scrutinising⁶¹,
- require members or employees of the relevant NHS body to attend and answer questions in connection with the matters it is scrutinising⁶², and
- respond to the consultation and make recommendations the NHS must consider and respond to⁶³.

Where substantial change proposals affect more than one local authority area, the affected local authorities must⁶⁴ form a Joint Committee to be consulted. Where a Joint Committee is formed only the Joint Committee may discharge these powers.⁶⁵ NHS bodies will have to take these arrangements into account from the earliest planning stages.

Local authorities have the power⁶⁶ to refer a proposed substantial development or variation to the Secretary of State for review if:

- It is not satisfied with the adequacy of content of, or time allowed to consult it (not the public) on the proposal.
- It considers that the proposal would not be in the interests of the health service in its area.
- It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

Some local authorities delegate the power to refer to the committee or joint committee discharging the scrutiny function. Some retain the power to a decision of the full council. NHS bodies should familiarise themselves with local arrangements.

Where the local authority does not comment on the proposal, or its comments do not contain a recommendation, the local authority must⁶⁷ inform the consulting commissioners of:

- its decision on whether to exercise its power to refer the proposal to the Secretary of State, or
- the date by which it proposes to make such a decision, make the decision by that date, and inform the commissioners of that decision.

⁶¹ Regulation 26 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁶² Regulation 27 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁶³ Regulations 23(4-5) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁶⁴ Regulation 30, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁶⁵ Commonly, but not always known as a Joint Health Overview and Scrutiny Committee (JHOSC)

⁶⁶ Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁶⁷ Regulation 23(7 & 8), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

5.3 Duty to seek agreement

Where there is disagreement between NHS bodies and local authorities on the subject of recommendations made in the response to consultation on change proposals, both parties share a statutory duty to seek to reach agreement.⁶⁸

5.4 Urgent service changes⁶⁹

NHS bodies in England may proceed to make urgent changes to services without consulting local authorities where those bodies are genuinely satisfied the welfare of patients or staff is at risk.⁷⁰ Where NHS bodies invoke this provision in the Regulations, they should inform the local authorities in the areas affected about changes and reasons for not consulting. A local authority may still choose to refer the matter to the Secretary of State for review if it is not satisfied that the reasons given for not carrying out consultation are adequate.⁷¹

⁶⁸ Regulation 23(5), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁶⁹ [See section 1.6](#)

⁷⁰ Regulation 23(2), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁷¹ Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; [See section 5.2](#)

6 Consulting patients and other stakeholders

Public consultation will not be appropriate for every service change proposal. This section focuses on legal requirements of formally consulting patients and other stakeholders on proposals for change where public consultation is required. It covers:

- Public law requirements for public consultation
- Deciding to consult the public
- Reporting consultation output
- Changed proposals

There are countless perspectives among stakeholders on service change. NHS bodies' duties mean they have to take each into account. NHS staff, patients, carers, visitors, clinicians, officers in partner organisations, elected representatives, action groups with a wider agenda, community groups, local businesses and others will have valuable insight to contribute.

6.1 Public consultation

Public consultation is a formal window of opportunity for any stakeholder to scrutinise and respond to proposals for change. Public consultation is liable to result in better decisions by ensuring that the decision-maker has access to all the relevant, properly tested information and must be conducted fairly⁷². The requirements for fairness in conducting a public consultation are set out in an extensive and growing body of case law, including the four Gunning Principles⁷³, which are:

1. Proposals must be at a formative stage

The decision-making body's mind needs to be open to influence from responses to a public consultation.

2. Consultors must provide sufficient information to allow consultees 'intelligent consideration' of the proposals

NHS bodies should satisfy themselves sufficient information is in the public domain, record and consider requests from consultees for additional information. Following the rigorous process of creating an externally assured pre-consultation business case (PCBC) will go a long way to meeting this requirement.

3. Consultors must allow sufficient time for consultation

NHS bodies should consider their own policy and practice, and the volume and complexity of the information being published to support when determining the deadline for responses to a public consultation.

⁷² 24, Wilson LJ in R(Moseley) v London Borough of Haringey [2014] UKSC 56

⁷³ R (Gunning) v Brent London Borough Council (1985) 84 LGR 168

4. Consultors must conscientiously consider the output of the consultation

Following consultation, the response to the consultation exercise must be analysed, fairly reported and considered in detail by the decision-makers.

6.2 Deciding to consult the public

Decisions on whether to hold a public consultation on proposals for service change as a means to discharge the duty⁷⁴ to involve should take account of:

- the description of arrangements for patient and public involvement included in the CCGs' constitution in response to its statutory duty⁷⁵;
- their patient and public involvement strategy or policy documents; and
- other established practices, undertakings and previous commitments made.⁷⁶

NHSEI guidance notes that where there is a duty for the commissioner to consult the local authority under the 2013 Health Scrutiny Regulations, it will almost invariably be the case that public consultation is also required.⁷⁷

Irrespective of how a decision to hold a public consultation is arrived at, the common law duty of procedural fairness will inform the manner in which that consultation should be conducted.⁷⁸

Each NHS organisation should satisfy itself that its public involvement duty and duty to consult affected local authorities has been met. In practice, a single, well-resourced period of consultation can be sufficient to satisfy commissioners' and providers' respective duties.⁷⁹ Note that public consultation will normally end before local authority consultation. "It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion."⁸⁰

6.3 Reporting consultation output

The responses to a consultation must be reported fairly in a format that allows decision-makers to take them fully into account in their considerations.⁸¹ It is advisable to engage an independent body to run the consultation analysis⁸² and brief them on decision-making requirements before the public consultation is launched.

⁷⁴ s13Q & 14Z2 National Health Service Act 2006 as amended

⁷⁵ s14Z2(c) National Health Service Act 2006 as amended

⁷⁶ R(Buckingham) v NHS Corby CCG [2018] EWHC 2080 (Admin)

⁷⁷ p11, *Planning, assuring and delivering service change for patients*, NHS England 2018

⁷⁸ R(Moseley) v London Borough of Haringey [2014] UKSC 56

⁷⁹ p12, *Planning, assuring and delivering service change for patients*, NHS England 2018

⁸⁰ s4.4.2, *Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny*, DoH 2014

⁸¹ 37, R (Kohler) v The Mayor's Office for Policing and Crime [2018] EWHC 1881

⁸² p31, *Planning, assuring and delivering service change for patients*, NHS England 2018

6.4 Changed proposals and further consultation

Based on the output of a public consultation, an NHS body may wish to adapt its published proposals to an extent that warrants consideration of further consultation. There should be further consultation if there is “a fundamental difference between the proposals consulted on and those which the consulting party subsequently wishes to adopt.”⁸³

⁸³ 45, R(Smith) v East Kent Hospital NHS Trust [2002] EWHC 2640

7 Decision-making

The culmination of a process to develop, discuss and consider proposals for changes to services is a formal decision. This section focuses on legal requirements that relate to decision-making on proposals for change. It covers:

- The types of decision to be made
- Decision-making arrangements
- Decision-making papers
- Local authority scrutiny decision

7.1 Types of decision to be made

It is likely in any substantial service change that there will be a series of decisions to be made:

1. First, commissioners will consider the evidence base and make decisions on:
 - a. the future service model (service change decision); and
 - b. the identity of the provider they wish to appoint (procurement decision).
2. Then, chosen providers will consider the evidence base as they make plans to implement the commissioning decisions.

Working in partnership at Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP) level does not automatically ensure arrangements are in place to discharge legal responsibilities in decision-making.

7.2 Decision-making arrangements

Decision-makers should satisfy themselves that sufficient evidence is in place to enable them to discharge each of their legal duties in the process. For commissioners this is a wide range of duties set out at Annex A. Care should be taken that each decision to be made is considered by a body that has the legal authority to make that decision.

The commissioners' decision is to be based on the best balance of evidence, including evidence gained through public engagement and consultation. A clear audit trail of how the decision was reached and the considerations taken into account should be captured.⁸⁴

7.3 Decision-making documents

The prescribed approach to meeting this requirement is to build a decision-making business case (DMBC), which can be built from the pre-consultation business case (PCBC) and should include: information on the sustainability and affordability of the proposals; analysis of output from public consultation and consultation with local

⁸⁴ p32, *Planning, assuring and delivering service change for patients*, NHS England 2018

authorities and other stakeholders, and show how that output has been taken into account. A DMBC may form the basis for an additional assurance check where required by NHSEI.

The elements needed for a decision-making business case are covered in *Planning assuring and delivering service change for patients*. Whether or not it is required as part of the assurance process, a DMBC should be organised in a way that supports decision-making and the entirety of the documentation that builds the case should be made available to decision-makers for consideration.

Clinical Commissioning Groups must make decisions in accordance with the arrangements for securing transparency around decision-making each has set out in its constitution⁸⁵. NHS trusts and NHSEI are required to conduct meetings in public⁸⁶. Decision-making should take place in line with normal organisational governance processes. An extraordinary meeting with a single agenda item may be organised to consider the issue. The decision-making body should address conflict of interest in the appropriate way. Decision-making in the NHS is complex and multi-factorial and must take into account a series of statutory duties that do not all pull in the same direction. To balance the competing factors decision-makers have to exercise substantial discretion, judgement or assessment.⁸⁷ The chair of the meeting may find it useful to consider each of the applicable considerations in turn to make sure legal duties set out at Annex A are demonstrably discharged.

It is helpful to video-record the meeting, particularly if it is being broadcast or webcast.

Decision-makers should again be mindful of their procurement duties at this stage.⁸⁸ There are occasions when the process of discussing service change proposals leads to a change in the proposals being considered to such an extent that further consultation might be required.⁸⁹

7.4 Local authority referral consideration

In practice local authorities (normally through their Health Overview and Scrutiny Committee or Joint Committee) will often reserve their considerations on referring a proposal for substantial service change to the Secretary of State for review⁹⁰ until after a commissioning decision has been made. The authority must inform the relevant NHS bodies of its decision.⁹¹

⁸⁵ para 4(2), Schedule 1A, National Health Service Act 2006

⁸⁶ Public Bodies (Admission to Meetings) Act 1960

⁸⁷ 75, Farbey J in R(A and Keppel) v South Kent Coast CCG and others [2020] EWHC 372 (Admin)

⁸⁸ [The Public Contracts Regulations \(2015\)](#); and The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

⁸⁹ See [Section 6.4](#)

⁹⁰ Regulation 23(9) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

⁹¹ s23(7 & 8), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; see [Section 5.2](#)

Further reading and resources (links embedded)

- [*The NHS Long Term Plan*](#) (NHS England, 2019)
- [*Planning, assuring and delivering service change for patients*](#) (NHS England, 2018),
- [*Effective Service Change – A support and guidance toolkit*](#) (available from NHSEI regional teams)
- [*Patient and public participation in commissioning health and care: Statutory guidance*](#) (NHS England, 2018)
- [*Guidance for NHS commissioners on equality and health inequalities legal duties*](#) (NHSE, 2015)
- [*Guidance on capital regime, investment and business case approval*](#) (NHS Improvement, 2016)
- [*Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners*](#) (DoH, 2014)
- [*Joint Working Protocol: When a hospital, services or facility closes at short notice*](#) (NHS England, 2017)
- [*Equality Act 2010: Summary Guidance on Services, Public Functions and Associations*](#) (EHRC 2014)

The Independent Reconfiguration Panel is available to offer generic advice and support to NHS and other interested bodies on the development of local proposals for service change, and publishes the advice it gives to the Secretary of State on each matter referred to it at <https://www.gov.uk/government/collections/irp-initial-assessment-advice>

NHSEI **regional leads for reconfiguration** can help guide you through national or regional assurance requirements, support you with understanding the broader service reconfiguration process including understanding public consultation duties, and signpost you to relevant support.

| | | |
|-----------------------|------------------|--|
| North (East and West) | Tim Barton | timbarton@nhs.net |
| Midlands | Kay Fradley | kfradley@nhs.net |
| East of England | Nigel Littlewood | nigel.littlewood@nhs.net |
| South East | Lawrence Tyler | lawrence.tyler@nhs.net |
| South West | Christina Button | christina.button@nhs.net |
| London | David Mallett | davidmallett@nhs.net |

You can access further support, examples, case study and resources at the national reconfiguration futureNHS workspace:

<https://future.nhs.uk/reconfiguration/grouphome>

Annex A - Legislation giving rise to relevant duties

National Health Service Act 2006 as amended by the Health and Social Care Act 2012

- 1I(2) – function of arranging provision of services for the purposes of the health service in England
- 3(1) – arranging for provision to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility
- 3(1)(f) – CCGs must act in a manner which is consistent with the duties of NHS England and the Secretary of State
- 14P – Duty to promote the NHS Constitution
- 14Q – Duty as to effectiveness and efficiency
- 14R – Duty as to the improvement in quality of services
- 14T – Duty as to reducing health inequalities
- 14V – Duty as to patient choice
- 14X – Duty to promote innovation
- 14Y – Duty in respect of research
- 14Z1 – Duty to promote integration
- 14Z2 – Duty as to public involvement and consultation
- 14Z8 – Duty to have regard to commissioning guidance published by NHSE
- 14Z11 – Duty to prepare and publish a commissioning plan
- 14Z13 – Duty to consult about commissioning plan, publish a summary of views expressed, and explain how the views have been taken into account

S2 Health Act 2009 Duty to have regard to the NHS constitution

The Public Contracts Regulations (PCR 2015)

NHS (Procurement Patient Choice and Competition) (No,2) Regulations 2013

Local Government and Public Involvement in Health Act 2007

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Section 149 Equality Act 2010 – Public Sector Equality Duty.

See also provisions in:

- The Public Services (Social Value) Act 2012
- The Autism Act 2009
- The Children's Act 2004
- Freedom of Information Act 2000



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Forecasting future impacts of Mental Health via COVID-19

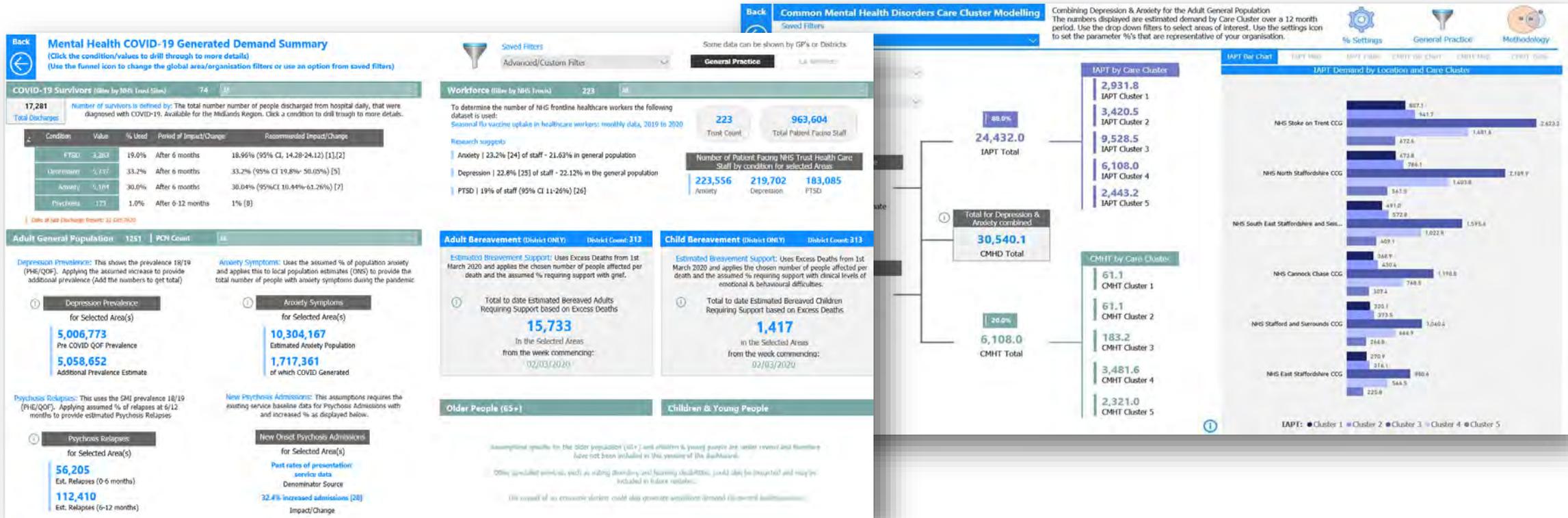
Staffordshire & Stoke-on-Trent ICP

19th October 2021



Mental Health Dashboard

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.



COVID-19 survivors in Staffordshire & Stoke-on-Trent ICP

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

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)

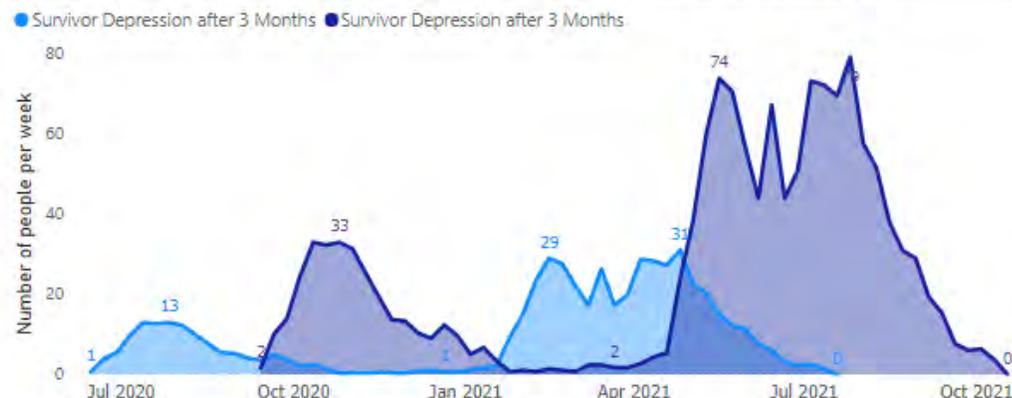
Number of survivors is defined by: The total number number of people discharged from Hospital daily that were diagnosed with COVID-19.

Research suggests

Within the first 3 months 13.5-17.5% [6]

After 6 months 30.04% (95%CI 10.44%-61.26%) [7]

Estimated number of survivors with symptoms of depression for 3 month and 6 month %'s



Estimated number of survivors with anxiety symptoms for 3 month and 6 month %'s



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)

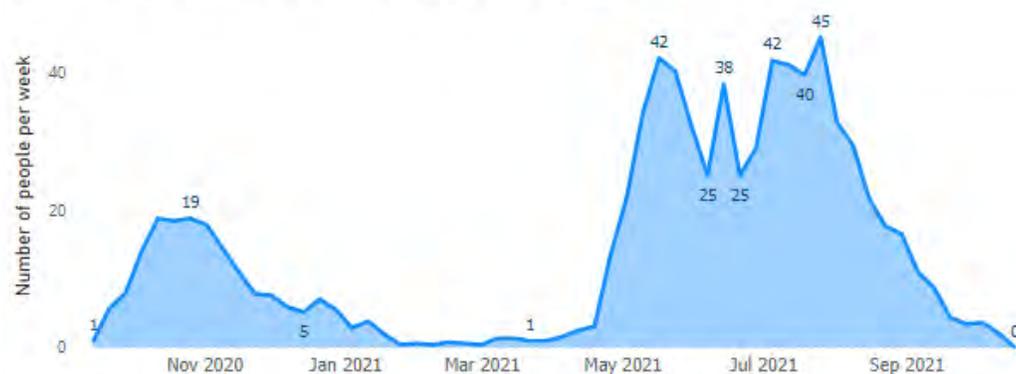
Number of survivors is defined by: The cumulative number number of people discharged from Hospital daily that were diagnosed with COVID-19.

Research suggests

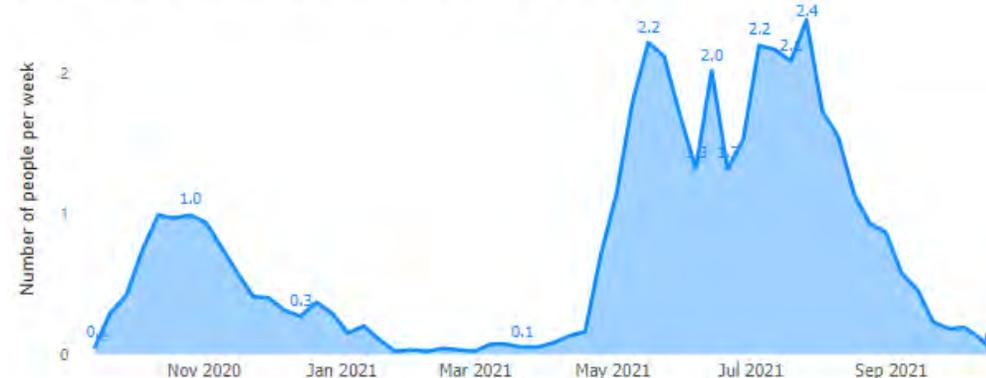
After 6-12 months 1% [8]

| 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

Appendix 4: MH Forecasting due to COVID-19 pandemic SSOT



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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.

General/Mild Anxiety prevalence in Adult population

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 |

Mental Health Dashboard

Appendix 4: MH Forecasting due to COVID-19 pandemic 3307



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Depression prevalence in Adult population

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.

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

Appendix 4: MH Forecasting due to COVID-19 pandemic SSOF



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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%

6,107

IAPT Total

1,527

CMHT Total

7,634

Year Total

Scenario 2: 50%

12,214

IAPT Total

3,054

CMHT Total

15,268

Year Total

Scenario 3: 75%

18,321

IAPT Total

4,580

CMHT Total

22,901

Year Total

Mental Health Dashboard

Appendix 4: MH Forecasting due to COVID-19 pandemic SSOT



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Psychosis relapses in Adult population

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 |

Mental Health Dashboard

Appendix 4: MH Forecasting due to COVID-19 pandemic BSOE



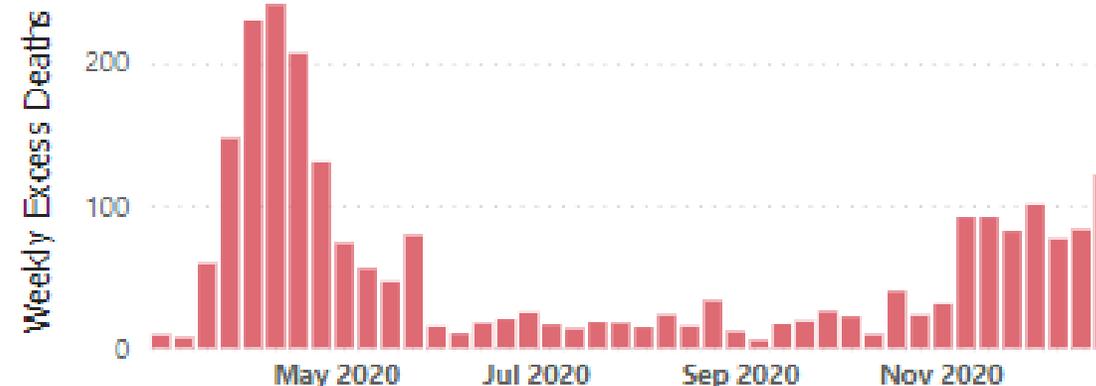
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Bereaved Adults requiring support

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

Appendix 4: MH Forecasting due to COVID-19 pandemic 3307



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NHS trust frontline staff

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*

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]

4

Trust Count

23,942

Total Patient Facing Staff

Number of Patient Facing NHS Trust Health Care Staff by condition for selected Areas

5,555

Anxiety

5,459

Depression

4,549

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

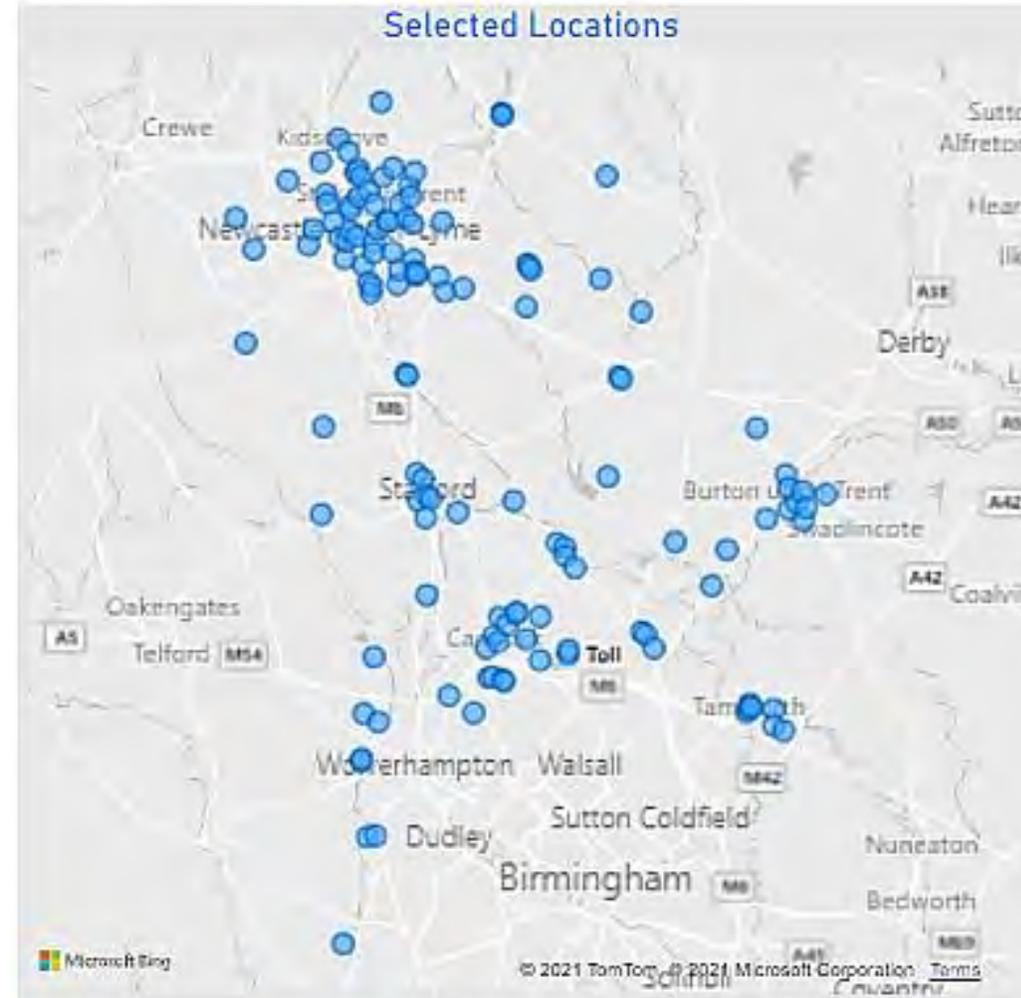
Appendix 4 MH Forecasting due to COVID-19 pandemic SSOT

Appendix 1: GPs included in prevalence denominators

CCG's

- 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

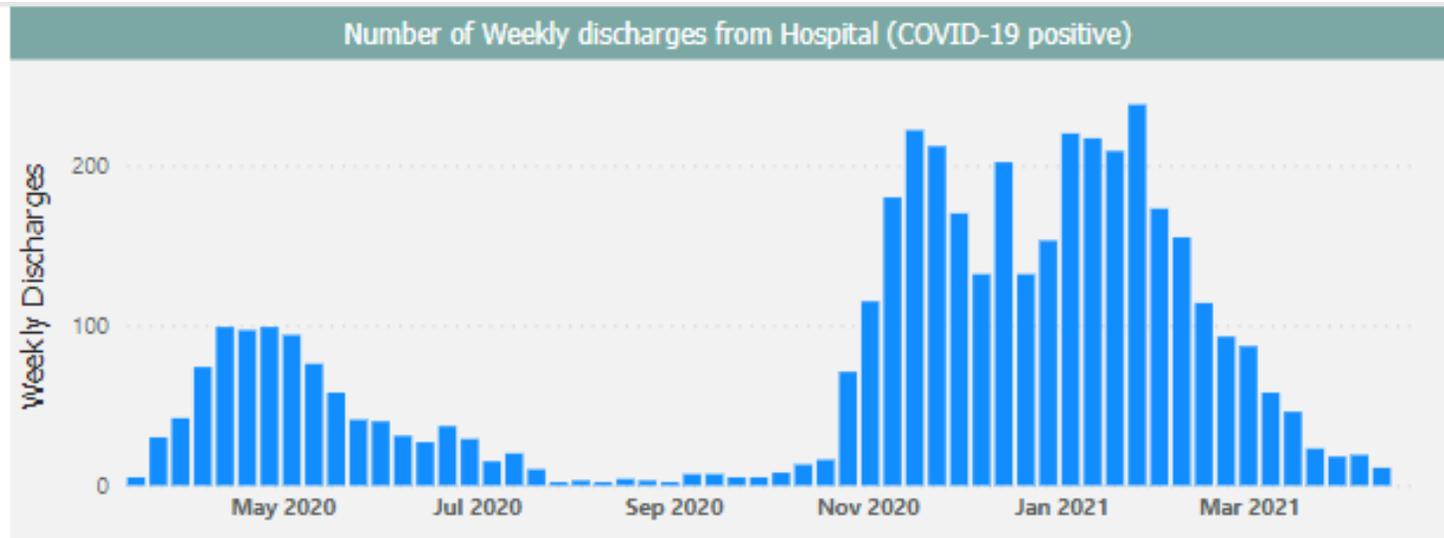
Appendix 4 MH Forecasting due to COVID-19 pandemic SSOT



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Appendix 2: Covid-19 discharges from SSOT Hospitals

| | | |
|-------------------|---|--------------|
| 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 Hospitals of Derby and Burton NHS Foundation Trust
(Only Burton Hospital totals included for discharges)

| | | |
|--|---|--|
| Service Specification No. | MH07 | |
| Service | Acute In Patient Service - Functional | |
| Commissioner Lead | Nicky Bromage | |
| Provider Lead | Lisa Agell | |
| Period | April 2019 – March 2020 | |
| Date of Review | As and when required by either Commissioner or Provider | |
| 1. Population Needs | | |
| 1.1 National/local context and evidence base | | |
| Policy context | | |
| <ul style="list-style-type: none"> • Department of Health, 2002 “National Service Framework Policy Implementation Guidance”. • Department of Health 2008, Mental Health Act 1983 Code of Practice • Department of Health, 2005 “The Mental Capacity Act”. DoH • No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011) • Closing the Gap: Priorities for Essential Change in Mental Health (Feb 2014) • Mental Health Crisis Care Concordat (Feb 2014) • The NHS Belongs to the people: A call to action | | |
| Local strategic context | | |
| <ul style="list-style-type: none"> • Staffordshire and Stoke on Trent Adult Mental Health Strategy ‘Mental Health is everybody’s business’ 2014-2019 • Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 • Up to date statistics can be found on the POPPI and PANSI HSCIC systems. | | |
| 2. Outcomes | | |
| 2.1 <u>NHS Outcomes Framework Domains & Indicators</u> | | |
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |
| 2.2 Local defined outcomes | | |
| Expected Outcomes for Service Users | | |
| <ul style="list-style-type: none"> • The support provided to <u>all</u> service users admitted to an in-patient setting will be coordinated via the Care Programme Approach. | | |

| |
|---|
| <ul style="list-style-type: none"> • Lengths of hospital admissions will be reduced through prompt, comprehensive assessments and multi-disciplinary working relative to identified needs. • Care plans will be designed to manage and reduce positive mental health symptoms • Providers will support a well trained workforce enabled to work with people with complex needs who will work with service users and carers promoting recovery models. • Care plans will address physical health needs resulting in the reduction of inequalities in health care. • Care plans will reduce the need for services by promoting self-advocacy, enabling service users to move to less intensive service interventions or away from secondary care. • Service users will be discharged to accommodation appropriate to their needs, and where required accommodation providers will be active participants of care teams • Service users will access therapy and social inclusion programmes appropriate to their needs, this will be reflected in care plans and where appropriate providers will be active participants in care teams • HONOS assessment will be applied at the reviews of service interventions. • Interventions will include assisting carers and families to gain knowledge with regard to service user's mental health diagnosis and who to contact should a crisis arise. • Service users will be active participants in their care process determining interventions and contact with provider services, where their wishes are over ridden clear rationale for the reasons will be recorded. • Care Plans will detail the role of carers and they will be active participants in the reviewing process. <p>Care plans will detail the responsibilities of partner agencies and they will be active participants in the reviewing process.</p> |
|---|

3. Scope

3.1 Aims and objectives of service

Overview of local adult in-patient services

The Inpatient services in Stafford include Chebsey, Bromley & Brocton House are assessment and treatment units. The Inpatient services in Tamworth are provided at the George Bryan Centre which is an assessment and treatment unit. These Inpatient facilities provide care and treatment for both male and female service users (aged 18 and above. Individuals under the age of 18 will be admitted based on clinical need) with broad spectrum mental health needs. Therapeutic activities are delivered on the units that are in line with national guidance.

There are section 136 assessments suites based at each of the sites.

West Wing, George Bryan Centre.

St Georges Hospital Stafford.

The unit's works closely with the Psychiatric Intensive Care Unit (Norbury House) based at St George's Hospital, Stafford.

Norbury is accessed when service users' needs require a level of intense support and observation.

Aims and objectives of service

The service will provide support in an In-Patient setting to service users whose severity of need is such that neither domiciliary acute care (Crisis Resolution/Home Treatment Team) nor acute day care would be sufficient to meet their needs or provide a required level of safety. Admission to hospital will be efficient and well-coordinated and all service users will be fully informed of the reason for their admission and will receive an information pack at admissions which will be in the Service Users first language.

Specialist inpatient care is delivered by a dedicated team of professionals which includes a specialist Consultant Psychiatrist. Inpatient reviews are held daily by the team to avoid

delays to the individual patient's pathway and to ensure a swift response to patient requests and needs. A Meeting is held approximately 72 hours after admission to rigorously identify the holistic needs of the individual. Main objectives of the functionalised model include:

- to provide a personalised model of care
- reduction in delayed transfers of care
- provide multidisciplinary specialist care
- diverse therapeutic interventions
- All requests for admission will be made to the Crisis Resolution & Home Treatment (CR/HT) teams, who will assess for the most appropriate care management in the community or possible admission.
- Where the service user is known to the services they will have a Care Co-ordinator or Lead Professional (typically based in a Community Mental Health and Social Care Team) who will provide relevant information to the CR/HT teams prior to any acute assessment taking place. It is required that the Care Co-ordinator must be an active participant in the assessment.
- Service Users who are admitted under the Mental Health Act will have their rights explained to them clearly, sufficiently often and in language such that they can understand their rights.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- The provision of safe and effective mental health inpatient services for those individuals whose mental health needs warrants admission with timely and appropriate interventions.
- Immediate assessment of psychological health and treatment requirements of accepted Service Users commenced within 24 hours
- Risk assessments will reflect any safeguarding issues for vulnerable individuals and where abuse has/or is likely to occur, a referral (VA1) will be made to the appropriate Single Point of Access as per the locally agreed joint policy and procedure on Safeguarding Vulnerable Adults
- Full evidence based multi-disciplinary Treatment package identified within 72 hours which aims to meet psychological, spiritual, physical cultural and gender needs
- Care and treatment which aims to reduce risk to others and self
- Care is offered utilising Recovery philosophies which promote social inclusion, self-confidence, building skills and strengths, offering hope and reducing stigma. The care offered places the individual and their carer at the centre
- Each of the Acute wards offers the Service User the right to independent advocacy
- Provision of purposeful, stimulating and appropriate mental and physical activities
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Establish effective liaison with local Community Mental Health and Social Care, Crisis Resolution and Home Treatment, Assertive Outreach, and Early Intervention in Psychosis approaches to establish processes to manage complex cases.

3.2 Service description/care pathway

Care Pathways – See Documents to be Relied on Schedule 5A



The service will have the appropriate multi-disciplinary workforce and have the adequate skills mixed to provide the relevant interventions and meet the required service objectives and outcomes.

Discharge process

The discharge process starts on admission and consultation must be documented at first review meeting. This process is in conjunction with the Admissions & Discharge Policy embracing the principles of CPA and Functionalisation model.

All discharge planning occurs with Service User and carer involvement and agreement.

3.3 Population covered

South Staffordshire CCG populations within the localities of Stafford, Cannock Chase, , East Staffs, South East Staffordshire and Seisdon

3.4 Any acceptance and exclusion criteria and thresholds

Days/ hours of operation

The Units are operational 24 hours a day 365 days a year.

Referral processes

Generally the Acute In patient units receive referrals through the Crisis/Home treatment teams. Emergency admissions I.e. admitted formally under section of the Mental Health Act, or through Section 136 assessments that are deemed suitable for admission.

Response times

Immediate response.

Exclusion criteria

- Individuals who do not meet the criteria for alternative to hospital admission
- Individuals with dementia
- Individuals under the age of 18 will be admitted based on clinical need

3.5 Interdependence with other services/providers

The Acute In patient units work closely with the Psychiatric Intensive Care unit (Norbury), the community mental health and social care teams (CMHT), Crisis Resolution & Home Treatment, Assertive Outreach and Early Intervention services, Liaison Psychiatry Teams. There is also collaborative working with the Police, Ambulance service and A+ E departments. There are close working arrangements with the Forensic, Learning Disability, Perinatal and substance misuse services. Key interdependency with Staffordshire & Stoke on Trent Partnership Trust; Acute and General Hospitals, and primary care.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All relevant NICE Guidance complied with

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983 Royal College of Psychiatrists April 2013
CR159. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales) Jul 2011 Royal College of Psychiatrists

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

5.2 Applicable CQUIN goals (See Schedule 4E)

| |
|---|
| 6. Location of Provider Premises |
| The Provider's Premises are located at: St Georges Hospital Corporation Street Stafford ST163AG George Bryan Centre, Tamworth. B78 3NG |
| 7. Individual Service User Placement |



Midlands Partnership
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Specification for the Provision of Financial Wellbeing Management and Support for Mental Health Services (Staffordshire)

Midlands Partnership NHS Foundation Trust



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- 2. Introduction**
- 3. Specification**
 - 3.1 Glossary
 - 3.2 Contract Length
 - 3.3 Scope
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 - 3.6 Expected Service Demand
 - 3.7 Trust Policies and Procedures
 - 3.8 Quality Assurance Requirements
 - 3.9 Management of the Contract
 - 3.10 Security
 - 3.11 Training
 - 3.12 Implementation
- 4. Cost**
- 5. Exit Arrangements**

1. Purpose

The purpose of this procurement exercise is to appoint a provider to support the provision of Financial Wellbeing Management and Support for Mental Health Services (Staffordshire) for Midlands Partnership NHS Foundation Trust (MPFT).

2. Introduction

Midlands Partnership NHS Foundation Trust have a new ring fenced investment to commission extra support from local and accessible services. This is available to mental health services in recognition of their vital role in responding to the pandemic and supporting some of the most acutely ill and vulnerable patients.

MPFT have developed a Community Mental Health Framework for Adults and Older Adults (CMHF) in line with the NHS Long Term Plan's vision for a place-based, community mental health model. This enables modernisation of community services to offer whole-person, whole-population health approaches, aligned with the Primary Care Networks (PCN).

Co-production will help develop services that combine lived experience with 'traditional' clinical skills. This will facilitate a more person centred service that is focused on the user's needs based on user experience and what is important to them and their general wellbeing.

The framework allows for a shift to a new model of community mental health provision, designed on an asset-based view of communities and integrated working across agencies, rather than a traditional Community Mental Health Team model.

The aim of the Community Mental Health Framework is to:

- Improve access to psychological therapies for those with Serious Mental Illness (SMI)
- Deliver support that is personalised and within a person's community
- Take an asset based approach with an emphasis on self-management and recovery
- Increase the number of people receiving SMI physical health checks
- Increase the number of adults who have access to Individual Placement and Support (IPS)
- Provide integrated models of support configured around the PCNs
- Implement a whole systems pathway supported by Structured Clinical Management for people with a 'personality disorder'
- Reduce occupied bed days within Acute Settings and a reduction in crisis contacts for people with a 'personality disorder'
- Ensure Eating Disorder provision that meets commissioning guidance across the age span

The object of the Financial Wellbeing Management and Support for Mental Health Services (Staffordshire) provision is to:

- Provide advice and support directly with people from the communities in Staffordshire via the Access Service within MPFT to support underpinning challenges that are related to financial instability and challenges
- Promote the Mental Health and Wellbeing services and initiatives that are provided by Midlands Partnership NHS Foundation Trust as well as external organisations to people across the area, which may intervene at an early stage and avoid further mental ill-health referrals
- Work in partnership with external organisations for on-going support on complex cases
- Capture insight gained in a format that can be easily be shared with all stakeholders (including our communities) and contribute to the broader needs via analysis

3. Specification

3.1 Glossary

| Term | Definition |
|----------|--|
| Contract | Shall be used to describe the final agreement made between the Trust and Contractor following the mini-competition exercise. |
| GP | Shall be used to refer to General Practitioners with General Medical Council certification. |
| Provider | Shall be used to describe the successful supplier of the Services described within this document to the Trust. |
| Services | Shall be used as a generic term for all requirements detailed for delivery as part of this Contract. |
| MPFT | Shall be used to refer to Midlands Partnership NHS Foundation Trust. |
| Trust | Shall be used to refer to Midlands Partnership NHS Foundation Trust, whether in whole or in part |

3.2 Contract Length

The contracts length for each Lot will be for 2 years with an option to extend up to 12 months. The contract length is based on a start date of 1st April 2022.

3.3 Scope

The service of the Financial Wellbeing Management and Support will be a service that offers a range of flexible support to people with financial difficulties within the Staffordshire community. The service will advise and support to patients contacting the Mental Health Services, whose mental health problems are worsened by issues relating to financial difficulties. There is evidence that financial difficulties, can cause and exacerbate mental ill-health, which could subsequently develop into severe mental health. By supporting an individual's financial worries and concerns at an early stage, it could have a positive impact on their mental health and prevent a more serious illness developing. This would reduce additional resources that are currently being utilised and required later in the pathway, for example crisis referrals.

Within Midlands Partnership NHS Foundation Trust (MPFT), a need has been identified to utilize this model to encourage the following aims and objectives of our services to be met:

- Provide advice and support directly with people from the communities in Staffordshire via the Community Mental Health Teams within MPFT to support underpinning challenges that are related to financial instability and challenges
- Capture insight gained in a format that can be easily be shared with all stakeholders (including our communities) and contribute to the broader needs
- Improve outcomes for individuals through using this financial management service, to ensure that the needs of the individuals are met

- To offer practical and emotional support to enable individuals to help themselves to identify needs and issues from all financial worries, concerns and aspects inc. (but not limited to): debt prevention, bankruptcy, budget management, consumer rights and Income / benefit optimisation. All which a significant impact on an individual's mental health
- An improvement in the health and wellbeing of local people through effective and relevant financial and debt advice with more clients accessing the service at an earlier stage to prevent financial difficulties
- Assess the individual on a case-by-case basis and guide the individuals to external financial organisations i.e. the local CAB services for further support and management via a seamless streamline approach
- Maximizing joint working with partner agencies to enable a more seamless financial and generalist advice service to Staffordshire individuals i.e. collaborative asset approach with external organisations who offer additional services and initiatives available for individuals
- Engage with external organisations within Staffordshire who have been developing programs and initiatives whilst collaborating with Midlands Partnership NHS Foundation Trust
- To improve Mental Health, which will mitigate the need to use secondary care mental health services i.e. Community Mental Health Pathways, Crisis Resolution and Home Treatment Teams (CRHTs) etc.

3.4 Service Description

The Contractor shall provide management and support advice regarding financial and generalist advice information service on a wide range of issues including but not limited to debt prevention, bankruptcy, budget support, consumer rights and Income / benefit optimisation. The service will directly link in with MPFT's Community Mental Health Teams. The service will be a wraparound approach, providing calls, emails etc. to individuals. However if an individual is digitally excluded, the contractor will adapt the service to meet their specific requirements. There may be a requirement in the future to extend the service to a face to face approach offering the same support and advice to individuals within the community. This will be revisited once the service has commenced and a review has taken place.

Each case will be assessed on a case-by-case basis and may require further discussion with external organisations for support and discussion around negotiating repayments with creditors.

3.5 Service Requirements

This service will be split into lots as per the below:

- Lot 1 - East Staffs - 1 whole time equivalent (WTE)
- Lot 2 - Burntwood & Lichfield - 0.5 whole time equivalent (WTE)
- Lot 3 – Cannock - 0.6 whole time equivalent (WTE)
- Lot 4 - Rugely & Great Haywood - 0.4 whole time equivalent (WTE)
- Lot 5 – Stafford - 0.6 whole time equivalent (WTE)
- Lot 6 – Seisdon - 0.4 whole time equivalent (WTE)

The contracted provider will provide the service role with the required IT Hardware and Software, along with any additional required equipment.

3.6 Expected Service Demand

The core hours of delivery will be Monday to Friday, 9am - 5pm Service with flexible working hours to meet Service User needs. Weekend and bank holiday working may be required as dictated by the needs of the service user but at the discretion of the Provider.

As this is a new service, it is unclear on what the demand will be. There may be a requirement in the future to extend the service to an appointment, face to face approach offering the same support and advice to individuals within the community. This will be revisited once the service has commenced and a review has taken place.

4. Trust Policies and Procedures

The Service's staff should adhere to the policies and procedures of the Trust, whilst working under the terms of the Contract. Copies of Trust policies and procedures can be found on <https://www.mpft.nhs.uk/>

The provider will have policies, procedures and systems as appropriate to assure the standards of clinical competences of staff that they employ. This will include but not be limited to:

- Employment of appropriately qualified staff
- Compliance with statutory and other national requirements,
- Compliance with professional standards e.g. participation in Quality Assurance and Accreditation schemes and child protection.

The Service provider will also work within national guidance and good practice guidelines relating to this service.

5. Clinical Governance Arrangements

The provider will have policies, procedures and systems as appropriate to assure the standards of competences of staff that they employ. This will include but not be limited to:

- Employment of appropriately qualified staff
- Compliance with statutory and other national requirements,
- Compliance with professional standards e.g. participation in Quality Assurance and Accreditation schemes and child protection.

6. Data Protection and Governance

Personal data provided by service users as part of the triage and testing process will be stored and protected according to GDPR legislation. Secure access to the database will be given to clinical staff in accordance to Trust IG policy.

7. Complaints

A formal process will be in place to deal with incidents / complaints as they occur, including central reporting and the notification of occurrences to the Trust(s) within 24 hours. Formal notification will be made to the Trust representative who will inform the relevant systems within the organisation. The Service Provider and Trust(s) will then engage in the joint resolution of complaints and incidents. For service users, complaints and comments will be dealt with as with any other NHS service, following NHS guidelines

8. Continuity arrangements:

- 8.1.1 **Minor disruption (1 day)** - The Sub-Contractor will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate, then control of the incident will be undertaken locally.

- 8.1.2 Medium/short term (2-7days) disruption** - Where the incident is deemed to result in minor disruption to the service, and the incident is unlikely to escalate, the Sub-Contractor will then inform the Head Provider and of the decision to manage the incident locally.
- 8.1.3 Major/long term (>7 days) disruption** - Where the incident is deemed to result in a major/long term disruption to the service, the Sub-Contractor must inform the Head Provider immediately and convene a meeting to discuss the continuity of the service

9. Quality Assurance Requirements

MPFT would welcome service providers who have lived experience or close encounters with financial or mental ill-health challenges which may enable them to have a more relatable approach for individuals.

The provider contracted should as a minimum be authorized to deliver debt advice and be an approved intermediary to be able to apply for debt relief orders i.e. licensed with the Financial Conduct Authority (FCA), Insolvency Agency or similar. It is desirable that the provider will be an approved intermediary to be able to apply for Debt Relief Orders. It is desirable to be registered with the Money and Pension Service (MaPS) Quality Framework and The Advice Quality Standard (AQS).

The contractor will work with MPFT's Community Mental Health Teams to identify individuals and how best to approach their financial difficulties to avoid further mental ill-health challenges.

The Provider will be flexible and offer a hybrid model offering home working and office based in-line with the government guidelines for COVID-19 Pandemic. If office based working is required, this will be located at a MPFT site which will be confirmed upon implementation.

The referrals will be provided by MPFT's Community Mental Health Teams.

The Provider may be required to record service user's notes directly on MPFT's clinical system. This may require the contracted provider to sign a 3rd party data sharing agreement or similar.

10. Management of the Contract

Service Levels

There is no incumbent service, therefore there is no direct service level data that can be shared to inform the service model design.

Performance

Regular contract meetings, initially monthly with a move to quarterly to closely monitor contract performance. Outcome measures are to be determined during the contract review meetings. The contract review meeting reports shall be sent to all meeting attendees prior to the meeting.

A dedicated account manager and support team must be able to support the service and call on relevant expertise to support aspects of the contract as and when required.



The Trust expects the account manager to support the team in attending review meetings. Review meetings will cover all management information as agreed with the Trusts' project team. Where the service or performance provided by the provider falls below the required level then the account manager shall ensure that appropriate support is provided to the Trust.

As above, this specification is an outcome based service. Therefore the Personal, Service and Strategic Outcome Measures will be closely monitored during the life of the contract. Patient Related Outcome Measurements (PROM) will support the Personal, Service and System/Population Outcome Measures and will be developed during the mobilisation period.

The Provider is expected to continually update Service provision based on Service User need, best practice and evidenced-based interventions, giving consideration of future guidance and local policy. Key Performance Indicators (KPIs); the below KPIs are not extensive and there is an expectation that the partner provider will work with the Trust to identify key performance indicators over the first year.

| Performance Indicator | Threshold | Frequency of Report | Method of Measurement | Consequence of breach |
|--|---------------------------------|----------------------------|---|--|
| Availability of suitably qualified Staff | 100% | Quarterly | Training records/ cancellations | Contract Performance Review triggered. |
| Financial & Activity Data Report | 100% | Quarterly | Contract reporting Dataset | Contract Performance Review triggered |
| Complaints | 4 per annum | Quarterly | Clinical Quality Performance report within 10 working days of the end of each month | Compliant Review and Investigation – 4 and Under. Contract Performance Review triggered – 5 and over. |
| Referrals Received | TBC during contract award | Monthly | Number of referrals received | Contract Performance Review triggered. |
| Support and Advice Provided to Service Users | FYI / TBC during contract award | Monthly | Types of advice and support given to service users and how many per type | Contract Performance Review triggered. |
| Outcomes and Closures | TBC during contract award | Monthly | Number of case closures. Contributed towards the positive outcomes of service users, and how many per type of outcome. | Contract Performance Review triggered. |
| Escalations | FYI / TBC during contract award | Monthly | Escalations made to NSCHT and/or Provider | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | How many adults and older adults have had at least one contact from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum. | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during | Monthly | How many adults and older adults have had at | Contract Performance Review triggered. |

| | | | | |
|---------------------------|---------------------------------|---------|---|--|
| | contract award | | least 2+ contacts from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum. | |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in a dedicated 'personality disorder' pathway or service provision (including primary care, VCS, and MH services) | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in a dedicated community rehabilitation pathway or service provision (including primary care, VCS, and MH services) | Contract Performance Review triggered. |

11. Security Requirements

All staff must sign in and out where required and wear their identification card at all times.

Any issues regarding safety and wellbeing of staff or service users should be immediately reported to their senior staff providing the service.

Should the assistance required be above and beyond what staff can manage, or should a crime be committed, then the most senior staff member will contact the Police for assistance.

Staff should never put themselves or the service user at risk. Staff should ensure service user safety and seek appropriate support.

Where suicide and/or serious self-harm has been identified via the risk assessment process, staff are to be confident in executing the risk management plan.

All staff should have awareness and understanding of the local safeguarding policy and process.

12. Training

All staff are advised follow the Trust's training expectations, which may include mandatory safeguarding refresh every 12 months, together with continuous practice development. Any staff who have a professional qualification will be supported to be competent and maintain their professional scope of practice. However if adequate training has been completed prior to the start of the contract i.e. external training which covers the training expectations, this will be discussed upon implementation to avoid any duplication.



The provider contracted will undertake the necessary checks on its staff and volunteers who are directly involved with performing the Contract i.e. two (2) references and an enhanced DBS and any other safeguarding requirements coming into effect to the extent that this is a statutory requirement relating to the Service.

The role will be given regular support and supervision by a suitably qualified manager/team leader on a continual basis. They will receive performance development reviews to identify training and development requirements and ensure this is implemented in a timely manner. In addition they will be kept up to date and informed of any changes in appropriate legislation relating to the services being provided, by the Trusts and the Provider will be notified.

13. Implementation

The implementation of the service will be a collaborative approach across health and social care services including primary, secondary and the voluntary sector, mainly including MPFT, PCN's and the contracted provider.

Within MPFT Community Mental Health Teams, there will be a mix of staff with blended skills, delivering clinical and non-clinical interventions to support the needs of individuals.

The contracted provider will support the safe and effective service delivery of contracted service under MPFT's Community Mental Health Teams in South Staffordshire, to ensure that the service meets all the requirements of the NHS Long Term Plan.

As this is a new service being implemented, MPFT will require support from the provider during the implementation process, for example, a mobilisation plan.

During the contract referrals will be made via the community mental health teams to the Service. As mentioned above within the specification, there may be a requirement to discuss with 3rd party organisations which will be assessed on a case-by-case basis. As this is a new service, further detail around the structure of the implementation will be approached by the contracted provider and MPFT to discuss the specific details.

14. Cost

The service will be funded by a ring fenced budget from Midlands Partnership NHS Foundation Trust's Community Mental Health Transformation. The specific budget for the Financial Wellbeing Management and Support is a total of £105,000.00 per financial year. As mentioned above in section 3.2 Contract Length, the duration will be a total of 2 years. The service will also be split into 6 lots. Therefore, please see the below structure of funding. This funding will include any additional costs associated with the service i.e. equipment and management costs where required etc.

| Lot | Year 1 Funding | Year 2 Funding |
|-------------------------------|----------------|----------------|
| Lot 1 - East Staffs (1 x WTE) | £30,000.00 | £30,000.00 |



| | | |
|---|------------|------------|
| Lot 2 - Burntwood & Lichfield (0.5 x WTE) | £15,000.00 | £15,000.00 |
| Lot 3 – Cannock (0.6 x WTE) | £18,000.00 | £18,000.00 |
| Lot 4 - Rugely & Great Haywood (0.4 x WTE) | £12,000.00 | £12,000.00 |
| Lot 5 – Stafford (0.6 x WTE) | £18,000.00 | £18,000.00 |
| Lot 6 – Seisdon (0.4 x WTE) | £12,000.00 | £12,000.00 |

Due to funding, invoices are to be issued quarterly. Any invoice not complying with the points below will be returned, or be provided with an “on-hold” status and the Provider will be contacted by the Trust. The Trust operates on 30 day payment standard terms from date of receipt of invoice. Invoices should be provided as per Purchase Order.

Invoices shall:

- be addressed to the relevant organisation;
- be sent to the correct address; Electronic invoices must be sent via email as a PDF Document;
- have the Trusts Purchase Order number;
- have the delivery note number, contract or quotation reference (where applicable);
- match the values agreed;
- be submitted in arrears;
- be forwarded to the Trust within 3 days of invoice date;
- be provided with supporting backing data where applicable including summary of usage and interpretations provided.

15. Exit Arrangements

This Contract is for 2 years with an option to extend up to 12 months. Any exit arrangements will be discussed as required, at least 3 months before the end of the Contract Period. Termination of the Contract by the Trust would be within 30 calendar days if there are Service delivery issues which the Service partner fails to rectify.

At the end of the contracted period, an end-of-contract meeting will be held between the Service and Provider to determine an exit plan to ensure the continuity of provision for the Service. The discussion will focus on:

- Last day of the service
- Arrangements on any outstanding notes or patients
- Providing all reasonable assistance and information as the Trust may require to enable it to re-procure the services or transfer the services to an alternative service provider.
- Lessons learnt feedback (both parties)



NHS Standard Contract 2021/22

Particulars (Full Length)

Contract title / ref:

Richmond Fellowship 2021-22 (CMT-843)

Prepared by: NHS Standard Contract Team, NHS England

nhscb.contractshelp@nhs.net

(please do not send contracts to this email address)

Version number: 1

First published: March 2021

Publication Approval Number: PAR478

| | |
|---------------------------|--|
| Contract Reference | Richmond Fellowship 2021-22 CMT-843 |
|---------------------------|--|

| | |
|-----------------------------------|---|
| DATE OF CONTRACT | |
| SERVICE COMMENCEMENT DATE | 1 April 2021 |
| CONTRACT TERM | 1 year, commencing 1 April 2021 |
| COMMISSIONERS | NHS Stafford and Surrounds CCG (05V) NHS Cannock Chase CCG (04Y) NHS East Staffordshire CCG (05D) NHS South East Staffordshire and Seisdon Peninsula CCG (05Q) |
| CO-ORDINATING COMMISSIONER | NHS Stafford and Surrounds CCG (05V) |
| PROVIDER | Richmond Fellowship (ODS AH05) Principal and/or registered office address: 80 Holloway Road London N7 8JG |

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PARTICULARS

| | |
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Definitions and Interpretation

CONTRACT

Contract title: Richmond Fellowship 2021-22

Contract ref: CMT-843

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

.....
Signature

CRAIG PORTER
For and on behalf of:
**NHS Stafford and Surrounds Clinical
Commissioning Group**
**NHS Cannock Chase Clinical
Commissioning Group**
**NHS East Staffordshire Clinical
Commissioning Group**
**NHS South East Staffordshire and
Seisdon Peninsula Clinical
Commissioning Group**

...Managing Director, South West Locality...
Title
.....
Date

SIGNED by

.....
Signature

**ROBERT TEMPLETON for
and on behalf of
RICHMOND FELLOWSHIP**

.....
Title
.....
Date

| SERVICE COMMENCEMENT AND CONTRACT TERM | |
|--|---------------------------------------|
| Effective Date | 1 April 2021 |
| Expected Service Commencement Date | 1 April 2021 |
| Longstop Date | 31 July 2021 |
| Service Commencement Date | 1 April 2021 |
| Contract Term | 1 year commencing 1 April 2021 |
| Option to extend Contract Term | NO |
| Commissioner Notice Period (for termination under GC17.2) | 6 months |
| Commissioner Earliest Termination Date | 12 months |
| Provider Notice Period (for termination under GC17.3) | 6 months |
| Provider Earliest Termination Date | 12 months |

| SERVICES | |
|---|---------------------------------------|
| Service Categories | Indicate <u>all</u> that apply |
| Accident and Emergency Services (Type 1 and Type 2 only) (A+E) | |
| Acute Services (A) | |
| Ambulance Services (AM) | |
| Cancer Services (CR) | |
| Continuing Healthcare Services (including continuing care for children) (CHC) | |
| Community Services (CS) | |
| Diagnostic, Screening and/or Pathology Services (D) | |
| End of Life Care Services (ELC) | |
| Mental Health and Learning Disability Services (MH) | ✓ |
| Mental Health and Learning Disability Secure Services (MHSS) | |
| NHS 111 Services (111) | |
| Patient Transport Services (PT) | |
| Radiotherapy Services (R) | |
| Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U) | |
| Services commissioned by NHS England | |
| Services comprise or include Specialised Services and/or other services directly commissioned by NHS England | NO |
| Co-operation with PCN(s) in service models | |
| Enhanced Health in Care Homes | NO |
| Primary and Community Mental Health Services | YES |
| Service Requirements | |
| Indicative Activity Plan | YES |
| Activity Planning Assumptions | YES |

| | |
|---|---|
| Essential Services (NHS Trusts only) | NO |
| Services to which 18 Weeks applies | NO |
| Prior Approval Response Time Standard | Not applicable |
| Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of this Contract? | NO |
| Is the Provider providing CCG-commissioned Services which are to be listed in the UEC DoS? | NO |
| PAYMENT | |
| Expected Annual Contract Value Agreed | YES |
| Must data be submitted to SUS for any of the Services? | NO |
| Under the Aligned Payment and Incentive Rules in the National Tariff, does CQUIN apply to payments made by any of the Commissioners under this Contract? | NO |
| QUALITY | |
| Provider type | Other |
| GOVERNANCE AND REGULATORY | |
| Nominated Mediation Body (where required – see GC14.4) | Centre for Effective Dispute Resolution (CEDR) |
| Provider's Nominated Individual | Robert Templeton Director of Operations Email: Robert.templeton@richmondfellowship.org.uk Tel: 07768 488 429 / 02076973409 |
| Provider's Information Governance Lead | Tracey Bell Group Director of Performance, Quality and Innovation Email: Tracey.Bell@richmondfellowship.org.uk Tel: 07775 928 931 |
| Provider's Data Protection Officer (if required by Data Protection Legislation) | Mark Burnett Founder and CEO Email: mark@hope-may.com Tel: 07817 779006 |
| Provider's Caldicott Guardian | Lynne Wood-Lord Head of Continuous Improvement Email: Lynne.wood-lord@richmondfellowship.org.uk Tel: 07786 192057 |
| Provider's Senior Information Risk Owner | Robert Templeton Director of Operations Email: Robert.templeton@richmondfellowship.org.uk Tel: 07768 488 429 / 02076973409 |

| | |
|---|---|
| Provider's Accountable Emergency Officer | Local Operational Lead and on call. Local Operational Lead; Christine Lawrence Area Manager Email: Christine.lawrence@richmondfellowship.org.uk Tel: 07788 916456 |
| Provider's Safeguarding Lead (children) / named professional for safeguarding children | Tracey Bell Group Director of Performance, Quality and Innovation Email: Tracey.Bell@richmondfellowship.org.uk Tel: 07775 928 931 |
| Provider's Safeguarding Lead (adults) / named professional for safeguarding adults | Tracey Bell Group Director of Performance, Quality and Innovation Email: Tracey.Bell@richmondfellowship.org.uk Tel: 07775 928 931 |
| Provider's Child Sexual Abuse and Exploitation Lead | Tracey Bell Group Director of Performance, Quality and Innovation Email: Tracey.Bell@richmondfellowship.org.uk Tel: 07775 928 931 |
| Provider's Mental Capacity and Liberty Protection Safeguards Lead | Robert Templeton Director of Operations Email: Robert.templeton@richmondfellowship.org.uk Tel: 07768 488 429 / 02076973409 |
| Provider's Prevent Lead | Tracey Bell Group Director of Performance, Quality and Innovation Email: Tracey.Bell@richmondfellowship.org.uk Tel: 07775 928 931 |
| Provider's Freedom To Speak Up Guardian(s) | Tim Anderson Director of People Organisational Development Email: tim.anderson@richmondfellowship.org.uk Tel: 07786 350619 |
| Provider's UEC DoS Contact | Not Applicable |
| Commissioners' UEC DoS Leads | 6 Staffordshire CCGs: Richard Topping Directory of Services Lead – Staffordshire West Midlands Ambulance Service NHS Foundation Trust Email: richard.topping@wmas.nhs.uk Tel: 07919 627 184 |
| Provider's Infection Prevention Lead | Jenny Dickson Service Manager Email: Jenny.dickson@richmondfellowship.org.uk Tel: 01543 899465 / 07824 550195 |
| Provider's Health Inequalities Lead | Group Director of Performance, Quality and Innovation Email: Tracey.Bell@richmondfellowship.org.uk |

| | |
|---|--|
| | Tel: 07775 928 931 |
| Provider's Net Zero Lead | Robert Templeton Director of Operations Email: Robert.templeton@richmondfellowship.org.uk Tel: 07768 488 429 / 02076973409 |
| CONTRACT MANAGEMENT | |
| Addresses for service of Notices | Co-ordinating Commissioner & all Staffordshire CCGs: Marcus Warnes Smithfield One Building, Leonard Coates Way, Stoke-on-Trent, ST1 4FA Marcus.Warnes@staffsstokeccgs.nhs.uk cc. MLCSU.CMT@nhs.net for all contract notices Provider: Robert Templeton Director of Operations Email: Robert.templeton@richmondfellowship.org.uk Tel: 07768 488 429 |
| Frequency of Review Meetings | Quarterly |
| Commissioner Representative(s) | Paul Jolley Head of Commissioning, SW Locality Commissioning Team Email: Paul.jolley@staffsstokeccgs.nhs.uk Tel: 07720 946428 / 01785 854117 |
| Provider Representative | Christine Lawrence (Locality Manager - Midlands) Email: Christine.lawrence@richmondfellowship.org.uk Tel: 07788916456 |

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents:

- | |
|--|
| <ol style="list-style-type: none">1. Evidence of appropriate Indemnity Arrangements2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors3. Evidence of Monitor's Licence in respect of Provider and Material Sub-Contractors |
|--|

The Provider must complete the following actions:

| |
|--|
| |
|--|

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

| Date | Document | Description |
|-----------------------|----------|-------------|
| Not Applicable | | |

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

NOT USED

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

| | |
|----------------------------------|---|
| Service Specification No. | 1 |
| Service | Mental Health Short-term Intervention Service |
| Commissioner Lead | Paul Jolley |
| Provider Lead | Christine Lawrence (Locality Manager – Midlands) |
| Period | 1 April 2021 – 31 March 2022 |
| Date of Review | As and when required by either Commissioner or Provider |

| |
|---|
| <p>1. Population Needs</p> <p>1.1 National/local context and evidence base</p> <p>The complex, dynamic relationship between mental and physical health can be seen in Staffordshire, unsurprising given the ageing population and high levels of people who have their day to day activities limited by their health or disability. 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. Some of the inequalities include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> People with a severe mental illness in Staffordshire are over three times more likely to die early than the general population. <input type="checkbox"/> <input type="checkbox"/> Staffordshire patients with a long-term mental health condition have much poorer health-related quality of life than people with long-term conditions and the general population. <input type="checkbox"/> <input type="checkbox"/> There is a large gap in employment rates between those with a mental illness and the general population. <input type="checkbox"/> <input type="checkbox"/> A third of people in contact with secondary mental health services do not live in settled accommodation. <ul style="list-style-type: none"> ▪ Around two-fifths of Staffordshire residents with a serious mental illness smoke. This is more than double the prevalence seen in the general population and compares with only 14% of people with a long-term condition. <input type="checkbox"/> <input type="checkbox"/> Women in Staffordshire with a severe mental health illness are less likely to have a cervical smear compared to the general population. <input type="checkbox"/> <input type="checkbox"/> Around two-thirds of people with a severe mental illness in Staffordshire do not have a record of completed physical health checks which can prevent late diagnosis of physical health conditions. <input type="checkbox"/> <input type="checkbox"/> A third of Staffordshire patients have to wait longer than six weeks for psychological therapies and 13% longer than 18 weeks, both below the national average. <input type="checkbox"/> <input type="checkbox"/> More adults in Staffordshire access secondary mental health and learning disability services than the national average. <input type="checkbox"/> <input type="checkbox"/> Overall patient experience at the two Staffordshire mental health providers is good in relation to their mental health care. However both providers score less favourably in terms of supporting patients with other areas of life such as physical health, finances, employment and accommodation. <input type="checkbox"/> <input type="checkbox"/> Around 16% of all hospital admissions also have a recorded diagnosis of a mental health condition (10% elective; 26% emergency). Emergency rates for people with a |
|---|

mental health condition or a severe mental illness are generally higher than the general population average. However only 3% of patients with a recognised mental health condition are admitted for their mental health condition with the remaining being admitted for a physical illness.

□□ Once admitted to hospital, people with a mental health condition have longer spells in hospital compared with the general population. The average cost of an admission is on average around £420 more than the general population.

□□ Readmission rates to hospital for people with a mental health condition are slightly higher than in the general population and only 82% of people in this cohort return to their “usual place of residence” after an emergency admission compared with 87% of patients in the general population.

□□ Less mental health clients using adult social care felt that services made them feel safe and secure compared with the average for all social care users.

□□ Stigma and discrimination are also barriers to full participation in health care, education and citizenship.

[Implementing the Five Year Forward View for Mental Health](#)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

| | | |
|-----------------|---|---|
| Domain 1 | Preventing people from dying prematurely | ✓ |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |

2.2 Local defined outcomes

the Provider shall use its reasonable endeavours to ensure that:

- (1) the Scheme helps to maintain and promote the independence of the service users by giving each of them greater choice and control over the way in which their needs are met;
- (2) the Scheme is of high quality and delivered by a well trained and enthusiastic workforce;
- (3) the Scheme is well planned and integrated, makes the most effective use of available resources and contributes to meeting the needs of a diverse community in the contract area;
- (4) service users receive the support and protection which is needed to ensure their wellbeing and the safety of society;
- (5) the Scheme is non-stigmatising and confidential;
- (6) the Scheme is free of charge to all service users (subject only to any express contrary provision of this contract);
- (7) the Scheme is sensitive and responsive and therefore efficient, flexible and effective when responding to the differing and changing needs of each service user;

(8) the Scheme is consultative in its operation and development;

(9) no eligible person or service user is either, excluded from the Scheme, or discouraged or prevented from accessing the Scheme, or otherwise discriminated against in relation to the Scheme, as a consequence of their race, or age, or class, or culture, or gender, or sexual orientation, or religion, or beliefs, or racial origin, or ethnic background and or disabilities.

3. Scope

3.1 Aims and objectives of service

The aim of the Scheme is to provide a safe, secure and therapeutic environment for people with severe and enduring mental health problems who are experiencing a personal or life crisis (such as social or relationship difficulties, depression and isolation, or a period of psychosis or self-harm) that is seriously affecting their mental health, placing them at risk of hospitalisation, and have a wish to find solutions and work on their recovery. There will be an expectation for service users to participate in their own recovery with co-support from the Scheme

The aim of the operation of the Scheme and the provision of Support at the House is to provide service users who are in distress or crisis and whose distress can be managed without the need for hospital admission or clinical intervention with:

(1) an alternative to acute hospital admission;

(2) Support in a non-medical setting for a short period, to engender personal recovery to move forward in their lives.

In order to achieve the aim which is described in paragraph, the Provider shall:

(1) assist each service user to solve practical problems which may have led to their personal or life crisis;

(2) assist each service user to consider strategies to enable them to cope with their symptoms of mental and emotional distress;

(3) assist each service user in building natural support networks to avoid the isolation and stigma associated with mental health problems;

(4) assist each service user to understand and develop crisis coping strategies that can be utilised in the event of further crisis(es);

(5) provide Support in a way which promotes autonomy, dignity, respect, choice, fairness and privacy;

(6) appoint staff who understand the cultural needs of service users;

(7) promote the philosophy of social inclusion, community involvement, normalisation and empowerment;

(8) be clear on what Support can be provided and what would be the most appropriate help for each service user at the point of their personal or life crisis.

Objectives of the Scheme

The objectives of the Scheme are to provide:

(1) a more appropriate option to acute hospital inpatient admission for service users who cannot stay at their own address, but whose distress can be managed without hospital admission;

(2) an opportunity for service users to talk about their problems and what they believe would benefit them, both in the short and long term, to sustain and improve mental wellbeing;

(3) service users in crisis with recovery focussed therapeutic Support and by doing so to reduce inappropriate hospital admissions and to reduce lengths of stay in hospital;

(4) a service that works in partnership with other services which promote well-being and recovery of the individual;

(5) Support that educates and offers help to service users who are in personal crisis.

3.2 Service description/care pathway

The Scheme will provide access by service users to the House for a minimum of three (6) consecutive nights week (Thursday to Wednesday). The provision of Support at the House during the week in question will always commence on a Thursday at 16:00 hours. The provision of Support at the House will end at 11:00 hours on the final day. The capacity of the Scheme will depend on the size of the House. If the House has three (3) bedrooms for occupation by service users, then the Scheme will have the capacity to provide Support at the House to a maximum of three (3) service users on each night/day during which the House is open to service users. Similarly, if the House has four (4) bedrooms for occupation by service users, then the Scheme will have the capacity to provide Support at the House to a maximum of four (4) service users on each night/day during which the House is open to service users.

Information for Service Users

The Provider shall:

(1) provide each service user (and their carers) with a leaflet about the Scheme (in an appropriate user friendly format) containing general information on the services and facilities which are operated by the Provider via the Scheme and in particular information about;

(a) the House opening times;

(b) the location of the House;

(c) the public transport facilities available in the locality of the House;

(d) the community facilities in the vicinity of the House;

(e) the details of the approved complaints procedure.

(2) distribute copies of the leaflet which is referred in sub-paragraph (1) of this paragraph to each service user at their induction to the Scheme;

(3) use its reasonable endeavours to ensure that each service user has a reasonable understanding of the leaflet which is given to them by the Provider pursuant to this paragraph;

(4) ensure information is available to service users in a style and language that is appropriate to each individual and with which they feel confident and comfortable.

Consent Agreement

The Provider shall ensure that each service user who accesses the Scheme and stays at the House enters into a Consent Agreement which sets out the rights and responsibilities of:

- (1) the service users when staying at the House including their access to and use of the House;
- (2) the Provider during the service users' stay explaining the operational arrangements of the House.

3.3 Population covered

A person shall only be entitled to access the Scheme if they comply with each of the following criteria

- (1) They are registered to a GP in Stafford and Surrounds CCG; Cannock Chase CCG; South East Staffs and Seisdon CCG; and East Staffs CCG
- (2) they are aged eighteen (18) or over;
- (3) they have a primary support need of mental ill-health;
- (4) they are known to primary or secondary mental health services;
- (5) they do not require hospital admission that necessitates clinical intervention;
- (6) The Provider shall only provide access to the Scheme to eligible persons who have been referred by a professional in one of the following capacities:
 - a) Community Psychiatric Nurses (CPN);
 - b) Social Workers; General Practitioners (GP);
 - c) Psychiatrists; Psychologists;
 - d) Emergency Duty Teams; Crisis Intervention Teams;
 - e) Early Intervention Teams; Assertive Outreach Team.

When providing Support to each service user, the Provider shall use its reasonable endeavours to address each category of need specified in paragraphs A3.3 to A3.7 (inclusive) by implementing the relevant "**specific requirements**" in order to achieve the relevant "**outcomes**".

The **social, emotional and intellectual needs** of each service user;

- (1) The **specific requirements** are as follows:
 - (a) where identified, to provide encouragement and support to each service user to continue to maintain their family links and friendships;
 - (b) to provide each service user with an interactive model of Support which encourages independent social interaction inside and outside the House;
 - (c) to be aware of and Support each service user to meet their individual spiritual and cultural needs;
 - (d) to provide each service user with information and Support in relation to their individual requirements and signpost them to other services and/or agencies where necessary;
 - (e) to support and encourage each service user to self-advocate in their best interests to engender personal recovery and to Support each service user to move forward in their life;
 - (f) to ensure the availability of a range of meaningful activities and facilities at the House for the use of service users.

(2) The outcomes are that each service user:

- (a)** has been provided with an alternative to acute care or home based treatment;
- (b)** has recognised and appreciated the need to strengthen and maintain personal, community and spiritual support networks;
- (c)** is aware of information and support available from other services and agencies to help support their recovery;
- (d)** has understood and enhanced their self-advocacy skills to improve self-esteem and confidence to support their recovery;
- (e)** has experienced a diverse range of activities and opportunities during their stay at the House.

The service users' **health needs**;

(1) The specific requirements are as follows:

- (a)** to respond promptly and appropriately to any change in each service user's physical and/or mental health;
- (b)** to record any changes in each service user's health on a central document to be kept private at the House;
- (c)** to ensure staff have the necessary skills and understanding to Support service users in their recovery and mental ill health needs;
- (d)** to facilitate close liaison between its staff, each service user, Social Care and Health and all other health care partner agencies;
- (e)** to support the Care Programme Approach (CPA), in relation to each service user where this is appropriate.

(2) The outcomes are as follows:

- (a)** staff have the necessary skills and understanding to Support service users who are experiencing mental ill health;
- (b)** staff have the knowledge and understanding to Support service users in their recovery whether through individual interventions during their stay at the House, or where appropriate, by liaising with other agencies to support the Care Programme Approach (CPA).

The service users' **access and mobility** needs:

(1) The specific requirements are as follows:

- (a)** where a service user has mobility difficulties, to ensure that the House environment and staff support each service user to gain appropriate access to the communal facilities in the House and to participate fully in the Support and activities offered by the Provider;
- (b)** where required, to ensure that each service user with mobility difficulties can access local community facilities.

(2) The **outcomes** are that each service user:

- (a) has been able to access all communal areas of the House;
- (b) with mobility difficulties has been supported to, and has been able to, access the local community during their stay at the House.

The service users' **personal and practical care needs**;

(1) The **specific requirements** are as follows:

- (a) to provide each service user with appropriate and sensitive support and encouragement to maximise their ability to undertake personal care tasks for themselves and increase their motivation to undertake and manage their own care;
- (b) to prompt each service user to maintain a good standard of personal hygiene.

(2) The **specific outcome** is that, when required, each service user has been motivated and supported to maintain and appreciate the need for good standards of personal care.

The ability of service users to carry out **practical support tasks**;

(1) The **specific requirements** are as follows:

- (a) to Support and encourage each service user to:
 - (i) prepare and cook their own meals;
 - (ii) be responsible for their own personal laundry.
- (b) to make available refreshments and non-alcoholic drinks at the House and ensure service users are encouraged to eat healthily;
- (c) to ensure that staff are aware of each service user's prescribed medication regime (if any) and support each service user to maintain this.

(2) The **outcomes** are as follows:

- (a) service users have been encouraged to look after their diet and have been supported in the planning and/or cooking of their own meals and have been responsible for their own personal laundry;
- (b) staff have been made aware of the service users' medication needs and supported service users to maintain their medication regime.

3.4 Any acceptance and exclusion criteria and thresholds

A person shall not be entitled to access the Scheme in circumstances where at the time of their referral:

- (1) they have a primary need other than mental ill-health;
- (2) They are not registered to a GP in Stafford and Surrounds CCG; Cannock Chase CCG; South East Staffs and Seisdon CCG; and East Staffs CCG
- (3) they are homeless;
- (4) they are subject to detention under the Mental Health Act 1983;

| | |
|------------|---|
| | <p>(5) they require treatment under the Mental Health Act 1983;</p> <p>(6) they have been discharged from an acute in-Patient ward in the period of seven (7) days prior to their referral.</p> |
| 3.5 | Interdependence with other services/providers |
| 4. | Applicable Service Standards |
| 4.1 | Applicable national standards (eg NICE) |
| 4.2 | Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges) |
| 4.3 | Applicable local standards |
| 5. | Applicable quality requirements and CQUIN goals |
| 5.1 | Applicable Quality Requirements (See Schedule 4A-C) |
| 5.2 | Applicable CQUIN goals (See Schedule 3E) |
| 6. | Location of Provider Premises |
| 6.1 | <p>The Provider's Premises are located at:</p> <p>5 Locketts Court, Cannock, Staffs, WS11 5FZ</p> |
| 7. | Individual Service User Placement |
| 8. | Applicable Personalised Care Requirements |
| 8.1 | Applicable requirements, by reference to Schedule 2M where appropriate |

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Not Applicable

SCHEDULE 2 – THE SERVICES

Aii. Service Specifications – Primary and Community Mental Health Services

Not Used

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

| Total Planned Activity (1 April 2021 to 31 March 2022) | | | | | | | |
|---|---------------|---------------|---------------|---------------|---------------|---------------|--------------|
| Availability | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Total |
| Service Nights Available Per Month | 26 | 26 | 26 | 26 | 26 | 26 | 156 |
| Beds Available per Month | 78 | 78 | 78 | 78 | 78 | 78 | 468 |
| | | | | | | | |
| Availability | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Total |
| Service Nights Available Per Month | 26 | 26 | 26 | 26 | 26 | 26 | 156 |
| Bed Available per Month | 78 | 78 | 78 | 78 | 78 | 78 | 468 |

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

The Indicative Activity Plan (IAP) sets out planned activity levels by service nights and bed utilisation. This will provide the basis on which Commissioners will monitor the delivery of the service and apply appropriate contract levers including but not limited to General Condition 9.

The IAP's are based on the service being available 6 nights per week with 3 beds being utilised/available each night for the defined periods.

Commissioner's expectations are that the Indicative Activity Plan will not be exceeded.

2. The IAP for 1 April 2021 to 31 March 2022 is based on:
 - a. 312 active service nights available in this period
 - b. 936 total beds available in this Period
 - c. Activity split across 12 whole months

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

| |
|------------------------------|
| <p>Not Applicable</p> |
|------------------------------|

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

Not Applicable

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

| Local Agreement, Policy or Procedure | Date & Weblink |
|---|---|
| Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile | February 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf |
| Adult Safeguarding: Roles and Competencies for Health Care Staff | August 2018 https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/august/pdf-007069.pdf |
| The NHS Long Term Plan | January 2019 https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ |
| Excluded and Restricted Procedures Policy 2017 (Version 6) Applicable to: Cannock Chase CCG South East Staffordshire and Seisdon Peninsula CCG Stafford & Surrounds CCG | October 2017 https://sesandspccg.nhs.uk/news-and-information/publications/policy-and-procedures/clinical/346-excluded-and-restrict-procedures-policy-2017/file |
| Procedures of Limited Clinical Value (PoLCV) | October 2019 Document – Excluded and Restricted Procedures Policy available at: https://www.staffordsurroundsccg.nhs.uk/about-us/our-policies/commissioning |

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Not Applicable

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

The Commissioner expects to incur no additional cost as a result of early termination of the contract.

In the event that the contract term expires and is not renewed, or any party terminates this agreement in accordance with the agreed terms, the following arrangements will apply:

Exit

The Service Provider shall (at no cost to The Commissioner) prepare an exit plan during the Implementation Phase and submit it to The Commissioner for Approval (the “Exit Plan”).

Where the Co-ordinating Commissioner exercises its right under General Condition 17.1 to terminate this Contract voluntarily prior to the expiry date, then the Provider will notify the Co-ordinating Commissioner of the direct costs it will incur as a result of early termination. Upon receipt of such notification the Parties shall meet and agree how such the direct costs will be recovered by the Provider, both Parties at all times acting reasonably and in good faith.

On termination or expiry of this Contract or any Service the Provider must, acting in accordance with the instructions of the Responsible Commissioner, promptly transfer, or deliver a copy of, any Service User Health Records held by the Provider to the Responsible Commissioner or to a third party nominated by that Commissioner.

The Service Provider shall ensure that the Exit Arrangements deals as a minimum with those areas set out in the Exit Strategy below, along with those areas set out in General Condition 17 Termination of this contract to the maximum level of detail as it is reasonably possible to determine at the time of preparation of any such Exit Plan, together with such other provisions as the Service Provider deems necessary or The Commissioner may request from time to time in relation to expiry and termination of this Agreement and Partial Termination.

1. The Service Provider should provide such assistance and information to The Commissioner or a New Service Provider as necessary to enable as efficient and effective a transfer of services as possible;
2. Data shall be presented in a reasonable format that is capable of being utilised by any New Service Provider;
3. It is critical to identify a process for the successful migration of Data to any new system or service;
4. The Service Provider shall ensure that Data is not compromised during the exit process;
5. The Service Provider shall not impose any barriers or restrictions to the smooth transition of Services to a New Service Provider or The Commissioner and minimise the costs of such transition;
6. There shall be no adverse impact on Patient experience in relation to the Services during the exit process;
7. Timely development and agreement of plans describing exit activity, and compliance with these plans;

8. The Service Provider shall participate in planning and co-ordinating and co-operate with The Commissioner, Other Service Providers and the New Service Provider(s)
9. The Service Provider shall continue to perform the Services during the exit process without disruption or deterioration of the Services in accordance with General Condition 17.

Provision of Information by the Provider

In addition to its obligations set out in GC18 and GC5, in the event of the expiry or termination or the pending expiry of the Contract or any Service or upon any notice of termination, having been served, pursuant to GC17, the Provider agrees that it shall supply to the Co-ordinating Commissioner, within 20 Operational Days of receipt of a written request from the Co-ordinating Commissioner, such details of the Staff, Provider's Premises, Services Environment, Equipment and the Provider's costs actually incurred in delivering the relevant Services as are set out in paragraphs 2 and 3 of this Schedule 2I, in such format as the Co-ordinating Commissioner shall request. Any request made by the Co-ordinating Commissioner pursuant to this paragraph 1 of Schedule 2I shall be made as a request for information in accordance with Service Condition 28.3. The Provider agrees that such a request shall constitute a 'reasonable and lawful' request on the part of the Commissioners pursuant to SC 28.3 and that any failure by it, to comply with the timescale for response set out in this paragraph 1 of Schedule 2I shall constitute a failure by the Provider to respond within a 'timely manner' as required by SC 28.3.

The Provider agrees in relation to the information that it is required to provide, pursuant to paragraph 1(i) of Schedule 2I above, that:

- a) where required to do so by the Co-ordinating Commissioner, it will provide the required information on an anonymous basis, directly to any provider who is identified by the Commissioners as a potential new provider of the Services;
- b) the Commissioners may share the information they receive (via the Co-ordinating Commissioner), on an anonymous basis, with any potential new provider of the Services;
- c) should the details of any information already provided by the Provider, subsequently change, the Provider will update the Commissioners and/or new or potential new providers to whom it has provided that information, as soon as possible.

The Provider acknowledges that the Commissioners are relying on the accuracy and completeness of the information to be provided pursuant to paragraph 1(i) above in connection with any re-procurement or re-commissioning process they may carry out in respect of the Services and that the information will be required in order to enable any potential new providers of the Services to assess the likelihood of TUPE applying on a transfer of the Services, and more generally, in order to enable any potential provider to undertake an adequate pricing exercise in relation to its proposed assumption of provision of the Services.

Staff Information

The Provider shall provide the following information:

- i) The organisational and management structure of the Services (including details of how the Services are provided and managed by the Staff and details of any vacant posts).

- ii) Whether the Services have dedicated employees (that is they **only** work on the Services) and if so, how many of those employees are so dedicated (not whole time equivalents, actual numbers); and
- iii) If employees undertake any or any part of provision of the Services, but are not dedicated to the Services, estimate for each individual, the percentage of their working time spent on the Services over the preceding 12 months and for each of these details of what other work they do.
- iv) For all employees identified at paragraphs 2ii) and 2iii), details of the following:
 - a) Payment method for wages
 - b) Pay day/date
 - c) Pay band and increment date
 - d) Pay and other remuneration along with any non-cash benefits
 - e) Pension scheme details
 - f) Normal hours of work
 - g) Overtime: whether undertaken, by which employees and whether compulsory or voluntary
 - h) Working time flexi scheme
 - i) Annual Leave entitlements
 - j) How annual leave pay is calculated
 - k) Whether any of the employees are mobile employees (a mobile employee means any employee who is not required to attend a particular dedicated place of work each day)
 - l) How mileage claims are calculated for mobile employees
 - m) For non-mobile employees their normal place of work
 - n) Whether there is in place a contractual mobility clause
 - o) Whether all required pre-employment checks (including DBS, entitlement to work in the UK etc.) have been undertaken/completed.
 - p) Any outstanding HR issues e.g. discipline, grievance, capability, ill-Health etc.
 - q) Numbers of employees not currently working and why, e.g. those on maternity leave, who have ill health, study leave or are taking a career break.

In addition to those employees identified at paragraphs 2ii) and 2iii), state what other Staff provide any of the Services and the basis upon which they do that, including bank staff, non-employed consultants, agency workers. Details of how much use has been made of those Staff over the previous 12 months.

Whether there are any existing or contingent liabilities towards any of the employees, for example, but not limited to awards of damages or compensation for, or existing claims in respect of unfair dismissal, personal injury, discrimination, breach of contract, unlawful deductions, whistle-blowing.

Communication with Patients

The Provider will agree with the Commissioner, the content, style and format of communications with patients which will include at least the following information to be sent by the Provider:

- Service(s) end date
- Provider's on-going responsibilities with regard to patient records in accordance with relevant legislation
- Details of arrangements for transfer of care

Other Communications

Commissioners will be responsible for agreeing a communications strategy with the Provider. This strategy will be delivered by the Commissioner and will include communications with:

- Other Providers on the care pathway
- Referrers
- Media
- Patient groups and members of the public

Patient Management and Transfer of Care

The Provider shall ensure all Patient Administration Systems remain in place during the notice period.

The Provider and Commissioner will agree the date from which new referrals will no longer be accepted by the service(s). After this date, any referrals received shall be returned to the referrer within 24 operational hours of receipt. The reasons for return of the referral will be provided to the referrer together with a list of alternative providers to ensure minimum disruption to the patient pathway. This service(s) shall continue for a period of 4 weeks post termination date and shall be reviewed by the Provider and Commissioner after 3 weeks to ensure that, where required, further provision for this service(s) is identified and agreed.

The Provider shall establish with the Commissioner how patients who may be booked for appointments post service(s) end date shall be managed. If agreeable, the Provider shall contact the affected patients and give them the choice of alternative providers to ensure minimum disruption to their patient pathway.

Patient data held by the Provider shall be retained and archived securely in accordance with NHS retention and archiving guidelines and relevant legislation. The Provider will continue its responsibilities under the Data Protection Act (2018) Freedom of Information Act (2000) and The EU General Data Protection Regulation (GDPR). Therefore, requests to access any data held by the Provider shall be managed using existing procedures, in accordance with the terms and conditions laid out in the contract and in accordance with current legislation.

Human Resources

All implications for staff employment will be managed by the Provider in accordance with current employment law and best practice.

Equipment

All equipment (clinical and non-clinical) shall remain in place for the duration of the notice period to ensure continuity of service(s). Post service(s) end date, the Provider will remain responsible for the removal of any of its equipment from NHS sites.

Premises

The Provider will continue to operate from agreed premises during the notice period. All signage will remain in place during this time and where applicable, any Commissioner or NHS signage will be removed upon the termination date.

Information, Management and Technology (IM&T)

The Provider will agree an IM&T exit strategy with the Commissioner. This will include:

- Milestones for e-Referral System changes
- Strategy for Smart Card Roles to be deactivated for relevant staff members
- Confirmation of archive and storage arrangements for any relevant electronic data.
- Confirmation that relevant procedures and policies such as disaster recovery, will stay in place until the termination date.
- Confirmation that the Provider will ensure any licenses purchased for the delivery of service(s) in accordance with this Agreement shall remain in place until the termination date. The Provider is responsible for all associated costs post termination.

Sub-Contractors

The Provider will be responsible for managing any sub-contractor relationships impacted by termination of the service(s) within this Agreement.

The Provider is responsible for ensuring the exit strategy agreed with sub-contractors does not impact service delivery prior to the service termination date.

The Provider is responsible for any costs associated with early termination of its sub-contracting arrangements.

Risk Assessment and Management

The Provider and Commissioner will undertake a joint risk assessment of the exit plan and will seek to manage these jointly to minimise any negative impact.

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

Not Applicable

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

In addition to the provisions set out in the General Conditions and Service Conditions, the Provider is required to adhere to the policies and procedures for safeguarding adults and children, Mental capacity Act and Deprivation of Liberty Safeguards which are available on the Coordinating Commissioner's website.

There is a single Staffordshire and Stoke on Trent Safeguarding Adults Partnership Board (SSASPB) details regarding this and the 'Inter-agency Adult protection Procedures' can be found at: <https://www.ssaspb.org.uk/Home.aspx>

The Staffordshire Safeguarding Children Board's Inter-Agency Procedures for Safeguarding Children and Promoting their Welfare is published by Staffordshire Safeguarding Children's Board and the equivalent Stoke-On-Trent procedures manuals are published by Stoke-On-Trent Safeguarding Children's Board. The provider is required to comply with these procedures. <https://www.staffsccb.org.uk/Home.aspx>
<http://www.safeguardingchildren.stoke.gov.uk/ccm/navigation/professionals/procedure-manuals>

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

Personalised care refers to people who have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. A growing body of evidence suggests that improved outcomes and experiences, as well as reduced health inequalities, are possible when people have the opportunity to actively shape their own care and support.

There has been a positive shift towards local health and care providers working collaboratively to centre care around the individual, and organisations are recognising the power of individuals as the best integrators of their own care. For these reasons, personalised care needs to become business as usual across the health and care system and this is illustrated in chapter 1 of the NHS Long Term Plan.

Providers should ensure that training for the workforce takes into account health inequalities, to identify these groups facing barriers and to support equal access to services.

Providers and the CCGs are committed to working towards the relevant evidence based components of the NHS England and Improvement Universal Personalised Care: Implementing the Comprehensive Model and focusing on:

- Shared decision making
- Personalised care and support planning
- Social prescribing and community-based support
- Supported self-management

Shared decision-making

Shared decision-making refers to people who are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing people's informed preferences.

Whilst the structure and process to the shared decision making is defined there is flexibility to adapt to individual needs.

Questionnaires to service users monitors the effectiveness of shared decision within the Crisis House Service.

Personalised care and support plans

Personalised care and support plans are proactive, personalised conversations which focus on what matters to people, paying attention to their clinical needs as well as their wider health and wellbeing. Health and care professionals tailor their approaches to working with people, based on the person's individual assets, needs and preferences, as well as taking account of any inequalities and accessibility barriers.

Social Prescribing & Community Based Support

Enables all local agencies to connect people with community based support, building on what matters to the patient as identified through shared decision making.

The Crisis House service should make patients aware of other relevant services within the community and voluntary sector including patient support groups.

Supported self-management

People have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system. There has been a positive shift towards local health and care providers working collaboratively to centre care around the individual, and organisations are recognising the power of individuals as the best integrators of their own care. For these reasons, personalised care needs to become business as usual across the health and care system and this is illustrated in chapter 1 of the NHS Long Term Plan

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

The Commissioners' intention is to produce a Health Inequalities Action Plan, which will set out specific actions which the Commissioner and/or the Provider will take, aimed at reducing inequalities in access to, experience of and outcomes from care and treatment, with specific relation to the Services being provided under this Agreement. The Commissioners intend to vary this agreed Health Inequalities Action Plan into the Contract once this has been finalised and agreed by all parties.

SCHEDULE 3 – PAYMENT

A. Local Prices

Not Applicable

SCHEDULE 3 – PAYMENT

B. Local Variations

Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

For

Not Applicable

SCHEDULE 3 – PAYMENT

D. Aligned Payment and Incentive Rules

Not Applicable

SCHEDULE 3 – PAYMENT

E. CQUIN

Not Applicable

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

| Expected Annual Contract Value | | |
|--------------------------------|---|---|
| Commissioner Code | Commissioner Name | Expected Annual Contract Value (Inc. CQUIN) |
| 05V | NHS Stafford and Surrounds CCG | £54, 846 |
| 04Y | NHS Cannock Chase CCG | £54, 846 |
| 05Q | NHS South East Staffs and Seisdon Peninsula CCG | £54, 846 |
| 05D | NHS East Staffordshire CCG | £54, 846 |
| Total | | £219,384 |

SCHEDULE 3 – PAYMENT

G. Timing and Amounts of Payments in First and/or Final Contract Year

| Invoicing Schedule | | | | | |
|---------------------------|--------------------|--------------------|--------------------|--------------------|---------------------|
| | 05V | 04Y | 05Q | 05D | |
| Apr-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| May-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Jun-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Jul-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Aug-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Sep-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Oct-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Nov-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Dec-21 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Jan-22 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Feb-22 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| Mar-22 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | £ 4,570.50 | |
| | £ 54,846.00 | £ 54,846.00 | £ 54,846.00 | £ 54,846.00 | £ 219,384.00 |

Invoices to be addressed as below, quoting the Purchase Order Number, and sent electronically via Tradeshift (<https://tradeshift.com>):

NHS Cannock Chase CCG
 NHS Cannock Chase CCG (04Y Payables L625)
 Phoenix House, Topcliffe Lane, Wakefield, West Yorkshire WF3 1WE

NHS Stafford & Surrounds CCG
 NHS Stafford & Surrounds CCG (05V Payables M015)
 Phoenix House, Topcliffe Lane, Wakefield, West Yorkshire WF3 1WE

NHS East Staffordshire CCG
 NHS East Staffordshire CCG (05D Payables L645)
 Phoenix House, Topcliffe Lane, Wakefield, West Yorkshire WF3 1WE

NHS South East Staffordshire and Seisdon Peninsula CCG
 NHS South East Staffordshire and Seisdon Peninsula CCG (05Q Payables M005)
 Phoenix House, Topcliffe Lane, Wakefield, West Yorkshire WF3 1WE

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

| Ref | Operational Standards | Threshold | Guidance on definition | Period over which the Standard is to be achieved | Application |
|---------|---|---------------------------|--|--|--|
| | Mixed-sex accommodation breaches | | | | |
| E.B.S.1 | Mixed-sex accommodation breach | >0 | See Mixed-Sex Accommodation Guidance, Mixed-Sex Accommodation FAQ and Professional Letter at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/ | Ongoing | A CR MH |
| | Mental health | | | | |
| E.B.S.3 | The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care | Operating standard of 80% | See Contract Technical Guidance Appendix 2 | Quarter | MH Except MH (Specialised Services) |

The Provider must report its performance against each applicable Operational Standard through its Service Quality Performance Report, in accordance with Schedule 6A.

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

| | National Quality Requirement | Threshold | Guidance on definition | Period over which the requirement is to be achieved | Application |
|-------|---|---|---|---|-------------|
| | Duty of candour | Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations | See CQC guidance on Regulation 20 at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour | Ongoing | All |
| E.H.4 | Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care | Operating standard of 60% | See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/ | Quarter | MH |
| E.H.1 | Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment | Operating standard of 75% | See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at: https://www.england.nhs.uk/operational-planning-and-contracting/ | Quarter | MH |

| | National Quality Requirement | Threshold | Guidance on definition | Period over which the requirement is to be achieved | Application |
|-------|---|---------------------------|--|--|--------------------|
| E.H.2 | Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment | Operating standard of 95% | See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at: https://www.england.nhs.uk/operational-planning-and-contracting/ | Quarter | MH |

The Provider must report its performance against each applicable National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A.

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

| Quality Requirement | Threshold | Method of Measurement | Period over which the Requirement is to be achieved | Applicable Service Specification |
|---------------------|-----------|-----------------------|---|----------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Local Incentive Scheme

Not Applicable

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

| Date | Document |
|----------------|----------|
| Not Applicable | |
| | |
| | |
| | |

Documents supplied by Commissioners

| Date | Document |
|----------------|----------|
| Not Applicable | |
| | |
| | |
| | |

SCHEDULE 5 - GOVERNANCE

B. Provider's Material Sub-Contracts

| Sub-Contractor [Name] [Registered Office] [Company number] | Service Description | Start date/expiry date | Processing Personal Data – Yes/No | If the Sub-Contractor is processing Personal Data, state whether the Sub- Contractor is a Data Processor OR a Data Controller OR a joint Data Controller |
|---|---------------------|------------------------|--------------------------------------|--|
| Not Applicable | | | | |
| | | | | |
| | | | | |
| | | | | |

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

| Co-ordinating Commissioner/Commissioner | Role/Responsibility |
|---|--|
| Coordinating Commissioner | <p>In partnership with the Midlands and Lancashire Commissioning Support Unit, the Co-ordinating Commissioner agrees to administer the Contract on behalf of all Commissioners.</p> <p>Role and responsibilities to include:</p> <ul style="list-style-type: none"> • Performing role of Coordinating Commissioner as outlined in the agreed Collaborative Commissioning Agreement • Negotiating and agreeing contract Schedules with the Provider and coordinating contract signature for each party • Chairing and administrating monthly contract review meetings with the Provider to monitor and discuss performance against the agreed activity, finance and performance standards included within the Contract • Monitoring clinical quality of the services delivered via regular CQRM meetings • Applying the NHS Standard Contract in accordance with the Service Conditions, General Conditions and Technical Guidance |
| Associate Commissioners | <p>Each Associate Commissioner agrees to play an active part in the contract relationship with the Provider through:</p> <ul style="list-style-type: none"> • Attending or inputting to Contract Review Meetings and other contract forums as and when applicable. • Performing role of Commissioner as outlined in the agreed Collaborative Commissioning Agreement • Working with the Coordinating Commissioner to resolve any matters which may arise during the contact term • Adhering to the requirements detailed in the Service Conditions, General Conditions and Technical Guidance. |

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

| | Reporting Period | Format of Report | Timing and Method for delivery of Report | Application |
|--|---------------------------------|---|---|--|
| National Requirements Reported Centrally | | | | |
| 1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services | As set out in relevant Guidance | As set out in relevant Guidance | As set out in relevant Guidance | All |
| 2. Patient Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms | As set out in relevant Guidance | As set out in relevant Guidance | As set out in relevant Guidance | All |
| National Requirements Reported Locally | | | | |
| 1a. Activity and Finance Report | Monthly | If and when mandated by NHS Digital, in the format specified in the relevant Information Standards Notice (DCB2050) | [For local agreement] | A, MH |
| 2. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: <ul style="list-style-type: none"> a. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; b. details of all requirements satisfied; c. details of, and reasons for, any failure to meet requirements. | Quarterly | Word Document.  Patient Experience Template for Provide | Within 15 Operational Days of the end of the quarter to which it relates. | All All All |

| | Reporting Period | Format of Report | Timing and Method for delivery of Report | Application |
|--|--|---|---|-------------|
| 3. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints | Quarterly |  Patient Experience Template for Provide Word document | Within 15 Operational Days of the end of the quarter to which it relates. | All |
| 4. Report against performance of Service Development and Improvement Plan (SDIP) | In accordance with relevant SDIP | In accordance with relevant SDIP | In accordance with relevant SDIP | All |
| 5. Summary report of all incidents requiring reporting | Quarterly |  Patient Experience Template for Provide Word document | Within 15 Operational Days of the end of the quarter to which it relates. | All |
| 6. Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (Staff) | Annually (or more frequently if and as required by the Co-ordinating Commissioner from time to time) | Word document | Within 15 Operational Days of the end of the period to which it relates. | All |
| 7. Report on compliance with the National Workforce Race Equality Standard. | Annually | Word document | Within 15 Operational Days of the end of the period to which it relates. | All |
| Local Requirements Reported Locally | | | | |
| 1 <u>Adult Safeguarding Reporting Dashboard</u> | Quarterly | Trust to complete the reporting template included in the Contract as Appendix 1 LRR08: Safeguarding Adults Reporting Dashboard.  Appendix 1 - Safeguarding Adults F | Report to be submitted to the Co-ordinating Commissioner within 15 operational days of the end of the quarter to which it relates. Reports to be submitted to the following inbox: mlcsu.cmt@nhs.net | |
| 2 <u>Adult Safeguarding Provider Assurance Plan</u> against recommendations set out in 'Adult Safeguarding Roles and Competencies for Healthcare Staff 2018' (See Schedule 2G) | Annual | Trust to provide an assurance plan detailing provider's trajectory of how the Trust will achieve the requirements in the Adult Safeguarding Roles and | Report to be submitted to the Co-ordinating Commissioner by the 15th operational day of April 2019. Reports to be submitted to the following inbox: mlcsu.cmt@nhs.net | |

| | Reporting Period | Format of Report | Timing and Method for delivery of Report | Application |
|--|-------------------------|---|---|--------------------|
| | | Competencies for Healthcare Staff 2018 document, and the outcome of the provider's staff training needs assessment. | | |

SCHEDULE 6A Appendix 1 – Embedded Documents

National Requirements Reported Locally – SQPR (2) , Complaints Monitoring (5), and Incidents Reporting (7).

Table of Contents Patient Experience Report

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| 2.4 Serious Incidents and Never Events | 7 |
| 2.5 Patient Feed-back..... | 9 |

Summary:

Overview of work undertaken with patient experience

1.0 Patient Safety and Experience (Numbers of..)

| Date | Complaints Received | Complaints Open | Complaints Upheld | Incidents | S.I. | Compliments | Total Contacts |
|---------|---------------------|-----------------|-------------------|-----------|------|-------------|----------------|
| Apr-18 | | | | | | | |
| May-18 | | | | | | | |
| June-18 | | | | | | | |
| July-18 | | | | | | | |
| Aug-18 | | | | | | | |
| Sept-18 | | | | | | | |

| | | | | | | | |
|--------|--|--|--|--|--|--|--|
| Oct-18 | | | | | | | |
| Nov-18 | | | | | | | |
| Dec-18 | | | | | | | |
| Jan-19 | | | | | | | |
| Feb-19 | | | | | | | |
| Mar-19 | | | | | | | |

2.0 Complaints (a Paragraph on the following)

All complaints, incidents and compliments:

Where are they recorded?

What are the main themes?

Themes Narrative: ‘You Said We Did’

i.e. – Over 18/19 three main complaint themes were noted:

- *E.g. 4 Complaints referred too The organisation did the service has improved by*

Actions to Improve patient experience:

i.e. anything else the organisation has done to improve patient experience e.g. patient groups, customer service training or even a water cooler in the waiting room etc.

2.1 Incidents

Themes and Trends:

Monthly Themes and Trends of Incidents and Complaints.

A table or chart to show monthly trends

Compliments (any compliments on the Service)

For Example *Themes were:*

- *Appreciated the service*
- *Will use the service again Thank you*
- *Prompt service and very grateful for the service and an appointment*

2.3 GP or Health Professional Feedback

Receiving health professional feedback ensures continued shared learning and development.

Themes and Trends of any feedback?

2.4 Serious Incidents and Never Events

If any? If nil state a null return

If so did the organisation apply Duty of Candour.

2.5 Patient Feed-back

How many Questionnaires?

Table or chart to show how many were given out?

How is the information reviewed?

What was their satisfaction or likelihood to recommend the service?

For example

| | |
|---------------------------|----|
| <i>Extremely Likely</i> | 47 |
| <i>Likely</i> | 20 |
| <i>Neither</i> | 1 |
| <i>Unlikely</i> | 1 |
| <i>Extremely Unlikely</i> | 2 |

Sample of positive responses in the patient's own words: Example

- *Very thorough and asked all the questions and gave a good amount of advice*
- *Fast appointment response*
- *Professional, efficient and friendly*

- *Contact was good, but you feel people without a car would find it difficult to access the services referred to.*

The extremely unlikely:

- *Delay on appointments*
- *Asked too many questions*

You Said We Did (Themes from patient feedback questionnaires)

| You Said | We Did |
|----------------|---|
| You said | We implemented, actioned revised and The service has improved by ... and we measured this how..... |
| | |

Local Requirements Reported Locally – Adult Safeguarding (1)

Version
 2019/
 20

CCG STRATEGIC DASHBOARD FOR SAFEGUARDING ADULTS

| National and Local Quality Metrics | | Definition of Metrics | | Q 1 | Q 2 | Q 3 | Q 4 | Trend | Reference Document | Exception Report |
|------------------------------------|--|--|--------|-----------|-----|-----|-----|-------|--------------------|------------------|
| 1 | Adult Safeguarding Level 1 Training (3 yearly update) reported as % of employed staff. Please provide numerator and denominator data | Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take. | Actual | | | | | | | |
| | | | Target | 90% | | | | | | |
| | | | Period | Quarterly | | | | | | |
| 2 | Number of staff who have received induction / basic awareness in Adult Safeguarding reported as % of employed staff. Please provide numerator and denominator data | All staff should have a basic awareness of Adult Protection procedures | Actual | | | | | | | |
| | | | Target | 90% | | | | | | |
| | | | Period | Quarterly | | | | | | |
| 3 | Number of <u>urgent</u> DoLS authorised | Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation | Number | | | | | | | |
| | | | Period | Quarterly | | | | | | |
| 4 | Number of <u>standard</u> DoLS applied for to the LA | Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation | Number | | | | | | | |
| | | | Period | Quarterly | | | | | | |
| 5 | Number of people with an authorised DoLS granted by Supervisory body as at end of quarter broken down into LA | Accurate records and monitoring of numbers ensures good governance and | Number | | | | | | | |
| | | | Period | Quarterly | | | | | | |

| | | | | | | | | | | | | | | | | | | | | |
|----|--|---|--------|--------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | compliance with legislation. | | | | | | | | | | | | | | | | | | |
| 6 | Mental Capacity Act /DoLs training for frontline / clinical staff reported as % of employed staff identified within training matrix. Please provide numerator and denominator data | MCA/DoLs awareness ensures compliance with legislation in relation to people who lack capacity to make decisions at appropriate time. | Actual | | | | | | | | | | | | | | | | | |
| | | | Target | 90% | | | | | | | | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | | | | | | | | |
| 7 | Compliance with CQC requirements, Regulation 11, Outcome 7 (Safeguarding people who use services from abuse) | All providers are required to reach compliance with CQC Essential Standards of Quality and Safety in all Areas of the Service | Actual | | | | | | | | | | | | | | | | | |
| | | | Target | | | | | | | | | | | | | | | | | |
| | | | Period | Annual (September) | | | | | | | | | | | | | | | | |
| 8 | The provider will complete the SSASPB Tier 2 Safeguarding Adults Self-Assessment and Assurance and share actions with the CCGs. | To support Health Services to meet Safeguarding Adult responsibilities and to demonstrate improved outcomes in preventing harm. | Actual | | | | | | | | | | | | | | | | | |
| | | | Period | Annual (September) | | | | | | | | | | | | | | | | |
| 9 | The provider will evidence implementation of Making Safeguarding Personal completing the CCG Making Safeguarding Personal Audit | To support Health Services to meet Safeguarding Adult responsibilities and to demonstrate individualised patient centred outcomes. | Actual | | | | | | | | | | | | | | | | | |
| | | | Period | Annual (Quarter 4) | | | | | | | | | | | | | | | | |
| 10 | Number of adult protection referrals made where abuse/neglect is within their own service. Brief to be provided within | Numbers of referrals from health staff to Social Care. Some providers | Actual | | | | | | | | | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |
|----|--|--|--------|-----------|--|--|--|--|--|--|--|--|--|
| | exception report highlighting themes/trends. | beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers. | | | | | | | | | | | |
| 11 | Number of adult protection referrals made by staff where allegation relates to other care providers. Brief to be provided within exception report highlighting themes/trends. | Numbers of referral from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers. | Actual | | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | |
| 12 | Numbers of staff referred to their professional body due to safeguarding concerns. Brief to be provided within exception report. | Total number staff referred due to concerns about their ability to practice safely. | Number | | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | |
| 13 | Provider has a fully resourced and authorised PREVENT Lead | Provider identify name of lead | Number | | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | |
| 14 | Prevent Wrap Training to be delivered to front line staff. Please provide numerator and denominator data | Number of identified staff group who require WRAP training from an accredited WRAP facilitator | Actual | | | | | | | | | | |
| | | | Target | 85% | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | |
| 15 | A Mental Health Professional is a core member and attends Channel Pannel | A Senior Mental health Clinician is required to attend CHANNEL Panel as a | Actual | | | | | | | | | | |
| | | | Target | 100% | | | | | | | | | |
| | | | Period | Quarterly | | | | | | | | | |

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s43 of the Contract Technical Guidance, which requires commissioners and providers to agree DQIPs in the areas below.

| Data Quality Indicator | Data Quality Threshold | Method of Measurement | Milestone Date |
|-------------------------------|-------------------------------|------------------------------|-----------------------|
| | | | |
| | | | |
| | | | |

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

| Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) other Patient Safety Incidents |
|---|
| <p>NHS Improvement Policy: ‘Serious Incident Framework: Supporting learning to prevent recurrence’ (Revised March 2015) https://improvement.nhs.uk/resources/serious-incident-framework/ https://improvement.nhs.uk/resources/serious-incident-framework/</p> <p>The above policy to be used in conjunction with the Co-ordinating Commissioner’s Serious Incident Policy– link below:</p> <p>https://www.stokeccg.nhs.uk/stoke-governance/policies/health-safety-incident-reporting/484-stoke-ccg-serious-incident-policy-march-2013-final1/file</p> <p>The commissioner must be informed (via STEIS and/or verbally if required) of a Serious Incident within 2 operational days of it being identified as an SI, where it is not clear whether an incident fulfills the definition of a serious incident, providers and commissioner shall engage in open and honest discussions to agree the appropriate and proportionate response.</p> <p>The provider must provide a 72 Hour briefing (as set out in SI policy and national / regional guidelines for those SI’s where this is appropriate).</p> <p>The Provider & Commissioner(s) will meet monthly forming a Serious Incident Review Group. The Serious Incident Review Group is an integral part of the Quality Management System within the CCGs to establish a system of good governance across the Local Health Economy to promote a culture of openness and an attitude that facilitates learning from all incidents. This should include prompt reporting, appropriate and robust investigation, identification of corrective actions, learning and effective and timely follow-up.</p> <p>Closure of an incident marks the completion of the investigation process only. Commissioners should close incidents on receipt of the final investigation report and action plan if they are satisfied that the requirements outlined within the serious incident framework are fulfilled. Incidents can be closed before all preventative actions have been implemented and reviewed for efficacy, particularly if actions are continuous or long term. Mechanisms must be in place for monitoring implementation of long term/on-going actions.</p> |

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Service Development and Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s41 of the Contract Technical Guidance, which requires commissioners and providers to agree SDIPs in the areas below.

| | Milestones | Timescales | Expected Benefit |
|--|------------|------------|------------------|
| | | | |
| | | | |
| | | | |

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

| Type of Survey | Frequency | Method of Reporting | Method of Publication | Application |
|--|-----------------------------|---|--|-------------|
| Friends and Family Test (where required in accordance with FFT Guidance) | As required by FFT Guidance | As required by FFT Guidance | As required by FFT Guidance | All |
| Service User Survey | Annual | Report containing findings and improvement plan where applicable | Submitted to coordinating commissioner & presented at CQRM. Submission date to be confirmed with CCG Quality Lead. | All |
| Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance) | Annual | Written report summarising survey results and an improvement plan with timescales evidence that improvements have been made following feedback. | Submitted to coordinating commissioner & presented at CQRM. Submission date to be confirmed with CCG Quality Lead | All |
| Carer Survey | Annual | Written report summarising survey results and an improvement plan with timescales evidence that improvements have been made following feedback. | Submitted to coordinating commissioner & presented at CQRM. Submission date to be confirmed with CCG Quality Lead | All |

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

Not Applicable

SCHEDULE 7 – PENSIONS

Not Applicable

SCHEDULE 8 – LOCAL SYSTEM PLAN OBLIGATIONS

Not Applicable

SCHEDULE 9 – SYSTEM COLLABORATION AND FINANCIAL MANAGEMENT AGREEMENT

Not Applicable

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Schedule 3

Specification for the Future Focus Support Services

Midlands Partnership NHS Foundation Trust

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1. Purpose

The purpose of this procurement exercise is to appoint a provider to support the provision of Future Focus Support Services. It should be read in conjunction with the Conditions of Contract and appendices. This specification sets out the requirements for the provision of a service to be provided in Southern Staffordshire.

2. Introduction

National Context

Nationally the Mental Health Taskforce Strategy of 2016 which formed the backbone of the government's Mental Health Five Year Forward View 2016 set six overarching objectives aimed at improving the mental health and wellbeing of the whole population and improving outcomes for service users. This strategy also highlighted the need for patient choice and expanding the role of caring for patients in the community as well as ensuring those services commissioned understand and can meet the needs of local people within their own home.

The NHS Long Term Plan identifies that health inequalities are a significant contributor in early mortality for patients with severe mental illness. At a Primary Care Network (PCN) level, health inequalities assessments, coupled with collaboration with local community services will work towards making support available to people where it is most needed including mental health away from hospital unless there is need.

The Community Mental Health Framework for Adults and Older Adults provides an opportunity to achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined-up care and whole population approaches aligned with Primary Care Networks.

One of the key objectives of the NHS Long Term Plan is to develop "new and integrated models of primary and community mental health care [which] will support adults and older adults with severe mental illnesses". The framework allows for a shift to a new model of community mental health provision, designed on an asset-based view of communities and integrated working across agencies, rather than a traditional Community Mental Health Team model.

Community Development is an approach to creating interventions for people with, or at risk of, mental health problems or a 'relapse' in their mental health in a way which is essentially empowering and ensures interventions take into account people's experiences and expectations. Communities have many assets that can support mental wellbeing, accessibility and reducing stigma.

Poor mental health brings with it costs to individuals and their families as well as to society as a whole through costs to public services: health, social care, housing, education, criminal justice, social security and the wider economy. People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be over-represented in the criminal justice system.

Local Context

Midlands Partnership NHS Foundation Trust (MPFT) have a new ring fenced investment to commission extra support from local and accessible services. This is available to mental health services in recognition of their vital role in responding to the pandemic and supporting some of the most acutely ill and vulnerable patients.

MPFT have developed a Community Mental Health Framework for Adults and Older Adults (CMHF) in line with the NHS Long Term Plan's vision for a place-based, community mental health model. This

enables modernisation of community services to offer whole-person, whole-population health approaches, aligned with the Primary Care Networks (PCN).

Co-production will help develop services that combine lived experience with 'traditional' clinical skills. This will facilitate a more person centred service that is focused on the user's needs based on user experience and what is important to them and their general wellbeing.

The framework allows for a shift to a new model of community mental health provision, designed on an asset-based view of communities and integrated working across agencies, rather than a traditional Community Mental Health Team model.

The aim of the Community Mental Health Framework is to:

- Improve access to psychological therapies for those with Serious Mental Illness (SMI)
- Deliver support that is personalised and within a person's community
- Take an asset based approach with an emphasis on self-management and recovery
- Increase the number of people receiving SMI physical health checks
- Increase the number of adults who have access to Individual Placement and Support (IPS)
- Provide integrated models of support configured around the PCNs
- Implement a whole systems pathway supported by Structured Clinical Management for people with a 'personality disorder'
- Reduce occupied bed days within Acute Settings and a reduction in crisis contacts for people with a 'personality disorder'
- Ensure Eating Disorder provision that meets commissioning guidance across the age span

By collectively achieving the benefits listed above, it is hoped that there is an improvement in outcomes for the local health economy, including:

- Reductions in mortality and morbidity rates
- Increased patient satisfaction
- Increase staff satisfaction
- Improved clinical and financial sustainability of the Sustainability and Transformation Plan (STP) / Integrated care systems (ICS)
- Improved attainment of constitutional targets
- Improved quality of life for people with long term conditions

3. Specification

3.1 Service Description and Model

The primary objective of this service will be to form a part of an integrated pathway across the voluntary sector, primary and secondary care mental health and social care. It should be based on recovery and social inclusion principles and designed to be accessible and to prevent people falling through gaps between services. The Future Focus Support Service will enable service users to stay well in their recovery journey. The ways in which people are supported can be flexible, should be person centred and help people to make the best use of their community resources.

This is an outcome-focused specification, the personal, service and strategic level outcomes below will need to be considered by the Provider as part of the Service model. Throughout the life of the Contract, the Trusts request the Provider to work in partnership with the Trust to improve and enhance the outcomes below.

Personal Level Outcomes (as applicable)

- Service Users are supported to connect to their communities and feel less lonely and socially isolated

- Service Users have choice, control, feel empowered and enabled to be active participants in making positive changes
- Service Users live safely and independently, learning to manage their long-term conditions in some instances
- Service Users are in stable accommodation and managing their life
- Service Users feel satisfied with Service delivery and Service outcomes, through the setting and measurement of goal-based outcomes
- Service Users are supported to be involved in Service design, Service offer and availability
- Service Users access a wide range of opportunities to support their personal recovery which include (but are not exclusively limited to): lifelong learning, social and leisure, healthy living support (including local opportunities to get fitter and make better lifestyle choices) and risk management.
- Service Users are effectively supported to secure and maintain employment, education, training or volunteering opportunities
- Service Users will have increased social skills
- Service Users will be appropriately supported to manage their recovery

Service Level Outcomes (as applicable)

Providers will work with Health and Social Care Partners to ensure the service will:

- Reduce the number of Service Users entering hospital in crisis
- Reduce the number of Service Users entering secondary mental health care
- Ensure timely specialist intervention are available to support individuals recovery
- Increase the numbers of Service Users being transferred from secondary services to primary care
- Increase the numbers of Service Users receiving support to address social stressors that impact on mental health
- Increase numbers of Service Users accessing support including information, advice and sign posting
- Increase number of Service Users self-caring following a period of enablement through the short-term recovery service
- Improve transition experiences from children and adolescent mental health services (CAMHS) to adult mental health
- Increase the number of Service Users in employment, education or training (inclusive of work with the Trust's Recovery College).
- Increase the number of Service Users in stable housing and managing their tenancies
- Increase the number of Service Users supported to achieve emotional wellbeing
- Reduce stigma and discrimination
- Support co-working and collaboration between primary care services, health and social care to meet the totality of service user and family needs
- Increase levels and models of mutual/peer support
- Improve outcomes for families and carers through signposting/referral
- Increase number of service users who engage & influence the service development and quality monitoring

Strategic Level Outcomes (as applicable)

- Demonstrate a collective strength to transform the lives of people with mental health needs in communities across Staffordshire and Stoke-on-Trent.
- Through an inclusive and engaging approach, positively influence whole communities around mental health through collaborative approaches ensure that communities are influenced.
- Addressing inequalities and increasing access to services for under-represented groups.

3.2 Scope

Close working between professionals in local communities is intended to eliminate exclusions based on a person's diagnosis or level of complexity. A more flexible model for providing support and care is envisaged by the Trust and this Service will directly contribute to achieving this for Service Users. Care will be centred on a Service User's needs and will be stepped up or down based on need and complexity, with clear aims and objectives.

The Trust promotes and support partnership, consortium or sub-contracting arrangements between providers to deliver this specification across Southern Staffordshire geography. The Trust will require that this Service work intuitively with other inter-dependent services that are commissioned as part of the community mental health transformation programme to provide seamless and intuitive services to Service Users, for example, peer support workers, financial wellbeing service, health and lifestyle service.

The Future Focus Support Services will work with individuals who have severe and enduring mental health needs, some individuals may have more complex needs. They will require strengths based holistic approach, individuals are likely to require regular support to enable them to build a trusted relationship with their named support worker to aid their recovery journey. This will involve working together to develop and work towards achieving SMART goals, these could relate to any area of the individual's needs from wellbeing to employment and from spirituality to sleep pattern. Progress will be reviewed regularly to enable development of new goals if required and to reflect on achieved outcomes. Individuals who may have additional complexities, will require a more intense and at times longer term support to aid their recovery. The service will help them to achieve and maintain their SMART goals. Engagement may at times be difficult due to a reluctance to accept support and lack of insight into the need for support. This client group may present as high risk to both themselves and others and may require joint visits by staff at times. They may also present with significant self-neglect and be highly vulnerable to exploitation. Substance and alcohol misuse may also be an issue with some individuals adding to the complexity of presentation.

Working hours/days

- The core hours of delivery will be Monday to Friday, 9am - 5pm Service with flexible working hours to meet Service User needs.
- Weekend and bank holiday working may be required as dictated by the needs of the service user but at the discretion of the Provider.

Delivery

- Will include face to face and digital support/ interventions using a blended model.
- It is expected that face to face delivery will be routinely offered to ensure accessibility (with consideration of digital accessibility, language, marginalised groups, cultural barriers and deprivation levels).
- Will be based within at least one community venue in each lot to support the promotion of community connectivity across Southern Staffordshire. It is encouraged to have more than one venue in the lotted areas, more than one community venue will be confirmed with Trust first. Trust estates may be made available for use where appropriate to support delivery and co-delivery of support/interventions.
- Where necessary, support will be provided in individual's place of residence for engagement, relational building, for service users who cannot access community based venues.
- To be linked to a Service User's care plan within Trust services and reviewed frequently, dependant on individual need or as part of a discharge plan.

- The providers staff will have a supporting qualification or willing to work towards a supporting qualification - AND/OR - Have experience in a relevant/similar role with at least 1 years' experience
- Will need to be passionate about rights and recovery-based work in adult mental health and have a natural affinity with the principles of co-production.
- Understanding of the impact of social exclusion on wellbeing.
- The Service workforce will have a combined experience of working across the whole age range linked to the eligibility criteria.
- Service Users will be supported within their own locality area, therefore Service workforce will be required to travel across an allocated locality area also in order to effectively meet need.
- Awareness of the legal frameworks that underpin and drive best practice: Human Rights Act (1998), Care Program Approach (2008), Care Act (2014), Mental Health Act (1983) amended (2007), Homeless, Reduction Act (2017), Equality Act (2010), s.75 Local NHS Act (2006)
- Optional additional lived experience and/or cared for others with mental-ill health challenges would be welcomed by the Trust.

The Service will embed the recovery focused approach across all delivery elements. The World Health Organisation (WHO 2012) define a recovery focused approach as "gaining and retaining hope, understanding of one's abilities and disabilities in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self". This approach supports people with mental health conditions to reclaim control of their own lives, managing their condition and overcoming the stigma and discrimination they all too often experience.

Core components and expectations:

- Trust system recording via Rio (MPFT)
- Support care and support planning and delivery
- Focused, time bound interventions with a co-ordinated approach to all support and care
- Will be flexible in style and frequency of delivery to meet Service User needs, but always clearly documented
- Outcome focused that considers the goals of the Service User.
- Innovative and strength-based approach to supporting the social stressors of a Service User, always seeking to develop community connectivity to ensure sustainable recovery and positive outcomes.
- Will deliver group and individual interventions that will include, but not limited to, horticulture (such as landscaping & gaining nursery skills), art & crafts, unleashing hidden talents through a wide variety of media and recreational groups, support to follow leisure interests.
- Develop and sustain close links with Trust services that can provide bespoke support for a Service User, for example; The Recovery College and Step On service, Day Care Services linked to Dementia.
- As a minimum the Service will have Professional Lead/Experts in relation to Housing and Employment/Education/Training/Volunteering to deliver effective partnership connectivity with statutory agencies, local authorities, district and borough council provision.

Mental Health Equality

The community mental health transformation programme seeks to address health inequalities that have been a priority in mental health services for years, as highlighted in the Five Year Forward View for Mental Health and the NHS Long Term Plan. In light of the COVID-19 pandemic, it has become more important than ever to address inequalities. While locally there is work underway to understand the causal factors for inequalities, the Trust is committed to supporting local health systems to better address inequalities in access, experience and outcomes of mental healthcare. The Service will be required to actively participate in a local Health Inequalities Co.Lab work stream of the transformation

programme and will seek throughout the contract term to improve access, experiences and outcomes for all under-represented groups. The initial findings of the Health Inequalities Co.Lab is that health literacy is an over-arching consideration for the adult mental health system, making it a priority for the Service.

The World Health Organisation (WHO) defines health literacy as “the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health”. As a minimum, the Service will seek to respond to local health literacy needs by:

- Taking up an active role within the Health Inequalities Co.Lab and implementation of Service improvements throughout the contract term in line with the recommendations of the Co.Lab
- Utilising community champions to link effectively with under-represented groups in the local area
- Ensuring all staff across the Service are culturally competent and confident
- Taking trauma informed approaches to support and care delivered
- Using visual content such as images or diagrams, in Service promotional information as well as in the delivery of services, to support lower levels of literacy, cognitive and visual impairment and any language barriers
- Harnessing the benefits of co-production to build strong links with communities and Service Users.
- Taking a multi-disciplinary approach; working with housing services, schools and colleges, the police and employers to improve experiences and outcomes across a range of domains.

Eligibility criteria

- 18–65-year-old service users whose care and support are co-ordinated within a community mental health team or as part of a recovery/discharge plan.
- 17–18-year-old young adults who will transition from children to adults' mental health services within the Trust or as part of a recovery/discharge plan.
- 65+ year old service users who's care and support is co-ordinated within the Trust's Older Adults Community Teams or as part of a recovery/discharge plan.

Whole System Relationships

Other services and pathways who will link with the service are:

- Public bodies
- External agencies
- General public
- Community Mental Health Teams

Lots

This service will be split into 4 Lots to be provided in the Community within Southern Staffordshire.

- Lot 1 - Cannock, Rugeley & Great Haywood
- Lot 2 - Stafford & Seisdon
- Lot 3 – East Stafford
- Lot 4 – Burntwood, Lichfield & Tamworth

Referrals

Access to the service will be via referrals from Health and Social Care within MPFT's Community Mental Health Teams.

Policies

The Service's staff should adhere to the policies and procedures of the Trust, whilst working under the terms of the Contract. Copies of Trust policies and procedures can be found on <https://www.mpft.nhs.uk/>

The provider will have policies, procedures and systems as appropriate to assure the standards of clinical competences of staff that they employ. This will include but not be limited to:

- Employment of appropriately qualified staff
- Compliance with statutory and other national requirements,
- Compliance with professional standards e.g. participation in Quality Assurance and Accreditation schemes and child protection.

The Service provider is recommended to have knowledge of 'Staffordshire and Stoke on Trent Partnership Adult Safeguarding Board' and related policies and procedures.

The Service provider will also work within national guidance and good practice guidelines relating to this service.

4. Contract Length

The contracts length for each Lot will be for 2 years with an option to extend up to 12 months. The contract length is based on a start date of 1st April 2022.

5. Clinical Governance Arrangements

The provider will have policies, procedures and systems as appropriate to assure the standards of competences of staff that they employ. This will include but not be limited to:

- Employment of appropriately qualified staff
- Compliance with statutory and other national requirements,
- Compliance with professional standards e.g. participation in Quality Assurance and Accreditation schemes and child protection.

6. Data Protection and Governance

Personal data provided by service users as part of the triage and testing process will be stored and protected according to GDPR legislation. Secure access to the database will be given to clinical staff in accordance to Trust IG policy.

7. Complaints

A formal process will be in place to deal with incidents / complaints as they occur, including central reporting and the notification of occurrences to the Trust(s) within 24 hours. Formal notification will be made to the Trust representative who will inform the relevant systems within the organisation. The Service Provider and Trust(s) will then engage in the joint resolution of complaints and incidents. For service users, complaints and comments will be dealt with as with any other NHS service, following NHS guidelines

7.1 Continuity arrangements:

- 7.1.1 **Minor disruption (1 day)** - The Sub-Contractor will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate, then control of the incident will be undertaken locally.
- 7.1.2 **Medium/short term (2-7days) disruption** - Where the incident is deemed to result in minor disruption to the service, and the incident is unlikely to escalate, the Sub-Contractor will then inform the Head Provider and of the decision to manage the incident locally.

- 7.1.3 Major/long term (>7 days) disruption** - Where the incident is deemed to result in a major/long term disruption to the service, the Sub-Contractor must inform the Head Provider immediately and convene a meeting to discuss the continuity of the service

8. Management of the Contract

Service Levels

There is no incumbent service, therefore there is no direct service level data that can be shared to inform the service model design.

Performance

Regular contract meetings, initially monthly with a move to quarterly to closely monitor contract performance. Outcome measures are to be determined during the contract review meetings. The contract review meeting reports shall be sent to all meeting attendees prior to the meeting.

A dedicated account manager and support team must be able to support the service and call on relevant expertise to support aspects of the contract as and when required.

The Trust expects the account manager to support the team in attending review meetings. Review meetings will cover all management information as agreed with the Trusts' project team. Where the service or performance provided by the provider falls below the required level then the account manager shall ensure that appropriate support is provided to the Trust.

As above, this specification is an outcome based service. Therefore the Personal, Service and Strategic Outcome Measures will be closely monitored during the life of the contract. Patient Related Outcome Measurements (PROM) will support the Personal, Service and System/Population Outcome Measures and will be developed during the mobilisation period.

The Provider is expected to continually update Service provision based on Service User need, best practice and evidenced-based interventions, giving consideration of future guidance and local policy. Key Performance Indicators (KPIs); the below KPIs are not extensive and there is an expectation that the partner provider will work with the Trust to identify key performance indicators over the first year.

| Performance Indicator | Threshold | Frequency of Report | Method of Measurement | Consequence of breach |
|--|---------------------------|---------------------|---|--|
| Availability of suitably qualified Staff | 100% | Quarterly | Training records/ cancellations | Contract Performance Review triggered. |
| Financial & Activity Data Report | 100% | Quarterly | Contract reporting Dataset | Contract Performance Review triggered |
| Complaints | 4 per annum | Quarterly | Clinical Quality Performance report within 10 working days of the end of each month | Compliant Review and Investigation – 4 and Under. Contract Performance Review triggered – 5 and over. |
| Referrals Received | TBC during contract award | Monthly | Number of referrals received | Contract Performance Review triggered. |
| Support and Advice Provided to Service Users | FY1 / TBC during | Monthly | Types of advice and support given to service | Contract Performance Review triggered. |

| | | | | |
|---------------------------|---------------------------------|---------|---|--|
| | contract award | | users and how many per type | |
| Outcomes and Closures | TBC during contract award | Monthly | Number of case closures. Contributed towards the positive outcomes of service users, and how many per type of outcome. | Contract Performance Review triggered. |
| Escalations | FYI / TBC during contract award | Monthly | Escalations made to NSCHT and/or Provider | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | How many adults and older adults have had at least one contact from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum. | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | How many adults and older adults have had at least 2+ contacts from NHS-commissioned VCS services disaggregated by, Age: 17-25, 25-65, 65+ years, gender, and ethnicity as a minimum. | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in a dedicated 'personality disorder' pathway or service provision (including primary care, VCS, and MH services) | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in a dedicated community rehabilitation pathway or service provision (including primary care, VCS, and MH services) | Contract Performance Review triggered. |

9. Security Requirements

All staff must sign in and out where required and wear their identification card at all times.

Any issues regarding safety and wellbeing of staff or service users should be immediately reported to their senior staff providing the service.

Should the assistance required be above and beyond what staff can manage, or should a crime be committed, then the most senior staff member will contact the Police for assistance.

Staff should never put themselves or the service user at risk. Staff should ensure service user safety and seek appropriate support.

Where suicide and/or serious self-harm has been identified via the risk assessment process, staff are to be confident in executing the risk management plan.

All staff should have awareness and understanding of the local safeguarding policy and process.

10. Training

All staff are advised follow the Trust's training expectations, which may include mandatory safeguarding refresh every 12 months, together with continuous practice development. Any staff who have a professional qualification will be supported to be competent and maintain their professional scope of practice. However if adequate training has been completed prior to the start of the contract i.e. external training which covers the training expectations, this will be discussed upon implementation to avoid any duplication.

The provider contracted will undertake the necessary checks on its staff and volunteers who are directly involved with performing the Contract i.e. two (2) references and an enhanced DBS and any other safeguarding requirements coming into effect to the extent that this is a statutory requirement relating to the Service.

The role will be given regular support and supervision by a suitably qualified manager/team leader on a continual basis. They will receive performance development reviews to identify training and development requirements and ensure this is implemented in a timely manner. In addition they will be kept up to date and informed of any changes in appropriate legislation relating to the services being provided, by the Trusts and the Provider will be notified.

11. Implementation

The implementation of the service will be a collaborative approach across health and social care services including primary, secondary and the voluntary sector, mainly including MPFT, PCN's and the contracted provider.

Within MPFT Community Mental Health Teams, there will be a mix of staff with blended skills, delivering clinical and non-clinical interventions to support the needs of individuals.

The contracted provider will support the safe and effective service delivery of contracted service under MPFT's Community Mental Health Teams in South Staffordshire, to ensure that the service meets all the requirements of the NHS Long Term Plan.

As this is a new service being implemented, MPFT will require support from the provider during the implementation process, for example, a mobilisation plan.

During the contract referrals will be made via the community mental health teams to the Service. As mentioned above within the specification, there may be a requirement to discuss with 3rd party organisations which will be assessed on a case-by-case basis. As this is a new service, further detail around the structure of the implementation will be approached by the contracted provider and MPFT

to discuss the specific details.

12. Exit Arrangements

This Contract is for 2 years with an option to extend up to 12 months. Any exit arrangements will be discussed as required, at least 3 months before the end of the Contract Period. Termination of the Contract by the Trust would be within 30 calendar days if there are Service delivery issues which the Service partner fails to rectify.

At the end of the contracted period, an end-of-contract meeting will be held between the Service and Provider to determine an exit plan to ensure the continuity of provision for the Service. The discussion will focus on:

- Last day of the service
- Arrangements on any outstanding notes or patients
- Providing all reasonable assistance and information as the Trust may require to enable it to re-procure the services or transfer the services to an alternative service provider.
- Lessons learnt feedback (both parties)

13. Cost and Invoicing

The service will be funded by a ring-fenced budget from the Trust's Community Mental Health Transformation. The specific budget for the Future Focus Support Services is £500,000.00 per financial year which will be broken equally down per lot, £125,000.00 per lot per financial year. The contract term will have an option to extend up to 12 months following the 2 year term. The budget for the extension will be confirmed at a later date, if chosen to extend.

Due to funding, invoices are to be issued quarterly. Any invoice not complying with the points below will be returned, or be provided with an "on-hold" status and the Provider will be contacted by the Trust. The Trust operates on 30 day payment standard terms from date of receipt of invoice. Invoices should be provided as per Purchase Order.

Invoices shall:

- be addressed to the relevant organisation;
- be sent to the correct address; Electronic invoices must be sent via email as a PDF Document;
- have the Trusts Purchase Order number;
- have the delivery note number, contract or quotation reference (where applicable);
- match the values agreed;
- be submitted in arrears;
- be forwarded to the Trust within 3 days of invoice date;
- be provided with supporting backing data where applicable including summary of usage and interpretations provided.

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|--|---|--|
| Service Specification No. | MH04 | |
| Service | Adult Community Mental Health and Social Care Team Service (CMHTs) | |
| Commissioner Lead | Nicky Bromage, | |
| Provider Lead | Lisa Agell | |
| Period | April 2019 – March 2020 | |
| Date of Review | As and when required by either Commissioner or Provider | |
| 1. Population Needs | | |
| 1.1 National/local context and evidence base | | |
| <u>Policy context</u> | | |
| <ul style="list-style-type: none"> • Policy Implementation Guidance CMHT DH 2002 • Refocusing the Care Programme Approach DOH 2008 • No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011) | | |
| <u>Local strategic context</u> | | |
| <ul style="list-style-type: none"> • Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019 • Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 • Up to date statistics can be found on the POPPI and PANSI HSCIC systems. | | |
| 2. Outcomes | | |
| 2.1 <u>NHS Outcomes Framework Domains & Indicators</u> | | |
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |
| 2.2 Local defined outcomes | | |
| <ul style="list-style-type: none"> • First contact after receipt of referral is made with the service user within 24 hours (urgent), 3 working days (Non urgent), either face to face or other form of communication to make formal arrangements for an assessment to commence. • Assessments will be completed within 4 weeks from first face to face contact. Assessments will be made from 4 weeks off initial referral date. | | |

- All assessments, Treatment / interventions commenced within eighteen weeks of referral.
- The need for hospital admissions will be reduced through early detection and providers working with service users and carers to develop effective relapse prevention plans.
- Out of area placements repatriated following review
- Transition service users to primary care resulting in the reduction of secondary care need.
- Reduction of inequalities in health care.
- Service users have access to accommodation suitable for their needs.
- Service users supported to maximise income.
- Service users are supported to retain and gain paid employment
- Service user's carers and families are well informed.
- A whole family approach is taken when working with service users.
- Service users are seen as partners in care and care plans are co-produced.
- To prevent crisis where possible
- To use of outcome measures, including user defined outcomes, to measure success

3. Scope

3.1 Aims and objectives of service

The team provides an integrated whole systems assessment and treatment service for individuals within the individuals home or a community setting close to home, including nursing and residential homes, that is person-centred and recovery focussed.

The Service objectives are to:

- Provide prompt and expert assessment of needs for people referred to the service.
- Provide effective, evidence-based treatments to reduce and shorten distress and suffering.
- Provide support to CR/HT services to ensure people are supported in the community.
- To provide multi-disciplinary team approach to support the users in the community.
- Ensure that inappropriate or unnecessary treatments are avoided
- Ensure the care is delivered in the least restrictive and disruptive manner possible.
- Assist service users and carers in accessing support, both to reduce distress but also to maximise personal development and fulfilment.
- To provide a comprehensive community Mental Health Service to older people presenting with functional disorders such as depression, bi-polar disorder, psychosis
- Provide advice and support to service users, families and carers.
- Stabilise and improve social functioning and protect community tenure.
- Establish a detailed understanding of all local resources relevant to support of individuals with mental health issues and promote effective interagency working.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this and religious and gender needs.
- Provide support and advice to primary care through collaborative working.
- Reduce the stigma associated with mental health care
- Establish effective liaison with local general practice, IAPT Teams, Acute Care, Early Intervention teams and other internal and external referring agents to establish processes to manage complex cases
- To ensure services users are supported to access appropriate physical health care and healthy lifestyles interventions/advice

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|--|
| <ul style="list-style-type: none"> To work in partnership with other providers eg third sector to avoid duplication of provision and maximise the opportunities for 'Recovery' for the individual <p>3.2 Service description/care pathway To deliver interventions underpinned by the principles of 'Recovery' and anti-discriminatory Practice whilst promoting Social Inclusion.</p> <p>Care Pathways – See Documents to be Relied on Schedule 5A</p> <p><u>Pathway</u> Referral ⇌ Assessment ⇌ Care Plan ⇌ Care & Treatment ⇌ Review ⇌ Discharge in accordance with CPA</p> <p>The service will have the appropriate multi-disciplinary workforce and have the adequate skills mix to provide the relevant interventions and meet the required service objectives and outcomes.</p> <p>3.3 Population covered South Staffordshire CCG populations within the localities of Stafford and surrounds, Cannock Chase, East Staffordshire, South East Staffordshire, and Seisdon.</p> <p>3.4 Any acceptance and exclusion criteria and thresholds <u>CMHT Service user groups covered</u></p> <ul style="list-style-type: none"> Adults and Older adults (age 16 and above) presenting with moderate to severe and/or enduring mental illness, including Care clusters 4 to 8 and 10 to 17 and with provision for joint working with IAPT services for 'step up and step down'. The service also provides assessment and support for carers of the above service users. <p><u>CMHT Exclusion criteria</u> Those whose needs are best met elsewhere include:</p> <ul style="list-style-type: none"> Individuals under the age of 16 years Individuals with organic disorders Individuals with a primary diagnosis (non-dual diagnosis) of learning disability, substance misuse, Individuals presenting with mental health needs at step 2 or below (stepped care model) <p><u>Days/ hours of operation</u> CMHT = Monday –Friday- 9.00 – 1700 (Excluding Bank Holidays)</p> <p><u>CMHT Referral processes</u> Referrals are accepted from any source through a Single Point of Access via phone, fax, post or in person</p> <p>3.5 Interdependence with other services/providers This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service: Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, CR &HT, CMHT's. Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. BME communities. Staffordshire and Stoke on Trent Partnership Trust, Social Inclusion and Recovery Services e.g. Life Links, Changes</p> |
| <p>4. Applicable Service Standards</p> |
| <p>4.1 Applicable national standards (eg NICE)</p> |

| | |
|--|---|
| <p>All relevant NICE Guidance complied with.</p> | |
| <p>4.2</p> | <p>Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)</p> |
| <p>4.3</p> | <p>Applicable local standards This is not intended as a non-exhaustive list:</p> <ul style="list-style-type: none"> • A seamless approach to mental health care in conjunction with other providers and other specialist mental health providers will be delivered. • A coordinated interface between primary and secondary care delivery will be maintained. • An integrated approach will be taken to the interface between physical and mental health care. • A positive coordinated approach to all physical long term conditions care is required. This service will offer emotional and psychological support/interventions where appropriate. • Consideration should be given to undertaking an assessment regarding safeguarding issues. • Where necessary specialist advice and support should be sought such as for substance misuse, housing support and criminal justice agencies |
| <p>5. Applicable quality requirements and CQUIN goals</p> | |
| <p>5.1</p> | <p>Applicable Quality Requirements (See Schedule 4A-C)</p> |
| <p>5.2</p> | <p>Applicable CQUIN goals (See Schedule 4D)</p> |
| <p>6. Location of Provider Premises</p> | |
| <p>The Provider's Premises are located at:</p> <p>Stafford & Surrounds CMHT Foundation House Stafford ST15 3AG Tel: 01785 783033</p> <p>Cannock Chase CMHT Park House 12 Park Road Cannock WS11 1JU0 Tel: 01543 431580</p> <p>Burton and Uttoxeter CMHT Horninglow Clinic Carlton Street Burton DE13 0TF Tel: 01283 538030</p> <p>Tamworth CMHT Andrew Ward, Sir Robert Peel hospital Plantation Lane Mile Oak Tamworth Staffs B78 3 NG. Tel: 01827 308820</p> <p>South Staffs (Seisdon) CMHT</p> | |

Codsall Lodge
Histons Hill
Wolverhampton
WV8 1AA
Tel: 01785 783030

Burntwood and Lichfield CMHT
St Michael's Hospital
15 Trent Valley Rd
Lichfield
WS13 6EF
Tel: 01543 414555

7. Individual Service User Placement

| | | |
|---|---|--|
| Service Specification No. | MH11 | |
| Service | Crisis Resolution and Home Treatment Teams (CRHT) & Acute Day Care | |
| Commissioner Lead | Nicky Bromage | |
| Provider Lead | Lisa Agell | |
| Period | April 2019 – March 2020 | |
| Date of Review | As and when required by either Commissioner or Provider | |
| 1. Population Needs | | |
| <p>1.1 National/local context and evidence base</p> <ul style="list-style-type: none"> National Service Framework for Older People DH 2001 Mental Health Crisis Care Concordat (Feb 2014) Refocusing the Care Programme Approach DOH 2008 No health without mental health. A cross government mental health outcomes strategy for people of all ages (2011) Mental Health Policy Implementation Guidance http://www.iris-initiative.org.uk/silo/files/mh-policy-implementation-guide-2003.pdf <p>Local strategic context</p> <ul style="list-style-type: none"> Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019 Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012 Up to date statistics can be found on the POPPI and PANSI HSCIC systems | | |
| 2. Outcomes | | |
| 2.1 <u>NHS Outcomes Framework Domains & Indicators</u> | | |
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |
| <p>2.2 Local defined outcomes</p> <p>Better service retention: service users prefer non-inpatient solutions to their mental health crises and this is reflected in higher rates of service retention in crisis resolution services than standard hospital treatment</p> | | |

Reduced admissions and bed use: home-based crisis resolution services can reduce hospital admissions

Reduced duration of admissions: where admission to hospital does occur, the intervention of a crisis resolution service can reduce length of stay

Service users will be supported and encouraged to engage in a comprehensive assessment, including areas associated with risk, of their presenting circumstances and will receive a considered response from specialist mental health services that promotes personal choice, self-management and resilience.

Service users will receive a Care Plan, Risk Management Plan, Relapse Prevention Plan, and Crisis Intervention Plan that records their individual needs and reflects their participation and choice/preferences. The documents will focus on the service user's strengths, interests, abilities and capabilities, not on their deficits, weaknesses or problems.

Service Users and their carers/family members will be informed of who their Care Co-ordinator is and how to contact them or their representative should the need arise.

Primary Health and General Practitioners, carers and families, will be active participants in supporting service users and the service will ensure that Primary Health and General Practitioners receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans that clearly records their participation and responsibilities.

Incidents of poly pharmacy will decrease due to the participation of primary health practitioners in Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and reviewing process.

Service users will be supported and encouraged to actively engage with services and the incidents of un-planned/self-discharge will decrease.

Service users will have the opportunity and be supported by the service to maintain social contacts and relationships, whilst receiving intensive support.

Robust links between the service and Community Mental Health and Social Care Teams will be in place resulting in seamless transitions for service users.

Psychiatric hospital admissions will be reduced as individuals are supported via more flexible options which meet their needs enabling them to maintain relationships and social contacts.

Service users, carers/family members, and care team members will be informed of changes in service interventions and transitions across provider services. For example the discharge from an in-patient resource will be co-ordinated and Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans will be disseminated to care team members prior to the event taking place.

Admissions to psychiatric hospital following requests for assessments under the Mental Health Act should decrease as the service will provide a less restrictive resource for Approved Mental Health Professionals co-coordinating assessments.

The aim of the service is to improve the quality of services and clinical outcomes, reduce psychiatric hospital admissions, reduce length of stay in psychiatric hospital and assist service users in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis.

Promotion of self-care and service user, and care/family member education

- The provider will work with service users in ways that assist them in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis.
- Supply resources that promote self-management e.g. advance decisions (Making my Wishes Known), Wellness Recovery Action Plans,
- Service users and their carers/family members will be given an explanation of their condition and advice about all management options which will be discussed with service users and their carers/family members

Service users and their family/carers should be provided with the following information as a minimum:

- Description of the service, range of interventions provided and what to expect
- Name and contact details of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice and help
- Care Plan, Risk Management Plan, Relapse Prevention Plan, and Crisis Intervention Plan
- Comprehensive information about medication
- Discharge Summary including information on how to re-referrer in the event of a relapse
- How to express views on the service.

3. Scope

3.1 Aims and objectives of service

The purpose of this specification is to set out the requirements for a Crisis Resolution and Home Treatment Service and Acute Day Care for the population of South Staffordshire.

The service will provide an alternative to psychiatric hospital based treatment for appropriate service users experiencing mental health difficulties who are either in crisis or severe distress that are referred to specialist mental health services. Service users will be referred to hospital only when there is a clearly identified clinical need for psychiatric hospital based specialist services – with inclusive reference to those individuals assessed under the Mental Health Act (including section 136) as well as those assessed within informal situations.

The aim of the crisis resolution and home treatment service and acute day care is to improve the quality of services and clinical outcomes, reduce psychiatric hospital admissions and assist service users in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis. Provision of intensive support in home treatment through integrated 'acute day care' function. Ability to deploy workers with clinical skills to work intensively with individuals in 'safe spaces' as an alternative to hospital admissions and Monitoring of care plans and interventions from clinically trained staff.

The service will also provide supports to service users (and their carers/family members) who have been admitted to a psychiatric hospital by assisting them in developing self-management techniques which maximise their resilience and reduce their vulnerability to crisis, enabling early discharge from psychiatric hospital and reducing the length of time they require in-patient support.

The service shall respond to referrals promptly, minimising presenting risk and alleviating stress faced by service users and others, such as carers as appropriate.

The multi-disciplinary service will provide a crisis response to individuals in the community experiencing and presenting in crisis with debilitating mental health difficulties and – for those individuals assessed as requiring an alternative to psychiatric hospital admission as a resolution to that crisis – the service will provide intensive support to that individual in their own homes or in other accommodation. The Home Treatment service will stay involved until the need for the intensive intervention is ended and the service user continues with an ongoing care package provided by another service typically this would be resolved within a period of 6-8 weeks to maximise the efficiency of the service.

The service will provide prompt and effective home treatment, including ongoing assessment and review, medication management and psycho-social interventions in order to prevent imminent psychiatric hospital admissions. People will be supported in the least restrictive environment possible with the minimum of disruption to their lives. The service is offered as an alternative to psychiatric inpatient care.

The service will support people in their community, ensuring the preservation of family networks and support and enabling service users to access local social networks. The service will also give support and advice to informal carers.

The service will gate keep all admissions. From the point of any necessary admission to psychiatric hospital, the home treatment service will be involved with all appropriate discharge planning with intensive support being provided to enable early discharge from psychiatric hospital to be achieved.

The service will practice in a framework that promotes personal recovery, assisting service users to develop self-management techniques which reduce their vulnerability to crisis and maximise their resilience.

The service will provide high quality, evidence-based interventions which represent good value and is responsive to local needs and national guidance and policy.

3.2 Service description/care pathway

The Service shall be provided within the principles defined by Refocusing the Care Programme Approach; *Policy and Positive practice Guidance*; DOH (March 2008)

Practitioners will be skilled and welcoming. Staff will be guests in peoples' homes (or other domicile which may include temporary accommodation). Practitioners will promote a good understanding of the service users' lives and life situations, with a focus on recovery and - with regards to their overall life situations - will promote an understanding that illness is only one aspect. All clinical and non-clinical staff will be provided with appropriate accredited training in line with individual competencies, and clinical governance to enable staff to provide accurate, impartial advice and support to service users and carers.

Services will be accessible by all members of the community, e.g. through appropriate opening times and location and provision of services for vulnerable and socially excluded groups. These might include interpreting/translation services, facilities for disabled people, the homeless, and those in remote or inaccessible areas.

The service provides short-term crisis intervention and, where appropriate, crisis resolution to assist adults aged 16 or above with no upper age limit, who are undergoing a crisis where mental illness appears to be a dominant factor or with a severe mental illness (e.g. schizophrenia, bi-polar disorders, severe depressive disorder) who are experiencing a life situational crisis that is affecting their ability to function normally and has overwhelmed their usual coping mechanisms.

The service provides support to adults aged 16 or above with no upper age limit, experiencing an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, psychiatric hospitalisation would be necessary

Where there is a risk of admission to psychiatric hospital the service will assist service users to remain at home during a period of ill health. The service will provide intensive care and treatment at home (or other appropriate domicile), including where necessary daily visits and assistance with medication.

If a psychiatric inpatient admission is necessary, the service will facilitate early discharge by early involvement in discharge planning, and consulting with inpatient multi-disciplinary teams, service users and carers. Staff will attend inpatient multi-disciplinary meetings to facilitate early discharge.

Discharge planning from the service will begin at the first contact with service users and should involve resources/personnel who will work with service users after discharge.

Service model

The service shall comprise a multi-disciplinary, specialist discreet team with a breadth of skills to ensure that it can;

- respond appropriately to referrals,
- engage service users in comprehensive assessments,
- respond appropriately to identified needs,
- allocate staff members to co-ordinate service users care,
- provide intensive support, including home visits, to support service users through episodes of crisis,
- deliver, administer, and monitor medication,
- assist service users with daily living issues e.g. housing, caring responsibilities, benefits,
- assist carers/family members by providing information and practical support,
- deliver interventions which promote the development of self-management techniques enabling service users and their carers/families to maximise their resilience reducing their vulnerability to crisis,
- assist service users in compiling plans that identify relapse indicators and define what to do in the event of a crisis.

- ensure that plans are shared with primary care, G.P. and others as appropriate,
- develop links to a range of respite options,
- if required facilitate transitions to psychiatric in-patient resources that enable service users to access lowest stigma/least restrictive environments,
- facilitate transfer or discharge of care to the most appropriate resource, ensuring that support options are available to service users and information relating to care episodes is communicated to relevant parties,
- actively involve service user and carer/family throughout the period of engagement, from referral through to discharge.

Staffing

Staff who will oversee the assessment and support of service users referred to this service shall:

- Hold a recognised medical, nursing, social work, occupational therapy, or psychology qualification with a level of skill and knowledge appropriate for the assessment and subsequent engagement with service users and their carers/family members,
- In addition, the provider will employ additional staff to provide relevant support to service user's and carers/family members under the appropriate clinical, professional and management supervision of one or more of the above,
- The service must have 24-hour access to senior psychiatrists to carry out assessments in locations outside of hospital settings.

Communication

- The provider will ensure that it provides all the information specified by the commissioner and that it communicates effectively and regularly with stakeholders.
- Service users and where appropriate their carer/family members will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.
- All members of care teams supporting service users will receive copies of Care Plans, Risk Management Plans, Relapse Prevention Plans, and Crisis Intervention Plans and be active participants in the assessment, intervention planning, reviewing and discharge processes.

Days/Hours of operation

The service will operate 7 days a week, 24 hours a day,

The team (as described above) will be available 24 hours a day to undertake home visits to service users who are known to specialist mental health services.

Care Pathways – See Documents to be Relied on Schedule 5A

3.3 Population covered

The service shall cover the operational boundaries of all the South Staffordshire CCG's including Stafford & Surrounds, Cannock Chase, East Staffs, South East Staffs and Seisdon.

3.4 Any acceptance and exclusion criteria and thresholds

Accessibility/acceptability

Referral criteria & sources

The service shall respond to requests for the assessment of adults aged 16 years or above (with no upper age limit, who are undergoing a crisis where mental illness appears to be a dominant factor. The service user must be aware of and agree to the referral to CRHT and must be able to give informed consent to receiving the service once referred (where capacity to make that decision exists).

The service shall respond to direct crisis referrals via Single Point of Access from primary care, community mental health and social care teams, Approved Mental Health Professionals, staff on inpatient wards, the criminal justice system, non-statutory agencies,

former service users and their family/carers, Accident + Emergency departments and other parts of the acute medical service.

Referral route

Referrals will be received in-hours via SPA and out-of-hours via CRHT providing, through both pathways, access 24 hours a day, 7 days a week, following which service users will be supported to engage in a comprehensive assessment of their needs,

Response time & detail and prioritisation

The service user will be contacted within 1 hour of the crisis referral being received by the CRHT team with the aim of establishing face to face contact with the service user wherever possible within 2 hours but certainly no later than 4 hours after time of referral to CRHT unless an alternative timescale is agreed with the referrer. If this is not achieved reasons why will be communicated to the referrer and an agreed plan will be documented.

Service users will be discharged from the service when the outcomes detailed on their care plan which relate to the service have been achieved.

Discharges will only occur following a review of service interventions and presenting circumstances, outcomes will be communicated to all agencies that have a role in interventions including General Practitioners.

If the service user requires to be supported by specialist mental health (for example by the Community Mental Health Team) following the intervention outcomes where CRHT had a role in those being achieved, the Care Co-ordination responsibility, if the home treatment service provided this function, will be allocated to an alternative, suitably qualified named individual. CRHT staff will work collaboratively with other professionals/teams to support take up by CPN or consultant as an outpatient in a timely fashion (target for CMHT response is 4 weeks)

Exclusion criteria

The service shall focus on assisting service users whose mental health issues are having such a significant impact on their lives that they could potentially be admitted to hospital. To determine this all service users (and carers/family members) referred to the service will engage in a comprehensive assessment of their presenting needs.

If the assessment does not identify the acceptance criteria outlined then this service is not usually appropriate and teams are less likely to be able to offer intensive support for the following conditions;

- Mild anxiety disorders,
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia
- Primary diagnosis of Learning Disabilities
- Recent history of self-harm but not suffering from a psychotic illness or severe depressive illness
- A crisis related solely to relationship issues

If following the assessment there is ambiguity about the appropriateness of service intervention, the service will provide support during the episode of crisis. The list above is not an exclusion criterion; the service will operate in dynamic environments with complex presentations of need. The decision to provide support will be based on recorded clinical judgement in response to service users presenting needs. If a referral is inappropriate then this should be documented and communicated to the referrer and/or the GP detailing why this decision has been reached and suggesting alternative pathways that might be followed.

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal

| | |
|--|---|
| Justice System. BME communities. Emergency Duty Service, Staffordshire & Stoke on Trent Partnership Trust. | |
| 4. | Applicable Service Standards |
| 4.1 | Applicable national standards (eg NICE) |
| 4.2 | Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) |
| 4.3 | Applicable local standards All relevant NICE Guidance complied with |
| 5. | Applicable quality requirements and CQUIN goals |
| 5.1 | Applicable Quality Requirements (See Schedule 4A-C) |
| 5.2 | Applicable CQUIN goals (See Schedule 4D) |
| 6. | Location of Provider Premises |
| The Provider's Premises are located at: | |
| 7. | Individual Service User Placement |
| | |

| | |
|----------------------------------|---|
| Service Specification No. | MH17 |
| Service | Psychiatric Liaison Service |
| Commissioner Lead | Nicky Bromage |
| Provider Lead | Lisa Agell |
| Period | April 2019 – March 2020 |
| Date of Review | As and when required by either Commissioner or Provider |

1. Population Needs

1.1 National/local context and evidence base

Policy context

- National Service Framework Mental Health DH 1999
- National Service Framework Older People DH 2001
- Managing Urgent Mental Health Needs in Acute Hospitals, Academy of Medical Royal Colleges, 2008
- NICE Guidance on Self Harm
- HM Government (2011). No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London: Department of Health.
- Aitken, P. (2007). Mental health policy implementation guide: liaison psychiatry and psychological medicine in the general hospital. London: Royal College of Psychiatrists
- NHS Confederation (2009). Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation.
- Closing the Gap: Priorities for Essential Change in Mental Health (Feb 2014)
- Mental Health Crisis Care Concordat (Feb 2014)
- The NHS Belongs to the people: A call to action

Local strategic context

- Staffordshire and Stoke on Trent Adult Mental Health Strategy 'Mental Health is everybody's business' 2014-2019
- Staffordshire Strategic Needs Assessment – Working Together for Better Health 2012

| People aged 65 and over predicted to have severe depression, by age, projected to 2030 | | | | | |
|--|---------|---------|---------|---------|---------|
| | 2014 | 2015 | 2020 | 2025 | 2030 |
| People aged 65-69 | 56,400 | 56,700 | 50,900 | 53,600 | 61,800 |
| People aged 70-74 | 43,200 | 45,200 | 53,600 | 48,400 | 51,200 |
| People aged 75-79 | 32,800 | 33,800 | 40,900 | 49,000 | 44,600 |
| People aged 80-84 | 22,800 | 23,300 | 28,100 | 34,500 | 41,900 |
| People aged 85-89 | 13,500 | 14,000 | 16,900 | 21,000 | 26,400 |
| People aged 90 and over | 7,700 | 8,100 | 10,500 | 14,000 | 18,900 |
| Total population 65 and over | 176,400 | 181,100 | 200,900 | 220,500 | 244,800 |
| Figures may not sum due to rounding. Crown copyright 2014 | | | | | |

| People aged 65 and over predicted to have depression, by age and gender, projected to 2030 | | | | | |
|--|------|------|------|------|------|
| | 2014 | 2015 | 2020 | 2025 | 2030 |
| | | | | | |

| | | | | | |
|--|--------|--------|--------|--------|--------|
| People aged 65-69 predicted to have depression | 4,735 | 4,763 | 4,278 | 4,506 | 5,191 |
| People aged 70-74 predicted to have depression | 3,558 | 3,722 | 4,419 | 3,990 | 4,229 |
| People aged 75-79 predicted to have depression | 2,781 | 2,858 | 3,445 | 4,129 | 3,759 |
| People aged 80-84 predicted to have depression | 2,146 | 2,194 | 2,639 | 3,254 | 3,942 |
| People aged 85 and over predicted to have depression | 1,916 | 1,997 | 2,429 | 3,057 | 3,923 |
| Total population aged 65 and over predicted to have depression | 15,136 | 15,534 | 17,210 | 18,936 | 21,044 |
| Figures may not sum due to rounding. Crown copyright 2014 | | | | | |

| | | | | | |
|---|--------|--------|--------|--------|--------|
| People aged 18-64 predicted to have a mental health problem, by gender, projected to 2030 | | | | | |
| | 2014 | 2015 | 2020 | 2025 | 2030 |
| People aged 18-64 predicted to have a common mental disorder | 82,304 | 82,129 | 81,300 | 80,356 | 78,887 |
| People aged 18-64 predicted to have a borderline personality disorder | 2,299 | 2,294 | 2,270 | 2,243 | 2,201 |
| People aged 18-64 predicted to have an antisocial personality disorder | 1,799 | 1,797 | 1,783 | 1,766 | 1,740 |
| People aged 18-64 predicted to have psychotic disorder | 2,045 | 2,040 | 2,019 | 1,996 | 1,959 |
| People aged 18-64 predicted to have two or more psychiatric disorders | 36,848 | 36,774 | 36,418 | 36,011 | 35,379 |
| Figures may not sum due to rounding. Crown copyright 2014 | | | | | |

Self-harm admissions

Nationally self-harm is one of the top five causes of acute medical admission and those who self harm have a one in six chance of repeat attendance at A&E within the year. During 2010/11 there were over 1,500 admissions due to self-harm in Staffordshire with overall rates being similar to the national average. However self-harm admission rates in Cannock Chase, East Staffordshire and Stafford are higher than the England average.

Self harm is often an expression of personal distress and there is a significant and persistent risk of future suicide following an episode of self harm

Although suicide rates have fallen nationally, in recent years they did show an upward trend in the south, where between 2006 and 2009 the number of suicides and undetermined injuries doubled from 36 to 73. The 2010 data shows that the numbers have fallen in the south (35 suicides and injuries undetermined). Suicide rates for men are over treble those for women.

National Context

- mental disorder accounts for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions
- self-harm accounts for between 150,000 and 170,000 A&E attendances per year in England
- MUS may account for up to 50% of acute hospital outpatient activity
- 13–20% of all hospital admissions and up to 30% of hospital admissions via A&E at weekends are related to alcohol
- in England, alcohol-related hospital admissions doubled in the 11 years up to 2007, and alcohol-related deaths also doubled in the 15 years to 2006

- one quarter of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not treated while the patient is in hospital.
- most patients who frequently re-attend A&E departments do so because of an untreated mental health problem
- two thirds of NHS beds are occupied by older people, up to 60% of whom have or will develop a mental disorder during their admission.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

| | | |
|-----------------|---|--|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | |
| Domain 4 | Ensuring people have a positive experience of care | |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | |

2.2 Local defined outcomes

The quality outcomes of liaison services include:

- improved service user experience and care outcomes
- improved access to mental health care for a population with high morbidity
- reduced emergency department waiting times for people with mental illness
- reduced admissions, re-admissions and lengths of stay
- reduced use of acute beds by patients with dementia in Burton General Hospitals Trust (Mid Staffs General Hospital Trust commission a dementia service separately).
- reduced risk of adverse events
- enhanced knowledge and skills of acute hospital clinicians
- improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)
- improved compliance with NHS Litigation Authority Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST).

3. Scope

3.1 Aims and objectives of service

The general remit of the Liaison Psychiatry Service is, and the

- All those involved in providing the service shall acknowledge and respect service user and carer's gender, sexual orientation, age, race, religion, culture, lifestyle and values. The service will be non-discriminatory and anti-oppressive by way of service delivery and Equality Impact Assessments will be completed as appropriate.
- The Service will be provided within the principles defined by Refocusing the Care Programme Approach; *Policy and Positive practice Guidance*; DOH (March 2008) which are:

- The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, and goals and aspirations as well as their needs and difficulties. It recognises the individual first and patient/service user second.
- Care assessment and planning views a person in 'the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical well-being.
- Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate equitable and co-ordinated care. The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.
- Care planning is underpinned by long term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.
- to offer full psychosocial assessment
- provide time limited interventions
- develop aftercare packages based on individual need for service users aged 16 and over who have a mental health concern and are in-patient. Including the A&E department.

Objectives:

- Support service users by building on their strengths, maintaining their levels of independence and promoting well-being
- Provide prompt and expert holistic mental health assessment of people presenting in A&E departments referred by the department to the service
- Provide effective, evidence-based treatments to reduce and shorten distress and suffering.
- Ensure that inappropriate or unnecessary treatments are avoided
- Ensure the care is delivered in the least restrictive and disruptive manner possible.
- Assist service users and carers in accessing support, both to reduce distress but also to maximise personal development and fulfilment.
- Provide advice and support to service users, families and carers.
- Establish an understanding of local resources relevant to support of individuals with mental health issues and promote effective interagency working.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.
- Reduce the stigma associated with mental health care

Establish effective liaison with local Community Mental Health and Social Care, Crisis Resolution and Home Treatment, Assertive Outreach, and Early Intervention teams to establish processes to signpost appropriate cases.

3.2 Service description/care pathway

Service description/ care package- overview ie what is provided

Dependant on the review of the current model and performance of the Liaison Psychiatry Service as highlighted in the current Service Development Plan which forms part of the South Staffs Commissioning Intentions, this section (and others within the document) is subject to change. Any proposed changes need to be agreed between the Commissioners and the Provider.

| Key component | Key Elements | Comments |
|---|--|---|
| <p>ASSESSMENT – Working in collaboration with Medical Team</p> | <ul style="list-style-type: none"> • Initial screening and discussion to ensure service is appropriate for the patient • Full psychosocial assessment • If appropriate, make referral to other services and ensure adequate continuity of care • Physical health assessment where appropriate • If appropriate, multi-disciplinary assessment of service user's needs and level of risk • Assessment should actively involve the service user, carer / family and all relevant others e.g. GP • Substance Misuse • Older Person Mental Health Issues • Risk Assessment • Medication Management | |
| <p>1.1.1 PLANNING Working in collaboration with Medical Team</p> | <ul style="list-style-type: none"> • Produce a focused care plan • Begin discharge planning at an early stage • After care plans • Follow – up with relevant services | <ul style="list-style-type: none"> • Team approach and team decision making • Active involvement of the service user • Include input from family / carers • Care Plan must be flexible enough to respond rapidly to changes in the clinical situation |

| | | |
|--|---|---|
| 1.1.2 INTERVENTION Team Approach | <ul style="list-style-type: none"> Responsible for co-ordinating the service user's care in collaboration with medical team Provides continuity of care and ensures effective communication within the team | <ul style="list-style-type: none"> Service user and family / carers involved in |
| On-going support | <ul style="list-style-type: none"> Frequent contact throughout in-patient stay for new referrals AND service users already known to mental services Ongoing risk and needs assessment Service must have the capacity to follow service user throughout in-patient stay | |
| Medication | <ul style="list-style-type: none"> Care designed to improve concordance (co-operation with treatment) Service user involved in decision making and monitoring effects of medication Side effect monitoring to be done regularly by service user and staff Advice to General Hospital staff regarding use of psychotropic medication | <ul style="list-style-type: none"> Staff need training in medication management Links with hospital and local pharmacies required to ensure evidence based practice Careful attention to avoiding / reducing side effects vital if engagement and concordance are to be maintained |
| Family / carer support | <ul style="list-style-type: none"> Ongoing explanation to family / carers Education about the service user's illness Arrange practical help as needed | <ul style="list-style-type: none"> Involvement of carers / family and provision of support during in-patient stay are key components of recovery |
| Co-ordinate Care/Linking services | <ul style="list-style-type: none"> Ensure high level of communication and smooth transition between services whether statutory or non statutory Liaise with other services to ensure continuity of care | |
| Interventions aimed at increasing resilience | <ul style="list-style-type: none"> Range of therapies for both service user and family / carers should be available including: -Problem solving | |

| | | |
|---|---|---|
| | <ul style="list-style-type: none"> -Motivational interviewing -Stress Management -Brief supportive counselling <ul style="list-style-type: none"> • Interventions aimed at maintaining and improving social networks | |
| Crisis management | <ul style="list-style-type: none"> • Hospital staff to have understanding of when to call for help • Out of hours for in-service users, on-call Consultant Psychiatrists are available • Out of hours for A&E Crisis Resolution Team are available | <ul style="list-style-type: none"> • Easy access to help 24 hours a day |
| 1.1.3 DISHCHARGE Plan/Links with others | <ul style="list-style-type: none"> • Discharge planning should begin early • Information about the mental health issue, interventions and ongoing care should be exchanged with relevant others (GP, CMHT) • Discharge possibilities will be dependant on clinical situation and local service provision but could include transfer of care to: <ul style="list-style-type: none"> ○ Primary Care ○ Assertive Outreach Team ○ Early Intervention Team ○ Continuing Care ○ Other Mental Health Services ○ Non statutory agencies | <ul style="list-style-type: none"> • Prior to discharge the team should ensure that: <ul style="list-style-type: none"> ○ There is a good understanding (service users, family, carers, relevant others) of why the mental health issue has occurred and how it could be avoided in future ○ Coping strategies have been explored with the service user and family / carers ○ Service user / family / carers have had the opportunity to express their views about the service and contribute to service improvement |

Close links with statutory and non statutory agencies are essential for Liaison Psychiatry so that:

- Handover and referrals are made easily
- Crises are anticipated and contingency plans are known to all involved in care
- Staff from the Crisis Resolution Team and Liaison Psychiatry Teams are clear about the close working practices shared between the teams

Discharge process

Once psychological assessment and plan of care is identified there is liaison with A and E Multi disciplinary team to ensure that service user is medically fit and an appropriate pathway is then initiated

Skill mix

The team will be skilled and welcoming and will have a good understanding of clients needs and will have a range of skills and the appropriate accredited training

STAFFING

| | |
|---|--|
| <p>Key skills</p> <ul style="list-style-type: none"> • High energy level • Team Player • Ability to creatively engage service users • Understanding of needs of service users, including specific needs related to cultural background / age / gender etc • Able to co-ordinate and provide broad range of interventions | <ul style="list-style-type: none"> • CNS/Team Leader • Liaison Mental Health Nurses • Sessional Consultant Psychiatrist |
| <p>Medical Staff</p> <ul style="list-style-type: none"> • SHO's active members of the team via clinical placement • 24 hour access to senior psychiatrists via on-call system-St. Georges (ext 5000) | <ul style="list-style-type: none"> • Involvement from both sessional Consultant Psychiatrist and Junior Doctor |
| <p>Administrative and Clerical</p> | <ul style="list-style-type: none"> • Admin support |

Training/ Education/ Research activities

The team will comply with the Trust's mandatory training programme and all staff will have appraisals at which training needs are identified

All staff will have the opportunity to take part in appropriate research and audit activity

Training opportunities provided by the Liaison team include:

- Understanding self-harm
- Working with people who self-harm
- Older people's needs
- Mental capacity
- SHO induction (Acute and Psychiatric)

Training provided to the liaison staff includes:

- Vulnerable adult training
- Child Protection training
- Equality and Diversity training
- Nurse Prescribing
- Medication Management

- Motivational Interviewing
- Values and Psychosocial Intervention
- AMSPAR(admin training)
- Certificate in Mental Health
- Values and Psychosocial Intervention
- AMHP course
- Physical Health in Mental Health Care
- Nurse Prescribing
- Psychosocial Intervention
- Leadership Role in Quality, Innovation & change
- Occupational Therapy Training
- Infection Control training
- Health and Safety training
- Lifting and Handling
- First Aid
- Carer support training
- Family Therapy
- Customer service training
- Dual diagnosis training
- Mental Health Act
- Fire Safety training
- Mappa
- SUI training
- Complaints training
- Learning Lessons event

3.3 Population covered

Service users attending County Hospital Stafford, Queens Hospital Burton, Robert Peel Tamworth, and Samuel Johnson Lichfield.

3.4 Any acceptance and exclusion criteria and thresholds

Service user groups covered (including care clusters, where relevant)

- Adults (16 years to end of life)
- Covering the whole range of Mental Health Issues
- In-service users (including A & E)

Exclusion criteria

This service is not usually appropriate for individuals without mental health difficulties and who suffer with:

- Primarily Learning Disabilities
- Uncomplicated bereavement issues
- Relationship issues
- Housing & Benefit issues
- Violent tendencies

However all referrals will be discussed at the time of referral

Days/ hours of operation

County Hospital:

Monday to Friday, 9:00 – 17:00 excluding Bank Holidays

Out of hours operation via crisis resolution and home treatment teams and duty psychiatrist (through Access Service)

Queen's Hospital Burton (including community hospitals):

Monday to Saturday 8:30 – 16:30 excluding Bank Holidays

Out of hours operation via crisis resolution and home treatment teams and duty psychiatrist (through Access Service)

Referral processes

- Telephone access (pager)
- Written referral accepted to team base

Response times

Emergency: an acute disturbance of mental state and/or behaviour which poses a significant, **imminent** risk to the patient or others. **These service users should be seen within 60 minutes.**

Urgent: a disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement. Or, service users who are judged medically fit for discharge from an acute hospital but require a mental health assessment before leaving. **These service users should be seen within one working day.**

Routine: all other referrals, including service users who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge. **These service users should be seen within two working days.**

3.5 Interdependence with other services/providers

This is not an exhaustive list but demonstrates the breadth of relationships required to provide an effective service:

Public Health, Health Protection, Health Promotion, Primary Care, Education, Community Development, Housing, Welfare Rights, Employment, Secondary Care Mental Health, Safeguarding, Mental Capacity Act, Alcohol Services and Substance Misuse. Criminal Justice System. BME communities.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

This is not intended to be an exhaustive list

NICE (2009). *Depression with a chronic physical health problem: the treatment and management of depression in adults with chronic physical health problems* (partial update of CG23). Clinical guidance 91. London: NICE.

Anxiety: <http://guidance.nice.org.uk/CG22/Guidance/pdf/English>

Dementia: <http://www.nice.org.uk/nicemedia/pdf/CG042NICEGuideline.pdf>

Depression: <http://www.nice.org.uk/nicemedia/pdf/CG23fullguideline.pdf>

Drug misuse: <http://guidance.nice.org.uk/CG51/NiceGuidance/pdf/English>

Schizophrenia: <http://www.nice.org.uk/nicemedia/pdf/CG82FullGuideline.pdf>

Self-harm: <http://guidance.nice.org.uk/CG16/Guidance/pdf/English>

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Aitken, P. (2007). *Mental health policy implementation guide: liaison psychiatry and psychological medicine in the general hospital*. London: Royal College of Psychiatrists

Quality Standards for Liaison Psychiatry Services. Royal College of Psychiatrists 2011.

4.3 Applicable local standards

| |
|--|
| |
| 5. Applicable quality requirements and CQUIN goals |
| 5.1 Applicable Quality Requirements (See Schedule 4A-C) |
| 5.2 Applicable CQUIN goals (See Schedule 4D) |
| 6. Location of Provider Premises |
| The Provider's Premises are located at: County Hospital , Stafford Queen's Hospital, Burton |
| 7. Individual Service User Placement |
| |

SERVICE SPECIFICATION - RRE-01291 – Out Of Hours Home Sitting Service (Mental Health)

| | |
|---------------------------|--|
| Service | RRE-01291 – Out Of Hours Home Sitting Service (Mental Health) |
| Head Provider Lead | Midlands Partnership NHS Foundation Trust |
| Period | 3 Years with an option to extend for 1 x 12 month period |
| Date of Review | 6 months |

Service Summary

Midlands Partnership NHS Foundation (MPFT) are looking to procure a non-clinical service for the provision of an Out of Hours Home Sitting Service for 3 Year period with an option to extend for 1 x 12 month periods. The service will work in partnership with clinical teams.

The service is required to deliver:

- Support people to remain as independent as possible in their own homes
- Support people in place of safety
- Provide respite for care

The Out of Hours (OOH) Home Sitting Service will be an 'on call' type approach service located onsite at 2 MPFT site locations. The service will attend service user's home; or place of safety to release clinical staff during out of hours and weekends. An assessment will be carried out by a MPFT clinical staff member before the OOH Home Sitting Service attends.

The service will not be required to deliver clinical interventions and all service users will be known patients to MPFT and have received a mental health assessment.

The main aims for the service are for service users to remain safely in their own home environment, or alternative environment and provide further support and respite to carers and relatives. If there are no call out during the out of hours shift, the staff will provide non-clinical support other mental health teams.

1. Purpose

1.1 Aims

The service aims to achieve the following outcomes for service users:

- Support known MPFT service users OOH.
- Increased reassurance to Carers and families, by providing a trusted environment for Service Users enabling them to make informed choices about the care they receive
- Improved/maintained health and emotional well-being through increased independence, and quality of life
- Support people to remain as independent as possible in their own homes or alternative environment.

1.2 Evidence Base

The provider will ensure it adheres to the following minimum standards:

- Will follow Midlands Partnership NHS Foundation Trust's local policies and guidance which can be issued upon request
- Ensure the service provided is from a qualified NVQ Level 3 in Health and Social Care, preferably with Mental Health background
- Will follow all legislation as well as guidance, circulars and publications issued by the Department of Health in relation to the transformation and personalisation of public services in health and social care and be responsible for complying with the requirements of all applicable enactments including but not limited to those outlined in Appendix 2

1.3 Expected Outcomes

| | | |
|-----------------|---|----------|
| Domain 1 | Preventing people from dying prematurely | X |
| Domain 2 | Enhancing quality of life for people with long-term conditions | X |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | X |
| Domain 4 | Ensuring people have a positive experience of care | X |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | X |

2. Service Scope

2.1 Service Description

2.1.1 General Overview

The awarded contractor will provide 5 WTE recovery /support workers qualified NVQ Level 3 in Health and Social Care, all will be required to attend service user's homes or alternative environment within the Southern Staffordshire area. The services will be provide form either St Michaels Court Hospital, Trent Valley Road, Lichfield, WS13 6EF and attend St George's Hospital, Corporation St, Stafford ST16 3SR, including possible support to the 136 Suit at St George's Hospital.

The Service should be sensitive, efficient, flexible and effective when responding to the differing and changing needs of each Service User. The Provider will meet the individual's outcomes specified in the Service User's Plan or as prescribed by the MPFT Clinicians.

2.1.2 Specified Tasks

The OOH Home Sitting will need to implement the action in the service user's plan set out by clinicians, and will need to provide the interventions below:

- Advice and guidance
- Reassurance
- De-Escalations (for services users with heightened sense of anxiety)
- Carer support & respite
- Prompting and supporting adherence to medication
- Brief interventions
- Risk management
- Physical Health checks as directed by the MPFT clinician

- Assisting with personal care and meaning full activity of daily living

The service will also be required to complete the administrative tasks, to include but not limited to:

- Service User updates to the Trust's clinical system i.e. Data Entries
- Making & receiving calls to/from medical professionals & service users whilst supporting onsite

MPFT will provide the IT equipment and licenses to support this. This does not include a telephone, the provider will be required to provide this to the staff providing the service.

2.1.3 Service Principles

The Provider will ensure that their staff and organization adhere to the principles of Personalisation, enabling people to undertake as many tasks as possible for themselves in line with their stage of development. The communication needs of the Service User and their preferred methods of communication should be understood and adhered to. Where a Service User is clearly unable to express a choice, an appropriate advocate must be sought.

Care and support services will be provided in a way that maintains and respects the privacy, dignity and lifestyle of the Service User at all times.

Both the Service User and any Carer will be treated with due respect to their race, culture, religion, disability, gender and sexual preference, and will not experience any form of discrimination.

Service Users will be supported to make decisions for themselves as far as possible.

Service Users will not be supported to make unwise and eccentric decisions without being judged as lacking capacity.

Decisions made on behalf of people who lack capacity will be made in the best interests of the Service User.

All decisions made on behalf of a person without capacity will be the least restrictive alternative

The Provider will ensure that personal care is always offered sensitively, discreetly and in a way, which respects the dignity and preferences of the Service User in the least intrusive way.

2.1.4 Risk Assessments

Clinical, Therapy and Environmental Risk assessments will be completed by the Trust; All handling must be carried out in accordance with the recommendations of the manual handling assessment (provided by the Trust) except in a life threatening or emergency situation. If an emergency can be foreseen, (e.g. person identified as at risk from falls or fire) a plan will be put in place. MPFT will be a trusted assessor, there will be no requirement for Providers to complete assessments prior to a service commencing.

2.1.5 Personal Care

The provider shall ensure that when the Service User cannot meet their own personal care needs, that personal care and support tasks are undertaken/ supported by a competent worker, suitably trained and experienced in such enablement tasks so as to promote the dignity, hygiene, comfort, wellbeing and independence of the Service User. The Worker should undertake such tasks with all due regard to Health and Safety and with the aim

of sustaining and wherever possible, improving the level of independence of the cared for person.

The provider must ensure that the care which it provides to each Service User complies with the requirements of their individual Support Plan (subject to any contrary instruction in writing from the Trust, or any contrary agreement in writing between the parties, in relation to the Service User in question) and is likely to achieve the outcomes specified in that plan.

Should a Service User request to have the same gender staff to provide intimate personal care, the Provider will seek to meet this request if it is possible. Where this is not possible it should be discussed and agreed with the Service User and Carer.

2.2 Training & Education

All staff who provide the service via the provider, will be required to follow MPFT's training expectations which have been listed below. Any staff who have a professional qualification will be supported to be competent and maintain their professional scope of practice. However if adequate training has been completed prior to the start of the contract i.e. external training which covers the training expectations, this will be discussed upon implementation to avoid any duplication.

- Undertake any Assistive Technology (AT) training and maintain awareness through regular updates, linking in to local resources and support mechanisms as required
- De-escalation Management & Intervention (DMI) Training which will be required for In-Patient, Ward and Community based settings
- 136 suit induction process which will be provided to the awarded provider during the implementation period
- MPFT Mandatory Training via ESR e-Learning
 - Local Induction
 - Corporate Induction
 - Promoting Safe and Therapeutic Services
 - Data Security Awareness - Level 1
 - Equality, Diversity and Human Rights - 3 Years
 - Fire Safety - 1 Year
 - Health and Safety - 3 Years
 - Infection Control - Level 1 - 1 Year
 - Prevent Awareness - 3 Years
 - Preventing Radicalisation - Awareness of Prevent (Level 3)
 - Safeguarding Adults Level 2 - 3 Years
 - Safeguarding Children Level 2 - 3 Years
 - Clinical Risk Management

The provider contracted will undertake the necessary checks on its staff and volunteers who are directly involved with performing the Contract i.e. two (2) references and an enhanced DBS and any other safeguarding requirements coming into effect to the extent that this is a statutory requirement relating to the Service.

The role will be given regular support and supervision by a suitably qualified manager/team leader on a continual basis. They will receive performance development reviews to identify training and development requirements and ensure this is implemented in a timely manner. In addition they will be kept up to date and informed of any changes in appropriate legislation relating to the services being provided, by MPFT and the contract provider will be notified.

3. Service Standards and Requirements

3.1 Minimum Standards and Evidence Based

- Midlands Partnership NHS Foundation Trust's local policies and guidance which can be issued upon request
- Ensure that the service is provided by a qualified/ working towards NVQ Level 3 in Health and Social Care, or by a person with evidenced experience in health and social care. Preferably in Mental Health.
- Shall have regard to all relevant legislation as well as guidance, circulars and publications issued by the Department of Health in relation to the transformation and personalisation of public services in health and social care and be responsible for complying with the requirements of all applicable enactments including but not limited to those outlined in Appendix 2.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The services will be based from either St Michaels Court Hospital, Trent Valley Road, Lichfield, WS13 6EF and attend St George's Hospital, Corporation St, Stafford ST16 3SR, including the 136 Suit at St George's Hospital. During the out of hours, the services will be limited to Southern Staffordshire.

The service will be provided from within Services Users own homes based in Stafford and Surrounding Areas, Burntwood, Lichfield and Tamworth. Travelling time must not be deducted from allocated visit duration provided within the relevant Service User's Plan.

The Provider shall be responsible for arranging transport, insurance, relevant travel equipment and all other requirements needed for travel to and from the Service Users' own home. The Provider shall use its best endeavours to minimise the travel time required between Service Users.

The Provider shall also fully participate in any consequential accident investigations.

4.2 Days/Hours of operation

MPFT require the service to be Out of Hours 7 days a week. The hours that will be covered are:

Monday to Friday 16:30 – 24:00

Saturday to Sunday 12:00 – 24:00

4.3 Incoming service users and prioritisation

All referrals for the Out of Hours Home Sitting Service 'on call' will be via MPFT clinicians who will prioritise and delegate the case appropriately. There may be occasions where there is more urgent cases, however this will be decided by the clinicians and then allocate the work to the staff provided by the successful provider.

If there is no call out during the out of hours shift, the staff will offer support to MPFT mental health teams as directed.

5. Governance and Continuity arrangements

5.1 Clinical Governance Arrangements

The provider will have policies, procedures and systems as appropriate to assure the standards of competences of staff that they employ. This will include but not be limited to:

- i) Employment of appropriately qualified staff
- ii) Compliance with statutory and other national requirements,
- iii) Compliance with professional standards e.g. participation in Quality Assurance and Accreditation schemes and child protection.

5.2 Data Protection and Governance

Personal data provided by service users as part of the triage and testing process will be stored and protected according to GDPR legislation. Secure access to the database will be given to clinical staff in accordance to Trust IG policy.

5.3 Complaints

A formal process will be in place to deal with incidents / complaints as they occur, including central reporting and the notification of occurrences to the Trust(s) within 24 hours. Formal notification will be made to the Trust representative who will inform the relevant systems within the organisation. The Service Provider and Trust(s) will then engage in the joint resolution of complaints and incidents. For service users, complaints and comments will be dealt with as with any other NHS service, following NHS guidelines

5.4 Continuity arrangements:

- 5.4.1 Minor disruption (1 day)** - The Sub-Contractor will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate, then control of the incident will be undertaken locally.
- 5.4.2 Medium/short term (2-7days) disruption** - Where the incident is deemed to result in minor disruption to the service, and the incident is unlikely to escalate, the Sub-Contractor will then inform the Head Provider and of the decision to manage the incident locally.
- 5.4.3 Major/long term (>7 days) disruption** - Where the incident is deemed to result in a major/long term disruption to the service, the Sub-Contractor must inform the Head Provider immediately and convene a meeting to discuss the continuity of the service

5.5 Exit Arrangements

At the end of the contracted period, an end-of-contract meeting will be held between the Service and Provider to determine an exit plan to ensure the continuity of provision for the Service. The discussion will focus on:

- Last day of the service
- Arrangements on any outstanding notes or patients
- Providing all reasonable assistance and information as the Trust may require to enable it to re-procure the services or transfer the services to an alternative service provider.
- Lessons learnt feedback (both parties)

5.6 Contract Management

A dedicated account manager should be available to help and support the Trust where possible. The dedicated account manager and support team must be able to support the service and call on relevant expertise to support aspects of the contract as and when required. There should be mechanisms in place to ensure continuity of a dedicated account management team. Review meetings will cover all management information as agreed with the Trusts' project team. Where the service or performance provided by the provider falls below the required

level then the account manager shall ensure that appropriate support is provided to the Trust.

The below reports are required to support with the contract management meetings which will be held monthly for the first 3 months, then decreased to every other month until end of year 1. When year 2 begins, the contract management meetings will be scheduled in quarterly.

Key Performance Indicators may be subject to change at the request of the Trust following contract implementation.

KPI reporting data should be received by the Trust Representative(s) by the 10th working day of each month and is the responsibility of the Service Provider to generate this report.

Should the Service Provider's performance standard fall below the levels indicated in the KPI matrix on three successive months, the Trust would look to remedy the situation by enacting clause 15 of Schedule 2, The General Terms and Conditions (NHS Terms and Conditions for Provision of Services).

Key Performance Indicators:

| Report Required | Timing and Method for delivery of Report | Indicator | Threshold | Consequence of Breach |
|--|--|--|-----------|---|
| Details of any occasion when it has been necessary to restrain a Service User, the measures taken, and the staff responsible. | Monthly Written Report | Number of restraints and name of staff involved | TBC | Contract review meeting |
| Details of any accident causing injury or death, to or inflicted on a Service User, visitor, or any accident sustained by a member of staff when on duty. | Monthly Written Report | Number of injured or death whilst deployed staff on duty and names of staff involved | TBC | Contract review meeting |
| Details and numbers of any material improvement or deterioration in each Service User's health or condition and the development of their social skills, domestic skills and interests. | Monthly Written Report | Number of service users who have improved and/or deteriorated | TBC | Contract review meeting |
| Cancelation of care calls | Monthly Written Report | Number of cancelation of care calls | TBC | Contract review meeting / action plan to be enacted |
| Number of hours delivered per Staff deployed by the provider | Monthly Written Report | Names and hours delivered | TBC | Contract review meeting |
| Number of episodes of Care provided | Monthly Written Report | Names and Number of visits | TBC | Contract review meeting |
| Number of Service Users per Staff deployed by the provider | Monthly Written Report | Names and Number of visits | TBC | Contract review meeting |
| Numbers and details of any | Monthly Written | Number of | TBC | Contract |

| | | | | |
|--|--------|--------------------------|--|----------------|
| complaints/ compliments received, and the result of any complaints | Report | complaints & compliments | | review meeting |
|--|--------|--------------------------|--|----------------|

5.7 Capacity/Workforce

At this moment in time, the capacity of the services required are unknown. This will be reviewed regularly to ensure the service does not get overloaded and therefor avoids the possibility of an unsuccessful service.

The Service Provider will assume responsibility for ensuring that their staff:

- Undertake continuing professional development relevant to their professional duties, and that the Service Provider adheres to the principles of continuous quality improvement informed by the audit process
- Are fully trained to relevant clinical or technical service provisions, relating to mental health, older adults and dementia. The skill mix of the staff working on behalf of the Service Provider will reflect the technical service provided in accordance with good professional practice.
- Will be suitably qualified and appraised regularly to ensure that the tasks assigned are within their known competence and capability
- Meet training expectation requirements as set out by the Trust
- Where applicable staff members would be registered with recognised professional organisations

The Provider shall also ensure that their workforce who are deployed to provide services to Service Users with complex and challenging needs are experienced in a range of approaches that enable effective communication. The Provider shall be able to evidence to the Trust that its Staff have a broad understanding of the issues impacting on people with complex care needs, including (but not limited to) physical disabilities, severe and enduring mental illness and how these issues may impact on service delivery. The Provider shall therefore ensure that its Staff has access to appropriate training.

Effective communication is essential; the workforce should be able to competently communicate in English.

The provider shall ensure that their workforce who are deployed to provide care to the service users are experienced in working with Service Users with a broad spectrum of needs including but not limited to; frail elderly, palliative care and end of life, dementia, physical disabilities, and severe and enduring mental illness who may present with a variety of complex and/or challenging needs/behaviours.

If any of the following occur at any time, the provider shall immediately (and in any event within twenty-four (24) hours of the relevant occurrence) notify the Trust;

- If any Carer or Service User dies
- If any Carer or Service User is absent from their home, or fails to admit support staff to their home to provide support, in circumstances which give cause for concern
- If any Carer or their Service User refuses to give support staff access to their home to enable the Provider to provide them with their Support
- If there are any serious concerns regarding the health, or safety, or welfare, of any Carer or Service User
- If there is a reason to believe that a Carer or Service User is at risk, either through self-neglect, or as a result of their behavior, or the behaviour of others
- A significant change to the needs of any Carer or Service User which may require a review of the care plan of the Carer in question or Service User
- Any positive changes in the situation and/or capabilities of any Carer or Service User
- If a Service User's behavior is a serious threat either to themselves, or to members of staff, then the

Provider must obtain appropriate medical or other intervention (including the Police and other statutory Provider as appropriate) and shall immediately inform the Authorised Officer of the action taken

The Provider must support the safeguarding adults who may be experiencing or at risk of abuse or neglect in line with their desired outcomes (where appropriate). The Provider must raise to the Trust timely safeguarding concerns should abuse or risk of abuse or neglect be suspected.

6. Prices & Costs

6.1 Price

To be included within the commercial schedule.

6.2 Invoicing

Any invoice not complying with the points below will be returned, or be provided with an "on-hold status and the Provider will be contacted by the Trust. The Trust operates on 30 day payment standard terms from date of receipt of invoice. Invoices should be provided as per call off Purchase Order.

Invoices shall:

- be addressed to the organisation;
- be sent to the correct address; Electronic invoices must be sent to APinvoices@mpft.nhs.uk as a PDF Document.
- have The Trusts Purchase order number;
- have the delivery note number, quotation reference (where applicable);
- match the monthly values agreed;
- be submitted in arrears;
- be forwarded to The Trust within 3 days of invoice date.
- be provided with supporting backing data where applicable including summary of usage and interpretations provided.

SERVICE SPECIFICATION – RRE-01315

| | |
|-----------------------|--|
| Service | Housing Support Services |
| Head Provider | Midlands Partnership NHS Foundation Trust |
| Period | Initial duration of 2 years, with an optional further extension of 12 months |
| Date of Review | 6 months prior to the end of the agreement |

Service Summary

Midlands Partnership NHS Foundation Trust have a new ring fenced investment to commission extra support from local and accessible services. This is available to mental health services in recognition of their vital role in responding to the pandemic and supporting some of the most acutely ill and vulnerable patients.

MPFT have developed a Community Mental Health Framework for Adults and Older Adults (CMHF) in line with the NHS Long Term Plan's vision for a place-based, community mental health model. This enables modernisation of community services to offer whole-person, whole-population health approaches, aligned with the Primary Care Networks (PCN).

Co-production will help develop services that combine lived experience with 'traditional' clinical skills. This will facilitate a more person centred service that is focused on the user's needs based on user experience and what is important to them and their general wellbeing.

The framework allows for a shift to a new model of community mental health provision, designed on an asset-based view of communities and integrated working across agencies, rather than a traditional Community Mental Health Team (CMFT) model.

The aim of the Community Mental Health Framework is to:

- Improve access to psychological therapies for those with Serious Mental Illness (SMI)
- Deliver support that is personalised and within a person's community
- Take an asset based approach with an emphasis on self-management and recovery
- Increase the number of people receiving SMI physical health checks
- Increase the number of adults who have access to Individual Placement and Support (IPS)
- Provide integrated models of support configured around the PCNs
- Implement a whole systems pathway supported by Structured Clinical Management for people with a 'personality disorder'
- Reduce occupied bed days within Acute Settings and a reduction in crisis contacts for people with a 'personality disorder'
- Ensure Eating Disorder provision that meets commissioning guidance across the age span

The object of the Housing Support Service provision is to:

- Provide a comprehensive range of housing related support, tailored to meet the needs of customers
- To support service users to access, navigate housing allocations processes and maximise opportunities to live in areas in properties that support their on-going mental health needs
- To support services to sustain tenancies and encourage and facilitate independence, quality of life, health and wellbeing by providing practical advice, information and support on a wide range of issues including housing rights, welfare benefits, personal finance and life skills, to promote personal independence

1. Purpose

1.1 Aims

This specification is for the provision of a Housing Support Services for people with mental health needs in South Staffordshire to enable individuals to have specific support around Housing Options and Allocations which will support their Mental Health recovery journey.

The Service will form a part of an integrated pathway across the voluntary sector, primary and secondary care mental health and social care. It should be based on recovery and social inclusion principles and designed to be accessible and to prevent people falling through gaps between services.

The aim of this service is to provide a variety of quality housing and support services to meet the needs of customers in maintaining and accessing sustainable tenancies, with a particular emphasis on interventions and support within the private rented sector where there is risk of landlord repossession.

This service will assist in the delivery of the Housing Options Service by providing a comprehensive range of housing related support, tailored to meet the needs of customers. This service will also provide inclusive early intervention packages to support and enable customers to access and sustain tenancies and encourage and facilitate independence, quality of life, health and wellbeing by providing practical advice, information and support on a wide range of issues including housing rights, welfare benefits, personal finance and life skills, to promote personal independence.

Another aim will see this service assist with the delivery of all services provided by the Housing Options Team including delivery of the homelessness function with the implementation of the Homelessness Reduction Act 2017

1.2 Evidence Base

Nationally the Mental Health Taskforce Strategy of 2016 which formed the backbone of the government's Mental Health Five Year Forward View 2016 set six overarching objectives aimed at improving the mental health and wellbeing of the whole population and improving outcomes for service users. This strategy also highlighted the need for patient choice and expanding the role of caring for patients in the community as well as ensuring those services commissioned understand and can meet the needs of local people within their own home.

The NHS Long Term Plan identifies that health inequalities are a significant contributor in early mortality for patients with severe mental illness. At a Primary Care Network (PCN) level, health inequalities assessments, coupled with collaboration with local community services will work towards making support available to people where it is most needed including mental health away from hospital unless there is need.

One of the key objectives of the NHS Long Term Plan is to develop "new and integrated models of primary and community mental health care [which] will support adults and older adults with severe mental illnesses". The framework allows for a shift to a new model of community mental health provision, designed on an asset-based view of communities and integrated working across agencies, rather than a traditional Community Mental Health Team model.

Community Development is an approach to creating interventions for people with, or at risk of, mental health problems or a 'relapse' in their mental health in a way which is essentially empowering and ensures interventions take into account people's experiences and expectations. Communities have many assets that can support mental wellbeing, accessibility and reducing stigma.

Further details of the NHS Community Mental Health Framework for Adults and Older Adults can be found here -

<https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf>

1.3 General Overview

1.4 Objectives

This will be a key position within the within the integrated mental health neighbourhood and housing options teams within Borough Councils or significant stock holding providers in the lot areas and will have a major impact on the delivery of services to customer and will influence the achievement of housing and corporate objectives.

1.5 Expected Outcomes

| | | |
|-----------------|---|----------|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | X |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | |
| Domain 4 | Ensuring people have a positive experience of care | X |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | X |

2. Service Scope

2.1 Service Description

Midlands Partnership NHS Foundation Trust (MPFT) are procuring a service for the provision of Housing Support Service. This will cover housing options and allocations, and tenancy sustainment, all of which will be a tailored approach to support people with Mental Health and housing difficulties. There is evidence that housing difficulties, can cause and exacerbate mental ill-health, which could subsequently develop into severe mental health. By supporting an individual's housing worries and concerns at an early stage, it could have a positive impact on their mental health and prevent serious mental illness (SMI) developing. This would reduce additional resources that are currently being utilised and required later in the pathway.

Housing Options and Allocations

This section of the service will be a tailored approach for individuals to help them access and navigate the housing allocations process. It will maximise their opportunities to have a successful housing allocation which will support their specific needs. Such as, encouraging allocation in specific areas that are tailored to their need, to ensure their neighbourhood and community do not make their recovery increasingly difficult, make sure the individual housing accommodation is adequate for their needs and recovery plan.

Tenancy Sustainment

The tenancy sustainment will be to identify how and what the individuals requires to stay in their tenancy as long as possible. For example, support any additional estates type of work that needs to be completed, support and navigate them through the correct processes which help individuals stay protected in their tenancy. The provider will be the conduit between the housing provider and/or the allocation provider to make sure we are providing a combined approach to support the individual's needs.

The key features of this service include an emphasis on Housing options/allocations and tenancy sustainment. The service will:

- Provide a comprehensive range of housing related support, tailored to meet the needs of customers
- To support service users to access, navigate housing allocations processes and maximise opportunities to live in areas in properties that support their on-going mental health needs
- To support services to sustain tenancies and encourage and facilitate independence, quality of life, health and wellbeing by providing practical advice, information and support on a wide range of issues including housing rights, welfare benefits, personal finance and life skills, to promote personal independence
- Be aware of and take advantage of local assets, community support, networks and programmes to help Service Users help themselves and connect with the wider community
- Take into account the individuals strengths, knowledge, experience, skills and utilise family and friends to support and motivate individuals to change their behaviours
- Have strong links with statutory housing teams or stick holding organisations, and have the ability to advocate on behalf of service users
- Provide advice and support directly with people from the communities in Staffordshire via MPFT's Housing Support Service to support underpinning challenges that are related to challenges around housing options and allocations, and tenancy sustainment.
- Capture insight gained in a format that can be easily be shared with all stakeholders (including our communities) and contribute to the broader needs
- Improve outcomes for individuals through using this service, to ensure that the needs of the individuals are met
- To offer practical and emotional support to enable individuals to help themselves to identify needs and issues from all housing worries, concerns and aspects inc. housing options and allocations, and tenancy sustainment . All which a significant impact on an individual's mental health
- An improvement in the health and wellbeing of local people through effective and relevant housing advice with more clients accessing the service at an earlier stage to prevent housing difficulties
- Maximizing joint working with partner organisations to enable a more seamless housing and tenancy advice service to Staffordshire individual's i.e. collaborative asset approach with external organisations who offer additional services and initiatives available for individuals. This will start the development of collaboration within the communities and have a more seamless approach.
- Demonstrate a collective strength to transform the lives of people with mental health needs in communities across South Staffordshire
- Through and inclusive and engaging approach, positively influence whole communities around mental health through collaborative approaches ensure that communities are influenced.
- Addressing inequalities and increasing access to services for under-represented groups.

The service will be divided into 4 lots. There will be no change in the service delivery, only differences between each lot will be based around the below locations:

- Lot 1 - Cannock, Rugeley & great Haywood
- Lot 2 - Stafford & Seisdon
- Lot 3 - East Stafford
- Lot 4 - Burntwood, Lichfield & Tamworth

2.2 Whole System Relationships and Interdependencies

Other services and pathways who will link with the service are:

- Council (Members and Officers)
- External agencies
- General public
- Tenants
- Resident groups
- Statutory housing bodies and teams
- Stock holding organisations

2.3 Training & Education

All staff are advised follow MPFT's training expectations, which may include mandatory safeguarding refresh every 12 months, together with continuous practice development. Any staff who have a professional qualification will be supported to be competent and maintain their professional scope of practice. However if adequate training has been completed prior to the start of the contract i.e. external training which covers the training expectations, this will be discussed upon implementation to avoid any duplication.

The provider contracted will undertake the necessary checks on its staff and volunteers who are directly involved with performing the Contract i.e. two (2) references and an enhanced DBS and any other safeguarding requirements coming into effect to the extent that this is a statutory requirement relating to the Service.

The role will be given regular support and supervision by a suitably qualified manager/team leader on a continual basis. They will receive performance development reviews to identify training and development requirements and ensure this is implemented in a timely manner. In addition they will be kept up to date and informed of any changes in appropriate legislation relating to the services being provided, by MPFT and the contract provider will be notified

3. Operational and referral information

3.1 Location(s) of Service Delivery

The services will be delivered within the communities of South Staffordshire.

- Lot 1 - Cannock, Rugeley & Great Haywood
- Lot 2 - Stafford & Seisdon
- Lot 3 - East Stafford
- Lot 4 - Burntwood, Lichfield & Tamworth

3.2 Days/Hours of operation

The providers will be required to offer four (4) staff to support this service, to work flexibly to meet individual service user needs over 37.5hrs per week, per worker (full time equivalent). This may therefore include some weekend and evening working, exc. bank holidays. The service will operate at times compatible with the needs of service users, where reasonable. The staff will form part of the integrated mental health neighbourhood teams and col-locate with housing options teams within Borough Councils or significant stock holding providers in the lot areas

3.3 Referral processes

Referrals will come via MPFT Mental Health Teams, specific details of this will be picked up within the mobilisation meetings.

4. Continuity arrangements

4.1 Continuity arrangements

- 4.1.1 Minor disruption (1 day)** - The Sub-Contractor will assess the severity of the incident and its possible consequences. If the incident is unlikely to escalate, then control of the incident will be undertaken locally.
- 4.1.2 Medium/short term (2-7days) disruption** - Where the incident is deemed to result in minor disruption to the service, and the incident is unlikely to escalate, the Sub-Contractor will then inform the Head Provider and of the decision to manage the incident locally.
- 4.1.3 Major/long term (>7 days) disruption** - Where the incident is deemed to result in a major/long term disruption to the service, the Sub-Contractor must inform the Head Provider immediately and convene a meeting to discuss the continuity of the service

5. Quality and Performance Standards

5.1 Management of the Contract

Regular meeting initially monthly with a move to quarterly to support the development of the service and support the performance. Initial KPI's have been outlined however further outcome measures are to be determined during the Contract Review Meetings.

The contract review meeting reports shall be sent to all meeting attendees prior to the meeting. If the provider is struggling to recruit / provide the service, or the contract is not delivered as per the contracted agreement, MPFT can withhold the payment. If this occurs, there will be regular contract review meetings that will determine the outcome.

The Provider is expected to continually update Service provision based on Service User need, best practice and evidenced-based interventions, giving consideration of future guidance and local policy.

Key Performance Indicators (KPIs); the below KPIs are not extensive and there is an expectation that the partner provider will work with MPFT to identify key performance indicators over the first year.

5.2 Monitoring Requirements and Key Performance Indicators (KPIs)

| Performance Indicator | Indicator | Threshold | Method of Measurement | Consequence of breach |
|--|---------------------------|-----------|---|--|
| Availability of suitably qualified Staff | 100% | Quarterly | Training records/ cancellations | Contract Performance Review triggered. |
| Financial & Activity Data Report | 100% | Quarterly | Contract reporting Dataset | Contract Performance Review triggered |
| Complaints | 4 per annum | Quarterly | Clinical Quality Performance report within 10 working days of the end of each month | Compliant Review and Investigation – 4 and Under Contract Performance Review triggered – 5 and over |
| Referrals Received | TBC during contract award | Quarterly | Number of referrals received | Contract Performance Review triggered. |
| Housing Advice Provided | FYI / TBC | Quarterly | Types of housing | Contract Performance |

| | | | | |
|---------------------------|---------------------------------|-----------|--|--|
| to Service Users | during contract award | | advice and support given to service users and how many per type | Review triggered. |
| Outcomes | 100% | Quarterly | Contribute towards the positive outcomes of the services users, and how many per type of outcome | Contract Performance Review triggered. |
| Escalations | FYI / TBC during contract award | Monthly | Escalations made to MPFT and/or Provider | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in new integrated model (including primary care, VCS, and MH services) across the core and the dedicated service provision | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Of those receiving 2+ contacts, how many adults and older adults have had at least one contact from NHS-commissioned VCS services | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Of those receiving 2+ contacts, how many adults and older adults have had at least one contact from Individual Placement and Support services | Contract Performance Review triggered. |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in a dedicated 'personality disorder' pathway | Contract Performance Review triggered. |

| | | | | |
|---------------------------|---------------------------------|---------|---|--|
| | | | or service provision (including primary care, VCS, and MH services) | |
| Activity Report (NHS E/I) | FYI / TBC during contract award | Monthly | Number of adults and older adults receiving 2+ contacts in a dedicated community rehabilitation pathway or service provision (including primary care, VCS, and MH services) | Contract Performance Review triggered. |

6. Activity

6.1 Activity in Contract

As this is a new service, it is unclear what the demand will be. This will be monitored once the service has commenced and a review has taken place. Once the service review has taken place, there may be a requirement to insert specific Key Performance Indicators (KPIs) into the contractual documents.

7. Implementation

7.1 Implementation

The implementation of the service will be a collaborative approach across health and social care services including primary, secondary and the voluntary sector, mainly including MPFT, PCN's and the contracted provider.

Within MPFT Community Mental Health Teams, there will be a mix of staff with blended skills, delivering clinical and non-clinical interventions to support the needs of individuals.

The contracted provider will support the safe and effective service delivery of Housing Support Services under MPFT's Community Mental Health Teams in South Staffordshire, to ensure that the service meets all the requirements of the NHS Long Term Plan.

As this is a new service being implemented, MPFT will require support from the provider during the implementation process, for example, a mobilisation plan.

8. Prices & Costs

8.1 Price

The service will be funded by a ring fenced budget from Midlands Partnership NHS Foundation Trust's Community Mental Health Transformation. The specific budget for the Housing Support Service is a total of £120,000.00 per financial year. This will be split equally across the 4 lots, £30,000.00 per lot per financial year. As the contract term will be for a duration of 2 years, the total contract value is for £240,000.00. This includes any additional costs associated with the service i.e. Management fees, IT hardware etc.

9. Exit Arrangements

9.1 Exit arrangements

This Contract is for 2 years with an optional extension of up to 12 months. Any exit arrangements will be discussed as required, at least 3 months before the end of the Contract Period. Termination of the Contract by

the Trust would be within 30 calendar days if there are Service delivery issues which the Service partner fails to rectify.



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



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survey responses
as of 18.10.2021

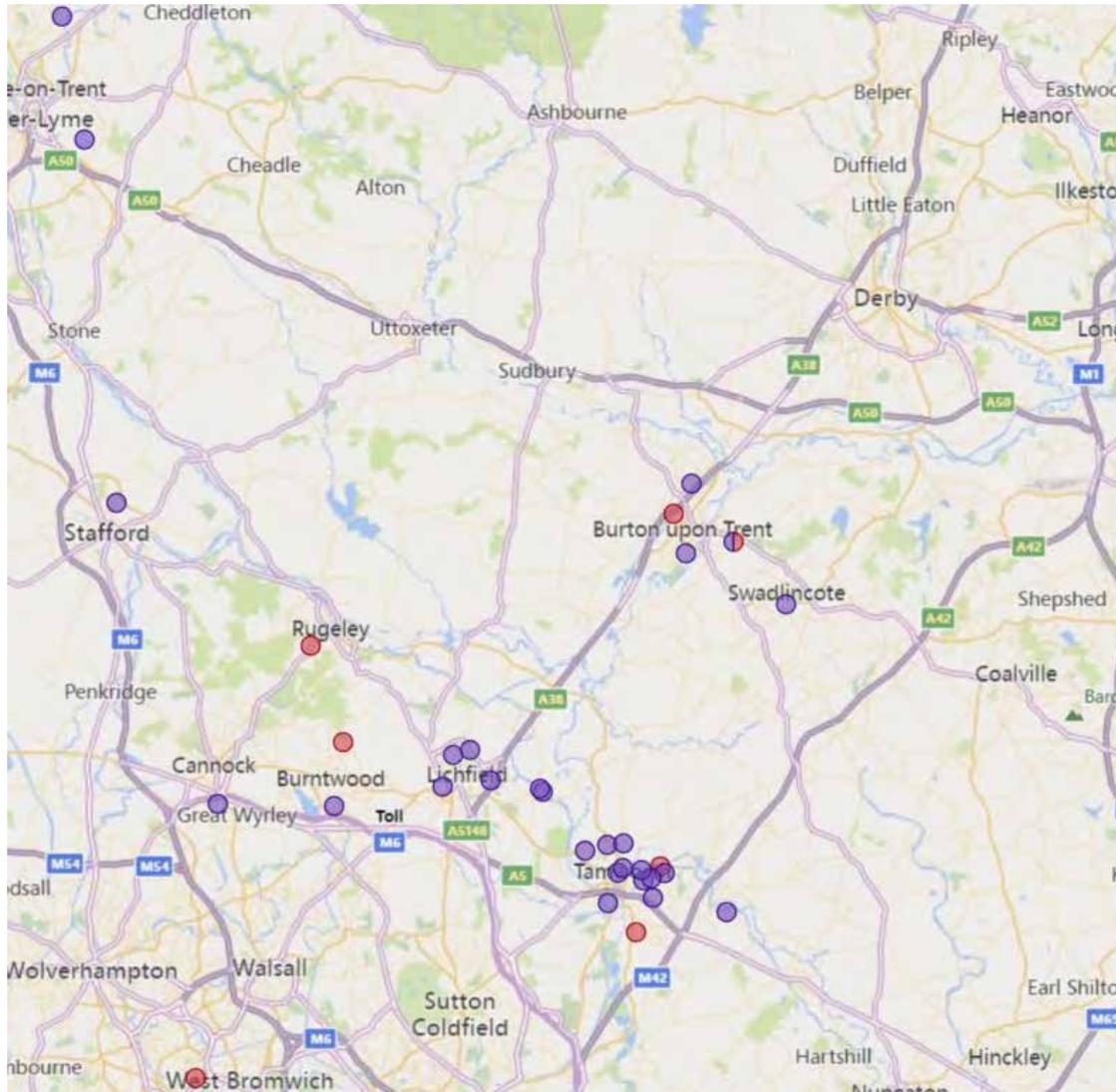


9

responses to the event
participant demographic
profiling questionnaire as
of 18.10.2021



Map of respondents



Key

- Event participant
- Survey respondent



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% |
| <i>Base</i> | - | | 28 | | 28 | |

Service usage

| <i>Mental health service usage</i> | 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% |
| <i>Base</i> | 32 | |

| <i>Mental health service usage - capacity</i> | 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 | | <i>Base</i> |
|---|-----------------------------|-----|---------------------|-----|---|-----|--|-----|-------------|
| 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 |

| <i>Mental health service usage – time period</i> | Before and during March 2019 | | After March 2019 | | <i>Base</i> |
|--|-------------------------------------|------|-------------------------|------|-------------|
| 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% | - |
| <i>Base</i> | 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% |
| <i>Base</i> | 9 | | 32 | | 41 | | 1,097,497 |

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% |
| <i>Base</i> | 9 | | 30 | | 39 | |

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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 6 | | 25 | | 31 | |

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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 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% |
| <i>Base</i> | 9 | | 32 | | 41 | |



Transforming health and care for
Staffordshire & Stoke-on-Trent

Location profiling





| 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% |
| <i>Total</i> | 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% |
| <i>Grand Total</i> | 9 | | 32 | | 41 | |

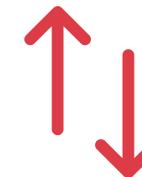
Comments and recommendations

- **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% |
| <i>Total</i> | 9 | | 32 | | 41 | |

Most deprived



Least deprived

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.

N Who you are

11

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 Section one: Which mental health services have you used and 13 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 Section two: Community mental health services in the future

14 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.

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@nort hstaffs.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



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

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



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.

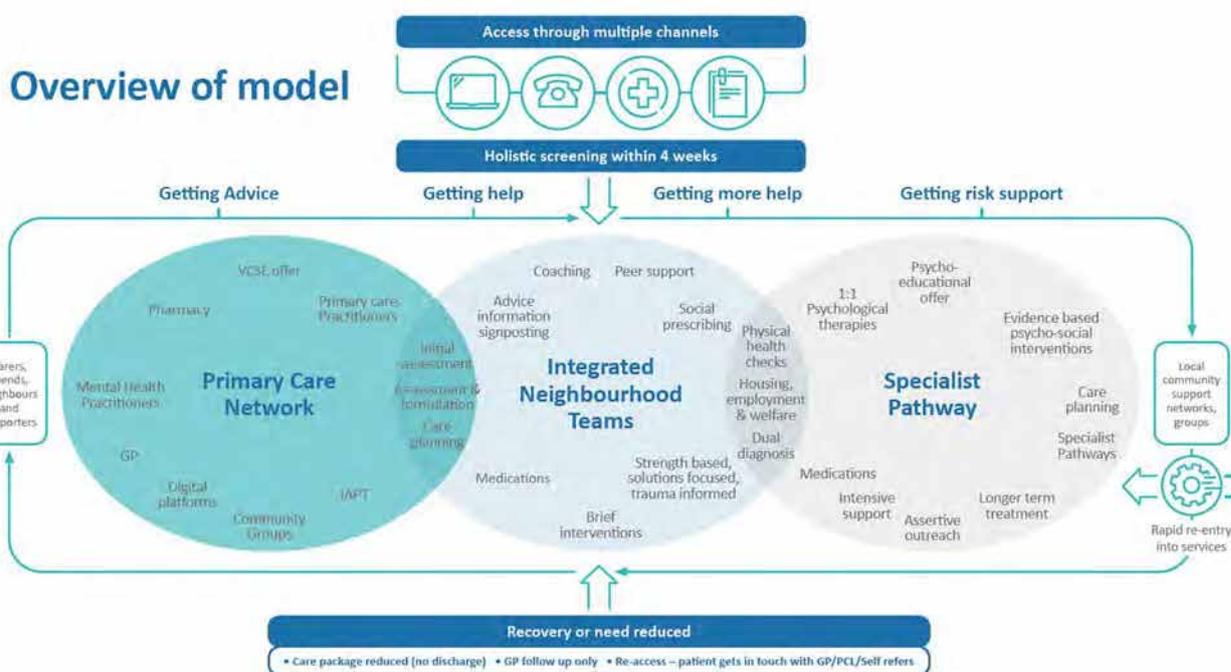
The guiding principles are:

- 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?

No

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.

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.

| | | | |
|---|------------------------|------------------------|----------------|
| <p>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.</p> <p>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.</p> <p>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).</p> | | | |
| Disability | Positive effect | Negative effect | Neutral |
| | ✓ | | |
| <p>Explanation:</p> <p>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.</p> <p>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.</p> <p>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.</p> | | | |
| Sexual Orientation | Positive effect | Negative effect | Neutral |
| | | | ✓ |
| <p>Explanation:</p> | | | |

| | | | |
|--|------------------------|------------------------|----------------|
| Both inpatient and community mental health services support patients from the LGBT community. | | | |
| Gender Reassignment | Positive effect | Negative effect | Neutral |
| | ✓ | | |
| <p>Explanation:</p> <p>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.</p> | | | |
| Sex | Positive effect | Negative effect | Neutral |
| | | | ✓ |
| <p>Explanation:</p> <p>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.</p> | | | |
| Race | Positive effect | Negative effect | Neutral |
| | | | ✓ |
| <p>Explanation:</p> <p>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.</p> <p>The service seeks to be inclusive through easy read, interpreter services, and materials in different languages.</p> | | | |
| Religion and Belief | Positive effect | Negative effect | Neutral |
| | | | ✓ |
| <p>Explanation:</p> <p>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</p> | | | |

| | | | |
|--|------------------------|------------------------|----------------|
| 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 |
| | | | ✓ |
| <p>Explanation:</p> <p>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.</p> | | | |
| Marriage and Civil Partnership | Positive effect | Negative effect | Neutral |
| | | | ✓ |
| <p>Explanation:</p> <p>It would be expected that both inpatient and community mental health services support patients irrespective of marital status.</p> | | | |
| Other groups at risk of poorer health outcomes: | | | |
| Carers | Positive effect | Negative effect | Neutral |
| | | ✓ | |
| <p>Explanation:</p> <p>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.</p> <p>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.</p> <p>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.</p> | | | |
| Socio-economic deprivation | Positive effect | Negative effect | Neutral |
| | | | ✓ |

| | | | |
|--|-------------------------------|-------------------------------|-----------------------|
| <p>Explanation:</p> <p>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.</p> <p>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.</p> | | | |
| <p>Other groups</p> <p>e.g. Asylum Seekers, Homeless, Sex Workers, Military Veterans, Rural communities – please state</p> | <p>Positive effect</p> | <p>Negative effect</p> | <p>Neutral</p> |
| | | | ✓ |
| <p>Explanation:</p> <p>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.</p> <p>MPFT’s discharge pathway is identifying a number of service users who have been admitted to an inpatient ward who do not have a fixed abode. These service users are referred to the council for housing support and the team:</p> <ul style="list-style-type: none"> • 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 | | | |
| <p>Equality Legal Duties – compliance</p> | | | |
| <p>Has the CCG given due regard and given consideration for the following:</p> | | | |
| <p>Eliminating unlawful discrimination, harassment, and victimisation</p> | | | <p>Yes</p> |

| | |
|---|---|
| <i>Unlawful discrimination takes place when people are treated 'less favourably' as a result of having a protected characteristic</i> | |
| Advancing equality of opportunity between people who share a protected characteristic and those who do not <i>Making sure that people are treated fairly and given equal access to opportunities and resources</i> | Yes |
| Fostering good relations between people who share a protected characteristic and those who do not <i>Creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference</i> | 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 <u>Service Conditions (SC13)</u> which includes <u>Accessible Information Standard</u> | Yes |
| Supporting narrative to support the above responses: <i>This section must be completed</i> 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 Shackleton – 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



Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

8 June 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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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**.

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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.

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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.

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Figure 1 The stepped model of care



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[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.

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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.

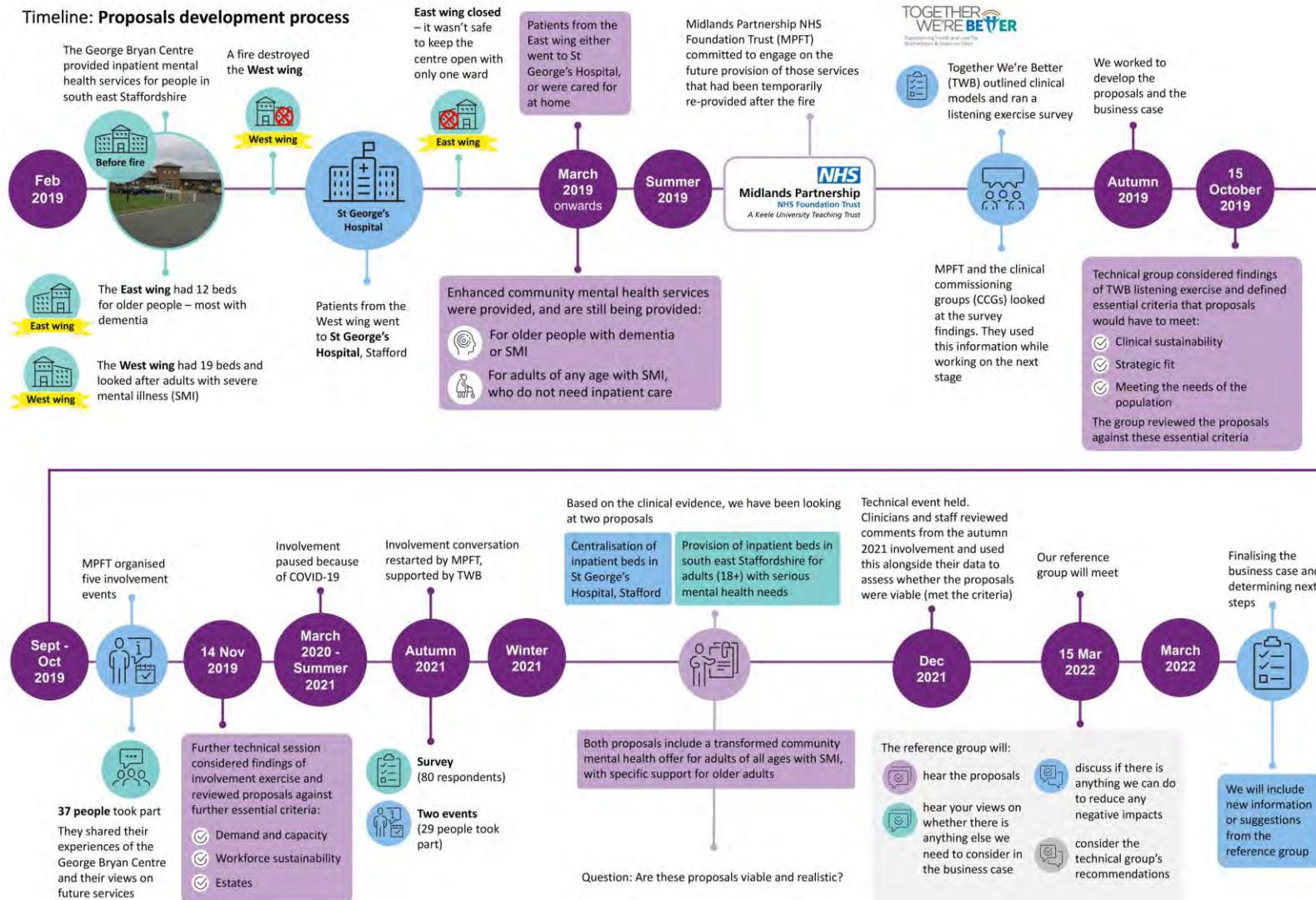
We will only take a proposal forward to the decision-making bodies (see page 20) when the business case has been completed.

(Figure 2 below is also supplied for you in PDF format.)

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**Figure 2
Proposals development process**



10 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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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 | | | |
| <p>Timely access to intensive psychiatric care</p> <p>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.</p> | | | <p>No on-site access to intensive psychiatric care</p> <p>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.</p> <p>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.</p> |

| 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 | | | |
| <p>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.</p> <p>This means staff can meet a wider range of needs. (Examples: perinatal mental health – around pregnancy and childbirth – and eating disorders).</p> <p>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.</p> | <p>Greater risk of health inequalities Evidence shows that being in touch with family, carers and friends is beneficial to patients with SMI.</p> <p>Some patients and carers will have to travel further to visit a person who is admitted to St George's Hospital in Stafford.</p> <p>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.</p> | <p>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.</p> | <p>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.</p> <p>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.</p> |

| Centralised beds at St George's Hospital | | 18-bed unit on site of George Bryan Centre | |
|--|---|---|---|
| Patient experience | | | |
| <p>Location</p> <p>Involvement comments have suggested that St George's location is an advantage – patients have access to activities outside hospital.</p> | <p>Travel impacts</p> <p>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.</p> <p>Travel was a major concern raised in both the 2019 and 2021 public involvement sessions</p> | <p>Easier travel</p> <p>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.</p> | <p>Location</p> <p>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).</p> |
| Clinical effectiveness | | | |
| <p>More consistent care provision</p> <p>More consistent care provision in a centralised centre, as no need for disruptive transfer to intensive psychiatric care or to access therapeutic interventions.</p> | <p>Travel impacts</p> <p>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.</p> | <p>Positive clinical impact of easier travel</p> <p>As noted, evidence shows that being in touch with family, carers and friends is</p> | <p>Less consistent care provision</p> <p>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</p> |

| 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. |
| <p>Fewer emergency call-outs</p> <p>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.</p> | | | <p>More emergency call-outs</p> <p>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.</p> |

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.

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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

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- 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.

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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” |

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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.

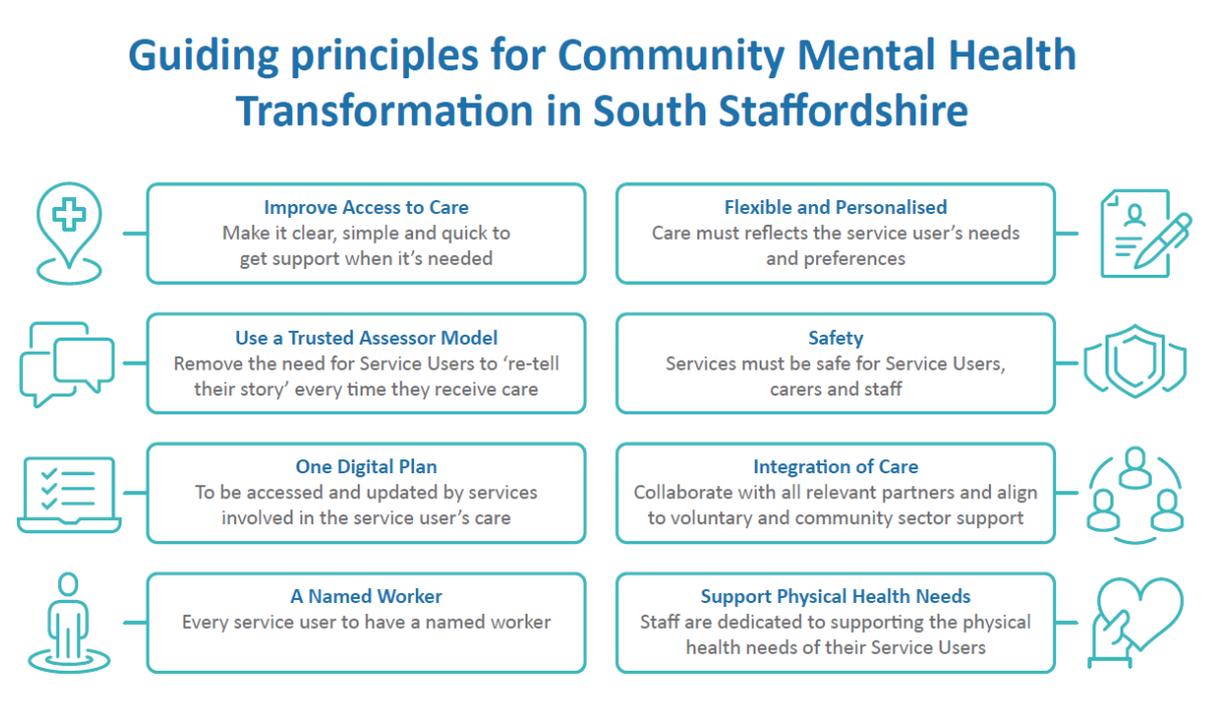
This section explains some of the specific changes and improvements we have already made. We also explain some of the new services we are developing.

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.

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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.

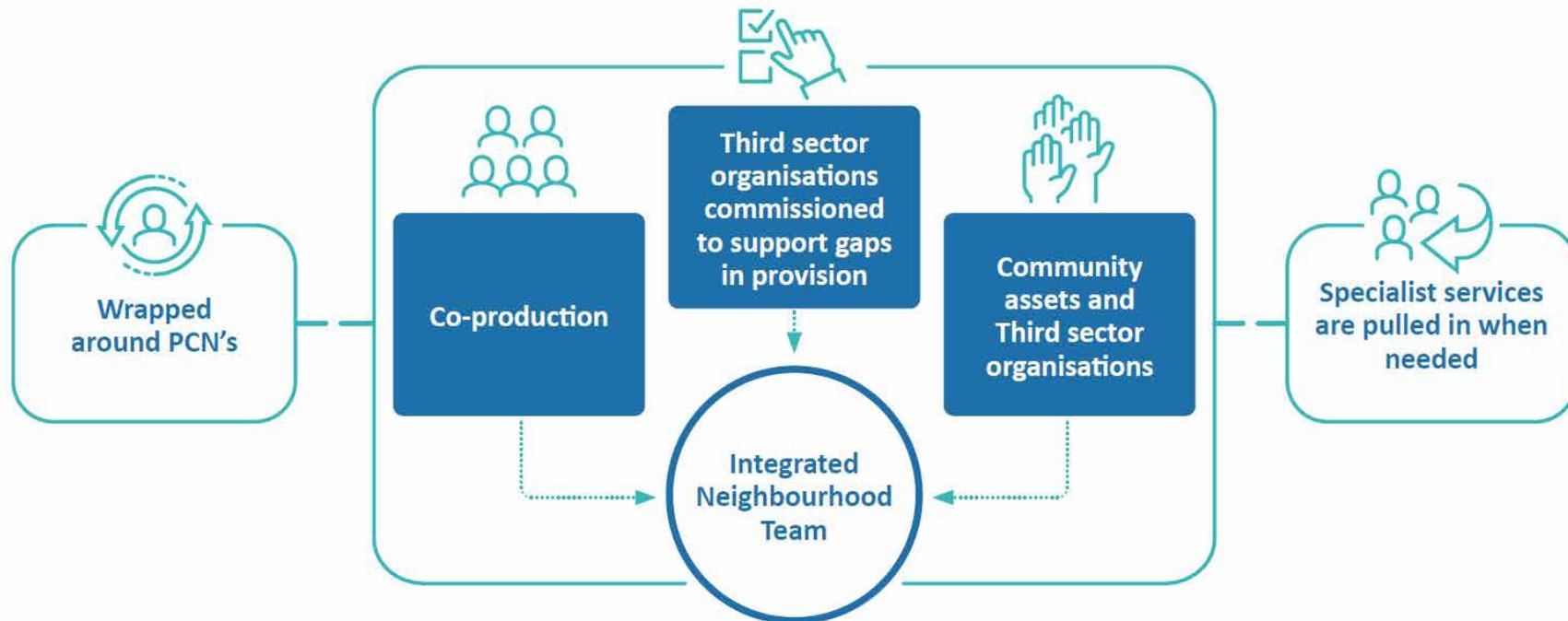
Our integrated teams will also make sure that people get specialist help when they need it. This could be from teams dealing with eating disorders, personality disorders, or substance abuse, or with teams that support people with learning disabilities, autism, or women who are affected by pregnancy or 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?

What does an Integrated Neighbourhood Team do?

There are four Integrated Neighbourhood Teams, who act as a core mental health team. These are located in East Staffordshire, Burntwood, Lichfield and Mercian (BLM), Stafford & Seisdon, Cannock & Rugely and Great Haywood.



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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.

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 minutes¹ 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 minutes² 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 minute¹ 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 minute² 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 update³ 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 website¹) 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 update¹ 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.

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 minutes¹ 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 agenda² 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.

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

Tamworth Borough Council Health and Wellbeing Scrutiny Committee

27 February 2019

The minutes¹ 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 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 minutes² 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 minutes³ 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 minutes⁴ 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.

¹ [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes](#) - Wednesday, 27th February 2019

² [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes](#) - Tuesday 23rd July 2019

³ [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes](#) - 19 September 2019

⁴ [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes](#) - 15 October 2019

There were also some comments relating to the engagement sessions.

26 November 2019

[The](#) minutes¹ 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 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 minutes² 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.

¹ [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes](#) - 26 November 2019

² [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes](#) - 26 February 2020

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 minutes¹ state:

The Chair further reported that the Midlands Partnership Foundation Trust had restarted its engagement process on the services previously provided at the George Bryan Centre and the Chair encouraged members as well as members of the public to consider this.

¹ [Tamworth Health and Wellbeing Scrutiny Committee Agenda and Minutes - 23 September 2021](#)



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Finding a long-term solution for the mental health services that were provided from the George Bryan Centre

Summary of findings



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Feedback on the model of care (survey)

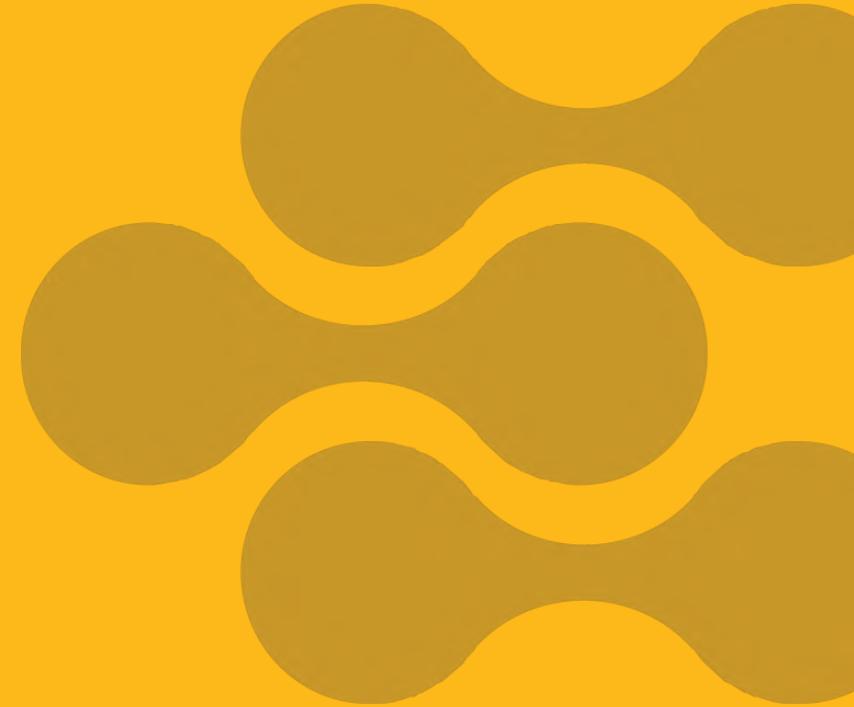
Feedback from the events

Summary of findings



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Introduction and background



Introduction



- This report presents the findings from the **George Bryan mental health** involvement survey and events
- This involvement aimed to gather feedback on 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 Together We're Better – the local health and care partnership – now wants to design the long-term solution
- This report was produced by NHS Midlands and Lancashire Commissioning Support Unit (MLCSU).

The George Bryan Centre provided an assessment, care and treatment service for working-age adults in an acute state of mental illness, and a mental health assessment and treatment service for people aged over 65.

Since the fire, anyone living in South East Staffordshire who has needed an inpatient stay has been sent to St George's Hospital in Stafford. An enhanced service has been in place in the community.

Background to the involvement

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.

The COVID-19 pandemic delayed any further engagement on the future of the services.

A sense-check engagement was undertaken in autumn 2021 to understand people's experiences since the fire.



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Communications and engagement



Channels used



Stakeholder engagement activity

- Stakeholders were contacted and asked to promote the survey and engagement events
- The involvement was promoted alongside engagement on urgent and emergency care
- Stakeholders included voluntary organisations, service providers, local councils, support groups and religious organisations.



783
stakeholders
engaged with



3,014
emails
sent



85
phone calls
made

Collateral and promotion

- The **survey and events** were promoted on the Together We're Better (TWB) and the Midlands Partnership Foundation Trust (MPFT) websites and associated social media accounts
- A **video** was produced explaining the model of care
- An **issues paper** was created to describe the proposed changes
- A **summary (accessible) issues paper** was also created.



TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

NHS
Midlands Partnership
NHS Foundation Trust
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Finding a long-term solution for the mental health services that were provided from the George Bryan Centre

7 October 2021

If you are affected by anything in this document, contact our Urgent NHS Mental Health Helpline for support, advice and triage.
FREEPHONE 24/7: 0808 196 3002



Social media

- Both paid and organic social media were used to promote the involvement.
- Posts were scheduled from TWB's accounts and posted by partner organisations including:
 - Midlands Partnership NHS Foundation Trust
 - Staffordshire and Stoke-on-Trent CCGs
 - Healthwatch Stoke-on-Trent
 - Tamworth Council
 - University Hospitals of Derby and Burton NHS Foundation Trust.

Twitter

39 posts

14 likes

23
retweets

Facebook

15 posts

1 like

11 shares

Social media advert

Together We're Better Staffordshire and Stoke-on-Trent
October 9 · 🌐

Do you care for someone who accessed mental health support from the George Bryan Centre? We want to find a long-term solution for how the services can be provided, since a fire caused the centre to close in 2019. Get involved: <https://gettinginvolved.mpft.nhs.uk/george-bryan-centre...>

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Improving health and caring for our communities

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Tell us your views on mental health services following the fire at the George Bryan Centre.



Clicks

980



Reach

53,809



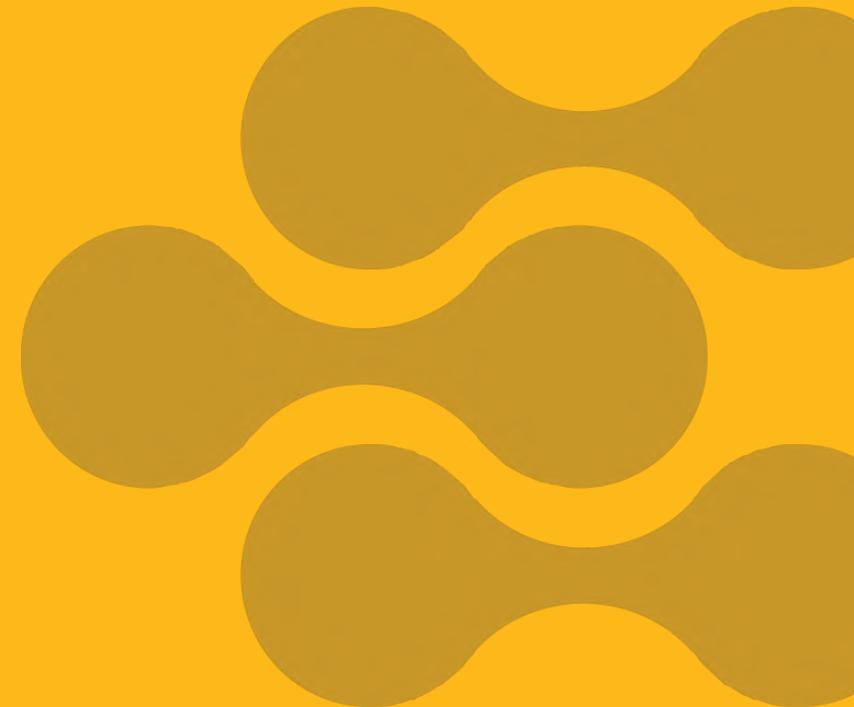
Impressions

182,223



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Reporting methodology



Methodology

- Feedback was gathered through a survey and two events
- The survey and events were promoted via the MPFT website and social media
- Stakeholders were contacted by email and phone, encouraging them to take part.



The survey was hosted online between Thursday 7 and Sunday 31 October. Paper versions were available on request.
80 responses were received.



Two online workshop events were held on 14 and 18 October.
There were 29 participants in total.

Event methodology

- The workshops were held on **Microsoft Teams**
- Participants registered in advance through an online form
- The workshops began with all participants viewing a presentation
- Feedback was collated on a **Jamboard** during the event. This acted as a virtual 'flipchart' with participants able to add their feedback directly to the board
- Participants were also asked to complete a **demographic profiling survey**. This was completed by nine participants.

Jamboard:

Share your experiences and ideas

Please tell us about your experiences of using community mental health services and St George's Hospital since February 2019.

- What do you feel went well?
- What challenges or issues did you face?

Please tell us your ideas or suggestions about how we could provide mental health services in the future.

Services at CB were great - we want to see that reinstated

It's been a shame communication has been non-existent. Services only just getting into gear since covid. There is a high need for services and unable to access the services I should have got.

Travel shouldn't be an issue if you need to access services. They need to be local to the community, especially in Tamworth.

Public transport links poor from Tamworth to St Georges

Lichfield in the south of staffs we need this facility. In improve for people in the north of the county who would like service to remain local. We were given assurance that this service will be reinstated.

lack of day care, lack of Admiral nurses in Tamworth

We don't want what we have got - we want what we had

CB was and is reasonably close to Tamworth Town Centre and Ventura

CB's Family involvement and patient experience improvement and consultation with care recipients. A national cross-sectional study in English psychiatric hospitals. BMC Psychiatry 2021. <https://doi.org/10.1186/s12888-021-02800-0>

the community wants CB back as a facility - but make it bigger so we can incorporate more local services

Services at CB helped a great deal. If I had to go to Stafford I would have been depressed to my health. These visits have been little involvement from my family due to financial issues as they wouldn't have been.

Tamworth population nearly 80,000

Travel to and from is costly when you don't have much money and we had two young children too which made commuting every day difficult.

resident of burtonham - to get to stafford is a nightmare. There has been no money to get there. What other facilities are there locally to help make suggestions and decisions on community services?

While I seek in it change but taking engaged with the service and it was great. But in looking after my wife I have felt totally isolated in Tamworth. Given the amount of demands in the area service provision isn't.

doing the best you can. For the love, not for the love.

In my experience of CB I had access to Art Therapy and occupational therapies.

Family involvement in discharge planning and Patient Participation Care, psychiatric care, mental health, <https://doi.org/10.1186/s12888-021-02800-0>

Future improvements across period of help. We don't know where to get help as I feel we are at a crisis point. Need interventions before our son dies. I know where to find them.

We have not used the services since the end of CB. Because if we have done the services but felt it was pointless.

Tamworth needs more services because of the population levels here

The evidence base suggests that Family/Carer involvement improves outcomes for inpatient and can reduce the length of inpatient stay.

when CB is gone there doesn't appear to be a right to stay in patient facility is your only option

I felt isolated while trying to care for my wife

When I first accessed mental health services they had me in a night shelter and it had to get when one day spent working they told me to give it a go. They made the day group sessions that did not help when I had them.

CB - there does need to be some sort of in patient facility.

I feel that unless crisis care that some mental health care necessary due to lack of services in care with things in place to ensure we don't get they need admission

CB's only service needs to be a mental health care. A collaborative 'consultation' review. <https://doi.org/10.1186/s12888-021-02800-0>

shaping services for the future needs to be worked out with patients who have experienced treatment

We need a pathway - people need to know where to go to get help

Demographic profiling survey:

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 engagement. 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.

Which of the following describes you? (Please tick as many as appropriate)

I am currently using maternity services
 I have used maternity services in the last 12 months
 I am hoping to have a baby and use maternity services
 I work in maternity services

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:

What is your ethnic group? (Choose one option that best describes your ethnic group or background)

White - English/Welsh/Scottish/Northern Irish/British
 White - Irish
 White - Gypsy or Irish Traveller
 White - Any other White background (please specify in the box below)
 Mixed/Multiple ethnic groups: White and Black Caribbean

Structure of the survey and events

Survey sections

Who are you?

Mental health services to give feedback on

Experiences of using the George Bryan Centre

Experiences of using St George's Hospital

Experiences of using community mental health services

Community mental health services in the future for South Staffordshire

About you

Event agenda

Continuing our ongoing conversation

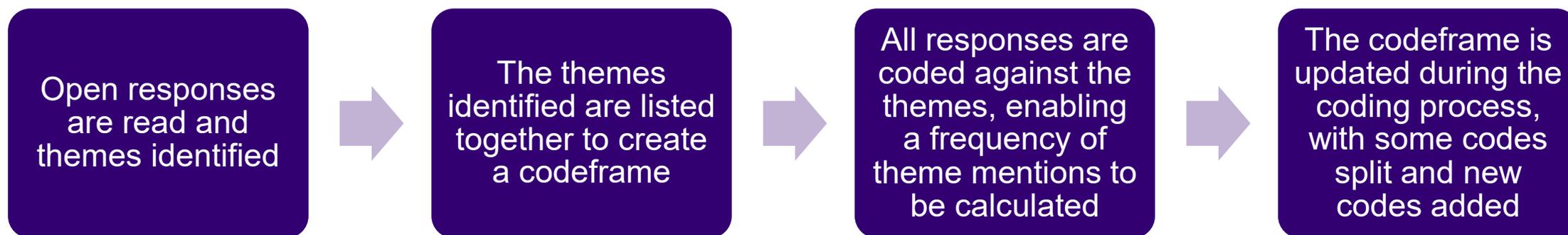
The George Bryan Centre and understanding your experiences

A model of mental health services for the future and your ideas/suggestions

Next steps and closing remarks

Approach to analysis: survey

- The survey used a combination of 'open text' questions for respondents to make written comments, and 'closed' questions where respondents 'ticked' their response from a set of pre-set responses
- Open responses received in the survey have been read and coded into themes. These themes include overarching 'main themes' and more detailed themes
- Coding is a subjective process
- The coding process is summarised below:



Presentation of findings

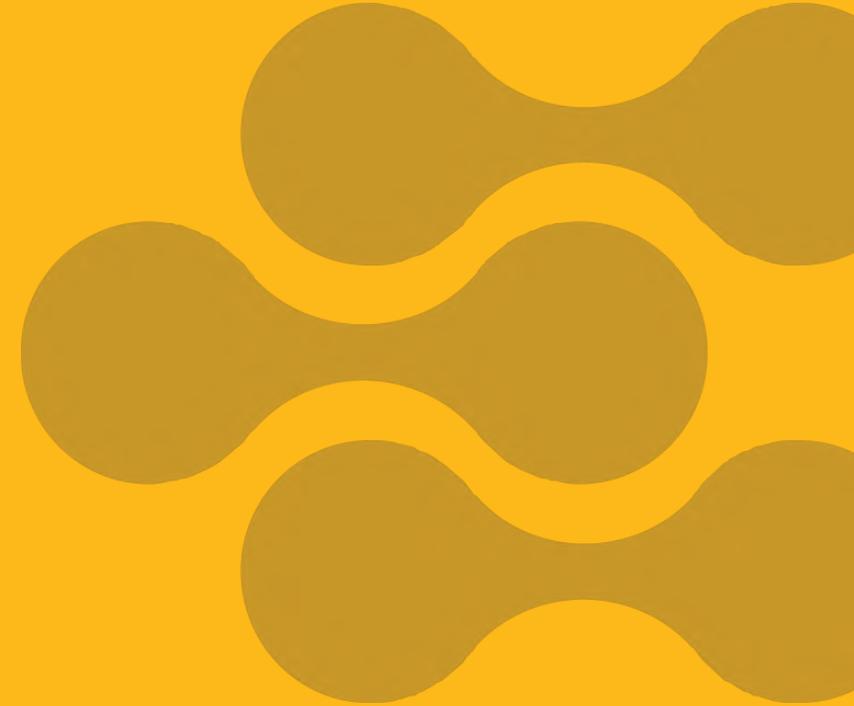
- Responses to the survey are broken down by the following variables:
 - CCG area
 - Respondent type
 - Service user capacity
 - Age
- For some questions, not all variables are shown. This is because:
 - Some questions were only asked of specific groups within the survey
 - There were limited responses to the questions.
- Percentages may not add up to 100% due to rounding or where respondents could choose more than one response.

| Variable | Source |
|-----------------------|---|
| CCG | Profiled from postcode question |
| Respondent type | <p>Questions: As an individual responding to this questionnaire, which of the following best applies to you?</p> <p>As an organisation responding to this questionnaire, which of the following best applies to you?</p> |
| Service user capacity | <p>Questions: In what capacity did you experience the George Bryan Centre?</p> <p>In what capacity did you experience St George's Hospital?</p> <p>In what capacity did you experience community health services?</p> |
| Age | What is your age category? |



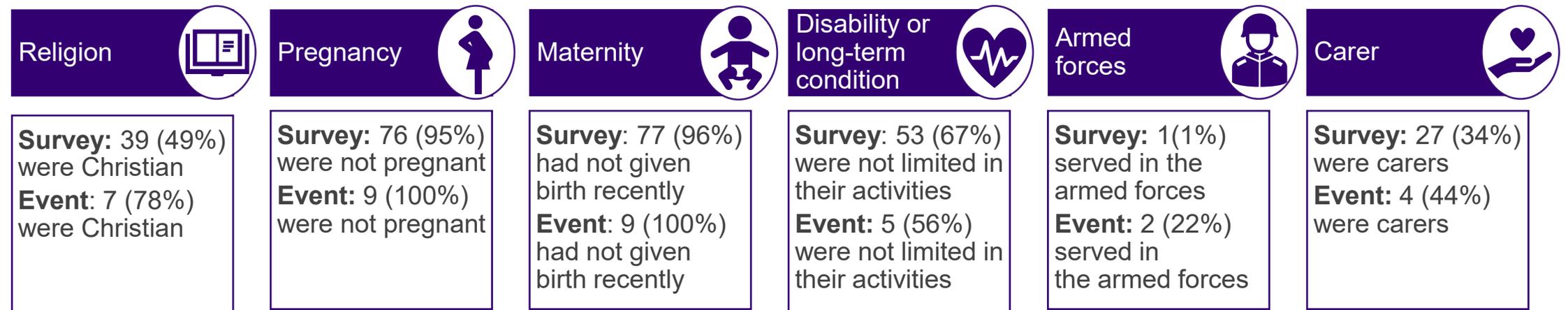
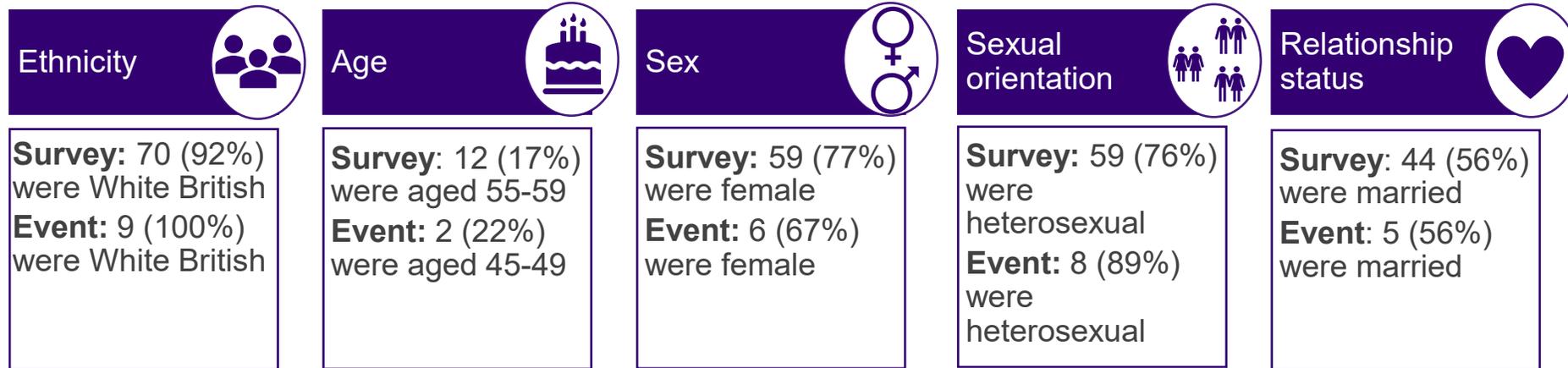
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Demographic profiling

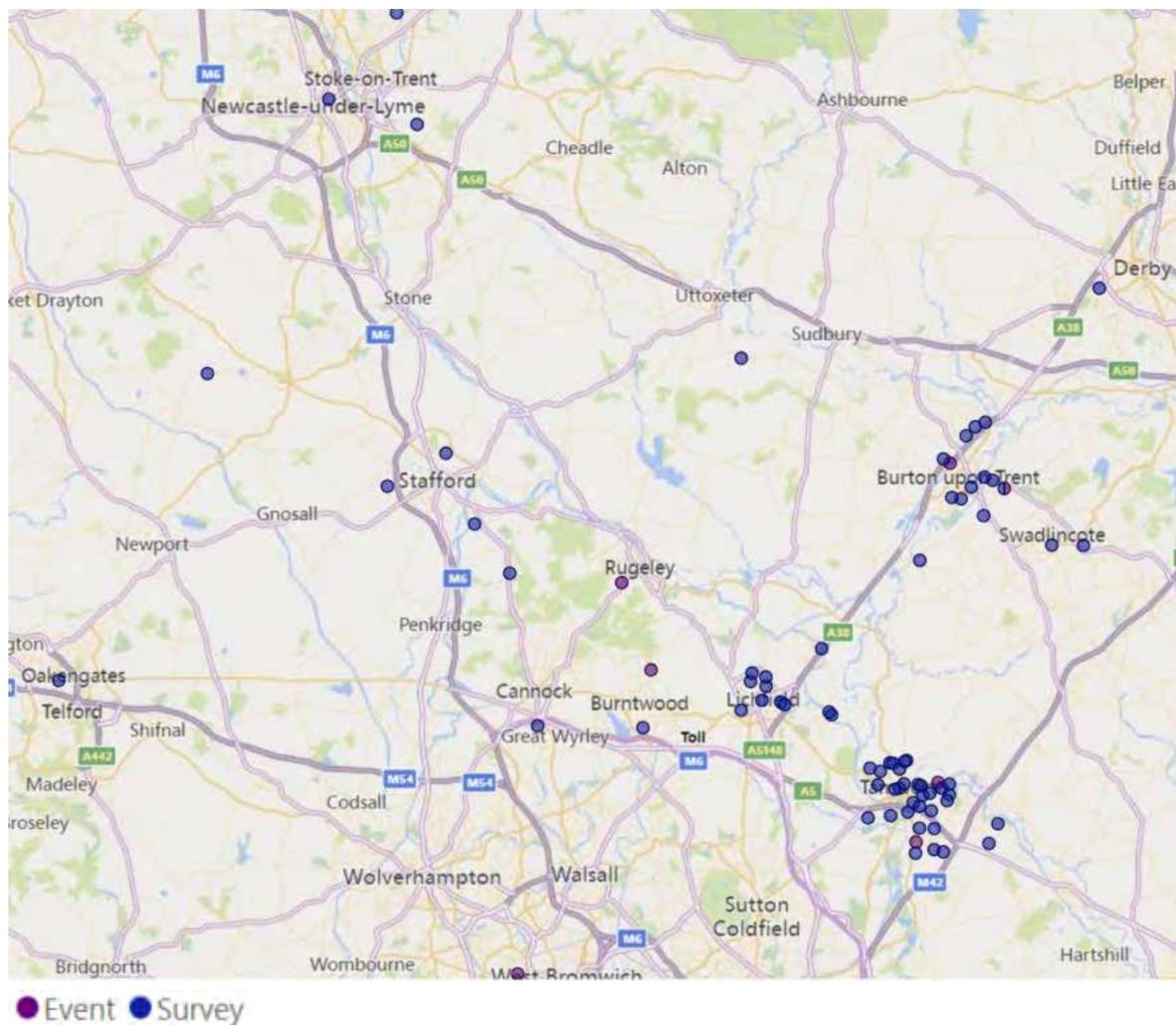


Demographic profiling

Survey respondents and event participants



Location of respondents



| CCG | Survey | | Events | |
|--|-----------|-----|----------|-----|
| | No. | % | No. | % |
| NHS South East Staffordshire and Seisdon Peninsula CCG | 42 | 53% | 4 | 44% |
| NHS East Staffordshire CCG | 13 | 16% | 2 | 22% |
| NHS Stafford and Surrounds CCG | 5 | 6% | - | - |
| NHS Stoke-on-Trent CCG | 2 | 3% | - | - |
| NHS Cannock Chase CCG | 1 | 1% | 1 | 11% |
| NHS North Staffordshire CCG | 1 | 1% | - | - |
| NHS Derby and Derbyshire CCG | 4 | 5% | - | - |
| NHS Warwickshire North CCG | 2 | 3% | - | - |
| NHS Telford and Wrekin CCG | 1 | 1% | - | - |
| NHS Sandwell and West Birmingham CCG | - | - | 1 | 11% |
| No postcode provided | 8 | 10% | 1 | 11% |
| Postcode unable to be profiled | 1 | 1% | - | - |
| <i>Base</i> | <i>80</i> | | <i>9</i> | |

Respondent type: survey

95%

Responding as an individual (for example a patient, member of the public or NHS employee) (76)

5%

Responding on behalf of an organisation (formal organisational response) (4)

Base: 80

As an individual responding to this questionnaire, which of the following best applies to you?



26%

User of mental health services
(20)



36%

Other member of the public
(27)



11%

Carer
(8)



22%

NHS employee
(17)



3%

From another public sector organisation
(2)



3%

From a health-related group, charity or organisation
(2)

Base: 76

Organisations responding to the involvement

Appendix 11 Report of findings from engagement 22 December 2021

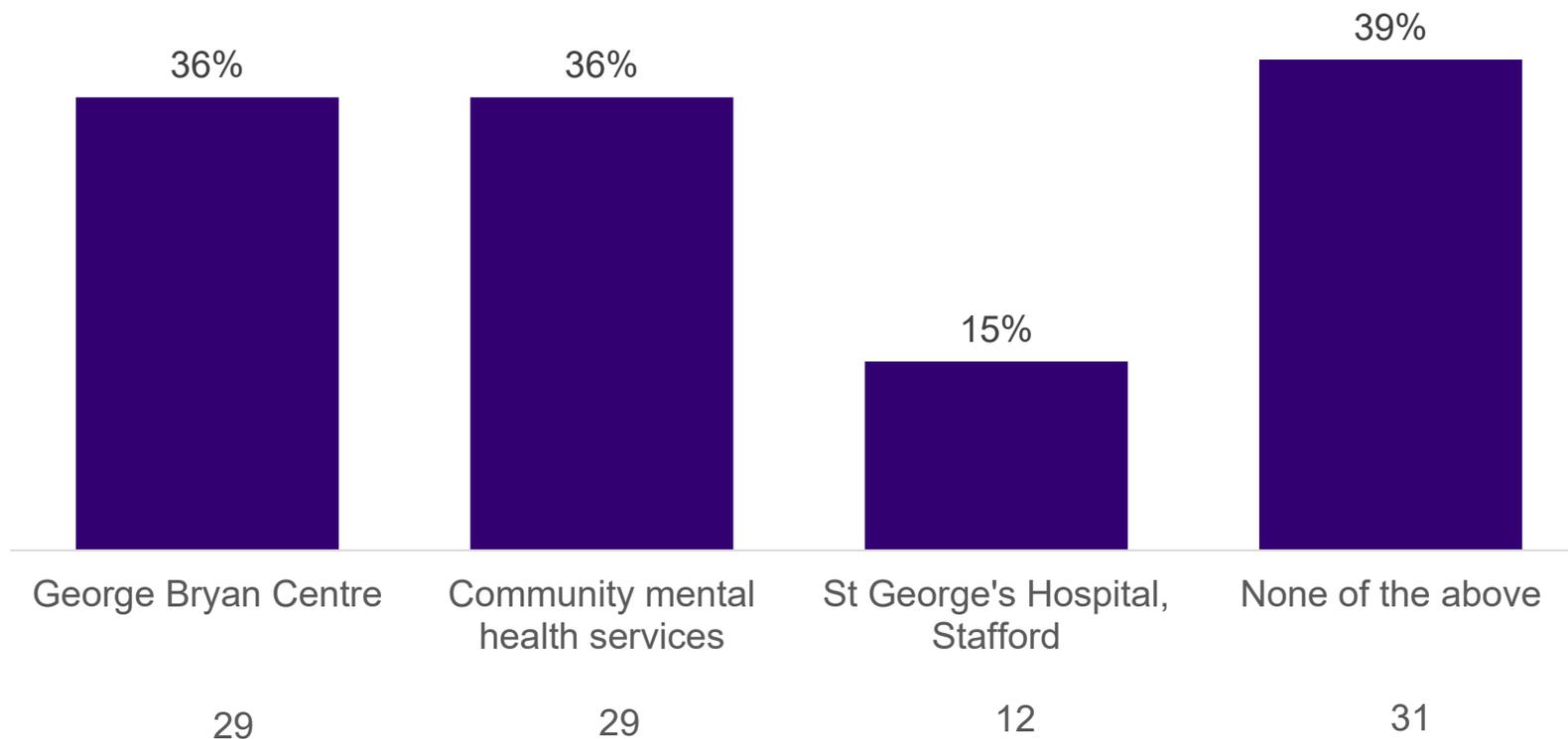


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| Survey | Events |
|--|---|
| Burton and District Mind | Combined Healthcare |
| Community Together CIC | Community Together CIC |
| Healthwatch Staffordshire | DPPG Cannock Chase |
| Midlands Partnership NHS Foundation Trust (MPFT) | East and South East Staffordshire CCG Patient Board |
| Sir Robert Peel Hospital | Healthwatch Staffordshire |
| The League of Friends of the Tamworth Hospitals | Lichfield District Council |
| The Rawlett School | Midlands Partnership NHS Foundation Trust |
| University Hospitals of Derby and Burton | South East Staffordshire and Seisdon Peninsula CCG |
| University of Birmingham | Tamworth Borough Council |



Feedback on services



Which of the following mental health care services would you like to give feedback on? **Base: 80**





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Feedback on the George Bryan Centre



George Bryan Centre: respondent type

In what capacity did you experience the George Bryan Centre?



28%
As a member of staff (8)



31%
As a patient (9)



35%
As a carer or support
worker for a patient (10)



7%
As a provider of a service
to a patient (2)

Base: 29

During which period would you like to provide feedback on?



14% after March 2019

86% before and during March 2019

Base: 29

Which wing were you in?



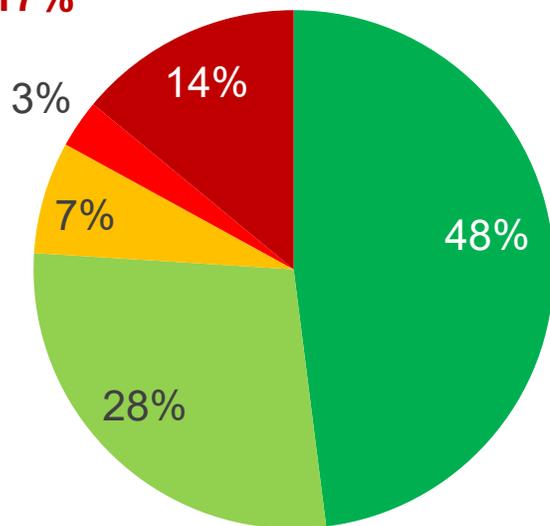
100% West (for under 65-year-olds)

Base: 9

George Bryan Centre ratings

Rate your experience of using the George Bryan Centre

Total very poor / poor: 17%
Total very good / good: 76%



■ Very good ■ Good
■ Neither good nor poor ■ Poor
■ Very poor

Base: 29

Proportion rating very good / good

CCG area



Limited feedback from other CCG areas

Age



Service user type



Base: 4–18 (CCG area); 2–10 (Service user type); 4–17 (Age)



Experiences of the George Bryan Centre

What do you feel went well and what challenges did you face?

Main themes

Access

Estates and facilities

Food

General

Quality of care

Service provision

Staff

Key themes



Quality of care:
Quality of care was good (e.g. patient-centred)
(8 / 33%)



Staff:
Staff were supportive and caring
(7 / 29%)



Staff:
Staff were unhelpful (e.g. rude, didn't listen)
(7 / 29%)

5
positive
themes

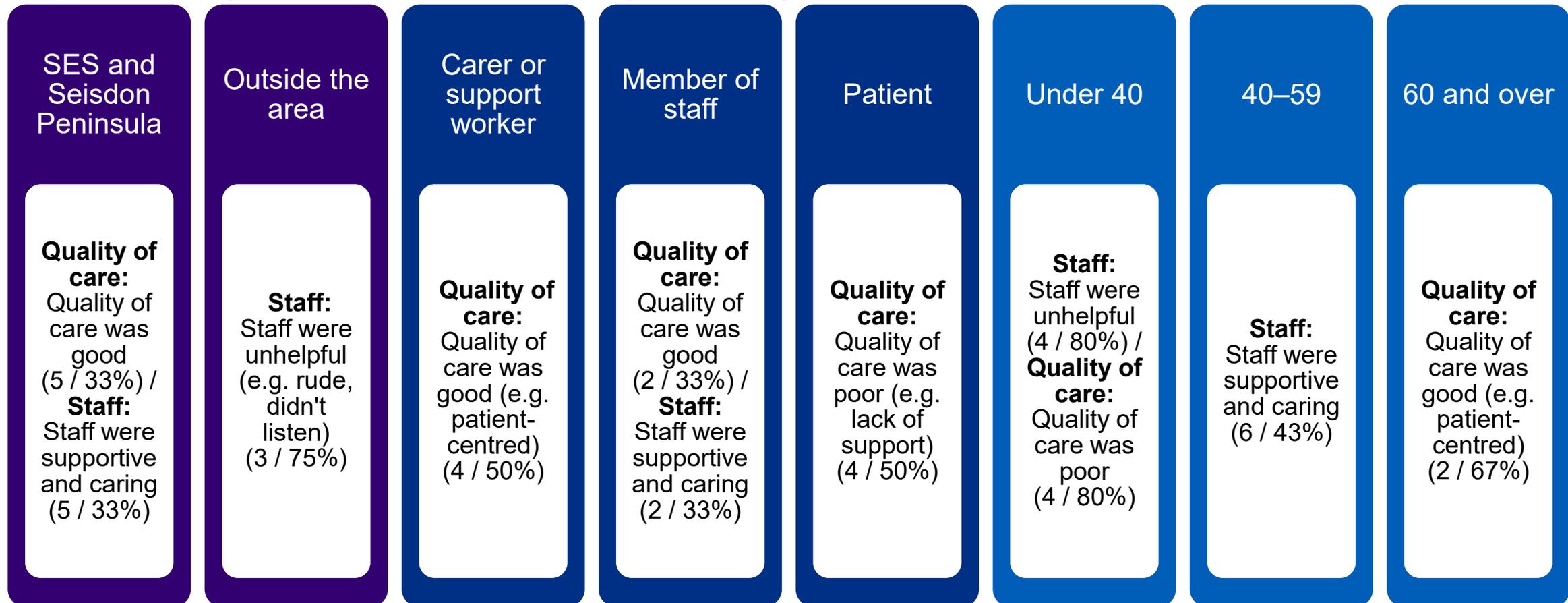
9
negative
themes

3
observation
themes

Base: 24

George Bryan Centre: top themes

What do you feel went well and what challenges did you face?
Top themes by CCG area, service user type and age



Limited themes for other CCG area and service providers. *Base: 4–15 (CCG area); 6–8 (Service user type); 3–14 (Age)*



George Bryan Centre: verbatims

*“West wing was already unfit for purpose prior to the fire Staff were rude and unhelpful
Management were shocking and obviously did not care”*
(NHS South East Staffordshire and Seisdon Peninsula CCG,
gender not indicated, 50–54 years)

“My wife was poorly diagnosed and treated until she was admitted to The George Bryan Centre. When she was discharged, she was under the care of the community team at Cherry Orchard House, after that was closed down we were left on our own.”
(NHS South East Staffordshire and Seisdon Peninsula CCG,
male, 70–74 years)

*“Superb care of a very close friend.
The GB team were beyond perfect”*
(NHS South East Staffordshire and Seisdon Peninsula CCG,
female, 55–59 years)

*“No communication from staff.
Unsafe premises for patients . Layout very poor.
communal areas poor and activities non existent.”*
(NHS Derby and Derbyshire CCG,
female, 30–34 years)

*“Member of family supported in George Bryan Centre.
Staff very good offering great support”*
(NHS South East Staffordshire and Seisdon Peninsula CCG,
male, 50–54 years)

*“Nothing I was left alone in the room til my time was up.
There was no engagement with me
and I don't want to leave my room”*
(NHS South East Staffordshire and Seisdon Peninsula CCG,
female, 35–39 years)

Tell us about your experience of using the George Bryan Centre. What do you feel went well and what challenges or issues did you face? **Base: 24**





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Feedback on St George's Hospital



St George's Hospital: respondent type

In what capacity did you experience St George's Hospital?



17%
As a member of staff (2)



58%
As a patient (7)



25%
As a carer or support
worker for a patient (3)



0%
As a provider of a service
to a patient (0)

Base: 12

During which period would you like to provide feedback on?



67% after March 2019

33% before and during March 2019

Base: 12

St George's Hospital ratings

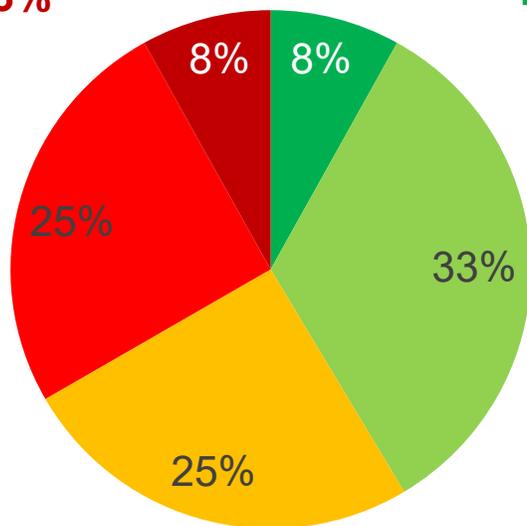


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Rate your experience of using St George's Hospital

Total very poor / poor: 33%

Total very good / good: 42%



- Very good
- Good
- Neither good nor poor
- Poor
- Very poor

Base: 12

Proportion rating very good / good

CCG area



Limited feedback from other CCG areas

Age



No feedback from respondents aged 60 and over

Service user type



Limited feedback from staff and service providers

Base: 6 (CCG area); 3-7 (Service user type); 4-6 (Age)



Experiences of St George's Hospital

What do you feel went well and what challenges did you face?

Main themes

Access

Communication

Estates and facilities

Quality of care

Service provision

Staff

Key themes



Communication:
Communication requires improvement
(5 / 50%)



Access:
St George's Hospital is not in an accessible location (e.g. too far)
(2 / 20%)



Staff:
Staff were caring
(2 / 20%)



Staff:
Staff were unhelpful
(2 / 20%)



Quality of care:
Quality of care was poor
(2 / 20%)



Service provision:
Lack of access to activities
(2 / 20%)

4
positive
themes

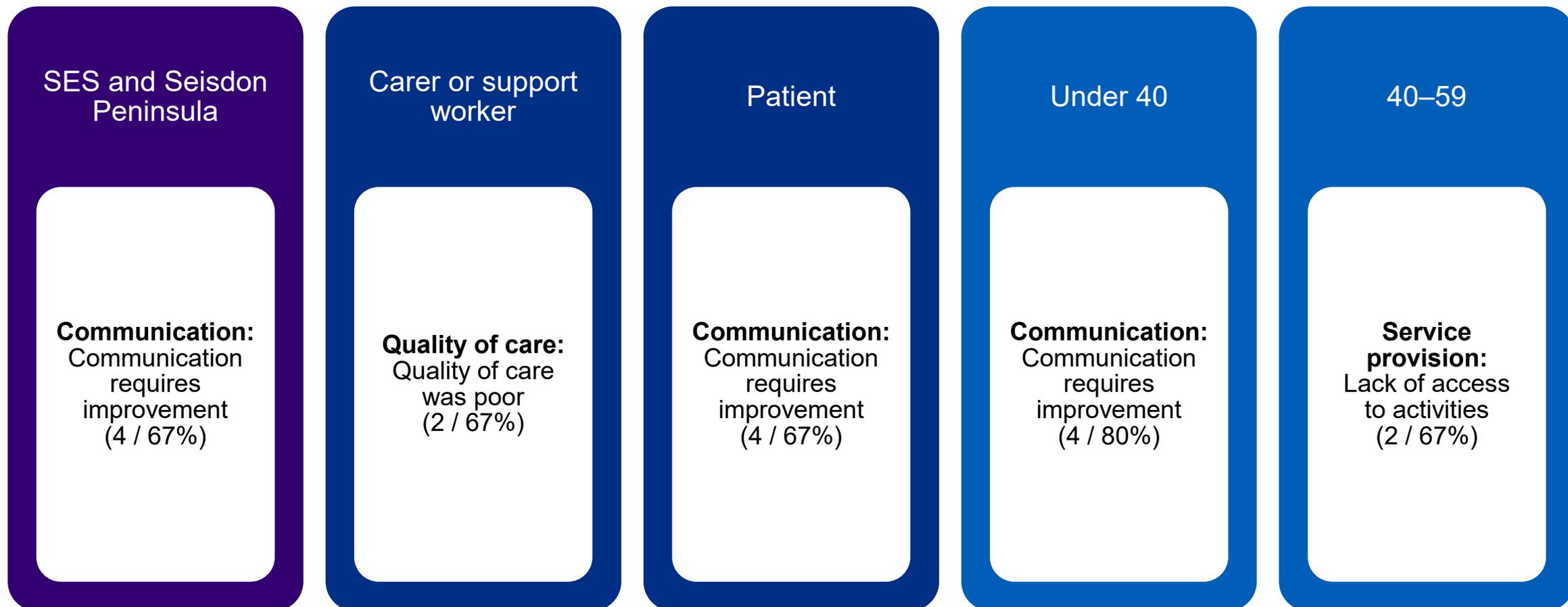
7
negative
themes

1
observation
theme

Base: 10

St George's Hospital: top themes

What do you feel went well and what challenges did you face?
Top themes by CCG area, service user type and age



Limited themes for other CCG area, staff, service providers and respondents aged 60+. Base: 6 (CCG area); 3-6 (Service user type); 3-5 (Age)



St George's Hospital: verbatims

"I was ignored my bag was not searched so I could have my belongings I refused to engage them as they were disrespectful to me and left the next day "
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 35–39 years)

"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. This is actually used in some places as torture."
(NHS Coventry and Warwickshire CCG, female, 50–54 years)

"Very bad layout. Extremely hot communal areas. Sandwiches left out in the sun. Staff too busy with very ill patients to spend time with other patients requiring support . Patients rolling around on the floor . Distressing for visitors"
(NHS Derby and Derbyshire CCG, female, age not indicated)

"Access to required services on site Distance is a challenge"
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 55–59 years)

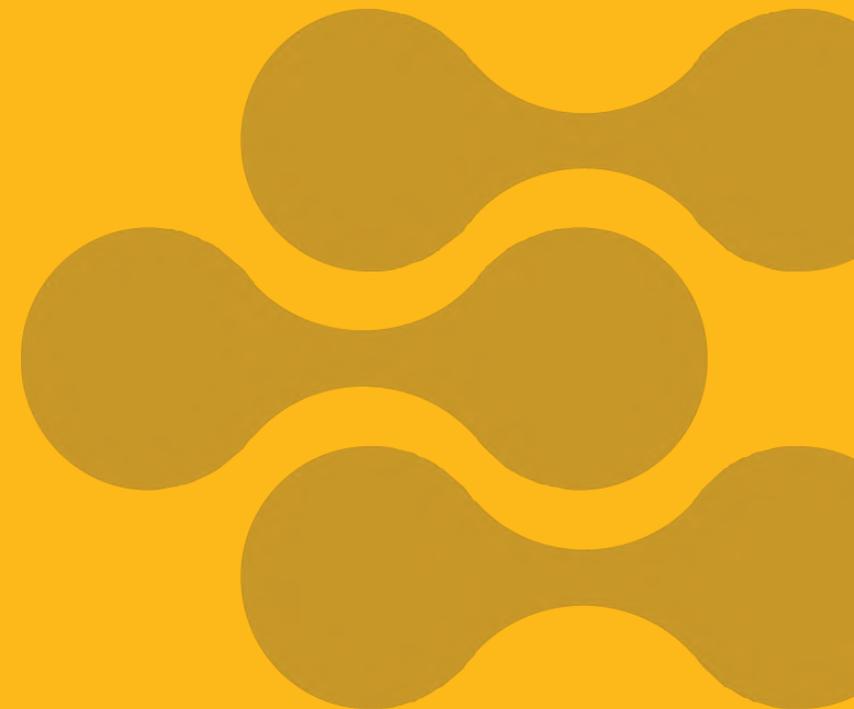
"I haven't even talked to any of the nurses there when I was a patient suffering major depression. They were always too busy. I know that as a NHS nurse, it could get overwhelming and very busy but they really don't talk to patients. They were like robots."
(NHS East Staffordshire CCG, female, 30–34 years)

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? **Base: 10**



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Feedback on community mental health services



Community services: respondent type

In what capacity did you experience community health services?



10%
As a member of staff (3)



62%
As a patient (18)



24%
As a carer or support worker for a patient (7)



3%
As a provider of a service to a patient (1)

Base: 29

During which period would you like to provide feedback on?



52% after March 2019

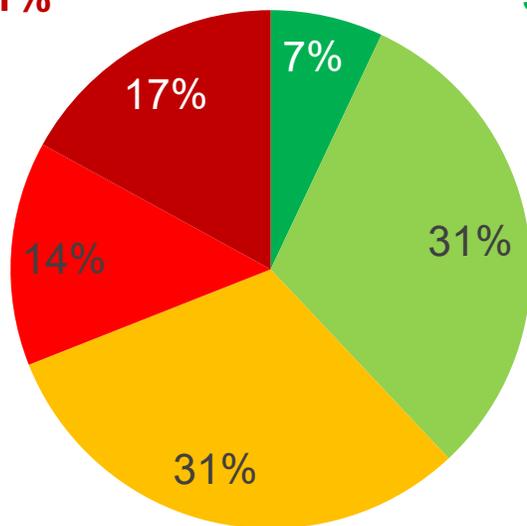
48% before and during March 2019

Base: 29

Community services ratings

Rate your experience of using the community services

Total very poor / poor: 31% **Total very good / good: 38%**



■ Very good ■ Good
■ Neither good nor poor ■ Poor
■ Very poor

Base: 29

Proportion rating very good / good

CCG area



Limited feedback from other CCG areas

Age



Service user type



Limited feedback from service providers

Base: 5-15 (CCG area); 3-18 (Service user type); 7-9 (Age)



Experiences of community services

What do you feel went well and what challenges did you face?

Main themes

Access

Communication

COVID

Estates and facilities

General

Quality of care

Service provision

Specific groups

Staff

Key themes



Access:
Difficulty in
accessing mental
health services
(10 / 42%)



Quality of care:
Quality of care was
poor
(7 / 29%)



Quality of care:
Lack of continuity
of care following
discharge
(6 / 25%)

4

positive
themes

8

negative
themes

5

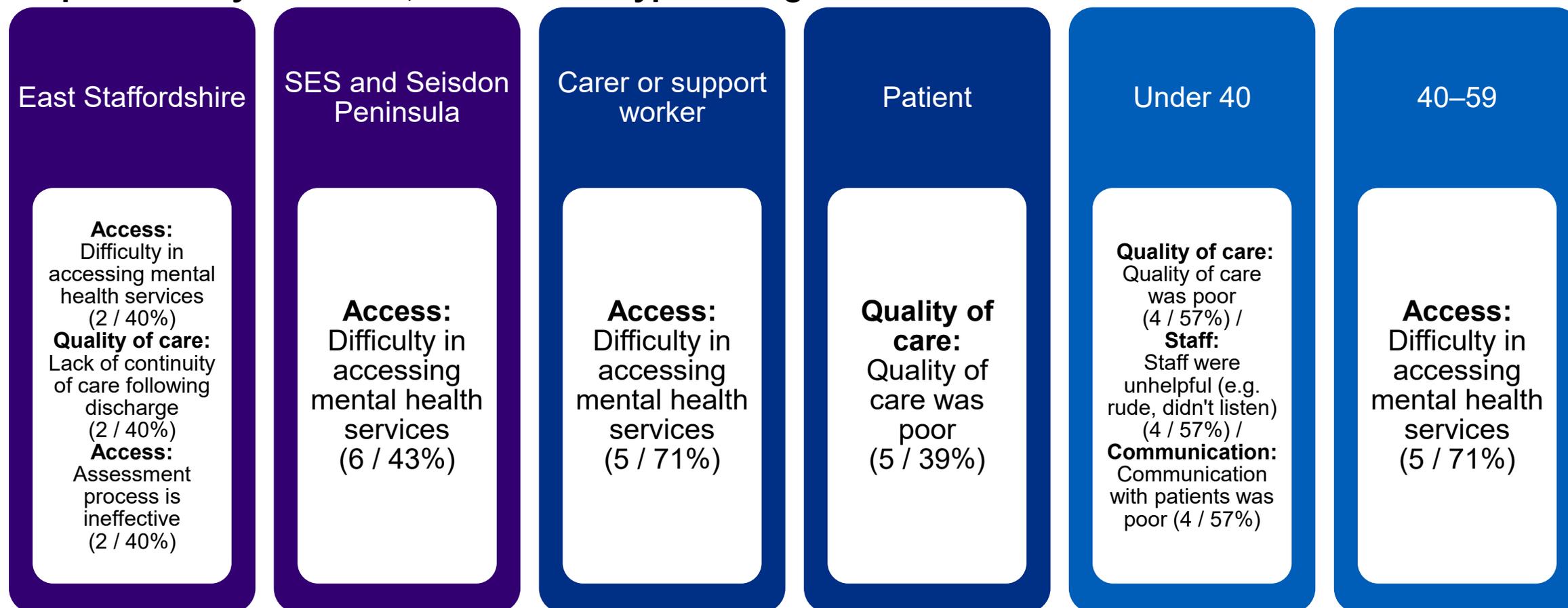
observation
themes

Base: 24

Community services: top themes

What do you feel went well and what challenges did you face?

Top themes by CCG area, service user type and age



Limited themes for other CCG areas, service providers and over 60s. Base: 5–14 (CCG area); 7–13 (Service user type); 7 (Age)



Community services: verbatims

“Constantly passed back and forward to people, not been listened to and didn’t get the help I needed”
(CCG area not indicated, female, 20–24 years)

“Difficult to access, took far too long”
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 55–59 years)

“Very difficult to access the services and often little continuity of care”
(NHS East Staffordshire CCG, gender not indicated, 55–59 years)

“My son has had 1 telephone check up since March 2020. He had a new diagnosis made out of area which hasn’t been followed up, no basic checks have been made like blood pressure let alone checks on his mental well-being.”
(NHS East Staffordshire CCG, male, age not indicated)

“Having worked in both inpatient and community the best place for treatment and support is in the persons own home especially those suffering dementia”
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 55–59 years)

“After the fire at George Bryan Centre the lack of a local inpatient facility put pressures on staff, oatients and relatives. The combined area of Staffordshire is too big to assist people with mental health challenges. It should revert back to local teams.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 65–69 years)

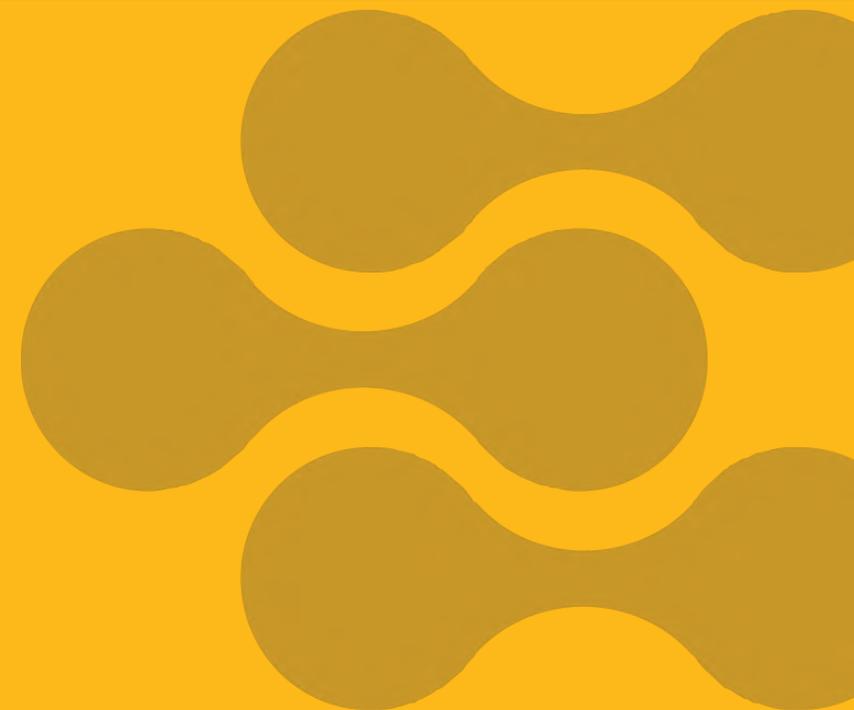
Tell us about your experience of using community mental health services. What do you feel went well and what challenges or issues did you face? **Base: 24**





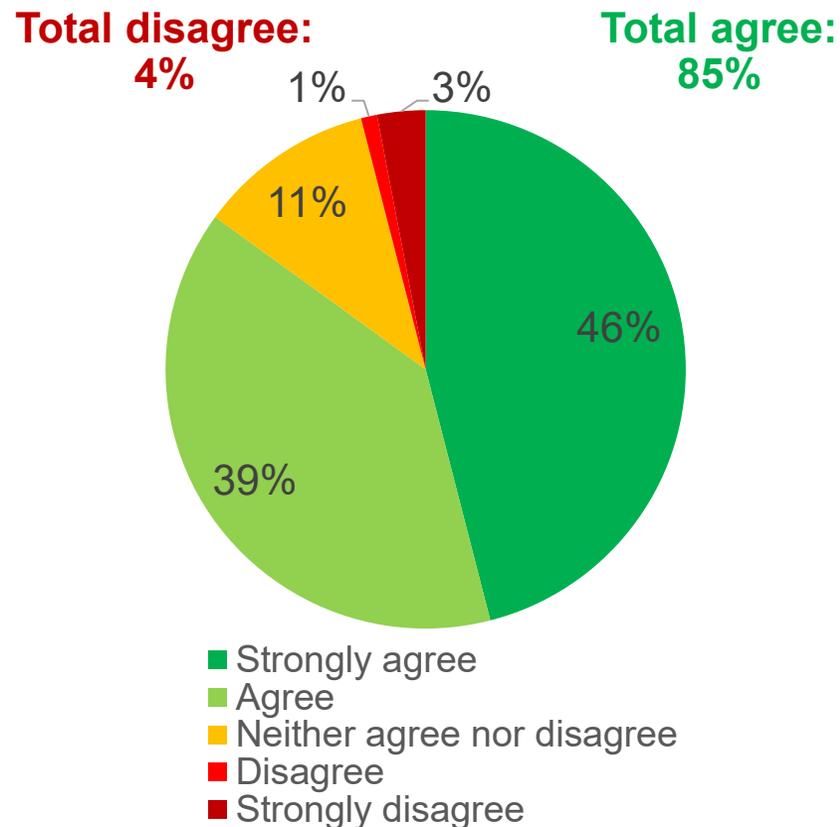
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Feedback on the model of care



Rating the model of care

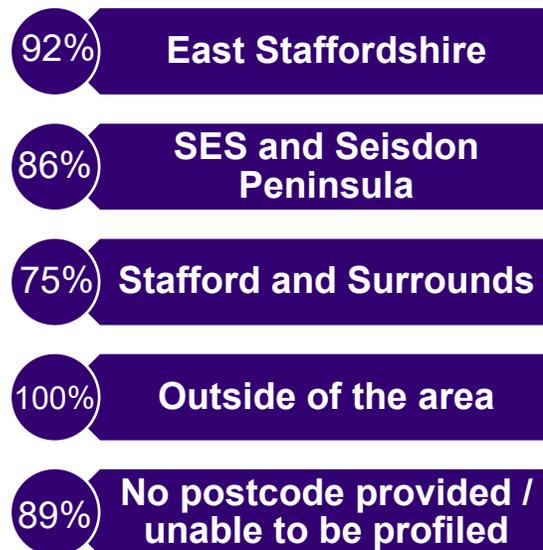
To what extent do you agree or disagree with these principles?



Base: 79

Proportion rating strongly agree / agree

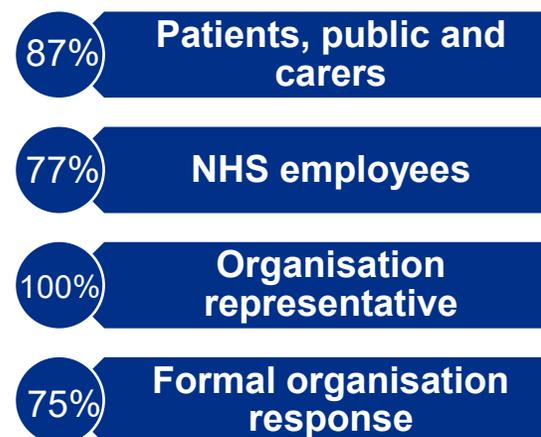
CCG area



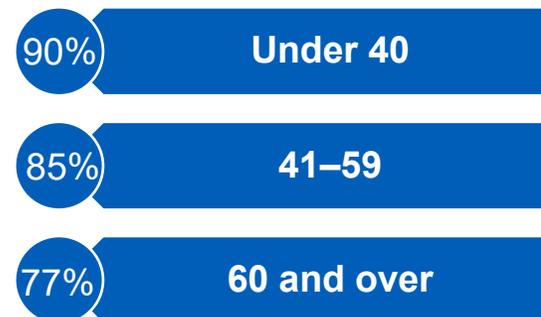
Limited feedback from other CCG areas

Base: 7-42 (CCG area); 4-54 (Respondent type); 17-33 (Age)

Respondent type



Age



Reasons for agreement / disagreement

Tell us why you agree or disagree with these principles

Main themes

Access

Communication

Cost and efficiency

Estates and facilities

General

Quality of care

Service provision

Specific groups

Staff

Key themes



General:

General agreement
with the principles
(19 / 38%)



Quality of care:
Principles will
improve quality of
care
(10 / 20%)



Cost and efficiency:
Consider the need
to implement the
principles
effectively
(9 / 18%)

3

agreement
themes

3

disagreement
themes

10

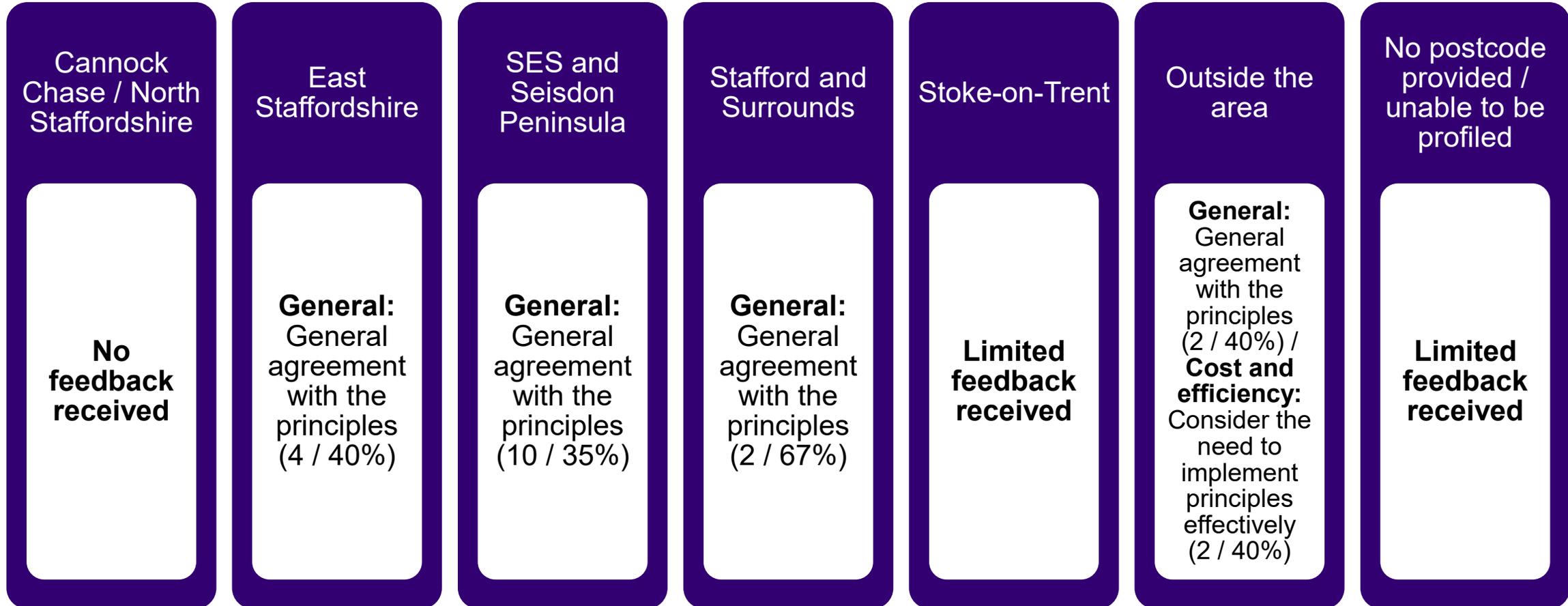
observation
themes

Base: 50

Reasons for agreement / disagreement

Tell us why you agree or disagree with these principles

Top themes by CCG area

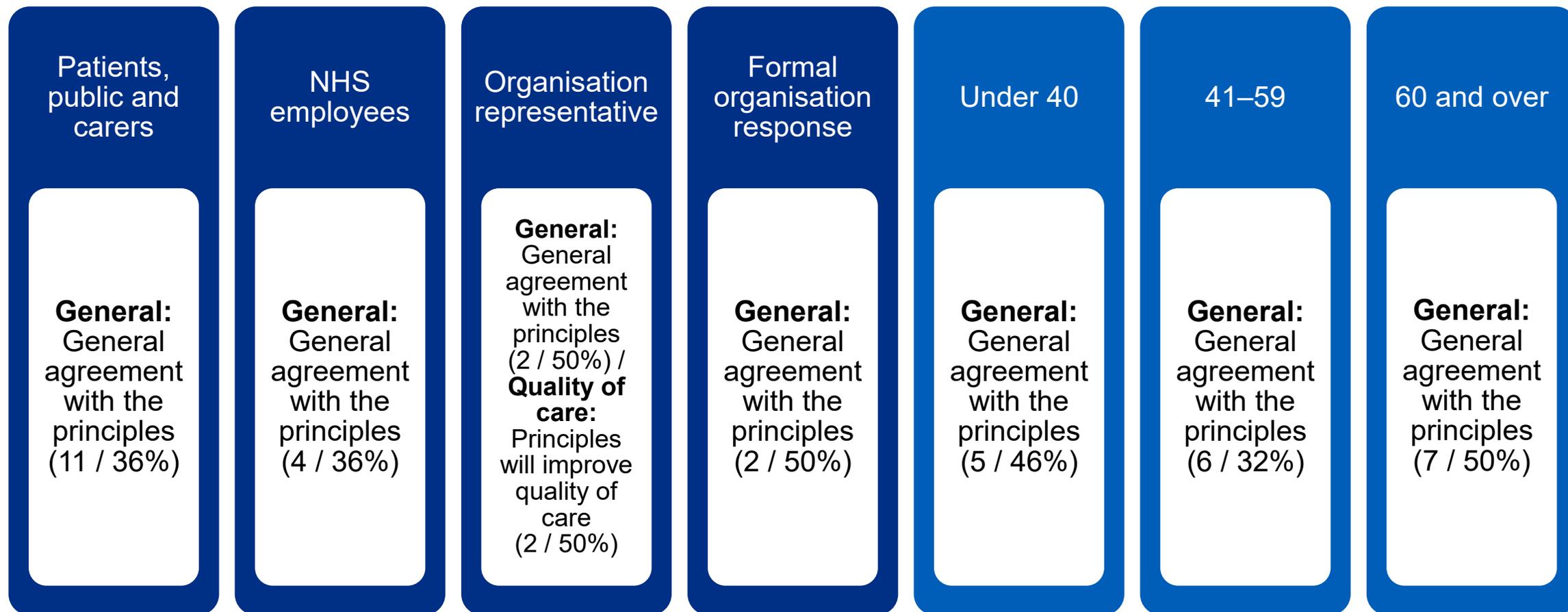


Base: 3–29

Reasons for agreement / disagreement

Tell us why you agree or disagree with these principles

Top themes by respondent type and age



Base: 4–31 (Respondent type); 11–19 (Age)

Reasons for agreement / disagreement: verbatims

“A joined up service that is tailored to your individual needs that can be accessed by the patient when needed. Mental health isn’t necessarily an illness that can be switched off”
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 55–59 years)

“Reducing the replication of story telling will reduce the re-traumatisation of the client and allow for quicker and more targeted treatments.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 30–34 years)

“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’.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, gender not indicated, 55–59 years)

“Throughout the six years that I have cared for my wife I have felt isolated and not always clear in terms of her treatment and the support available. Services are not joined up and there are gaps in the provision of support for people with dementia.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, male, age not indicated)

“The principles sound great, however I don’t think they happen in reality, from what patients regularly feedback”
(NHS Derby and Derbyshire CCG, female, 40–44 years)

“Lack of communication. A central hub does not work for all concerned”
(NHS South East Staffordshire and Seisdon Peninsula CCG, female, 65–69 years)

Tell us why you agree or disagree with these principles. **Base: 50**



Ideas or suggestions

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?

Main themes

- Access
- Communication
- Cost and efficiency
- Estates and facilities
- General
- Integration
- Quality of care
- Service provision
- Specific groups
- Staff
- Technology

Key themes



Staff:

Consider the need for adequate staffing
(e.g. trained staff, improved pay)
(14 / 31%)



Access:

Consider the need for access to care
locally (e.g. through GPs)
(6 / 13%)



Communication:

Consider improving the levels of
communication between staff and
patients
(8 / 18%)



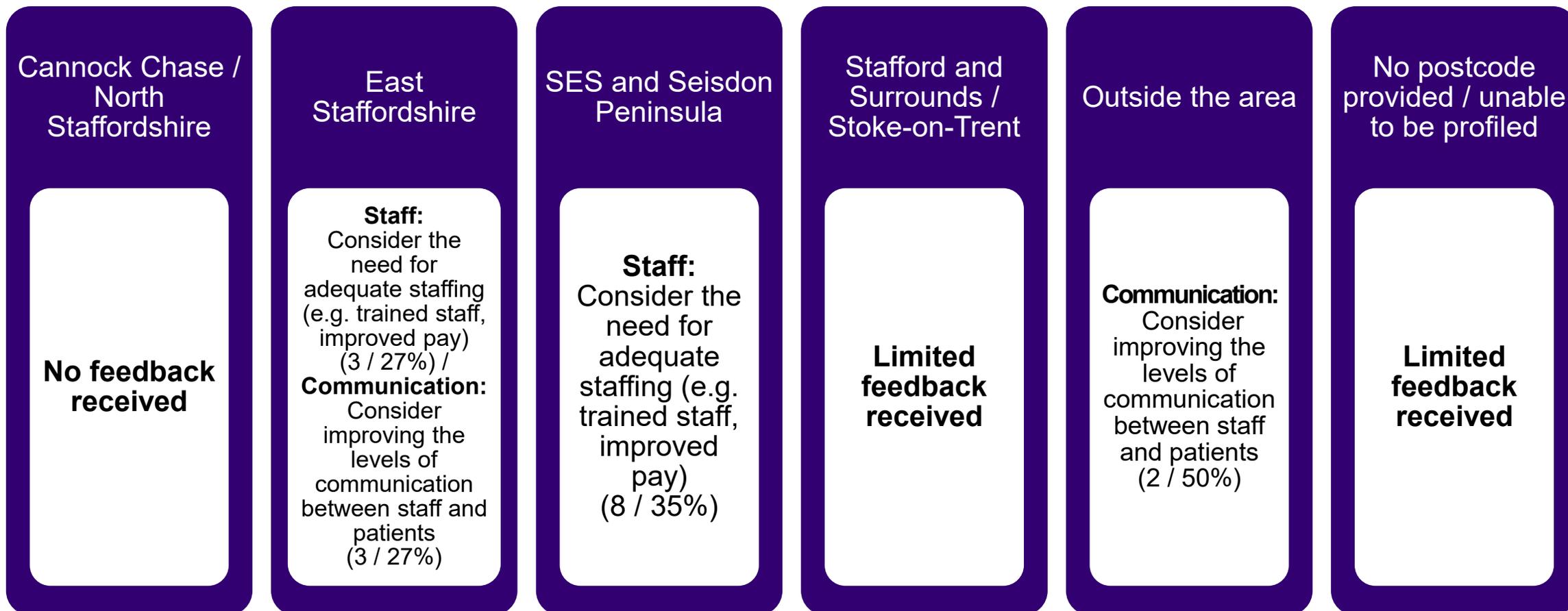
Quality of care:

Consider the need to improve
quality of care
(6 / 13%)

Base: 45

Ideas or suggestions

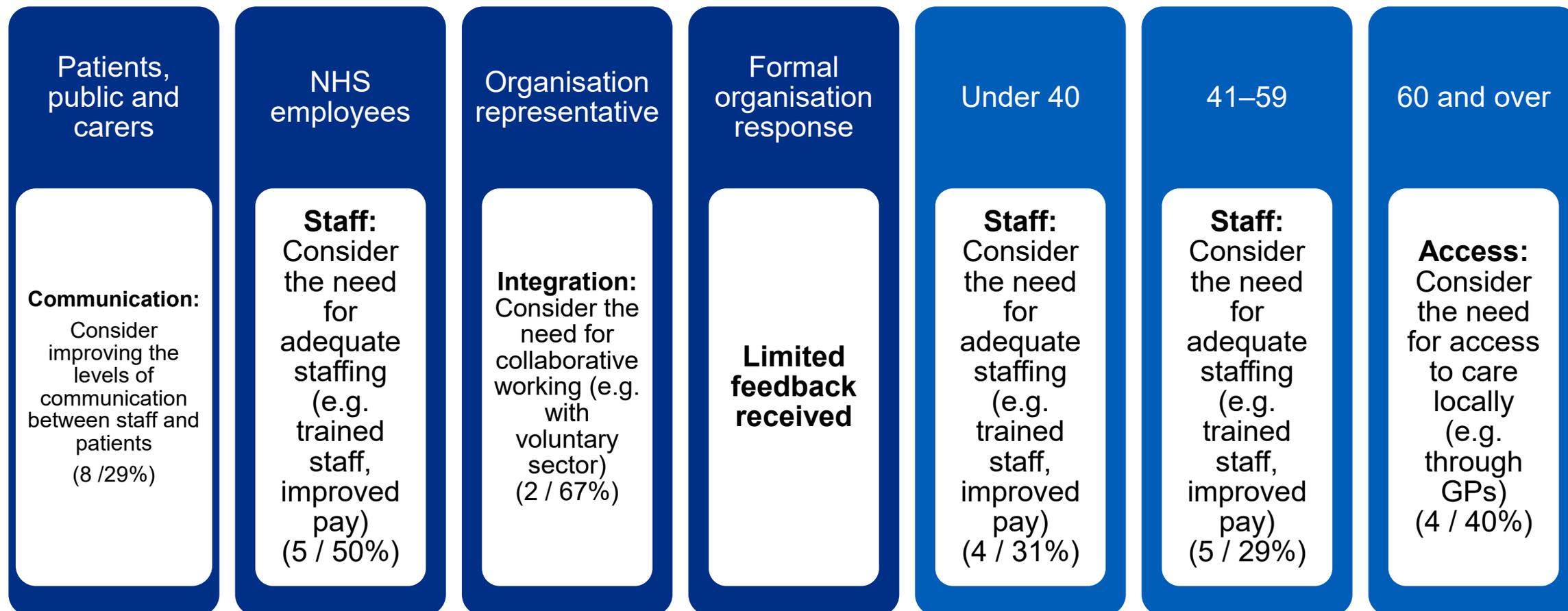
Do you have any other ideas or suggestions about how we could provide mental health services in the future which we can use to help shape this model? Top theme by CCG



Base: 4–23

Ideas or suggestions

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? Top theme by respondent type and age



Base: 3–28 (Respondent type); 10–17 (Age)



Ideas and suggestions: verbatims

“Money needs to be invested in rebuilding the George Bryan Centre. However, not in its previous form. It needs to be a HUB of excellence covering all aspects of the support required for the well being of mental health patients.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, gender not indicated, 65–69 years)

“In south Staffordshire we need: at least one Admiral Nurse; a daycare facility dedicated to supporting people with dementia; an an increase in the support for people being cared for at home.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, male, age not indicated)

“Involve Patient Experts before decision are made.”
(NHS East Staffordshire CCG, female, 75–79 years)

“more groups that are art /craft therapy based rather than cbt etc . respite beds /houses . Sometimes you need to have a safe space that is not at home without needing proper admission - a breathing space .”
(NHS Stafford and Surrounds CCG, female, 55–59 years)

“Take urgent mental care out of hospitals and into small community centres, somewhere where a patient with an urgent condition can walk in and be seen.”
(NHS South East Staffordshire and Seisdon Peninsula CCG, male, 70–74 years)

“Funding probably so that staff aren't at breaking point and to frustrated to support people. It feels like at the moment mental health services are not there to serve patients.”
(NHS Stoke-on-Trent CCG, female, 35–39 years)

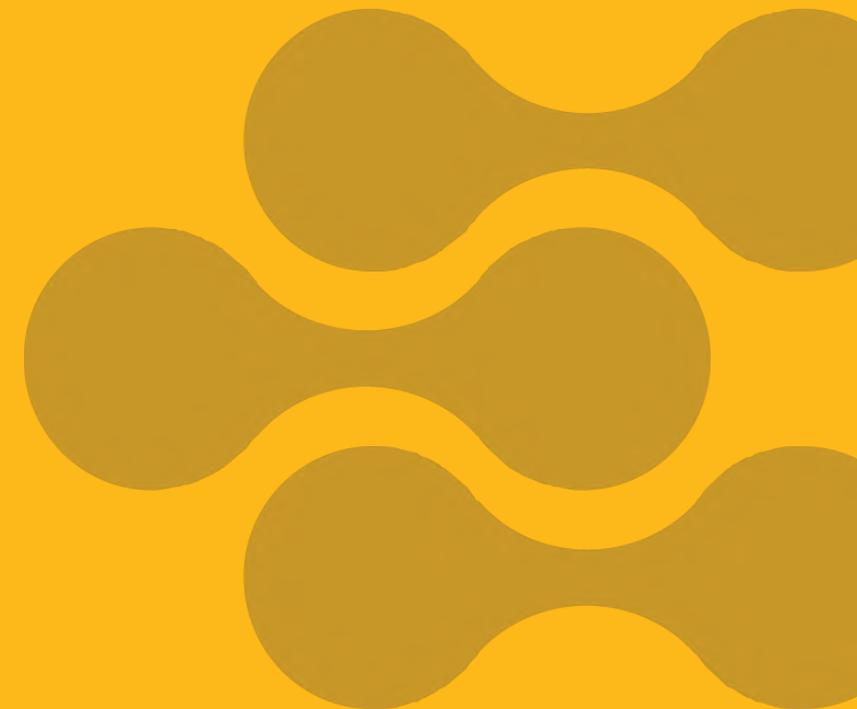
Do you have any other ideas or suggestions about how we could provide mental health services in the future which we can use to help shape this model? **Base: 46**





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Feedback from the events



Experiences and ideas: key themes



Reinstate George Bryan Centre services



Mixed feedback on care during pandemic



Need to improve access to care



Need to ensure adequate staffing



Need to ensure that stakeholder feedback is considered



Consider provision of non-medical services (e.g. art therapy, finance)



Need to increase provision of dementia services



Consider the role of family and carers in supporting patients



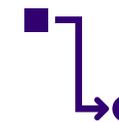
Consider role of voluntary sector



Need to have access to care locally



Consider preventative services



Good discharge process and support

Experiences and ideas: detailed feedback

14 October

- Care was person-centred
- Community-based services worked well
- A&E crisis team provided good quality of care
- Staff were professional and enthusiastic
- Services provided during lockdown were good
- Agreement with plans for community services
- Consider improving inpatient services
- Concern over poor communication between mental health services and GPs
- Communication between staff and service users should be improved
- Concern that stakeholder feedback has not been considered
- Need to improve adult autism services
- Concern over poor quality of community-based services
- Consider the need to support carers/family members of mental health patients
- Consider provision of non-medical support (e.g. housing, debts, life skills)
- Need appropriate staffing (e.g. fewer bank staff)
- Access to diagnosis for people with dementia was difficult during pandemic
- George Bryan Centre should be used as base for charities and mental health teams
- Need to improve access to primary care services
- Concern over increased staff workload and adjustment to remote working
- Discharge process was well organised with support available
- Greater integration with charities is needed
- Consider providing a community hub to connect inpatient and community services
- Consider the need for preventative services
- More mental health support is needed
- Community psychiatric nurses are required in GP practices
- Horninglow Clinic needs updating

18 October

- Concern over poor services during pandemic
- Services should be provided locally in the community
- Concern over travel to St George's Hospital (e.g. poor transport links)
- George Bryan Centre provided good services that should be reinstated
- Location of the George Bryan Centre is accessible
- George Bryan Centre should be extended to incorporate more local services
- Impact of travelling on health should be considered
- Concern over travelling cost to services
- Consider population size
- Lack of services for patients with dementia (e.g. admiral nurses, day care)
- St George's Hospital provided good quality of care
- Access to alternative therapies was available at the George Bryan Centre (e.g. art therapy)
- Need to improve access to mental health support before crisis
- George Bryan Centre provided poor quality of care
- Greater carer / family involvement is needed to improve patient outcomes
- Lack of alternatives to the George Bryan Centre
- Need for further consultation with service users regarding service provision
- Need to improve quality of mental health care to reflect patient needs
- Need for clear pathway on how to reach mental health support



Views on the model of care: key themes



Positive feedback on model of care



Need to implement new model effectively



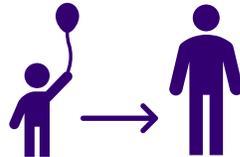
Further consultation is required



Ensure equitable access to mental health services



Need to improve the quality of mental health care



Improve the transition from child to adult services



Greater information about support available is required



Consider provision of activities and non-medical support



Consider dementia services



Ensure collaboration between services



Improve access to mental health support



Need to ensure adequate staffing

Feedback on the model of care

14 October

- Agreement with new model
- Ensure integration and collaborative working
- Need to implement new model effectively
- Consider provision of wide range of activities (e.g. alternative therapies, reiki, yoga, massage)
- Ensure care is patient-centred
- Need for greater integration between community and mental health services
- Need for information about mental health support available and how to access it
- Consider increased population size of areas
- Ensure appropriate staffing without relying on bank staff
- Consider elderly people and patients with dementia
- Need for non-medical support (e.g. shopping)
- Improve the transition from child to adult services
- Need for further consultation with service users
- Transformation planning should involve all stakeholders (e.g. GPs, local authorities, voluntary sector)
- Consider needs of carers
- Need for equal access to mental health support (e.g. no postcode lottery)
- Positive about patient involvement in discussion of personal care plans
- Need for appropriate communication and collaboration between all stakeholders
- Need for continuity and consistency of mental health support (e.g. ongoing support)
- New model will help to reduce pressure on other services (e.g. free up GPs)
- Need to reduce discrimination against people with mental health problems
- Mental health services should be accessible for everyone
- New model offers holistic care.

18 October

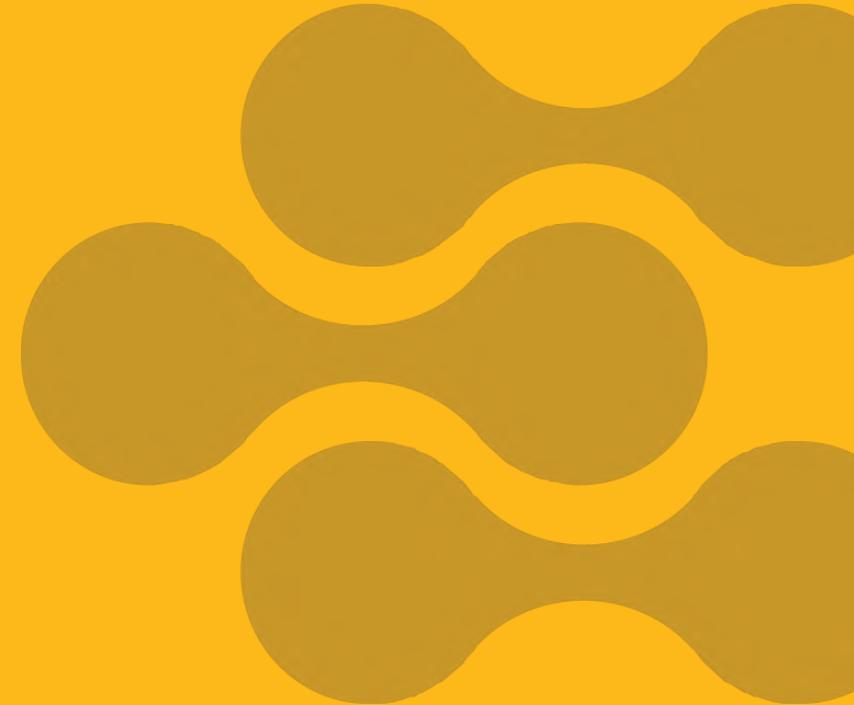
- Need to improve quality of mental health care
- Need to implement new model effectively
- Consider greater utilisation of community facilities to provide mental health support
- Mental health patients require help of professional staff not police
- More details are required
- Waiting times are too long
- Need to access mental health support out of hours
- Greater information about mental health support available is required
- Greater integration between healthcare services is required
- More centres like George Bryan are needed (e.g. in the south of the county)
- Concern over lack of day care and admiral nurses
- Concern over disjointed service provision for patients with dementia
- George Bryan Centre should be used to bring services together





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Summary



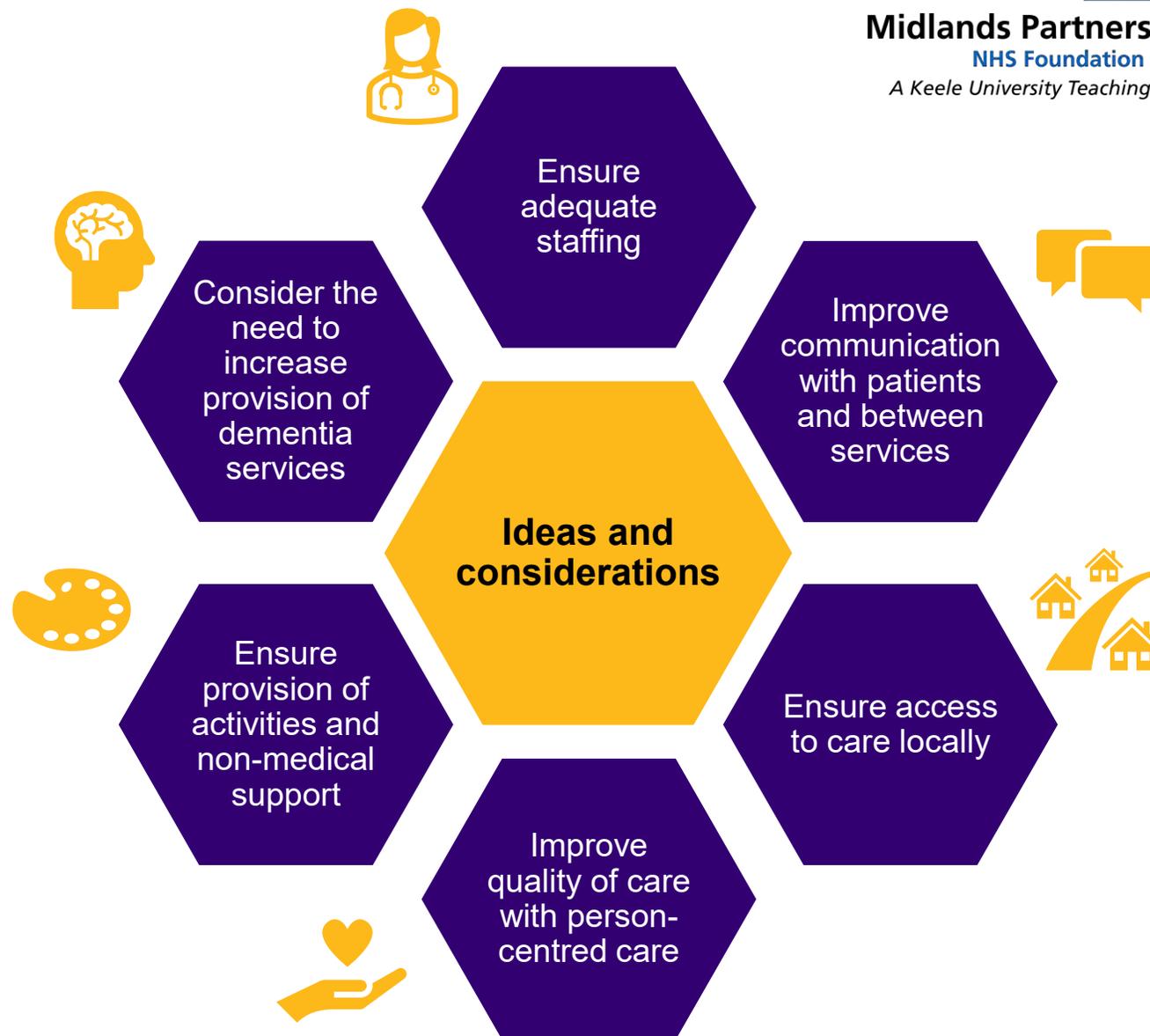
Summary

Experiences of services

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

Views on the model of care

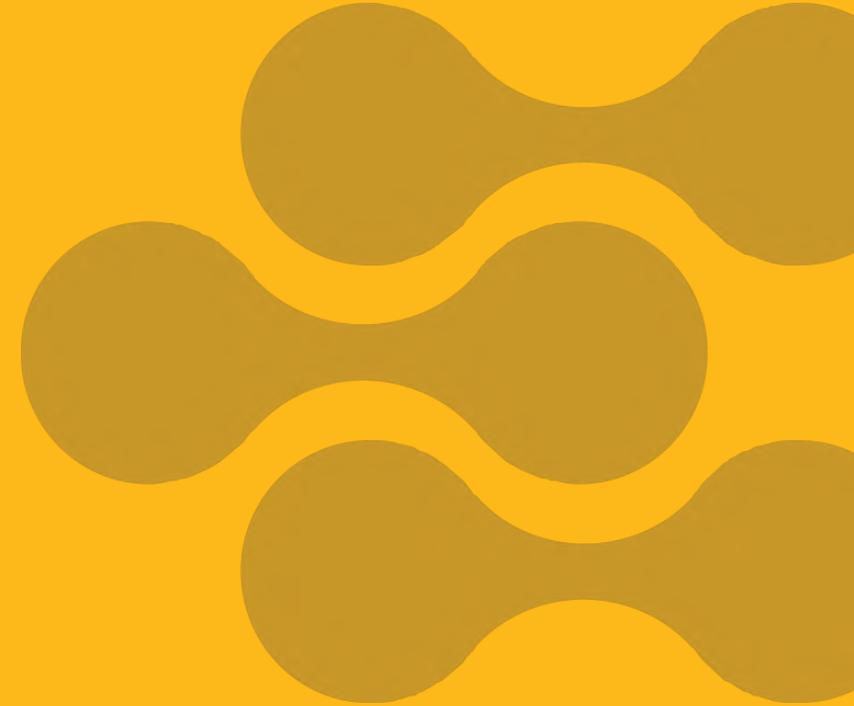
- Agreement with the model and principles
- Need to implement the model effectively
- Need further consultation about changes





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Appendix



Experience of the George Bryan Centre

| Sentiment | Specific themes | Code | Count |
|-------------|------------------------|--|-------|
| Positive | Quality of care | Quality of care was good (e.g. patient-centred) | 8 |
| Positive | Staff | Staff were supportive and caring | 7 |
| Negative | Staff | Staff were unhelpful (e.g. rude, didn't listen) | 7 |
| Negative | Quality of care | Quality of care was poor (e.g. lack of support) | 6 |
| Positive | Access | The George Bryan Centre is in an accessible location (e.g. local) | 5 |
| Observation | Quality of care | Consider the need for support in a crisis | 4 |
| Negative | Service provision | Lack of access to activities (e.g. art room) | 4 |
| Positive | Estates and facilities | The building provided a welcoming and therapeutic environment | 3 |
| Negative | Estates and facilities | The building was not fit for purpose (e.g. poor layout) | 3 |
| Negative | Staff | Not enough staff to meet patient needs | 3 |
| Negative | Quality of care | Lack of care and support following discharge | 2 |
| Negative | Staff | Lack of support available for staff | 1 |
| Negative | Food | The food given to patients was poor | 1 |
| Negative | Access | The George Bryan Centre was not accessible for patients and family members (e.g. lack of public transport) | 1 |
| Observation | Access | Consider the need to reduce waiting times during admission | 1 |
| Observation | Service provision | Consider using the George Bryan Centre as a community mental health support hub | 1 |
| Positive | Service provision | Activities provided were good (e.g. craft, running) | 1 |
| | General | Other | 1 |

Tell us about your experience of using George Bryan Centre. What do you feel went well and what challenges or issues? **Base: 24**



Experience of St George's Hospital

| Sentiment | Specific themes | Code | Count |
|--------------------|-------------------------------|--|-------|
| <i>Negative</i> | Communication | Communication requires improvement | 5 |
| <i>Positive</i> | Staff | Staff were caring | 2 |
| <i>Negative</i> | Quality of care | Quality of care was poor | 2 |
| <i>Negative</i> | Access | St George's Hospital is not in an accessible location (e.g. too far) | 2 |
| <i>Negative</i> | Staff | Staff were unhelpful | 2 |
| <i>Negative</i> | Service provision | Lack of access to activities | 2 |
| <i>Positive</i> | Communication | Communication with patients and family members was good | 1 |
| <i>Positive</i> | Quality of care | Quality of care was good | 1 |
| <i>Negative</i> | Estates and facilities | The building is not fit for purpose (e.g. poor layout) | 1 |
| <i>Negative</i> | Staff | Not enough staff to meet patient needs | 1 |
| <i>Observation</i> | Estates and facilities | Consider the need for single-sex facilities | 1 |
| <i>Positive</i> | Estates and facilities | The building provided good facilities | 1 |

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? **Base: 10**



Experience of community services

| Sentiment | Specific themes | Code | Count |
|-------------|-------------------------------|---|-------|
| Negative | Access | Difficulty in accessing mental health services | 10 |
| Negative | Quality of care | Quality of care was poor | 7 |
| Negative | Quality of care | Lack of continuity of care following discharge | 6 |
| Negative | Staff | Staff were unhelpful (e.g. rude, didn't listen) | 5 |
| Negative | Access | Assessment process is ineffective | 4 |
| Negative | Communication | Communication with patients was poor | 4 |
| Negative | Access | Long waiting times to access the service | 3 |
| Positive | Quality of care | Quality of care was good | 2 |
| Positive | Staff | Staff were helpful and supportive | 2 |
| Positive | Access | Waiting times were short | 1 |
| Observation | Estates and facilities | Consider reopening the George Bryan Centre | 1 |
| Observation | Access | Need more localised services | 1 |
| Observation | COVID | Consider the need for face-to-face care | 1 |
| Observation | Specific groups | Consider the needs of dementia patients (e.g. care at home) | 1 |
| Positive | Estates and facilities | Services were accessible locally | 1 |
| Observation | Quality of care | Maternal mental health services require improvement | 1 |
| Negative | Service provision | Concern over loss of services (e.g. Together for Mental Health) | 1 |
| | General | Other | 1 |

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? **Base: 24**

Feedback on the model of care

Reasons for agreement / disagreement

| Sentiment | Specific themes | Code | Count |
|--------------|-------------------------------|--|-------|
| Agreement | General | General agreement with the principles | 19 |
| Agreement | Quality of care | Principles will improve quality of care | 10 |
| Observation | Cost and efficiency | Consider the need to implement the principles effectively | 9 |
| Observation | Access | Consider the need to improve access to mental health services | 8 |
| Observation | Communication | Consider the need to improve communication | 8 |
| Observation | Cost and efficiency | Consider the need for more joined-up working | 7 |
| Observation | Quality of care | Consider the need to improve quality of care | 2 |
| Disagreement | Service provision | Concern over the closure of the George Bryan Centre reducing service provision | 2 |
| Observation | Specific groups | Consider the needs of vulnerable patients (e.g. who cannot be cared for at home, dementia) | 2 |
| Observation | Cost and efficiency | Consider the need for adequate resources to implement principles | 2 |
| Agreement | Access | Principles will improve access to care | 2 |
| Disagreement | Cost and efficiency | A central hub will reduce service efficiency | 2 |
| Observation | Quality of care | Consider the need for improved continuity of care (e.g. after discharge) | 2 |
| Disagreement | Cost and efficiency | Concern that principles will involve privatisation of NHS services | 1 |
| Observation | Staff | Consider the need for adequate staffing | 1 |
| Observation | Estates and facilities | The George Bryan Centre should be demolished | 1 |
| | General | Other | 2 |

Tell us why you agree or disagree with these principles. **Base: 50**

Feedback on the model of care

Other ideas or suggestions

| Sentiment | Specific themes | Code | Count |
|-------------|-------------------------------|--|-------|
| Observation | Staff | Consider the need for adequate staffing (e.g. trained staff, improved pay) | 14 |
| Observation | Communication | Consider improving the levels of communication between staff and patients | 8 |
| Observation | Access | Consider the need for access to care locally (e.g. through GPs) | 6 |
| Observation | Quality of care | Consider the need to improve quality of care | 6 |
| Observation | Access | Consider simplifying the access to services for patients | 4 |
| Observation | Cost and efficiency | Consider the need for greater investment in mental health services (e.g. more beds) | 4 |
| Observation | Estates and facilities | Consider rebuilding the George Bryan Centre | 3 |
| Observation | Service provision | Consider greater provision of therapies and interventions (e.g. psychological therapies) | 3 |
| Observation | Access | Consider greater access to mental health assessments | 3 |
| Observation | Communication | Further consultation with patients and the community is required | 2 |
| Observation | Quality of care | Consider improving discharge process (e.g. aftercare) | 2 |
| Observation | Technology | Consider the use of video calls (e.g. instead of telephone) | 2 |
| Observation | Integration | Consider the need for collaborative working (e.g. with voluntary sector) | 2 |
| Observation | Specific groups | Consider the needs of vulnerable patients (e.g. patients with disabilities, dementia) | 2 |
| Observation | Service provision | Consider provision of art and craft therapy | 1 |
| Observation | Quality of care | Consider taking care of physical and mental health together | 1 |
| Observation | Integration | Electronic patient records should be accessible in social and health care | 1 |
| Observation | Access | Consider widening access to services at the George Bryan Centre (e.g. walk-in, all ages) | 1 |
| Observation | Quality of care | Consider the need to improve maternal mental health services | 1 |
| Observation | Service provision | Consider the need for preventative services | 1 |
| Observation | Estates and facilities | Consider utilising existing NHS estate (e.g. Geoffrey Hodges Building) | 1 |
| | General | Other | 4 |

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? **Base: 46**



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 |

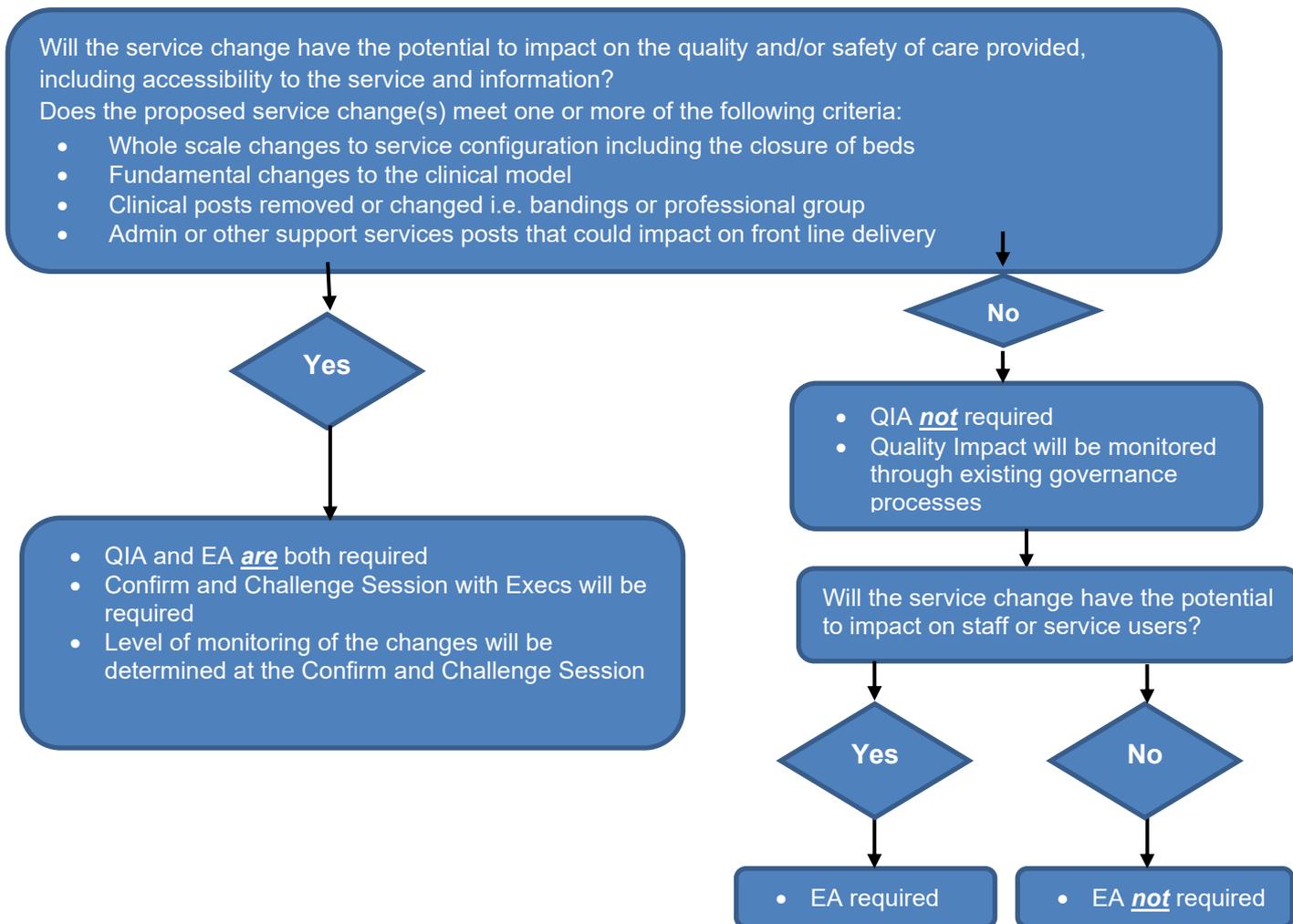
Section 1 - Screening - is an Impact Assessment Required?

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 31 st 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 an 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.

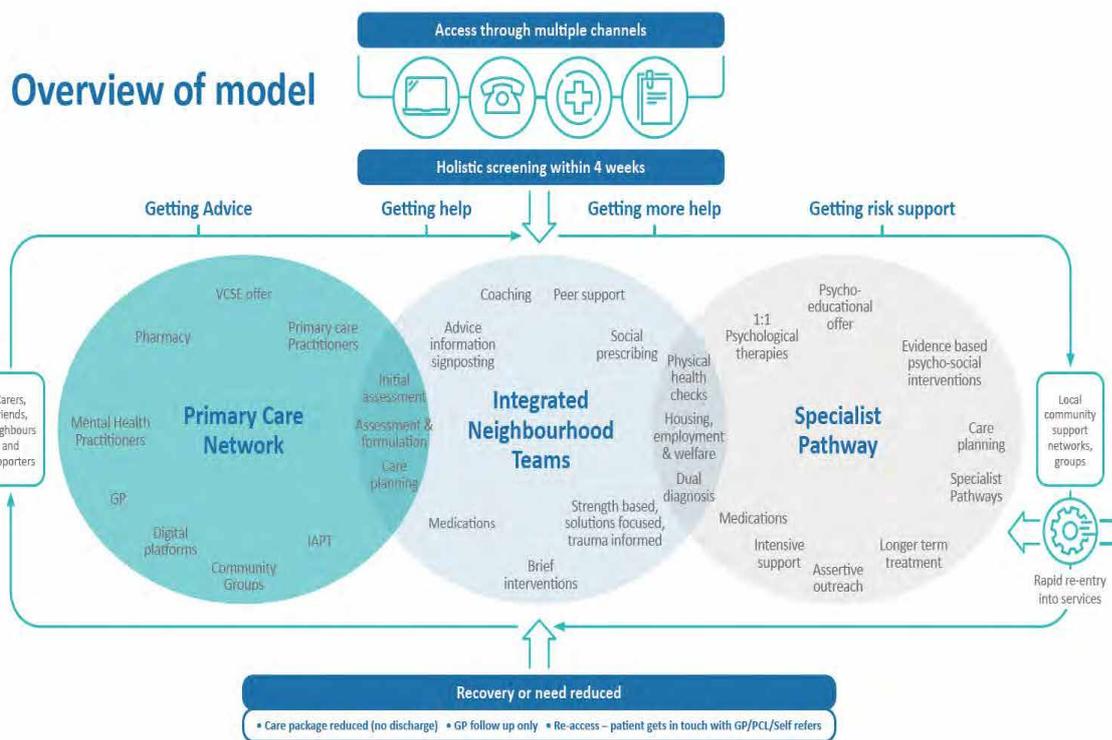
Option Two is the consolidation and re-affirming of the current transformed community service pathway and inpatient facilities.

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’ November 2021*
- *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 | <p>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.</p> <p>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</p> | |

| | | | |
|--|-----|--|--|
| | | <p>the Trust is overall.</p> <p>The clinical evidence suggests that older adults are better served in the community than an admission to hospital. <i>Literature review available for reference: 'Literature Search Results: Dementia and inpatient facilities' November 2021</i></p> <p>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.</p> <p>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 which include reputational risks which have been mitigated by our communications team. <i>George Bryan Project Risk Register</i></p> | |
| 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. <i>Literature review available for reference: 'Literature Search Results: Dementia and inpatient facilities' November 2021</i> | |
| 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 | <p>Advantages</p> <ul style="list-style-type: none"> • 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 <p>Disadvantages</p> <ul style="list-style-type: none"> • 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. <i>Mitigations: George Bryan Project Risk Register</i> | |

| Overall Baseline Risk Assessment | | | | | | |
|--|---------------------|---|----------------------|---|--------------------|--|
| What is the likely overall impact of this service change on quality? | Improves Quality | ✓ | Maintains Quality | ✓ | Reduces Quality | |
| <p>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.)</p> | | | | | | |
| <p>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:</p> <p>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.</p> <p>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.</p> <p>There are also new elements to the pathway which enhance the community care and ensure the service is running safely:</p> <ul style="list-style-type: none"> • 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' November 2021*

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. | |
|--|---|--|

| | | |
|---|--|--|
| | <p>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.</p> <p>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.</p> <p>Service to work with data or information from the consultation feedback to support a positive impact.</p> <p>Learning from any Serious Incidents, PALs Complaints or Service User Feedback to be shared with the Service/Staff.</p> <p>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.</p> | |
| How and why is this protected characteristic relevant to the proposed activity? | <p>Age – is a relevant protected characteristic due to the age of service user that commonly requires the service.</p> <p>Services are for older adult mental health needs.</p> | |
| 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? | <p>Potential for additional travel time and costs for families and carers.</p> <p>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.</p> | |
| 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; | | | |
| <ul style="list-style-type: none"> - 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

Appendix 13 – Governance process boards and committees

| | Meeting | Chair | Paper/Author | Frequency |
|---|--|---|---|--|
| | Trust Board | Non-Executive Director | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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 | <p>The Care Group summaries are bi-monthly, however Care Groups can take additional reports if required.</p> <p>Serious Incident Report and Board Assurance Framework Report – Monthly</p> <p>Mental Health Act Legislation Report - Quarterly</p> |
| ↑ | Staffordshire and Stoke on Trent Care Group Quality Governance Sub Committee | Clinical Care Director for the Care Group | <ul style="list-style-type: none"> • 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 |

| | | | | |
|---|--|---|--|---------|
| | | | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |

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:

Brief Description of the scheme (including proposed timescales):



The image shows a large, empty rectangular box with a thin black border, intended for the user to provide a brief description of the scheme. The box is currently blank, except for a large, faint, diagonal watermark that reads 'FINAL' in a stylized font.

Methods to be used to monitor quality impact:

Monitoring of data will come from MPFT's internal 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 |

| | |
|-----------------|--|
| 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 | |

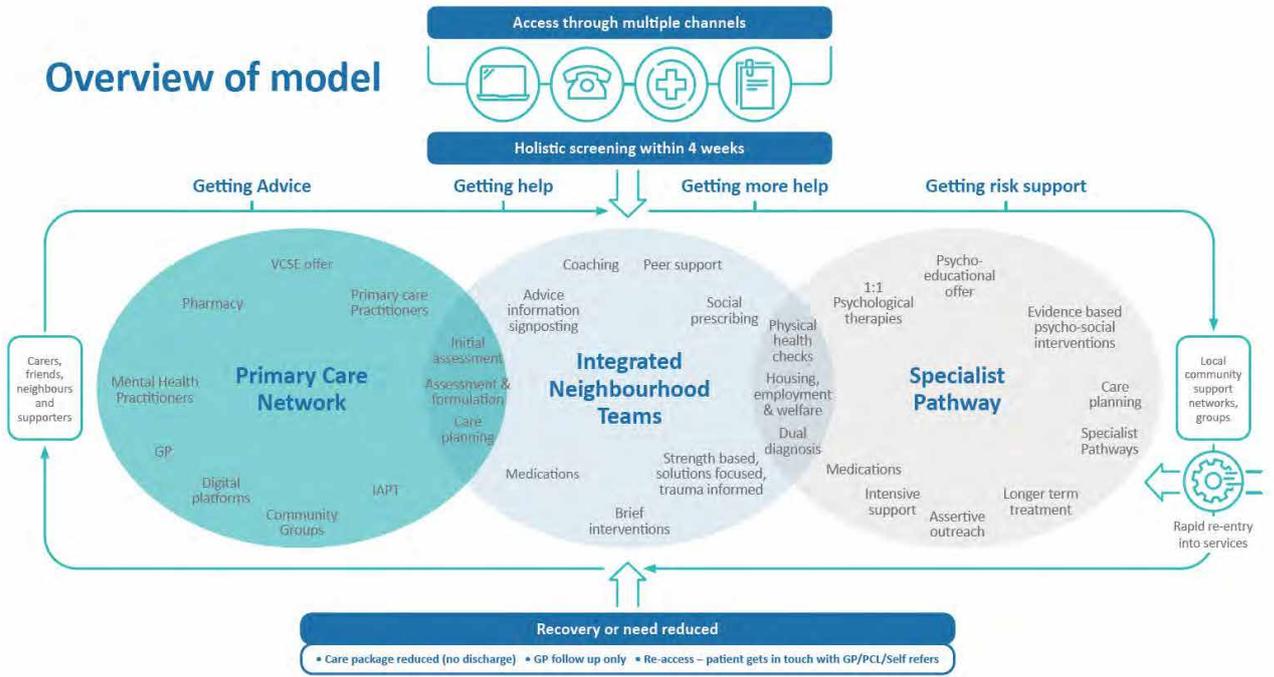
PLEASE INSERT THE SERVICE REFERRAL PROCESS

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



FEMNT

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.

| <u>Patient Safety</u> | | | | | | | | | |
|---|------|------|------|-------|------|------|----------------|--|--|
| Consider: <i>Any potential harm to patients</i> <i>The potential for impact on incidents</i> <i>Healthcare Associated Infections</i> <i>Safeguarding of adults and children</i> <i>Impact on children and Young People aged 0-25 with Special Educational needs and Disabilities (SEND)</i> | | | | | | | | | |
| Positive Impact | | | | | | | Neutral Impact | Negative Impact | |
| <u>SMI inpatient admissions</u> | | | | | | | | | |
| 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) | | | | | | | | | |
| Site | Ward | 2017 | 2018 | 2019* | 2020 | 2021 | Grand Total | There have been no issues identified over the 2-year period that the model has been in situ. | |
| | | | | | | | | | |

Appendix 14 QIA
 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

| | | | | | | | | | |
|-----------------------------|----------------------------|-----------|-----------|-----------|-----------|-----------|------------|--|--|
| 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 | | |

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| <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | | |
| <p><i>Mitigation: for negative impact (include score below)</i></p> | | |
| <p>Likelihood Score</p> | <p>Consequence Score</p> | <p>Overall Risk Score</p> |

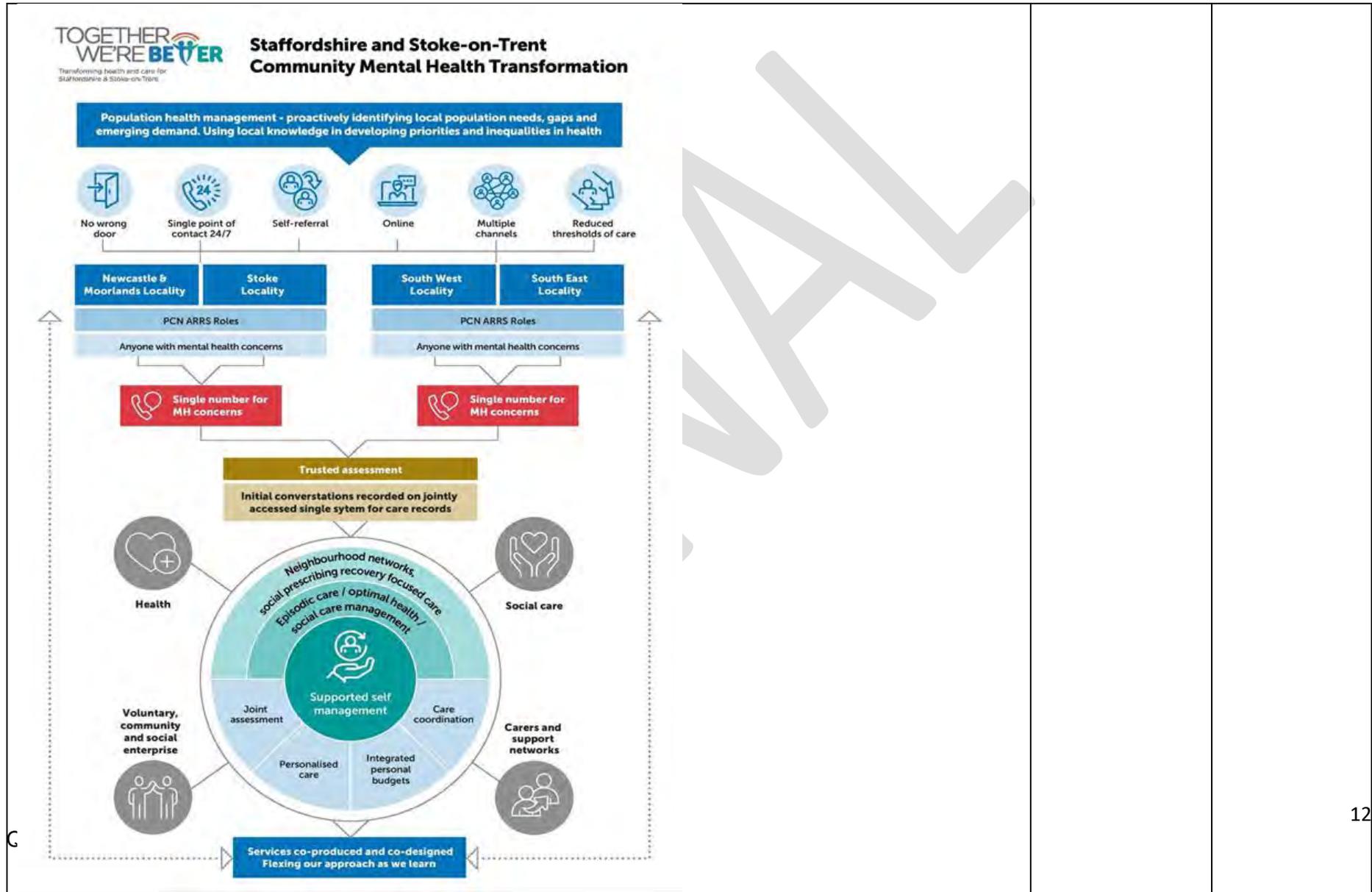
September 2020

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| <u>Duty of Quality</u> Consider: <i>Continuous improvement</i> <i>The NHS Constitution</i> <i>Strategic partnerships</i> <i>Alignment to the STP</i> <i>Impact on the wider health economy</i> <i>Health inequalities</i> <i>Shared risk</i> <i>Children and Young People aged 0-25 with Special Educational needs and Disabilities (SEND)</i> | | |
| Positive Impact | Neutral Impact | Negative Impact |
| <p>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.</p> <p>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.</p> | <p>SMI inpatient admissions</p> <p>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</p> | <p>Greater risk of health inequalities</p> <p>Evidence shows that being in touch with family, carers and friends is beneficial to patients with SMI.</p> |

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| <p>Local challenges</p> <ul style="list-style-type: none"> • Health and wellbeing • Service provision • Resource utilisation • Prevention • Primary care • Fragmented contracted pathways • Frailty <p>Delivering the five year plan</p> <p>Delivered through</p> <ol style="list-style-type: none"> 1. Focussed prevention 2. Enhanced integrated primary and community care 3. Urgent and emergency care 4. Planned care 5. Personalised care 6. Mental health 7. Maternity and neonatal 8. Cancer 9. Learning disability and autism 10. Children and young people <p>Evidenced by:</p> <ul style="list-style-type: none"> • Metrics and measures • Diagnostics • Benchmarks <p>Delivering our system priorities</p> <p>Delivered through</p> <ol style="list-style-type: none"> 1. Primary Care Transformation 2. Workforce 3. Digital 4. Estates 5. Research and innovation <p>Evidenced by:</p> <ul style="list-style-type: none"> • Benchmarking • Metrics and measures <p>Delivery of a sustainable system architecture</p> <p>Delivered through</p> <ol style="list-style-type: none"> 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 <p>Evidenced by:</p> <ul style="list-style-type: none"> • Supporting strategies and action plans <p>Core principles: Reduce service demands and costs, improving service provision</p> | <p>that can be offered in a larger hospital.</p> <p>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.</p> | |
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| <p>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.</p> <p><u>Inpatient Beds for patients with severe mental illness</u> 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.</p> | | |
| <p>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:</p> <ul style="list-style-type: none"> • 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. <p><i>Mitigation: for negative impact (include score below)</i> <u>Enhanced Community Service Offer for older adults with severe mental illness, including dementia</u></p> | | |

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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 |
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| 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.*

Appendix 14 QIA
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

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| Children and Young People aged 0-25 with Special Educational needs and Disabilities (SEND) | | |
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| Positive Impact | Neutral Impact | Negative Impact |

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| <p>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</p> <div style="border: 1px solid blue; padding: 10px; margin: 10px 0;"> <p>The themes from that exercise included:</p> <ol style="list-style-type: none"> 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. </div> <p>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.</p> | | <p>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.</p> <p>Patient experience Some patients gave positive feedback about GBC</p> |
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| <p>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.</p> <p>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.</p> <p>The 2021 events produced similar comments to those listed above from 2019. Specifically, the themes numbered 1, 3 and 5 above were repeated.</p> <p>There was continuing support for the George Bryan Centre to be kept, to meet local needs.</p> <p>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.</p> <ul style="list-style-type: none"> • “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.” <p>New themes in the 2021 events were:</p> <table border="1" data-bbox="203 1214 1406 1401"> <tr> <td data-bbox="203 1214 808 1326">Need for improved communication</td> <td data-bbox="808 1214 1406 1326">“We need a pathway – people need to know where to go to get help”</td> </tr> <tr> <td data-bbox="203 1326 808 1401">Reports of difficulties during COVID-19 pandemic</td> <td data-bbox="808 1326 1406 1401">“Access to diagnosis for people with dementia was difficult during pandemic”</td> </tr> </table> | 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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| Reports of difficulties during COVID-19 pandemic | “Access to diagnosis for people with dementia was difficult during pandemic” | | | | | |

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| <p>Need for earlier intervention and preventative services</p> | <p>“With things in place people would not get to the point where they need admission”</p> | | |
| <p>At the events, people were also asked to comment on the new model of care. The themes that emerged included:</p> | | | |
| <p>Ensure integration and collaborative working</p> | <p>“Services across the patch are not aware of each other and their services. GB should be bringing all these services together”</p> | | |
| <p>Need for communication and information (like about how to access services)</p> | <p>“Make the pathway available to everyone so they are aware”</p> | | |
| <p>Need to implement the new model effectively</p> | <p>“Proposal sounds great in theory. It’s the practice that counts. Remove barriers and expand access”</p> | | |
| <p>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.</p> | | | |

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| <p>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.</p> <p>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.</p> <p>Location Involvement comments have suggested that St George’s location is an advantage – patients have access to activities outside hospital.</p> <p>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)</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • Community Mental Health Nurse (CMHN) allocated from the Home Treatment team | | |
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| <ul style="list-style-type: none"> • 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. <p>Community service provision based on previous patient experience</p> <p>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.</p> | | |
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| <p>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</p> <p>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.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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</p> | | |
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| can safely remain at home, or an alternative environment and provides support and respite to carers/ relatives out of hours. | | |
| <i>Mitigation: for negative impact (include score below)</i> | | |
| <p>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.</p> <p>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.</p> <p>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.</p> | | |
| Likelihood Score | Consequence Score | Overall Risk Score |
| 2 | 2 | 4 |
| <p><u>Clinical Effectiveness</u></p> <p>Consider:</p> <p><i>Evidence based practice</i></p> <p><i>The Clinical leadership and engagement</i></p> <p><i>Impact on consistency of care</i></p> <p><i>NICE compliant treatment / care</i></p> <p><i>Potential re-admission rates to inpatient facilities</i></p> | | |

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| Positive Impact | Neutral Impact | Negative Impact |
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| <p>Clinical Evidence Base</p> <p>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:</p> <ul style="list-style-type: none"> • Holistic, person-centred care, with services that are joined up <ul style="list-style-type: none"> ➢ 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 <p>Treatment of patients with dementia</p> <p>Evidence from the dementia care pathway (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can:</p> <ul style="list-style-type: none"> • 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. <p>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:</p> | | <p>Greater risk of health inequalities</p> <p>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.</p> |

| <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p> <p>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.</p> <p>Timeline and details of Clinical Engagement</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Meeting</th> <th>Notes</th> </tr> </thead> <tbody> <tr> <td>2018/19</td> <td>STP MH Programme Board</td> <td>Mental Health case for change developed through the Board, building on the NHS Long Term Plan</td> </tr> <tr> <td>May 2019</td> <td>West Midlands Clinical Senate</td> <td>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</td> </tr> </tbody> </table> | 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 | | |
|--|-------------------------------|---|-------|---------|------------------------|---|----------|-------------------------------|---|--|--|
| 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 | | | | | | | | | |

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| | | 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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| | | <p>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.</p> | | | |
| <p>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.</p> | | | | | |
| <p>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.</p> | | | | | |
| <p>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.</p> | | | | | |
| <p><i>Mitigation: for negative impact (include score below)</i> 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</p> | | | | | |

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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 |
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| <p>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)</p> | | <i>No negative impact</i> |

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| <p>Service user involvement in developing the new model of care, which will also encourage promotion of self-care.</p> <p>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.</p> <p>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.</p> | | |
| <p><i>Mitigation: for negative impact (include score below)</i></p> | | |
| <p>Likelihood Score</p> | <p>Consequence Score</p> | <p>Overall Risk Score</p> |
| <p>2</p> | <p>1</p> | <p>2</p> |
| <p style="text-align: center;"><u>Prevention</u></p> <p>Consider: <i>promoting people to stay well</i> <i>promoting self-care for long term conditions</i> <i>reduction of health inequalities</i> <i>prevention of people dying prematurely</i></p> | | |
| <p style="text-align: center;">Positive Impact</p> | <p style="text-align: center;">Neutral Impact</p> | <p style="text-align: center;">Negative Impact</p> |
| <p>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</p> | | |

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| | | |
|--|--|---|
| <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | | <p><i>No negative impact identified</i></p> |
| <p><i>Mitigation: for negative impact (include score below)</i></p> | | |

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| Likelihood Score | | | Consequence Score | Overall Risk Score |
|--|--|--|-------------------|---|
| 2 | | | 1 | 2 |
| Operational Impact | | | | |
| <p>Consider: <i>Staff having relevant capability, skills and knowledge</i> <i>Impact on violence/aggression experienced by patients or staff</i> <i>Impact on targets such as waiting times</i> <i>Staff engagement</i> <i>Staff terms of conditions, base change, role change</i> <i>Potential impact on other services / stakeholders such as primary care</i></p> | | | | |
| Positive Impact | | Neutral Impact | | Negative Impact |
| <p>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.</p> <p>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</p> | | <p>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.</p> | | <p>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.</p> |

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| | | |
|--|---|--|
| <p>anticipated as a result of this proposal. There are no foreseen TUPE transfers as a result of this proposal.</p> <p>Redeployment process Staff were involved throughout the redeployment process and were enabled to choose which post they wished to move to.</p> <p>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.</p> <p>All West and East staff have been redeployed following the fire.</p> <p>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.</p> <p>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.</p> |  | |
|--|---|--|

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| | | |
|--|--------------------------|---------------------------|
| <p>Staff supported Staff more supported to successfully deal with patients in crisis- evidenced by police call out data.</p> <p>There is Consultant support on site at all times.</p> | | |
| <p><i>Mitigation: for negative impact (include score below)</i> Additional wards have been made available at St. Georges Hospital. Staff have been given excess travel costs to cover the additional mileage.</p> | | |
| <p>Likelihood Score</p> | <p>Consequence Score</p> | <p>Overall Risk Score</p> |
| <p>2</p> | <p>2</p> | <p>4</p> |

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

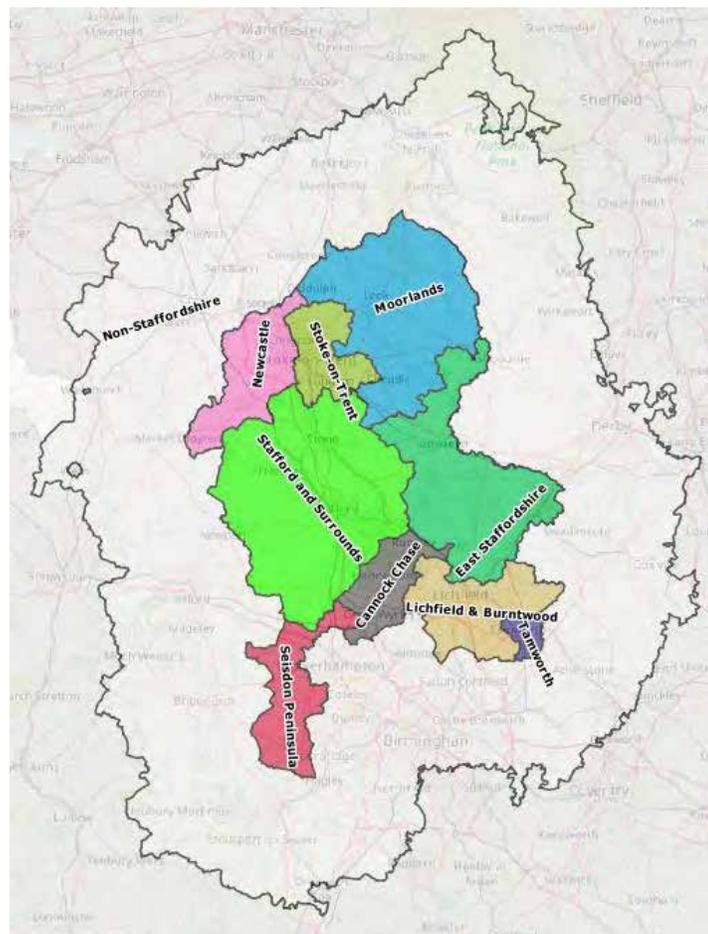
Admissions of adult patients (aged 18+) from 6 local authority district areas to wards with security level = 0 at St. George's (excluding Kinver and Mother & Baby Units), Redwoods and Harplands Hospital in the 24 months after closure have been included to assess the potential impacts on those patients 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

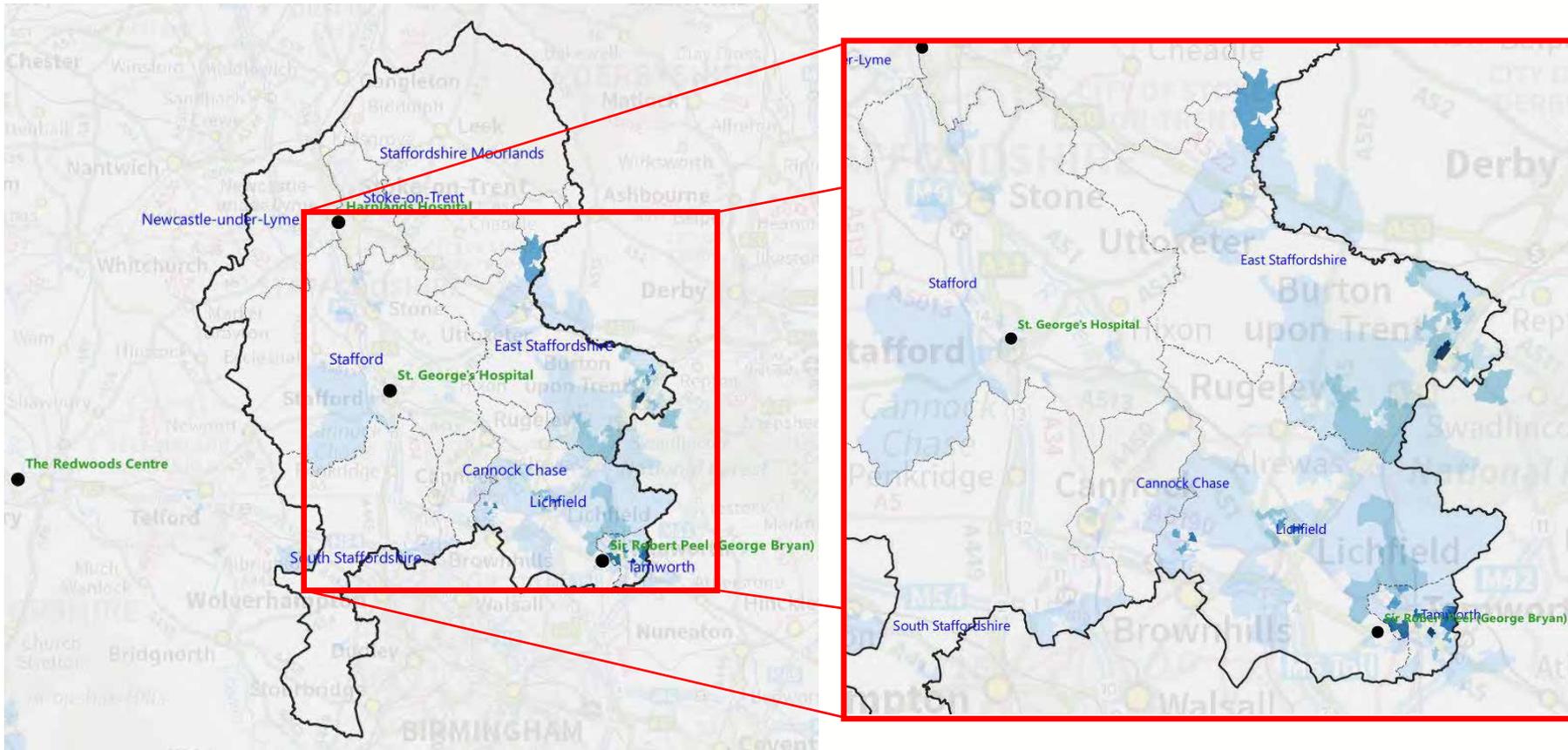
There are no data collected on mode of transport to inpatient settings in routine health and care data nor of any arrangements for visitors. As such, we will analyse all patient admissions by both modes from the output area of their usual residence to give a sense of relative impacts should either car 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

| Variable | Pre-closure @ George Bryan | | Post-closure 'assigned' to GB | |
|---|----------------------------|----------|-------------------------------|----------|
| | % 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 |

| Variable | Pre-closure @ George Bryan | | Post-closure 'assigned' to GB | |
|-----------------------|----------------------------|----------|-------------------------------|----------|
| | % 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.

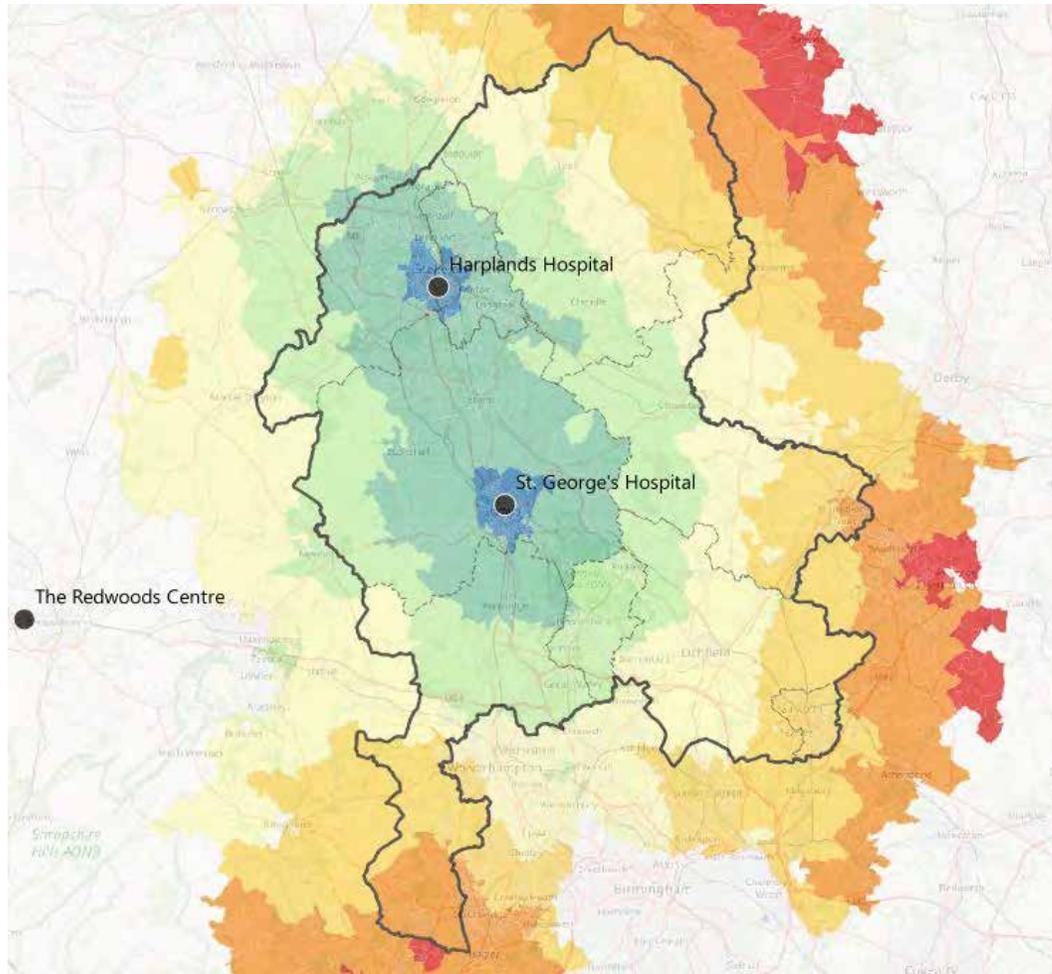
Given current public transport routes and schedules, there will only be a small geographical area for whom public transport access will be improved by re-instating a facility at the George Bryan site. This affects mainly Lichfield and Tamworth.

Some patients that previously would have admitted to George Bryan will be nearer to care.

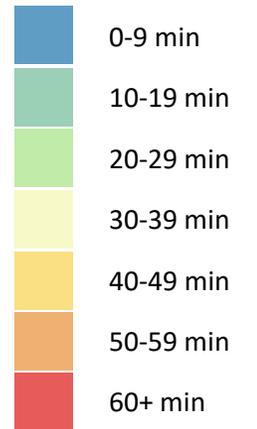
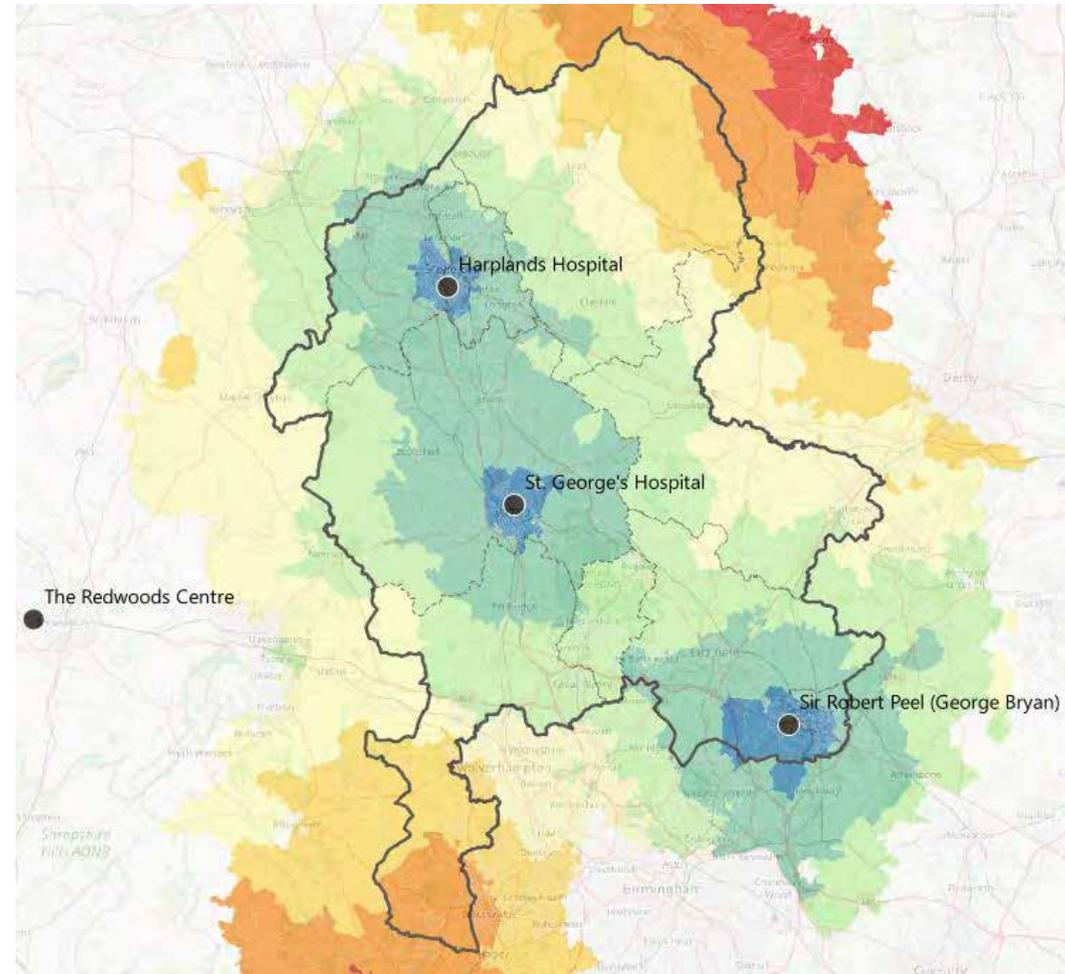
In general, public transport access to inpatient mental health facilities is poor with large areas being an hour or more away and some areas having no access at all.

Car travel, peak weekdays

Current configuration

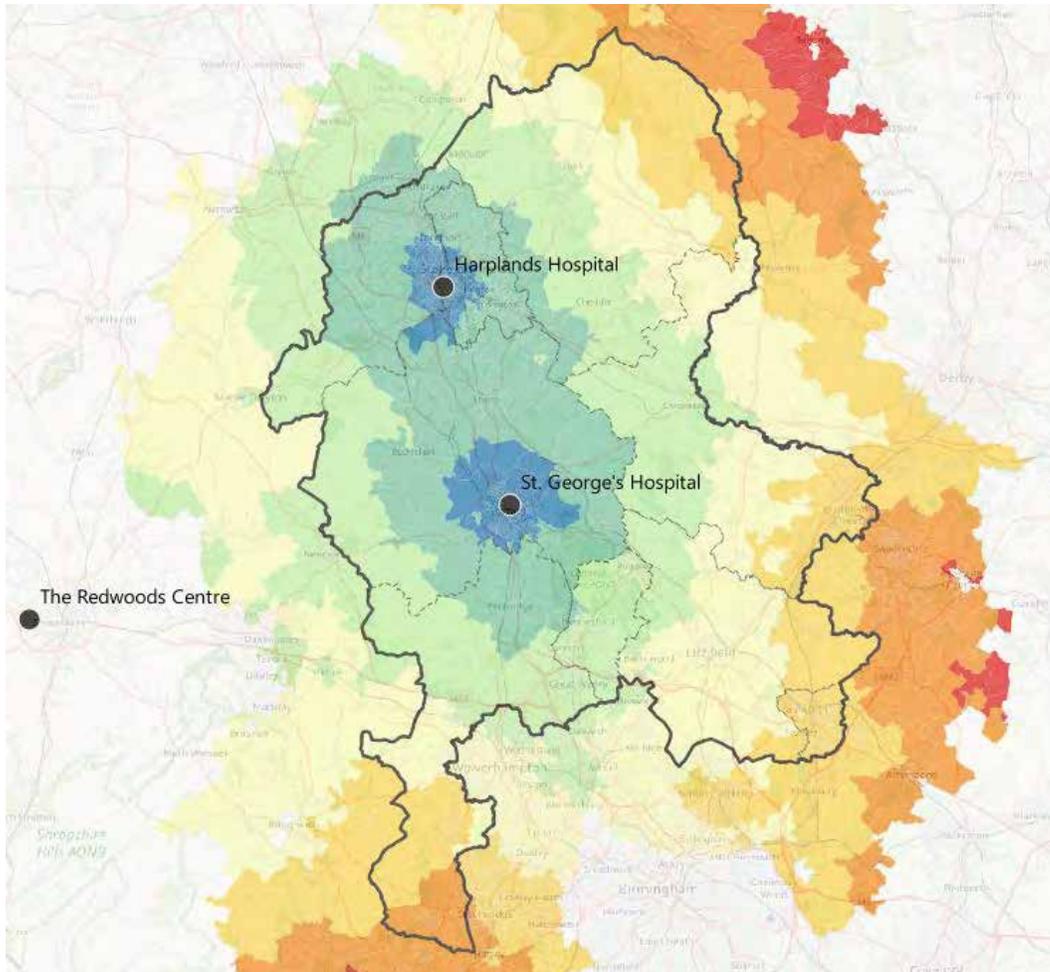


If George Bryan centre open

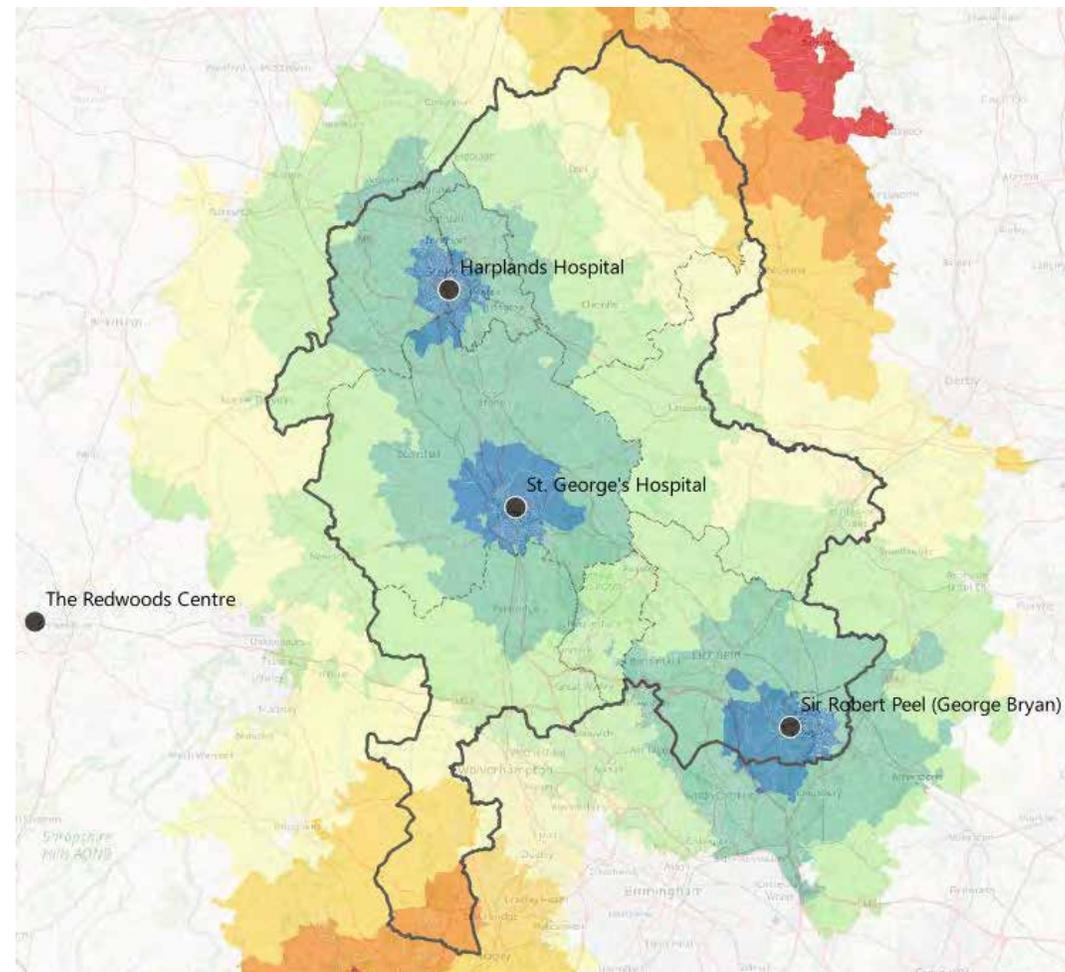


Car travel, weekends

Current configuration

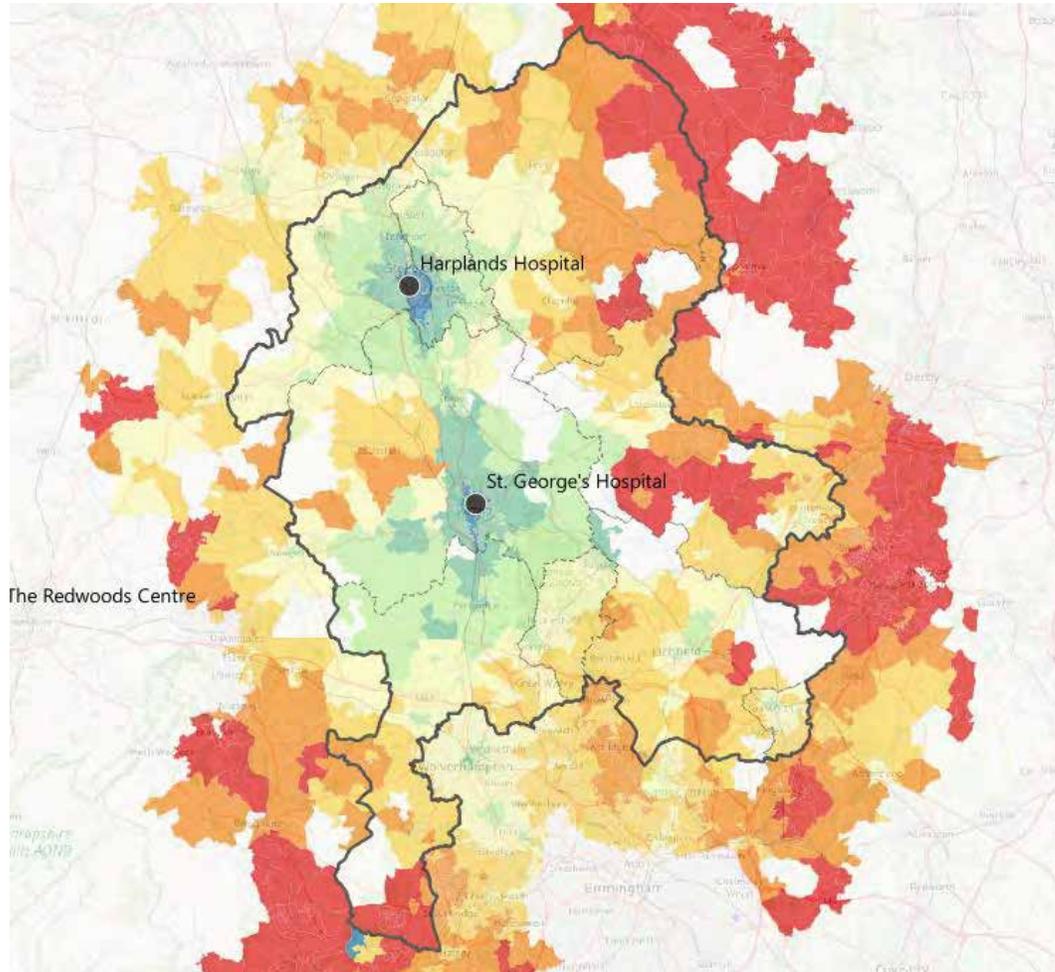


If George Bryan centre open

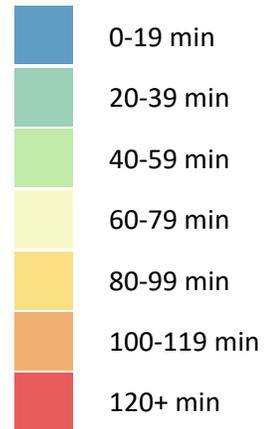
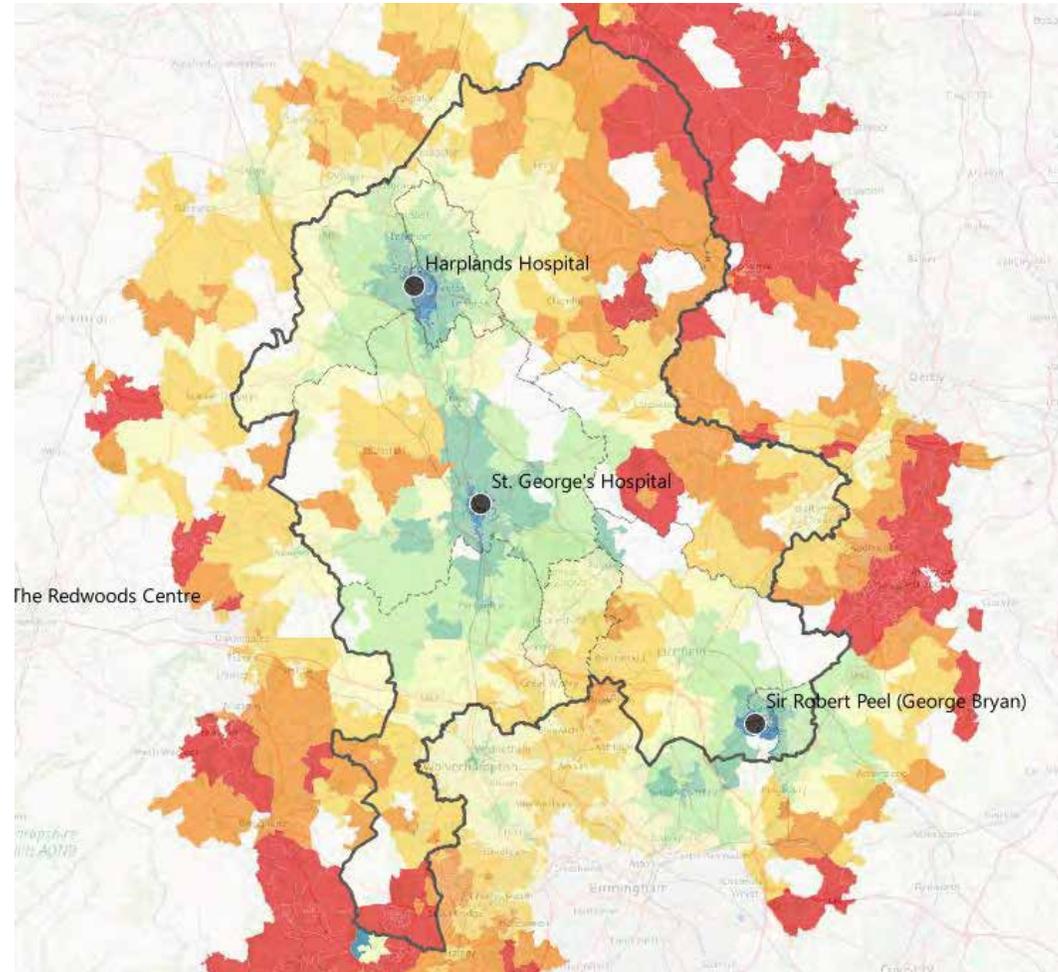


Public Transport travel, weekdays

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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