NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Thursday 21 December 2023

1.00pm-3.30pm

Newcastle Room, Beaconside Conference Centre, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF

[A = Approval / R = Ratification / S = Assurance / D = Discussion / I = Information]

	Agenda Item	Lead(s)	Enc.	A/R/S/ D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact	Chair	Enc. 01	S	1.00pm	2
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 19 October 2023 and Matters Arising	Chair	Enc. 03	A		5-16
5.	Action Log	Chair	Enc. 04	D		17
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	1.02pm	
	Strategic and System Development					
7.	ICB Chair and Chief Executive Update	DP/PA	Enc. 05	D/I	1.10pm	18-27
8.	Decision-making business case (DMBC) for the long-term solution for Inpatient Mental Health Services previously provided at the George Bryan Centre	CB	Enc. 06	A	1.15pm	28-415
	Questions from the Public followed by Board Vote					
9.	Assisted Conception	PEJ	Enc. 07	A	2.15pm	416-452
	Questions from the Public followed by Board Vote					
10.	ICB Quality Strategy	LT/BS	Enc. 08	R	2.50pm	453-467
	System Governance and Performance					
11.	Quality and Safety Report	LT/BS	Enc. 09	S	3.00pm	468-471
12.	Finance & Performance Report • Finance & Performance Committee Assurance Report	PB/PS MN	Enc. 10 Enc. 11	S	3.10pm	**TO FOLLOW** 472-477
	Any other Business					
13.	**Items notified in advance to the Chair**	All		D		
14.	**Questions from the floor relating to anything heard during the meeting not relating to items 08 and 09**	Chair			3.20pm	
15.	**Meeting Effectiveness**	Chair				
16.	**Close**	Chair			3.30pm	
17.	**Date and Time of Next Meeting** 18 January 2024 at 12.30pm held in Public - Stoke City Council, Council Chamber, Civic Centre, Glebe Street Stoke-on-Trent ST4 1HH					

ICS Partnership leadership compact

Trust

- We will be **dependable**: we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency**, working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be **open to changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness and honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by example

- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

Respect

- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to understand others' points of view and **empathise** with their position
- We will respect and uphold **collective decisions** made.

Kindness and compassion

- We will show **kindness**, **empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion**.

System first

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire and Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.

Looking forward

- We will **focus on what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution**.

Staffordshire and Stoke-on-Trent Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2023-2024
INTEGRATED CARE BOARD (ICB)
AS AT 12 DECEMBER 2023

Kev

Declaration completed for financial year 2023/2024
Declaration for financial year 2023/2024 to be submitted

Note: **Kev relates to date of declaration**

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company.
1st April 2023	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 8. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u11 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st April 2023	Mr	Peter	Axon	CEO ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
6th April 2023	Mr	Chris	Bird	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim Chief Transformation Officer, NHS Staffordshire & Stoke-on-Trent ICB until 31.07.23. Substantive role - Director of Partnerships, Strategy & Digital , North Staffordshire Combined Healthcare NHS Trust (April 2023 - July 2023)	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (April 2023 - March 2024)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
2nd August 2023	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014-March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	Nothing to declare	Nothing to declare	No action required
1st April 2023	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	University Hospitals of North Midlands NHS Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Governing Council (November 2019 - November 2023) 2. Governor of Newcastle and Stafford Colleges Group (NSCG) (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
26th July 2023	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.	
3rd April 2023	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Charity Trustee of Royal British Legion Industries (RBLI) who are a UK wide charity supporting military veterans, the unemployed and people with disabilities (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
6th December 2023	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
1st April 2023	Mrs	Gillian (Gill)	Hackett	Executive Assistant	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st April 2023	Dr	Paddy	Hannigan	Clinical Director for Primary Care	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Salaried GP at Holmcroft Surgery integrated with North Staffordshire Combined Healthcare Trust and contract responsibilities taken over by NSCHT (1st January 2020 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mrs	Julie	Houlder	Non-Executive Director Chair of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner of Elevate Coaching (October 2016 - ongoing)	1. Chair of Derbyshire Community Health Foundation Trust (January 2023 - ongoing) (Non-Executive since October 2018) 2. Non-Executive George Eliot NHS Trust (May 2016 - ongoing) 3. Director Windsor Academy Trust (January 2019 - ongoing) 4. Associate Charis Consultants Ltd (January 2019 - ongoing)	1. Owner Craftykin Limited (July 2022 - ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
4th May 2023	Mr	Chris	Ibell	Chief Digital Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
12th July 2023	Ms	Mish	Irvine	ICS Director of People	ICS/MPFT (hosted)	Nothing to declare	Nothing to declare	1. Trustee (NED) of the YMCA, North Staffordshire (July 2023 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
21st April 2023	Mrs	Heather	Johnstone	Chief Nursing and Therapies Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Visiting Fellow at Staffordshire University (March 2019 - March 2025)	Nothing to declare	1. Spouse is employed by UHB at Heartland's hospital (2015 - ongoing) 2. Daughter is Marketing Manager for Voyage Care LD and community service provider (August 2020 - ongoing) 3. Daughter in law volunteers as a Maternity Champion as part of the SSOT maternity transformation programme (2021 - ongoing) 4. Brother-in-law works for occupational health at UHNM (ongoing) 5. Step-sister employed by MPFT as Staff Nurse (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mr	Shokat	Lal	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Local government employee (West Midlands region) and there are no direct or indirect interests that impact on the commissioning arrangements of the ICB (ongoing)	Nothing to declare	Nothing to declare		(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
19th April 2023	Ms	Megan	Nurse	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Hospital Manager for Mental Health Act reviews, MPFT (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association, member of Audit Committee and Renumeration Committee (September 2022 - ongoing)	1. Chair Acton Academy Governing Body, part of North-West Academies Trust (September 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register
1st April 2023	Mr	David	Pearson	Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Non-Executive Chair Land based College linked with Chester University (2018 - ongoing) 2. Membership of the Royal College of Nursing (RCN) (1978 - ongoing) Membership cancelled with effect from 30/11/2022 (declaration to be removed from the register in May 2023)	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing: redeclared 21.11.21)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th October 2022	Mr	Jon	Rouse	Local Authority Partner Member and CEO of Stoke City Council	Stoke-on-Trent City Council	1. Employee of Stoke-on-Trent City Council, local authority may be commissioned by the ICS (June 2021 - ongoing) 2. Director, Stoke-on-Trent Regeneration Ltd, could be a future estates interest (June 2021 - ongoing) 3. Member Strategic Programme Management Group, Staffordshire & Stoke-on-Trent LEP, may have future financial relationship with the ICS (June 2021 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Works shifts on Chebsey ward at MPFT (December 2022 - ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - 06 November 2023) (Declaration to be removed from register May 2024) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	Mr	Phil	Smith	Chief Delivery Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st December 2023	Mrs	Josie	Spencer	Independent Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Non-Executive Director Leicestershire Partnership Trust (May 2023 - ongoing) 2. Non-Executive Director for Coventry and Rugby GP Alliance (December - ongoing	1. Company Director for Coventry and Rugby GP Alliance (December 2023 - ongoing)	1. Chief Executive Coventry and Rugby GP Alliance (May 2022 - 31st August 2023) (Declaration to be removed from the register February 2024)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register.
17th May 2023	Mr	Baz	Tameez	Healthwatch Staffordshire Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
3rd April 2023	Mr	Paul	Winter	Associate Director of Corporate Governance / ICB Data Protection Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

ANY CONFLICT DECLARED THAT HAS CEASED WILL REMAIN ON THE REGISTER FOR SIX MONTHS AFTER THE CONFLICT HAS EXPIRED

1. Financial Interest *(This is where individuals may directly benefit financially from the consequences of a commissioning decision, e.g. being a partner in a practice that is commissioned to provide primary care services)*
2. Non-financial professional interests *(This is where an individual may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the ICB)*
3. Non-financial personal interests *(This is where an individual may benefit personally, but not professionally or financially, from a commissioning decision e.g. if they suffer from a particular condition that requires individually funded treatment)*
4. Indirect interests *(This is where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g. spouse, close relative (parent, grandparent, child etc) close friend or business partner*
5. Actions taken *to mitigate identified conflicts of interest*
(a) Change the ICB role with which the interest conflicts (e.g. membership of an ICB commissioning project, contract monitoring process or procurement would see either removal of voting rights and/or active participation in or direct influencing of any ICB decision)
(b) Not to appoint to an ICB role, or be removed from it if the appointment has already been made, where an interest is significant enough to make the individual unable to operate effectively or to make a full and proper contribution to meetings etc
(c) For individuals engaging in Secondary Employment or where they have material interests in a Service Provider, that all further engagement or involvement ceases where the ICB believes the conflict cannot be effectively managed
(d) All staff with an involvement in ICB business to complete mandatory online Conflicts of Interest training (provided by NHS England), supplemented as required by face-to-face training sessions for those staff engaged in key ICB decision-making roles
(e) Manage conflicts arising at meetings through the agreed Terms of Reference, recording any conflicts at the start / throughout and how these were managed by the Chair within the minutes
(f) Conflicted members to not attend meetings, or part(s) of meetings: e.g. to either temporarily leave the meeting room, or to participate in proceedings but not influence the group's decision, or to participate in proceedings / decisions with the agreement of all other members (but only for immaterial conflicts)
(g) Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
(h) Recording of the interest on the ICB Conflicts of Interest/Gifts & Hospitality Register and in the minutes of meetings attended by the individual (where an interest relates to such)
(i) Other (to be specified)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Minutes of the Meeting held on Thursday 16 November 2023 12:30 pm- 2.00pm Via Microsoft Teams

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (CMO) or the Director of Nursing & Therapies (CNTO) • three Independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three cohorts	✓	✓	✓	✓	✓	✓	✓				
Peter Axon (PA) Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✗	✓	✓	✗	✓				
Phil Smith (PSm) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✗	✗	✗				
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✗	✓				
Chris Bird (CB) Chief Transformation Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				
Julie Houlder (JHo) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✗	✓	✓	✗	✓				
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✓				
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✗				
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	✓	✗	A	✗	✗	✗				
John Henderson (JH) Chief Executive, Staffordshire County Council		✗	✗	✓								
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	✓	✓	✓	✓				
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council					A	✓	✓	✗				
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✗	✓	✓	✓	✗	✓				
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands NHS Trust		✓	✗	✓	✓	✓	✓	✓				
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	✗	✗	✓	✓	✗	✗				
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✗	✓	✓	✓	✓	✓	✓				
Participant Members:												

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
Sally Young (SY) Director of Corporate Services, Staffordshire & Stoke-on-Trent ICB		✓										
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓	✓	✓	✓	✗	✓				
Baz Tameez (BT), Staffordshire Healthwatch		✗	✓	✓	✗	✗	✓	✗				
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				
Alex Brett (AB) Chief People Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✗						
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✗	✓	✓	✓	✓				
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✗	✓	✓	✓	✓	✓	✓				
Steve Grange (SG), Midlands Partnership University NHS Foundation Trust		✓	✓	✗	✓	✗	✗	✗				
Helen Ashley (HA), University Hospitals of North Midlands NHS Trust			✓	✗	✗	✓	✗	✗				
Claire Cotton (CC), University Hospitals of North Midlands NHS Trust		✓	✓	✗	✓	✓	✗	✗				
Lynn Tolley (LT) Acting						✓	✓	✓				
Richard Harling (RH) Staffordshire County Council								✓				
Chris Sands (CS), Chief Finance Officer, Midlands Partnership University NHS Foundation Trust				✓	✗	✗	✗	✓				
Helen Dempsey (HD) Director of Finance & Performance, Staffordshire & Stoke-on-Trent ICB				✓								
Mish Irvine, People Directorate, Midlands Partnership University NHS Foundation Trust				✓	✗	✗	✓	✓				
Karen Webb (KWe), Deputy SRO Learning Disability and Autism, Staffordshire & Stoke-on-Trent ICB					✓							
Katie Weston (KW), EPRR Strategic Lead, Staffordshire & Stoke-on-Trent ICB					✓	✗	✗	✗				
Jacqui Charlesworth, Deputy Finance Director, Staffordshire & Stoke-on-Trent ICB							✓	✓				
Rachel Gallyot, Staffordshire & Stoke-on-Trent ICB							✓					
Gill Hackett (GH), Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✗	✓	✓	✓				
Kay Johnson (KJ), Executive Assistant, Staffordshire & Stoke-on-Trent ICB					✓							

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting. DP advised that the was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP reinforced the importance of the Leadership Compact document which was used in all of the meetings transacted by the ICB and it guides the way they conducted business and they would return to that at the end of the meeting It was noted that the meeting was quorate.	
2.	**Apologies**	

	Apologies were received from Jon Rouse, Heather Johnstone (Becky Scullion attending), Patrick Flaherty (Richard Harling attending), Neil Carr (Chris Sands attending) and Josie Spencer.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 19 October 2023**	
	The minutes of the meeting held on 19 October 2023 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
5.	**Action Log**	
	There were no actions to review.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	Ian Syme ***Finance*** *I put a question re the worst-case scenario deficit of £141 million that was mentioned in October 2023 Board Paper. The ICBs response mentioned a further risk namely achieving and receiving Elective Recovery Fund (ERF) payments in full. At UHNM Board Wednesday 8th November UHNMs FD mentioned that clarification re ERF by NHSE was imminent.* *Is the ICB now informed as to this recent clarification and what is the impact of any recent clarification on the 'Worst Case Scenario' ICB Deficit?* **Response**: We have received guidance which has provided clarity of where we are with the ERF for the rest of the year. The impact of the industrial action has resulted in the cost weighted activity, the amount of elective activity that we provide has reduced the target from 101% to 100%, which is based on pre-Covid levels of activity. The issues of the risk position is not affected by that guidance. The Acute Providers who provide care to our patients (UHDB, Derby & Burton and Royal Wolverhampton Trust) is a risk of £17m and he believes that we will be successful. ***Safety*** *On 25th October 2023 HM Coroner Stoke-on-Trent and North Staffordshire issued a Regulation 28 Report to Prevent Future Deaths. That report was addressed to NHSE and UHNM but NOT the ICB. The report highlighted amongst other things HM Coroner's grave concerns at the lack of a Tissue Viability team at weekends.* *Considering the ICBs Safety Remit how are Safety Structures within the ICS aligned so that such important interventions by HM Coroner namely Regulation 28 Reports are universally acknowledged within the ICS and supplementary actions become swiftly embedded so that issues raised by HM Coroner are sustainably fully addressed? I am somewhat puzzled that in this case the report was only addressed to NHSE and UHNM and did not include the ICB!* **Response**: The case report and where they are sent is determined by the coroner. However, our providers do notify us of anything that comes through from the coroner. We also have the Clinical Quality Review Meeting: CQRM as a way of managing that and learning across the system and are included in the safety assurance discussions	

	at Quality & Safety Committee and our System Quality Group with regard to any actions that need to be undertaken. ***Ambulance usage*** *At Monday's Staffordshire OSC (13/11/23) with WMAS present it was mentioned that there seems to significant 'anecdote' that self-presentation at EDs was increasing. A significant proportion of such self-presentation seem to be Cat 2 and Cat3 patients that would 'normally' be transferred by Ambulance. There seems some logic that individuals will self-present even with Emergency Conditions given at times Ambulance Delays in responding.* *Is the ICS/ICB sighted on this 'self-presentation' at EDs?* **Response**: We are unable to do a full statistical analysis on the data because we see patients coming into ED via ambulance or walk in and are not categorised the same way. Over the last 18 months we have been under the most pressure operationally, resulting in longer ambulance delays, both in terms of one the drive at the hospital and response times, that the proportion of ambulance concerts to hospital reduced slightly and walk-ins increased . We maintain the focus and commitment to make sure that the actions that are being taking by all partners in the system, including the ambulance service, are working to reduce the overall delays in relation to ambulance response and the time on the drive at the hospital. Although we are still under pressure, we have seen an almost 30% reduction in over 30 minute delays at UHNM this year to date compared with last year to date.	
7.	**Changing Futures**	
	Peter Tomlin & Gemma Finn from Stoke-on-Trent City Council gave a presentation on changing futures and their approach to improve outcomes of those experiencing multiple disadvantage – homelessness, offending, substance use, mental health difficulties, victim of domestic abuse. DP thanked Peter and Gemma and commented that the passion came through in the overview. He stated that they brought to life the quadruple aim of improving outcomes, tackling inequalities, enhancing productivity and value for money and helping us to support the broader social and economic development areas across the City. DP asked if this work was linked into the Portfolio work that the ICB were undertaking together with the refresh of the Strategy of the City and how would that link to the operational plan for the ICS. PEJ commented that it was integration around the individual and he saw the 5Ps coming out from the ICP Strategy around personal responsibility, prevention, personalised care, people and communities and productivity. He liked the fact that the presentation was based on lived experience. He supported this item coming to the Board because of the sustainability and the work they were doing to help the most vulnerable in society. PA stated that it was a great initiative and asked how they would take forward with the improvement programme across three areas around locality based transformation and improvement. He added that they were embarking on a neighbourhood journey in the ICS and this could not come soon enough as it showed the support around the most vulnerable and ensuring they were using evidence and data in decision making around resource allocations.	

	BA felt it was great work and as a clinician, she would endorse this work. She asked if the integration of mental health could be expanded to make sure that such successful initiatives were sustainable moving forward. JHo asked how this would cut across the Portfolios. She heard in the presentation that the support given was often when people were in crisis and in terms of the wider prevention, it was critical that support could stop people getting to the point when support and help is needed. PT confirmed that they did not want to lose the multi-agency approach. Also in terms of Personal Health Budgets – how do we fix things before they get worse. He added that they struggled with the Portfolio areas and confirmed that they were working on how it would fit in which was key.	
8.	**ICB Chair and Chief Executive Update**	
	PA advised that the paper described in detail, the work they were doing in year around the Recovery Plan and they were focusing equally on 2024/25 and planning for the future. CS commented that the planning was following the same approach from 2023/24 – there was a lot of learning they needed to take from the Recovery Plan that would inform planning going forward and they would need to focus work around how they get demand assumptions, capacity, performance and quality standards, workforce and finance equilibrium which would provoke some difficult conversations. PA agreed that the triangulation of quality, finance and workforce was critical. He added that they would look at a longer period for planning of perhaps 3 years, to ensure they were sustainable. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information.	
9.	**System Recovery Plan**	
	PB explained that In previous reports, they had set out the eight thematic areas of priority and the 16 underpinning projects which made up the System Recovery Programme, which were both financial and operational in nature. 25 products (key deliverables) were identified which were expected to be delivered as a result of implementing the 16 projects. The products were approved at the System Performance Group on 25 October and they would be reporting on the delivery of those 25 products as opposed to the priorities / projects themselves, as that would provide the level of granular assurance that was required. PB advised that they had started to identify a range of workforce challenges and emerging risks, which would be monitored closely by the weekly system recovery meeting and would be escalated appropriately. They continue to finalise the Recovery Dashboard, which should help to demonstrate whether the 25 products were having the required impact on the metrics chosen. PB reported that they now had the detail to have a strong grip on the recovery and working well was the grip and control around Continuing Health Care: CHC and putting the patient first, ensuring the right patients got the right care when they needed it. The financial numbers for CHC was at £10.6m, to a full year of £31.9m. With the evolvement of the Provider Collaborative led by Tracy Bullock and the CHC	

	Collaborative led by Neil Carr, the whole system buy-in was what was leading to these improvements. PB advised that they had previously agreed seven key priority areas, but had now added an eighth which was Medicines Management across the system. He drew attending to the care homes piece which was led by Richard Harling. There was currently a large number of patients in Care Homes and also receiving CHC. That piece of work was fundamental to changing the number of patients who were currently referred from the care home where they were safe and happy, into the acute hospital. Richard was leading the work around 'Respect' documents which was to ensure that each patient had a Personalised Care Plan. They did have some risk around capacity and they were currently working through that. DP mentioned the System Finance meeting that was held the previous night were there were excellent presentations received and a lot of work was going on and felt that they were developing a common approach around this. JHo reiterated that they needed to be clear that it was not just about the money, it was also about the patients. The risk that concerned her was communication with patients and families and asked how they were going to mitigating that risk. JHo also asked how this would feed into the 2024/25 planning. PB responded that there were two parts to consider, the actual savings on CHC were making a difference to the financial plan in getting the right care for patients and the £100m was going to be cash into the system. He added that the rest of the programme was around ensuring only the right patients go into hospital in the first place unless they need to. He was working with colleagues to achieve the sweet spot of only the right patients going into hospital and the capacity of the hospital and have more patients going through elective surgery. He confirmed that was how they would create the planning for the next year. He added that there was an opportunity to develop a more compassionate model of care although it would take a big change in clinical and cultural practice. DP felt it would be helpful to have a future meeting on this subject. JA commented that a lot of this work should sit within the community, general practice and primary care. DP agreed that it was not about the money, it was about doing the right thing. He suggested that perhaps Richard Harling could present a 'Deep Dive' session to the board on care homes before the end of the financial year. MN explained that it was a transformation plan on how they look after the frail and elderly and how we deliver improvements for our patients. RH agreed that the common theme was how they managed the frail elderly and the priority was the extension of life rather than quality of life. The Staffordshire and Stoke-on-Trent Integrated Care Board: • **NOTED** the approval of the 25 products by the System Performance Group (Turnaround Board), which would now become the primary currency for monitoring delivery • **NOTED** the emerging risks and workforce challenges to delivering the programme of work around capacity. • **NOTED** that the Recovery Dashboard would be included in future reports	
10.	**Digital Update**	
	CI explained that the Digital enabling function for Staffordshire and Stoke-on-Trent was comprised of multiple stakeholders across the Integrated Care System, as well as across the Integrated Care Board. Across the ICB, organisationally there were four key areas where Digital was a key enabler, including Population Health Management	

	(PHM), Primary Care, Finance and Digital Transformation, each reporting up through separate executive teams. Distinct Digital Teams also existed in each ICS health and care Provider, including Acute, Community, Mental Health, Primary Care, Ambulance and Local Authority provision. Whilst the Digital roles and responsibilities were distributed across teams and organisations, the ICB Digital Transformation Team had taken the lead role in coordinating and facilitating digital and data collaboration. CI provided assurance that although they had a relatively low level of Digital Maturity across the ICS, they had co-produced a Digital Roadmap with health and social care colleagues that reflected what was needed across the region. • Electronic patient record was due for replacement in 2027, and was recorded on the risk register. CI added that they were forming a business case, including system partners, to identify a stream lined solution across all areas. • Cyber security risks were increasing – they had put additional investment and were implementing a 24/7 protection system wide. • One Health & Care Record – well used for Direct Care purposes. • PHM – they have had a number of conversations with neighbouring ICBs and there was a link in the report on how they were supporting their population. • The NHS App was well used and was implementing patient empowerment. CI reported that one of their challenges was their ability to use data effectively to make optimal decision for care and they were submitting a CAG application (Section 251) so that they could make use of the Shared Care Record in driving analytics. CI asked for endorsement from the Board on grip and control on the Digital side through the Digital Collaboration Forum to have the authority to review Digital spend. CI highlighted the model hospital information that was available publicly on NHS Futures and they needed to recognise that they had an uneven distribution of allocation of funding across healthcare Providers. He asked for consideration of this when moving into the financial planning as to the level of investment needed. JHo liked what was set out in the Roadmap. She asked how they relate to each other; how that road map supported the Portfolios and our Recovery Plan; and was there an agreed vision on what the priorities were and what would make the most difference. Ci responded that the Digital function was not centralised, but a federated function across the various stakeholders and the paper defined the principles for that operating model and each of the CEOs have the responsibility for engagement through the portfolios to make sure that the Digital Roadmap was aligned with each one of the portfolio plans, as well as the Recovery Plan. With regard to Digital Governance, it highlighted a duplication of effort across individual Trusts and organisations, so they could avoid duplication and taking on procuring new systems that already exist. CI confirmed that there was a shared vision across all the key stakeholders across all organisations and they met on a fortnightly basis. JA felt that the cost was an issue, but would counsel against the spend into the infrastructure, but there was the transformation piece around the willingness to use the technology and adopt that technology. He added that it took the Pandemic to change what he had been trying to do for years in getting everyone to work together and he felt that the cultural piece was a far more important area. CI responded that they work very closely with Paddy Hannigan and Zia Din and they had the core infrastructure in place. The Staffordshire and Stoke-on-Trent Integrated Care Board**:**	

	RECEIVED and **WERE ASSURED** as to the ICS digital Transformation progress against the Digital roadmap and **NOTED** the recommendation to move authority to control digital spend.	
11.	**Winter Surge Plan**	
	The Integrated Care Board was asked to ratify the decision of the System Finance and Performance Committee and confirm approval of the System Surge Plan for 2023/24. The System Surge plan articulated the system approach to mitigating the impacts upon all facets of the Urgent & Emergency Care: UEC system during periods of increased UEC demand, specifically during the forthcoming winter period. The System Surge Plan described three core principles of the system approach to surge and winter planning: • The System Capacity Plan – based on the learning from last year and updated from that leaning. This was also subject to a 'Deep Dive' in October and had strengthened the input from the voluntary sector this year. • The System Escalation Plan • The System Workforce Plan – additional workforce recruitment and retention. Each component was designed to support system partners in proactively putting into place provision to address the forecast increases in demand expected during the winter period. The forecast activity had been calculated utilising the System Capacity Modelling tool and builds upon previous work to forecast bed requirements and activity levels during the forthcoming months. The collective development of the System Surge Plan outlined the many initiatives and schemes that had been or would be implemented to provide mitigation to those pressures and to facilitate the System's collective efforts to manage demand during winter. PS confirmed that it was a live document that would be continually reviewed by the System Co-ordination Centre. PS reported that they now had an annualised view of demand and also a five year view of demand growth that would feed into System Recovery Plan. DP acknowledged the amount of work that had taken place into the production of this plan. CS felt that the de-escalation element was missing and asked if this could also be considered. PS confirmed that the annualised view of demand could look at the de-escalation and the System Surge Group would be tasked with the De-escalation Plan. SL stated that the People Culture & Inclusion: PCI Committee had spoken about the workforce element. He asked if they had the workforce to initiate that demand. PS responded that workforce was the highest risk on the risk register and he had concerns around particular pockets of workforce. MI added that they needed to continue to evaluate workforce. PEJ stated that it was good to see they were moving towards a whole year plan, rather than a Winter Surge Plan. He advised that there had been a lot of clinical involvement in building the plan and there was a clear link between this plan and the Primary Care Plan and they would not be taken in isolation.	

	JA recognised the current financial and workforce pressures. However, the system was more permissive that it ever had been in General Practice and the NHS and he asked that the People Hub around the local Higher Education Institutes as there were lots of opportunities and a lot of innovation going on. The Staffordshire and Stoke-on-Trent Integrated Care Board **RATIFIED** the decision of the Finance & Performance Committee and **CONFIRMED APPROVAL** of the System Surge Plan for 2023/24	
12.	**System Level Access Improvement Plan (SLAIP)**	
	PEJ advised that the System Level Access Improvement Plan had been brought to the Board for assurance. SJ explained that General Practice was seen as the bedrock of the healthcare system, and remained the first point of contact for many people seeking health services in their local community. GPs and their teams made up the vast majority of NHS contacts that take place in Staffordshire & Stoke on Trent and 6m appointments took place last year. SJ added that General Practice was under extreme pressure with intense workload and workforce challenges and was struggling to maintain a level of service that would meet the demand and accessibility needs for our patient populations. People want to be able to get through on the telephone at 8am and know how their appointment was going to be dealt with. The ICB's ambition was to enable people to have more choice around when, where and how they access general practice, to have greater continuity where this was needed and to have a positive experience. SJ advised that a national Delivery Plan for Recovering Access to Primary Care was published by NHSE in May 2023 to help to address these challenges and ensure that general practice could keep at pace with the growing demand and be sustainable and resilient now and in the future. The System Level Access Improvement Plan had been written in response to national plan and works through the 4 national ambitions; to empower people, to build modern General Practices, to cut bureaucracy and build capacity. This plan is in draft form and being presented for information and discussion at this stage. The final deadline for submission to NHSE is 31st March 2024 and SJ confirmed that the final plan would be signed off by the Board prior to submission. DP acknowledge that there had been a lot of work put in to the development of this plan. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the plan and discussed any amendments required before the final version was submitted in March 2024	
13.	**Quality and Safety Report**	
	BS explained that the report summarised several key programmes of work that were discussed by the Quality & Safety Committee, and the paper was intended to provide assurance to the Integrated Care Board in relation to: • Deep Dive Discussions • Updates from System Partners (from SQG) • ICB Updates • Portfolio Quality Updates • PSIF	

	• UHDB waiting for formal CQC report - The Staffordshire and Stoke-on-Trent Integrated Care Board**:** **Receive** this report and seek clarification and further action as appropriate. **Be assured** in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System. **RATIFIED** the decisions of the Quality & Safety Committee with regard to: • the **minor amendment** to the Committee's Terms of Reference, • launch of the ICB's Quality Strategy • **recruitment** of 2x Patient Safety Partners • **approval** of providers Patient Safety Incident Response Plans and Policies • **update** of Managing Safeguarding Allegations Against Staff Policy • **establishing** the ICS Safeguarding Provider Collaborative Terms of Reference • **minor amendment** to the Non-Invasive Ventilation criteria within the Excluded and Restricted Policy.	
14.	**Finance and Performance Report**	
	The report was presented at the Finance & Performance Committee on 7 November 2023 with discussion around: • **UEC performance remains** challenging with business continuity incidents impacting on performance and delivery at University Hospitals of North Midlands (UHNM). Deterioration in Category 2 ambulance response times and increase in ambulance handover delays. Focus on front door alternative pathways continues along with focus on all discharges, frailty and outward flow. The System Escalation Plan level 4 plus actions are in place to manage risk across the UEC pathway. • **Serious Mental Illness (SMI) annual Physical Healthchecks** in Quarter 1 and the actions required both in relation to getting the checks undertaken but then recorded in GP systems so they pull through into the data feeds, to ensure fully accurate reporting. • A separate in-depth paper was presented outlining **Elective Care Long Wait Performance**. System Partners continued to address the backlog of patients on the elective waiting list with the ambition of treating all those waiting more than 65 weeks by the end of March 2024 in accordance with the national planning guidance. However, despite progress being made the rate of improvement was being hampered by the ongoing industrial action by both Junior Doctors and Consultants. • At month 6 at System level a year-to-date deficit position of £66.4m is reported, which was a £52.7m adverse variance against the £13.7m deficit plan (Month 5 – year to date deficit £58.6m; variance to plan £45m). The System had reported a net risk of £141m prior to recovery actions. They were currently working through the impact of the recovery actions to determine the most likely outturn. Drivers of the deficit continued to be excess inflation, Continuing Healthcare and the impact of industrial action. Capital was forecasted as expected, however medium-term challenges remained and would require national monies to achieve the plan. PS added that Covid cases had dissipated but they were now seeing the seasonal flu curve.	

	The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the reports for information and **RATIFIED** the decisions made at the Finance & Performance Committee.	
15.	**Board Assurance Framework (BAF)**	
	TS advised that the report presented a more mature Assurance Map, which would assist the Committees and Board to agree their levels of assurance and would be linked to the Committee Business CycleS. One risk had seen a reduction in risk score during the Quarter; which was BAF 7 Improving Productivity. All other scores had remained static. The 'most threatened' Strategic Ambitions remain: SA2: Address inequalities in access, experience and outcomes from health and social care services and SA3: Achieve a sustainable and resilient integrated care system In addition to the ICB BAF, work had progressed well with the development of a system wide risk map, although it should be noted that this remains ongoing. The Scores were approved by the Quality & Safety and the People, Culture & Inclusion Committees. The Audit Committee were currently reviewing the document and would feed in their views at the ICB Board. JHo & MN both agreed that they did not feel there was a need to reduce BAF 7 and that it would be useful for the infographics to be circulated to Board members. The Staffordshire and Stoke-on-Trent Integrated Care Board **WERE ASSURED** that the ICB was on course for delivery of the Strategic Objectives by their target dates.	
16.	**Assurance Reports from Committees of the Board**	
	People, Culture and Inclusion Committee (PCI) SL stated that they had seen improvement around turnover of 2% and sickness absence of 1%. JHo commended that the addendum that was attached to the report and suggested that perhaps it could be brought into the other reports to the Board. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information and **RATIFIED** the decision made by the PCI Committee to proceed to signing up to the Sexual Safety Charter.	
17.	**Any Other Business**	
	No other items of business raised.	
18.	**Questions from the floor relating to the discussions at the meeting**	
	Ian Syme *Within the System Recovery Plan it states that the CRIS workforce remains fragile due to significant loss of experienced staff to ARRS roles. This is a key team involved in your recovery plan, winter surge plan and any surges through the year, how are you going to mitigate this situation.*	

	MI explained that what we are seeing is career progression. She acknowledged it as a risk and they need to work more closely as organisations to ensure that individuals can have their career progression at the same time as still delivering services in the right place. MI offered to find out the detail behind the point made and feedback. The were no further questions received from the floor.	
19.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact.	
20.	**Close**	
	There being no further business, the Chair closed the meeting.	
21.	**Date and of Next Meeting**	
	21 December 2023 at 1.00pm in public in Newcastle Room, Beaconside Conference Centre, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent ICB Board Meeting

Date of Meeting 21/12/2023

Open Actions

Reference Number	Meeting Date	Agenda Item	Agenda No	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
2023-24/004	20/07/2023	Questions from the public	14	TB to correspond with Ian Syme information in relation to work being undertaken by the Medical Director in relation to re admissions from virtual wards/beds.	12/12/2023	TB	**COMPLETE** - TB shared a review of work done by UHNM in relation to virtual wards.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 05

Report to:	**Integrated Care Board**					
Date:	**21 December 2023**					
Title:	Chair and Chief Executive Officer Report					
Presenting Officer:	David Pearson, Chair, and Peter Axon, CEO					
Author(s):	David Pearson, Chair, and Peter Axon, CEO					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent system that are not reported elsewhere on the agenda.

Specifically, the paper details a high-level summary of the following areas:

1. System and General Update
2. Finance
3. Planned Care
4. Urgent Care
5. Key figures from our population
6. Quality and safety
7. COVID-19

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
N/A	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC or Patient Safety	This report type may assist the 2024 ICS CQC inspection

Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications
Sustainability	N/A for the report
Workforce or Training	N/A – no specific training implications; workforce matters are inherent to each topic
Equality & Diversity	N/A in terms of Equality Act 2010 or Public Sector Equality Duty
Due Regard: Inequalities	Access to services and reducing inequalities is implicit throughout
Due Regard: wider effect	N/A – no decisions are required for the paper itself: it is to raise awareness

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	**BAF5**	High Quality, Safe Outcomes	☐
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

To receive the report and be assured the leadership are working on each topic as raised.

1.0 System and general update

1.1 Primary Care

A System Level Access Improvement Plan has been developed and presented to the Finance and Performance Committee, ICB Board and Stoke-on-Trent Overview and Scrutiny Committee in November. The plan outlines the Integrated Care System's (ICS) approach to working with GP practices and Primary Care Networks (PCNs) in tackling the 8am rush and making it quicker and easier for patients to get the help that they need. The plan focuses on empowering patients in managing their own health and through an expansion of pharmacy services, a model to modernise general practice and the way patients access their GP practice. This will build the workforce capacity and cut bureaucracy to enable GP practices to focus their time on delivery of patient care.

In Staffordshire and Stoke-on-Trent (SSOT), over 6million appointments are delivered annually which is a 19% increase since September 2022. Nearly 46% of these appointments are booked on the same day. The ICS has seen an improvement across four of the five key patient satisfaction questions as part of the National GP patient survey compared to 2022 and SSOT is the only ICS in the region to have seen an improvement this year. However, the plan does aim to tackle where we know there is variation to access and patient experience across practices.

To support the success of the access plan, it will be vital for this to be embedded in a system approach. This will include how general practice access fits into the system urgent access work by simplifying how patients can access the care they need at the right place, right time and by the right professional. The broader utilisation of workforce in general practice also requires building on the communications campaigns that have been taking place with the public to understand these roles and to build confidence in their utilisation.

1.2 Workforce round table innovation event

Further to the update in the November report, a follow-up event took place with leads across the system to continue the actions identified at the Workforce Summit. The focus was on delivery of the long-term workforce plan, with particular focus on a 'reform' approach.

The three workshops focussed on the following areas and outputs were agreed as detailed below:

- Securing our Trainee Pipeline – outputs included working with universities and providers to develop alternative training models, working together to review clinical placement capacity, 2024/25 workforce planning aligned to METIP.
- Attracting new Communities to work in Health and Social Care – Create System wide Attraction / Inclusive Recruitment Strategy and Action Plan, develop System wide Working Group to agree priorities and collaborate to deliver the Action Plan
- The Flex Working Conundrum – expansion of flexible working pilots, continue to support Self Rostering/Team rostering pilots, create a 'Myth Busting' resource, refresh the Flex Working Group into more of a Flex Network to create opportunity for sharing and discussing challenges.

All work will be taken forward via the established People Programme working groups.

1.3 People Hub Winter Campaigns

The People Hub, managed by the ICS Health and Care People Team, is our System bank of 'Reserves', people with the right values and behaviours, that work across Staffordshire and Stoke-on-Trent supporting teams and services within NHS Trusts, Social Care and Primary Care. During October and November, around 550 shifts were undertaken by People Hub staff, predominantly support workers for wards at Royal Stoke Hospital and administrators within PCNs. This Winter, we are running three campaigns to bolster the People Hub and support our Partners in readiness for surge.

1.4 Companion Volunteers

This initiative provides “Companions” to sit with patients who do not have visitors, supporting ward staff to feed, serve drinks, link in with family members and be an extra pair of hands where needed in wards at Royal Stoke Hospital, County Hospital and Haywood Hospital.

1.5 Social Care Hub

Through collaboration with Staffordshire County Council, a bank of Reserves, predominantly brand new to care, who have been taken through accredited training in readiness to pick up ad hoc shifts in care homes and with a view to then finding permanent employment.

1.6 New2Care

The key aim within the People Hub is always to bring new people into the sector and this Winter a social media campaign is running to attract New2Care into health and care organisations across Staffordshire and Stoke-on-Trent. This aligns to our ‘Journey to Work’ concept and our Outreach work stream.

1.7 Maternity deliberative event

The Maternity deliberative event was held on Wednesday 6 December. The event was attended by staff from the Integrated Care Board, provider Trusts, partner organisations and the CSU.

Presentations were delivered to the group and then debated in three breakout rooms where facilitators asked three questions about the proposals and recorded feedback. The feedback is now being collated to be analysed and reported on. A report of findings will be delivered in the new year.

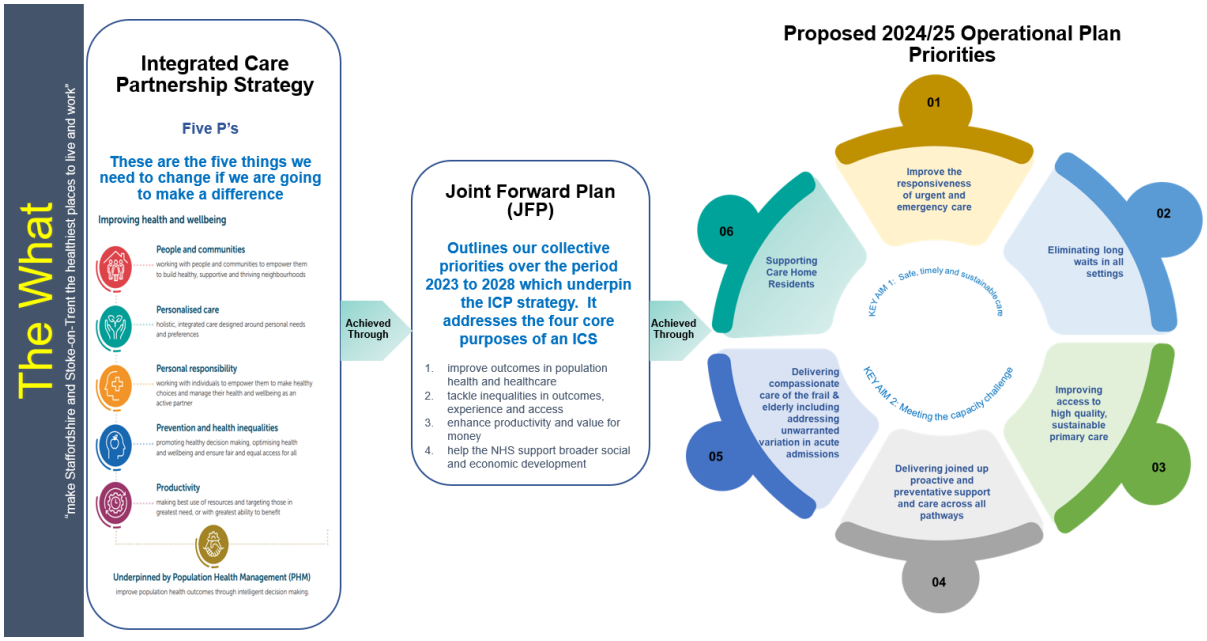
2.0 Finance

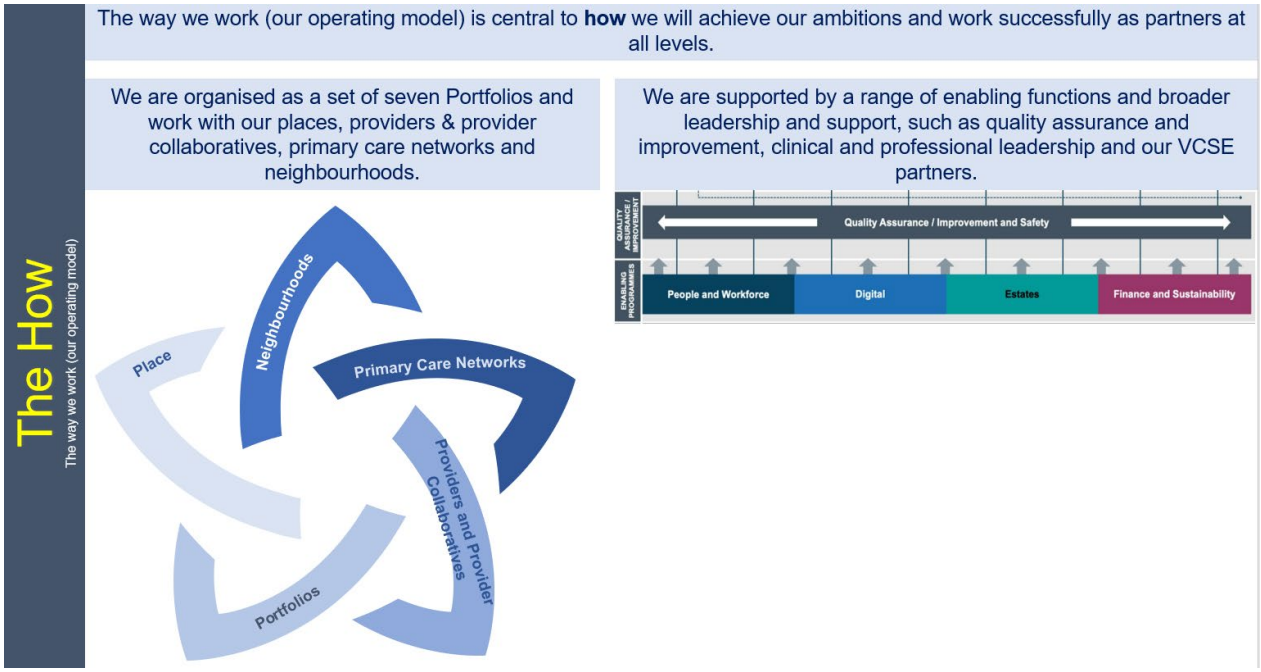
At month 7, at a system level, we are reporting a £60.7m adverse variance against plan. The adverse position drivers are consistent with prior months across Continuing Health Care (CHC) and prescribing inflationary pressures, slippage on efficiency programmes, the ongoing retention of escalation beds due to urgent and emergency care (UEC) demands and industrial action throughout the financial year. Our original break-even plan included a number of upside assumptions. Unfortunately a number of these assumptions have not come to fruition. As part of the financial reset request, the system informed NHS England this month that we are unable to breakeven at year end, due to the pressures highlighted throughout our in year financial reporting. New guidance has been received in respect of potential additional allocations to support systems with financial pressures, as well as more clarity on system Elective Recovery Fund (ERF) targets and funding. These amendments, coupled with the agreed system recovery plan results provide a revised forecast deficit for 2023/24 of £91.4m.

3.0 Planning for 2024/25 and beyond

We have proposed a set of six local high level operational plan priorities for 2024/25 (the what), this detail is being widely socialised with key committees and leads. The priorities are wrapped around two key aims for us all, in *ensuring we have safe, timely and sustainable care*, and *meeting the capacity challenge* particularly around our system bed gap. They build on the priorities set in the system “triangle” last year and priorities emerging either as part of the financial recovery programme or as the result of the outputs of other strategic work throughout the year.

There has been good engagement and support from a wide range of partners across the system. The main work to date has been on reviewing and reflecting the feedback on the wording. Our ambition in developing the operational plan is that there is a clear line of sight back to the Joint Forward Plan (JFP) and the Integrated Care Partnership (ICP) strategy. A further update will be provided for the Board in January as part of a broader planning update.





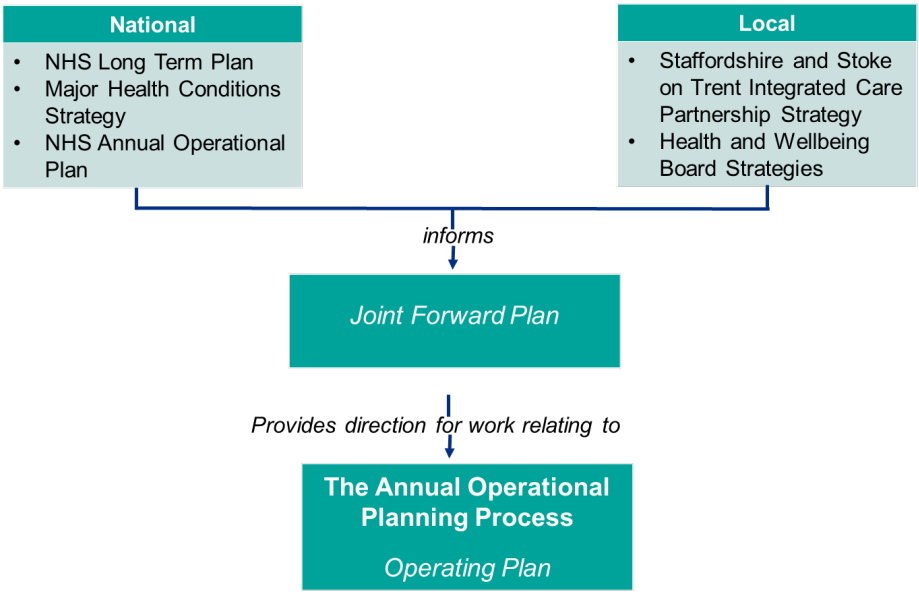
The System Planning Task and Finish Group has met twice, with representation from key system leads. Good progress is being made towards our first internal milestone of 15 December which will primarily involve portfolios and leads considering their priorities and deliverables for 2024/25 and how these will align to the six high level operational priorities and key aims. Our acute and community providers, within and outside the ICB footprint, are progressing with developing their operational plans.

The first meeting of the Activity, Workforce and Finance Task and Finish Group will take place in December. The meeting will start to collate and test out initial 2024/25 forecasts at Trust and system levels. These will be reviewed alongside our operational plan priorities and deliverables to start to identify any issues and challenges.

As we develop our operational plan for 2024/25 it is important to recognise that the system is going to make a sizeable deficit in 2023/24. A recovery programme is now in place and is delivering results but will not be sufficient on its own to eliminate the significant underling deficit that we hold. A proposal is in development around a financial framework for 2024/25 that sets some of the parameters within which we will need to develop our operational plan. The proposal will suggest that we need a system approach, focussing on a number of components including productivity, reducing unwarranted variation and progressing our Continuing Health Care (CHC) recovery work. Productivity and value for money is one of the four core purposes of an ICS, meaning the framework for the financial plan will be a key component of the planning approach.

A document skeleton is in development for the JFP refresh. The document will be a limited number of pages and be a supporting document to the JFP published in June and wrap around the 2024/25 operational plan. Consideration is also being given to the production of a three-year operating plan, that would provide a bridge between the JFP and one year plan.

National Planning Guidance is expected late December 2023 and a summary will be provided for the Board in January as part of a broader planning update.



4.0 Planned Care

4.1 Elective Waits (104, 78 and 65 week-waits)

The Integrated Care Board (ICB) and system partners continue to address the backlog of patients on the elective waiting list with the ambition of treating all those waiting more than 65 weeks by the end of March 2024, in accordance with the national planning guidance. However, despite progress being made, the rate of improvement has been impacted by the ongoing industrial action by both junior doctors and consultants.

Significant work has been undertaken to eradicate 104-week breaches. It is forecasted there will be one patient who will breach 104 weeks at the end of December at University Hospitals of North Midlands NHS Trust (UHNM) which is due to custom equipment being needed and will be treated in January. Therefore, it is hoped that the system will have no further 104-week breaches.

For patients waiting beyond 78 weeks for treatment, the number of breaches forecasted across the system at the end of December is 86 (79 at UHNM and 7 at Nuffield), the forecast position for the end of January is 29 (all at UHNM) but a continued focus is required to ensure that we reduce this further.

Good progress is being made overall on the 65-week-wait cohort. Numbers have continued to improve with the potential cohort of patients breaching 65 weeks by the end of March now standing at circa 7,000,

this is compared to over 37,000 at the start of the financial year. This is ahead of trajectory, but it is becoming clear that some specialities are making much better progress than others. Work is ongoing to identify the specialties where performance is not currently assured to allow appropriate support to be given.

To accelerate delivery of the 65-week-wait target, NHS England issued a letter on 4 August asking that systems challenged themselves to ensure that all patients within the 65-week-wait cohort had received their first outpatient appointment by the end of October. UHNM had flagged this target wouldn't be met and have completed their analysis to identify which specialties would deliver on the ask and which would not. As of 3 December, there were 1,701 patients in total who still require a first outpatient appointment, 372 already have one booked before 31 December, 162 have one booked after 31 December and 1,167 were still without an appointment booked.

As a result of industrial action, we had seen an increase in the 78-week-wait cohorts for Staffordshire and Stoke-on-Trent patients awaiting treatment from providers outside our system, this has now started to improve. The number has decreased from 144 as of 15 October, to 102 as of 26 November. Similarly, Staffordshire and Stoke-on-Trent patients greater than 65-week-waits outside our system has seen a reduction from 1,292 as at 15 October to 1,069 as at 26 November.

3.2 Cancer Performance

University Hospitals of North Midlands NHS Trust (UHNM) is reporting a continued steady reduction in the 62-day cancer backlog, following a period of deterioration during September. As of 3 December, the 62-day backlog was 360 against a revised trajectory of 380, this has been an improved position since the end of October where the backlog was 427 against a revised trajectory of 430. The 104+ day backlog has reduced, as of 29 October, to 104 against a fair share's trajectory of 78, this is a reduction from 130 as of 29 October. The total Patient Treatment List (PTL) volume has continued to reduce, and as of this week (3 December) it is currently at 3,249, compared to 3,783 at the end of October.

The position of 28-day faster diagnosis standard for cancer has again improved with a projected performance of 66.3% for November. UHNM has drafted a forecast to improve performance against the FDS metric – to a point of achieving 79% against the standard by March 24, with the national target being 75%.

5.0 Urgent and Emergency Care (UEC)

Unvalidated 4-hour performance has continued to be challenged with the latest pressures within UEC during November resulting in a further reduction to 64.4%. This reduction has been backed up by sustained levels of breaches within Minor Injury Unit (MIU) activity whilst overall attendances in these units dropped by around 10%, and reduced performance at County Hospital due to a 5.4% increase in breaches.

12-hour unvalidated performance continued to feel the impact of the increased pressure reported as 9.6% for November, only 0.1 percentage points down in October. The mean for the calendar year has increased slightly to 8.4% with the week ending 3rd December rising as high as 11.8%, significantly higher than the desired 2% target.

Long Length of Stay (LoS) performance has reflected the impact of recent pressures, with each of 7+, 14+ and 21+ numbers rising through November but continuing to report below pre-pandemic levels for the month.

Category 2 performance continued to be challenged within the local system and at regional level, however, the latest 4-week average saw a 12-minute improvement for Staffordshire and Stoke-on-Trent ICS which held us at 8th out of 11 regionally and up to 31st out of 42 nationally.

Medically Fit for Discharge (MFFD) has marginally increased at Royal Stoke Hospital, primarily in Medicine, whilst County Hospital followed previous periods in showing little variation. However, both remain below the assumption made within the predictive bed modelling tool as part of the system surge plan.

COVID-19 bed numbers, having fallen as low as 33 by the end of November are rising and as of 10 December stood at 93 which continued the pressure on demand for beds. COVID related staff absences are also showing signs of trending upwards. The latest flu surveillance report indicates no immediate evidence of the beginning of the seasonal surge; however, rates are beginning to increase as are bed numbers for confirmed flu cases.

Following the ratification of our System Surge Plan at the November ICB Board we have mobilised additional acute and community capacity to support the management of seasonal pressures, and to maintain flow throughout our system.

At this time, we remain in a capacity deficit overall against the predicted demand, with some slippage noted in the mobilisation of all escalation beds, Outpatient Parenteral Antimicrobial Therapy (OPAT), Hospice/End of Life, and Virtual Wards. System partners have agreed an Escalation Plan, designed to identify key additional actions partners will take to manage periods of increased pressure.

6.0 Key figures for our population

	Jul-23	Aug-23	Sep-23	Oct-23
* **111 calls received**	30,868	29,579	30,021	35,316
Percentage of 111 calls abandoned	5.3%	8.2%	5.8%	5.7%
A&E and Walk in Centre attendances (UHNM)	20,696	19,573	20,502	21,360
A&E and Walk in Centre attendances (other providers)	17,882	16,960	17,265	18,284
Non elective admissions (UHNM)	7,594	7,424	7,469	8,016
Non elective admissions (other providers)	5,746	5,505	5,558	5,959
Elective and Day Case spells (UHNM)	6,685	6,872	6,592	7,194
Elective and Day Case spells (other providers)	8,011	8,118	7,848	8,307
Outpatient procedures (UHNM)	4,306	4,931	5,021	5,225
Outpatient procedures (other providers)	9,048	8,315	8,235	7,686
GP Appointments (all)	500,967	506,811	580,922	621,388
** **Physical Health Community Contacts (attended)**	132,625	128,840	129,825	138,610

**	**Mental Health Community Contacts (attended)**	46,000	43,590	42,150	

**NHS 111 - latest month is provisional and subject to change*
***Physical and Mental health contacts - latest month is provisional and subject to change and both datasets are sometimes one month behind the other datasets depending upon the publication dates*

Most datasets are subject to change following refresh

Variation in Planned Care type activities (e.g. Elective/ Day Case admissions, OP/ GP appointments) is influenced by a variety of factors, including the number of working days in the month (activity in some months is affected by bank holidays). We will flag up if variation in these activities is abnormal.

Please note: There is a seasonal increase every October as we approach winter, usually from September to November as there is a higher volume of appointments. In addition, there's a substantial amount of work ongoing to ensure practices are capturing all appointment activity.

7.0 Quality and safety

7.1 Meeting with the new Chief Midwifery Officer for England

Kate Brintworth, who was appointed to the role of Chief Midwifery Officer (CMO) for England in June this year, visited maternity and neonatal services at University Hospitals of North Midlands NHS Trust (UHNM). Kate has worked in London previously and stated at a national meeting, that she wanted to get to know the areas in the north of the country, and was promptly invited by Sarah Jamieson, Director of Midwifery at UHNM, to visit the Trust.

The visit took place on 5 December which the ICB Acting Chief Nurse and Therapies Officer (CNTO) attended. The visit was a great success, both with the assurance provided by UHNM but also her new increased knowledge about maternity services in the Midlands.

The CNTO took the opportunity to share information on how Staffordshire and Stoke-on-Trent is looking at using the Single Health Resilience Early Warning Database (SHREWD) to highlight escalations which she was really interested in and a commitment to keep her updated on progress, was made.

7.2 Staff Celebrations

Members of the UHNM Maternity and Neonatal team were invited to a reception at Buckingham Palace. The Recruitment and Retention Leads were invited by King Charles, along with other organisations, in recognition of the work to recruit international midwives.

8.0 COVID-19

COVID-19 and flu vaccinations are continuing across Staffordshire and Stoke-on-Trent and will continue throughout December with targeted work to improve inequalities continuing until 31 January 2024. The National Booking Service (NBS) and NHS119 processes for booking appointments will end on 14 December, however walk-in clinics and clinics with local booking options will continue until the end of January to enable those who have not yet received a vaccination to get one.

8.1 COVID-19 vaccination data

- Total COVID-19 vaccinations given = 271,441 (as at 4/12/2023)

- Staffordshire and Stoke-on-Trent is the third highest performing system within the region at 58.95% of eligible individuals vaccinated this autumn (other systems 41.17 - 65.21%).
- Current performance for 5–11-year-olds at risk is slightly below national average, however there are additional clinics planned in early December for these individuals to access vaccinations over the coming weeks.

Uptake Performance by ICS and JCVI Cohorts

Data Correct as at 04/12/23

Data Source: https://ppds.palantirfoundry.co.uk/workspace/contour-app/overview/ri.contour.main.analysis.29ccdc59-3b93-4ea0-a9df-a9c72f77e184?viewMode=edit

Uptake by AW23 Cohorts – As at 4th December

AW23	England	Midlands	BSOL	BC	CW	Derby	HW	LLR	Lincs	Nhants	Notts	STW	SSOT
1: Care Home Residents	80.5%	80.2%	73.6%	70.9%	83.0%	83.0%	★ 84.5%	79.8%	80.6%	81.7%	81.9%	81.8%	82.9%
2: Healthcare Workers	30.9%	28.7%	21.3%	20.6%	28.0%	★ 35.0%	34.8%	28.6%	31.7%	28.7%	27.1%	30.5%	34.3%
3: Social Care Workers	22.3%	22.0%	16.7%	17.2%	27.3%	24.4%	★ 29.1%	23.1%	23.6%	22.3%	19.7%	21.5%	21.6%
4: 80+	78.1%	77.8%	66.7%	66.9%	79.6%	81.2%	★ 84.8%	77.8%	83.1%	80.5%	77.7%	80.5%	80.8%
5: 75-79	77.5%	77.5%	68.7%	66.1%	78.6%	80.1%	★ 83.8%	77.4%	81.9%	80.0%	77.1%	79.1%	79.6%
6: 70-74	72.8%	72.5%	60.9%	59.0%	74.0%	76.4%	★ 80.1%	71.4%	79.2%	75.5%	72.1%	74.9%	76.0%
7: 65-69	63.5%	63.3%	50.6%	48.6%	65.2%	68.3%	★ 72.5%	61.5%	71.6%	66.6%	61.9%	66.3%	68.0%
8: At Risk	28.9%	28.4%	19.8%	20.3%	29.3%	32.7%	35.8%	27.3%	★ 36.5%	31.7%	27.2%	30.2%	32.2%
9: 12-15 At Risk	13.1%	11.4%	8.6%	6.8%	13.3%	12.0%	14.8%	11.7%	★ 15.2%	10.8%	11.2%	10.8%	12.0%
10: 12-17 Household contacts of immunosuppressed	1.2%	1.3%	0.9%	0.5%	1.6%	1.5%	1.5%	1.5%	1.5%	1.2%	1.3%	1.3%	★ 1.7%
11: 5-11 At Risk	17.3%	14.7%	10.2%	8.5%	20.1%	15.4%	18.4%	12.2%	15.5%	14.8%	★ 20.4%	16.2%	10.9%

NHS England Midlands

8.2 Flu vaccination data

- Total flu vaccinations given = 349,130 (as at 1/11/2023)
- Staffordshire and Stoke-on-Trent is the third highest performing system within the region at 52.62% of eligible individuals vaccinated this autumn (other systems 35.89 – 60.47%).
- Highest vaccination activity within region for Staffordshire and Stoke-on-Trent.
- School Age Immunisation Service (SAIS) teams have seen a good early start showing the highest vaccination events in schools compared to other systems within the region.

9.0 Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

David Pearson, ICB Chair

Peter Axon, ICB Chief Executive Officer

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

Report to:	**Integrated Care Board**					
Date:	**21 December 2023**					
Title:	**Decision-making business case (DMBC) for the long-term solution for inpatient mental health services previously provided at the George Bryan Centre**					
Presenting Officer:	Chris Bird, Chief Transformation Officer, ICB					
Author(s):	Helen Slater, Associate Director of Transformation, ICB and Kathryn Whitfield, Transformation Programme Manager, ICB					
Document Type:	Other		If Other: Decision-making business case			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	**Decision-making business case for the long-term solution for inpatient mental health services previously provided at the George Bryan Centre**					

(1) Purpose of the Paper:

To describe the process undertaken to develop and assure the recommendation presented for the long-term solution for inpatient mental health services previously provided at the George Bryan Centre, in order to support decision making.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Finance and Performance Committee (FPC) S/A	05/12/2023
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:

Legal or Regulatory	The legal duty to involve the public in planning, proposals, and decisions regarding NHS services (as outlined in the National Health Service Act 2006 (as amended by the Health and Care Act 2022)) has been assured through the Staffordshire Health Overview and Scrutiny Committee.
CQC or Patient Safety	The DMBC reflects the recent CQC inspection findings and improvement actions. The proposal has sought contributions from clinicians across the system and implements national best practice guidance.
Financial (CFO-assured)	Financial impact has been assessed and the proposal does not present a risk to system finances.

Sustainability	The mitigations proposed within the DMBC align with the ICS green plan.
Workforce or Training	The impact of the proposal on workforce is outlined within the DMBC; the proposal is currently in place on a temporary basis and staff have been realigned to support this temporary way of working.
Equality & Diversity	EIA considered impact. Details of EIA outlined within the DMBC
Due Regard: Inequalities	EIA considered impact. Details of EIA outlined within the DMBC
Due Regard: wider effect	QIA considered impact and went through gateway 2. Details of QIA below and within DMBC.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☒	☐	☐	Refreshed August 2023 to include response to consultation feedback
	QIA	☒	☐	☐	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on 23/08/2023
Has there been Public / Patient Involvement?		☒	☐	☐	Extensive engagement was undertaken between 2109 - 2021, including sense-check engagement following the programme pause due to Covid-19. A formal public consultation ran from 9 February to 23 March 2023, enabled a robust dialogue with an extensive range of stakeholders

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The enclosed decision-making business case outlines the recommendation for the long-term solution for inpatient mental health services previously provided at the George Bryan Centre. This recommendation is consistent with national and local strategy for mental health services and has been developed following extensive involvement and formal consultation which was considered by the public and stakeholders for 6 weeks from 9 February 2023 to 23 March 2023.

The ICB Board approved the pre-consultation business case, which detailed how the single viable proposal had been reached. The ICB sought advice from its legal advisors and the Consultation Institute, who confirmed that it is lawful to consult on one option only. The report of findings from the consultation was received at a meeting of the Inpatient Mental Health Services Technical Group on 9 June 2023 and the group agreed that the feedback received did not suggest any new proposals which had not previously been considered. Therefore, one viable proposal remains. The report of findings contained prominent themes of feedback related to the impact of the proposal, on travel, technology and support for carers. Impact assessments have subsequently been updated to reflect this feedback and outline the mitigations.

The report of findings was subsequently presented to the ICB Quality and Safety Committee on 12 July 2023.

The process to develop and assure the recommendation is detailed, which adheres to the NHSE Planning, assuring and delivering service change guidelines (2018).

The role of the DMBC is to conscientiously consider the consultation outcomes and ensure that progress to

implementation is fully informed by solid detailed analysis of consultation outcomes. The DMBC exists in order to assist the ICB Board to make decisions as opposed to being a decision-making document itself. It should also be noted that the DMBC is a technical, NHS facing document.

Assurance has been obtained for each element of the process as below:
- The clinical model has been assured by the West Midlands Clinical Senate.
- The five tests of service change have been assured by NHSE through a Stage 2 Assurance panel.
- The legal duty to involve the public in planning, proposals, and decisions regarding NHS services (as outlined in the National Health Service Act 2006 (as amended by the Health and Care Act 2022)) has been assured through the Staffordshire Health Overview and Scrutiny Committee.

The DMBC was taken to the ICB Finance and Performance Committee (FPC) on 5 December 2023, with the Committee asked to:

CONFIRM that the process undertaken has adhered to NHSE Planning, assuring and delivering service change guidelines (2018).

CONFIRM that the recommendation presented poses no risk to system finances.

AGREE that the decision-making business case can be presented to the ICB Board for decision making.

The FPC confirmed the two points above and agreed that the decision-making business case can be presented to the ICB Board for decision making.

(7) Recommendations to Board / Committee:

The Board is asked to:

APPROVE the recommendation within the decision-making business case; namely, to make permanent the existing temporary service change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board
and Midlands Partnership University NHS Foundation Trust

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

Decision-making business case

Document control sheet

Version	Date	Owner	Action
1.0	12.07.23	ICB	First draft circulated
2.0	09.08.23	ICB	Narrative reviewed and expanded by Upkar Jheeta, Sara Reeve, ICB finance team and Helen Slater.
3.0	14.08.23	ICB	Further detail added by Upkar Jheeta. Kathryn Whitfield and Helen Slater amended sections on the process.
4.0	17.08.23	ICB	Detail added and narrative reviewed by Nicola Bromage.
5.0	04.09.23	ICB	Formatting and reviewed references. V5 sent for review
6.0	15.09.23	ICB	Section 5: Rachel Hees reviewed and updated. Section 8: Ruth Shepherd reviewed and updated. Nicola Bromage reviewed and amended narrative. Helen Slater reviewed and amended narrative. Minor change made by Upkar Jheeta.
7.0	30.10.23	MLCSU	Proofreading
7.1	06.11.23	The Consultation Institute	Review by the Consultation Institute
8.0	13.11.23	ICB	Final version for publication

Table of contents

Appendices

1. Staffordshire and Stoke-on-Trent ICS Designation Development Plan
2. Consultation plan
3. Report of findings
4. Equality and Health Inequalities Impact and Risk Assessment (EHIIRA)
5. Quality Impact Assessment (QIA)
6. MPFT Travel standard operating procedure (SOP)
7. MPFT response to West Midlands Clinical Senate recommendations

Purpose of the document

The purpose of this decision-making business case (DMBC) is to present and summarise the extensive work undertaken in the programme of work relating to inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire.

The purposes of the DMBC are to:

- Describe the proposal development process, which has followed NHS England's service change guidance: 'Planning, assuring and delivering service change for patients'
- Demonstrate that the proposal is aligned to the national NHS Long Term Plan and both national and local mental health policies and guidance
- Demonstrate that benefits for and impacts on service users have been considered
- Demonstrate that the planned decision has taken account of the views of patients and members of the public who may be impacted by the proposal
- Inform the necessary assurance processes. These include providing evidence that the proposal meets the government's four tests of service change, the additional patient care test (otherwise known as the 'NHS beds test') and other relevant best practice checks for planning service change and consultation
- Ask the Board of the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) to make a decision in relation to the proposed service change for inpatient mental health services.

This DMBC is written for the following audiences:

- Staffordshire and Stoke-on-Trent Integrated Care Board, which is the organisation that carries the legal responsibilities for public involvement duties and deciding whether to implement the permanent service change proposal described in this DMBC
- The Board of Midlands Partnership University NHS Foundation Trust (MPFT) so they are informed of the proposed change to their services
- The Health Overview and Scrutiny Committee (HOSC) of Staffordshire which will scrutinise this proposal in line with their responsibilities
- Members of the public who might be impacted by these proposals.

This DMBC should be read in conjunction with the pre-consultation business case (PCBC) and the public consultation document published on 9 February 2023, which provide the background to the proposals and the content of the consultation. For transparency, the final draft of this DMBC will be made available publicly, but the document is not written with a public audience in mind.

Document status

Until published, this is a confidential document for discussion purposes. Any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in section 22 (Information intended for future publication), section 36 (Prejudice to effective conduct of public affairs) and section 43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The material set out in this document is for decision-making purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

1. Executive summary

1.1 Background

1.1.1 Midlands Partnership University NHS Foundation Trust (MPFT) provide physical and mental health, learning disabilities and adult social care services. The majority of their services are delivered in Staffordshire, Stoke-on-Trent, and Shropshire, Telford and Wrekin.

1.1.2 MPFT are committed to ensuring high-quality treatment and support for people with mental health needs who need it most, while helping people to remain independent.

1.1.3 For many years, commissioners have been working with providers to enhance community mental healthcare and reduce reliance on a bed-based model of care, consistent with the growing body of evidence, including that set out in the NHS Long Term Plan and the Mental Health Implementation Plan (2019).

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

1.1.5 Investment in community mental health services has improved care for patients who do not need a hospital stay (the majority of patients), with new services and networks established to support people within their communities.

1.1.6 Until 2019, there were two main sites that provided inpatient mental health care for residents in south east Staffordshire – St George's Hospital in Stafford and the George Bryan Centre near Tamworth.

1.1.7 Most residents (75%) with serious mental health needs would be admitted to St George's Hospital in Stafford, which provides a full range of hospital (acute) mental health care. This includes access to a range of arts and therapies, specialist restraint rooms for people in crisis and other specialist teams including eating disorders.

1.1.8 A small number (25%) of residents who required an inpatient admission would use the smaller, standalone facility at the George Bryan Centre. This included:

- The West Wing, which had 19 beds for adults aged 18 to 65 with severe mental illness – like mood disorders, psychosis, anxiety and depression
- The East Wing, which had 12 beds for older people (65 and over) with dementia and/or other mental health problems.

1.1.9 A small number of patients may have used other specialist services, or out of area placements if these were most appropriate for their needs.

1.1.10 Delivering services at the standalone George Bryan Centre was becoming increasingly challenging by 2019, due to the isolated nature of the site. Examples included:

- It was increasingly difficult to cover for staff sickness because of the limited specialist mental health workforce
- Patients would have to travel or wait to access specialist arts and therapy services, which can support recovery and wellbeing

- If a patient's condition worsened, there could be long transfer times (up to six hours) to admit people to St George's Hospital (as multiple clinicians were needed to accompany the patient)
- The police were often called to the centre to support with patients who were in crisis, because of estate and workforce constraints. This could be distressing for patients, family members and the staff involved. It also impacts on a patient's long-term wellbeing.

1.1.11 In February 2019, there was a fire at the George Bryan Centre that destroyed the West Wing. Patients in the West Wing were immediately moved to St George's Hospital, into a ward that was kept for use during peaks in demand, like winter. Since then, this ward has been refurbished and provides 18 mental health beds.

1.1.12 Soon after the fire, MPFT Board made the decision to temporarily close the East Wing, for safety reasons.

1.1.13 This incident accelerated work that had already begun to transform mental healthcare, aligning to national guidance to enhance community-based services by:

- Utilising the workforce differently, with more staff working in community teams to offer earlier support and treatment
- Following clinical best practice, by supporting people with dementia to be looked after in their usual place of residence, or in other specialist care settings, rather than being admitted to hospital.

1.1.14 Now, if a person cannot be cared for safely in the community, they are admitted to the specialist St George's Hospital in Stafford. It is estimated this meant an additional five patients a month are admitted due to the temporary closure of the George Bryan Centre.

1.1.15 The aims of the programme were defined as finding a long-term solution for inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire. The programme has:

- Involved patients and carers, staff, mental health clinicians and the public throughout its journey
- Considered the findings from the public involvement, along with clinical evidence, while developing and reviewing proposals
- Held a series of technical events to consider proposals for change against a set of essential criteria: strategic fit, clinical safety, and meeting the needs of the local population.

1.1.16 Two proposals were considered through most of the process.

a) Centralisation of inpatient beds at St George's Hospital, Stafford, supported by the enhanced community mental health service

b) Provision of inpatient beds in south east Staffordshire for adults (aged 18 and over) with serious mental illness, supported by the enhanced community mental health service.

1.1.17 Following a pause in the programme due to the response to the COVID-19 pandemic, 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, attended by 29 people.

1.1.18 At a technical event 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.

1.1.19 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. Even if the 18 acute beds were reinstated, reinstatement 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.

1.1.20 It was agreed that it is not safe to run an inpatient mental health unit with 18 beds as a standalone site, given the clear safety issues of remote service provision. This is essentially what option (b) proposes.

1.1.21 After listening to clinicians, staff, service users, carers and representatives, and carefully considering their input, the technical group agreed that this leaves a single viable proposal:

- To provide acute mental health inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia living in south east Staffordshire on a single site: St George's Hospital, Stafford. This is supported by the transformed community offer across the MPFT footprint in south Staffordshire.

1.1.22 In January 2023, the ICB Board received the pre-consultation business case (PCBC), which details the proposal development process and the involvement that had taken place to date.

1.1.23 Since the establishment of the programme, key elements around evidence development and assurance have been carried out, including:

- Development of a case for change and a clinical model
- Patient, public and stakeholder engagement.

1.1.24 The NHS in Staffordshire and Stoke-on-Trent has undertaken a wide variety of engagement programmes across the county, with a diverse range of staff, public and stakeholders. This dialogue has played a pivotal role in developing the case for change, guiding and shaping the proposal.

1.1.25 Engagement on the programme fell into three phases:

- Broad engagement by the clinical commissioning groups (CCGs) – now ICB (2019)
- Provider engagement by MPFT (2019)
- Sense-check/ pre-consultation engagement (2021):

The process for developing the proposal included:

- Discussions of proposals with the Health and Overview Scrutiny Committee for Staffordshire
- Development and ongoing refinement of a PCBC exploring the proposal and its impacts
- Regulatory and best practice assurance, including:
    - A review of the clinical model by the West Midlands Clinical Senate
    - Submission of the PCBC for NHS England regional assurance.

1.1.26 The PCBC was approved by the NHS Integrated Care Board on 19 January 2023, and it was agreed to proceed to a six-week period of public consultation on the proposal set out in the PCBC.

1.1.27 This DMBC is a technical document that follows the PCBC and completion of the public consultation exercise.

1.1.28 The formal public consultation, which ran from 9 February to 23 March 2023, enabled a robust dialogue with an extensive range of stakeholders.

1.1.29 A mid-point review was held on 7 March 2023, to review all consultation activity to date, the outputs of that activity and a review of future planned events, in order to highlight any identified gaps in knowledge and/or reach.

1.1.30 The review concluded that the consultation was largely delivering to plan, but highlighted areas of gaps of knowledge/reach that had been identified, where focused attention was required. The recommended mitigation was to provide Support Staffordshire with additional income to focus on engaging with specific cohorts that had been identified as gaps in the review.

1.1.31 This recommendation was agreed, and Support Staffordshire were commissioned to continue working to target these specific groups, such as people experiencing homelessness and organisations supporting homeless people, asylum seekers and refugees, and people identifying as lesbian, gay, bisexual, transgender, queer/questioning and other (LGBTQ+).

1.1.32 The number of participants in the different activities held during the consultation are below:

Table 1: Participants in consultation activities

Survey	Engagement events with specific communities	Online events	Drop-in roadshows	Targeted workshops	Other channels
48	81	6	55 – 74	133	4

Notes: Feedback from other channels includes the March 2023 Overview and Scrutiny Committee meeting minutes and reports from Healthwatch. A range rather than an exact number is given for attendance at drop-in roadshows because of the difficulty in recording an exact number in high-footfall areas.

1.1.33 NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) commissioned NHS Midlands and Lancashire Commissioning Support Unit's (MLCSU's) Communications and Engagement Service, on behalf of Midlands Partnership University NHS Foundation Trust, to coordinate the independent analysis of the feedback from the consultation and to produce the enclosed report. (Appendix 3).

1.1.34 Some equalities concerns were raised by particular groups or communities. They focused on travel and transport, particularly for those with limited access to private transport. Specific groups mentioned in this regard included: older people; people with disabilities and long-term conditions and co-morbidities; and people living in rural and isolated communities, areas of deprivation or with low incomes.

1.1.35 The second theme of feedback was around the impact on carers and the request that support for carers should be considered.

1.1.36 The third prominent theme was around technology and how the increased use of technology could lead to digital exclusion of some cohorts, who require support to successfully utilise technological solutions.

1.1.37 This feedback and the further consideration and evidence compiled following the public consultation in response to it, together with the evidence contained within the PCBC, have been brought together into a DMBC, which is put before the Board for decision.

1.2 Proposal development

1.2.1 Specifically, this DMBC document sets out the request for the NHS Staffordshire and Stoke-on-Trent ICB Board, as the Consulting Authority, to approve the proposal outlined in this business case.

1.2.2 This document and the recommendations within it have been underpinned by a clinically led review and evaluation process which considered the evidence collated in the PCBC, the feedback received through the public consultation and the consideration by the Steering Group of the consultation feedback received.

1.2.3 The NHS Staffordshire and Stoke-on-Trent ICB Board is grateful for all the feedback and fully acknowledges both the support and concerns relating to the proposal. Following the extensive programme of work to review the findings of the public consultation and ensure conscientious consideration of the feedback, the overarching conclusions of the subject matter expert groups and clinical leaders were that the change proposal consulted on was still supported.

1.2.4 However, as set out in detail in the DMBC and highlighted here, review and consideration of the feedback has identified some actions that would help to address the concerns raised in feedback. The actions would be implemented if the proposal is agreed.

1.2.5 It is recommended that the NHS Staffordshire and Stoke-on-Trent ICB Board approve the following proposed service change:

- Make permanent the temporary change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.

1.2.6 It should be noted that:

- The ICB Board is not bound by the recommendations or conditions put forward in this DMBC. The ICB Board can choose to support, reject or amend the recommendations as members see fit
- The proposal has been built on a solid base of clinical evidence
- The proposal has heard, considered and responded to the themes that emerged from public consultation
- The proposal is assured by the West Midlands Clinical Senate
- The proposal is recommended in order to improve patient outcomes and deliver against national clinical guidance.

1.2.7 The recommendation is set out below, together with an overview of key areas of consultation feedback, considerations given and identified actions if the proposal is agreed. The full extent of consultation feedback, the consideration given, and the resulting conclusions and actions of the subject matter expert working groups should be read in full and can be found in the DMBC and its appendices.

1.3 Recommendation

1.3.1 To make permanent the existing temporary service change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.

1.3.2 This would mean inpatient mental health beds would not be reinstated at the George Bryan Centre.

1.3.3 Patients who would previously have been admitted to the West Wing will be admitted to St George's Hospital.

1.3.4 Patients who would previously have been admitted to the East Wing will continue to be cared for by the community team and would only be admitted to a hospital or nursing/care home if they are no longer safe to remain in their home.

1.3.5 MPFT have confirmed this proposal is sustainable and results in improved outcomes, as demonstrated through the temporary service being in place since the fire. This is evidenced by:

- Alignment of 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
- Providing care to older adults through community teams, which evidence shows results in better outcomes. This evidence includes:
    - NICE guidance (NG97[1], 2018) states that, when admission to hospital is considered for a person living with dementia, the value of keeping them in a familiar environment should be considered
    - National Collaborating Centre for Mental Health (2018) Guidance on the

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

Dementia Care Pathway[2] notes that hospital admissions can exacerbate symptoms of dementia, permanently reduce independence, and increase the likelihood of discharge to residential care and re-admission to hospital. Necessary admissions should be as brief as possible to minimise adverse consequences of hospitalisation

  - The Health Evidence Network (part of the World Health Organisation in Europe) synthesis report on the effectiveness of old-age mental health services[3] states that overall, the strongest evidence supports the development of community multi-disciplinary teams as a major service-delivery component.

- Enhancement of the existing community team for older adults with dementia, which includes:
  - 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.
- Reduction in the average length of stay in an inpatient mental health bed when compared to the length of stay at the George Bryan Centre (compared data from 2017–19 for George Bryan Centre against St George's Hospital admissions post-fire)
- Patients who require an inpatient admission have access to a greater range of specialist services than the George Bryan Centre offered, including electroconvulsive therapy (ECT), art and music therapy and occupational therapy. George Bryan Centre patients would have needed to travel to access these therapies prior to 2019
- Simpler process for escalation if a patient's condition deteriorates. For George Bryan Centre patients, this would have required a secure transfer to St George's Hospital The relative isolation of the George Bryan Centre could have implications for staff safety and would have implications for recruitment
- Improved workforce sustainability through running a bed model on one centralised site, and avoiding the difficulties of recruiting to smaller, isolated units
- Ensuring safe staffing levels through one larger, centralised site. Reinstating inpatient services at the George Bryan Centre would require 9.9% (16.6 whole-time equivalent (WTE)) more staff than centralising beds at St George's Hospital, Stafford, as calculated by the Mental Health Optimal Staffing Tool (MHOST)
- Ensuring financial value and utilising existing estate – calculations show that the cost of the outlined proposal is slightly less than the cost of running the George Bryan Centre, and avoids rebuild costs, calculated at £11.5 million.

1.3.6 The concerns raised by the public during the consultation in relation to travel impacts are acknowledged and were considered and reviewed by MPFT and the ICB.

[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

1.4 Travel and transport

1.4.1 It is acknowledged that feedback from the engagement and consultation on the proposal has identified travel and transport as a significant concern for patients and the public.

1.4.2 This concern was generally expressed in terms of:

- The effect of the proposed change on the ability of patients and their family/ carers to access services at a more distant site
- Family/ carers wishing to visit at times when public transport tends not to operate creating an additional challenge for people without their own transport
- The negative impact on patients if they did not have visitors as a result of these difficulties.

1.4.3 A travel impact analysis has been considered, which contains an assessment of the proposal on different cohorts.

1.4.4 The feedback from the public and the travel impact analysis have been considered in detail and, while it is recognised there will be an impact on a small cohort, the following advantages are significant for MPFT to deliver the best-quality care:

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

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

1.4.6 Between February 2019 and July 2022, 783 patients who lived in south east Staffordshire were admitted for a mental health inpatient stay. This equates to five patients a month who would have been admitted to the George Bryan Centre, had it remained open.

1.4.7 Although the number of people directly impacted by this change is small, mitigations have been fully explored, to support those cohorts.

1.4.8 MPFT has developed a standard operating procedure (SOP) to help those affected by the proposal, which includes support with travelling costs for a time-limited period.

1.4.9 MPFT already offers support related to visiting in a range of ways:

- Being flexible about visiting times at St George's Hospital, to make it easier for those who use public transport
- Supporting 'virtual visiting' – staying in touch through video calls. This includes making sure that patients and visitors have access to devices like tablets. **MPFT's website**

(www.mpft.nhs.uk/about-us/digital/training) has a page with support and guidance about digital skills.

1.4.10 As part of the consultation, MPFT asked for ideas and suggestions about how they can further support visitors to St George's Hospital. MPFT have reviewed these ideas and suggestions to support the finalisation of the travel SOP.

1.4.11 If the proposal is agreed, this support would be monitored, to assess the true impact of the additional travel for this small cohort. This will support MPFT to understand the impact and to develop further mitigations as necessary.

1.5 Financial and resource implications

1.5.1 Detailed financial analysis was undertaken for the PCBC. Since its production, the following activities have been undertaken:

- Update to the financial context within which the Staffordshire and Stoke-on-Trent health system is operating
- Re-validation of the clinical model financial projections.

1.5.2 The baseline cost of running the George Bryan Centre was calculated, and costs extrapolated to the present day. This shows 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.

1.5.3 No additional capital resource is required to progress with the viable proposal.

1.5.4 The costs associated with this proposal have been contained and pose no risk to system finances.

1.6 Next steps

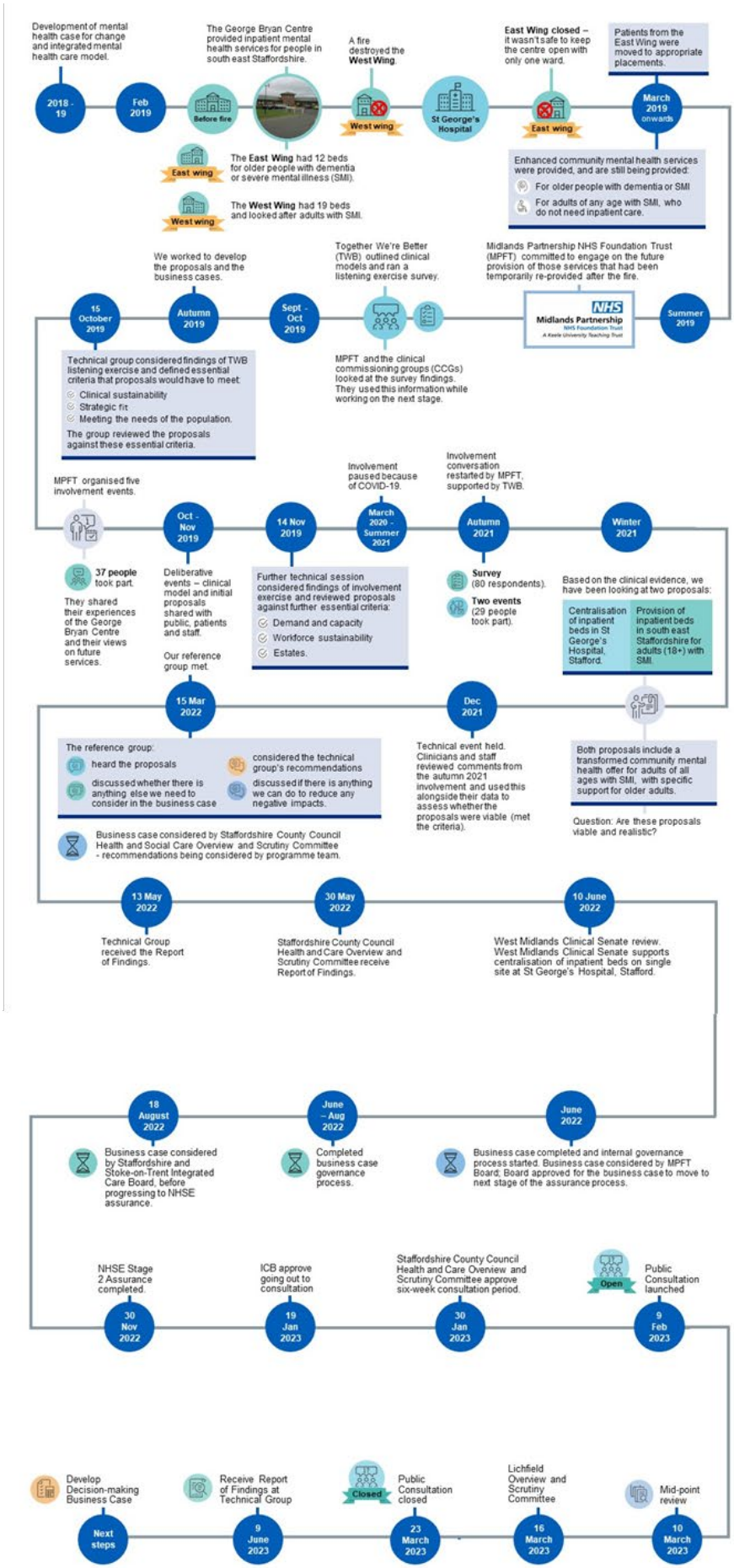
1.6.1 This decision-making business case will be reviewed by the NHS Integrated Care Board (ICB) as the statutory decision makers.

1.6.2 The ICB will then consider the proposal and the evidence presented and make a decision on long-term provision. The recommendation is to make permanent the existing temporary service change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.

1.6.3 If the service change outlined in this business case is agreed by the Board of the NHS Staffordshire and Stoke-on-Trent ICB, implementation and ongoing monitoring of service provision will be driven by the responsible provider organisation.

1.6.4 The ICB will oversee the strategic commissioning of the new model of care and implementation of the service changes, as the NHS commissioning authority for the Staffordshire and Stoke-on-Trent health system.

Figure 1: Process timeline for the development of this decision-making business case



2 Introduction

2.1 Background

2.1.1 Midlands Partnership University NHS Foundation Trust (MPFT) provide physical and mental health, learning disabilities and adult social care services. The majority of their services are delivered in Staffordshire, Stoke-on-Trent, and Shropshire, Telford and Wrekin.

2.1.2 MPFT are committed to ensuring high-quality treatment and support for people with mental health needs who need it most, while helping people to remain independent.

2.1.3 For many years, commissioners have been working with providers to enhance community mental healthcare and reduce reliance on a bed-based model of care, consistent with the growing body of evidence. This evidence includes that set out in the NHS Long Term Plan and the Mental Health Implementation Plan (2019).

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

2.1.5 Investment in community mental health services has improved care for patients who do not need a hospital stay (the majority of patients), with new services and networks established to support people within their communities.

2.1.6 Most residents (75%) with serious mental health needs would be admitted to St George's Hospital in Stafford, which provides a full range of hospital (acute) mental health care. This includes access to a range of arts and therapies, specialist restraint rooms for people in crisis and other specialist teams including eating disorders.

2.1.7 A small number (25%) of residents who required an inpatient admission would use the smaller, standalone facility at the George Bryan Centre. This included:

- The West Wing, which had 19 beds for adults aged 18 to 65 with severe mental illness – like mood disorders, psychosis, anxiety and depression
- The East Wing, which had 12 beds for older people (65 and over) with dementia and/or other mental health problems.

2.1.8 A small number of patients may have used other specialist services, or out of area placements if these were most appropriate for their needs.

2.1.9 Delivering services at the standalone George Bryan Centre was becoming increasingly challenging by 2019, due to the isolated nature of the site. Examples included:

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

accompany the patient)

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

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

- St George's Hospital in Stafford, providing inpatient accommodation for up to 168 people and a range of specialist assessment and treatment services for adults and older adults experiencing severe mental illness and dementia. It also provides psychiatric intensive care for adult men, perinatal, eating disorders, mother and baby unit, and forensic psychiatry services
- 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.

2.1.11 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.

2.1.12 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.

2.1.13 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.

2.1.14 Following the fire, plans for enhanced community services were accelerated. A new pathway was put in place 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.

2.1.15 Plans to upgrade and extend contingency accommodation at St George's Hospital, which had been approved in 2018 and paused in response to system winter pressures, were revised and implemented. The building work was completed in July 2021.

2.2 National and local context

2.2.1 In line with national ambitions set out in the Five Year Forward View for Mental Health (2016)[4], the NHS Long Term Plan (2019) and a Case for Change[5] published in 2019 by the Staffordshire and Stoke-on-Trent Integrated Care System (formerly Sustainability and Transformation Partnership (STP)), work to transform community mental health services has been taking place across the MPFT footprint in south Staffordshire over several years.

2.2.2 The new national model of mental health services supports community-based care wherever possible. Clinical evidence demonstrates that treating patients with severe mental illness as close to home as possible is better for care and outcomes.

2.2.3 For patients with dementia, hospital admissions can make the symptoms worse, permanently reduce the person's independence and make it more likely that the patient will be discharged into residential care and/or readmitted to hospital[6].

2.2.4 The aims of the ICS detailed in the Staffordshire and Stoke-on-Trent ICS Designation Development Plan (see Appendix 1), published in December 2020, include for mental health:

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

2.2.5 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 2019/20 Quality and Outcomes Framework (QOF) registers, around one in 10 (12%) Staffordshire adults are on a depression register and approximately 0.8% are recorded as having a severe mental illness.

2.2.6 In 2020/21, one in three (33%) emergency hospital admissions in Staffordshire were for adults with a recorded diagnosis of a mental health condition.

2.2.7 Both national and local strategies emphasise shifting from a bed-based model to a community-based model. This is the strategic backdrop to the development of proposals for the future of inpatient mental health services previously provided at the George Bryan Centre.

2.2.8 The local model of care has been designed and is delivered in partnership with service users, carers, the 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. They provide intensive intervention and support at times of need to help service users avoid having to be admitted to hospital.

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

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

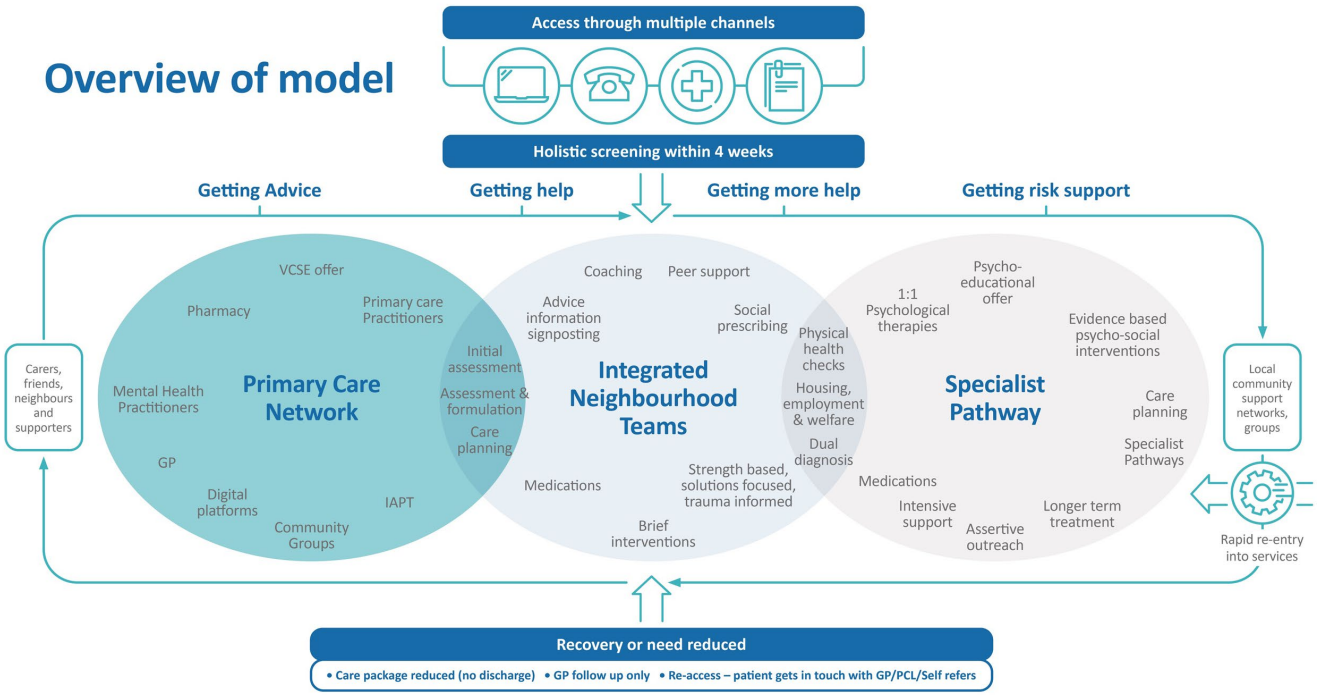
[6] Guidance on the Dementia Care Pathway, National Collaborating Centre for Mental Health, 2018

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

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

2.2.11 The figure below shows MPFT's model for mental health services.

Figure 2: MPFT's model for mental health services



2.3 Overview of process to date

2.3.1 The proposal put forward in this DMBC case stems from a lengthy process of discussion and engagement with patients, the public, partner organisations and health and care professionals, spanning several years.

2.3.2 It takes account of feedback from the formal public consultation, as well as reviews of service change proposals undertaken by clinical experts and an assessment of impact undertaken by the local health system.

2.3.3 Decision-making responsibility falls solely with the NHS Staffordshire and Stoke-on-Trent ICB. As such, this document, while set in the context of the Integrated Care System, is owned by the ICB Board.

2.4 Broad engagement by the CCGs (now ICB) (2019)

2.4.1 Patient, public and stakeholder involvement took place across 2019–20 as mental health services in south east Staffordshire were considered as part of a wider transformation programme.

2.4.2 The case for change was articulated to the public and findings from this engagement exercise were shared with participants at options appraisal events for the public and staff. The report of findings from the engagement work was received by the Governing Body of the Staffordshire and Stoke-on-Trent CCGs.

2.5 Provider engagement by MPFT (2019)

2.5.1 MPFT organised a further programme of engagement specifically to gather feedback about patients' experiences of the George Bryan Centre in September and October 2019, with the aim to engage on the permanent solutions for the two services that were provided from the centre prior to the fire.

2.5.2 The report of findings was shared with the Together We're Better (TWB) programme team and was incorporated into the evidence base for the options appraisal process. (Together We're Better was the partnership of health and care organisations before the Staffordshire and Stoke-on-Trent ICS was formed.)

2.6 Sense-check/ pre-consultation engagement (2021)

2.6.1 The process of developing proposals for the future of these services was paused in 2020 because of the COVID-19 pandemic.

2.6.2 In late summer 2021, the process was re-started with further engagement across autumn 2021 and spring 2022. This aimed to understand whether there were any additional considerations about the future of mental health services or any further proposals which had not been considered.

2.6.3 An involvement Equality Impact Assessment (EIA) was produced that outlines the approach to involving seldom heard groups. The Communications and Engagement team worked closely with the CCGs[7] Local Equality Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

2.6.4 Commissioning and provider staff were involved in the various engagement programmes through internal communications including the intranet and staff newsletters and briefings. They were able to complete questionnaires and were invited to attend events. Staff were offered one-to-one interviews to help share their feedback.

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

2.7 The pre-consultation business case

2.7.1 The pre-consultation business case (PCBC) was prepared by Staffordshire and Stoke-on-Trent ICB in conjunction with MPFT, to provide assurance to local governance boards and NHS England (NHSE) that the system had thoroughly considered all potential proposals before deciding to move to public consultation.

2.7.2 The PCBC included:

- A detailed case for change, supported by system partners
- The proposed change to mental health inpatient services
- Alignment of the proposal with NHS policy and plans
- Assessments of impacts related to quality, equality and travel
- The rationale for proceeding with a single viable proposal
- Governance and decision-making arrangements
- Clinical assurance of the proposal, including the West Midlands Clinical Senate
- A description of the public engagement that has occurred in the development of the proposal.

2.7.3 It should be noted that throughout the process, another option was considered and appraised. The proposal described here is the one that meets the needs of the population while aligning with national and local strategies and guidance.

2.7.4 The ICB sought advice from its legal advisors and the Consultation Institute as to whether it is legitimate to consult on one option only. It is lawful to consult on one option only and section 3.2 outlines how the consultation was conducted, in line with the Gunning principles.

2.8 Independent expert advice and assurance

The proposal contained within the PCBC had successfully passed through rigorous regional and national assurance processes.

2.8.1 Clinical

2.8.1.1 The West Midlands Clinical Senate was set up as a source of independent, objective and strategic advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

2.8.1.2 The Senate's review of the proposal was jointly commissioned by Staffordshire CCGs and MPFT. It was carried out on 10 June 2022 by a panel of experts from the Senate, most of whom are practising clinicians.

2.8.1.3 The purpose of the review is to offer external clinical assurance on the single proposal. The clinical senate review and responses to the points raised in its recommendations formed an essential part of the preparation for the stage two assurance checkpoint process as set out in NHSE's service change guidance: 'Planning, assuring and delivering service change for patients'.

2.8.1.4 The report[8] contained five recommendations for the programme to consider. These are outlined below, with a detailed programme response to the recommendations set out in Appendix 7.

2.8.1.5 The West Midlands Clinical Senate recommendations were:

- The current surplus dementia beds (average five out of 12 occupied) are being utilised by functional adult mental health patients; this is considered sub-optimal practice and the panel recommended alternatives should be sought to prevent this from occurring and poor patient experiences for both patient groups
- The panel recommend a review of the current Crisis Resolution and Home Treatment (CRHT) team to assure themselves that there are no barriers to older people accessing the service and that older people's needs would be met in the service. This is to ensure that patients who would have ordinarily been admitted to the George Bryan Centre and the dementia ward in Stafford will have alternative community provision
- The panel recommend utilisation of both real time and process and outcome data are more widely used to both monitor and drive improvements. There is strong positive leadership at MPFT, which is enabling the transformations to take place. However, greater use of data will ensure these remain on track, with progress assessed regularly against a set of agreed process and outcome measures
- The panel recommends engaging with operational and clinical colleagues to understand the need for community sites for staff to use as bases for clinics and to run events. This will support the focus of bringing care closer to home for patients
- The panel recommends a review of the staffing shortages and the recruitment and retention plans to ensure MPFT remains an employer of choice and does not see attrition at a level which will have a detrimental effect on patient care and safety. In addition, ensuring any risks are presented on the relevant risk registers.

2.8.1.6 The panel concluded that it was largely supportive of the recommended proposal of a single site for inpatient services. It considered that the clinical model has alignment with the national strategy for mental health services and, considering all available evidence, concluded that negative impact to patients is low and mainly involves travel time for patients, carers or relatives.

2.8.2 NHS regulator

2.8.2.1 The PCBC and associated documentation was presented to a Regional NHSE panel on 30 November 2022.

2.8.2.2 NHSE were assured that proposals met the five tests of service change as well as other good practice tests and were content that the ICB proceed to consultation.

[8] Report of the Independent Clinical Senate Review Panel, 10 June 2022

2.9 Decision to proceed to consultation

2.9.1 On 19 January 2023, following completion of the NHSE assurance process outlined above, the PCBC was considered by the Staffordshire and Stoke-on-Trent ICB Board, and the Board decided to proceed to a six-week public consultation.

3 Public consultation

3.1 Overview of consultation

3.1.1 The consultation on the proposed NHS service change set out in the pre-consultation business case (PCBC) was planned and delivered in line with national guidance, good practice and the statutory 'Duty to Involve'.

3.1.2 There is a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- Section 242 of the NHS Act 2006 places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate
- Section 244 requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees)
- The Health and Care Act 2022 places a duty on the ICB to make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways):
    - In the planning of the commissioning arrangements by the ICB
    - In the development and consideration of proposals by ICB for changes in the commissioning arrangements 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
        - in decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

3.1.3 NHS Staffordshire and Stoke-on-Trent ICB was the NHS organisation legally responsible for approving the PCBC and agreeing to proceed to a public consultation on the service change proposal set out within it. Decision-making responsibility, through the decision-making business case (DMBC) following the public consultation, also falls solely with Staffordshire and Stoke-on-Trent ICB.

3.1.4 Through public bodies giving an account of their plans or proposals and listening to feedback, public consultation promotes accountability and assists decision making.

3.1.5 It should be noted, however, that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects widely varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, in order for decision-makers to be able to conscientiously consider the issues raised.

3.1.6 NHS Staffordshire and Stoke-on-Trent ICB is also required to make sure the consultation activities meet the requirements of The Equality Act 2010, which requires a demonstration of how the Public Sector Equality Duty is being met.

3.1.7 An overview of the consultation process is provided below. More detail is available in Appendix 2, which contains the Communications and Involvement plan.

3.2 Overview of consultation process

3.2.1 The NHS Staffordshire and Stoke-on-Trent ICB launched the public consultation on 9 February 2023. It ran for six weeks until 23 March 2023. The approach to consultation was underpinned by the Gunning principles which say consultations must have the following principles applied:

- Consultation takes place when proposals are still at a formative stage
- Sufficient information is provided to give 'intelligent consideration'
- There is adequate time for consideration and response
- Consultation responses must be 'conscientiously' taken into account.

3.2.2 In line with the Communications and Involvement plan, a suite of materials was produced, which included the main consultation document, a summary document, and survey. The Communications and Involvement plan was developed to allow a flexible approach if further involvement was deemed necessary following the mid-point review.

3.2.3 Consultation resources included:

- Printed and online versions of the consultation documents
- Animations hosted on the consultation website. Audio versions of the edited consultation document text that accompanied the online survey questions were made available.

3.2.4 Recognising that the consultation phase followed the involvement activity in 2019 and 2021, the aim was to build on the relationships already established and previous conversations with stakeholders. A range of activities was launched, including:

- A roadshow of drop-in events, workshops, one-to-one in-depth interviews and virtual workshops online

- A survey to gather views about the business case and understand if there was anything else that should be taken into consideration.

3.2.5 The consultation methods reflected the government guidelines in force at the time relating to COVID-19, while continuing to ensure the needs of all communities were met.

3.2.6 The public consultation was supported by a comprehensive communication strategy:

- A social media campaign that ran from 6 February to 23 March 2023 on Facebook and Twitter. Two social media assets were designed to accompany the posts – one with a call to action of 'Find out more' and the other with encouragement to 'Have your say'. The combined number of Facebook impressions was 14,259. For Twitter, there were 7,643 impressions.
- Advertisements on Facebook/ Instagram, targeting those aged over 18 across a 23km area covering Tamworth, Lichfield, Burton and Stafford. The adverts were rolled out between 9 February and 23 March 2023.
- Printed newspaper advertising included a quarter-page advert rolled out on 9 February 2023 in the Tamworth Herald, Express & Star, and Burton Mail.
- A suite of display advertisements, including mid-page units (MPUs – a form of digital adverts) on the Lichfield Live website. Adverts launched on 9 February and ended on 21 March 2023.
- There were eight pieces of press coverage between 26 January and 16 February 2023.

3.2.7 Partner organisations and key stakeholder groups were also asked to share these materials on our behalf via their online methods and extensive venue and distribution lists.

3.2.8 An Equality Impact Assessment (EIA) was produced. This outlines the approach to involving seldom heard groups and ensuring events and documentation were accessible, by:

- Writing in plain language and 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 opportunities to attend, and attendance
- Asking people if there are any reasonable adjustments needed when attending virtual events and offering alternative ways for people to share their feedback (for example, by telephone)
- Providing reasonable adjustment and support, for example using interpreters or offering smaller focus groups with existing networks where appropriate.

3.2.9 The plan also articulated working with Support Staffordshire as a delivery partner. Support Staffordshire are a countywide support organisation for the voluntary, community and social enterprise sector. It was felt that their engagement networks could help reach people who might be affected by the proposal but who might not engage via the traditional methods outlined above.

3.2.10 Support Staffordshire were commissioned to reach and engage with specific targeted communities during the consultation. The communities included:

- People of Eastern European, South Asian, Black (Afro-Caribbean) and mixed race ethnicities
- People in the most deprived areas – particularly in Lichfield, Burton and Tamworth
- Men aged 65 and over
- Women aged 25 to 44
- People experiencing homelessness
- Carers – particularly young carers
- People involved in substance misuse
- Lesbian, gay, bisexual, transgender, queer/questioning and other (LGBTQ+) groups
- People currently in the military and veterans.

3.2.11 Online events were held to gain feedback from participants on the proposal. Members of the clinical team were present to answer questions and listen to participants' views. Feedback was gathered anonymously using a digital platform. Despite people registering, nobody attended the first event; the team ensured all who had registered their interest were given the opportunity to join the next event. The second event had six participants.

3.2.12 Five drop-in events were planned in areas of high footfall in the Tamworth, Lichfield and Burton areas, with the aim of promoting the survey and encouraging people to give their feedback. In response to feedback from the public and an MP, two further drop-in events were added in Tamworth. The drop-in events were held between 16 February and 21 March 2023 with about 74 attendees.

3.2.13 Six targeted workshops were organised, to deliver a presentation and receive feedback. The targeted workshops took place between 9 February and 22 March 2023, with a total of 133 attendees. In some sessions, this method was adapted to suit the participants, with the message delivered through a targeted conversation. The team engaged with people from local communities, specifically with groups of people who had experienced mental health issues and challenges – either themselves or as carers. They also worked with groups who support people experiencing or caring for someone with dementia. These groups included:

- Burton Caribbean Association, which runs community groups for local people who have dementia or mental health conditions, are carers, or feel isolated/ lonely
- Better Way Recovery, a Lichfield-based group for people who are addicted to alcohol, drugs or have serious mental health conditions
- The Rotary Club, which hosts a regular Memory Café for people with dementia and their family/ carers
- MIND, who invited the team to their arts and crafts group for people who have mental

health conditions and/or learning disabilities.

3.2.14 When the Communications and Involvement plan was developed, it was recognised it would need to be 'dynamic' in nature. Throughout the public consultation, the team listened to feedback from the public and other stakeholders and adjusted the plan to improve delivery.

3.2.15 Examples of additional events covered include:

- Lichfield Overview and Scrutiny Committee asked to engage with the team about the consultation and the proposal. The team gave a presentation to the committee on 16 March 2023 and received a copy of the minutes of the meeting
- The League of Friends at Robert Peel Community Hospital, Tamworth, asked for the chance to engage with the team about the consultation and the proposal. The team gave a presentation on 20 March 2023 to the League of Friends' board.

3.2.16 In line with good practice, the Communications and Engagement team conducted a mid-point review of the consultation on 7 March 2023. Recommendations were made to the Inpatient Mental Health Services (IMHS) Steering Group for consideration on Friday 10 March 2023.

3.2.17 The mid-point review looked at evidence of the consultation data to date, including:

- Findings and themes that had emerged from the survey and events
- An overview of the events and promotional activities delivered
- Information on gaps identified and key learnings
- Recommendations for the IMHS Steering Group on possible changes to the Communications and Involvement plan for the final weeks of the consultation.

3.2.18 The review concluded that the consultation was largely delivering to plan, but highlighted areas of gaps of knowledge/ reach that had been identified, where focused attention was required. The recommended mitigation was to provide Support Staffordshire with additional income to focus on engaging with specific cohorts that had been identified as gaps in the review.

3.2.19 This recommendation was agreed, and Support Staffordshire were commissioned to continue working to target these specific groups, such as people experiencing homelessness and organisations supporting homeless people, asylum seekers and refugees, and people identifying as LGBTQ+.

3.3 Staffordshire Health Overview and Scrutiny Committee

3.3.1 In accordance with the National Health Service Act 2006 and Regulation 23 of The Local Authority Regulations 2013, the Staffordshire Health Overview and Scrutiny Committee (HOSC) was requested to respond to the consultation.

3.3.2 Overview and Scrutiny Committee responsibilities are outlined at the beginning of the PCBC. NHS commissioners and MPFT have kept the Staffordshire County Council HOSC updated with information about the programme.

3.3.3 Updates have also been provided 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 HOSC.

3.3.4 The table below outlines the nature of each meeting attended and the outcomes:

Table 2: Summary of engagement with Health Overview and Scrutiny Committees

HOSC meeting	Date	Purpose of meeting	Outcome
Lichfield District Council Community Housing and Health (OSC) committee	25 March 2019	Update on process	It was noted that a permanent plan for the George Bryan Centre would be subject to consultation.
Healthy Staffordshire Select Committee	15 July 2019	Update on process	Following the consultation, the CCGs should bring detailed proposals to the committee for consideration.
Healthy Staffordshire Select Committee	28 October 2019	Update on process	The Committee to be formally consulted on any proposed changes to the George Bryan Centre.
Staffordshire County Council HOSC	9 August 2021	Update about the ongoing temporary closure of the George Bryan Centre	The update report and presentation were noted. The Committee requested: • The link to more detailed information from engagement feedback, data of re-admissions and confirmation of the insurance funding details. • The final draft proposal be considered by the Committee at a future meeting.
Staffordshire County Council HOSC	15 March 2022	Overview of the autumn 2021 engagement and a summary of the feedback, position with regard to the options appraisals process for the	Members highlighted the importance of reliability and value of data in the options appraisal to inform decision

HOSC meeting	Date	Purpose of meeting	Outcome
		transformation programmes, including inpatient mental health services in south east Staffordshire.	making for the George Bryan Centre. Members were assured that links were being built into processes to speak to all communities.
Staffordshire County Council HOSC	1 August 2022	Presented draft business case outlining the proposal to centralise the inpatient mental health services formerly provided by the George Bryan Centre for adults with severe mental illness and older adults with severe mental illness and/or dementia, alongside an enhanced community offer	The Chair established that Committee was broadly in support of the principle to move towards community services and that further information would strengthen the proposal. Committee was in support of the principle to move people with dementia into community services if it benefited those individuals.
Staffordshire County Council HOSC	17 October 2022	Shared the Communication and Involvement Plan and the consolidated response to the questions raised at the 1 August 2022 meeting.	It was agreed that the report of findings would be circulated to members, following the technical event in June 2023.
Staffordshire County Council HOSC	30 January 2023	Shared the contents of the Communications and Involvement plan and asked the committee to consider whether, in the context of all the NHS services provided in Staffordshire, members deem this proposal to be a substantial change to services in its area.	The Communications and Involvement plan was received and noted. The committee agreed that, in the context of all the NHS services provided in Staffordshire, members did not deem the proposal to be a substantial change to services in the area.
Letter to Staffordshire County Council HOSC	26 July 2023	Report of findings sent to OSC Chair to circulate to members	No further correspondence received.

3.3.5 Following the ICB's decision to proceed with the six-week public consultation, the ICB presented an update report and the Communications and Involvement plan to the Staffordshire HOSC. During the discussion, the HOSC agreed that they did not deem this proposal substantial service change and therefore did not want to be directly consulted. It was made clear that committee members could contribute to the consultation on an individual basis.

4 Public consultation findings

4.1 Overview

4.1.1 The public consultation process on the change proposal set out in the pre-consultation business case (PCBC) enabled a robust and detailed dialogue with an extensive range of stakeholders.

4.1.2 Staffordshire and Stoke-on-Trent ICB commissioned a report of findings from Midlands and Lancashire Commissioning Support Unit (MLCSU) – this detailed report included a thematic breakdown of comments received and demographic analysis of participants.

4.1.3 It is not the intention of this decision-making business case (DMBC) to repeat all of this, but rather to focus on specific issues that need to be highlighted to decision-makers and the responses of relevant subject matter experts.

4.1.4 A sample of comments from the 48 consultation survey responses are presented below.

4.1.5 The full independent consultation report of findings should be read in full and can be found in Appendix 3, and an overview is provided in this section.

Feedback themes

Table 3: Experience of inpatient mental health services

George Bryan Centre	St George's Hospital
• The quality of care provided was good • Staff were caring and professional • The quality of care provided was poor • Staffing levels were not sufficient.	• Some staff were not professional and caring • Staff were good • Concern over the location of St George's Hospital.

- **Experience of community mental health services**
  - The services provided were good
  - Staff were not caring and lack of knowledge
  - Waiting times for community services are too long
  - Concern over the lack of continuity and consistency in the care provided.

Feedback on the care model

Table 4: Community model for severe mental illness

Community model for severe mental illness	Suggestions to improve model
• Community care may not be suitable for everyone • Consider greater provision of mental health services locally • Ensure appropriate staffing in the community • The care model is good.	• Re-open the George Bryan Centre • Ensure appropriate staffing • Consider raising awareness around mental health services available in the community and how to access them.

Table 5: Community model for dementia

Community model for dementia	Suggestions to improve model
• Being close to home or at home is better for patients with dementia than being in a hospital • Consider the need for more local inpatient units • The new care model is good • Residents of Tamworth and Lichfield may be disadvantaged by this care model • Concern over the lack of awareness of dementia care services available in the community (for example, GPs may not be aware) • Contact via technology is not appropriate for people with dementia.	• Consider the need for day hospitals/centres • Re-open the George Bryan Centre • Consider improving access for visitors (for example, flexible visiting times, free parking, transport) • Consider the need for greater support for carers.

Table 6: Feedback on the proposal for delivering inpatient mental health services

Feedback on the proposal for delivering inpatient mental health services	Suggestions to improve model
• Concern over travel for visitors and patients • Concern over the lack of inpatient beds available in the area • The proposal is not a good solution (for example, unrealistic) • Residents of Tamworth and Lichfield may be disadvantaged by the proposal • Non-drivers could be disadvantaged by the proposal • Transport is the major concern for those in Tamworth, due to lack of access to a car or bus stops near people's homes.	• Re-open the George Bryan Centre • Consider greater provision of mental health support locally • More mental health units across the county are needed • Ensure sufficient funding for healthcare services • Consider providing transport for patients and visitors.

Table 7: Feedback on travel and access

Feedback on travel and access	Supporting travel for visitors
• Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) • Concern over the travel cost • Concern over the negative impact on patients if they cannot see their relatives • No concerns around travel (for example, can drive).	• Consider the need to align visiting times with public transport timetables • Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) • Consider ongoing financial support until a patient returns home (for example, cover travel expenses) • Open a hospital in south Staffordshire.

Table 8: Feedback on technology

Feedback on technology	Supporting people with technology
• 93% said they had access to internet in their homes, while 7% said they didn't have access to the internet • 84% said they used mobile phones, 57% used laptop computers and 34% used a tablet device • 86% said they had a camera in their device, while 10% said they did not • 66% said they could easily use their device to contact someone in hospital, while 24% said they could do this with assistance • This is a good idea.	• Prefer face-to-face contact • Consider the needs of older people • Not everyone is tech savvy • Contact via technology is not appropriate for people with dementia.

4.1.6 Survey respondents were asked to share their views on the community model for severe mental illness. 28 (60%) respondents said that the care model was poor or very poor, while 19 (40%) said it was good or very good. Some of the positive themes from across the various channels were that the care model was good, and that being close to home is better for mental health patients than being in hospital. Some negative themes were that the pathway is not as smooth as described in the model, and that community care may not be suitable for everyone. Participants suggested that the care model could be improved by providing better local mental health support, and that more detail was needed around the model.

4.1.7 When asked about the community model for dementia, 10 (46%) survey respondents said that the care model for dementia was good or very good, while 8 (36%) said it was poor or very poor. Positive themes were that being close to home is better for patients with dementia, and that dementia cafés and local groups provide good support. Some expressed concern over the safety and security of patients with dementia, and it was suggested that people are not sufficiently aware of the dementia services available in the community. It was also suggested that the care model for dementia could be improved by incorporating more support for carers, and by providing continuity of care.

4.1.8 When survey respondents were asked to share their views on the proposal to deliver inpatient mental health services, 26 (59%) said the proposal was poor or very poor, while 7 (15%) said it was good or very good. Positive themes were that the proposal is a good solution, and that it may help to improve the quality of care. In contrast, some participants said the proposal was not a good solution and expressed concern about a lack of hospital beds to meet demand. It was also suggested that the proposal could be improved by rebuilding the George Bryan Centre, or by providing transport for patients and visitors.

4.1.9 Survey respondents were asked to share their concerns about travel for visitors. 40 (87%) respondents said they were concerned or very concerned, while 3 (6%) said they were not concerned. Suggestions included providing financial support until patients can return home, and to consider aligning visiting times with public transport timetables.

4.1.10 Finally, survey respondents were asked if they could easily use their devices to contact someone in hospital. 27 (66%) said they could easily do this, while 10 (24%) said they could use their device to contact someone in hospital – but that they would need help. Consultation participants also commented that technology cannot replace human contact, and it was suggested that we should consider the needs of older people who have difficulties using technology.

5 Addressing themes from the consultation

5.1 Review of feedback

5.1.1 Following the end of the public consultation there has been a programme of work to collate the findings of the public consultation into a report of findings.

5.1.2 The report of findings was received (Appendix 3) with all feedback considered and noted at a meeting of the Inpatient Mental Health Services Technical Group on 9 June 2023.

5.1.3 At this meeting, the methodology and reach of the consultation was outlined, and the analysis approach detailed to attendees. It was agreed that the consultation had been conducted as planned.

5.1.4 Key themes, responses to questions and verbatim feedback were drawn from the report and presented to the group and discussed at length.

5.1.5 It was agreed that the feedback received did not suggest any new proposals which had not previously been considered. Therefore, one viable proposal remained – to make permanent the existing temporary service change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.

5.1.6 Prominent themes of feedback related to:

- Travel
- Technology
- Support for carers.

5.1.7 It was agreed that impact assessments would be updated to reflect the feedback and any mitigations that have been implemented or are planned to reduce the impact of the proposal. It was agreed to progress to a decision-making business case (DMBC).

5.1.8 MPFT have responded to the report of findings and outlined actions to mitigate known impacts. These are fully outlined in the Quality Impact Assessment and Equality Impact Assessment (refer to Appendices 4 and 5 for updated impact assessments).

5.1.9 This section presents the key conclusions and actions identified by the Inpatient Mental Health Services Technical Group for each main theme of feedback about the change proposals.

5.2 Travel and access

5.2.1 Travel emerged as an early key concern of patients, carers, and the Health Overview and Scrutiny Committee on this journey towards a long-term solution.

5.2.2 A detailed access analysis was completed during the development of proposals to clarify the impacts of centralising beds at St George's Hospital in Stafford. A very small proportion of the George Bryan Centre admissions came from out of county prior to the fire. The full analysis is available in the pre-consultation business case (PCBC) on the **ICB's website**.

5.2.3 Prior to the fire, 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, as not all treatments and interventions were available to people staying in the George Bryan Centre. Centralisation of bed provision will ensure equal access to these facilities based on need.

5.2.4 Analysis shows that 75% of south east Staffordshire patients admitted for an inpatient mental health stay were admitted directly to St George's Hospital. For many of these patients, this was because their illness was too serious for them to be treated at the George Bryan Centre. Data demonstrated that between February 2019 and July 2022, this equated to five people a month who would have been admitted to the George Bryan Centre, had it remained open.

5.2.5 During the consultation, concerns were raised for people who live in a rural location, and about the limitations of public transport, the difficulty of evening visits if relying on public transport, and the cost of travel.

5.2.6 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. This has been recognised as a positive impact for people with disability, removing any barriers to access for the patient or carer. It is also a positive impact for age, as for people 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.

5.2.7 However, for people who do require an inpatient admission, visits and support are very important and there is evidence to demonstrate they support wellbeing and recovery. This negative impact 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.

5.2.8 MPFT have considered feedback and suggestions from the consultation to support the finalisation of their travel standard operating procedure (SOP). Those visitors within scope of the SOP, and eligible to make a claim against it, are those who are visiting people who would previously been admitted to the George Bryan Centre, that have now been admitted to St George's Hospital, Stafford, and who are in receipt of a benefit or other financial support from the government.

5.2.9 In response to further feedback from the consultation, MPFT have increased the amount that can be claimed from 18 pence per mile to 45 pence per mile and clarified how people can claim back for using public transport.

5.2.10 MPFT have also outlined other ways they can support patients and carers with visiting a loved one:

- Being flexible about visiting times at St George's Hospital, to make it easier for those who use public transport and are reliant on the public transport timetable. It will also help those carers who wish to visit after the working day or have other caring commitments at home
- Supporting 'virtual visiting' – staying in touch through video calls, which proved to be very successful during the COVID-19 pandemic. This includes making sure that patients and visitors have access to devices like tablets. **MPFT's website (www.mpft.nhs.uk/about-us/digital/training)** has a page with support and guidance about digital skills.

5.3 Technology

5.3.1 Technology emerged as a key concern during the public consultation, with participants noting that not everybody has access to technology, that some people will not be able to use it, that technology cannot replace human contact and that communication via technology may not be appropriate for some patients, for example, those with dementia.

5.3.2 Following the public consultation, an update was received from MPFT regarding ongoing work to ensure that carers of patients on mental health inpatient wards are supported through a range of digital methods. These include:

- **Video calls:** Carers can use video calling apps that they are already familiar with, such as WhatsApp, Facebook Messenger, and FaceTime
- **KOMP**[9]**:** KOMP is a secure digital communication device that carers can use to engage with patients. Carers can use their own smartphones to access KOMP. MPFT staff are happy to support carers who want to use this facility
- **MPFT has a Digital Angel IT project that supports our staff with new technology:** This ensures that staff are confident with using technology to support patients and carers. This also forms part of our **Digital Strategy (www.mpft.nhs.uk/about-us/digital/digital-strategy)** as outlined in the Transformation Plan section
- **Staff newsletter and ward manager meetings:** MPFT have created an inpatient staff newsletter and monthly ward manager meetings to ensure that key messages are cascaded to staff. This will form part of their communications plan.

5.3.3 MPFT are committed to providing carers with the support they need to stay connected with their loved ones who are on inpatient mental health wards and are constantly looking for new ways to use technology to support carers.

5.3.4 MPFT's digital strategy has a strong emphasis on inclusion and reducing inequalities. The Trust are committed to tailoring services based on people's digital preferences for communication, their capability, accessibility and individual needs, including protected characteristics.

[9] Komp website, accessed October 2022

5.4 Support for carers

5.4.1 Feedback was received during the public consultation about the need for greater support for carers, with participants noting that carers may require greater support, particularly out of hours, that peer support could be useful and that some carers struggle to access carer's allowance.

5.4.2 MPFT continually review and adapt their services to meet the needs of their service users, and some of these initiatives are outlined below.

- MPFT work with the Alzheimer's Society to support patients and carers post-diagnosis
- All information regarding MPFT services can be found on **MPFT's website (www.mpft.nhs.uk)**. MPFT are working with patients and carers to simplify the language used when developing information for them
- MPFT are also developing a 'message in a bottle', as part of the transformation of dementia services. This will contain useful information such as contact details for patients and carers. It will be kept in the fridge for patients and carers to access post-diagnosis for information if needed and is expected to be implemented April 2024
- MPFT are improving partnerships with system partners such as Staffordshire County Council to improve and join up care for dementia patients and carers. Further information can be found in section 9.7.
- The Hospital Avoidance team (HAT), which includes older adult specialists, gives support at home to help older people stay out of hospital. The team offers phone calls and home visits, and carers can call for help in a crisis
- Support for carers – a new home sitting service is being developed to support carers who need a break during the evening or at weekends. The crisis team will refer patients to this service, which will give carers some much-needed time to themselves, while their loved one is looked after in their own home.

6 Approach to decision making on service change proposals following consultation

6.1 Overview

6.1.1 Following the public consultation, the proposal has been reviewed in light of the feedback received and the work undertaken by the Inpatient Mental Health Technical Group to consider it (the previous section set out the key conclusions).

6.1.2 The proposal had been assessed against local criteria for service and the prescribed national tests for service change within the PCBC and there is no new proposal or change to the existing proposal, so further assessment against these criteria was not required at this stage of the process.

6.2 Local considerations for service change

6.2.1 In the pre-consultation phase, options for service change were assessed against six local criteria. This DMBC uses the same criteria against which to judge the proposal and make recommendations.

6.2.2 The table below describes the local criteria and the evidence that has been reviewed, as part of the options appraisal / PCBC development, to support decision making and the development of recommendations being placed before the NHS Staffordshire and Stoke-on-Trent ICB Board.

Table 9: Local criteria and evidence considered

Local criteria	Evidence considered
Clinical sustainability	• Review of the clinical model and recommendations made by the West Midlands Clinical Senate • Review of case for change within regional NHSE assurance processes.
Strategic fit	• Alignment to national and local strategies • Review of case for change within regional NHSE assurance processes.
Meeting the needs of the population	• Quality Impact Assessments (QIAs) led by local clinical leads that have been reviewed through ICB governance routes • Stage 1 and Stage 2 Equality Impact Assessments (EIA) that have been reviewed through ICB governance routes.
Demand and capacity	• Analysis of attendances and capacity of the enhanced community offer • Sustainability of service provision outlined by MPFT due to the enhancement of community services, in line with national policy not to admit to an inpatient bed unless 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 • There is 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

Local criteria	Evidence considered
	locally, so for this cohort of patients, a placement would be appropriate and required.
Workforce sustainability	• Analysis by local workforce leads • Recruitment and training of the appropriate number of staff with the right skills for future needs as outlined in section 9.
Estates	• Utilising existing estate – the Milford Ward at St George's Hospital has been refurbished to provide 18 beds • Calculations show that the cost of the outlined proposal is slightly less than the cost of running the George Bryan Centre, and avoids rebuild costs, calculated at £11.5 million.

6.3 National tests for service change

6.3.1 This section describes the evaluation of the scenarios/ options for the future of the services previously provided at the George Bryan Centre.

6.3.2 In 2010, the NHS set four key tests for service reconfiguration:

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

6.3.3 In 2017 a further test was added in relation to proposed bed closures. 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 NHSE 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).

6.3.4 The table below describes the national tests for service change and the evidence that has been reviewed to support decision making and the development of recommendations being placed before the ICB Board.

Table 10: National tests of service change and the evidence considered

National criteria	Evidence considered
Strong public and patient involvement	• Extensive engagement while developing proposals • Options appraisal process • Review of case for change within regional NHSE assurance process.
Consistency with current and prospective need for patient choice	• Low number of out of area placements (although patients can choose to be admitted out of area) • The ICB is signed up to the Midlands Regional Guidance to support the repatriation of people who find themselves out of their normal catchment area (acute adults) • Regional NHSE assurance process.
Clear clinical evidence base	• Alignment with national best practice of community care where possible and short length of stay if inpatient admission is required • Alignment with strong evidence base for treating people with dementia in their own home/ community • Review of the clinical model and recommendations of the West Midlands Clinical Senate • Review of case for change within regional NHSE assurance processes.
Support for proposals by clinical commissioners	• Strong clinical involvement at all stages of the process, including at technical events to evaluate proposals • Confirmation of support for the proposal outlined within the business case from neighbouring ICBs, including Shropshire, Telford and Wrekin ICB, North Staffordshire Combined NHS Trust and the Staffordshire and Stoke-on-Trent ICS Mental Health Transformation Programme Board • PCBC approved by ICB Board • Pre-consultation activities led by ICB (previously CCG).
Bed closures	Point one is relevant to this proposal: 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. There is no national evidence for the number of mental health beds per head of population. • 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 • MPFT's Crisis Resolution and Home Treatment Team (CRHTT) gatekeep requests for admission, to ensure that admission to an inpatient bed is the right treatment plan for the patient • Length of stay is a metric that Trusts aim to keep low, as evidence demonstrates improved outcomes for most people who receive treatment and care in their usual place of residence • The ICB is signed up to the Midlands Regional Guidance to support the repatriation of people who find themselves out of their normal catchment area (acute adults) • For older people, the existing community pathway was enhanced to support older adults by Older Adult Services/Care Teams treating patients in the community.

6.3.5 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 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 focused 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 are in the process of commissioning cultural sensitivity training and demographic information collection training.

6.3.6 The funding for the service has not reduced and will be maintained. See section 8 for further financial context.

7 Analysis of proposal

7.1 Overview

7.1.1 The proposal is to centralise inpatient mental health beds on one site in St George's Hospital in Stafford, supported by an enhanced community mental health offer.

7.1.2 This section provides an overview of the assessment of the proposal, following public consultation, against local and national criteria.

7.2 Strategic fit and clear clinical evidence base

7.2.1 Our proposal has been developed taking into account evidence outlined in national strategy and guidance:

- Evidence shows that patients, including adults and older adults with severe mental health needs, have better recovery and outcomes if they are kept out of inpatient services and supported in the community wherever possible. National best practice in mental health has shifted from a bed-based model to a community-based model
- Patients benefit from greater choice and control over their care, with access to a range of community-based services, such as therapeutic care and crisis support
- Particular focus is needed to support people whose needs are deemed too severe for Talking Therapies, but not severe enough to require inpatient care
- Integration between primary and community mental health care, enabled by core community mental health teams moving towards a new place-based, multi-disciplinary service across health and social care aligned with primary care networks
- Person-centred care delivered in partnership with people, their families and carers, tailored to the person's individual needs and preferences and delivered in a way that is respectful and dignified
- Proactive approach to reducing health inequalities, ensuring care is accessible to people from all backgrounds and tackling any disparities or inequalities
- A more comprehensive service system wrapping around people in the community – 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
- When inpatient care is needed, guidance states 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.

7.2.2 National guidance

7.2.2.1 This approach is underpinned by the following national guidance, including:

- The NHS Long Term Plan[10] published in 2019 set out key ambitions for the NHS over the following 10 years until 2029. It sets out mental health as a priority, and reasserted the commitment to improving mental health services, both for adults and for children and young people, and that mental health funding would 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. The Community Mental Health Framework[11] published by the National Collaborating Centre for Mental Health emphasised the modernisation of place-based community mental health services
- The Royal College of Psychiatrists' Core Standards for Mental Health[12] lay out best practice for mental healthcare and provide key guidance about how mental healthcare is provided and organised, including the best type of environments for care
- The NHSE 2023/24 Planning Guidance sets out a requirement for ICBs to co-produce a strategic plan to localise and realign mental health inpatient services over a three-year period. To support this, a new Commissioning Framework for Mental Health Inpatient Services has been developed, setting out the principles and standards for the delivery of acute inpatient mental health care for adults and older adults in England. It covers the whole pathway of care, from assessment and admission to discharge and aftercare.

7.2.3 The Staffordshire context

7.2.3.1 ICS plans and strategies for 2023/24 and beyond, such as the Five Year Joint Forward Plan (JFP) and the Integrated Care Partnership (ICP) Strategy, are underpinned by the Five Year Forward View and the NHS Long Term Plan as well as other related policies and guidance. The key themes of integration, improving population health, personalised care and care closer to home run through both documents.

7.2.3.2 The ICP Strategy outlines how the Staffordshire and Stoke-on-Trent Integrated Care Partnership will work over the next five years to improve services for our people and communities. The strategy focuses on long-term priorities to prevent ill health, reduce inequalities, and deliver better health and care services for our population.

7.2.3.3 The Joint Forward Plan 2023–2028 was developed by Staffordshire and Stoke-on-Trent ICB and partner NHS Trusts. It sets out how we will transform services and pathways to support delivery of the vision and ambitions outlined in the ICP Strategy. The ambition for mental health in the JFP is that:

- We will work in an integrated and collaborative way to ensure mental health is given equal priority to physical health needs and that people receive the help and support they need closer to home and family
- By bringing together leaders from all local partners, we will continue to raise the profile of mental health in our system and enable new models of support to be developed,

[10] NHS Long Term Plan, 2019
[11] Community Mental Health Framework, Sept 2019
[12] Royal College of Psychiatrists' Core Standards for Mental Health, 2019

delivered by a wide range of partners

- The vision for mental health, learning disabilities and autism is to ensure older people, adults, young people and children feel supported – whether they find themselves in need of help in crisis or to maintain their day-to-day mental health and wellbeing.

7.2.3.4 The publication of the Mental Health Implementation Plan[13] (2019) provides the new framework to ensure delivery of this commitment and the detail of what this means for us at a local level in Staffordshire and Stoke-on-Trent.

7.2.3.5 The following table shows 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. Following this three-year implementation period, funding for this programme of work will be recurrent.

Table 11: Funding for the Community Mental Health Transformation Framework

Taken from the outline of three-year delivery plan – Community Mental Health Transformation Framework	2019/20	2020/21	2021/22	2022/23	2023/24
Transformation Programme (TP) provisional 'fair shares' transformation funding allocation as per Analytical Tool (non-cumulative)	N/A	N/A	£2,170,703	£5,281,898	£6,892,000

7.2.3.6 The Good Mental Health in Staffordshire strategy aims to help everyone improve and maintain their mental wellbeing, help those who have short periods with problems to regain their mental health and wellbeing, and help people of all ages with severe long-term mental health problems to live productive and fulfilling lives.

7.2.3.7 The strategy takes into account recent national policy changes, the impact of the COVID-19 pandemic on people's mental health, and related local strategies and plans to improve mental health and wellbeing and mental health services. It has been co-produced by Staffordshire County Council and NHS with other partners, the public, mental health professionals, the people who use these services, and their carers.

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

7.3 Consistency with current and prospective need for patient choice and meeting the needs of the population

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

7.3.2 NSCHT provide mental healthcare at Harplands Hospital, Stoke-on-Trent, which serves north Staffordshire and Stoke-on-Trent. These services are not included in the scope of this document.

7.3.3 The PCBC covered, in detail, how MPFT and key partners provide services in keeping with the aims and ethos of the national and local strategies:

- Benchmarking of MPFT against other mental health trusts across the UK for metrics including length of stay, number of inpatient beds and re-admissions. All indicate that the move to community-based care is working well in Staffordshire
- MPFT's Care Group Business Plan for 2020–2022 for adult mental health services, including developing a new community-based offer to people with mental health problems, is in its third year and delivering as expected
- Staffordshire and Stoke-on-Trent Community Mental Health Transformation model creates a framework for supporting people in the community as much as possible – involving partnership between council providers, NHS providers, and primary care networks (PCNs), with involvement from the voluntary, community and social enterprise (VCSE) sector
- Enhancement and further development of community-based crisis support by MPFT, including a crisis café delivered from Sacred Hearts Church, Tamworth, on a temporary basis until a permanent location is secured. MPFT are hoping to secure a permanent location by mid-2024
- Working alongside the crisis café service will be the 'Safe Hands' Out of Hours Home Sitting Service, working from Tamworth and Stafford. This service will provide a crisis café-style intervention in service users' homes for those who are unable to travel to the crisis café
- VCSE providers are commissioned to provide support around lifestyle management, housing-related support and financial wellbeing
- The provision of services at the crisis house is currently carried out by Richmond Fellowship, a leading mental health charity in the UK. The fellowship has a proven track record of facilitating recovery for people with mental health issues and is highly recognised for its collaborative approach. As part of the transformation of mental health community services, the location of this service will be reviewed to ensure it is able to support the crisis care pathway
- The Core24 service at Queen's Hospital, Burton, and Liaison Services in County Hospital function as a multi-disciplinary team for individuals who are admitted or self-present to the acute hospitals, ensuring that people who experience a crisis can access timely and effective crisis care. This could help to relieve pressure on other services
- PCN mental health practitioners becoming embedded across PCNs in south Staffordshire, along with Support Time and Recovery Workers (STRW). These practitioners act as a first point of contact in GP practices, there to assess the mental

health needs of people who present to primary care. All mental health practitioner and STRW roles are joint funded between PCNs and MPFT.

7.3.4 Since the PCBC was completed, there have been further developments to support the provision of mental health support in the community.

7.3.5 NHSE is investing £10 million in mental health ambulances this winter, with the aim of reducing the number of people who are taken to hospital by ambulance for mental health reasons. The new mental health ambulances will be staffed by trained mental health professionals, who will be able to assess the situation and provide the appropriate care.

7.3.6 NHS 111 should be used for people experiencing a mental health crisis who need urgent but not emergency help. This includes people who are feeling suicidal, experiencing psychosis, or having a severe panic attack. NHS 111 operators will be able to provide advice and support, as well as arrange for the person to be seen by a crisis team or mental health professional. The longer-term plan is for rollout of the NHS 111 option 2, which will become the single point of access for mental health crisis care and urgent help.

7.3.7 Mental health ambulances should be used for people who are at risk of harming themselves or others, or who are experiencing a mental health crisis that is so severe that they cannot wait for help from NHS 111 or a crisis team. This includes people who are actively suicidal, who have a history of violence, or who are experiencing a psychotic episode that is causing them to behave dangerously. Mental health ambulances are staffed by trained mental health professionals who can assess the situation and provide the appropriate care.

7.3.8 The guidance aims to ensure that people who are experiencing a mental health crisis receive the right care at the right time, and that they are not unnecessarily taken to hospital by ambulance. It also aims to improve the availability of mental health services and to reduce the number of people who are admitted to hospital for mental health reasons.

7.4 Support for proposals by clinical commissioners

7.4.1 The programme has had strong clinical involvement at all stages of the process, including at technical events to evaluate proposals.

7.4.2 Written confirmation of support for the proposal outlined in the business case has been received from neighbouring ICBs, including Shropshire, Telford and Wrekin ICB, North Staffordshire Combined NHS Trust and the Staffordshire and Stoke-on-Trent ICS Mental Health Transformation Programme Board.

7.4.3 The West Midlands Clinical Senate review of the proposal was jointly commissioned by Staffordshire CCGs and MPFT. It was carried out on 10 June 2022 by a panel of experts from the Senate, most of whom are practising clinicians.

7.4.4 The panel concluded that it was largely supportive of the recommended proposal of a single site for inpatient services. It considered that the clinical model has alignment with the national strategy for mental health services and, considering all available evidence, concluded that negative impact to patients is low and mainly involves travel time for patients, carers or relatives.

7.4.5 At a regional NHSE assurance panel, NHSE were assured that proposals met the five tests of service change – as well as other good practice tests – and were content that the ICB proceed to consultation.

7.4.6 The PCBC was approved by the NHS Integrated Care Board on 19 January 2023.

7.5 Clinical sustainability and demand and capacity

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

7.5.2 As outlined in the previous sections, the framework for supporting people in the community includes a range of service provision from MPFT and the VCSE sector, with most delivered in patients' usual place of residence.

7.5.3 In addition to this, there are mental health services available in each locality via a range of community venues. The table below shows the venues that make up the hub and spoke model for providing clinical and non-clinical space across the east and south east of Staffordshire.

Table 12: Venues that make up the hub and spoke model

Area	Hub location	Spoke locations
East Staffordshire	Horninglow clinic, Burton	• Balance St Clinic, Uttoxeter • Cross St Clinic, Burton
Tamworth	Sir Robert Peel Hospital	• Humankind offices, Tamworth • Merlin House, Tamworth • Manna House, Glascote • Tamworth Library
Lichfield/Burntwood	St Michael's Court, Lichfield	• Lichfield Fire Station

7.5.4 The community mental health team for south east Staffordshire is currently based at the Sir Robert Peel Hospital. MPFT are actively working towards bringing Cherry Orchard, Tamworth, back online as an adult mental health community venue, with a refurbishment and extension in progress. The clinical teams will move into the building when the building work has been completed in March 2024.

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

Figure 3: Stepped model of care

7.5.6 When comparing length of stay during 2017–19 at the George Bryan Centre with data from the period of transition to St George's Hospital (2019–21), there is a reduction in length of stay which reflected the move towards more support in the community. This indicates that the new configuration of beds since the move to St George's Hospital has not had an adverse impact on patients. This data has not been updated, as the acuity of patients requiring inpatient care in the present day, when compared to 2017–19, would skew the results.

7.5.7 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.

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

Table 13: Configuration of beds before and after the fire at the George Bryan Centre

Number of beds	Configuration of beds at George Bryan Centre site BEFORE the fire	Configuration of beds at St George's Hospital site BEFORE the fire	Configuration of beds at St George's Hospital site AFTER the fire
Number of beds	31	66	84 (18 of 19 beds created) – removal 12 beds

7.5.9 The PCBC outlined issues that previously occurred for patients at the George Bryan Centre, due to the remote and isolated location of the site, including:

- Difficulties responding to psychiatric emergencies. Transfers to St George's Hospital could take up to six hours because of the need for secure travel
- Transfers required due to a patient need that escalated or deteriorated, which had implications for staff safety
- Data shows a reduction in the number of police call-outs following the centralisation of inpatient beds at St George's Hospital. This can partly be explained because the facilities for supporting patients in crisis at St George's Hospital are more comprehensive than those that were available at the George Bryan Centre and there is a wider range of staff able to support patients in crisis, so the police rarely need to be called.

7.5.10 The benefits realisation and outcomes framework below was shared with the reference group deliberative event on 15 March 2022, illustrates the positives and negatives of the proposal for the future of inpatient services, showing the potential outcomes of the proposal.

Centralised beds at St George's Hospital

Table 14: Advantages and disadvantages of centralising beds at St George's Hospital

Patient safety

Advantages
Timely access to intensive psychiatric care: As a larger hospital, now with 84 beds for adults with severe mental illness, St George's Hospital has a wider range of specialist staff. Its facilities include a psychiatric intensive care unit (for male patients) and seclusion rooms. The most unwell patients have faster access to specialist care, without having to be transferred from another site. 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. 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.

Duty of quality

Advantages	Disadvantages
Meeting a wider range of needs: A bigger staff, with a wider skill mix, at St George's Hospital can meet a wider range of needs. Patients can be looked after by staff with a wider range of skills and specialisms. Additional interventions available at St George's Hospital that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy.	**Greater risk of health inequalities:** Evidence shows that being in touch with family, carers and friends is beneficial to patients with severe mental illness. Some patients and carers will have to travel further to visit a person who is admitted to St George's Hospital in Stafford. This could have an impact on people living in rural areas without good transport links, people without a car, and those on low incomes – with a risk of greater risk of health inequalities for some patients.

Patient experience

Advantages	Disadvantages
Location: Some involvement comments have suggested that the location of St George's Hospital is an advantage – patients with approved leave have access to activities outside hospital in Stafford town centre**.**	**Travel impacts:** Some patients and carers will be impacted by having to travel further to visit a person who is admitted to a bed in St George's Hospital in Stafford. This could affect those who live in rural areas without good transport links, people without a car and those on low incomes. Travel was a major concern raised in both the 2019 and 2021 public involvement sessions.

Clinical effectiveness

Advantages	Disadvantages
More consistent care provision: More consistent care provision in a centralised site, as no need for disruptive transfer to intensive psychiatric care or to access therapeutic interventions. Fewer emergency call-outs: Fewer police call-outs since the centralisation of beds at St George's Hospital (nine in 2021) than at the George Bryan Centre before the fire. This reflects that a larger site with senior clinical back-up, more staff, and intensive psychiatric care facilities, can manage crises more effectively.	**Travel impacts:** Centralisation of beds at St George's Hospital would impact on travel for some carers and there is evidence that family/ carer visits improve outcomes.

8 Financial analysis

8.1 Introduction

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

8.1.2 The section includes:

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

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

8.1.4 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.

8.2 Community Mental Health Investments

8.2.1 The Mental Health Investment Standard (MHIS), set by NHSE, requires all ICBs in England to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year. The ICB is required to produce a compliance statement to state whether the ICB has met the MHIS.

8.2.2 The change from assessing and treating people in the wards 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.

8.2.3 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 including older adults. Called Service Development Funding, this is ring-fenced for this purpose only. We have also shown in the table below the existing spend on community mental health services across the ICB. The table demonstrates our increasing investment in community mental health services.

Table 15: Investment in community mental health services

Mental Health Spend Category	2021/22 £'000	2022/23 £'000	2023/24 £'000
Community A – community services that are not bed-based / not placements	**48,950**	**55,373**	**54,206**
SDF Allocations	**2021/22 £'000**	**2022/23 £'000**	**2023/24 £'000**
Adult Mental Health Crisis (AMH Crisis)	563	743	1,521
Adult Mental Health Community (AMH Community)	2,171	5,220	7,113
Adult Mental Health Liaison (Crisis/Liaison flexible funding)	0	336	0
Total SDF Allocations	**2,734**	**6,299**	**8,634**
Total	**51,684**	**61,672**	**62,840**

NB - 21/22 & 22/23 are actuals; 23/24 is forecast

8.2.4 The table outlines the investment in adult community services only (excludes inpatient and children's services). Staffordshire and Stoke-on-Trent ICB and ICS are committed to meeting the MHIS in 2023/24 and all future years.

8.3 MPFT baseline financial situation

8.3.1 The table below provides a high-level summary of the operating expenditure attributed to the George Bryan Centre service line, dating back to before the re-provision 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.

Table 16: Baseline (George Bryan Centre) summary financial trajectory

	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

Notes to table:

- 2018/19 extracted from Trust Service Line Reporting (SLR) data
- 2019/20 through to 2021/22 based on 2018/19 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. However, this is notional and variable based on changing methodology over time, and would be fixed in the medium term regardless of changes in operating models.

8.4 Staffordshire and Stoke-on-Trent ICB finances

8.4.1 The Staffordshire and Stoke-on-Trent ICB submitted a balanced plan on 4 May 2023, which included material risks in order to achieve the break-even plan. Early indicators suggest a year-to-date deficit position. Despite this, the system remains committed to delivering a year-end breakeven position.

8.4.2 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.

8.4.3 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. While 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.

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

8.5 Impact on MPFT

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

- The former George Bryan Centre model ceased in 2019 and indicative costs have been projected forward on a 'standstill' 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 costs are not identifiable discretely. Costs have been apportioned accordingly where relevant and necessary to provide a reasonable proxy for the patient cohort in the scope of the review
- The workforce pressures experienced in inpatient facilities with regard to recruitment and retention, and double running costs associated with the COVID-19 pandemic over the last two years, make comparisons with the baseline complex.

8.5.2 The 'current model' operating spend is based on 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 at 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.

Table 17: Subjective summary of financial trajectory – 2018/19 to 2022/23

	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

8.5.3 The above table provides a subjective summary of the financial trajectory, based on the methodology set out earlier. The table 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.

Table 18: Comparison of baseline financial resource to current resource

	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	

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

8.6 Refurbishing Milford Ward

8.6.1 A business case for redeveloping Milford Ward was first approved in June 2018. The business case was approved for the outturn projected costs identified in the detailed summary table below. The outturn cost estimate identified and approved was for the value of £1.375 million.

8.6.2 Several factors led to delays in implementing the original business case, including the use of Milford House to support winter pressure acute bed numbers. 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.

8.6.3 With the fire at the George Bryan Centre resulting in the decant and full occupation of the Milford Ward, the scope of works and delivery method was significantly changed – 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 well as maintaining fire escapes. All of these added to the cost.

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

8.6.5 Based on the returned lowest priced tender that was checked and validated, there was an outturn budget deficit of £630,842.36 (inclusive of VAT and fees) against the initial high-level costs developed within the original cost plan submitted in the 2017 business case. It is noted that the business case costing was not based on a competitive tender so some variation would be expected. The original cost plan was also 30 months out of date, and based on vacant possession. The following table summarises the final returned costs and updated financial position. This was funded through the Trust's annual capital plan.

Table 19: Final returned costs and updated financial position

Description	Cost (£)
PM14 – South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) business case estimated costs – vacant possession	£1,375,000.00
Updated estimated outturn 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**

8.7 Future prospects and funding

8.7.1 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 2023/24. The landscape in which NHS systems have operated has changed considerably since the COVID-19 pandemic. A funding regime has been established for 2023/24 as part of the journey back towards financial improvement targets, and this will pose increasing financial challenges, particularly for those systems like Staffordshire and Stoke-on-Trent that remain in an underlying forward deficit.

8.7.2 A draft plan submission for each ICS, and providers within it, was submitted in March 2023, with a final submission at the end of April 2023. 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.

8.7.3 The service model within the spotlight of this financial case is important, but a relatively small proportion of the overall spend of the Trust.

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

9 Workforce analysis

9.1 Introduction

9.1.1 As set out in the pre-consultation business case (PCBC), workforce is a key focus of the change proposal. An overview of the key workforce considerations relating to the proposal is set out below.

9.1.2 The process used to develop the workforce plans has been documented in the PCBC and is not covered here. This section does examine previous and current workforce levels/profiles, the impact of the proposal on the workforce and measures taken to ensure future sustainability.

9.2 Previous and current workforce levels and profiles

9.2.1 MPFT use the Mental Health Optimal Staffing Tool (MHOST) to calculate safe levels of staffing. Data has been collected over 12 years where the needs of patients over a 24/7 period have been reviewed, including all 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.

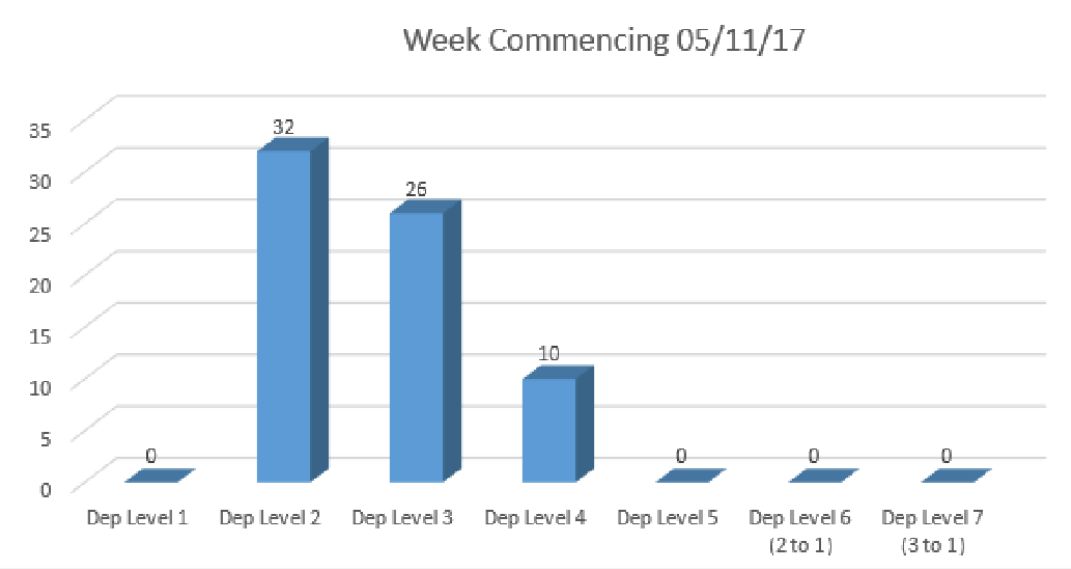
Table 20: Adult acute admission mental health wards

Acuity and dependency level	Descriptor
Level 1: Low dependency	Self-caring and able to do most daily living activities 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 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 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 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 others. Leave from the ward isn't allowed – other than planned hospital appointments with escort. May be awaiting step-up to psychiatric intensive care unit (PICU) or low-secure environment.

9.2.2 Dependency Level 1 is the least dependent, and Level 5 requires one-to-one observations. There are also dependency levels 6 and 7, but these are most commonly seen in the forensic area of St George's Hospital. There are multipliers for the individual mental health specialties, based on the five dependencies. Each one breaks down into care hours per patient day, and this is analysed to produce a health roster, with unfilled shifts visible.

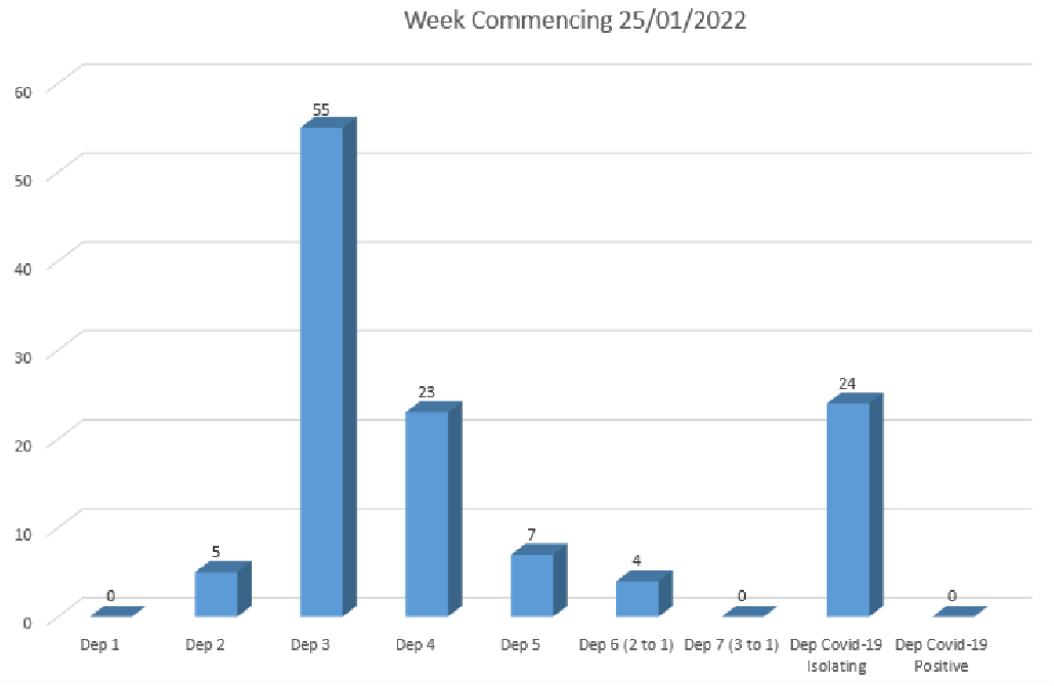
9.2.3 The figure below gives an example of levels of acuity at the George Bryan Centre in November 2017.

Figure 4: Acuity for the George Bryan Centre in November 2017



9.2.4 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.

Figure 5:Acuity for Milford Ward in January 2022



9.2.5 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.

9.3 Workforce profiles

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

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

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

9.4 Implications of analyses

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

9.4.2 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 additional travel and engaged about where they wanted to work.

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

9.4.4 **Changes to bed numbers and resulting staff requirements**

9.4.5 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. These patients were discharged into appropriate care settings, moved to the community with the enhanced support offer or repatriated to St George's Hospital, depending on their need.

9.4.6 Two proposals were considered during the options appraisal process. The staffing numbers required for centralising beds at St George's Hospital in Stafford and reinstating the beds at the George Bryan Centre were fully considered.

9.4.7 Data showed that, to meet safe staffing requirements, reinstating beds at the George Bryan Centre would require 9.9% (16.6 WTE) more staff than centralising beds at St George's Hospital, Stafford. This potential recruitment requirement was considered alongside existing recruitment and staffing pressures.

9.4.8 During the technical event held in December 2021, it was agreed that reinstating the beds at the George Bryan Centre was not a viable option. This was due to safety concerns of operating inpatient mental health services at an isolated site.

9.4.9 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 previously. This is because patients are more likely to be supported in the community unless they become seriously ill.

9.5 Workforce impact for the proposal

9.5.1 There are significant challenges with recruitment and retention – with nursing staff, including mental health nurses, on the national shortage occupation list. Allied health professionals and Band 8A psychologists are also on the shortage list.

9.5.2 Centralisation of inpatient mental health beds at one larger hospital site enables MPFT to compete with larger trusts across Birmingham and surrounding areas which also provide mental health services.

9.5.3 As staff who provide therapeutic interventions are skilled and specialist, they 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. This is because they work across wards as required and tend to prefer being part of a larger team.

9.6 Safety

9.6.1 There were fewer police call-outs to St George's Hospital when compared with the George Bryan Centre, taking into account the proportion of patients at each site. Staff working at a larger centralised site have protection afforded by the larger numbers of staff.

9.7 Measures for sustainability

9.7.1 In terms of the wider workforce implications of the NHS Long Term Plan, 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.

9.7.2 MPFT is carrying out several 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.

9.7.3 By applying measures of patient acuity, they can assess how many staff they need to safely care for and treat patients, and they review this twice a year and review staffing daily using Safe Care Live tool.

9.7.4 There are regular reviews of the workforce skill mix to see whether there are any gaps. Training is then provided as appropriate, with the help of the Trust's clinical education team.

9.7.5 Training guidance from NHS England and National Institute for Health and Care Excellence (NICE) are continuously monitored, and appropriate training provided as required.

9.7.6 The Trust 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 NHSE – including assistant practitioner and clinical associate psychology roles. A quality lead is in post to support this process, and recruitment of the clinical education trainer is underway.

9.7.7 The Trust are working with Health Education England on training for nurse associates and mental health and wellbeing practitioners. They have direct links with Keele University and are developing a course for clinical associate psychologists. The first intake for this course was September 2022.

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

9.7.9 The Trust are 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.

9.7.10 In terms of recruitment to support sustainability, MPFT are running a recruitment drive. It has employed a talent acquisition specialist to support advertising and seek out people from different employment backgrounds, not just the NHS. As a result of this, there has been a significant reduction in vacant posts and use of agency staff.

9.7.11 MPFT are undertaking a Trust-wide initiative (Project Synergy). This aims to transform the way MPFT recruits, attracts, and retains and on-boards staff. Specific objectives have been set around reducing reliance on agency staff, reducing staff turnover and developing a more contemporary workforce – ensuring workforce requirements are fit for the future.

9.7.12 The transformation funding for the community model provides opportunities to contract the VCSE 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.

9.7.13 The Trust are looking at creative ways of ensuring that people are supported effectively after discharge. They are working with the VCSE 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.

9.7.14 **Brighter Futures** deliver a Staffordshire and Stoke-on-Trent mental health helpline that is available during the evenings and weekends. 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.

9.7.15 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, can move between wards as acuity levels require. This would be more difficult or impossible with a smaller staffing establishment.

9.7.16 Healthcare support workers are employed both in St George's Hospital and in community mental health teams. They provide flexibility within the workforce, providing 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.

9.7.17 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.

9.7.18 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.

9.7.19 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.

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

9.7.21 The ICB is assured that the existing service model that has been in place since 2019 provides a sustainable workforce model that will meet future population needs. This is evidenced through the current enhanced service model showing sustained improvements to outcomes including reducing patient length of stay and improved access This has meant that patients and families/ carers are supported in their own home/usual place of residence improving overall quality and experience of care.

10 Governance and decision making

10.1 Introduction

10.1.1 To enable and facilitate the governance and assurance process, the programme has involved stakeholders from across the Staffordshire and Stoke-on-Trent health and care system to provide input and advice to the decision-making process.

10.1.2 An overview of the governance and decision-making timeline is set out in the table below.

Table 21: Key milestones and dates

Date	Activity/ meeting	Meeting purpose
23 March 2023	Consultation finished	
9 June 2023	IMHS Steering Group/ Technical Group	Receive report of findings, oversight of consultation feedback, analysis and evaluation
30 June 2023	Strategic Transformation Group	Review of consultation process. Confirmed that no new proposals were identified, and work would progress with development of a DMBC
23 August 2023	Quality Impact Assessment (QIA) panel	Present refreshed QIA (including response to consultation feedback) for consideration
24 August 2023	Equality Impact Assessment review	Present refreshed EIA (including response to consultation feedback) for consideration
15 November 2023	MPFT Major Transaction Committee (MTC)	Update on process, timeline and report of findings
30 November 2023	MPFT Board	Report from MTC for information
5 December 2023	ICB Finance and Performance Committee	DMBC for consideration
21 December 2023	ICB Board	DMBC for consideration and decision
25 January 2024	MPFT Board	Outcome of ICB Board and implications for Trust

10.1.3 The ICS Mental Health, Learning Disability and Autism Portfolio Board provides the strategic direction for development of mental health services and ensures that the deliverables as outlined in the Mental Health Implementation Plan are achieved across the whole ICS on time and in a cost-effective manner.

10.1.4 Strategic leadership, partnership engagement and assurance are delivered through the Programme Board and wider project structures, ensuring the priorities set out in the NHS Long Term Plan are realised. Assurance is provided as and when required to regulators and external partners that the Staffordshire and Stoke-on-Trent system delivers the requirements laid out in the national plan.

10.2 Risk management

10.2.1 The programme has created a risk register, with appropriate mitigations relating to the process of the programme. Clinical and operational risks are reported via MPFT corporate mechanisms. These risks have been managed throughout the process.

11 Implementation and monitoring

11.1 Implementation of the service

11.1.1 If the NHS Staffordshire and Stoke-on-Trent ICB Board approves the proposals, the service will be agreed through standard planning processes around how the ICB arranges the provision of health services for its population.

11.1.2 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. As this is an option that is already in place on a temporary basis, implementation in this case would simply mean confirming the changes as permanent.

11.1.3 As this has been the temporary solution in place, the usual implementation period following a decision will not be applicable.

11.1.4 However, the ICB would recommend that MPFT communicate with groups who contributed to the involvement and consultation process and maintain an ongoing dialogue with service users about community service developments. The ICB would also recommend that MPFT continue to work with the local authority and the VCSE sector to ensure local services meet the needs of the population.

11.2 Monitoring of the service

11.2.1 If the recommendation is approved to make permanent the changes in service provision that have been in place since the fire, the impact of the service change will be monitored through the Mental Health Learning Disability and Autism (MHLDA) Portfolio Board. This Board meets monthly.

11.2.2 The Quality Impact Assessment panel also recommended that the impacts are monitored and formally reported to both the Quality and Safety Committees as part of routine reporting for the first 12 months.

11.2.3 As part of the monitoring and assurance mechanisms with NHSE, the ICB is required to provide updates around a range of key performance indicators across all the NHS Long Term Plan priorities including community mental health and inpatient care. Assurance meetings between the ICB and NHSE take place monthly around these metrics. Examples of some of the metrics associated with inpatient care are in the table below:

Table 22: Inpatient care metrics

Metric	Definition
12-hour A&E breaches – adults/ children	The proportion of mental health A&E attendances (Type 1 departments) that breached 12 hours for those aged 18 and over/ 0-17
Inappropriate adult acute mental health out of area placement (OAP) bed days	An inappropriate out of area placement for acute mental health inpatient care is defined as when a person with assessed acute mental health needs who needs inpatient care is admitted to a unit that: doesn't form part of their usual local network of services doesn't usually admit people living in the catchment of the person's local community mental health service
Adult mental health inpatients receiving a follow-up within 72 hours of discharge	Discharges followed up within 72 hours of the patient being discharged from psychiatric inpatient care
Admissions with no prior contact (all inpatients)	Admissions of patients who have had no prior contact with community mental health services
Adult acute long length of stay (60 days and over)	Rate of people discharged per 100,000 in the reporting period from adult acute beds, aged 18 to 64 with a length of stay of 60 days or more
Adult acute long length of stay (90 days and over)	Rate of people discharged per 100,000 in the reporting period from older adult acute beds, aged 65 and over with a length of stay of 90 days or more

11.2.4 In addition, the ICB System Performance Committee has oversight of the performance against the national standards, as does the ICS MHLDA Portfolio Board. Performance with individual providers is monitored through contracts as routine. Metrics are scrutinised at a provider level and ICB level and benchmarked with comparators across the Midlands.

11.2.5 As part of the ICS Community Mental Health Transformation Framework Programme there is a specific workstream Evaluation, Outcomes and Performance Quality (EOPAQ) group. This group has been established to locally determine additional measures and metrics to demonstrate the impact of the programme, including those developed by patients and family and carers, in addition to the nationally mandated measures.

11.3 Care Quality Commission (CQC)

11.3.1 The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. They monitor, inspect and regulate services and publish reports following an inspection visit.

11.3.2 The CQC carried out a comprehensive inspection of MPFT in February and April 2019 and inspected nine core services, including acute wards for adults of working age and psychiatric intensive care units (PICUs). As a result, the Trust were rated as good overall, with 'safe', 'caring', 'responsive' and 'well-led' rated as 'good', and 'effective' rated as 'requires improvement'.

11.3.3 The CQC undertook an inspection of MPFT's acute wards for adults of working age and the PICU in November 2022. This was an unannounced inspection, focused on specific areas of the 'safe' and 'well-led' key questions.

11.3.4 In relation to this DMBC, the Trust provides acute wards for working-age adults in three wards on the St George's Hospital site:

- Brocton Ward
- Chebsey Ward
- Milford Ward.

11.3.5 Milford Ward was refurbished to accommodate residents following the fire at the George Bryan Centre. When people are admitted, they are placed on the ward that will best meet their needs.

11.3.6 During their inspection visits on 2, 3 and 18 November 2022, the CQC only visited Brocton Ward on the St George's Hospital site. Following the inspection, the CQC asked the Trust for a range of information and data specific to all acute wards for adults of working age. This information was included in the report that was published on 19 May 2023[14].

11.3.7 The report of the inspection updated the ratings for two of the five domains inspected by the CQC. These were 'safe' and 'well-led'.

11.3.8 As a consequence, the rating of the service was revised from 'good' to 'inadequate'. This does not affect the overall Trust-wide rating, which remains 'good'.

11.3.9 All three wards on the St George's Hospital site are classified as mixed-sex by the CQC, but they comply with the national guidance and expectations governing the provision of single-sex accommodation. Each person has a single en-suite room. The wards have clearly separated and defined corridors of sleeping for each sex and there are female-only lounges. Staff record breaches of mixed-sex accommodation as sexual safety incidents and the risk registers of the acute wards at St George's Hospital identified mixed-sex accommodation as a risk and provided actions to manage the risk.

[14] CQC inspection report of MPFT, 2023

11.3.10 Between May 2022 and October 2022, 32 incidents of assault, verbal threat of sexual assault and sexual orientation-related abuse were recorded at St George's Hospital. Sexual safety awareness training is available to staff and wards at St George's Hospital display a sexual safety ward charter that details expected standards of behaviour.

11.3.11 The following key findings and areas of good practice were found relating to Milford Ward and are taken from the report issued in May 2023.

- Milford Ward had the lowest use of agency staff (10%)
- Milford Ward had the lowest annual sickness rate (6.5%)
- Milford Ward had the lowest compliance for 'foundation in violence and aggression' training
- The Trust had a specific mandatory training action plan in place for Milford Ward which reflected the local response to the Trust-wide requirements
- Milford Ward had the lowest incidents of restraint, with just 20 between May and October 2022.

11.3.12 Findings related to other adult acute wards on the St George's Hospital site.

11.3.13 The Trust provide staff with life support training through two courses, Basic Life Support Level 1 and Life Support Level 2. Level 2 is for registered nurses and Level 1 for all other staff. The Trust recorded an overall completion rate for Level 2 of 73%, with wards at St George's Hospital recording 82%.

11.3.14 Brocton Ward had the highest compliance rate for 'foundation in violence and aggression' training and an 88% compliance rate for mandatory training overall (the Trust's compliance target is 90%).

11.3.15 12 patient care records were reviewed as part of the inspection. Four records on Brocton Ward did not demonstrate staff assessment of a patient's mental state and risk presentation at the point of taking leave and did not record a decision about leave.

11.3.16 Brocton Ward had a system in place for staff to record when they gave items of potential risk to patients for unsupervised use and when they were returned following use. However, this system did not always appear robust.

11.3.17 Staff from Brocton Ward reported feeling happy and positive working within their team.

11.3.18 The CQC identified 10 'must do' actions in the report and four relate to the key findings of the acute wards for working-age adults at St George's Hospital.

11.3.19 The Trust must ensure that staff working in the acute mental health wards for working-age adults and the PICU safely manage items of potential risk as part of patients' personal property.

11.3.20 The Trust must review mixed-sex accommodation arrangements within the acute mental health wards for working-age adults, with a view to reducing sexual safety incidents.

11.3.21 The Trust must ensure that staff working in the acute mental health wards for working-age adults and the PICU always assess patients' mental state at the point of taking leave and record these discussions and decisions in patients' clinical records.

11.3.22 The Trust must ensure that staff working in the acute mental health wards for working-age adults and the PICU is complete and remains up to date with mandatory training requirements.

11.3.23 Following the CQC's inspection, a robust improvement plan was put in place and significant work has taken place to address the issues identified. Focused work will continue to ensure that new ways of working are, and continue, to be embedded across the ward environments. This work will be monitored through internal checks and audits.

11.3.24 Examples of actions taken include:

- The procedure for managing items of potential risk (such as disposable lighters and razors) has been reviewed and standardised across acute wards and a new standard operating procedure has been developed. This is included as part of the induction checklist for new and bank/agency staff
- Raising awareness of and checking to ensure that leave is documented. MPFT's audits show that documentation of assessment of mental state prior to patients taking leave has improved since the visit
- The establishment of a professional group to focus on sexual safety and to consider the provision of mixed-sex wards at the Trust. This includes reviewing key policies and data, and sharing learning
- Reviewing of mandatory training compliance and the level of training compliance has increased since the visit
- MPFT have also improved consistency in the processes for inducting temporary staff, with standardised documentation introduced across the service and all electronic record systems made more accessible to agency staff
- Continuing to try innovative ways to recruit staff.

11.4 ICB monitoring of CQC reporting

11.4.1 Following a focused unannounced inspection in November 2022 the CQC issued MPFT with a section 29A warning notice. The Trust returned an improvement plan and evidence of progress to the CQC, which is monitored by the Trust's executive team.

11.4.2 Updates are reported by MPFT monthly to the System Quality Group and it is a standing agenda item on the bimonthly Clinical Quality Review Meeting. In May 2023, the CQC published an inspection report rating MPFT's acute wards for adults of working age and psychiatric intensive care units as 'Inadequate' for both the safe and well-led domains, as well as the overall core service.

11.4.3 This does not affect the overall Trust-wide rating which remains 'Good'. The full report is available online: Core Service - Acute wards for adults of working age and psychiatric intensive care units - (19/05/2023) INS2-14244779411 (cqc.org.uk)

11.4.4 The CQC undertook a follow-up inspection on 27 and 28 June 2023. This was to review progress against the areas for improvement outlined in the warning notice.

11.4.5 At this latest inspection in June, CQC found the Trust had met the requirements of the previous warning notice but found additional concerns. Therefore, it will be monitored and assessed to check that sufficient improvements have been made and CQC will keep it under close review during this time to make sure people are safe.

11.4.6 As this was a focused inspection looking at the areas of ‘safe’ and ‘well-led’, neither service was re-rated and both remain rated as inadequate overall and for being safe and well-led.

11.4.7 Partnership working remains in place between MPFT, Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB. The ICB are joining CQC assurance spot-check visits at St George’s Hospital in collaboration with the Trust to provide assurance that improvement actions are embedded.

12 Conclusion

12.1 Summary of the process

12.1.1 This decision-making business case (DMBC) has presented and summarised the extensive work undertaken on the proposal for inpatient mental health services previously provided at the George Bryan Centre.

12.1.2 This technical document follows the pre-consultation business case and has described the proposal, the consultation feedback and the programme's response to that feedback, to enable decision makers to decide whether there is a case to implement the changes to these service areas.

12.1.3 The programme of work has been underpinned by public involvement and the clinical model put forward is aligned to the NHS Long Term Plan and both national and local mental health strategies.

12.1.4 In conclusion, the ICB Board is being asked to make a decision on the long-term future of inpatient mental health services in south Staffordshire.

12.1.5 The recommendation to the ICB Board is to make permanent the existing temporary service change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.

12.1.6 The implications of this decision are set out in full within this business case and summarised below.

12.2 Impact on patients

12.2.1 The proposal aligns to national best practice and evidence that outcomes for patients are improved when care is provided in the community, and patients are only admitted to an inpatient mental health bed when they cannot be safely cared for at home.

12.2.2 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.

12.2.3 This community support is further enhanced by initiatives and services provided by MPFT working in partnership with council providers, NHS providers, and primary care networks (PCNs), with involvement from the voluntary care sector.

12.2.4 Concerns raised through the public consultation have been mitigated and these mitigations are outlined in sections 5.2, 5.3 and 5.4 of this business case.

12.3 Impact on finances

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

12.3.2 Data showed that, to meet safe staffing requirements, reinstating beds at the George Bryan Centre would require 9.9% (16.6 WTE) more staff than centralising beds at St George's Hospital, Stafford.

12.4 Impact on workforce

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

12.4.2 The centralised model is also more sustainable in terms of staffing.

12.4.3 The ICB is assured that the existing service model that has been in place since 2019 provides a sustainable workforce model that will meet future population needs and maximise existing resource to deliver the best care possible.

12.5 Assurance of the proposal and process

12.5.1 NHSE are assured that the proposal meets the five tests of service change, as outlined in section 6.

12.5.2 There has been extensive public, patient and staff involvement and a six-week formal public consultation, discharging its legal duty to involve patients and the public in the planning of service provision and the development of proposals for change. The details of this are set out in section 3.1.

12.5.3 Throughout the process, there has been continual engagement with the Staffordshire County Council Health Overview and Scrutiny Committee (HOSC) as outlined in section 3.3.

12.5.4 Updates have also been provided to Lichfield District Council's Community Housing and Health (Overview and Scrutiny) Committee and Tamworth Borough Council Health and Wellbeing Scrutiny Committee.

12.5.5 The HOSC have been supportive of the process and are assured that there has been appropriate involvement with the public. The committee supported the principle of moving towards community services, particularly for people with dementia.

12.5.6 In accordance with the National Health Service Act 2006 and Regulation 23 of The Local Authority Regulations 2013 the Staffordshire HOSC was requested to respond to the consultation. The committee agreed that, in the context of all the NHS services provided in Staffordshire, members did not deem the proposal to be a substantial change to services in the area.

12.5.7 Throughout the pre-consultation period, MPFT and the ICB received Parliamentary Hub enquiries in relation to the temporary closure of the George Bryan Centre. These are questions raised to the Secretary of State for Health and Social Care by MPs, where the NHS organisation is asked to provide the Department for Health and Social Care with details to help the department respond.

12.5.8 In August 2022 the MP for Cannock Chase raised queries verbally. These were responded to by letter in October 2022. During an ICB meeting before the start of the consultation (February 2023) the MP for Tamworth raised a series of questions. These were responded to by letter during the consultation period.

12.5.9 During the consultation period, no formal letters of support or concern were submitted from local councillors or Members of Parliament. However, within the consultation survey we received one response from the MP for Tamworth but no identifiable councillor responses.

13 Recommendation

13.1 To make permanent the existing temporary service change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer

13.1.1 This would mean inpatient mental health beds would not be reinstated at the George Bryan Centre.

13.1.2 Patients who would previously have been admitted to the West Wing will be admitted to St George's Hospital.

13.1.3 Patients who would previously have been admitted to the East Wing will continue to be cared for by the community team and would only be admitted to a hospital or nursing/ care home if they are no longer safe to remain in their home.

TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Staffordshire and Stoke-on-Trent
ICS Designation Development Plan

December 2020

Final Version

Foreword

The system response to Covid-19 has demonstrated the personal and collective commitment, we have as a system, to work together in the interests of our workforce and population. Equally there has been considerable learning from how system partners responded to the initial impact of Covid-19 and the subsequent ongoing response.

We will continue to capture and build on this learning to find ways to embed the improved ways of working and collaboration. System partners also recognise that there are perhaps 4 things that define external opinions of us as a system-

1. System relationships. Partners have worked hard to tackle some of the previous long-standing relationship issues that existed in the system. Good progress has been made on this front. However, there is an acceptance that we need to continue to focus on this area to ensure that we can bring constructive challenge and honest disagreement to the table without impacting on the relationship. The development of our OD approach will help with this at a senior level and maturity of relationships will also develop.
2. The financial position of the system. Significant progress has been made in this regard with the system expected to deliver on its breakeven position for 20/21. Whilst we recognise that this is an unusual year, we continue to take great strides in terms of setting a different financial strategy and an aligned approach that will support the 3 spatial levels that will exist with an ICS. The bold steps taken to move to the Intelligent Fixed Payment Approach have set the necessary foundations to progress the place-based delegation discussions
3. Urgent Care. The systems response to Covid-19 has demonstrated an ability to work collectively and in an integrated manner to best support each other and to focus on the best outcome for the resident / patient. There is more to do though, and we are committed to build on the Covid-19 response in a way that tackles some of our continued challenging performance across the urgent care agenda.
4. Forming a single strategic commissioning organisation (SCO). System partners recognise the importance of ensuring that the GP membership vote to support the merger of the 6 CCGs. This is recognised as a system responsibility and a priority that we will deliver on. Positive progress has been made in recent discussions with the LMC and with lead GPs across the system.

- System partners are clear that ICS designation is not an end, but rather, is a process that continues to evolve as the system tackles the challenges that it is facing. For our population, greater integration would allow them to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations, we can take big decisions around how and where care is delivered to make the most impact. This will include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible.

- We recognise that across our system there are very real health inequality challenges, many of which have worsened as a result of the Covid-19 pandemic. This is not an acceptable position and not one that sits comfortably with any of us. We have to do more to tackle these inequalities, but we know that one organisation working in isolation will not be able to solve these issues. We have to work differently at every level, and we have to make the local communities the focus of our approach to care.

- Our staff are undoubtedly our greatest asset and it is essential that we create the environment and conditions where they can deliver outstanding care in a coordinated and joined up manner. Too many times in the past we have allowed artificial barriers or boundaries to impede this. Our commitment is to find solutions to these blocks and to enable more integrated care to be the ever-increasing norm rather than the case study or the exception. The staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in current organisational structures. It is important to us that staff feel valued and are able to work in the way that enables them to provide high quality, compassionate and safe care.

- This development plan sets out how we will embrace the opportunities that integration provides for us and use it to tackle the health inequality challenge that exists. This is an exciting period and one that we embrace fully as we look to ensure that the residents of Staffordshire and Stoke-on-Trent get the very best health and care that they deserve.

Prem Singh
Independent Chair
Together We're Better

Who we are and who are our partners

- Around 1.1 million people live in Staffordshire and Stoke-on-Trent, across a geographical area of 1,048 square miles.
- Together We're Better is the partnership working together to transform health and care for the people of Staffordshire and Stoke-on-Trent.
- Together We're Better is one of 44 Sustainability and Transformation Partnerships (STPs) in England, which brings together local NHS organisations, Stoke-on-Trent City Council, Staffordshire County Council, voluntary, and the two Healthwatch organisations. Our partners are committed to changing the way we provide health and care, so that it better meets the needs of our local people and improves everyone's lives. (Diagram 1)
- Our partner organisations work together across two local authorities and six clinical commissioning groups (CCGs) as part of Together We're Better.

Diagram 1: Partners

Who we are and who are our partners

- The two local authorities within the footprint are Staffordshire County Council and Stoke-on-Trent City Council, which are both upper tier local authorities.
- Staffordshire County Council is split into eight districts and boroughs: Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands, and Tamworth.
- The clinical commissioning groups are:
    - North Staffordshire CCG
    - Stoke-on-Trent CCG
    - Stafford and Surrounds CCG
    - East Staffordshire CCG
    - Cannock Chase CCG
    - South East Staffordshire and Seisdon Peninsula CCG
- As a partnership, we work with a range of other organisations across the area to deliver care, including:
    - Acute trusts including University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and The Royal Wolverhampton NHS Trust (RWT)
    - Mental health trusts including North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership NHS Foundation Trust (MPFT)
    - NHS community trusts, including University Hospitals of Derby and Burton NHS Foundation Trust and Midlands Partnership NHS Foundation Trust (MPFT)
    - 151 General Practices, Vocare (urgent care services) and West Midlands Ambulance Service
- The local health and social care service landscape is complex. In terms of NHS capacity, there are five other main acute hospitals on the borders of the STP footprint that deliver services to Staffordshire and Stoke-on-Trent population:
    - New Cross (The Royal Wolverhampton NHS Trust)
    - Good Hope (University Hospitals Birmingham NHS Foundation Trust)
    - Walsall Manor (Walsall Healthcare NHS Trust)
    - Royal Derby (University Hospitals of Derby and Burton NHS Foundation Trust)
    - Leighton (Mid Cheshire Hospitals NHS Foundation Trust)
- NHS elective services are also provided to the local population by the following non-NHS providers: Nuffield North Staffordshire, Nuffield Derby, Nuffield Wolverhampton, Rowley Hall, Malling, Ramsey, Spire Little Aston, and Spire Regency.
- The voluntary, community and social enterprise (VCSE) sector plays an important role in providing services in the community and we recognise their ability to access those who may be considered ‘seldom heard’ but may in fact be the daily contact for the sector.

Introduction

- NHS England published the NHS Long Term Plan (LTP) in January 2019 that sets out a phased programme of improvements that all systems are expected to deliver on over the next five years.
- The STP responded to the national priorities set out in the LTP with a Five-Year Delivery Plan (FYDP). The plan set out our priorities and commitments to the population of Staffordshire and Stoke-on-Trent.
- The majority of the objectives of the LTP and our FYDP remain as valid now as when first written, but Covid-19 has highlighted the urgency with which we should take action, and the need to focus on working as a system to make rapid change to improve services.
- The impact of Covid-19 has meant that all our plans and ways of working have needed to be reviewed and updated to ensure they remain relevant and appropriate for the challenges that we face.
- The response to the Covid-19 pandemic demonstrated our personal and collective commitment, as a system, to work together in the interests of our workforce and population: we provided (and relied upon) mutual aid, we coordinated PPE, we enabled flexible staffing, increased frequency of communication messages and ensured we shared vital clinical and operational intelligence.
- Our Phase 3 submission set out how we would look to tackle some of the resulting issues from the initial Covid-19 response and restore services to meet the needs of the population that we serve. This submission helps to ensure a line of sight through from the LTP to the systems FYDP submission and through into the ICS designation process
- Staffordshire and Stoke-on-Trent have a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation, as well significant health inequalities. In order to address these inequalities, a place-based system of care is crucial so that clinicians and professionals, from areas with very different healthcare needs, are empowered to deliver different models of care.
- We have an established Health & Care Senate (H&CS) which has had increased focused in response to Covid 19; demonstrating the strength in working together across Staffordshire & Stoke on Trent as health, care and clinical leaders.
- This document sets out our development plan around how the system will continue to collaborate and deepen its approach to partnership working to tackle the challenges set out in the FYDP, whilst continuing to respond to the Covid-19 pandemic.
- It is essential that this development plan be read in conjunction with the system wide Five-Year Delivery Plan and the Phase 3 Recovery Plan. Each of these documents sets out some of the population and health inequality challenges. Read together they provide a compelling evidence base to support the need for integration of services that are focussed on the resident being at the heart of everything that we do.
- For residents, greater integration would allow people to tell their story once, navigate confidently between organisations and experience greater continuity of care. By working together as organisations we can take big decisions around how and where care is delivered to make the most impact. This could include reorganisation of care to deliver support closer to home and helping people to live independently in their own home for as long as possible.
- Staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in current organisational structures. We want to remove more barriers to let people work in the way that they already know makes the most sense for local people. It is important to us that staff feel valued and are able to work in the way that enables them to provide high quality, compassionate and safe care.

Our Vision and Aims – Long Term Plan submission

Diagram 2

Our vision is to ***make Staffordshire and Stoke-on-Trent the healthiest places to live and work.***

This means:

1. Helping our population live well, for longer, and supporting you to be as independent as possible so we can be there when you need us.

2. Delivering care as close to home as possible, ensuring that experience of health and care is the best it can be.

3. Treating people rather than conditions and giving mental health equal priority to physical health.

Our aims are to:

1. Promote prevention strategies and empower people for self-care and shared decision making.

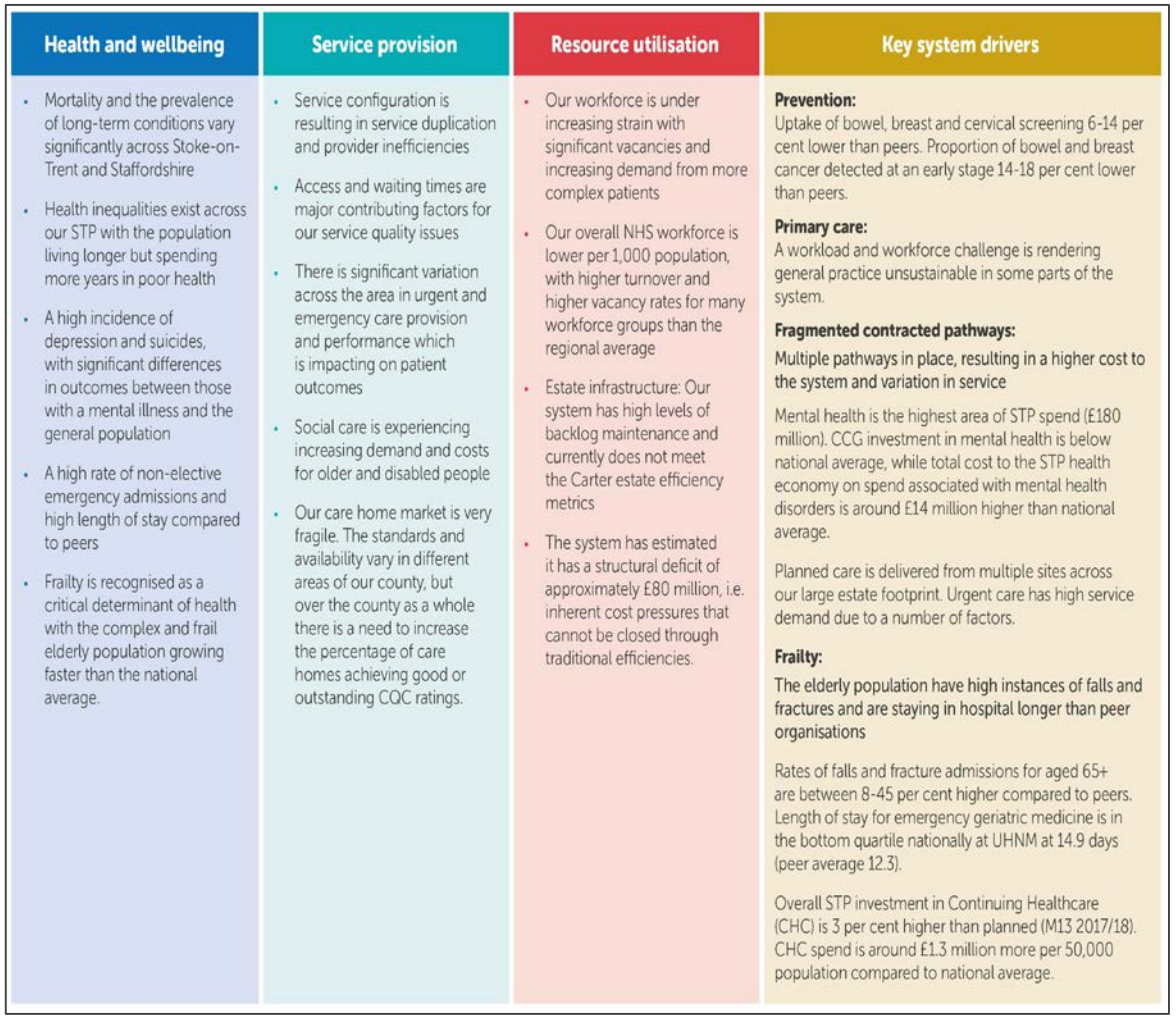
2. Co-ordinate and integrate care, with early intervention and step-down possible where appropriate and greater use of digital technologies.

3. Reduce unwarranted clinical variation, through providing evidence-based, effective care and using our workforce in the best way.

System Challenges and Opportunities

- We have been fortunate to be supported by regulators in the development of a range of strategic system diagnostics and thematic reviews. There are a range of population health and wellbeing drivers along with some key system drivers that were identified as part of the system diagnostic work.
- The drivers and issues identified are outlined in diagram 3 and have been tested and validated with partners. These areas will continue to inform our decision-making and focus our transformation agenda.
- A fundamental aspect of the system wide ICS Development Plan is how we use and evolve the initial work (that delivered an agreed and ambitious system FYDP) in order for us to meet the challenges of Restoration and Recovery from Covid-19.
- There is significant learning from the Covid-19 response that will support the ICS delivery programme and we will ensure that these do not sit in isolation of each other.
- Partners from across the system are aware that the frameworks developed to support delivery of the FYDP will need to be reviewed and updated to ensure that they remain fit for purpose given the impact of Covid-19.
- The frameworks that exist, such as the anchor institution approach, should enable the NHS to use its scale and size to develop better opportunities for local people. We need to maximise on these frameworks and approaches in manner that supports the development of our future workforce but also creates local momentum to improve the ambitions of local people.

Diagram 3: Drivers and Issues



Health and wellbeing	Service provision	Resource utilisation	Key system drivers
• Mortality and the prevalence of long-term conditions vary significantly across Stoke-on-Trent and Staffordshire • Health inequalities exist across our STP with the population living longer but spending more years in poor health • A high incidence of depression and suicides, with significant differences in outcomes between those with a mental illness and the general population • A high rate of non-elective emergency admissions and high length of stay compared to peers • Frailty is recognised as a critical determinant of health with the complex and frail elderly population growing faster than the national average.	• Service configuration is resulting in service duplication and provider inefficiencies • Access and waiting times are major contributing factors for our service quality issues • There is significant variation across the area in urgent and emergency care provision and performance which is impacting on patient outcomes • Social care is experiencing increasing demand and costs for older and disabled people • Our care home market is very fragile. The standards and availability vary in different areas of our county, but over the county as a whole there is a need to increase the percentage of care homes achieving good or outstanding CQC ratings.	• Our workforce is under increasing strain with significant vacancies and increasing demand from more complex patients • Our overall NHS workforce is lower per 1,000 population, with higher turnover and higher vacancy rates for many workforce groups than the regional average • Estate infrastructure: Our system has high levels of backlog maintenance and currently does not meet the Carter estate efficiency metrics • The system has estimated it has a structural deficit of approximately £80 million, i.e. inherent cost pressures that cannot be closed through traditional efficiencies.	**Prevention:** Uptake of bowel, breast and cervical screening 6-14 per cent lower than peers. Proportion of bowel and breast cancer detected at an early stage 14-18 per cent lower than peers. **Primary care:** A workload and workforce challenge is rendering general practice unsustainable in some parts of the system. **Fragmented contracted pathways:** Multiple pathways in place, resulting in a higher cost to the system and variation in service Mental health is the highest area of STP spend (£180 million). CCG investment in mental health is below national average, while total cost to the STP health economy on spend associated with mental health disorders is around £14 million higher than national average. Planned care is delivered from multiple sites across our large estate footprint. Urgent care has high service demand due to a number of factors. **Frailty:** The elderly population have high instances of falls and fractures and are staying in hospital longer than peer organisations Rates of falls and fracture admissions for aged 65+ are between 8-45 per cent higher compared to peers. Length of stay for emergency geriatric medicine is in the bottom quartile nationally at UHNM at 14.9 days (peer average 12.3). Overall STP investment in Continuing Healthcare (CHC) is 3 per cent higher than planned (M13 2017/18). CHC spend is around £1.3 million more per 50,000 population compared to national average.

Strategic Framework

- In response to our challenges and to deliver the Long-Term Plan, we have developed a strategic framework (diagram 4) that captures our vision, aims, objectives, and delivery priorities in a way that is accessible to our staff and our partners.

- We have used a series of strategic tests to model our thinking and provide a framework as we develop our maturity into an integrated care system:

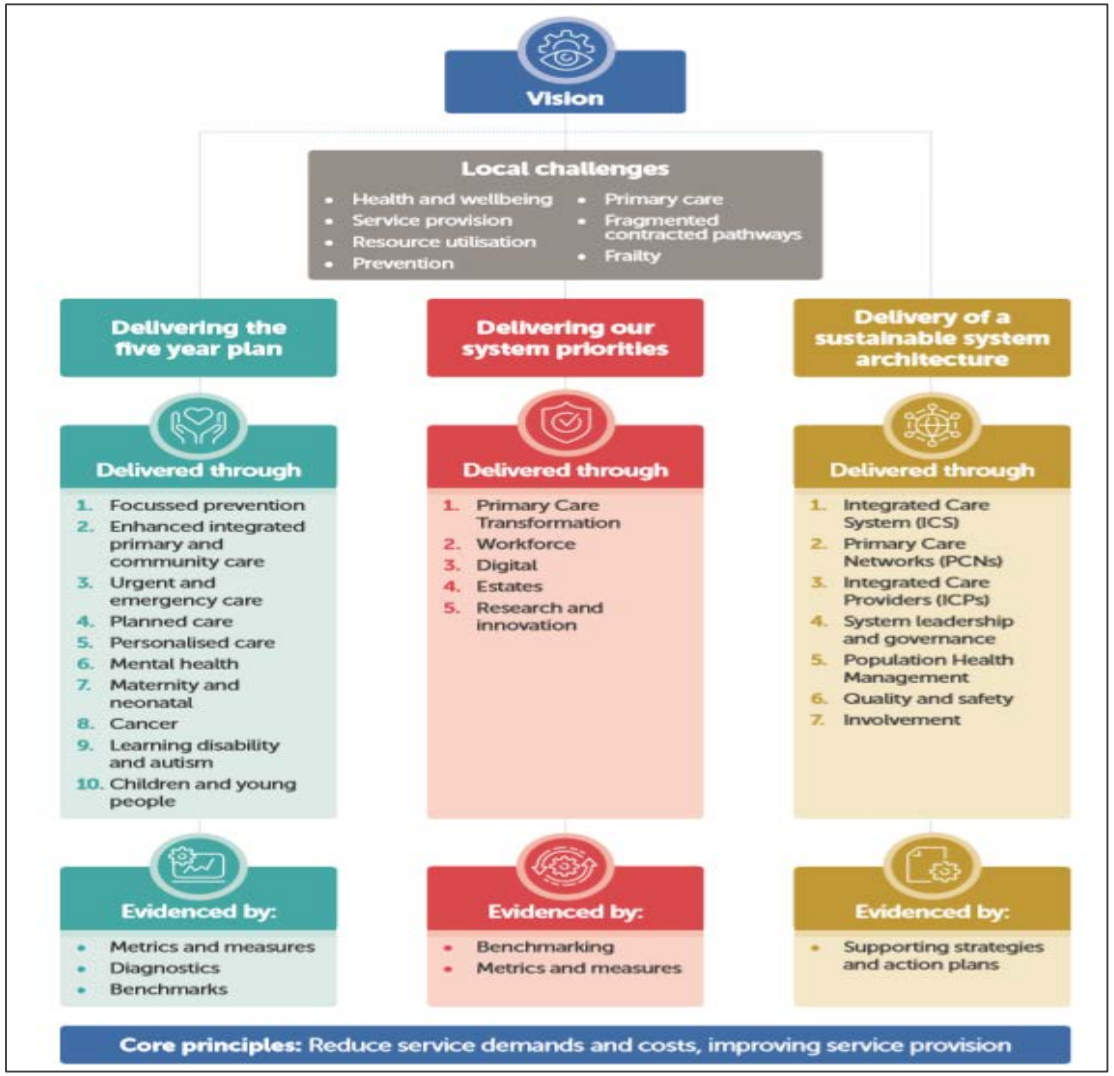
    - Do we have the right level of care for our population?
    - Are we doing this at / in the right place and at the right time?
    - Are we as efficient as we should / could be?
    - Do we have the right outcomes for people, communities and our population?

- We will use this framework to inform and align our organisational operational plans and as the baseline against which we will agree projects and schemes to deliver improvements.

- We recognise that this will need to be refreshed and revisited as the system continues to develop. However, it is essential to recognise that we are not starting from a blank sheet of paper and that the local challenges are not new.

- Our approach to integration, based around the strategic framework, enables us to genuinely tackle these issues and develop solutions in the best interests of the population that we serve.

Diagram 4: Strategic Framework



Delivering the Five-Year Delivery Plan and Phase 3 Recovery Plan

The ICS Development Plan is aligned to our Five-Year Delivery Plan to ensure that we continue to pursue our ambition to make Staffordshire and Stoke-on-Trent the healthiest places to live and work by:

- Treating people rather than conditions and giving mental health equal priority to physical health
- Becoming an Integrated Care System by April 2021 that is clinically and professionally led and focussed on system-wide, sustainable improvement
- Working in partnership to streamline the commissioning approach and to develop a system-wide strategic commissioner across health and care, which will align, and, for some services, be integrated with social care commissioners
- Providers and commissioners working collaboratively across primary, community and mental health services, including health and care professionals and the voluntary and independent sector to promote behavioural change and deliver service transformation – co-ordinated by Integrated Care Partnerships
- Strengthening primary and community services through developing sustainable primary care networks and the implementation of integrated care teams to cover the entirety of the population – adopting a population health management approach and driving the local place-based integration agenda
- Setting clear aims and outcomes for our clinical models of care, aligning with a strength-based social care model, which will continue to evolve as we listen to our public
- Transform our urgent and emergency care offer that reduces fragmentation and is focussed on meeting the needs of those in urgent need of health and care services
- Delivering effective elective services that are pathway-based and ensure activity is evidence-based and improves outcomes
- Tackling the prevention agenda at every level for our main long-term conditions of CVD, respiratory and diabetes
- Delivering increased value in everything that we do with a focus on the sustainability of our health and care system

Our aspirations for the success of this journey will result in the delivery of our key objectives as determined within the FYDP, deliver the local priorities that are unique to Staffordshire and Stoke-on-Trent, and create a sustainable and integrated system for health and care.

Learning from Covid-19 and Impact of National Legislative Proposals

Learning from Covid-19

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

As part of the regional work undertaken on learning from Covid-19 we have looked to focus our efforts on a number of main themes:

- The clear and common purpose which was understood by all health and care partners and their workforce was hugely empowering. This was supported by a strong sense of freedom to act.
- The robust governance arrangements that were implemented were felt to be supportive, enabling rapid decision making and implementation.
- The removal of the existing financial arrangements facilitated cross organisational working. Investment decisions were fast tracked, often in care delivery models which crossed organisational boundaries.
- Consistent and prolonged high levels of energy from staff with the emergence of new leaders from a range of organisations and professions, many with clinical backgrounds. This assisted the adoption and spread of new approaches.
- A reflection on our focus on place. This was where services and multi-organisational responses came together and there is an even stronger desire to really now strengthen and support local people in their own communities. We will make this a central feature of our continued transformation and improvement plans.
- The availability of co-ordinated data around population health and health inequalities has been shown even more starkly. We have to prioritise this over the coming months and use intelligence to direct our efforts

Legislative Proposals

The publication of 'Integrating care: Next steps to building strong and effective integrated care systems across England' sets out a clear direction of travel regarding the future of integrated care for the NHS. We broadly welcome the proposals that are detailed in the paper. However, there is recognition that any proposed change such as this can be unsettling for staff that are directly affected by it. It is our collective responsibility to ensure that we work as a system to maximise on the skills and attributes that currently support our health and care system.

We have reviewed the proposals, the ICS consistent operating arrangements and maturity matrix to establish a select number of key priorities that will help us to make significant progress. These are as follows:

- building on the success and learning from Covid-19
  - embedding the shift to agile leadership and decision making,
  - refresh and strengthen the common purpose that sets us apart as a system,
  - digital and innovative approaches to delivering care
- stepping up efforts to build on place through our approach to clinical and professional leadership and provider collaboratives;
- rapidly progressing transformation work – we are part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System work that is being led out by the region and we are keen to roll the approach t across a number of pathways;
- stepping up our efforts to work collaboratively to tackle the wider determinants of health and well-being,
  - focussing the NHS contribution towards social and economic development using frameworks for collective effort such as anchor institutions
  - building a different relationship with our voluntary and community sector partners that links us into communities and closer to the challenges
  - fully supporting the children and young people agenda across health and local government to give local children the very best start in life
- developing as a learning system, further OD/system effectiveness work such as PCN development and board effectiveness;
- an immediate demonstration of openness and transparency - board meetings in public (alternate months from February 2021) with papers published and in the public domain.

Strategic Risks

Risk	Mitigations
Insufficient system resource and capacity identified to assure and deliver the ICS Development plan.	• A transparent work programme that constituent organisations lead. • ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements. • Agree 2021/22 budget with system partners based on review of functions required. • Agree budget hosting arrangements until primary legislation in place. • Review of core team resource required as part of the functional review and agree any new posts required to support transition to ICS.

Impact of a 'negative' vote from the CCG membership, to forming a single strategic commissioning organisation (SCO).	• Campaign Steering Group (CSG) discussions and process; supported by
	  • NHSE approved Communications & Engagement Plan for Merger;
	  • Additional CCG Clinical Chair and Executive discussions with key opinion formers / clinical leaders - e.g. Local Medical Committees, Primary Care Network Clinical Directors and GP Federations
	  • Member-facing narratives developed for financial strategy and devolved functions / staff / budgets to support ICP development during transition;
	• "Protected Primary Care" pledges included.
	• STP/ICS Chair and Executive Lead working collaboratively with the CCG Accountable Officer and CCG Clinical Chairs to promote the merger as part of the direction of travel to becoming an ICS.

Retention of valued workforce due to the national ICS proposals and an anticipated further period of organisational change.	• A detailed plan to support delivery of the Strategic Commissioner Development with an Executive Lead. • A communications plan and HR plan to support the workforce regarding alignment of posts to Strategic Commissioning or ICP based upon the functions.
PCN and place based engagement with delivery of Population Health Management (PHM) during Covid-19, acknowledging clinical time now until February is at a premium	• Progress is being made with the PHM Strategy readiness phase and foundations of PHM are in place. • PHM approach agreed and signed off through the Health and Care Senate.
Integration of Health and Social Care due to the spend assessments Local Authorities are currently subject to.	• Joint working on key service changes impacting health and social care looking at pathways in their entirety within existing budgets and identifying joint efficiencies. • Identification of lead commissioner arrangements and pooled budgets. • Moving towards joint posts working across health and social care.

Summary of Alignment of Development Plan Actions and Delivery Priorities

ICS Establishment Priorities	ICS Delivery Priorities	Development Plan Alignment (minimum operating requirements)	Impact
Development and implementation of our future model of care Underpinned by: 1. strong place based approach to care through our ICPs; 2. strategic commissioning arrangements that support a focus on outcomes and are underpinned through population health management; 3. simplified and understood governance; 4. integrated reporting that adds value and enables partners to focus their collective efforts in the right areas; 5. Clinical and professional leadership that is core to everything that we do and supports decision making as close to the resident as possible.	**Integrated delivery of UEC priorities to enable safe navigation of winter and future Covid-19 waves** • Digital first approach where this adds value and improves outcomes. • Agreed priority projects refreshed. **Restoring Elective and diagnostic capacity** • Clinical prioritisation of waiting lists. • Improve and maintain cancer pathways and support diagnostic developments. **Integration of Primary Care and Community Services** • Support development of Primary Care Networks (PCN) • Alignment of community physical and mental health services around a PCN to meet population needs. • Increased collaboration with local authority (LA) and Voluntary Community and Social Enterprise (VCSE) partners. **Health Inequalities** • Detailed review and refresh of current approach. **Children and Young People** • Alignment to refreshed LA strategies and targeted approach to joint commissioning. **Mental Health** • Strong crisis response integrated into community based offer. • Community transformation programme with all partners.	**System Planning/System Functions** • Develop and embed System Outcomes Framework. • Maximise system learning from Covid-19. • Develop our approach and implement population health management (PHM). • Finalise and embed system-wide approach to managing Finance, Quality and Performance. • Update Five-Year Delivery plan through reprioritisation exercise for 2020/21. • Finalise Operating Model confirming work at System, Place and Neighbourhood levels. • Estates Programme to oversee system-wide programme, future prioritisation and capital funding bids. • A system capital prioritisation and risk criteria developed. • Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery. • Take a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.	• Undertaking the development Plan actions will put in place the key enablers to drive the development of integrated models of care in areas detailed in our delivery priorities. • Build on the approach of the Intelligent Fixed Payment (IFP) model to further strengthen the collaborative approach to developing solutions and reducing avoidable transactional costs. • Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure. • Set clear outcome improvement targets at both system and place level to enable demonstration of delivery. • Use PHM to prioritise effort and to show outcomes in tackling the health inequality challenges. • Enable us to use our collective workforce resources more wisely, and support our staff to work in different ways with a “system” ethos.

Summary of Alignment of Development Plan Actions and Delivery Priorities

ICS Establishment Priorities	ICS Delivery Priorities	Development Plan Alignment (minimum operating requirements)	Impact
Transition of STP Governance to ICS Governance refreshed for system decision making and accountability for system strategy, performance and planning.	• Put our residents first, delivering person-centred care, close to home, and give them confidence that the changes we are making work well for them. • Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area. • Integrated reporting underpinned by the principle of subsidiarity. • Alignment of priorities with the two Health and Well Being Boards and use necessary governance to support improved outcomes – challenge duplication and bureaucracy.	**System Leadership and Governance** • Appointment of ICS Lead Director. • Potential further additions to ICS Core Team as per the nationally indicated direction of travel with NHSE/I Board paper on options for primary legislation. • ICS Board to meet in public and for papers to be available to the public. • Focussed organisational development approach to support ICS Board membership development – support to have challenging conversations and build on previous OD work. • Distributive leadership approach.	• Clear and owned transition to ICS status with clarity on partners roles and responsibilities. • Governance approach that is light touch and proportionate to support agile decision making. • Clinical and professional leadership empowered to make decisions and then supported to implement at pace.
Developing and ensuring system accountability within, Safety, Quality, Performance and Finance.	• Delivery of Phase 3 submission with refreshed trajectories. • Integrated approach to reporting that reduces burden on individual organisations but improves timeliness of decision making.	**System Leadership and Governance** • Refresh of STP / ICS governance. • ICS / STP budget and resource to be reviewed and agreed in line with the delivery of the consistent operating requirements. • Strengthening of core STP team to support transition to ICS. • Refresh and update of current programme boards and transformation plans to ensure that there is clarity and alignment with system wide priorities. • Dedicated development time for committees and executive.	• Established ICS that meets the core operating requirements.

Executive Summary: Progress Against Consistent Operating Requirements

	Theme	Strengths	Development plan
System Functions	System Capabilities	• An established System Strategy, Finance and Performance (SFP) Committee • A System Performance and Assurance Working Group (SPAWG) • Confirmation of successful Wave 3 PHM Development Programme application • An established Health and Care Senate (H&CS) at ICS level with health inequalities as a priority • Investment in a central communications and engagement resource • System workforce planning has taken an 'open book approach' • Providers, Local Authorities, WMAS and GP practices are partners in the Integrated Care Record (ICR) • Commissioned the National Development Team for Inclusion (NDTI) to support in the development and delivery of a Community Led Support (CLS) programme.	• Finalise and embed system-wide approach to managing Finance, Quality and Performance • Agreed way of working to deliver PHM at scale to inform service and system change and integration • Communications and engagement team supporting the health inequalities programme, with a focus on reaching seldom heard groups • Consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce • Continued development of the ICR
	Streamlined Commissioning	• A confirmed and finalised CCG merger timeline and roadmap • A detailed plan to support delivery of the Strategic Commissioner Development • A shared care record • During Covid-19 worked increasingly more as partners rather than commissioners and providers	• Achieve single CCG covering the STP footprint by April 2022 • Implement the plan to deliver a Strategic Commissioner function • Deployment of personal health records application • Develop work to plan and deliver specialised services as locally as possible
System Planning	System Plans	• System approach to developing Phase 3 recovery plans • An agreed Five-Year Delivery plan (FYDP) in response to the long term plan • Submission of a system Phase 3 Recovery plan agreed by relevant organisational boards • ICP plans outlining priorities identified in the summer of 2020 • A system ICS development plan • Part of the first 6 systems in the Midlands to work on the GIRFT/ Model Health System	• Stocktake of system plans to be completed • UEC plan and priority areas to be reviewed and refreshed • Covid-19 lessons learnt review to be progressed • Develop the system level strategic framework and system operating plan • Development of Digital Financial planning
	Capital and Estates Plans	• A system estates plan and strategy, rated "Good" • A System Capital Prioritisation Group to support a system by default approach. • System Local Estates Forum	• A system capital prioritisation and risk criteria • A system Estates Strategy (covering capital and estates), to include disposals • An agreed broader system section 106 policy
System Leadership and Governance	Leadership Model	• ICS Independent Chair appointed and in place • Clinical and professional input provided by the H&CS • A health inequality executive at board level within each organisation and a system inequalities lead • ICPs have been developed with PCNs at their heart • Provider collaboration across a number of levels	• Appoint to ICS Lead Director • Ongoing leadership development of health and care professionals • Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning • Development of provider collaboration – vertical and across neighbouring STPs where this makes sense and is in the best interest of our residents
	System-Wide Governance	• Agreed terms of reference and membership of the ICS Partnership Board (ICS PB) • System Strategy Finance and Performance Committee • Good relationships with the Overview and Scrutiny Committees • H&CS, Healthwatch and voluntary sector partners on the ICSPB • Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level. • A culture of transparency, openness and collective ownership in relation to finance	• Progress the ICS PB to meet in public and to publish its papers • Integrated quality, finance and performance dashboard reported into the ICSPB • Delegation of financial responsibility to ICPs • A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets

Self-assessment and areas of development:
Consistent operating requirements

Self Assessment: System Capabilities

Theme	Strengths	Development Plan
System capabilities in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21. Confidence in the system leadership to resolve current performance challenges	*Co-ordination of Transformation - System, Place and neighbourhood* • Agreed terms of reference and membership of the ICS Partnership Board (ICS PB) • An agreed FYDP. • An ICP Programme Board to coordinate ICP development activity. • A detailed ICP plan developed to support achievement of the critical path of ICP development. • Each ICP has aligned Director of Strategy capacity to provide the connection back to individual organisation and system wide transformation activity. • We have adopted an 'asset based' approach which means each ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups. • We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme. *Collective Management of System Performance* • An established System Strategy, Finance and Performance (SFP) Committee. • A System Performance and Assurance Working Group (SPAWG). • Strong system delivery of mental health standards. • Recognition of areas e.g. urgent care where we have struggled to meet emergency care standards. • Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited. *Resolving performance challenges* • Consistent approach to performance reporting and agreed data sets • Honesty of challenge and debate with agreed actions set out • Collaborative approach to problem solving • Build on system response to Covid-19 and UEC pressures *Population Health Management (PHM)* • An Executive Director providing senior leadership and expertise, acting as SRO for this programme of work. • A CCG Public Health Consultant in post leading delivery of PHM. • Active involvement with the NHSE PHM programme, and use of external experts Milliman, which supports the development of PHM capacity and capability across the system. • Confirmation of successful Wave 3 PHM Development Programme application with funding of £50k. • An established Health and Care Senate (H&CS) which has health inequalities as one of it's core priorities ensuring that inequalities are a key issue for wider clinical and professional leadership groups. • An inequalities strategic oversight group involving clinical and public health expertise to bring together the inequalities and prevention work streams.	*Co-ordination of Transformation - System, Place and neighbourhood* • Identify key transformation / change programmes that are likely to be locally and system driven. • OD plan to support system and place clinical leadership. • Identification and development of ICP leadership *Collective Management of System Performance* • Finalise and embed system-wide approach to managing Finance, Quality and Performance. • Continue to develop our performance reports to become an Integrated quality, finance and performance dashboard which provides appropriate and accurate information that is effectively processed, challenged and acted upon. • Clear and effective processes for managing risks, issues and performance. • Develop a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues. *Resolving Performance Challenges* • Ensure that the system SFP has the correct membership and intelligence to support decision making and challenge • Clear route of escalation through to the CEO forum • Agree priority areas of focus and simplify list to an agreed and appropriate level *Population Health Management (PHM)* • Agreed way of working to deliver PHM at scale to inform service and system change and integration. • Continue to develop data sharing particularly in primary care. • An OD programme for the H&CS including PHM and inequalities. • Co-production of outcome measures, both qualitative and quantitative, with ICS and ICP representation. • Refreshed approach to PHM and full engagement with the PHM national programme. • PHM approach to be widened from public health colleagues and repurposed to support ICP development. • Approach to be set out for the January ICS Board and workplan to be agreed with confirmed timelines. • PHM priorities to be agreed by the January meeting of the ICS Board. • Clarity on resource available and LA partner engagement to be part of that key discussion.

Self Assessment: System Capabilities

Theme	Strengths	Development Plan
System capabilities in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21.	*Communications, Involvement and Engagement* • Investment in communications and engagement (C&E) resource providing focused support across key development areas. • Integrated approach to C&E with a shared Director of Communications across the CCGs and ICS footprint, with a seat at the ICSPB. • Strong partnership working across C&E recognised regionally. *Workforce* • System expertise in place around workforce planning and workforce information/data. • Long-term workforce planning at system level as taken an 'open book approach', with all providers engaged in the process and sharing their workforce projections across the system. • A strong ICS workforce team in place to improve workforce supply and solutions are created in partnership as "System by Default." • Our system wide leadership programmes all have equality, health/wellbeing, fairness and reduction of bullying/harassment and violence at work as a golden thread running through them. *Digitisation* • A well established Digital Board comprising senior Digital, Clinical and Service leaders from all of main partners within the ICS footprint, chaired by a current CCG Clinical Chair. • A digital strategy that focuses around six strategic goals which collectively describes how digital technology will help transform health and care for citizens, health and care professionals and the wider system. • A Digital Clinical Advisory Group and Digital Design Authority. • Technology enabled care implemented prior to Covid-19 and rapidly expanded during the Covid-19 pandemic. *Resourcing* • Current resource supporting STP identified and based on partner contributions (NHS) • Small core team at present and reliant upon resource in kind from system partners • Core finance and workforce teams good examples of collaboration • Partner commitment to shared resource to support ICS Development • Integrated approach to communication and engagement with a shared Director of Communications across the CCGs and ICSPB footprints, with a seat at the ICSPB	*Communications, Involvement and Engagement* • Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21). • Supporting the equality programme, with a focus on reaching seldom heard groups. • System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23). *Workforce* • Further develop the People Hub locally to make it the route into health and care careers in Staffordshire and Stoke-on-Trent. • Consider and develop consistent system HR, OD and recruitment processes, policies and programmes to support a system workforce. • Focus on inclusivity and diversity in our workforce utilising targeted approaches. *Digitisation* • Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS. • Development of the Digital Financial planning (sub-group of the Digital Board) to agree financial planning and management activities and prioritise and manage capital investments. *Resourcing* • Review national direction of travel and agree core STP / ICS transition team • Agree 21/22 budget with system partners based on review of functions required • Confirm partner commitment to supporting the ICS core functions • Agree budget hosting arrangements until primary legislation in place • A clear funding model for the collective functions that sets out how core capabilities will be funded across the system and agreement that resources will be shared and flexible.

Self Assessment: Streamlined Commissioning

Theme	Strengths	Development Plan
Streamlined commissioning arrangements, including one CCG per system with clearly defined commissioning functions at system, place and neighbourhood.	• A confirmed and finalised CCG merger timeline and roadmap. • Strategic Commissioning identified as a priority programme by the CEO Forum and the ICSPB. • A detailed plan to support delivery of the Strategic Commissioner development . • The Strategic Commissioner blueprint has been reviewed and detail added behind the identified functions. • During our response to Covid-19 we have worked increasingly more as partners rather than commissioners and providers, instead operating as a single team with clear lines of accountability.	• Formal merger application to be submitted by July 2021 (at the latest). • Delivery of programme of work to deliver the strategic commissioning function. • Identify hand over points from strategic commissioning into ICPs for delivery at a place based level. • LA and CCG integrated commissioning development - to develop an approach towards integrated health and social care services that improves outcomes for service users and efficiencies within resource allocated at the most appropriate level. • Develop an approach for planning and delivery of specialised services as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.

Self Assessment: Implementing a full shared care record

Theme	Strengths	Development Plan
Plans for developing and implementing **a full shared care record,** allowing the safe flow of patient data between care settings, and the aggregation of data for population health.	• The system has a live Integrated Care Record Solution, which is already well populated with data from partner organisations and provides the foundation upon which to build integrated care tools and enhanced data to improve health and care for the local population. • Active members of the Local Health and Care Records (LHCR) Group across the West Midlands and accordingly are committed to sharing the data in the Integrated Care Record with partners across the region through the LHCR programme. • Close collaboration with Shropshire, Telford and Wrekin STP will see the Staffordshire and Stoke-on-Trent ICR shared to create a single integrated care record covering both regions, which will prove especially useful for MPFT who provide services in both areas.	• During 2021, continued development of the ICR through our Shared Care Record (One Health & Care) delivery plans. • Deployment of personal Health records app, by February 2021, to the local population to empower the self-management agenda. • Core reviews planned of foundation IT services and planned maturity assessments utilising the HIMMS continuity of care model. • Digital and PHM work streams to continue to collectively work on data sharing protocols.

2 Self Assessment: System Plans

Theme	Strengths	Development Plan
System plans that reflect the key local recovery, performance and delivery challenges and that incorporate a development plan for the system. This should explicitly reference delivery across the system architecture, i.e. place and provider collaborative(s). **Confidence in reprioritised LTP delivery and recovery plans**	• The system development plan is contained within this document and is based on a detailed review of the ICS must dos, consistent operating arrangements and the ICS maturity matrix. • An agreed FYDP that was determined ready to publish pre Covid-19. • For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan. • System partners developed a Phase 3 delivery plan which set out how the STP would recover health and care services, whilst managing the additional demand of winter pressures, and living alongside Covid-19. • Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level. • ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP. • A Transformation Delivery Unit in place that supports the transformation agenda with recognition that this will need to be refreshed in order to fulfil the system wide PMO function. • Strong engagement with PCN CD to ensure alignment with the place agenda.	• Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning by *March 2021.* • UEC plan and priority areas to be reviewed and refreshed. • Develop the system level strategic framework and system operating plan. • Focus on delivery on of the trajectories in the Phase 3 recovery plan. • Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards. • Directors of Strategy take the leadership on development of the system operating plan. • Delivery of the ICP priority areas with a refreshed focus on place • Confirmation of place leadership to help drive local delivery and implementation

2 Self Assessment: Capital and Estates Plans

Theme	Strengths	Development Plan
Capital and estates plans agreed at a system level, as the system becomes the main basis for capital planning, including technology.	• A system estates plan and strategy, rated “Good”. • A System Capital Prioritisation Group, to review and prioritise capital plans across the system. • A system approach to developing plans (Phase 3, FYDP, system savings plans etc.) that involve strategy, finance and operational directors.	• A system capital prioritisation and risk criteria. • A system Estates Strategy (covering capital and estates), to include disposals. • An agreed broader system section 106 policy.

3 Self Assessment: Leadership Model

Theme	Strengths	Development Plan
A leadership model for the system, that explicitly includes the following: **1. ICS core leadership** team including: a. an STP/ICS leader with sufficient capacity and a non-executive chair appointed in line with NHSEI guidance and with delegated authority from system partners to act on their behalf and for the good of the local population. b. Sufficient leadership and delivery capacity to carry out the functions above **2. Place leadership** arrangements for each place within the system, ensuring that primary care (as a provider) is reflected in these arrangements. **3. Provider collaborative**(s) lead arrangements for "hospital systems", ambulance services and "acute mental health systems"	*ICS Core Leadership* • The role of the ICS Independent Chair appointed to and in place. • Clinical and professional input provided by the Health and Care Senate (H&CS) and its associated sub-groups. The structures support clinical and professional input from the front line of care. This professional leadership is readily accessible to the ICS Board. • A health inequality executive at board level within each organisation and a system inequalities lead. *Place Leadership* • Each of our ICPs are developing arrangements that reflect their unique identities and partners in the local system. • There is an established commitment to the three ICPs, each with leadership and governance in place which has been and will continue to be developed on an inclusive basis, including key partners and stakeholders. • The H&CS is supported by Health and Care Assemblies. • ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS. *Provider Collaboratives* • Provider CEO's have taken lead roles on the 5 system workstreams. • Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS. • UHNM is part of the N8 pathology network. • MPFT and NSCHT are actively involved in the development of the Regional mental health provider collaborative. • NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN). • Long-term workforce planning across the system has taken an 'open book approach'. • Acute provider and Community Teams already work closely to ensure that for patients with Long Term conditions (LTCs) every opportunity is taken to ensure care can be provided close to home.	*ICS Core Leadership* • Our focus will now concentrate on the appointment of the ICS Leader. The Regional Director will be part of the final appointment panel and decision-making process in line with NHSE/I guidance. • Ongoing leadership development of health and care professionals. • Review of core team resource as part of the functional review and agree any new posts required to support transition to ICS *Place Leadership* • Develop shared and collectively agreed view of placed-based leadership. • Develop clear and shared vision for ICPs aligned to transition towards strategic commissioning. • Develop 'Values /Behaviour Charter' to support collaborative working approach via Accelerated Design Events. • OD support programme aligned to System-Wide OD Programme. • Agree joint OD programme to support transition to locality commissioning arrangements. • Confirm ICP leadership and ensure there is clear PCN visibility and involvement *Provider Collaboratives* • Review all current collaborations – internal and external. • Establish simplified review process to identify specific risk areas re provider collaboration. • Facilitate vertical provider collaborations to support the integration agenda into ICPs. • Develop diagnostic collaborative with UHNM and other acute partners from neighbouring STPs.

3 Self Assessment: System Wide Governance

Theme	Strengths	Development Plan
System-wide governance arrangements to set out clear roles of each organisation and enable a collective model of responsibility, and nimble decision-making between system partners. These arrangements will include a system partnership board that sits in public and should be complemented by a public engagement approach that ensures full transparency of decision-making. The system-wide governance arrangements should be underpinned by agreed decision-making arrangements across the system architecture (i.e. place and neighbourhoods/PCNs) and agreements with respect to financial transparency.	*System-wide governance* • An interim governance structure based on 'function' has been established. The sub committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work. • The Terms of Reference and Membership of the ICSPB have been agreed and has continued to evolve as the role and task of the system wide Board becomes clearer. • Membership of the ICSPB includes all Statutory Organisations (Chair and CEO), both Local Authorities (elected members and officers), HealthWatch, Voluntary Sector and representatives of the PCN Clinical Directors. • The ICS Shadow Board is chaired by the Independent Chair of the STP. *Decision making* • Covid-19 response has demonstrated that system partners can be agile in decision making and make rapid progress when unified around a single compelling objective • Care home support response with both LA's, MPFT and the CCGs • Workforce deployment cell to trigger mutual aid across partners through a single approach • Tackling MFFD through rapid deployment of joint teams across both NHS and LA partners to free up hospital beds and to get people home safely and quickly *Public Engagement* • Robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level. • Over 12 weeks during the summer of 2019, we worked with health and care professionals, partners and the public to understand their priorities for local health and care services. Their feedback helped inform our FYDP and priorities. • During summer/autumn 2020 we undertook further engagement with local community groups, to understand people's experiences during Covid-19, including future priorities. Working with our Healthwatch partners a wider public survey was carried out. This feedback will be considered by the restoration and recovery programmes and the ICSPB to inform future priorities and the approach to wave two. Financial Transparency (Place and neighbourhood) • A culture of transparency, openness and collective ownership and accountability in relation to finance.	*System-wide governance* • The governance structure will be reviewed as part of the ICS designation process and is part of our system development plan. • Progress the ICS Shadow Board to meet in public and to publish its papers by February 2021. • Develop the decision making arrangements. • An integrated quality, finance and performance dashboard reported into the ICSPB. Decision making • Review of current decision making forums and light touch governance review to enable clear base line to be set out • System wide review of lessons learnt report and gap analysis presented back to the ICS Board *Public Engagement During 2020/21* • Delivery of the Winter C&E plan and response to Covid-19 *(2020-21).* • Primary care, partner and public engagement on the development of the Strategic Commissioner function *(2020-21).* • System wide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care *(2021-23).* • Significant mental health transformation programme over three years *(2020-23)* • Supporting the equality programme, with a focus on reaching seldom heard groups *(2020-21).* Financial Transparency (Place and neighbourhood) • A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets. • Delegation of financial responsibility to ICPs. • Refinement of the IFP approach to make sure that delegation of budgets is meaningful and supports integration • System approach to capital prioritisation that is built on place based priority areas

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Information Governance/ PHM	Maximisation of the use of data to improve health and care for the local population. by establishing clear data sharing models.	• Data sharing agreements in place across the system. • Population health management tools that can be used at system and place level. • A defined and agreed IG structure across the system.	• National directive for data sharing resolved. • Population health management support re 'best in class' tools and shared learning
Performance	A system based approach for collectively managing performance across Staffordshire and Stoke-on-Trent. Delivering assurance that is based on partnerships for improvement.	• System Strategy, Finance and Performance Committee. • A system-wide outcomes framework across health and care. • Integrated quality, finance and performance dashboard reported into the partnership board. • Single point of contact agreed for any system performance queries.	• NHSE/I are fully integrated into our Partnership Board as a key partner to support a fully integrated model of assurance, commissioning and delivery. • Agreed alignment of resource and staff into the ICS to support the continued devolution of specialised commissioning and independent contractor commissioning
Quality	A system-wide approach to quality and safety to achieve the best health outcomes for our population. Our shared vision and underpinning framework will not only focus on quality assurance but also quality improvement.	• A shared QI approach and methodology to support system wide change projects in line with system priorities. • A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement. • A system wide Quality Impact Assessment process. • A system wide approach to harm and mortality reviews	• Support for understanding how regulatory frameworks will apply to a system by default model and delivery of the frameworks.
Workforce	Delivery of the Staffordshire and Stoke-on-Trent People Plan which sets outs our plans for leadership & culture, education, CPD, new roles and recruitment in order to create a sustainable model of care for our population and its projected future needs.	• An STP/ICS People, Culture and Inclusion Board with agreed governance model for decision making, prioritisation and ensuring delivery and accountability. • A System Workforce Group with an STP/ICS Workforce lead and team to deliver our Local People Plan. • A Staffordshire People Hub which will hold system wide contingent workforce to support the recruitment, retention and deployment of workforce both in line with urgent pressures (but also as a career development mechanism in the medium term. • Leadership development programmes: High Potential Scheme pilot, Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes, Winter Inclusion school, Cultural Racial Inclusion development programmes. • An STP Black, Asian and Minority Ethnic (BAME) network, networking with individual organisation BAME networks. • A System Health and Wellbeing Group developing the collective Health and Wellbeing offer. • Sharing practice (as regional leads) on People Hub, BBS and Reservists with other STPs.	• Clarity on the expected functionality of the ICS People function and devolved funding to resource this. • Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce. • Clarity of funding allocations for learning/development and leadership between HEE/NHSI/E and transparency of destination for these. • Ongoing support from regional HEE and NHSEI leads. • Clarity on the governance of the Primary Care Training Hub within the ICS and funding commitment confirmed for 3 years minimum rather than annually.

System by Default

Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Digital Transformation	A digitally enabled health and care system underpinned by a strategy that focuses around six strategic goals which collectively describe how digital technology will help transform health and care for citizens, health and care professionals and the wider system.	• A Digital Board with a single governance model for overseeing decision making, assurance and accountability. • A Digital Clinical Advisory Group and Digital Design Authority before being turned into defined work packages for delivery. • Quality assurance approach for signing off new digital systems and process. • Use of pioneer new technologies where appropriate and acting as a fast follower in others, learning from and sharing our learning and best practice with other systems. • Digital technology and processes wrapped around the needs of our citizens rather than directed by organisational boundaries. • Use of system wide digital maturity models to establish a common baseline and drive for common standards. • A commitment to the use of common tools, technologies and services within the ICS where applicable to simplify access for staff, achieve common data and information standards, deliver a seamless patient experience and gain best value for money.	• Strong engagement with our system to shape national digital policy and strategy and make the most exploit national opportunities and available funds. • Devolved allocation of Staffordshire and Stoke-on-Trent transformation funding will be used against our digital strategy priorities. • Fast follower funding where applicable. • Support to develop IT resources to improve the functionality of the people hub and the database of contingent workforce.
Clinical priorities for our ICS model	An agreed approach by the Health and Care Senate (H&CS) to identify system clinical priorities against which we will test our ICS model of care against in terms of both devolved commissioning and provision of care.	• Clinical and professional input provided by the H&CS, its associated sub-groups & the Health and Care Assemblies. • An established H&CS which has health inequalities as one of it's core priorities. • ICP place based priorities aligned to the FYDP and Phase 3 Recovery Plan.	• OD plan to support system and place clinical leadership.
STP Boundaries	Partners recognise the importance of coterminous boundaries and being able to be clear in regards to a defined population. Recognition that the system has flows across boundaries and into other areas.	• Three ICPs established with defined geographical footprints and formal place leadership confirmed. • Agreement to work with neighbouring STPs on boundary flows. • Work with Staffordshire County Council and Stoke-on-Trent City Council to ensure full engagement and added value for the work of the ICS. • Defining place in a way that works for residents and takes care as close to their normal place of residence as possible.	• National clarity / guidance on the role of the Health and Well Being Board in any future legislative change.

System by Default

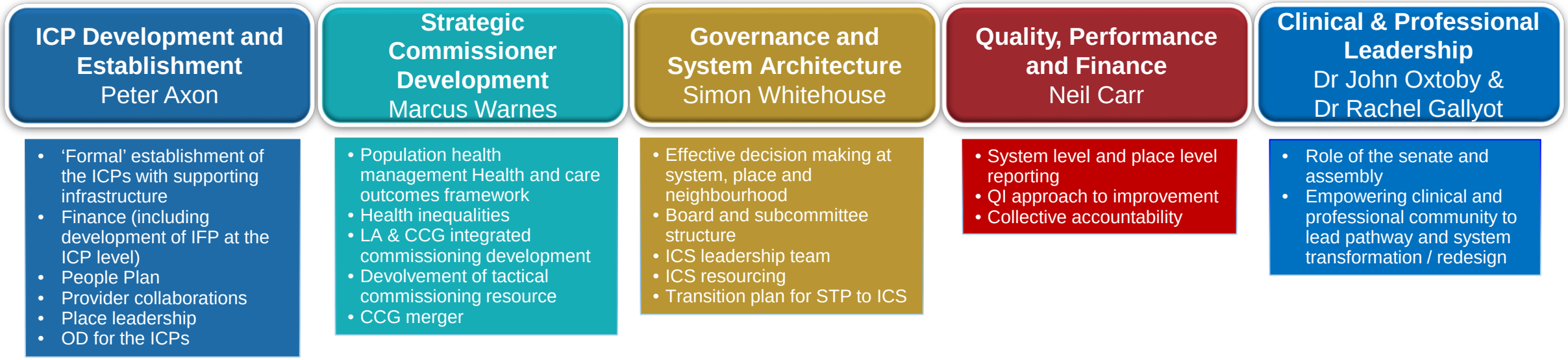
Priority area	What are we trying to achieve?	What will this look like in practice?	What potential support will we need from NHSE/I?
Finance	Allocation of resources to incentivise the best outcomes for our population. There will be a focus on collaboration and on system resources, rather than organisational, with an “open book” approach.	• A System Strategy, Finance and Performance Committee, supported by a System Finance Sub-Committee. • An agreed system financial strategy that articulates how the system and the organisations within it will work together to deliver its financial objectives & targets, and the roles and responsibilities of ICPs within this. • System allocation and agreement on distribution of resources, including a financial framework for ICPs. • Evolution of the current “Intelligent Fixed Payment” arrangements in place locally, including risk sharing arrangements. • Agreed system financial reporting and modelling, at system and place based level. • A culture of transparency, openness and collective ownership and accountability. • An agreed funding model for collective functions, recognising the required core capabilities.	• Clarity on broader longer term financial framework and expectations, coupled with the local flexibility around implementation models. • Confirmation of multi-year settlements, including capital, will support the development of a system by default arrangement to finance. • Clarity and transparency of specialised commissioning budgets, pressures, risks, and opportunities to help the system consider phasing of any future devolved direct commissioning as our system financial framework evolves.
Estates	An STP estates strategy to maximise the value from our public estate, outside of NHS boundaries and to embrace integrated service opportunities more widely with other partners beyond health and social care.	• An agreed system estates strategy and plan including estates pipeline and disposal plans; alignment to overarching capital planning. • A combined STP/OPE Estates Programme Board with a single governance model for overseeing decision making, assurance and accountability. • An agreed broader system section 106 policy across all planning authorities, with broader consideration of health infrastructure needs and increased engagement with health. • A System Capital Prioritisation Group, with multi functional representation to review and prioritise capital plans across the system.	• Ongoing access to capital funding to deliver our overarching strategy e.g. community hospitals. • Sharing of best practice around development of funding models.

Development Plan

Introduction

- The following sections describes the 5 system priorities agreed by the CEO Forum and the ICSPB, as key areas for development.
- These areas form the foundation of the ICS development plan, each with an identified Executive lead, as outlined in diagram 5 below.

Diagram 5: Agreed System Development Priorities



High Level Timeline

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Overarching Timeline	Develop plan post September submission	Draft ICS submission to Regional Team	· Present readiness assessment to QSRM · Final submission of system application for Feb review point	· Formal regional decision point · Documentation is submitted to national team for review.	RD presents submission to national team for discussion & ratification	Transition to ICS									
ICP Development and Establishment	Establish ICP Programme Board	· Develop place leadership, shared vision & values charter	Agree shadow governance arrangements and links to statutory organisational and system governance	· Shared view of ICP population health · Health outcome monitoring and reporting system · Planning for Change and Signs for Change workshops		· Co-design of financial framework · Strengthened involvement of patient and voluntary groups.	Co-design of future contracting models		· Embed a process to develop joint priority setting at place-based level						
Strategic Commissioner Development	Establish programme structure	· Set out output of functions mapping work	· Agree IG structure · Identify clinical leadership · Develop vision · Develop outcome frameworks linked to the Phase 3 recovery plans and FYDP (PHM)	Present PHM work plan to the ICSPB setting out the approach	Agreed way of working to deliver PHM at scale	· Co-production of inequalities outcome measures · Implement OD framework supporting new ways of working · IFR and the Covid-19 funding arrangements utilised to reconsider the future role of commissioning.	Identify hand over points from Strategic Commissioning into ICPs for delivery at a place based level		· Embed a process to develop joint priority setting · Membership Vote	· Formal Merger Application	· LA & CCG integrated commissioning development				
Governance and System Architecture	System Partners reviewed ICS development plan and signed off interim governance structure	Appoint ICS independent Chair		Engagement with major out of area acute providers and neighbouring STPs to ensure inclusion in system and ICP development work	· ICS Board Public Meeting · Establishment of ICP	· Appointment of ICS Director (TBC) · Covid Wave 1 lessons learned, FYDP and phase 3 stock take to inform ICS planning	· ICS Board Membership reviewed · Light touch review of ToR & supporting committee membership	Self-assessment against the ICS maturity matrix	Quarterly review of board acheivements	Transition to ICS					
Quality, Performance & Finance	Approval of pathway to a financial strategy.		Engagement with out of STP providers for system assurance report	Establish clear links with clinical senate to enable alignment of priorities	· An integrated quality, finance and performance dashboard reported into the ICSPB. · System Quality and Safety Committee established. · Agreement of 2021/22 IFP arrangements.	· Increased provider level data in the system assurance report · Mobilisation of ICPs and PCNs, agree delegated scope & accountability framework · Agreed 2021/22 system finance plan and strategy	A system wide approach to harm reviews in place	A shared QI approach and methodology to support system wide change projects	An integrated quality strategy that is aligned to organisational plans as well as the system, place and neighbourhood need	Development of a system wide customer care culture					
Clinical & Professional Leadership	Identified dedicated resources for the Senate to support its business	· OD support programme aligned to System-Wide OD Programme	Vision, Role and Terms of Reference in place for the Staffordshire & Stoke-on-Trent Health & Care Senate	· Role and ToR are in place for the Health and Care Assemblies · Conduct a Needs Assessment for the development of cross health economy pathways	· Develop and introduce an OD Leadership Programme that will help the Senate to deliver an ICS · Deployment of personal Health records app, by February 2021	· Process, tools and method to develop evidenced based health, care and clinically led strategy established	· Health & Care Senate and Assemblies launched · Achieve state of readiness to receive Population Health Management intelligence		· Empower the health, care and clinical community to develop clinically led system strategy and to lead the delivery of local transformation / redesign						

Integrated Care Partnership (ICP): Development and Establishment

ICP development and establishment

- A detailed ICP development plan has been produced to support achievement of the critical path of ICP development and establishment, built around three core themes of-
  - culture
  - governance and
  - operations

- The plan has been co-produced in collaboration with the Strategic Commissioner workstream to ensure that relevant interdependencies have been identified and a consistent approach agreed. It has been used to inform the ICS Roadmap and as a companion piece to the Phase 3 Recovery plan.

- The ICP Programme Board coordinates the ICP development activity whilst continuing to provide space for locally tailored responses to local issues.

- Oversight of the plan is coordinated through the ICP Programme Board, led by Peter Axon (CEO, NSCHT), which includes representatives from all three ICPs and the CCGs. This ensures that there is a strong local context to development, General Practice is represented as a provider in each ICP and that the link to neighbourhoods is strong.

- There is an established commitment to the three ICPs, each with leadership and governance in place which has been and will continue to be developed on an inclusive basis, including key partners and stakeholders.

- The ICPs have developed organically and at a pace that reflects local factors. ICS and ICP boundaries reflect local authority boundaries with good engagement at all levels of the ICS and ICPs, including opportunities for District and Borough Councils to engage at ICP level.

- There will be three core products that will support development:

  1. ICP Visioning Document – This articulates agreement between the ICS and ICP on key aspects of ICP development
  2. ICP Partnership Agreement - ICP level publication that sets out membership and governance of the individual ICPs
  3. ICP Delivery Plan - ICP level publication that sets out plans for improving health and care outcomes for local people within the ICP footprint

What is different about an ICP? Developing an Asset Based Approach

- The transition to an ICP provides a fundamental opportunity to place a new emphasis on the strengths and assets of our communities and open up new ways of thinking about improving health.

- We have adopted an 'asset based' approach which means each ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups.

- We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme. This approach and the work that we have commenced is outlined in the **Appendices** of this development plan.

ICP (Place) Agreed Priority Areas for Transformation

The matrix below shows the individual ICP priorities identified in the summer of 2020 and the ICP self-assessment alignment to the FYDP. The self-assessment has been developed further to reflect consistent alignment for each ICP to the FYDP priorities. These priority areas form the work plans for the place agenda across our 3 geographical place footprints. These have been shared with Shadow ICS Board and each ICP has been working to deliver these through their agreed governance arrangements

ICP Priorities ↓	FYDP Priorities →	Focused Prevention	EPCC	UEC	Planned Care	Personalised Care	Mental Health	Maternity & Neonatal	Cancer	Learning Disability & Autism	CYP
South East ICP											
Long Term Conditions		*	*	*	*	*					
Enhanced Health in Care Homes			*			*					
Covid Rehab											
Cancer and Diagnostics									*		
Elective Pathway Priorities			*		*						
CRIS Roll out			*								
Mental Health		*	*			*	*			*	*
North ICP											
Sustained focus on restoration and Recovery		*	*	*	*	*	*			*	*
Improved access to integrated Mental Health Services		*	*			*	*			*	*
Children and Young People			*			*	*	*		*	*
Long Term Conditions (incl Tier 3)		*	*	*	*	*					
Frail Elderly			*	*	*	*	*				
Asset based demand management		*	*		*	*	*			*	*
South West ICP											
Admission Avoidance Pathways			*								
Mental Health Pathways - Post Covid Mental Health &Wellbeing		*	*			*	*			*	*
Enhanced support to care homes			*			*					
Effective Referral Pathways for Planned Care (Triage and Treat)			*		*	*			*		
Long Term Condition Pathways		*	*	*	*	*					
Staying Well Pathway (Frailty)			*			*					

Provider Collaboratives

Provider Collaboratives

- Each of our provider organisations play an active and strong leadership role through the governance structures of the ICS including the ICS (Shadow) Board and the System Strategy, Finance and Performance Committee.
- Provider CEO's have taken lead roles on the 5 system workstreams, agreed by the CEO Forum, as key areas for our development (slide 26).
- Long-term workforce planning across the system has taken an 'open book approach' through development of the FYDP and Phase 3 recovery plan. Arrangements for mutual aid have been have been utilised and effective during Covid-19.
- In order to build a compassionate and engaged workforce we have designed numerous initiatives which underpin the delivery of our system wide Local People Plan. We have developed programmes to support multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and developing an agile workforce.
- Whilst there is recognition that more can be done, provider collaborations within the STP are not new. Collaboration has been ongoing and our commitment to this will continue.
- Collaborations within the STP are structured as follows:
  - Horizontal Collaborations
    - Collaborations between acute providers on clinical services and / or clinical support & corporate functions. The majority of which are with partners external to the STP,
  - Vertical Integration
    - Collaborations between STP providers such as Social Care, Primary Care, Community Services and Mental Health,
  - Specialised Collaborations
    - These are in the early stages of development and are generally outside the STP and in support of developing safe and sustainable highly specialised tertiary services.
- University Hospital of North Midlands (UHNM) has on-going partnerships with a range of acute providers on a different footprint to our ICS boundaries but also within the ICS particularly with the 2 local mental health providers.
  - Clinical networks and specialist partnership arrangements are in place to support the delivery of the best possible outcomes for the population.
  - There are numerous opportunities for collaborative working and partnership/network arrangements available to explore in light of GIRFT network recommendations. UHNM is fully engaged with Specialised Commissioners to review these collaborative arrangements across wider geographies.
  - The Trust is part of the N8 pathology network that also includes Mid and East Cheshire and Shrewsbury and Telford Hospitals. From the 1st of December 2020 the Trust became the host of the North Midlands and Cheshire Pathology Service, providing services to the populations of Mid and East Cheshire, Staffordshire and Stoke-on-Trent.
  - Acute provider and Community Teams already work closely to ensure that for patients with Long Term conditions (LTCs) every opportunity is taken to ensure care can be provided close to home. All ICPs have identified LTCs as a priority which will strengthen that integration further.
  - Providers across Staffordshire are looking to work together in order to create Community Diagnostic hubs for the population of Staffordshire and Stoke-on-Trent. By reviewing both current provision and demand, data will be used to determine geographically where Diagnostic Hubs will have the most impact on patient pathways and access to healthcare.

Provider Collaboratives

Provider Collaboratives

- Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) are part of or lead on work within the Mental Health provider collaboratives.
    - Eating Disorders New Care Model - led by Midlands Partnership Foundation Trust
    - Child and Adolescent Mental Health services (CAMHS) New Care Model - led by Birmingham Women's and Children's Hospital.
    - Adult Low and Medium Secure Services - led by Birmingham & Solihull Mental Health NHS Foundation Trust (also work with St Andrew's Healthcare as part of the Reach Out).
- MPFT are leading on the deployment of long Covid clinics supporting rehabilitation of people that have had Covid-19. As a system we will use these clinics to profile the demand and data in order to shape a strategy that aligns to increases in acuity within general practice, primary care and community services. We plan to establish these clinics as part of our system resilience to support patients providing alternatives to hospital admission.
- MPFT and NSCHT are supporting the development of mental health surge plans. This has become one of four national models that form a community of practice and will influence surge planning into the new year. This data is being used locally within ICPs to understand the changes currently and build plans to support vulnerable people as the pandemic continues.
- At a PCN level, MPFT has signed contracts to deliver the DES including physical care and mental health. MPFT have worked collaboratively with general practice, to place workforce within practices, including occupational therapists, nurse prescribers for mental health to support the joint management of Serious Mental Illness (SMI), physiotherapists and extended hours which are all part of the DES and ultimately all part of hospital avoidance.
- The system continues to place a strong focus on admission avoidance and the work, which started twelve months ago, on the Community Rapid Intervention Service (CRIS) for North Staffordshire. The service is a joint partnership providing an integrated model across community, acute and social care services to provide sub-acute care in the community. Further detail on the work undertaken is explained in more detail in the Appendices of this development plan.
- Case studies in the Appendices also outline collaborative work on the NHS Continuing Healthcare Fast Track Pathway and The Staying Well Service (SWS) which was co-designed with partner organisations.
- NSCHT is an active part of the Stoke-on-Trent Collaborative Network (CN). The CN is a collective of around 20 plus voluntary organisations coming together with public bodies, chaired by the Chief Executive of the YMCA. The agenda is focussed on cross-cutting themes such as loneliness and economic prosperity to understand the linkages across all providers and better coordinate our resources.
- NSCHT has a small number of key voluntary sector bodies that are part of the supply chain of provision for services such as Community Drug & Alcohol Services and IAPT.
- Each ICP has been established with an inclusive governance model that sets a core membership of statutory partners but also allows sufficient local flexibility for ICPs to work with those voluntary/third sector partners which might be relevant in their local geographies.
- The North Staffordshire ICP model has active representation from both VAST and Support Staffordshire to represent the voluntary sector (VS) more generally but there is specific representation from larger VS partners in the Northern geography as well.
- ICP priorities developed in the summer were approved by ICP Stakeholder Group including VS representation. Subsequent working groups all have VS representation on them to ensure we make connections across the whole pathway of care
- Work will continue on our provider collaborative arrangements alongside any changes in legislation and as part of our development plan.

Strategic Commissioner Development

- Effective commissioning at the right level across the ICS is vital to create an environment in which our system is focussed on outcomes, our places and neighbourhoods are able to flourish and the benefits of integrated care can be realised.
- The vision is
    - A strategy agreed once for the whole system
    - Clinicians working in ICPs to agree the care pathways that work in that local context
    - Delivery in the neighbourhoods where primary care are empowered to work on the implementation of pathways
- The Strategic Commissioner Development work and ICP (Place) Development work are very closely connected. The leads from each area are working closely together to ensure that the interdependences are mapped across and to ensure that key milestones and decisions complement the other work stream.

Planning and Delivery

- A detailed plan has been developed to support achievement of the critical path of Strategic Commissioner Function, built around the core milestones of-
    - Population health management
    - Health and care outcomes framework
    - Health inequalities
    - LA & CCG integrated commissioning development
    - Devolvement of tactical commissioning resource into ICPs
    - CCG merger
- The Executive lead accountable for this development priority is Marcus Warnes (CCG Accountable Officer).

Specialised Commissioning Planning and Delivery

- We will build on the opportunities provided by our transition to an ICS by ensuring specialised services are planned and delivered as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.
- We will work with Specialised Commissioning to plan specialised services alongside locally commissioned services, providing the opportunity to transform and improve clinical engagement across integrated whole system pathways and positively influence health outcomes.
- The end-to-end integration of pathways will deliver benefits to patient outcomes and experience, reduce unwarranted variation and improve value for money. Where required and appropriate, services will be redesigned at a system or broader level to maximise clinical efficiency and financial resources.

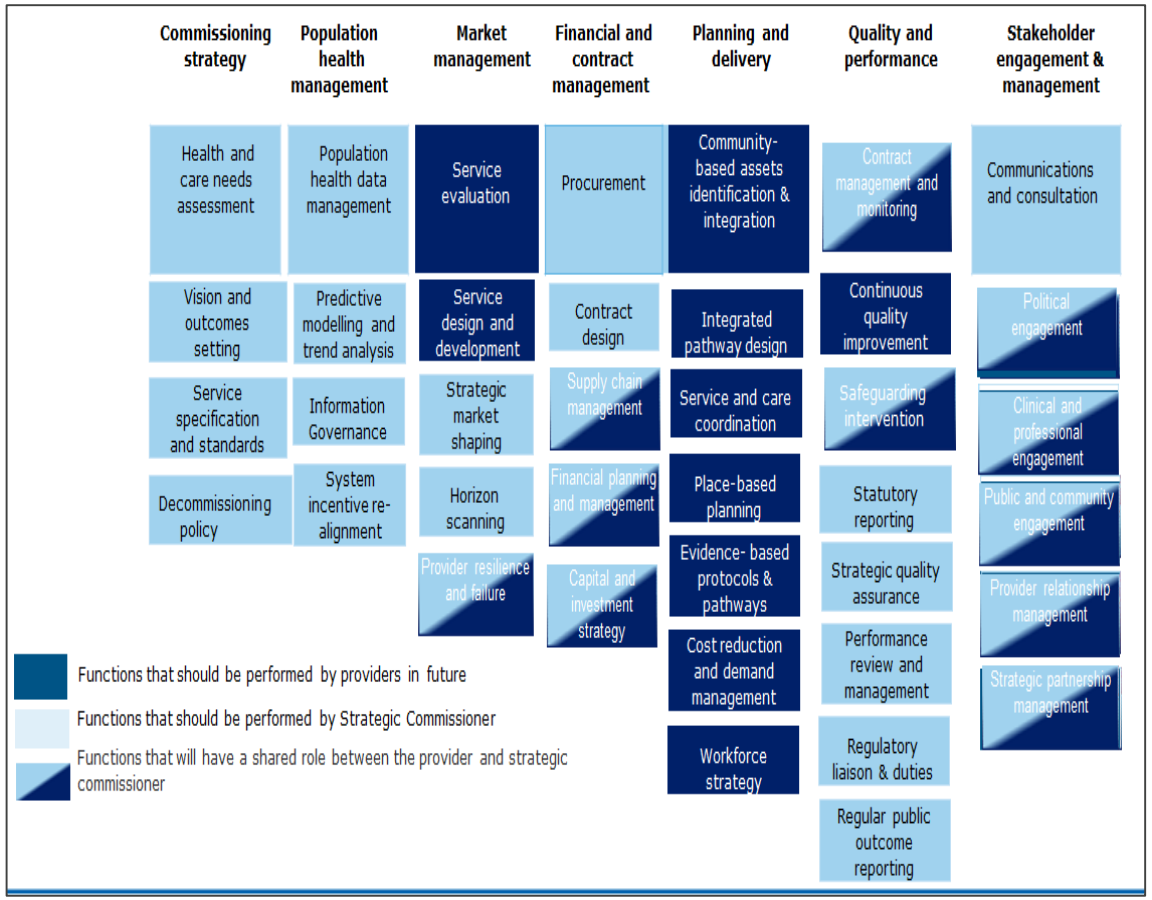
Engagement and Partnership Working

- The CCGs participate in the two Health and Wellbeing Boards (HWBBs), part of their role in this board is to ensure that the ICS Development Plan is aligned with the two Health and Well-being Strategies.
- We will work together with the two local authorities to align the ICS Plan with their respective corporate plans and provide regular updates to the HWBBs on progress of implementation.
- The CCG Clinical Chairs and Accountable Officer have been in detailed dialogue with NHSE/I regarding the CCG merger roadmap and timelines. This programme of work is underpinned by a more detailed plan which should be read as an accompanying piece to the ICS development plan.

Strategic Commissioner Blueprint

Strategic Commissioner Development

- The diagram below sets out the blueprint for the overarching functions that need to be delivered through the strategic commissioning work plan.



The Strategic Commissioner will:

- Ensure an in depth understanding of the health needs of the population in the System with a data driven population health management and a risk stratified approach;
- Identify and agree with all interested parties the priorities, which emerge from the above. This will involve aligning priorities, outcomes and resources with the two Local Authorities including the joint commissioning of services wherever possible;
- Develop and put in place outcome-based approaches for the delivery of priorities by all providers including ICPs;
- Take responsibility for allocating resources to ICPs and other providers to encourage local commissioning and delivery ownership;
- Ensure ongoing dialogue with patients and citizens so their views can contribute to the development of priorities and outcomes; and,
- Responsibility for public consultation over major service changes (including the PCBC)

Progress to Date

- We have taken the blueprint and added detail behind the functions in line with the vision for a Strategic Commissioner and place based care through the ICPs. These are split into determining the 'what' and delivering the 'how' and are outlined on the next slides.
- A communications plan underpins the work to ensure that the approach is supportive, managed internally with CCG staff and socialised with system partners.
- A HR plan underpins the function mapping in order to support the workforce through the transition of alignment of posts to Strategic Commissioning or ICPs.
- We have worked across the ICS work streams to co ordinate the approach linking to the ICP development and financial framework in particular;
- Clinical chairs, directors and lay members have been involved in the work to sense check functions.
- There are a number of functions that will need to sit centrally as part of an ICS and for the purpose of the splits, they have been aligned to Strategic Commissioning. If legislation changes in the future, there is a potential that a number of areas could move into the ICPs for delivery.
- The 6 CCG Governing Bodies in Common have previously agreed to the establishment of 3 Locality Commissioning Boards (LCBs) as a sub Committee of the Governing Bodies covering each of the Integrated Care Partnership (ICP) footprints. The Terms of Reference of the LCBs have been developed and agreed by the Governing Bodies in Common.

Functions Mapped

Strategic Commissioner Development

Strategic Commissioning		ICP	
Vision and outcomes setting	Strategic market shaping	Service evaluation	Service design and development
Health and Social Care Integration - Strategic planning	Whole system procurement	Health and Social Care Integration - local delivery	Local procurement
Consultation and engagement - whole service change	Contract design	Provider resilience and failure	Community - based assets identification & integration
System incentive re- alignment	Financial planning & management	Integrated pathway design	Service and care coordination
Capital and investment strategy	Contract management and monitoring - ICP and services commissioned across more than one ICP	Place-based planning	Evidence - based protocols & pathways
Provider relationship management	Strategic Partnership Management	Contract management and monitoring - local sub contracting	Financial monitoring - delegated budgets
Population health data management	Horizon scanning	Cost reduction and demand management	Engagement – Political / Clinical / Professional / Public / Community
Predictive modelling and trend analysis	EPRR	Outcome based service specifications	Management of delegated budgets
CPAG/IFR	Primary Care Strategy and Contracting	Local quality monitoring and delivery	Primary Care development and commissioning
Safeguarding and statutory quality functions	Strategic Urgent Care - 111/WMAS/OOH	Management of Urgent care performance and remedial actions	Medicines Optimisation
Corporate services - complaints, exec administration, FOIs, MP letters	Continuing Healthcare	Administration aligned to the ICPs	

Examples of Functions Mapped and Next Steps

Strategic Commissioning	ICP
Consultation and engagement -whole service change • CCGs will remain the statutory body and therefore responsible for consulting on material service changes (subject to change following the national engagement proposals around ICS's being placed on a statutory footing). • ICPs will feed the areas of consultation and engagement will be taken at a local level via the ICPs feeding into the formal process which will sit within strategic commissioning (to be determined as part of the new Health and Care Bill.).	**Engagement –Political / Clinical / Professional / Public / Community** • Engagement across multiple stakeholders to be undertaken through the ICPs in determining service and pathway changes. This will be both informal and formal. • ICPs will determine the methods and types of engagement working with the communications team in Strategic Commissioning to ensure legal requirements are met. • Relationships with MPs and Councillors including attendance at OSCs • Other public sector provision -fire and police etc.
Vision and outcomes setting • Taking the PHM data and information and develop strategies and outcome frameworks to define the 'what'. • Set the strategic priorities for delivery through the ICPs. • Work in partnership with ICP leads to define the outcomes.	**Service design and development and Integrated Pathway Redesign** • ICPs to take the required outcomes co-produced with strategic commissioning to design integrated services to meet the needs of the local population -'the how'. • Clinically led process aligned with the available financial envelope. • Lead provider arrangements to be identified and financial movements co ordinated. • QIPP/CIP/system savings to be considered in all redesign. • Care co-ordination and integration. • Consideration given to cross border commissioning by ICPs where appropriate and decided at ICP level. • Providers and commissioners across health, social care and the voluntary sector to take the co- produced required outcomes and develop integrated pathways. • Agreement of any financial realignment between providers. • Agree appropriate use of facilities and technology identifying efficiencies. • Development of CIP/QIPP programmes/system savings. • Identification of lead provider and mechanisms to hold to account through the ICP.

- The table shows an example of the detail of the "what" and "how" that sits within each function mapped.

Next Steps

- There is further work to be undertaken in breaking down the CSU functions into Strategic Commissioning or ICPs. Once the CSU work has been completed, this will then allow a breakdown of the ICP resource across the three ICPs and a gap analysis to be undertaken in terms of capacity and/or capability gaps to deliver against the functions.
- In quarter 4 discussions will commence with staff regarding alignment of posts to Strategic Commissioning or ICPs based upon the functions mapping.
- The functions mapping is a starting point and the way in which we work will evolve and change as we move forwards and the relationships and arrangements mature.
- The final version of the functions work (recognising that this is an iterative process), and structures will continue to be socialised with system partners as part of the ICS and ICP development work. This will enable provider partners to wrap staff around the functions to ensure that there is capacity and capability in place to deliver the requirements.

Health Inequalities and Prevention

Strategic Commissioner Development

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

Leadership and Governance Progress to Date

- An inequalities strategic oversight group has been established, involving clinical and public health expertise, aiming to bring together the inequalities and prevention work streams. This now needs to set out clearly its plans and ambitions and for these to be agreed by the ICS Board
- An Executive Director is in place providing senior leadership and acting as SRO for this programme of work.
- A Public Health Consultant in the CCGs is leading delivery of the development and of population health management across the system.
- An integrated intelligence group in place undertaking population modelling around Covid-19.
- Progress on both health inequalities and the population health management approaches that support it will be reported via the ICS partnership board.
- A Health inequality champion at board level within each organisation and a system inequalities lead will be identified as a priority
- We are working collaboratively and engaging with local communities through existing assets such as community groups, peer support groups and work undertaken by the voluntary sector to aid place based approaches.
- The Health and Care Senate which will be used to ensure that inequalities are a key issue for clinical and professional leadership groups and are represented in clinical prioritisation decisions.
- Work will continue with LA public health leads to ensure that the Phase 3 recovery plan health inequalities priorities are linked to the wider health inequalities and prevention agenda, via the Health and Wellbeing Boards as they begin to meet again.

Planned work programme -

- The system inequalities and prevention programme is based on a practical and pragmatic view of what can be achieved and where the most impact can be gained.
- The Strategic Oversight Group will present its work plan to the ICSPB in January 2021 and will set out its approach to PHM
- Key areas of work around health inequalities will cover four main programmes outlined in the diagram below.

Reduce the risk of worsening inequalities

A clinical prioritisation framework;
Linking clinical and population data;
Equality Impact Assessment (EIA) and
Quality Impact Assessments

Provide an improved understanding of the population risks

(Population Health Management)

Integrated System Intelligence Hub;
Population segmentation and risk stratification;
Core performance monitoring of service use and outcomes
STP level metrics
Vulnerable population

Accelerate preventative programmes, which proactively reduce inequalities and support the recovery of services in the community.

Address significant ongoing inequalities that are in the long term plan

Population Health Management: Providing an improved understanding of the population

- While every person will have their own unique requirements and circumstances, when working at scale across a whole population, groups with similar needs and characteristics can be identified. By understanding these groups, we can plan and deliver services in the most appropriate way and in the most convenient locations for their population.
- Population Health Management (PHM) is one of the key ways that we are working to develop effective and efficient system integration.
- The city and county both have areas of high deprivation and the PHM approach will help us to focus on reducing inequalities and to work together across health and care to improve wellbeing for everyone.
- PHM requires partners across the system to come together in new ways and we are proud of what we have achieved together so far.

Progress to Date

Pre-Covid-19

- A PHM task group was set up and endorsed by the shadow ICS board
- Establishment of the Intelligence cell
- Increased recognition and drive in the system for collaborative, cross-organisational system wide PHM approach

During Covid-19 response

- The Intelligence and Modelling cell have consolidated the analytical and intelligence skill set across the system.
- We have seen successful collaborative and system working with sharing of data, intelligence and resources.

Developing Clinically Led Strategies

- PHM will be a key tool utilised by the Health and Care Senate (H&CS) to generate evidence based strategy and prioritisation.
- The H&CS will deploy cross system population health analysis, in order to establish areas of need and priorities for targeting resource. The Health & Care Assemblies will have health, care and clinical representation at the local and PCN level. These smaller populations are well positioned to reflect local areas of needs at a granular level.

System:
How can we use population health analysis to decide how to allocate resources across providers?

Place:
How can we support people on multiple waiting lists in deprived areas?

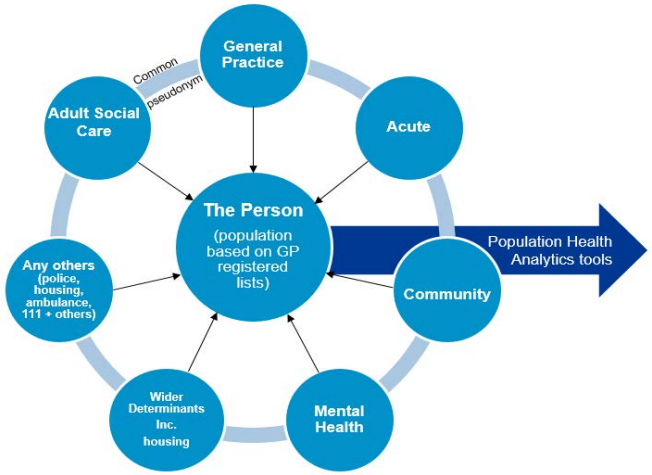
Neighbourhood:
Which at-risk patients should our MDT proactively engage in preventive efforts?

Person:
How can we leverage our neighbourhood assets to support this person who is at risk?

Resources = money, time, people, skill level, etc.

PHM Infrastructure

- Our Population Health Management (PHM) approach supports integrated teams at every level of a system with the 'person-based' analytics they need to drive better outcomes.



- The approach will support local teams to answer some of the questions they are faced with.
- By bringing together a linked data set that represents the total need of this population (Infrastructure), and providing advanced analytics that help professionals understand and prioritise risk, complexity and need (Intelligence), PHM supports these teams with the insights that can drive new proactive care models at scale (Interventions) at system, place and neighbourhood level.

Current action to support linked data sets

- Improving the recording of population data (ethnicity etc.) in clinical data
- Working with Upper Tier Local Authorities (UTLAs) to link clinical data to population testing data to support the management of outbreaks and understand and reduce the spread of infection in the community
- Working with UTLAs to link NHS data with LA data on vulnerable people to understand the impact of Covid-19 on health inequalities

Next steps include:

- Continuing to progress the infrastructure required for linked data sets
- Information Governance- SIRO, IG leads, data sharing agreements with system partners.

PHM Development Programme

- The system will benefit from the Wave 3 PHM development programme having been successful in the application to join.
- The programme aims to build capacity and capability by working with all tiers of the system to transform service delivery around key population groups.
- The intensive 22-week programme is designed to accelerate Integrated Care System (ICS) development through action learning sets, additional training and development

SYSTEM WORKSTREAM:

- 5 SME facilitated Action Learning Sets that **bring together all system stakeholders to develop a common understanding** and learn from international good practice
- Focus on **sharing learning across workstreams** and **collectively unblocking barriers** to scale PHM

PLACE & ICP WORKSTREAM:

- 3 Action Learning Sets with providers, Local Government and wider partners to **develop a scalable plan to restore services inclusively and address inequalities** by linking elective data with person level analysis

** 1 place funded through programme*

PCN WORKSTREAM:

- 5 Action Learning Sets with primary and secondary care partners, social care and third sector teams to **identify at risk groups and develop & deliver new holistic model of care**
- **Regular coaching** throughout the to key members of PCN MDTs

** 3-4 PCNs funded through programme depending on system footprint*

ANALYTICAL WORKSTREAM:

- 7 Action Learning Sets that bring together system analysts for **hands-on learning of PHM analytical techniques** and a facilitation to **create a sense of shared purpose** for system intelligence teams
- Local analyst community learns to directly **support MDTs designing intelligence-based care models** within the programme

FINANCE & CONTRACTING WORKSTREAM:

- 7 Action Learning Sets that bring together **finance and contracting leaders from commissioners and providers**
- Trained use of actuarial and predictive modelling to develop whole system demand models and drill down into a **new blended payment model based around a population cohort**

Population Health Management: Providing an improved understanding of the population

PHM Intelligence

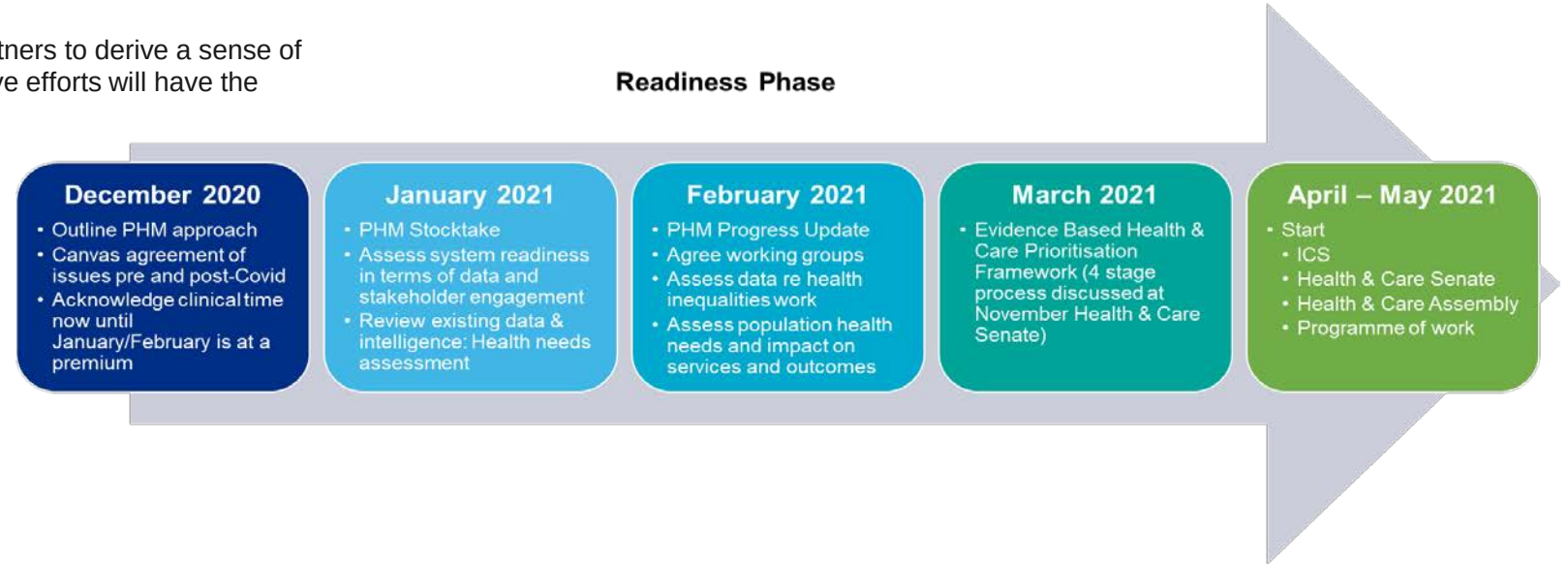
- Over the last nine months we have focussed on improving collaboration and sharing of data across the system and developing shared intelligence that is agreed collectively by all the organisations across the system.
- The H&CS is in a phase of readiness to use PHM intelligence to develop clinically led prioritisation and strategic development.

Next steps include working through the readiness phase to

- Undertake a pilot project using linked data sets to assess population health needs, prioritisation and using PHM analytics for developing appropriate interventions
- Work on Insights on how the use of linked datasets with integrated teams can support prioritisation and deliver change. e.g. interventions to reduce inequalities

Broader development and engagement in the system PHM approach will continue through delivery of:

- Development of core capabilities
- Stakeholder engagement by working with system partners to derive a sense of common purpose, priorities and agree where collective efforts will have the biggest impact



Model of Care

- Our overarching model of care and support is designed from the perspective of individual needs across an integrated pathway recognising that people will move both up and down the continuum of care in terms of the support and the intervention needed at specific points in their lives.
- Our approach to specific models of care is based on the application of a set of agreed design principles outlined below

1. Inpatient settings

- Reduced reliance on inpatient services
- Short-term support delivered as part of individual service designs including personalised risk and escalation plans

2. Entry intervention (de-escalation and management of crises)

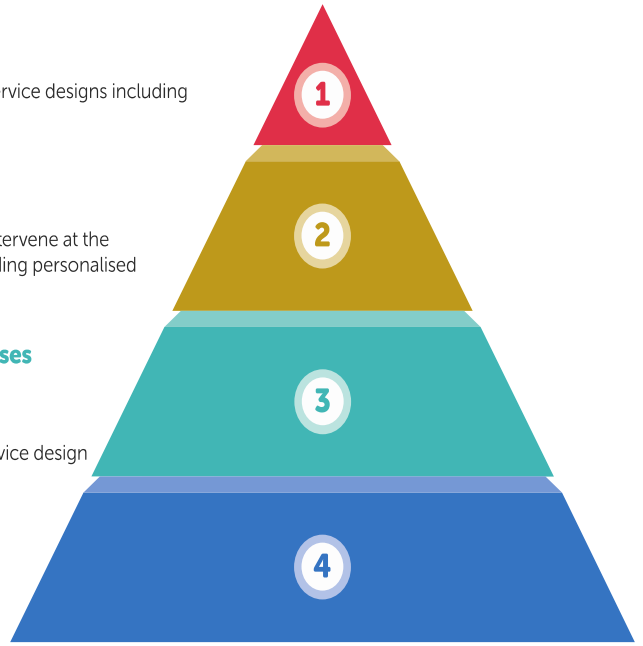
- Collaborative arrangements between partners to intervene at the right time based on individual service designs including personalised risk and escalation plans

3. Case management and prevention of crises

- Collaborative approach to care and support
- Early triggers and use of risk registers
- Flexibility of commissioning based on individual service design

4. Mainstream provision

- Public health prevention
- Primary care
- All services adapted to support



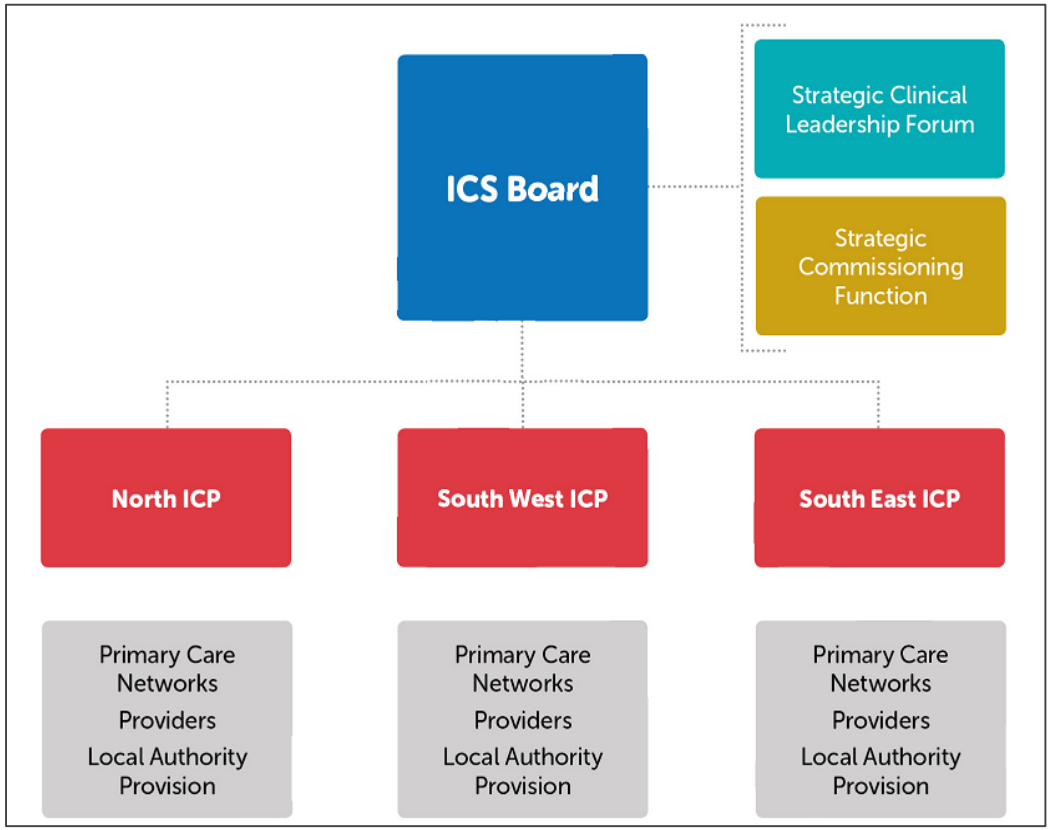
Delivered through

1. Integrated Care System (ICS)
2. Primary Care Networks (PCNs)
3. Integrated Care Providers (ICPs)
4. System leadership and governance
5. Population Health Management
6. Quality and safety
7. Involvement

System, Place and Neighbourhood Functions

Governance and System Architecture

- The FYDP set out a commitment to establishing a new system architecture by April 2021.
- ICPs will adopt an inclusive approach to promote engagement from all health & care partners including NHS, LA, Primary Care, Third Sector and other partners (e.g. Universities) who can influence the delivery &/or transformation of services.
- At ICP level, the focus is likely to be centred around three key elements:
    - Operational liaison and local coordination
    - Delivery of transformation aligned to STP/ICS priorities
    - A clear focus on how we tackle health inequalities through PHM
- The simplified governance set out opposite shows the ambition that the system has in order to move to fully functioning ICS, that is built on the ICP (Place) based model of care.

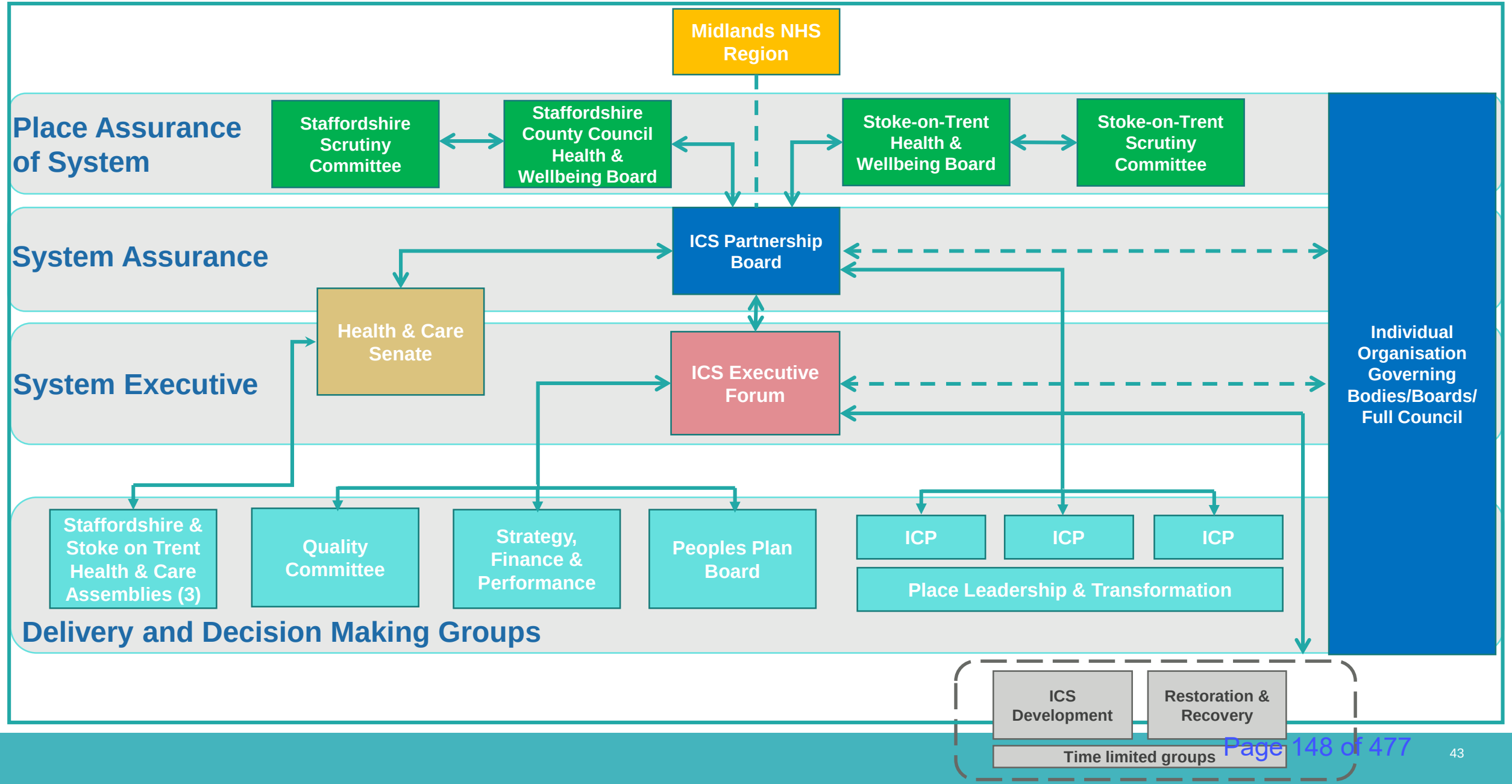


Draft (Interim) Governance Structure

Governance and System Architecture

- To support the ongoing partnership working an interim governance structure based on 'function' has been established and is shown in on the next page.
- The sub committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work.
- Central to the effectiveness of this structure is the tripartite relationship between the ICSPB, the Executive forum and the H&CS. These functions are are already established and will act as the vehicle to help facilitate ICS maturity development.
- This approach will continue to evolve but is focussed on-
    - Clarity of roles and responsibilities
    - Effective and simplified decision making
    - Recognising statutory organisations and their respective responsibilities and accountabilities
    - ICS & ICP development
    - Enabling the 'System by Default' Operating Model
- Progress continues to be made in regards to supporting decision making at the appropriate level – the principle of subsidiarity is applied in everything that we do
- The next stage of this work is to work through the functional requirements of an ICS and look to set them out at each level. This will require partner input and ownership and is an essential step to support the place (ICP) agenda.
- The functional analysis work will subsequently support the review of decision making. This will require legal support and input to ensure that any schemes of delegation are lawful and well understood. Partners are clear of the importance of getting this right but have not underestimated the scale of this task.
- The ICSPB will receive regular updates from the main standing committees to detail progress against the agreed objectives. These will be system based reports and will build from individual partner performance. The Board will rely on the Executive Forum to execute delivery and monitor implementation.
- We have a robust and well-functioning Mental Health (MH), Learning Disability and Autism Programme Board (MHPB) which will continue to operate within the ICS governance structure. There is appropriate representation from NHS partners within the STP and oversees deliverables in the FYDP. The MHPB will continue to oversee a transparent investment process of the Mental Health Investment Standard (MHIS) into priority programmes. More recently the MHPB have overseen the response and sign off of the submission in relation to the additional 2020/21 winter funding for post-discharge support for mental health patients.

Draft (Interim) Governance Structure



Place Assurance of System

Governance and System Architecture

- It is clear that there is still work to do to evolve and develop the governance to support effective system working. The recent publication from NHSE/I on the next steps for integration and the statutory establishment of ICS's provides an outline framework for us to work to but we anticipate that as further detail is provided that we will need to reflect this in our local approach.

Scrutiny Committees

- There are already strong relationships with both scrutiny committees and regular engagement enables a constructive and transparent process of scrutiny to function.
- We are clear that we expect this to continue as we move forward. However, there will be a need to consider how and who will have the statutory responsibility for any formal consultation that the system wishes to undertake. This will be dependent on the national legislation.
- Equally the role of the scrutiny committee in relation to the local place agenda will be an area that will need to be developed. It is likely that there will be a significant amount of local flexibility around the governance that is put in place and there is a strong local commitment

Better Care Fund

- The proposal for 2021/22 is to roll forward the Better Care Fund agreement as currently agreed. This is aligned to the national directive but the system will review this if that guidance changes as part for the Operational Planning Guidance for 2020/21. In future years it is likely that there will need to be a review of this budget as part of the budget setting process for the place based agenda. The future process for sign off will be revisited if the statutory responsibilities change as part of the ICS establishment.

Health and Well-Being Boards

- The 2012 Health and Social Care Act established Health & Well-being Board's (HWBBs) as committees of the Council. They were given statutory responsibility for producing the JSNA and for building a collective momentum in tackling the health inequalities in the local area. Each upper tier local authority is required to have a H&WBB.
- Locally there are two HWBB's (one for each LA) and system partners are represented on both. They have an important role to play given their responsibility for the JSNA. AS our ICPs develop and become more mature, there will be a need for much closer working.
- It remains unclear as to whether the proposed legislative changes will consider the purpose or need for HWBBs.

Involvement

Governance and System Architecture

- We have a strong track record in involving staff, service users and the voluntary sector in developing our priorities and plans. Understanding the views of our population helps to explore ideas such as the smarter use of technology, providing care in different settings closer to home and supporting the STP to seek ways to reduce health inequalities.

Existing feedback

- Over 12 weeks during the summer of 2019, we worked with health and care professionals, partners and the public to understand their priorities for local health and care services. Their feedback helped inform our FYDP and priorities.
- During summer/autumn 2020 we did further engagement with local community groups, to understand people's experiences during Covid-19, including future priorities. Working with our Healthwatch partners a wider public survey was carried out. This feedback will be considered by the restoration and recovery programmes and the ICSPB to inform future priorities and the approach to wave two.

Future communications and involvement activity at a system level, will include:

- Delivery of the Winter C&E plan and response to Covid-19 (2020-21)
- Primary care, partner and public engagement on the development of the Strategic Commissioner function (2020-21)
- Publication of Long Term Plan and support for the local People Plan
- Systemwide approach to transformation, including key areas of urgent care, maternity, community care, mental health and planned care (2021-23)
- Significant mental health transformation programme over three years (2020-23)
- Supporting the equality programme, with a focus on reaching seldom heard groups

Approach to Communications and Involvement

- We have robust foundations locally for capturing the patient voice to inform and support transparency of the work at ICS and ICP level.
- Healthwatch and voluntary sector partners are involved at a board level
- Integrated approach to C&E with a shared Director of Communications across the CCGs and ICSPB footprints, with a seat at the ICSPB
- Investment in a central STP C&E resource, led by the Director, that supports system transformation and co-ordination
- C&E leaders across providers/CCGs lead on specific priorities, using their individual expertise and report to the system group
- A C&E system group, with members from all partners, including local authorities, Healthwatch and the voluntary sector meets monthly chaired by the Vice Chair of the ICSPB
- The LRF C&E group meets weekly (during Covid-19) to co-ordinate the C&E response
- Aligned patient networks to support systemwide conversations, including the digital People's Panel and the face to face local representatives group. These are then supported with face to face groups at an ICP level.
- At an ICP level we are working to strengthen local networks with the voluntary and community sector, to inform future engagement activity
- Plans to strengthen our Local Equality Advisory Forum, working at a system level to listen to seldom heard groups
- Regular reporting on engagement activity into the PPI lay member committee within the CCGs (future Strategic Commissioner function) and the ICSPB to inform priorities
- Good relationships with the Overview and Scrutiny Committees to inform approach to involvement.

Quality

- Our underpinning philosophy is that quality should permeate everything we do, from the way we jointly plan and commission and deliver care, to the way we work collaboratively to drive improvement and innovation.
- To enable us to provide outstanding quality services for all our shared vision and underpinning quality framework will not only focus on quality assurance but also quality improvement.
- Fundamental elements of the quality framework are Quality Improvement and Quality Assurance.

Quality Improvement Elements

- Deploy a shared QI approach and methodology to support system wide change projects in line with system priorities, in particular and with initial focus on those priorities identified in the Phase 3 recovery plan response which broadly include:
  - Acceleration or preventative programmes which proactively engage those at greatest risk of poor health outcomes
  - Programmes to support those who suffer mental ill health
  - Action to address health inequalities
  - Restoration of services
- Establishment of a system QI steering group to prioritise and coordinate QI programmes
- Ensure all improvement programmes put the service user and carers right at the centre, and staff in the driving seat of change
- Establish a cohort or trained QI leaders able to work in partnership across boundaries
- Deploy a shared system and approach for report out of QI work programmes at key milestones
- Ensuring that we recognise and reward achievement

Quality Assurance Elements

- A system Quality and Safety Group to steer the delivery of system wide quality assurance and improvement
- Setting standards for what outstanding quality care looks like.
- Improving patient and carer experience through the development of ICS wide customer service culture
- Take findings from CQC Provider Collaboration Review and work together across the system to embed the learning both from examples of best practice and areas for improvement
- Embed a system wide Quality Impact Assessment process that ensures that system wide service development and changes do not put at risk the safety of our service users and their carers
- Establish a system wide mortality review process to better understand, measure and review patient mortality with the longer-term aim of reducing health inequalities
- Establish a system wide approach to harm reviews in line with the serious incident framework and national guidance on learning from deaths.

- The response to Covid-19 has seen dramatic changes in how health and care services are delivered and used. In the **Appendices** of this delivery plan we have outlined case examples of how the system has already worked together to overcome challenges in respect of the quality and safety agenda.

Performance, Improvement and Assurance

Quality, Performance and Finance

- One of the key roles of the ICS is to manage our own system performance and improvement process, taking on some of NHS England and Improvement's regulatory role, to ensure the best achievement of constitutional standards and of the commitments in the Long Term Plan.
- In the past this process has at times been characterised by a lengthy process that covers all areas of interest to regional, national and local leads that can absorb considerable resource and not always achieve a clear performance improvement.
- Our aim is that this becomes a more focused and supportive process taking a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues. We want to use the same principles that have worked through Covid-19 to underpin our work on future performance challenges. Assurance will be a dialogue of equals focused on improvement for the population, system and organisation.
- The focus will be on improvement, supporting the spread and adoption of innovation and best practice between partners. The ICS are committed to delivering assurance that is based on partnerships for improvement.
- There is a well established system Strategy, Finance and Performance Committee (SFP) which responsible for agreeing the messages on performance. It will define the issues and actions that need to be taken to deliver the plan and will break these actions down into individuals / organisations and ensure that the action plan is coordinated across organisations.
- The SFP has the correct membership and intelligence to support discussion of the main issues, decision making and challenge on system performance.
- Where consensus on the actions or decisions can not be reached in the meeting there is a clear route of escalation through to the CEO forum.
- A System Performance and Assurance Working Group (SPAWG) was formed in July 2020 to support the remit of the SFP.
- The purpose of the SPAWG is to support an approach to gain shared understanding of system performance and intelligence in advance of the SFP and regulator system review meetings. The aim is that system partners collectively own and are sighted on the key issues and actions to improve performance. Partners are all involved in developing a jointly owned System Performance and Assurance report.
- The outputs of the group feed in to the SFP Committee.

Progress To Date

- The SPAWG meets on a monthly basis prior to the SFP.
- The monthly meetings and report produced by the SPAWG are evolving and will continue to develop as required. Currently the initial provider data contained within the report has come from those organisations that sit within STP. Progress is being made with University Hospitals of Derby and Burton and the Royal Wolverhampton NHS Trust to expand the report to include their data and to develop data flows from non-acute settings including primary care, community and mental health.

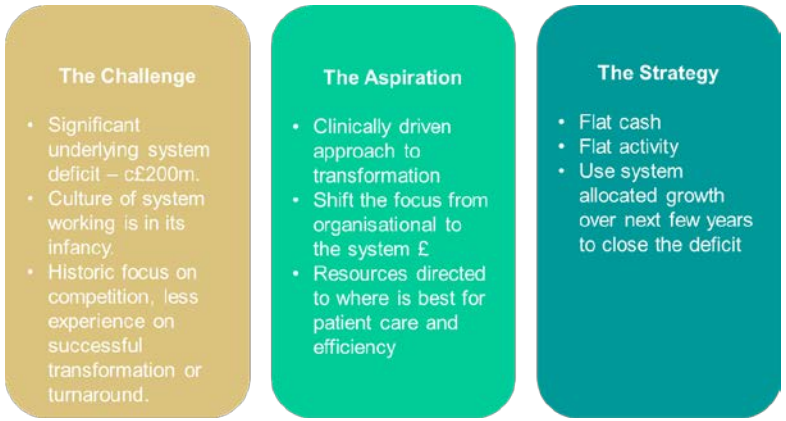
Finance

Quality, Performance and Finance

Financial Strategy

- The ICS will facilitate the development of a financial strategy that articulates how the system and the organisations within it will deliver the financial targets. It will define how the system will ensure that it is delivering the best healthcare for our population within the overall financial envelope.
- The strategy will define how the ICPs will deliver these outcomes. It will use evidence and data to define what can be done. It will define the expectations for the major drivers of the system financial position including provider productivity (system savings), investment in new services, funding, and managing activity growth, funding the delivery of system operational targets and managing financial risk.
- The pathway to a financial strategy was approved in October.
- Work on agreeing the principles of the financial strategy across the system has gone well, and all system partners understand the need for the strategy.

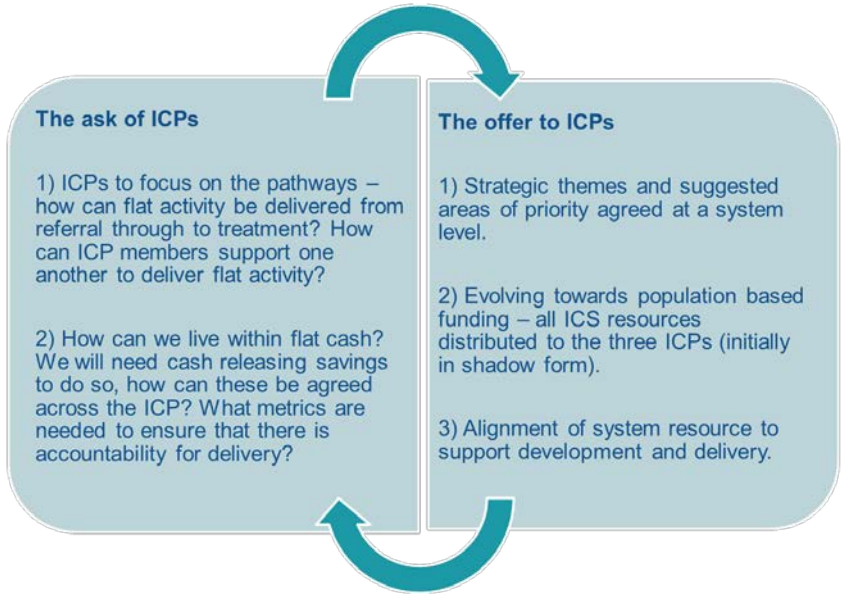
Financial Strategy on a Page



- The financial strategy principles recognise that, while there is a significant amount of uncertainty with respect to future ways of working and the financial regime, there are some key underlying assumptions and challenges that we can be confident of and start to shape our approach and response to.
- The strategy aims to strike a balance between what we do know and what we're waiting on confirmation of.

ICPs

- The approach proposed utilises the ICPs as the place where the work can be done across the system - to agree how flat cash and flat activity can be achieved.



- Once the more detailed arrangements for ICS and ICP is developed nationally we will continue to work flexibly to ensure that the analysis undertaken can accommodate all these views of the system's financial position

Finance

Quality, Performance and Finance

Opportunity Analysis

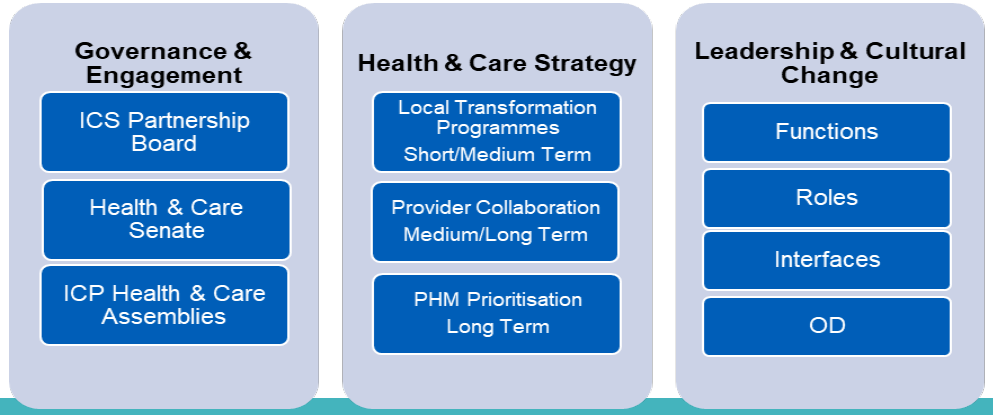
- The development of system opportunities was progressing throughout the late Winter and early Spring of 2020, however with the onset of the Covid pandemic this work was curtailed.
- Focus over the summer period has been the development of the restoration and recovery plan as well as the preparations for winter surge planning and the upturn in Covid. The next steps which sits alongside the development of the financial strategy roadmap is the preparation for the Phase 4 "Reset" plan. One of the key aspects of this will be the "refresh" of the FYDP priorities and opportunities as well as the consideration of the service developments implemented to respond to Covid-19.

The Intelligent Fixed Payment Approach

- The system is committed to evolving the Intelligent Fixed Payment (IFP) model to support the development of the ICS and ICPs. This will include the allocation of resources and the financial framework for ICPs, alongside supporting risk and gain share arrangements.
- The IFP represented a key step change in how we work together as a system to manage our financial positions. As we undertook 2020/21 planning, it was agreed that the IFP continue with similar arrangements before the Covid-19 central finance regime was put into place.
- The Finance Directors of the 4 statutory organisations oversee the management and development of the IFP and have agreed to establish a "shadow" IFP for ICP system in 2021/22 with a view to implanting it in full in 2021/22. This will allow partners to better understand the changes that are being proposed and not to destabilise individual organisation positions.
- Very early modelling of the 2021-22 baseline positions has been undertaken
- In the first instance, it is anticipated that the ICS holds the overall resource envelope for the system and is the level of aggregation that NHS England and NHS Improvement will hold the system to account for.
- Below this the 3 Integrated Care Providers would be delegated the CCG budgets which are relevant at a "Place" level – prescribing, continuing health care, and potentially delegated Primary Care.
- Providers would form "provider collaboratives" in both acute and community/mental health services to work with ICPs and each other in the best delivery of healthcare.
- In the first instance allocations would be made directly to the 5 NHS providers and 3 ICPs by the ICS. Risk and gain share arrangements would be agreed between each ICP and the 2 provider collaboratives to best manage care at a "place" level to improve patient pathways. Alternative risk and gain share agreements would be made between providers to manage risk and reduce competition.
- Whilst there is a significant amount of work to be done to establish this model, early modelling is now commencing. The financial allocations, and risk and gain share agreements, will need to be able to look at:
    - The organisational view;
    - The collaboration view; and
    - The place view.

Clinical and Professional Leadership

- Clinical and professional input for the ICS is provided by the Staffordshire and Stoke-on-Trent Health and Care Senate (H&CS) and its associated sub-groups, the Health and Care Assemblies. This will ensure strong clinical leadership at the centre of ICS decision-making.
- By working collaboratively with other system partners, strategic, evidence based, intelligence driven, health, care, clinical advice and leadership is at the heart of commissioning and service delivery. This will lead to improved provision of quality, safe and equitable health and social care resulting in improved outcomes for the population.
- The H&CS was established in 2019, by a group of health and care professionals who recognised the need for a concise system wide professional body, with representation from across the health and care sector. The structures support clinical and professional input from the front line of care, across Staffordshire and Stoke-on-Trent. This professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery.
- The Executive leads for this area of development are Dr John Oxtoby and Dr Rachel Gallyot.
- A detailed plan has been developed to support the provision of strong clinical leadership at the centre of ICS decision-making. The plan is built around 3 core areas of work:



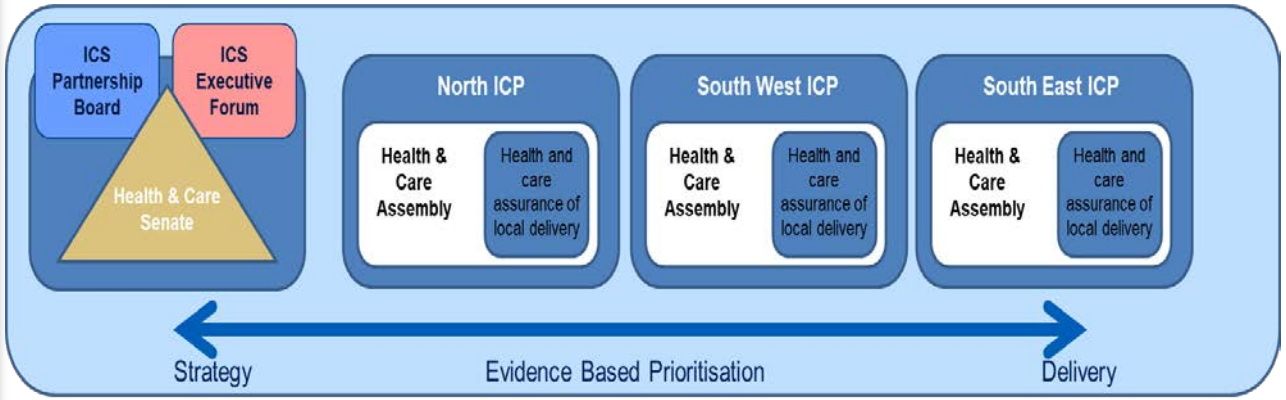
Engagement

- The H&CS is multi-disciplinary and inclusive of representation from across health and social care, comprising representatives from Social, Primary and Secondary care clinicians as well as representatives of Local Authorities and senior doctors and nurses. The H&CS meets monthly with the frequency of meetings having been increased in response to Covid-19; demonstrating the strength in working together across the system as health, care and clinical leaders
- The H&CS is supported by three affiliated, place based Health & Care Assemblies. Initially the vision was of a single sub-group Assembly for the system. With the development of the three ICPs, the reality is that each ICP will form a local Health & Care Assembly affiliated to the H&CS.
- Clear strategic direction and prioritisation by the H&CS will enable the local Assemblies to lead, support and deliver clinical decision making at ICP level. The Assemblies are inclusive of a wide-range of health, care and clinical professionals who can assure the local delivery against the system strategy a prioritisation that they are affiliated to.
- Primary, Secondary and Community Care, Mental Health and C&YP Networks are integral to the H&CS and Assembly structures. the H&CS will co-opt members of these assemblies to provide specific expertise to assist with its work.
- The H&CS and Assemblies are powerful forums for harnessing the energy and expertise of health, care and clinical professionals across the system.

The Role of the Health and Care Senate in the ICS Partnership Board

Clinical and Professional Leadership

- The relationship between the H&CS and the ICSPB is crucial and symbiotic. The H&CS is represented directly on the ICSPB by its Chair and Vice-Chair, with a defined system function in clinically supporting the Board.
- The H&CS will provide clinical scrutiny of proposed developments from the ICS and, in addition, a conduit, ensuring that the views of professionals from across the system are communicated and well represented.
- The Chair or Vice-Chair of the H&CS will provide clinical representation at the Executive forum.
- The H&CS provides a clear link to the ICPs, through each Health and Care Assembly.
- Engagement with the ICSPB, and the level of clinical influence and visible effect on strategy decisions, will sustain the full support and involvement of senior professionals. This input is vital to the ICS, in order to ensure that the right decisions are made early, and to satisfy the important requirement for health, care and clinical engagement.



- In order to ensure that this relationship is strong, the following points are key:-
  1. The Chair and Vice-Chair of the H&CS are co-opted onto the Executive Forum and ICSPB
  2. Any major area of strategic work undertaken will have health, care and clinical involvement with representation agreed via the H&CS and Assemblies with additional input as required. All final documents and/or developments before they are agreed by the ICS Partnership Board will go through the H&CS as a mandatory gateway process
  3. The H&CS has the delegation to refer clinical matters, which it deems significant, to the Executive Forum and ICSPB;
  4. The H&CS is used to provide reviews of services across the system, utilising expertise from within the Assemblies;
  5. The H&CS works with Executive Leaders across the system and is integral in the development of clinical strategy.
- The developing structures described are well defined, guaranteeing strong clinical and professional input. This provides a broad range of expertise and ensures strong linkage between health, care and clinical professionals and the ICSPB.

Clinical and Professional Leadership

Tackling Variation across the System through Clinically Led Strategy and Prioritisation

- The H&CS is responsible for the development of clinically led strategic developments that will inform the ICS strategic direction considering:
  - Standing Items: The H&CS discusses the current health, care and clinical positions of Primary, Secondary and Community Care, Mental Health, Children & Young People and other health and care professions, offering independent strategic and objective health and care advice that is based on evidence, best practice, data intelligence and robust understanding of population health needs
  - Emerging & Time Critical Issues: The H&CS is an essential forum to get quick health, care and clinical representation. This has proven invaluable during the Covid-19 pandemic in matters such as:
    - Discussion and agreement around the legality of End of Life care
    - Local trust clinical assessment of referrals and how these are prioritised
    - Urgent pathway reviews, i.e. paediatrics
  - Proactive Development of the System Agenda: The H&CS will lead on the most urgent and top clinical priorities across the health and social care system that are informed by population health management.

Leadership and Cultural Change

- The model of health, care and clinical professional leadership has the key enablers to provide broad and robust delivery for the system. The H&CS is already operational and will evolve with the development of the ICS.
- The structure provides strong and clear linkage between the health, care and clinical providers and the ICSPB. This provides real influence to a wide group of health and care professionals, which is a key requisite to ensuring their continued engagement. The governance structure is multidisciplinary, with engagement from all spheres of health and care as well as social care and clinical professionals
- There is ongoing leadership development of the health, care and professionals, to ensure these individuals are equipped with the skills to drive and lead the health, care and clinical strategy across the system.

Progress To Date

Governance & Engagement

- Resource to support the H&CS functions and work programme is confirmed and providing input. The levels of resource and skills required will continue to be reviewed to ensure that there is sufficient capacity in place.
- The H&CS Terms of Reference have been approved and the meeting format and a proposed annual business cycle developed.

Health & Care Strategy

- During Covid-19 the H&CS has already begun to provide an essential function to get quick health, care and clinical representation on emerging time critical issues.
- The evidence based prioritisation framework has been developed and agreed
- The readiness phase to receive PHM as a tool to develop strategy has commenced.
- The PHM readiness phase has been presented at the H&CS.

- The system approach to PHM is outlined further in the strategic commissioner development section.

Becoming a Mature H&CS

- The H&CS has utilised the format of the ICS maturity matrix to critically assess its current position. This has been used to plot and develop its path to becoming a mature H&CS for Staffordshire and Stoke-on-Trent.
- A self-assessment of the leadership state of maturity will be undertaken on a quarterly basis.

Integrated Care Record (One Health & Care) Summary

- Staffordshire and Stoke-on-Trent have a live Integrated Care Record Solution, which is already well populated with data from partner organisations and provides the foundation upon which to build integrated care tools and enhanced data to improve health and care for the local population.

- We are active members of the Local Health and Care Records Group across the West Midlands and accordingly are committed to sharing the data in the Integrated Care Record with partners across the region through the LHCR programme. Our close collaboration with Shropshire, Telford and Wrekin STP will see the Staffordshire and Stoke-on-Trent ICR shared to create a single integrated care record covering both regions, which will prove especially useful for MPFT who provide services in both areas.

- The requirement for an ICR was identified in our original Digital Roadmap submission in the autumn of 2016. The procurement process used the HSS framework and a contract award was made to Graphnet / System C in July 2019. An implementation project began in September 2019 and the ICR achieved full Go Live status in August 2020.

- All of the ICS provider Trusts, both Local Authorities, WMAS and all 150 GP practices are partners in the ICR resulting in a comprehensive health and care record.

- An outline roadmap has been developed which will see further datasets added, additional users from within the Health and Care Economy connected and a range of new and exciting features being made available.

- The diagram summarises the organisations and data that are presently live, the future datasets that are currently in development and further features to be implemented over the coming months. The roadmap is presently being prioritised by the Digital Clinical Advisory Group and the Digital Design Authority before being turned into defined work packages for delivery.

Shared Care Record (One Health & Care) Delivery Plans

- University Hospitals Derby and Burton have commenced their data-sharing project following delays due to resource issues around the response to Covid-19. These delays continue although data is expected to be integrated into the solution from January 2021.
- Social Care data for Children will commence in early 2021 as there are dependencies on Staffordshire County Council system upgrades
- Community Data: MPFT are dependent on system upgrades to enable data flows for Community data, which will follow in 2021 once the two community systems in MPFT have been merged.
- User access: All main partners (with the exception of UHDB) are enabled to access the Shared Care Record. Further developments access will be deployed in further care settings such as hospices, care homes and NHS111 provider.
- Personal Health Record: The project has agreed the scope for the Personal Health Record, which is a mobile app, and website, which will empower patients/service users to manage their conditions and support wellbeing. Features include viewing appointments, medication and correspondence. Individuals will be able to record information such as weight and mood; there is the ability to link smart devices to include heart rate etc. An initial version of the app is expected to go live in February 2021 accompanied by a roadmap detailing when additional functionality will be available.
- Care Planning and end of life: The project team are working with the RESPECT collaborative group to explore how the solution can support the national standard. Currently the information is paper based with various local processes, which uploads copies to partner organisation local system. The requirement is to make the most up to date information available to all those involved in the individuals Health and Care provision. Once the latest version of the RESPECT document is finalised by the Resuscitation Council this will be loaded into the solution and deployed.
- Business Intelligence Tool: The project team are working with UHNM Lung Screening Team to identify the initial cohort of patients who meet the criteria to be part of the screening programme to pilot the BI tools. The Project Team are exploring the wider use of the solution with Information Governance Colleague to ensure all aspects of secondary use of data is understood before a wider role out is planned.
- Regional Expansion: Staffordshire are working really closely with our neighbours to breakdown the digital boundaries of the Shared Care Record. Most advanced is in Shropshire, Telford and Wrekin where the current Shared Care Record will be expanded to include Health and Social Care partners from within this area. Black Country discussions are underway to establish the most appropriate way to share data into the record.
- Information Governance: The current IG articles will be expanded both the include a wider range of organisations into the agreement but include further uses of the data specifically the secondary use of data to support health analytics.

Detailed maturity self-assessment and development plan against the five domains

Introduction: Maturity Matrix Self-Assessment

- The system took part in an ICS development programme in July 2019. At that point the system completed the self-assessment against the ICS Maturity Matrix.
- An initial gap analysis was undertaken to map the current system position against the maturity matrix and the July 2019 assessment. This forms the basis of the development needs that have been identified by the system to ensure that there is progress made towards the 'Thriving ICS' ambition.
- A stock take of our current position demonstrates that good progress is being made against most elements of the maturity matrix.
- The system has demonstrated an improved ability to work collaboratively as part of the Covid-19 response. Being part of the region wide review on lessons learnt has facilitated the system undertaking its own review to help support the process.
- Further work is being undertaken to map these development needs against the 5 workstream areas to ensure that there is comprehensive coverage.
- The following section provides a description of the progress made in accordance with the maturity matrix along with development points, owner / resources and timelines.
- In contrast to the previous assessment all domains we have assessed our progress against against the "thriving" characteristics, with actions identified to achieve this level of maturity.

Domain 1: System Leadership, Partnership & Change Capability

Themes	Progress	Development Points	Owner / Resources	Timeline
Strong collaborative and inclusive system leadership and governance	• ICS Independent Chair appointed and in place. • H&CS established at ICS level mirrored at ICP level by Health and Care Assemblies. • Clinical and professional leadership is readily accessible to the ICS Board, establishing early and ongoing clinical input into system strategy and delivery. • A health inequality executive at board level within each organisation and a system inequalities lead. • Focus on inclusivity and diversity at senior level in our workforce is a priority of the system workforce group. • Established commitment to the three ICPs , each with leadership and governance in place which has been developed on inclusive basis, including key partners and stakeholders • CEO leadership to ICP development supported by an Executive programme lead. • System wide ICP Programme Board in place to coordinate activity to support ICS roadmap.	• Independent Chair to work with ICS leadership team to put in place ICS governance in order to transition from the shadow ICS Shadow Board. • The H&CS is currently revisiting its terms of reference, identifying the role of clinical and professional leadership and the senate at a system level; and the role of leadership and assemblies at the ICP/Place level and developing work programme. • An OD plan to support system and place clinical and professional leadership. • ICP Visioning Documents, Partnership Agreements and Delivery Plans to be signed off.	STP Exec Forum	Feb 2021
Shared system vision and objectives	• Overall ICS vision as set out in the FYDP. • The H&CS has agreed an approach to identify the system clinical priorities. • Developing outcomes frameworks at both the system and programme level • The FYDP and ICS Roadmap 2020 sets out commitment to an ICS supported by an ICP model of delivery. • Each ICP identified 6 priorities during Summer 2020 which have been shared with the ICSPB. The ICPs have been working to deliver these through their current governance arrangements.	• Refresh and reframe the Vision and System Objectives, overarching strategy and strategic priorities in the FYDP post Covid-19. • The PHM team will continue to work with the H&CS focusing the areas outlined in the FYDP into a set of priorities based on population need. This will then be used to develop a system level strategic and outcome framework and form the basis of the strategic commissioning framework.	STP Exec Forum	April 2021
System transformation partnership and engagement	• The system has captured the learning and service changes resulting from Covid-19 and are using this to understand the opportunities for transformation as part of recovery. • Organisational phase 3 plans were used to support the development of recovery plans at the system and ICP level • The system has actively engaged with the population and used focus groups for specific patient groups to understand how the changes during Covid-19 have impacted on our population. • The ICPs have developed on the basis of inclusivity and are supported by governance and servicing arrangements • Each ICP has an aligned Director of Strategy to provide the connection back to individual organisation and system wide transformation activity.	• Developing outline proposals for major service change as a result of Covid-19 and feeding those in to our transformation work. • ICP Delivery Plans will include a communication and engagement plan to support delivery. • At ICP level strengthen the involvement of patient and voluntary groups.	ICS Leads ICP Leads	April 2021 March 2021

Domain 1: System Leadership, Partnership & Change Capability

Themes	Progress	Development Points	Owner / Resources	Timeline

Capacity and system transformation change capability	• System performance and assurance report developed based on system strategic and recovery priorities.
	• A Transformation Delivery Unit is in place that supports our transformation agenda.
	  • Projects are aligned to the FYDP and Phase 3 recovery plan
	  • Standardisation has been applied to our programmes and projects including reporting and oversight
	  • Project management discipline has been deployed against system priorities reporting into our system SFP and providing oversight on programme delivery
	• System:
	  • Commitment to ICP model of delivery with oversight through the ICS Roadmap and CEO leadership to the 5 priority areas identified
	  • ICP development has been co-designed with the strategic commissioner programme of work to ensure alignment of future models
	• Place:
	  • Three ICPs established with defined geographical footprints
	  • Cross- organisation work between health and social care partners delivered on ICP priorities identified throughout Summer 2020
	• Neighbourhood:
	  • 25 PCNs in place
	  • PCNs and Local Authority locality approaches have been critical to the development of the ICPs to date
		• Achieve a single CCG covering the STP footprint by April 2022.
		• Implement the plan to deliver a Strategic Commissioner function
		• Working to increase the provider level data from out of area acute providers, community care and primary care to improve the impact of the system assurance report
		• PHM work stream and programme work streams are working on developing outcome frameworks linked to the Phase 3 recovery plans and FYDP.
		• Development of ICP delivery plans which set out priorities for action
		• Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms
		• TDU capacity to be reframed and enhanced to support local ICP delivery and place based transformation – system wide PMO capacity and capability
		• Transformation projects to be rebased following refresh and reframe of the Vision and System Objectives, overarching strategy and strategic priorities post Covid-19
			Strategic Commissioner
			
			ICP / ICS Leads
			
			ICP Programme Lead / CCG CFO
				April 2022
				
				March 2021
				
				December 2020
				
				April 2021

System culture and talent management	• Increasing diversity in senior positions is a priority for the system workforce group • Leadership development programmes: High Potential Scheme pilot leading the way nationally in pilot programme. Winter Inclusion school guest speaker and programme of sessions agreed, Cultural Racial Inclusion development programmes • A range of Stepping Up, Stepping up Alumni, Reverse Mentoring, Pilot ICP Programmes in place • A capability and capacity review of analytical/intelligence resource has been undertaken in the system to support development of PHM	• System workforce group co-ordinating across organisations to increase the diversity of workforce in senior posts • An integrated intelligence group to develop analytical and intelligence skills across the system	People Board	March 2021

Domain 2: System Architecture and Strong Financial Management and Planning

Themes	Progress	Development Points	Owner / Resources	Timeline
System architecture and oversight	• An interim governance structure based on 'function' has been established. • Sub-committees that have been formed enable the dual role of an ICS to be fulfilled and ensure that there is full partner engagement in all of this work. • System Performance and Assurance Working Group (SPAWG) set up to bring together an integrated provider and system view of performance and the key issues and actions for the system. • ICPs have been established and have been operational for several months working to deliver self-identified priority areas.	• Increase the provider level data from out of area acute providers, community care and primary care to improve the impact of the system assurance report. • System integrated Intelligence group and the SPAWG are working on the development of a system level dashboard and outcomes framework. • Digital Board development to aid the progression from a voluntary collaborative group into being a key part of the governance structure of the ICS.	CCG DoS ICP SRO	March 2021 March 2021

Streamlined commissioning arrangements	• A confirmed and finalised CCG merger timeline and roadmap.
	• A detailed plan to support delivery of the Strategic Commissioner Development particularly in relation to
	  • the functions delivered at system level by the strategic commissioner.
	  • a work programme on how current commissioning functions are part of ICP functions.
		• Developing a programme for further expansion of integrated commissioning with the Local Authority.
		• IFR and the funding arrangements utilised during Covid-19 are being used to reconsider the future role of commissioning.
		• Collaboration between ICP and strategic commissioning functions to determine nature and scale of locality commissioning support to enable ICP delivery.
		• Develop an approach for planning and delivery of specialised services as locally as possible, joining up care pathways from primary care through to specialised services with the ultimate aim of improving patient outcomes and experience.
			Strategic Commissioner	September 2021
				
				March 2021

System control totals, operating plans and financial risk sharing	• Implementation of Intelligent Fixed Payment (IFP) arrangements in 2019/20, and agreed these in shadow form in 2020/21 prior to the Covid-19 financial regime. • A System Capital Prioritisation Group, to review and prioritise capital plans across the system. • A system approach to developing plans (Phase 3, FYDP, system savings plans etc.) that involve strategy, finance and operational directors.	• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets taking on board the learning from Covid-19. • Directors of Strategy to take the leadership on development of the system wide plans (eg Phase 3, operating plans) • Development of the system/provider capacity/demand models to prioritise system actions and resource allocation. • Involvement of ICPs in development of system-wide financial strategy and schemes to support recovery to balanced financial position over the medium terms.	ICP Programme Lead / CCG CFO / System DoS	March 2021
System wide financial governance and cross-cutting strategies	• A System Strategy, Finance and Performance group in place ensuring collective overview and ownership of current system position and plans. • A System Finance Director Group , with supporting infrastructure in place. • TDU established to support system efficiency opportunities.	• A financial strategy that articulates how the system and the organisations within it will deliver the financial objectives and targets taking on board the learning from Covid-19. • Development of system approaches to system savings. • Delivery programmes are in place but will need rebasing.	System DoFs	March 2021

Domain 3: Integrated Care Models

Themes	Progress	Development Points	Owner / Resources	Timeline

Population health management	• Developed an integrated intelligence function during Covid-19 that includes involvement from all organisations this has supported:
	  • Development of Covid-19 population models
	  • Capacity and demand modelling
	  • Population data on outbreaks and on the demographic distribution of Covid-19 admissions
	• An established system H&CS which has health inequalities and PHM as one of it's core priorities ensuring that inequalities are a key issue for wider clinical leadership groups.
	• A process for PHM based prioritisation at the system and place level
	• An initial work plan for the next six months.
	• Supporting the system understanding on health inequalities and the development of the inequalities work streams.
	• Active involvement with the NHS England regional team and PHM programme, and use of external experts Milliman, which supports the development of PHM capacity and capability across the system.
		• Population health management tools that can be used at system and place level.
		• Digital and PHM work streams continue to collectively work on data sharing protocols
		• Working with the H&CS and the system PHM group on developing a PHM Strategy and work programme for 2021/22.
		• Developing work on understanding the use and impact of CCGs inequalities funding on health inequalities.
		• Develop a plan to address the deficits identified as part of the Capability and Capacity review of functions.
		• Working with the integrated intelligence group on single population/clinical data sets for use at system and place level.
		• Work starting to develop primary care intelligence and PHM programme.
		• Development of system PHM infrastructure that can support ICP level needs analysis.
			ICP Programme Lead / CCG Director of Strategy	March 2021

Long term plan - care models and service changes	• Covid-19 has resulted in cross organisational system working on:
	  • Care homes
	  • Community care models
	  • Discharge and admission avoidance
	• All service changes as a result of Covid-19 have been captured, have QIAs and EIAs and are being used to inform the FYDP service change models/opportunities
	• There is an agreed overarching model of care and support outlined in the FYDP.
		• Consider which service changes made as a result of the response to Covid-19 need to be built into the FYDP service change models
		• For 2021/22 partners will be reinvigorating the System Objectives, overarching strategy and strategic priorities in the FYDP post Covid-19.
			Directors of Strategy	March 2021

Redesigning outpatient services and using new technologies and digital advances	• Rapid uptake of digital consultation in primary care – including video consultations. • Radical transformation to none face to face consultations across all sectors. • All system partners have deployed virtual technology during Covid-19.	• Embedding of change in practice and exploiting further opportunities for transformation e.g. patient initiated follow up.	Planned Care Cell Digital Board	March 2021

Domain 3: Integrated Care Models Continued

Themes	Progress	Development Points	Owner / Resources	Timeline
Development of Primary Care Networks	• ICPs have been developed with PCNs at their heart and PCN representatives are fully involved in each of the three ICPS. • An agreed Primary Care Strategy is in place. • 25 PCNS in place each with Clinical Directors.	• CCG Primary Care support to PCN Development to include link to ICP development to support PCN CDs to contribute at wider system level. • PCNs currently working on the Delivery of Enhanced services specification. • The CCG is refreshing the GP strategy post Covid-19, focusing on embedding the primary care operating model, continuing to support an expansion of the workforce, focussing in on cutting bureaucracy, refocusing QOF, and making more funding available. • Deliver development plan with PCNs: this is currently being refreshed and relates to the leadership and development of PCNs.	ICP Programme Lead / CCG Director of Primary Care	March 2021
The prevention agenda and addressing health inequalities	• Our system Phase 3 recovery plan set out a clear commitment to tackling inequalities including population analysis of Covid-19 admissions. • Development of a system prevention group and work programme. • An inequalities strategic oversight group has been established in the STP, involving clinical and public health expertise to bring together the inequalities and prevention work streams. • A health inequalities expert group. • Inequalities identified as a key priority and work programme by the H&CS • ICPs progressing delivery of 6 areas of priority, including a focus on reducing health inequalities and promoting the prevention agenda. • A bid is under consideration by the regional Health Equality Partnership Programme.	• A system inequalities and prevention programme of work focussing on actions that mitigate the impact of inequalities and help take pressure off services by supporting people and communities. • Work to be undertaken to improve healthcare recording of demographic and inequalities data • Work on understanding the use and impact of CCGs inequalities funding on health inequalities • Work with LAs and Voluntary sector on community approaches to prevention • Developing the social prescribing/interventions within PCNs. • Developing risk stratification approaches to identify pathways where health inequalities are important. • Development of inequalities metrics as part of the system outcomes framework • Continue work with LA public health leads to ensure that the Phase 3 and FYDP prevention agenda is linked to the wider health inequalities and prevention agenda via the Health and Wellbeing Boards. • Develop the system level strategic framework and system operating plan to include clear objectives around health inequalities. • Development of system wide PHM infrastructure that can support ICP level needs analysis.	ICP Programme Lead / CCG DoS	March 2021
Workforce models	• Long-term workforce planning across the system has taken an 'open book approach' through development of the FYDP and Phase 3 recovery plan, with all providers engaged in the process and sharing their workforce projections across the system. • Arrangements for mutual aid in place and effective during Covid-19	• Review of integrated workforce models post Covid-19, with opportunities for new roles and ways of working to be embedded.	People Board	March 2021
Personalised care models	• System partners are working with local authorities to deliver personalised care.	• Continued development of the long-term conditions pathways and specific operational areas such as wheelchairs, continuing healthcare. • Work with local authority to implement an integrated PHB offer.	Joint Commissioning Board	March 2021

Domain 4: Track Record of Delivery

Themes	Progress	Development Points	Owner / Resources	Timeline
Evidencing delivery of LTP priorities and service changes	• The system Phase 3 recovery plan was built on and around our FYDP priorities. • During summer/autumn 2020 further engagement was undertaken with local community groups, to understand their experiences during Covid-19, including discussion of future priorities. • All of the Covid-19 service changes have been reviewed against the FYDP ICP priorities have been cross referenced against the FYDP. • Delivery of priorities designed, developed and delivered through individual ICPs to support maturity and build tangible evidence base for added value enabled through ICPs.	• Use learning to inform transformation against an agreed methodology to consider whether in accord with the FYDP areas should be developed further as permanent service changes. • Continue the work with the H&CS to develop the clinical priorities supporting the FYDP. • Maintain focus on main priorities in the Phase 3 recovery plan. • Further development through ICP Delivery Plans which will include assessment of alignment to FYDP including evidence base of case for change.	ICS / ICP Leads	March 2021
Delivery of constitutional standards	• Strong system delivery of mental health standards. • A system assurance framework. • Recognition of areas e.g. urgent care where the system have struggled to meet emergency care standards. • Significant progress in delivery of cancer standards. Acute Trusts working through cancer hub to ensure opportunities for mutual aid are exploited. • Extensive data validation has reduced the number of patients waiting for elective care. • Good use of the independent sector with system wide plans for utilisation from January 2021.	• Focus on delivery on of the trajectories in the Phase 3 recovery plan. • Use Phase 3 recovery plans as a platform from which to deliver the constitutional standards.	ICS and ICP leads	March 2021
System operating plans	• An agreed FYDP that was determined ready to publish pre Covid-19. • For 2021/22 started to develop system level strategic framework design and delivery groups for the system operating plan.	• Directors of Strategy to support the development of the system operating plan in conjunction with ICP leads and the H&CS. • ICPs will become the 'engine rooms' of delivery for transformation and integration of health care pathways that harness expertise of Providers in translating plans into action	ICS and ICP Leads	March 2021
Challenging systemic issues	• Improved relationships through previous winters and in response to Covid-19 has given system partners the opportunity to work collaboratively to address systemic challenges • Significant evidence of co-production and co-delivery e.g. Care Homes • Covid-19 has focused the system to work collaboratively in providing joined up care. • As part of the our EPRR response a daily call is in place for leaders to address emerging issues in responding to Covid-19	• Confirm ICS role in developing provider relationships and alliances to system wide models of care (end to end pathways.) • Improved intelligence to support real-time demand and capacity modelling	ICP SRO	December 2020

Domain 5: Meaningful Geographical Footprint

Themes	Progress	Development Points	Owner / Resources	Timeline
Do you have a meaningful geographical footprint that respects patient flows and, where possible, is contiguous with local authority boundaries or have clear arrangements for working across local authority boundaries?	• Whilst geographical boundaries of the ICS do not respect patient flows the footprint of the ICP's create a closer alignment. • ICS and ICP boundaries reflect local authority boundaries with good engagement at all levels of the ICS and ICPs, including opportunities for District and Borough Councils to engage at ICP level. • ICPs cross local authority boundaries, though this is recognised, with clear arrangements in place for cross boundary working. • The upper tier Local Authority boundaries are coterminous with the boundary of the proposed ICS • The proposed single merged CCG boundary coterminous with the ICS boundary	• Engagement with major out of area acute providers and neighbouring STPs to ensure inclusion in system and ICP development work • Developing partnerships with Staffordshire County Council and Stoke-on-Trent City Council, and the VCSE sector.	ICS Lead	December 2020 Ongoing

Summary

- This plan sets out the work that has taken place in order to support the ICS development across Staffordshire and Stoke-on-Trent and progress against key operating requirements.
- The ICS development plan does not exist in isolation though. It is essential that this document is read in conjunction with-
    - The Five-Year Delivery Plan for Staffordshire and Stoke-on-Trent
    - The Phase 3 Recovery Plan
    - CCG Merger Project Plan
- As such, this plan helps to facilitate and support a change to the way that the system works to meet the changing needs of the population. Simply, it is not an end in itself.
- Equally there has been considerable learning from how partners responded to the initial impact of Covid-19 and the subsequent ongoing response. This plan looks to capture and build on this learning in order to find ways to embed the improved ways of working and collaboration.
- As system partners we demonstrated that during the Covid-19 we could respond by implementing and executing plans quickly and effectively. We need to carry this forward into our approach to delivering transformation.
- There is an exciting opportunity emerging around the approach towards truly integrated place-based care and the development of our ICPs. It remains early days with some of this work but there is a strong commitment from all partners to make this happen and for it to change how we deliver care to the population that we serve.
- In recognising the positive steps that have been made, there is a clear and coherent view on the next steps and the associated key risks. In producing this development plan, it has highlighted a number of areas where there is further work required if we are to deliver on the benefits of being an ICS.
- The ICS Partnership Board will have oversight of this process and the small steering group will progress the agreed actions. This will report through into the Exec Forum, but each CEO is expected to keep their own organisation fully informed of the progress being made and the associated risks.

Appendices

Case Studies and Patient Stories

Case Study: What is different about an ICP? Developing an Asset Based Approach

- The transition to an Integrated Care Partnership approach provides a fundamental opportunity to place a new emphasis on the strengths and assets of our communities and open up new ways of thinking about improving health.

- By adopting an 'asset based' approach, the ICP can make visible and value the skills, knowledge and connections that already exist in our communities and build on locality-focussed identities and groups. Working with patients and community groups, the ICP will empower people with the confidence to look after themselves and take control of their own health and care needs, thus help to prevent or delay ill-health in the longer term.

- We have commissioned the National Development Team for Inclusion (NDTI) to support us in the development and delivery of a Community Led Support (CLS) programme

- The CLS programme involves selected local authorities and health and social care partnerships implementing a new way of delivering community support. It brings innovation to how services are delivered; designed and driven by practitioners along with local partners and members of the community they are serving.

- There are a number of key principles that have been recognised as guiding this work;
  - Co-production brings people and organisations together around a shared vision
  - There is a focus on communities and each will be different
  - People can get support and advice when they need it so that crises are prevented
  - The culture becomes based on trust and empowerment
  - People are treated as equals, their strengths and gifts built on
  - Bureaucracy is the absolute minimum it has to be
  - The system is responsive, proportionate and delivers good outcomes

- The programme also provides access to a strong national network to enable sites to share experiences, learning, tools and ideas and address common challenges.

Community Led Support Programme Progress

- The programme is coordinated through the Assistant Director of Adult Social Care and offers a tangible commitment of the ICP to work in true collaboration across Local Authority and NHS boundaries.

- To date 20 community conversations with over 100 groups have been held to shift the emphasis away from 'what is the matter with you' to 'what matters to you'. A clear area of priority emerging through the conversations was a CLS approach to redesigning 'front doors' of service access including acute hospital, community and social care

- Learning from experience of introducing CLS change elsewhere, the focus will initially be on two 'innovation centres' within Stoke-on-Trent to mobilise CLS change at locality/neighbourhood level

- A focus on Community Wellbeing Teams and redesign of the Front Door utilising Social Care First Contact Teams and Social Care Community Teams based in community venues alongside partners to drive contact and communication with residents in the community. Establish a Community Front Door in order for residents to access help through the community as a method of supporting early and intervening with appropriate support.

- Good progress has been made in a short space of time and the next steps include:
  - Innovation Team to meet prior to Christmas break
  - Communication content to be agreed and distributed
  - Local Community Organisations contact to be made and a community meeting pulled together for the new year.
  - The geographical boundary is currently being developed and will be ready for the new year.
  - Planning for Change and Signs for Change workshops have been scheduled week commencing 11th January 2021.

Case Study: NHS Continuing Healthcare Fast Track Pathway - Integrated Working with Partners

- As of the 1st September 2020, the NHS Continuing Health Care (CHC) Framework restarted, including the reintroduction of NHS CHC Fast Track. To support this, the sourcing of Fast Track packages at home transferred to the CHC Team within the Midlands and Lancashire Commissioning Support Unit from 24th August 2020.
- Guidance mandates that the CCGs should consider the delivery of end of life care in the context of the *Hospital Discharge Service: Policy and Operating Model*. The guidance also defines the importance of the function of community referrals from a single point of access that retains responsibility for overseeing communication with the system.
- The guidance does not define the six week funding for any specific patient cohort or clinical need and therefore there was an opportunity to consider Fast Track/ End of Life Care Pathways, both in terms of admission avoidance and hospital discharge to ensure individual's needs are met safely, in a timely manner in their preferred place of care.
- There is recognition that to meet the national guidance current pathways require improvement.

Challenges

- Inconsistent wrap around provision across the Staffordshire and Stoke-on-Trent footprint for fast track patients to receive care and support to meet preferred place of care (home) in a timely manner.
- Delays/issues are experienced with timely identification of fast track patients leading to increased length of stay in hospital and deconditioning.
- The fast track process does not currently meet the requirements to support same day discharge as per the national discharge guidance.
- No current function in place to commence packages of care over a 7 day period.

Revised Pathway

- The overarching principle of this pathway is to support individuals who would ordinarily meet NHS Continuing Healthcare Fast Track criteria to receive care and support in a timely manner to prevent a hospital admission or facilitate hospital discharge. The pathway will provide
  - Rapid step down care for individuals who meet fast track criteria
  - The ability to support individuals who are in the community who require rapid intervention;
  - Standardisation & equity of care provision through a single point of access;
  - Building trust, up-skilling across organisations & strengthening of clinical expertise within the community;
  - Training and education;
  - Completion of care assessments at home and support patients to achieve their preferred place of care/ death.

Integrated Approach Across Partners

- Patients will be supported based on assessed need by Midlands Partnership NHS Foundation Trust (MPFT) community staff; this will include both personal and clinical care as required.
- Onward referral to other services such as Hospice at Home will be facilitated through the Palliative Care Co-ordination Centre and community services
- The Hospices (Douglas MacMillan, Compton and St Giles) have worked collaboratively with the CCGs and MPFT to enable them to provide an enhanced offer of provision and to support the implementation & mobilisation of this pathway.

Anticipated benefits

- Opportunity to work with Hospices to support future commissioning arrangements/ models of care.
- Quality and patient centred response.
- Reduced delays in discharge/prevention of unnecessary acute admission.
- Minimal hand off.
- Clear lines of responsibility and governance.
- 7 day working 9-8.
- Opportunity to undertake change management approach, learning as we go, developing the process as it is rolled out.

Case Study: Staying Well Service (SWS)

- Responding to Frailty is one of the key transformational elements which underpins delivery of the NHS long term plan. The ambition locally is to develop new services for older people to proactively manage frailty and associated system consequences.

- The Staying Well Service (SWS) was co-designed with partner organisations including CCGs, GP practices, mental health and community trust, acute trusts, voluntary sector and GP Federations. Extensive stakeholder engagement resulted in a 12 week pilot which was evaluated and learning was used to inform further roll out.

- The Staying Well pathway uses a proactive population health approach, utilising system partners to enable earlier detection and planned interventions to prevent or delay progression to severe frailty. It can help to identify undiagnosed disorders such as heart failure or potential impacts of Covid-19 (both physical and mental) as well as supporting social inclusion using local support networks, communities, and the voluntary sector.

- During the first phase of the pathway, the model involves primary care identification of patients with mild-moderate frailty, using a combination of risk stratification tools, in some areas the model also includes a multi-disciplinary team meeting between the GP Practice and a Staying Well Facilitator to discuss individuals identified by the practice.

- Patients identified are then referred to a single point of contact, within a community provider, who maps which services the patient is currently engaged with. A Staying Well Facilitator (SWF) follows this stage with a home visit or a booked telephone call to complete a holistic assessment of the patient's needs. The patient can then be:
    - Case managed by a SWF; and/or
    - Referred into a commissioned service as appropriate.

- The second phase of the pathway, includes referring the most vulnerable patients to a Staying Well Hub where a multi-disciplinary team, including a consultant, therapist (addressing occupational therapy and physical requirements), memory services, prescribing pharmacist and community connector (a voluntary sector role to address social isolation), decide which professionals needs to see/speak to the patient, contribute to the individuals assessment and co-produce an action plan.

- This will then be communicated to the patient, tracked after attendance to ensure delivery, and communicated back to primary care.

- The service is currently delivered in South East Staffordshire and Seisdon CCG, Stafford and Surrounds CCG and will be rolled out to Cannock Chase CCG

- The SWS enhances coordination of care for the population and working this way means:
    - More care in people's homes and in their local neighbourhoods
    - Person-centred care (holistic), organised in collaboration with the individual and their carers
    - Better experience of care for people and their carers
    - Coordinated care that is pro-active and preventative, rather than reactive and episodic
    - Better value care and support at home, with less reliance on care homes and hospital based care
    - Less duplication and 'hand-offs'
    - Stronger, more resilient communities

- Work with front line teams has ensured colleagues from partner organisations feel like one team despite being employed by different organisations. The model is continually improving and with a 6 monthly Plan Do Study Act cycle in place.

- The service aims to contribute to the following system benefits:
    - Shared skills, information knowledge, expertise, and resources
    - Building strong trusting relationships across sectors & organisational boundaries
    - Building local connected communities linking with 3rd sector
    - Improving Population Health with partners, moving towards ICS
    - Delivering system priorities, recovery and planned costs out
    - Improved patient pathways and better outcomes

- Findings and recommendations from the Service evaluation will enable focus on key success factors for working in collaboration in the future, ultimately contributing to building a sustainable dynamic health and social care system.

Staying Well Service (SWS): Patient Story

Background of Case

- Referral sent by GP practice to the Staying Well Service Single Point Of Contact.
- Patient contacted same day to arrange assessment.
- Holistic Assessment by Staying Well Facilitator

- Patient lives alone in sheltered accommodation has been there for 21 years. Previously had a very active social life and lots going on at accommodation when she moved in. Accommodation is now supported living no meetings or groups in the building, all friends have moved out and patient feels very isolated.
- Past Medical History: Hypertension, Cataracts, Anxiety,

Identified Issues

- Poor vision due to cataracts so struggles to go far alone. Does walk into hospital ground 3-4 times weekly to sit on bench and talk with people.
- Mobility is deteriorating and now uses own stick, this appeared too tall in height.
- Is struggling to use bathing facilities at home and is at risk of falling. No aids in situ. Is independent with other daily living activities.
- Patient reports that she is concerned that her memory is deteriorating and is worried about this. Is low in mood and very tearful about the fact that life has changed and isn't as it used to be. Does not attend any lunch clubs or befriending groups as feels too low in mood.
- Son in 70's and has commitments with Grandchildren so cannot visit patient very often, however does food shopping on weekly basis.

Actions:

- Referral to Emotional Wellbeing Clinic for anxiety.
- OT saw patient in clinic and agreed to do a follow up home visit to complete a bathing and mobility assessment in own home.
- Voluntary Agency to locate social groups.

What difference did it make to the patient, their independence and wellbeing?

6 Week Review:

- Patient reports feeling more positive has Emotional Wellbeing Clinic appointment in 1 week.
- OT assessment has been very positive now has bathing aids and grab rails so life much easier. Has new walking stick at correct height and feels more confident.
- Has made contact with an afternoon group for natter and tea and has attended 1 session to date.
- Patient states that she feels supported and listened to now and feels more positive about life.

Has intervention been preventative?

- Early intervention by Occupational Therapist reducing risk of falls/injury and admission to hospital.
- Emotional support and allowing patient time to talk may have given her the confidence to link in with afternoon group, reducing social isolation.
- All services have been provided within a rapid time scale from referral to Staying Well Facilitator Anxiety, clinic and follow up
- All services have been provided within the patient's own local community
- Joined up working by Community Provider, GP, Acute Hospital and voluntary services

Case Study: Community Rapid Intervention Service (CRIS)

The proposed service model set out 2 components of a future Attendance/Admission Avoidance service, to support residents of care homes, frail older people and people with multiple LTC's, through engagement with senior acute and community health and social care practitioners in the Staffordshire system:

- **Unscheduled Care Coordination Centre (UCCC):** A single point of access as a viable alternative to ED/hospital attendance. Offering real time access to a senior clinician who will take responsibility for patient care. Referrers are treated as trusted assessors with rapid transfer of care. One Stop Shop where coordinators liaise with planned care services and arrange care as required
- **Community Rapid Intervention Service (CRIS):** A service which provides a two hour rapid clinical response to patients within their own homes. Offering assessment, diagnostics, prescribe and administer treatment, and ongoing review as an alternative to ED. A medical consultant lead multi-disciplinary team that ensures individuals get the most appropriate care. Right care in the right place, every time.

Healthcare professionals worked together to identify **several principles** that would underpin a future model:

- Our aim is to have one integrated model across our entire system (Pan Staffordshire).
- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to improve patient outcomes and experience through the prevention of avoidable non-elective emergency admissions
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- Personalised and timely care delivered within their usual place of residence
- Staff across organisations work together (co-locating where appropriate) to champion the 'home first' ethos.
- And the result of all these points - more people will remain and live more independently in their own homes.

Working this way means:

- Reduced pressure on the Emergency Department and hospital inpatient beds
- Reduced unnecessary admissions and decrease Healthcare Acquired Functional Decline (HAFD)
- Reduced level of deconditioning and increased dependency on Primary Care
- Improved patient outcomes and better experience
- No wrong door for someone that needs help.

The CRIS sought to measurably deliver the following outcomes:

- Reduction in non-elective emergency admissions to hospital by 4,173 per annum
- Equivalent to 22 admissions per day across the UHNM footprint
- Achieve £1.3m in efficiency savings
- Reduce ambulance conveyance by 20-25 a day

The service is **on track** to deliver the following outcomes by March 2021:

- Receive over 12,000 calls into the UCCC
- Accept on average 80 referrals a week from WMAS
- Complete over 6,500 CRIS patient visits
- Signpost/Refer approximately 1400 patients onto other Community Services
- Offer Clinical advice and support with clinical decision making for over 4000 patients
- UCCC will have prevented over 10,000 possible ED attendances
- CRIS will have prevented around 5,950 unnecessary hospital attendances/admissions following a patient contact

Community Rapid Intervention Service (CRIS) Patient Story

Background of Case

Frail 87 year old male with extensive co-morbidities presented as unconscious to District Nurses (DNs) on a routine visit.

Identified Issue

GCS was 3, with apnoeic episodes of 30-40 seconds. Likely massive stroke. NACPR in-situ but no ReSPECT form/ceilings of care in place, no palliative diagnosis and not expected to die imminently. Son was in London holding Lasting Power of Attorney for Health & Welfare. He was understandably distressed and requesting his father be conveyed to A&E.

Actions

West Midlands Ambulance Service paramedics attended, performed a full assessment, gathering the views of wife, son, care staff and DNs. They decided that although this gentleman was not in cardiac arrest he was clearly end-of-life and it was in his best interests to be made comfortable at home, with arrangements made for his family to be at his bedside.

A CRIS referral was made by the attending paramedics, and after discussions with the gentleman's son, he agreed his dad ought to be made comfortable at home.

An Advanced Clinical Practitioner visited, affirming the assessment made. A ReSPECT document and anticipatory medication to control any end-of-life symptoms, were put in place.

The gentleman's wife was able to attend to be with him and his son drove up from London.

In situations such as this, the easiest solution with the least resistance would be to convey the patient to A&E where he would have potentially passed away on a trolley, potentially after burdensome and invasive investigations/treatments.

It was a bold and brave decision to refer into CRIS and manage the gentleman at home, especially in light of his son's initial thoughts.

What difference did it make to the patient, their independence and wellbeing?

As a result of the referral the CRIS were able to put into place a clear plan for the gentleman to be managed comfortably in his preferred place of care, get the family including son on board and enable him to spend his final hours/days surrounded by his loved ones in a familiar setting.

Case Studies: Overcoming Challenges in Quality and Safety

Case Study 1 – Tissue Viability (Quality Assurance)

University Hospitals North Midlands (UHNM) observed an increase in pressure ulcer incidents reported during a three month period.

This increase was mainly related to Deep Tissue Injury. In particular there were six cases with potential infection transferred from the community.

In response to this Midlands Partnership NHS Foundation Trust (MPFT) and UHNM worked collaboratively to review the incidents and identify any key learning.

As a result of this joint review the two organisations have established a joint weekly review process that has enhanced communication and ongoing care for patients being transferred from one health provider to another.

Additionally MPFT have developed a patient information poster regarding risk factors associated with the development of pressure ulcers that has been shared with UHNM so that this can now be provided to patients on discharge.

Case Study 2 – Musculoskeletal and Community Physiotherapy Access Redesign North Staffordshire (Quality Improvement)

This work was facilitated by MPFT Quality Improvement Team and involved participants from MPFT, CCG, UHNM, Primary care, North Staffordshire Combined Healthcare and Keele University. Key elements of the work included:

- An away day training all attendees on QI, identifying opportunities to improve and looking at prioritising the major improvement work
- Progressing one of the priority areas around reviewing Access into the services.
- The development of a current state and vision the future state of how access might look, the aim is to reduce the wait times, standardise the access routes and to improve the operating consistency with the services to release capacity back into the services for clinical delivery.

Case Study 3 – Respiratory Pathway Redesign (Quality Improvement)

This work was facilitated by the CCG with support from MPFT Quality Improvement Team and involved participants from MPFT, UHNM, CCG, Primary Care, Staffordshire County Council and the voluntary sector.

The event was aimed at unifying and understanding where the cross cutting opportunities for improvement were.

QI principles were used to help frame the activities within the workshop which included a waste/values mapping exercise. This work is ongoing but currently paused due to Covid-19.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

CONFIDENTIAL – NOT FOR ONWARD CIRCULATION

Communications and Involvement Plan

Contents

*NOTE: This document has been prepared to support the Pre-Consultation Business Case for Inpatient Mental Health Services previously provided at the George Bryan Centre. This document is in DRAFT form, setting out **potential activity** in the event further public involvement is required following the completion of the Business Case and the Assurance process.*

This document follows previous communications and engagement (C&E) plans for the inpatient mental health services previously provided by the George Bryan Centre in south east Staffordshire. The contents are subject to discussions following the assurance process – the document sets out two anticipated scenarios and will be updated to reflect the required activity once known.

Background

Following a fire in the West Wing of the George Bryan Centre, Tamworth, in February 2019 – inpatients of the West Wing were transferred to St George's Hospital in Stafford. The decision was also taken by the Midlands Partnership NHS Foundation Trust's (MPFT) Board that the 12 inpatient beds on the East Wing supporting older adults should also be temporarily closed due to clinical safety reasons.

This closure impacts on two services:

- Acute inpatient for functional mental health illness for working age residents (18+) – currently transferred to St George's Hospital in Stafford

- Inpatient beds for older patients (65+) (the majority of which had forms of dementia) – with a primary community model put in place to support their needs. If an inpatient stay were required, they would be transferred to St George's Hospital in Stafford.

It was recognised a long-term solution would need to be identified to provide acute mental health inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia who were previously supported at the George Bryan Centre.

In 2019, MPFT led a listening exercise to understand people's experiences of using the services before the fire occurred. They held five events in south east Staffordshire and received a range of correspondence. More details about this activity are available on the MPFT website.

This listening exercise was also held alongside a larger listening exercise by the Together We're Better Partnership in summer 2019, which gathered views on a range of services including mental health. More details about this activity are available on the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) website.

Information gathered during these activities was considered by MPFT's clinicians and staff to inform the development of proposals for the future of inpatient mental health services formerly provided by the George Bryan Centre.

The programme was paused in March 2020 to allow clinicians and staff to respond to the COVID-19 pandemic. It was restarted in 2021 with a sense-check involvement to understand any new considerations or experiences. The details of this work are available on the dedicated Integrated Care Board (ICB) website page for this programme.

Current position

This plan has been drafted to cover the period **after** the completion of the Business Case and the relevant corresponding governance steps required – it has been prepared in the event that any further formal involvement activity is necessary. Given the uncertainty, this plan includes two potential scenarios:

- Involvement to gather views before a decision is made
- Involvement to share information about a decision, after a decision has been made.

This **draft document** will support planning in the event that further involvement activity may be required to articulate the outputs of the activity since 2019, and to explain the latest position and proposed future of inpatient mental health services previously provided at the George Bryan Centre. Insight from our work in 2021 has identified a need to articulate the wrap-around services and community offer to ensure people are aware of the additional support available.

If required, any further involvement would include the service users, staff, the wider public, and other stakeholders.

Scope of this work

This involvement activity will inform the decision-making about the long-term solution to the inpatient services that have temporarily been suspended at the George Bryan Centre.

We recognise this work has connections with the involvement activity for the Community Mental Health Transformation Programme and the Mental Health Strategy for Staffordshire. Comments received will also be shared with these programmes to support the wider mental health vision.

Aims and objectives

In the event that further involvement activity to gather views is required, the aims of this would be to:

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the single viable proposal identified through the options appraisal process and wider involvement activity since 2019
- understand views about the Business Case and the technical group's recommendation about the single viable proposal detailed within it
- review the views of the service users, carers, and carer representatives to date to inform our approach to involvement to articulate the current position and the single viable proposal for the future of inpatient mental health services previously provided at the George Bryan Centre
- inform decision-making, by listening to the views of:
    - people involved in the 2019 and 2021/22 engagement activity and others who were not to understand if there is anything new/additional that needs to be considered
    - service users and carers living in south east Staffordshire who have experienced the temporary arrangements between February 2019 and July 2021
    - other stakeholders with views about the provision of mental health services.

We will seek to understand people's views on the proposal, and in particular:

- if there are any ideas we have not considered
- if there is any positive or negative impact we need to plan for if we decide to go ahead with this proposal
- how we can support people if these changes are agreed, including how we can support people with travel.

The objectives of this work will be to gather any further information needed to inform the decision by decision-makers to meet our statutory duties.

In the event that further involvement activity to share information is required, the aims of this would be to:

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and outcome of the involvement activity since 2019 to identify long-term solutions for inpatient mental health services previously provided by the George Bryan Centre
- articulate the current position and the single viable proposal for the future of inpatient mental health services previously provided at the George Bryan Centre
- communicate the future solutions for inpatient mental health services previously provided by the George Bryan Centre.

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

Key messages

- We're committed to an open and transparent dialogue with service users, carers and carer representatives, staff, and partners
- Clinical evidence and best practice shows that a community-led model of mental health is better for the individual than admitting them to hospital
- When an inpatient stay is needed, we want it to be delivered by specialists, as short as possible and focussed on recovery
- We are investing in long-term community mental health services
- This exercise is focused on the services and when this is complete, we will look at the building

Key spokespeople

The following key spokespeople will be media trained and will act as spokespeople for the ICB and MPFT.

Clinical spokespeople:

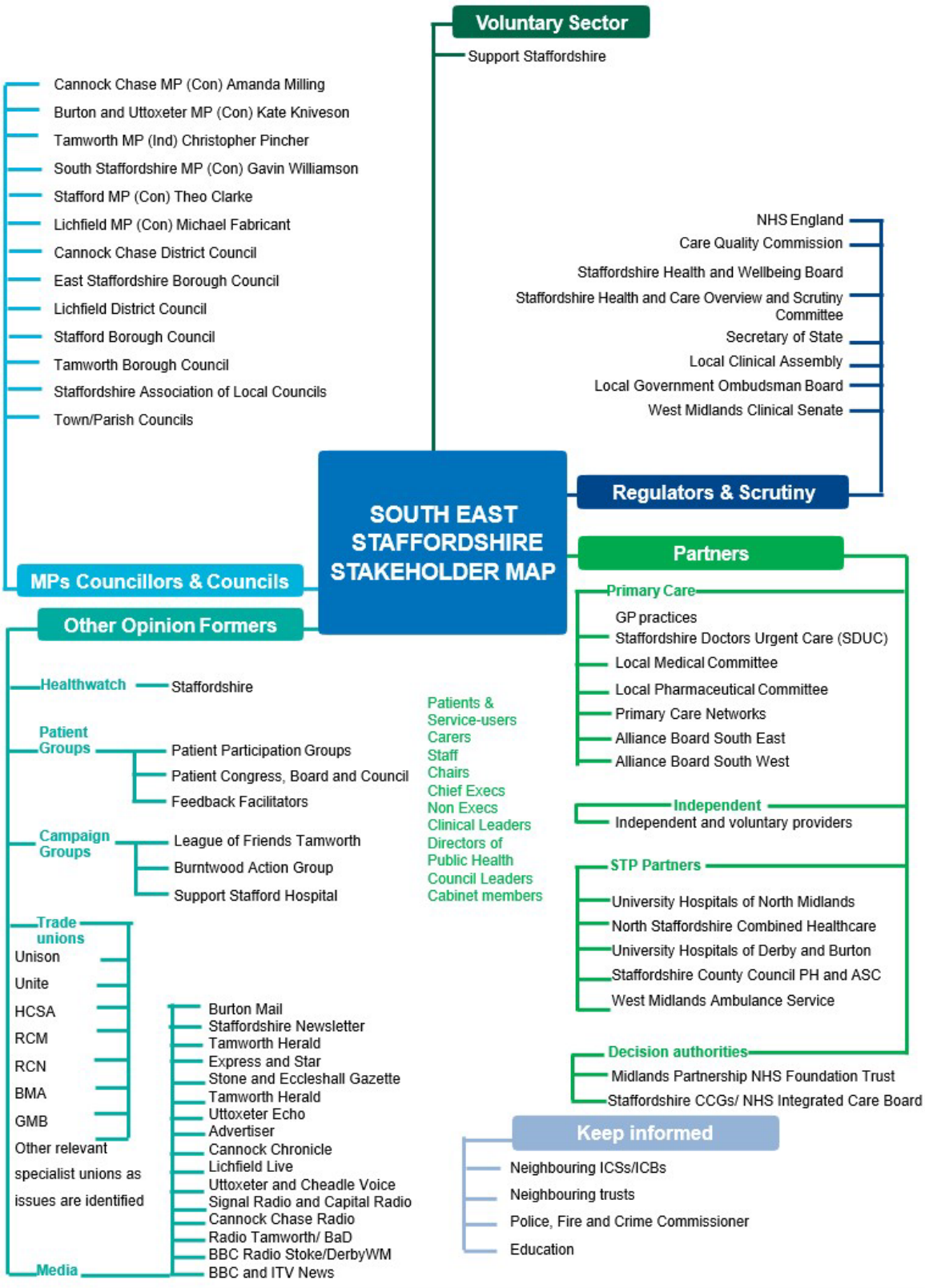
- Paul Edmondson-Jones, Chief Medical Officer, ICB
- Mental health clinician at MPFT – to be identified.

Executive spokespeople:

- Paul Edmondson-Jones, Chief Medical Officer, ICB
- Steve Grange, Deputy Chief Executive, MPFT

Key stakeholders

Our work to map stakeholders has been an iterative process throughout this programme of involvement activity and continues to be so. We have developed a comprehensive database of stakeholders. This is a live stakeholder management system which is updated as details change, and new or additional stakeholders are identified. This is the high-level stakeholder map:



Approach to involvement

Recognising that this phase follows involvement activity in 2019 and 2021/22, we will seek to build on the relationships already established and previous conversations with stakeholders as well as giving people who have not participated so far, the opportunity to have their say.

We will involve the Staffordshire Health Overview and Scrutiny Committee (OSC) in developing our approach to involvement and information activity in autumn 2022. This plan is an iterative document and sets out our initial thinking, subject to the views of the OSC and the ICB Board.

We have reflected on all previous engagement activity and are recommending a six-week involvement period. We believe this will give sufficient time for people to participate and provide an informed response – but is balanced against the demand on our clinicians during winter and also the potential for 'involvement fatigue'. This timeline is subject to our discussions with the OSC and ICB Board. A midpoint review will guide whether there is a need to undertake more targeted activity with certain groups and whether there is a need to extend this timeline.

Face-to-face activity will be subject to COVID-19 Infection Prevention Control (IPC) requirements to ensure the public safety of staff and public who participate in events and discussions. We will also prepare for a **digital first** approach in the event national guidance or restrictions are in place. Should face-to-face events need to be replaced with online alternatives, this would be communicated at the earliest opportunity.

We would also be looking to launch a range of activities, including but not restricted to:

- **Survey** – To gather views about the proposal and understand if there is anything else that should be taken into consideration. The survey will also allow us to understand any potential impact of the proposal to retain the additional beds at St George's Hospital, Stafford, and the enhanced community-led model. We would also seek to understand if there are any alternative considerations to this proposal that are viable
    - **Traditional responses** – In addition to our online survey, people will be invited to phone our Involvement Team on X or to send a survey to our freepost address (add in) to be received by the closing date. People can request a paper copy of the survey or can request support in completing the survey by phoning X or emailing X
- **Offer a meeting with campaigners/campaign groups** – To seek their views on the proposal, the impacts and the mitigations
- **Online meetings** – Two meetings (one in working hours and one during an evening). These will include a presentation from the ICB and MPFT and a series of breakout sessions to seek views on the proposal
- **Drop-in roadshow events** – These would be face-to-face, subject to any Government guidance and organisational policy in place at the time in relation to COVID-19. Recognising this involvement activity is in the autumn or winter, we believe drop-in events will give the opportunity for face-to-face dialogue but will mitigate any risk of infection transmission. There will be a minimum of four roadshows, in the key towns of Tamworth, Lichfield and Burton, and at least one event each at Sir Robert Peel Hospital and at St. George's Hospital in Stafford. We will review the level of interest in and attendance at these events and organise more if appropriate. In selecting suitable venues, we will seek COVID-19 secure areas and areas of high. They will be promoted through traditional media, digital channels and through stakeholder channels.
- **Break-out rooms** – These would be provided at both face-to-face and online events and meetings to allow space for one-to-one discussions or to support people requiring time away from the main meeting
- **Targeted focus groups/one-to-one interviews** – We recognise that for some seldom heard groups, alternative channels may be needed. We will work closely with Healthwatch and the voluntary sector to identify existing community and voluntary groups that we can attend. These will be detailed in our action plan.

Provisional timeline

Milestone	Anticipated Date/Timeline
NHS England Assurance Process	November 2022
Update to Staffordshire County Council Health and Care Overview and Scrutiny Committee (status of programme and potential plans for involvement)	January 2023
Integrated Care Board to decide whether to proceed with involvement	January 2023
Potential involvement activity launches	February 2023
Analysis of involvement activity	April- June 2023
Develop decision-making business case	Summer/Autumn 2023

Communication channels

We recognise there is a need to keep people informed throughout this journey to develop a long-term solution for the inpatient mental health services previously provided by the George Bryan Centre. We will use the following channels to keep people informed:

Channel	Stakeholder	Frequency/timeline
Newsletters / intranet / team meetings, and dedicated focus groups	Staff	Monthly
Stakeholder bulletin – using existing bulletins through ICS and MPFT	Partners/other health and care professionals	Monthly
One-to-one virtual briefings/correspondence	MPs/Council Leaders/OSC	As required
Website – the dedicated website page will be updated to provide the latest information about the programme	All (including service users and public	Ongoing
Media – we welcome the support of the media in helping us to deliver balanced information that will support patients to participate and share their	Media/public	At key milestones

views. We commit to providing regular and timely press releases that are written in plain language and, where appropriate, giving advance notice to reporters. We will launch an ongoing dialogue through the local media, including press releases, social media posts and radio interviews. We will respond to media enquiries in a timely manner, recognising the deadlines that reporters operate within		
Social media – promotion of opportunities to have say.	All	At key milestones
In-depth interviews with representatives or and members of seldom heard groups to gather people's experiences and views as appropriate	Service users / interested public and seldom heard groups (targeted engagement)	Ongoing
Workshops to be organised to gather people's experiences and views (as appropriate)	Service users/ interested public/seldom heard groups	TBC
Survey tool to seek feedback from people who cannot attend events	All	TBC

Communications and Engagement resources

We are developing a range of resources to support the planned involvement activity. The resources have been planned to support stakeholders who are interested in the subject matter and will be used as required and as appropriate.

Resources include, but are not restricted to:

Public Information Products:

- Integrated consultation document and survey – online. Including videos or animations where applicable

- Printed consultation document and survey. Links to online resources provided to facilitate access to videos/animations etc
- Summary consultation document
- Accessible consultation document and survey.

Promotional Information Products:

- Website content (including the Business Case and a range of case studies and further information)
- Handout flyer for events
- Poster to promote consultation and/or events. To include QR code to facilitate online access to materials. Translated posters to also be prepared
- Videos/animations
- Toolkit to support partners to promote on social media channels
- Press releases and media briefing
- Stakeholder updates (letters, emails and telephone scripts).

Event Products:

- Event registration form
- Event participation form, including demographic profiling questions
- Facilitator briefing notes and note-taking templates for events
- Presentations for deliberative online events
- Presentation for focus groups and voluntary sector events
- Voluntary sector collateral – presentation, facilitator booklet, and copies of printed promotional materials.

Supporting seldom heard groups

An Equality Impact Assessment (EIA) will be produced that outlines the approach to involving seldom heard groups. We will work closely with the ICS' Local Equality Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

We will ensure our communications are accessible by:

- Writing in plain language
- Using visuals (including diagrams, animations and accessible documents)
- Providing access to other languages, other document formats (large print, Braille, etc) and British Sign Language (BSL) interpretation when needed
- Arranging events to be at various times and days of the week to maximise attendance
- Asking people if there are any reasonable adjustments needed when attending virtual events and offering alternative ways for people to share their feedback (for example by phone)
- Providing reasonable adjustment and support, for example using interpreters or offering smaller focus groups with existing networks where appropriate.

We will build on our relationships with the voluntary and community sector, to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, we will work with trusted advocates, for example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that is approachable and understandable.

Action Plan

The activity set out below is indicative of what would be included in the event future public involvement is required. This is a summary of the key milestones.

Task	Description	Stakeholder	Timeline
TCI review of involvement document	TCI advice on involvement document	TCI	August – September 2022
Business case taken to ICB Board meeting	Approval to go to NHS E assurance	Public meeting	22 September 2022
Internal briefing for staff	West Midlands Clinical Senate Report published	Staff	September 2022
Stakeholder letter including MP briefing	West Midlands Clinical Senate Report published	Stakeholders including MPs/Councillors	October 2022
Press release and offer for proactive interviews	West Midlands Clinical Senate Report published	Media	September 2022
NHS E assurance process	Assurance review meeting	Internal/ regulators	November 2022
User testing of involvement document	Small focus group of service users/clinicians	N/A	November 2022
TCI review of revised draft of involvement document	TCI advice on involvement document	TCI	November 2022
Ongoing development of a toolkit of public resources	See communications and involvement products	N/A	September – January 2022

Monthly update in ICS newsletter/ internal channels	Regular (monthly update) on programme's progress	All	w/c 26/09/22 and ongoing thereafter as applicable
Health Overview and Scrutiny Committee	Involving the Committee in planning the approach for involvement activity	Scrutiny Committee	17 October 2022 January 2023
ICB Quality and Safety Committee	Update on programme and sharing draft involvement plan	Assurance	9 November 2022
MPFT Board meeting update	Update on programme	Board	27 October 2022
Media release and offer for proactive interviews	Update on the paper to ICB Board	Media	1 week before ICB meeting
Stakeholder update/ website update	Promotion of Board meeting and what will be discussed	Stakeholders including MPs/Councillors	1 week before ICB meeting
ICB Board meeting	Outcome of NHSE assurance and decision on whether to proceed to involvement, including plan and draft involvement document	ICB meeting	January 2023
Stakeholder update/ website update	Post Board update on next steps and potential involvement activity – include save the dates for events	Stakeholders including MPs/Councillors	After the ICB meeting
Media release and offer for proactive interviews	Post Board update on next steps and potential involvement activity – include save the date for events	Media	After the ICB meeting

Finalise involvement document and materials, finalise events post Board	Final amendments post Board meeting Accessibility checks Printing	N/A	2 weeks after ICB meeting
Offer of phone call to MPs/Council Leaders pre-launch	Update on planned involvement activity	MPs/Council leaders	Week before launch
Website updated	Programme documentation, survey, involvement document, events, animation	All	Day 1
Staff promotion	Internal channels/posters on site	Staff	Day 1
Stakeholder letter	Letter to announce launch of involvement activity and promote ways to participate	All	Day 1
Media release and social media updates	Promotion of ways to participate and information e.g. animation/summary	Media	Day 1
Toolkit for partners	Promotional materials and key messages to cascade information across ICS channels	All	Day 1
Email to voluntary sector groups	Offering attendance at meetings seeking support for promotion	Seldom heard groups	Day 1
GP bulletin	Promotion to GPs through weekly bulletin	GPs	Week 1

Launch of advertising	Social media adverts to target groups Potential newspaper adverts to promote drop in events	All	Week 1
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 1-2
Meeting with campaign group	Deliberative event to understand any views	Campaign Group	Week 1
Focus group for staff	Promotion of focus group for staff	Staff	Week 2
Existing service user focus group	Dedicated focus group	Service users	Week 2
1st Roadshow drop in event	See approach	All	Week 3
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 3-4
1st Online event	First online event	All	Week 4
2nd Roadshow drop in event	See approach	All	Week 4
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 3-4
Midpoint review	Review of activity at mid-point to understand efficacy of messaging, responses to information and ask of the activity and identification of any further activity which may be required as part of	Internal teams	Week 4

	the overall action plan		
2nd Online event	See approach	All	Week 5
OSC meeting	Offer for update to OSC through involvement activity	Scrutiny Committee	TBC
3rd Roadshow drop in event	See approach	All	Week 5
4th Roadshow drop in event	See approach	All	Week 6
Community/voluntary sector events	One-to-one/focus group conversations	Seldom heard/ targeted groups	Week 5-6
Staff message	Reminder of deadline for involvement and how to participate	Staff	Week 5
GP bulletin	Reminder of deadline for involvement and how to participate	GPs	Week 5
Press release	Reminder of deadline for involvement and how to participate	Media	Week 5
Stakeholder letter	Reminder of deadline for involvement and how to participate	Stakeholders	Week 5
Closure of survey on website	Website updated to thank people for participating and to explain next steps	Stakeholders	Midnight last day of survey Week 6
Analysis of findings	Report of findings and public summary to be developed to inform decision making process	N/A	Week 7-17 (depending on volume of responses)

Next steps

A detailed analysis report will be produced by MLCSU on the comments from the involvement activity; this will include a thematic breakdown of comments received and demographic analysis from participants, subject to them sharing this information.

These reports will be shared with the programme team to conscientiously consider the findings to inform the next steps and any decision-making resulting from the findings.

The proposals will be reviewed by the relevant governance routes within MPFT and ICB (with statutory responsibility for decision making). The findings will be shared with the Staffordshire Health Overview and Scrutiny Committee for discussion. The full report of findings and a public summary will be published on our ICB website.

Appendix one: What people have told us so far

2019 listening exercise:

- Listening exercise paper
- Summary listening exercise paper
- Report of findings
- Summary report of findings
- Public responses on general practice which should be read with the main report of findings.

2019 involvement activity (MPFT):

A series of engagement events took place in 2019 to establish what was good about the services and what needed improving, to help shape the long-term solutions. Feedback could also be submitted by email or by post.

The Board of MPFT received a report detailing the outcomes of the engagement exercise on 30 January 2020.

2021 listening exercise refresh:

- Listening exercise refresh issues paper
- Summary listening exercise refresh paper
- Report of findings
- Summary report of findings
- Reference Group report of findings

Appendix two: Our Communications and Involvement Charter

Our approach to communications and involvement includes:

- **Awareness** – we will provide clear and timely communications that help stakeholders to understand the complex case for change. We will ensure that the people involved have enough information to make an intelligent contribution and input into the discussion and any later process of options development. We will use multiple channels to help a wide range of stakeholders to understand and influence the issues
- **Discussion** – we will actively encourage two-way dialogue to understand the concerns, ideas, and solutions our stakeholders have. Our clinicians and decision makers will be proactively shaping and attending our public events to listen to feedback first-hand. We will utilise the knowledge, experience, and existing networks of patients, third sector and staff champions to involve as many people as reasonably possible
- **Inclusion** – we will support seldom heard groups to actively participate. Our communications will meet recognised accessibility standards and our activities will be designed to reach groups that may find it difficult to take part
- **Clinically-led** – we will listen to our workforce and clinicians as the experts in their field. We recognise how busy they are and will use the latest tools and technology to support

them to participate in meaningful conversations. Our clinical leaders will encourage their peers to actively participate in clinically led workshops and debates

- **Collaboration and co-creation** – we will work in partnership, facilitating workshops with clinicians, service users and partners to design the right services based on local needs. During the listening exercise phase, we will work to gather information and insight, which we might use later to develop selection criteria
- **Openness and transparency** – we will be open minded and not pre-determine any decisions. We will assure our ICS, Healthwatch and Health Overview and Scrutiny partners, in their essential remit of providing critical challenge. We will provide regular updates and seek their views at every stage of the process
- **Compliance** – we will undertake a robust communications and involvement programme, following the latest best practice and legal guidance. We will adhere to the guidance and statutory duties of the regulators in designing our approach. We will work closely with the Consultation Institute to seek assurance on our approach
- **Feedback** – we will evidence how decision-makers have taken public opinion into account and provide feedback to those consulted.

Appendix four: Version control

Version	4b
Status	Draft
Name of originator / author	Communications and Engagement Team
Name of responsible committee	Transformation Programme Board
Date issued	17 May 2022
Last review	17 June 2022 – signed off by CT
Activity	26 September 2022 refreshed and shared with Programme leads 30 September 2022 26/09/22 Timeline updated following latest meeting with NHS England and shared with Board 09/11/22 Shared with ICB Quality and Safety Committee 10/11/22 Provisional timeline updated
Next review date	Live document
Target audience	Internal with the intention to become a public document

NHS Arden and Greater East Midlands CSU
NHS Midlands and Lancashire CSU

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

Report of findings

May 2023

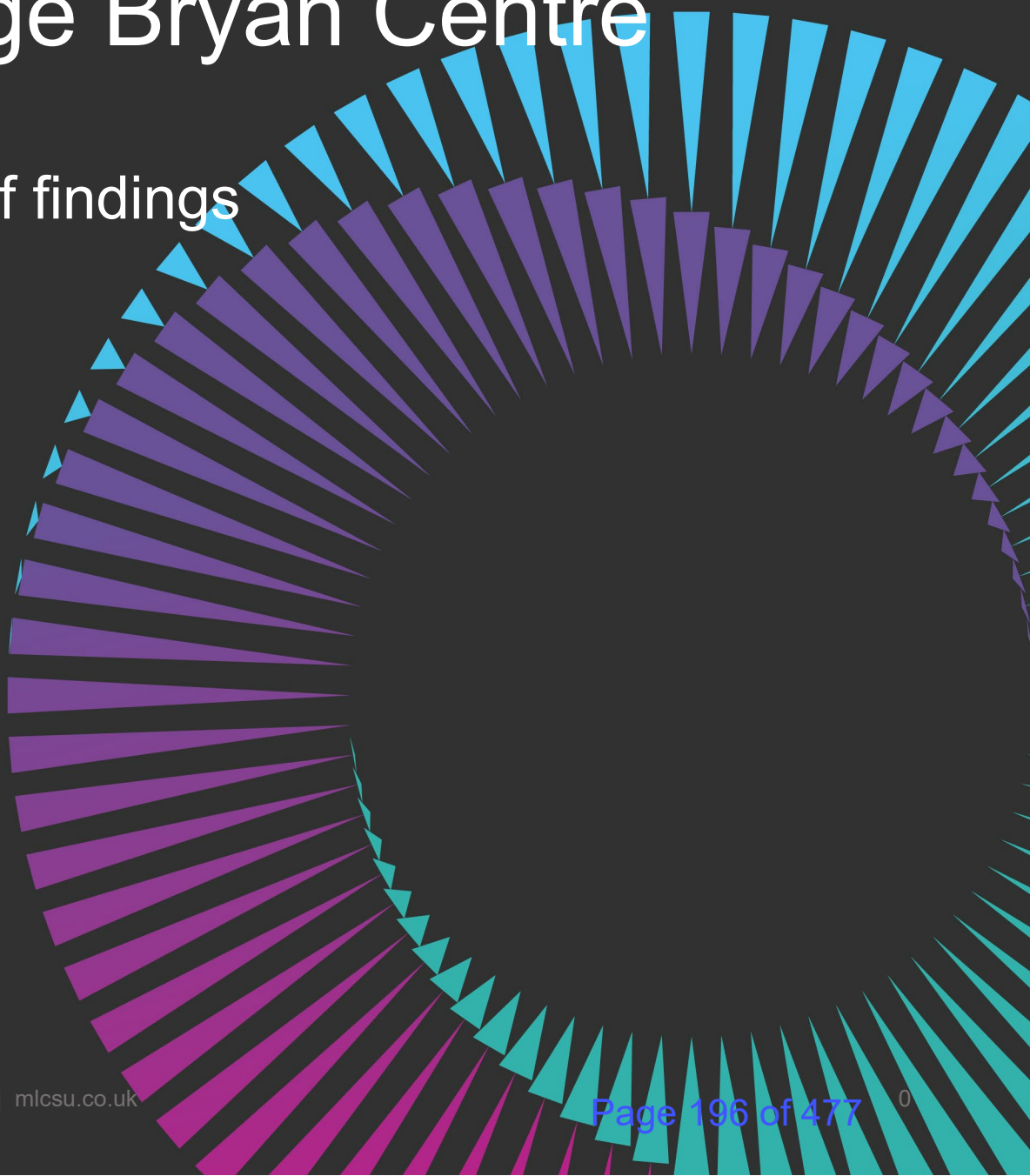


Table of Contents

1 Executive summary

1.1 Introduction

This report presents the findings from the consultation on sourcing a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre.

The purpose of this report is to present the views of consultation participants so they can be taken into account by the NHS in Staffordshire and Stoke-on-Trent during subsequent decision-making processes.

1.2 Background

The NHS in Staffordshire and Stoke-on-Trent has been working with local patients, staff, interested groups and partners to redesign inpatient mental health services in the area.

The priorities are to deliver quality mental healthcare for patients in their own home or community rather than in hospital and to give people more choice and control over their treatment. For the small number of patients who do need a hospital stay, we want to make sure that the right specialist staff are on hand to give them the best care.

The proposal set out by NHS Staffordshire and Stoke-on-Trent looks at how to provide the inpatient (hospital bed) services that were previously provided at the George Bryan Centre for people living in south east Staffordshire with severe mental illness or dementia.

The public consultation ran from 9 February to 23 March 2023. Its aims were to:

- Explain the proposal, including:
    - setting out the context of national changes in best practice in mental healthcare and the clinical evidence supporting these changes
    - how the proposal had been reached and why a single viable proposal was being recommended
- Ask people their views on:
    - whether there were other ideas that had not been considered
    - any advantages or disadvantages that would need to be planned for, if the proposal is implemented
    - how to support people if the proposal is implemented, especially with travel.

1.3 Communications and involvement

This section gives an overview of the communications and engagement approach for the consultation.

The communications and engagement approach was articulated in the communications and involvement plan, created in September 2022 by Midlands and Lancashire Commissioning Support Unit (MLCSU) on behalf of Staffordshire and Stoke-on-Trent ICB. Although the plan was an iterative document, it outlined the key areas of activity and thinking at that time. These can be summarised as follows.

- Recognising that this phase followed involvement activity in 2019 and 2021/22, consultation activity should build on relationships already established with

stakeholders and conversations that had already taken place, as well as giving people new to the discussion the chance to have their say
- Based on experience of previous involvement, a six-week involvement period was recommended
- A combination of face-to-face activity (subject to any COVID-19 Infection Prevention Control (IPC) requirements) and digital methods would be used to engage with the public and patients
- The range of activities proposed included:
    - A survey, which used digital and traditional methods of collating responses
    - Attending meetings held by groups if requested
    - Online meetings
    - Drop-in roadshow events – in places of high public footfall and for staff
    - Targeted focus groups and one-to-one interviews – with those from seldom-heard communities, for whom alternative engagement channels might be more useful
- The plan also articulated working with Support Staffordshire as a delivery partner. Support Staffordshire are a countywide support organisation for the voluntary, community and social enterprise sector. It was felt that their engagement networks could help reach people who might be affected by the proposal but who might not engage via the traditional methods outlined above.

1.3.1 Involvement resources

- Various printed and online versions of the consultation documents were developed. In addition to the full-length and summary versions of the consultation document, there were edited sections to accompany the survey questions online. This provided contextual information for any respondents who might not have referred to the consultation document before responding to the survey. Audio recordings of these sections were also provided
- Three animations were hosted on the consultation website. Audio versions of the edited consultation document text that accompanied the online survey questions were made available
- Additional resources were available on the consultation website, including case studies, the pre-consultation business case, FAQs, a leaflet about investment in mental health services, and more.

1.3.2 Communication channels

- Relevant stakeholders and local community organisations were contacted, either by telephone, email, post or by online meetings, to inform them about the consultation
- There were printed copies of the full consultation document with survey, accessible consultation document with survey, summary consultation document, double-sided A5 flyer, A4 poster and pull-up banners. Copies of the consultation documents, flyer and poster were distributed to 30 key stakeholders' venues across the target area. Staff members brought the pull-up banners to events and engagement sessions
- Digital versions of these materials were emailed to more than 147 contacts in the Staffordshire and Stoke-on-Trent community stakeholder database

- Correspondence was used to engage with key stakeholders but also received from the public as a form of consultation feedback. The Communications and Engagement team undertook a range of activities to correspond with stakeholders, including:
  - Emailing 30 local organisations who shared the consultation materials with their communities
  - Developing and sharing a comprehensive event plan, containing details of 17 planned events
  - Emailing local community groups to ask them to spread the word in their newsletters and external communications
  - Creating and sending:
    - a general email with information about the consultation
    - a launch letter
    - updates to appropriate stakeholders
    - emails to people who had registered for online events, to confirm their attendance.

1.3.2.1 Social media and online promotion

The consultation was promoted on various webpages.

The table shows the numbers of downloads/views of consultation documents and other key supporting documents.

Table 1. Numbers of downloads and views of the consultation documents

Document	Downloads/views
Full consultation document	149
Accessible consultation document	37
Summary consultation document	79
Mental health investment leaflet	36
The move towards more community-based mental healthcare (with timeline)	39
Case studies	69 views of 6 case studies
Business case	60
Document on financial assistance for travel	27

The section below shows how the consultation was promoted via social media:

- The organic social media campaign ran from 6 February to 23 March 2023 on Facebook and Twitter. Two social media assets were designed to accompany the posts, one with a call to action of ‘Find out more’ and the other with encouragement to ‘Have your say’. A variety of posts were used, from more general messages informing people about the consultation to posts highlighting specific events. The combined number of Facebook impressions was 14,259. For Twitter there were 7,643 impressions
- Two adverts were launched on Facebook/Instagram, targeting those aged over 18 across a 23km area covering Tamworth, Lichfield, Burton and Stafford. The adverts were rolled out between 9 February and 23 March 2023.

1.3.2.2 Media, public relations and advertising

Printed newspaper advertising included a quarter-page advert rolled out on 9 February 2023 in:

- Tamworth – *Tamworth Herald*
- Stafford – *Express & Star* – East Zone
- Burton – *Burton Mail*
- Lichfield – *Burton Mail.*

A suite of display adverts was created. They included mid-page units (MPUs – a form of digital adverts) on the *Lichfield Live* website. Adverts launched on 9 February, and ended on 21 March 2023.

There were also eight pieces of press coverage between 26 January and 16 February 2023.

1.3.2.3 Events

1.3.2.3.1 Engagement sessions with specific communities: led by VCSE partner Support Staffordshire

Support Staffordshire were commissioned to reach and engage with specific targeted communities during the consultation. The communities included:

- People of Eastern European, South Asian, Black (Afro-Caribbean) and mixed race ethnicities
- People in the most deprived areas – particularly in Lichfield, Burton and Tamworth
- Men aged 65 and over
- Women aged 25 to 44
- People experiencing homelessness
- Carers – particularly young carers
- People involved in substance misuse
- Lesbian, gay, bisexual, transgender, queer/questioning and other (LGBTQ+) groups
- People currently in the military and veterans.

Two members of the Support Staffordshire team attended facilitator training to enable them to deliver a range of focus groups and one-to-one interviews. Materials were adapted to meet their needs and specifications.

Support Staffordshire used the feedback mechanisms set up for the consultation to report findings from all their engagement sessions. They engaged with 81 participants between 9 February and 29 March 2023.

1.3.2.3.2 Online events

The purpose of the online events was to present the key messages of the consultation and gain feedback from participants on the different components of the proposal. Feedback was gathered using a publicly accessible digital platform called Jamboard, which provides an anonymised method of leaving notes and comments. Events were conducted using Microsoft Teams, and members of the clinical team were present to answer questions and listen to participants' views.

Event 1 was planned for Friday 2 March 2023. Although a small number of people had registered for this event, none attended. The team ensured that all who had registered were offered an opportunity to join the next event, and were sent a link to the online survey as well.

Event 2 was held on 9 March and had six participants. They used the breakout sessions and the Q&A to give feedback and ask questions about the consultation and the proposal.

1.3.2.3.3 Drop-in roadshows

The initial plan was for five drop-in events, to give the consultation a presence in places with high footfall in the Tamworth, Lichfield and Burton areas.

The aim was to engage with the public about the proposal and to promote the survey, encouraging people to use it to give their feedback.

During the consultation, in response to feedback, including feedback from an MP, two more drop-in events in Tamworth were added. These were at the Ankerside Shopping Centre and the Coton Centre (an evening event). This gave the Tamworth community further opportunities to give their views on the consultation.

Because these events were added after the launch of the consultation, they were promoted online only – it was not possible to update the printed promotional materials at that stage.

The drop-in events were held between 16 February and 21 March 2023 with about 74 attendees.

1.3.2.3.4 Targeted workshops

Six targeted workshops were organised. The Communications and Engagement team worked with existing groups from specific communities to organise the sessions, where they intended to deliver a presentation and receive feedback. It became clear that the method of delivering the workshops could be adapted to better meet the needs of some attendees. This meant that in some sessions the message was delivered through targeted conversation, rather than using the original presentation, but feedback was still gathered via notes and completed surveys.

The team engaged with people from the communities of Tamworth, Burton upon Trent and Lichfield. They specifically engaged with groups of people who had experienced mental health issues and challenges – either themselves or as carers. They also worked with groups who support people experiencing or caring for someone with dementia.

The groups the team attended included:

- Burton Caribbean Association, which runs community groups for local people who have dementia or mental health conditions, are carers, or feel isolated/lonely
- Better Way Recovery, a Lichfield-based group for people who are addicted to alcohol, drugs or have serious mental health conditions
- The Rotary Club, which hosts a regular Memory Café for people with dementia and their family/carers
- MIND, who invited the team to their arts and crafts group for people who have mental health conditions and/or learning disabilities.

The targeted workshops took place between 9 February and 22 March 2023, with a total of 133 attendees.

1.3.2.3.5 Attendance at additional meetings and events

- Lichfield Overview and Scrutiny Committee asked to engage with the team about the consultation and the proposal. The team gave a presentation to the committee on 16 March 2023 and received a copy of the minutes of the meeting.
- The League of Friends at Robert Peel Community Hospital, Tamworth, asked for the chance to engage with the team about the consultation and the proposal. The team gave a presentation on 20 March 2023 to the League of Friends' board.

1.3.3 The midpoint review

In line with good practice, the Communications and Engagement team conducted a midpoint review of the consultation on Tuesday 7 March 2023. Recommendations were made to the Inpatient Mental Health Services (IMHS) Steering Committee for consideration on Friday 10 March 2023.

The review looked at evidence of the consultation data, as of 7 March 2023, including:

- Findings and themes that had emerged from the survey and events up to that date
- An overview of the events and promotional activities delivered up to that date
- Information on gaps identified and key learnings at that date
- Recommendations for the IMHS Steering Committee on possible changes to the communications and involvement plan for the final weeks of the consultation.

Overall, the review found the consultation was delivering to plan. However, it highlighted areas in which the team should adapt the plan, and recommended subsequent activities for the remainder of the consultation. These were areas where the team had identified gaps of knowledge/reach, where they would need to focus their attention and resources, including providing Support Staffordshire with additional income to focus on engaging with specific cohorts that had been identified as gaps in the review.

Support Staffordshire was commissioned to continue working to target these specific groups, such as people experiencing homelessness and organisations supporting homeless people, asylum seekers and refugees, and people identifying as LGBTQ+.

1.4 Numbers of respondents and participants

The table below shows the numbers of people who attended the different consultation activities.

Table 2. Number of participants in the different activities held during the IMHS consultation

Survey	Engagement events with specific communities	Online events	Drop-in roadshows	Targeted workshops	Other channels
48	81	6	55 – 74	133	4

Feedback from other channels includes the March 2023 Overview and Scrutiny Committee meeting minutes and reports from Healthwatch. A range rather than an exact number is given for attendance at drop-in roadshows because of the difficulty in recording an exact number in high-footfall areas.

Consultation participants had the freedom to share their views through the consultation survey and by attending any of the events, workshops and roadshows that were held.

1.5 Demographic profiling

This section presents a summary profile of those participating in the consultation (survey and events combined). The demographic profile summary below is based on the 48 survey responses and 62 responses from the demographic profiling questionnaire event participants were asked to complete. Completion of the demographic profiling questionnaire was not a mandatory requirement, meaning people could choose not to complete it.

For a detailed profile, please see the profiling section in the main report.

- 35 (35%) said they were members of the public, while 32 (33%) were users of mental health services
- 94 (88%) said they were White British
- 27 (27%) were under 44 years old, 45 (42%) were aged 45 to 64, and 30 (29%) were over 65
- 72 (67%) were female and 32 (30%) were male
- 90 (84%) stated they were heterosexual, 3 (3%) said they were gay, and 3 (3%) were bisexual
- 61 (57%) said they were Christian, while 33 (31%) said they had no religion
- 45 (42%) said they were married, while 27 (25%) said they were single
- 102 (92%) said they were not currently pregnant and 100 (94%) said they had not recently given birth
- 44 (41%) said they were limited in their day-to-day activities, while 57 (53%) said they were not
- 50 (46%) said they did not have any disabilities, while 29 (27%) said they have a mental health condition, and 25 (23%) have a physical disability
- 50 (47%) were carers and 53 (50%) did not provide care to a friend or family member
- 95 (89%) said they have not served in the armed services
- 45 (41%) said they were from the Tamworth area and 20 (18%) were from the East Staffordshire area
- When considering Index of Multiple Deprivation (IMD), 49 (45%) were from the most deprived areas, while 43 (39%) were from the least deprived areas.

1.6 Findings

This section summarises the key findings from the consultation.

The figures presented are calculated from the 48 consultation survey responses. Please note, not all respondents answered all survey questions and not all percentages are calculated with a base (the number of people answering the question) of 48. In the main report, the base sizes are shown.

For the event feedback presented, the base refers to the total number of feedback notes submitted by facilitators / note takers in response to each question.

1.6.1 Experience of mental health services

When asked which mental health services respondents had used or experienced, 22 (49%) survey respondents said they had used or experienced community mental health services,

13 (29%) said they had used or experienced the George Bryan Centre, and 8 (18%) said they had used or experienced St George's Hospital, Stafford. 15 (33%) said they had not used or experienced any of these services.

Table 3 shows in what capacity respondents experienced the mental health settings they provided feedback on.

Table 3. In what capacity respondents experienced the mental health settings they were providing feedback on

	George Bryan Centre		St George's Hospital, Stafford		Community mental health services	
	No.	%	No.	%	No.	%
As a patient	5	39%	4	50%	15	62%
As a carer or support worker for a patient	5	39%	3	38%	6	26%
As a provider of a service to a patient	2	15%	1	13%	2	9%
As a member of staff	1	8%	-	-	-	-
Base	*13*		*8*		*23*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

The following sections present a summary of consultation survey respondents' experiences of these services.

1.6.1.1 Experience of mental health services previously provided at the George Bryan Centre

When consultation survey respondents were asked to share their experience of using the mental health services previously provided at the George Bryan Centre, the most frequently mentioned themes were:

1. Quality of care – The quality of care provided was good (5 / 39%)
2. Staff – Staff were caring and professional (3 / 23%)
3. Quality of care – The quality of care provided was poor (2 / 15%); Staff – Staffing levels were not sufficient (2 / 15%); Quality of care – The quality of care provided was poor (2 / 11%)

1.6.1.2 Experience of St George's Hospital, Stafford

When consultation survey respondents were asked to share their experience of using mental health services at St George's Hospital Stafford, the most frequently mentioned themes were:

1. Staff – Some staff were not professional and caring (3 / 33%); Staff – Staff were good (3 / 33%)
2. Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 22%)

1.6.1.3 Experience of community mental health services

When consultation survey respondents were asked to share their experience of using community mental health services, the most frequently mentioned themes were:

1. Quality of care – The services provided were good (for example, ongoing support) (5 / 25%)
2. Staff – Staff were not caring and lack of knowledge (4 / 20%); Quality of care – Services provided were poor (for example, poorly organised) (4 / 20%)
3. Access – Waiting times for community services are too long (for example, too many cancellations) (3 / 15%); Quality of care – Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups) (3 / 15%)

1.6.2 Feedback on the community model for severe mental illness

1.6.2.1 Feedback on the care model

When asked to what extent the care model was a good one, 19 (40%) consultation survey respondents stated it was very good / good, while 28 (60%) said it was poor / very poor.

When consultation survey respondents were asked to explain their rating, the most frequently mentioned themes were:

1. Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (11 / 26%)
2. Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (9 / 21%)
3. Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (7 / 16%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (7 / 16%)

During the engagement sessions with specific communities, participants were asked to what extent they thought the care model was a good one. In response, the most frequently mentioned themes were:

1. Service provision – Consider the need for better mental health support locally (12 / 36%)
2. Access – In practice, the pathway is not as smooth as described in the model (5 / 15%); Health and wellbeing – Consider negative impact a lack of community support has on patients and their families (5 / 15%); General – The care model is good (5 / 15%)

1.6.2.2 Groups that may be disadvantaged by this care model

Consultation survey respondents and participants in the engagement sessions with specific groups were asked which groups they felt might be disadvantaged by this care model. In response, the most frequently mentioned themes raised by survey respondents were:

1. Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (13 / 33%)
2. General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (12 / 30%)

3. Specific groups – Patients with serious mental health problems (for example, patients in crisis, with long-term conditions) (8 / 20%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (12 / 43%)
2. Specific groups – Everyone may be disadvantaged (for example, patients, carers, visitors) (7 / 25%)
3. Specific groups – Carers and family members would be negatively impacted (for example, visitors) (6 / 21%)

1.6.2.3 Suggestions to improve the care model

Consultation survey respondents and participants in the engagement sessions with specific groups were asked to share suggestions on how the care model could be improved. In response, the most frequently mentioned themes raised by survey respondents were:

1. Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (13 / 35%)
2. Service provision – Consider the provision of mental health services locally (for example, including inpatient services) (7 / 19%)
3. Staff – Ensure appropriate staffing (for example, trained staff, sufficient staffing levels) (4 / 11%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Service provision – Consider greater provision of mental health support locally (for example, local drop-in centres) (7 / 23%)
2. Quality of care – Ensure that care reflects the individual needs of patients (6 / 19%)
3. Awareness – Consider raising awareness around mental health services available in the community and how to access them (5 / 16%)

1.6.2.4 Feedback on the care model from other channels

This section presents the feedback received on the care model from the online events, targeted focus groups, drop-in roadshows, correspondence and other channels, which include the March 2023 Overview and Scrutiny Committee meeting minutes and reports from Healthwatch.

The most frequently mentioned themes raised during the online events, targeted focus groups and drop-in roadshows were:

1. Awareness – Consider improving awareness around the support available in the community and how to access it (7 / 8%)
2. Staff – Concern over inadequate staffing levels (6 / 7%)
3. Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (4 / 5%)

The most frequently mentioned themes raised in the correspondence were:

1. Access – Concern over poor access to GPs (for example, long waiting time) (2 / 4%)

2. Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (2 / 4%)

A summary of key themes raised through the other channels:

- Being able to offer a more personalised and integrated approach to supporting and treating service users locally, allows for more people to be managed at home successfully
- The improvement of staff recruitment and retention has resulted in community services being delivered more consistently and effectively
- Suggestions were raised about providing services on the old George Bryan Centre site to speed up the response times for those living in the Lichfield and Tamworth areas
- It was commented that the helpline operates 24 hours, 7 days a week, and is a free service from any phone. However, the need for greater promotion of the helpline was highlighted.

1.6.3 Feedback on the community model for dementia healthcare services

1.6.3.1 Feedback on the care model

When asked to what extent the care model was a good one, 10 (46%) survey respondents said it was very good / good, while 8 (36%) said it was poor / very poor.

When consultation survey respondents were asked to explain their rating, the most frequently mentioned themes were:

1. Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (13 / 36%)
2. Service provision – Consider the need for more local inpatient units and hospitals (3 / 8%)

During the engagement sessions with specific communities, participants were asked to what extent they thought the care model was a good one. In response, the themes most frequently mentioned were:

1. Health and wellbeing – Being close to home is better for patients with dementia than being in a hospital (7 / 21%)
2. General – The new care model is good (6 / 18%)
3. Safety – Concern over the safety and security of patients with dementia (for example, lack of supervision in community) (5 / 15%)

1.6.3.2 Groups that may be disadvantaged by this care model

Consultation survey respondents and participants in the engagement sessions with specific groups were asked which groups they felt might be disadvantaged by this care model. In response, the most frequently mentioned themes raised by survey respondents were:

1. Specific groups – All patients with dementia (8 / 32%)

2. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (5 / 20%)
3. Specific groups – Residents of Tamworth and Lichfield (4 / 16%)

The most frequently mentioned themes raised by participants of the engagement sessions with specific groups were:

1. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (6 / 20%); Access – Concern over not being able to visit patients with dementia in hospital (for example, travel cost, too far to travel) (6 / 20%)
2. Specific groups – All patients with dementia (4 / 13%)
3. Specific groups – Everyone could be disadvantaged by the model (2 / 7%); Specific groups – Carers and family members could be negatively impacted (2 / 7%)

1.6.3.3 Suggestions to improve the care model

Consultation survey respondents and participants in the engagement sessions with specific groups were asked to share suggestions on how the care model could be improved. In response, the most frequently mentioned themes raised by survey respondents were:

1. Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 35%)
2. Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (6 / 26%)
3. Service provision – Consider the need for day hospitals/centres (3 / 13%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Access – Consider improving access for visitors (for example, flexible visiting times, free parking, transport) (6 / 19%); Service provision – Consider the need for greater support provided locally (6 / 19%)
2. Quality of care – Ensure the care provided is appropriate (for example, timely, continuity of care, reflects patient needs) (5 / 16%)
3. Staff – Ensure appropriate staffing levels in the community (for example, trained staff, sufficient staffing level, more permanent staff) (4 / 13%)

1.6.3.4 Feedback on the care model from other channels

This section presents the feedback received on the care model for dementia from the online events, targeted focus groups, drop-in roadshows and other channels, which include March 2023 Overview and Scrutiny Committee meeting minutes and reports from Healthwatch.

The most frequently mentioned themes raised during the online events, targeted focus groups and drop-in roadshows were:

1. Support for carers – Consider the need for greater support for carers (10 / 12%)
2. Awareness – Concern over the lack of awareness of dementia care services available in the community (for example, GPs may not be aware) (9 / 11%)
3. Quality of care – Consider the need for continuity of care for patients with dementia (3 / 4%); Technology – Contact via technology is not appropriate for people with dementia (3 / 4%)

A summary of key themes raised through the other channels:

- Concerns were raised around the availability of extra support for carers looking after patients with dementia at home
- Concerns were raised around the management of people with dementia who have challenging behaviour
- A need was highlighted for greater clarity on when Continuing Health Care applies to people with dementia.

1.6.4 Feedback on the proposal for delivering inpatient mental health services

1.6.4.1 Feedback on the proposal

When asked to what extent the proposal was a good one, 7 (15%) consultation survey respondents said it was very good / good, while 26 (59%) said it was poor / very poor.

When consultation survey respondents were asked to explain their rating, the most frequently mentioned themes were:

1. Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (19 / 50%)
2. Specific groups – The proposal disadvantages inpatients, their carers and relatives (8 / 21%)
3. Service provision – Concern over the lack of inpatient beds available in the area (7 / 18%)

During the engagement sessions with specific communities, participants were asked to what extent they thought the proposal was a good solution. In response, the themes most frequently mentioned were:

1. General – The proposal is not a good solution (for example, unrealistic) (5 / 17%)
2. Access – Concern over the location of the services (for example, too far to travel from some parts of Staffordshire) (4 / 14%)
3. Cost and efficiency – Concern over the lack of hospital beds to meet demand (3 / 10%)

1.6.4.2 Groups that may be disadvantaged by this proposal

Consultation survey respondents and participants in the engagement sessions with specific groups were asked which groups they felt might be disadvantaged by proposal. In response, the most frequently mentioned themes raised by survey respondents were:

1. Specific groups – Patients who need inpatient care (9 / 31%)
2. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (6 / 21%); General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (6 / 21%)
3. Specific groups – Residents of Tamworth and Lichfield (5 / 17%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Specific groups – People who need to travel (for example, distance, poor public transport) (7 / 24%)
2. Specific groups – Non-drivers (4 / 14%)
3. Travel cost – Concern over the cost of travel (2 / 7%); Specific groups – Everyone could be disadvantaged (2 / 7%); Specific groups – People experiencing homelessness (2 / 7%)

1.6.4.3 Suggestions to improve the proposal

Consultation survey respondents and participants in the engagement sessions with specific groups were asked to share suggestions on how the proposal could be improved. In response, the most frequently mentioned themes raised by survey respondents were:

1. Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (11 / 31%)
2. Service provision – Consider greater provision of mental health support locally (9 / 26%)
3. Service provision – More mental health units across the county are needed (3 / 9%); Cost and efficiency – Ensure sufficient funding for healthcare services (3 / 9%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Service provision – Provide mental health services locally (6 / 24%)
2. Service provision – Re-open the George Bryan Centre (for example, rebuild it) (3 / 12%); Estate and facilities – Consider providing access to appropriate facilities for patients with mental health problems (for example, quiet room) (3 / 12%)

1.6.4.4 Feedback on the proposal from other channels

This section presents the feedback received on the proposal from the online events, targeted focus groups, drop-in roadshows, correspondence and other channels, which include the March 2023 Overview and Scrutiny Committee meeting minutes and reports from Healthwatch.

The most frequently mentioned themes raised during the online events, targeted focus groups and drop-in roadshows were:

1. Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (10 / 12%)
2. Specific groups – Residents of Tamworth are disadvantaged by this proposal (5 / 6%); Travel support – Consider providing transport for patients and visitors (5 / 6%)
3. Access – The George Bryan Centre is accessible (4 / 5%); Health and wellbeing – Consider the positive therapeutic effect of visitors on inpatients (4 / 5%)

The most frequently mentioned themes raised in the correspondence were:

1. Access – Concern over travelling to inpatient mental health services for patients and visitors (2 / 4%)
2. Health and wellbeing – Consider the positive therapeutic effect of visitors on inpatients (2 / 4%)
3. Consultation – Concern that the decision has already been made (2 / 4%)

4. Service provision – Concern over the closure of the George Bryan Centre (2 / 4%)
5. Service provision – Rebuild the George Bryan Centre (2 / 4%)

A summary of key themes raised through the other channels:

- The need to travel to Stafford was highlighted as a disadvantage
- Transport is the major concern for those in Tamworth, due to lack of access to a car or bus stops near people's homes
- The need for a patient transport service was highlighted
- The importance of family and friends being able to visit service users was highlighted
- Concerns were raised around whether St George's Hospital has sufficient capacity to meet demand.

1.6.5 Feedback on travel and access

When asked to what extent consultation survey respondents were concerned about travel for visitors under this proposal, 40 (87%) consultation survey respondents said they were concerned / very concerned, while (3 / 6%) said they were very unconcerned / unconcerned.

When consultation survey respondents were asked to the explain their rating, the most frequently mentioned themes were:

1. Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (25 / 64%)
2. Travel cost – Concern over the travel cost (14 / 36%)
3. Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (10 / 26%)

During the engagement sessions with specific communities, participants were asked whether they were concerned or unconcerned about travel for visitors under this proposal. In response, the themes most frequently mentioned were:

1. Travel – Concern over travel for visitors and patients (for example, distance and time, public transport) (13 / 45%)
2. Travel cost – Concern over the cost of travel (4 / 14%)
3. Planning – Consider the need to align visiting times with public transport timetables (3 / 10%); Access – The proposal makes it challenging for patients and visitors to see each other (3 / 10%); Access – No concerns around travel (for example, can drive) (3 / 10%)

1.6.5.1 Supporting travel for visitors

Consultation survey respondents and participants in the engagement sessions with specific groups were asked to share suggestions on how to support visitors with their travel. In response, the most frequently mentioned themes raised by survey respondents were:

1. Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (10 / 28%)
2. Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (9 / 25%)
3. Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (8 / 22%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Travel support – Consider providing transport for visitors (11 / 39%)
2. Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (8 / 29%)
3. Access – Consider the need to align visiting times with public transport timetables (6 / 21%)

1.6.5.2 Views on patient travel

Consultation survey respondents were asked how they would travel. In response, the most frequently mentioned themes were:

1. Access – By car (20 / 56%)
2. Access – Will not travel (for example, wouldn't be able) (7 / 19%)
3. Specific groups – Concerns for those who do not drive (5 / 14%)

1.6.6 Feedback on technology

When asked whether consultation survey respondents had access to the internet, 42 (93%) said they had access in their homes, while 3 (7%) said they didn't have access to the internet.

When asked what type of device respondents had, 37 (84%) consultation survey respondents said they used mobile phones, 25 (57%) used laptop computers and 15 (34%) used a tablet device.

When asked whether their device had a camera that could be used to contact someone in hospital, 36 (86%) consultation survey respondents said they had a camera in their device, while 4 (10%) said they did not.

When asked whether respondents could use their device to contact someone in hospital, 27 (66%) said they could easily use their device to contact someone in hospital, while 10 (24%) said they could do this with assistance.

1.6.6.1 Supporting people with technology

Consultation survey respondents and participants in the engagement sessions with specific groups were asked to share suggestions on how to support respondents to contact someone in hospital. In response, the most frequently mentioned themes raised by survey respondents were:

1. Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (9 / 30%)
2. General – No support required (7 / 23%)
3. Specific groups – Consider the needs of older people (5 / 17%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. Specific groups – Consider that not everyone is tech savvy (for example, older people) (11 / 39%)
2. Technology – Concerns around who will help patients with the technology (8 / 29%); General – This is a good idea (8 / 29%)
3. Specific groups – Contact via technology is not appropriate for people with dementia (6 / 21%)

1.6.7 Additional views and considerations

Consultation survey respondents and participants in the engagement sessions with specific groups were asked to share any other information to be considered. In response, the most frequently mentioned themes raised by survey respondents were:

1. Service provision – Reopen the George Bryan Centre (4 / 22%)
2. Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (3 / 17%)

The most frequently mentioned themes raised by participants in the engagement sessions with specific groups were:

1. General – Concern that the Tamworth community has been left behind (3 / 7%); Access – Concern over travel to mental health services (for example, distance, transport) (3 / 16%); Quality of care – Ensure the care provided reflects the individual needs of patients (3 / 16%)
2. Access to support – Concern over poor access to mental health support (2 / 10%); Cost and efficiency – Ensure sufficient funding for mental health services (2 / 10%); Quality of care – Consider the need for prevention and early intervention (for example, timely support from GP) (2 / 10%); Awareness – Consider improving awareness of support available in community (2 / 10%); Estate and facilities – Ensure appropriate facilities for visitors (for example, access to cafés over the weekend) (2 / 10%); Cost and efficiency – Concern over the allocation of financial resources (for example, extra funding for community services) (2 / 10%)

1.7 Conclusion

Survey respondents were asked to share their views on the community model for severe mental illness. 28 (60%) respondents said that the care model was poor or very poor, while 19 (40%) said it was good or very good. Some of the positive themes from across the various channels were that the care model was good, and that being close to home is better for mental health patients than being in hospital. Some negative themes were that the pathway is not as smooth as described in the model, and that community care may not be suitable for everyone. Participants suggested that the care model could be improved by providing better local mental health support, and that more detail was needed around the model.

When asked about the community model for dementia, 10 (46%) survey respondents said that the care model for dementia was good or very good, while 8 (36%) said it was poor or very poor. Positive themes were that being close to home is better for patients with dementia, and that dementia cafés and local groups provide good support. Some expressed concern over the safety and security of patients with dementia, and it was suggested that people are not sufficiently aware of the dementia services available in the community. It was

also suggested that the care model for dementia could be improved by incorporating more support for carers, and by providing continuity of care.

When survey respondents were asked to share their views on the proposal to deliver inpatient mental health services, 26 (59%) said the proposal was poor or very poor, while 7 (15%) said it was good or very good. Positive themes were that the proposal is a good solution, and that it may help to improve the quality of care. In contrast, some participants said the proposal was not a good solution, and expressed concern about a lack of hospital beds to meet demand. It was also suggested that the proposal could be improved by rebuilding the George Bryan Centre, or by providing transport for patients and visitors.

Survey respondents were asked to share their concerns about travel for visitors. 40 (87%) respondents said they were concerned or very concerned, while 3 (6%) said they were not concerned. Suggestions included providing financial support until patients can return home, and to consider aligning visiting times with public transport timetables.

Finally, survey respondents were asked if they could easily use their devices to contact someone in hospital. 27 (66%) said they could easily do this, while 10 (24%) said they could use their device to contact someone in hospital – but that they would need help. Consultation participants also commented that technology cannot replace human contact, and it was suggested that we should consider the needs of older people who have difficulties using technology.

2 Introduction

This report presents the findings from the consultation on sourcing a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre.

The purpose of this report is to present the views of consultation participants so they can be considered by the NHS in Staffordshire and Stoke-on-Trent during subsequent decision-making processes.

This report is structured as follows: introduction, communications and involvement, approach to analysis, demographic profiling, findings, conclusion and appendix.

2.1 Background

The NHS in Staffordshire and Stoke-on-Trent has been working with local patients, staff, interested groups and partners to redesign the mental health services in the area. The priority is to deliver quality mental healthcare for patients in their own home or community whenever possible, rather than in hospital. This model of care is the national ambition set out in the NHS Long Term Plan. It is based on the latest clinical evidence, which shows that this approach gives the best outcomes for most patients with mental health problems, supporting their wellbeing and independence.

The NHS in Staffordshire and Stoke-on-Trent have been working with their partners and investing in community mental health services for many years.

For the small number of patients who do need a hospital stay, the NHS across Staffordshire and Stoke-on-Trent want to make sure that the right specialist staff are on hand to give them the best care.

The proposal set out by NHS Staffordshire and Stoke-on-Trent looks at how to provide the inpatient (hospital bed) services that were previously provided at the George Bryan Centre. These are services for people living in south east Staffordshire: adults (18–65 years of age) with severe mental illness, and older adults (over 65 years of age) with severe mental illness or dementia.

The consultation ran from 9 February to 23 March 2023. Its aims were to:

- Explain the proposal, including:
    - setting out the context of national changes in best practice in mental healthcare and the clinical evidence supporting these changes
    - how the proposal had been reached and why a single viable proposal was being recommended
- Ask people their views on:
    - whether there were other ideas that had not been considered
    - any advantages or disadvantages that would need to be planned for, if the proposal is implemented
    - how to support people if the proposal is implemented, especially with travel.

2.1.1 Overview of the models and the proposal

2.1.1.1 Community model for severe mental illness

Community mental health services support people in their own homes and in their communities. They help with different conditions, from mild levels of depression and anxiety to more severe mental illness.

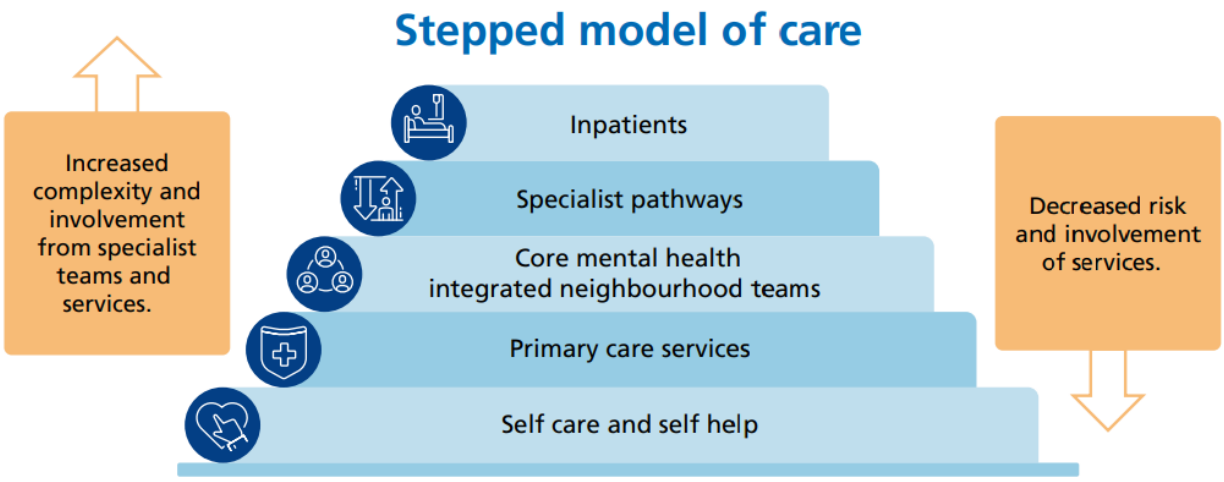
Clinical evidence shows that most patients get the best outcomes (the best experience and the best chance of recovery) if mental healthcare and support are provided in the community, rather than in a hospital. Getting the right support and treatment, while living in your usual home with loved ones close by, gives people the best chance to recover and stay well.

Based on this clinical evidence, the latest national guidance on mental healthcare says that most patients should be treated in the community.

Sometimes people become so unwell that they must go to hospital. But the national best practice is that hospital stays should be as short as possible – giving essential treatment and care until patients can safely go home, with continuing support in the community as needed.

Figure 1 shows the 'stepped' model of care, with most patients being supported without the need for hospital stays.

Figure 1. Stepped model of care



Over the last three years, the NHS across Staffordshire and Stoke-on-Trent have been investing in local community mental health services and improving them, so they are easier to access and can offer earlier and more flexible support.

They have been strengthening the services to provide better support for people experiencing crisis. For example, they have opened a crisis café in Tamworth, which can support people in crisis with advice, information on the services they can use, and a safe space with emotional support.

The community mental health teams are working closely with primary care (GPs), council staff (like social workers) and voluntary sector providers who are experts on particular issues – like drug and alcohol abuse, housing, or finance and debt. It is known that mental illness

can be impacted by other problems in people's lives, from physical illnesses to money worries. By having mental health teams work with these other services, more meaningful care that 'wraps around' a patient's needs can be offered.

These enhanced community services mean that most of the patients who would previously have been cared for at the George Bryan Centre can now be supported within the community, which is better for their long-term wellbeing and independence.

2.1.1.2 Community model for dementia health care service

Community mental health services support older adults with dementia and other forms of mental illness in their own homes and in their communities.

For older people with dementia, clinical evidence suggests that hospital stays do not help. Instead, there is a big risk of losing their independence.

Getting the right support and treatment, while living in their usual home, gives older people the best chance to stay independent for longer. Sometimes people become so unwell that they must go to hospital. But the national best practice is that hospital stays should be as short as possible.

Over the last three years, the NHS across Staffordshire and Stoke-on-Trent have been investing in local community mental health services and improving them. This includes specific support for older adults, who can have particularly complex needs. Below are some examples.

Making it easier to get the right help – an older adult specialist is now involved when a patient or carer first gets in touch. The specialist helps to get the right teams in place for each patient, and to speed up the process.

Crisis support and avoiding hospital stays – the Hospital Avoidance team (HAT), which includes older adult specialists, gives support at home to help older people stay out of hospital. The team offers phone calls and home visits, and carers can call for help in a crisis.

Support for carers – a new home sitting service is being developed to support carers who need a break during the evening or at weekends. The crisis team will refer patients to this service, which will give carers some much-needed time to themselves, while their loved one is looked after in their own home.

Support from voluntary sector partners – arrangements have been made with some voluntary organisations to provide some services. These are non-clinical services (not medical), delivered by organisations including:

- Alzheimer's Society dementia advisers supporting patients at home
- Mental Health Matters supporting older adults after a hospital stay and connecting them with community groups that can offer ongoing support
- MASE Group (Monthly Alzheimer's Support Evening) in Stafford providing dementia support.
- Burton MIND providing the home sitting service mentioned above.

These enhanced community services mean that most of the older patients who would previously have been cared for at the George Bryan Centre can now be supported within the community, which is better for their long-term wellbeing and independence.

2.1.1.3 Proposal for delivering inpatient mental health services

Clinicians and experts in the NHS across Staffordshire and Stoke-on-Trent have recommended that there is one viable (realistic and achievable) proposal. This is to make the changes that were made in 2019 permanent. This means keeping the 18 mental health beds at St George's Hospital.

The NHS in Staffordshire and Stoke-on-Trent have involved patients and carers, staff, mental health clinicians and the public throughout this journey. They have considered the findings from the public involvement, along with clinical evidence, while developing this proposal.

Listening to people's feedback, they have also looked at any potential impacts if these temporary changes are made permanent. This includes considering the workforce, clinical safety, health inequalities (fair care), and travelling times for family and carers.

The evidence suggests that an isolated ward at the George Bryan Centre would not:

Be clinically safe

- It would not have a psychiatric intensive care unit for people who need additional support
- It would not have seclusion rooms for patients in crisis
- Without these facilities, patients in crisis may have to be transferred to St George's Hospital, which disrupts their care
- It would have limited numbers of specialist staff compared to St George's Hospital, which is a larger site.

Be sustainable in terms of staffing

- There is a national shortage of mental health staff and it is harder to recruit staff to work in smaller, isolated units
- If beds were reinstated at the George Bryan Centre, some staff would have to transfer there from St George's Hospital, impacting on patient care at the bigger site.

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

- Much greater range of specialist services at St George's Hospital, including art and music therapy
- Those with approved leave can easily walk into Stafford town centre – helping patients keep their independence and connection with everyday life
- On a larger site like St George's Hospital, staff are used flexibly across different wards, providing cover and maintaining a high level of care, particularly during periods of staff sickness. This is not possible at a smaller unit.

2.2 Number of respondents

The engagement period for the consultation ran from Thursday 9 February to Thursday 23 March 2023 – 6 weeks. During this period participants were able to share their views by completing the consultation survey or by attending a range of online and face- to-face events. Table 4 shows the number of responses received across the different feedback channels.

Table 4. Summary of consultation responses / participation

Feedback channel	Number of responses / participants
Consultation survey (including easy read and hard-copy submissions)	48 survey responses
Engagement sessions with specific communities led by VCSE partner Support Staffordshire	81 participants across 29 engagement sessions
Online events	6 participants across 2 events
Drop-in roadshows	55 to 74 (estimated) participants across 7 roadshows
Targeted workshops	133 participants across 6 targeted workshops
Other channels	4 Overview and Scrutiny Committee meeting minutes and reports from Healthwatch

Consultation participants had the freedom to share their views through the consultation survey and by attending any of the events, workshops and roadshows that were held.

For more information about the activities undertaken to promote the consultation and gather feedback, please see the communications and involvement section below.

2.3 Report authors

NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) commissioned NHS Midlands and Lancashire Commissioning Support Unit's (MLCSU's) Communications and Engagement Service, on behalf of Midlands Partnership NHS Foundation Trust, to coordinate the independent analysis of the feedback from the consultation and to produce this report.

3 Communications and involvement

This section gives an overview of the communications and engagement approach for the consultation.

The communications and engagement approach was articulated in the communications and involvement plan, created in September 2022 by MLCSU on behalf of Staffordshire and Stoke-on-Trent ICB. Although the plan was an iterative document, it outlined key areas of activity and thinking at that time. These are summarised as:

- Recognising that this phase followed involvement activity in 2019 and 2021/22, consultation activity should build on relationships already established with stakeholders and conversations that had already taken place, as well as giving people new to the discussion the chance to have their say
- Based on experience of previous involvement, a six-week involvement period was recommended
- A combination of face-to-face activity (subject to any COVID-19 Infection Prevention Control (IPC) requirements) and digital methods would be used to engage with the public and patients
- The range of activities proposed included:
    - A survey, which used digital and traditional methods of collating responses
    - Attending meetings held by groups if requested
    - Online meetings
    - Drop-in roadshow events – in places of high footfall and for staff
    - Targeted focus groups and one-to-one interviews – with those from seldom-heard communities, for whom alternative engagement channels might be more useful.
- The plan also articulated working with Support Staffordshire as a delivery partner. Support Staffordshire are a countywide support organisation for the voluntary, community and social enterprise sector. It was felt that their engagement networks could help reach people who might be affected by the proposal but who might not engage via the traditional methods outlined above.

3.1 Engagement resources

3.1.1 Consultation documents

A suite of consultation documents was developed.

- Full consultation document with survey (printed)
- Full consultation document (online)
- Accessible consultation document with survey (printed)
- Accessible consultation document (online)
- Summary consultation document (printed and online)

Print quantities are given in section 3.2.2 and downloads are shown in section 3.2.4.1.

In addition to the full-length and summary versions of the consultation document, there were edited sections to accompany the survey questions online. This provided contextual

information for any respondents who might not have referred to the consultation document before responding to the survey. Audio recordings of these sections were also provided.

3.1.2 Audio and visual resources

Three animations were hosted on the consultation website:

- Journey to develop a long-term solution (originally produced for the March 2022 reference group and updated for the consultation)
- Pathways to mental health support
- Dementia services.

Audio versions of the edited consultation document text that accompanied the online survey questions were made available.

3.1.3 Additional key resources

Additional resources available on the consultation webpages were:

- Mental health investment leaflet
- The move towards more community-based mental healthcare (with timeline)
- Case studies (three on dementia, three on severe mental illness)
- Activity and travel analysis – Q&As
- A document about financial assistance for travel
- Business case
- Link to the West Midlands Clinical Senate Review report
- FAQs.

Resources used to support the delivery of the events:

- PowerPoint Presentation summarising the consultation documents (long version)
- PowerPoint Presentation summarising the consultation documents (shorter version).

3.2 Communication channels

3.2.1 Telephone calls, emails and briefings

Relevant stakeholders and local community organisations were contacted, either by telephone, email, post or by online meetings, to inform them about the consultation. Activities included:

- Creating and using a stakeholder database with approximately 150 contacts
- Compiling and using a distribution list of 30 local organisations who shared materials and key messages with their communities
- Developing a script for telephone calls
- Developing and sharing a comprehensive event plan with details of 17 planned events
- Preparing and delivering staff briefings, emails and electronic updates
- Sharing briefings on a section of the ICB website

- Providing an editorial piece to local community groups to spread the word in their newsletters and external communications
- Developing and sending:
    - a general email to stakeholders with information about the consultation
    - a launch letter
    - an email to project leads in the county who might have an interest in the involvement
    - an email to people who had registered for online events asking them to confirm their attendance.

3.2.2 Printing and distribution of materials

Table 5 shows the quantities of consultation documents printed.

Table 5. Number of copies printed

Document	Copies printed
Full consultation document with survey	190
Accessible consultation document with survey	565
Summary consultation document	465

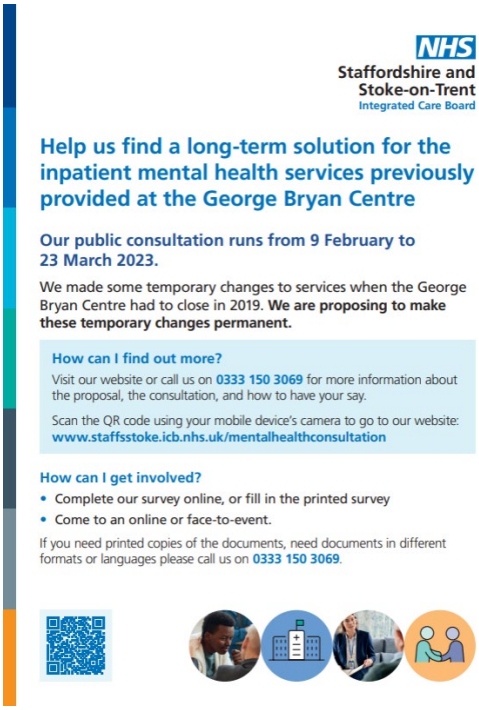
The following printed promotional materials were produced:

- double-sided A5 flyer
- A4 poster
- pull-up banners.

Copies of the consultation documents, flyer and poster were distributed to 30 key stakeholders' venues across the target area. Digital versions of these materials were emailed to more than 147 contacts on the Staffordshire and Stoke-on-Trent community stakeholder database.

Staff members brought the pull-up banners to events and engagement sessions.

Figure 2. Poster used to promote the consultation



3.2.3 Correspondence

Correspondence was used to engage with key stakeholders but also received from the public as a form of consultation feedback.

The team undertook a range of activities to correspond with stakeholders (see section 3.2.1 above),

The team developed a protocol for receiving (and if appropriate, responding to) public correspondence about the consultation.

During the consultation we received **three pieces** of correspondence. All three pieces have been analysed in this report, along with social media posts.

Feedback given by Healthwatch Staffordshire has also been included in this report.

3.2.4 Social media and online promotion

3.2.4.1 Online promotion

The consultation had a dedicated set of webpages. Along with information about the consultation, it hosted:

- the consultation documents and other key resources
- the consultation survey (plus an accessible version of the survey)
- documents from previous involvement activities
- FAQs.

The table shows the numbers of downloads/views of consultation documents and other key supporting documents.

Table 6. Numbers of downloads and views of the consultation documents

Document	Downloads/views
Full consultation document	149
Accessible consultation document	37
Summary consultation document	79
Mental health investment leaflet	36
The move towards more community-based mental healthcare (with timeline)	39
Case studies	69 views of 6 case studies
Business case	60
Document on financial assistance for travel	27

3.2.4.2 Social media

3.2.4.2.1 Organic social media

The organic social media campaign ran from 6 February to 23 March 2023 on Facebook and Twitter. Two social media assets were designed to accompany the posts, one with a call to action of 'Find out more' and the other with encouragement to 'Have your say'. A variety of posts were used, from more general messages informing people about the consultation to posts highlighting specific events.

The combined number of Facebook impressions was 14,259. For Twitter there were 7,643 impressions.

3.2.4.2.2 Social media advertising

Two adverts were launched on Facebook/Instagram, targeting those aged over 18 across a 23km area covering Tamworth, Lichfield, Burton and Stafford. The adverts were rolled out between 9 February and 23 March 2023.

Figure 3. Adverts launched on Facebook and Instagram promoting the consultation

Advert	Creative	Copy
Ad 1		We're running a consultation about the inpatient (hospital) mental health services that were provided at the George Bryan Centre until 2019. Find out how you can have your say here.
Ad 2		Help us find a long-term solution for the inpatient mental health services in south east Staffordshire. Join an online event, come to one of our drop-in roadshows, or complete our survey to have your say. Get involved today.

The table below summarises each advert's performance. (Definitions are provided below.)

Table 7. Performance of the adverts on social media

Ad	Reach '	Impressions ²	Frequency ³
Ad 1	145,251	556,573	3.83
Ad 2	101,808	324,573	3.19
Total	**190,318**	**881,146**	-

' **Reach** is the number of unique (individual) users who have seen the adverts.
² **Impressions** are the number of times the page is located and loaded by a user (number of times an advert is shown).
³ **Frequency** is the average number of times that each person saw the advert.

This table summarises how people engaged with the campaign. (Definitions are provided below.)

Table 8. Interactions with the adverts on social media

Ad	Link clicks ¹	Post reactions ²	Post shares ³	Post comments
Ad 1	3,395	39	19	11
Ad 2	1,414	50	35	11
Total	**4,809**	**89**	**54**	**22**

¹**Link clicks** are the number of people that clicked on the advert to visit the landing page, indicating interest and engagement.
²**Post reactions** are how users have interacted with adverts from a choice of six emotions – Like, Love, Haha, Wow, Sad, and Angry.
³**Post shares** refer to the number of times people shared adverts on their own or friends' timelines, in groups and on their own pages.

3.2.4.2.3 Pulsar reporting

Throughout the consultation, the social listening tool Pulsar was used to monitor social media activity. Social listening is the ability to capture and gain insights from online conversations.

When the Pulsar searches were originally set up, the main objectives were to:

- measure the conversations around the consultation, focused on reach, response, audience insights/demographics (such as location based on bio information)
- measure messages from all partners to get an understanding of how people felt about the consultation.

By understanding the sentiment of real-time trending conversations and topics relating to the consultation, the team were better informed about public views and opinion.

During the consultation, there were clear peaks when engagement was highest. This tended to be when the consultation was promoted from the ICB social media account and when event registration was promoted. The highest engagements with posts were on 8 March and 21 March 2023.

A deeper look into the data shows that the majority of replies to posts tended to have a negative tone and sentiment. However, throughout the consultation, there was a high amount of overall engagement and visibility of posts with over **19k impressions**.

Over the course of the consultation Pulsar picked up **134 social media posts**. The majority of the posts were originated by the online community promoting the consultation and feedback mechanisms, but Pulsar also picked up posts from members of the public and other stakeholders sharing feedback on the proposal in the consultation. These posts have been analysed alongside correspondence received by the public.

3.2.5 Press, public relations and advertising

3.2.5.1 Newspaper advertising

Printed newspaper advertising included a quarter-page advert rolled out on 9 February in:

- Tamworth – *Tamworth Herald*
- Stafford – *Express & Star* – East Zone
- Burton – *Burton Mail*
- Lichfield – *Burton Mail*

A suite of display adverts was created. These were branded for the campaign to engage the audience and took people to the consultation web page. They included mid-page units (MPUs – a form of digital adverts) on the *Lichfield Live* website. Adverts launched on 9 February and ended on 21 March.

Table 9.Interactions with the online adverts

Clicks	Impressions	Click through rate
430	200,000	0.22%

3.2.5.2 Proactive media activity

Proactive media activity resulted in the following eight pieces of press coverage:

Table 10. Summary of proactive media activity

Date	Coverage
26/01/2023	*Atherstone & Coleshill Herald* (circulation 1,785) **Headline:** Public consultation planned for future of mental health care throughout Staffordshire
	Tamworth Herald (circulation 9,548) **Headline:** Public consultation planned for future of mental health care throughout Staffordshire
01/02/2023	*Leading Healthcare* **Headline:** Staffordshire and Stoke-on-Trent ICB gives go-ahead for public consultation on inpatient mental health services
09/02/2023	*Tamworth Herald* (circulation 9,548) **Headline:** Public consultation on the future of the George Bryan Centre gets underway this week
	Lichfield Live (circulation 5,538) **Headline:** Consultation launches over future of inpatient mental health services
13/02/2023	supportstaffordshire.org.uk **Headline:** South East Staffordshire Inpatient Mental Health Services Consultation
16/02/2023	*The Coleshill and Castle Brom Post* (circulation 1,785) ***Headline:*** Drop in sessions over centre future
	Tamworth Herald (circulation 9,548) ***Headline:*** Drop in sessions over centre future

3.2.6 Events

3.2.6.1 Engagement sessions with specific communities, led by VCSE partner Support Staffordshire

Support Staffordshire were commissioned to reach and engage with specific targeted communities during the consultation. These included:

- People of Eastern European, South Asian, Black (Afro-Caribbean) and mixed race ethnicities
- People in the most deprived areas – particularly in Lichfield, Burton and Tamworth
- Men aged 65 and over
- Women aged 25 to 44
- People experiencing homelessness
- Carers – particularly young carers
- People involved in substance misuse
- LGBTQ+ groups
- People currently in the military and veterans.

Two members of the Support Staffordshire team attended facilitator training to enable them to deliver a range of focus groups and one-to-one interviews. Materials were adapted to meet their needs and specifications.

Support Staffordshire used the feedback mechanisms in place for the consultation to report findings from all their engagement sessions. Their findings have been included in this report.

Table 11. Communities engaged with by Support Staffordshire during the consultation.

Date	Participants	Organisation / group hosting the event	Audience engaged
09/02/2023	1	Survivors of Bereavement by Suicide	Carer
15/02/2023	1	Support Staffordshire with Changes Tamworth	User-led mental health charity
15/02/2023	12	St Peter's Church, Tamworth – Warm Space	Carer, service users, volunteers and general public
16/02/2023	1	Heart of Tamworth Sacred Heart Church	Carer
16/02/2023	2	Heart of Tamworth Sacred Heart Church	Volunteers
16/02/2023	3	Heart of Tamworth Sacred Heart Church	Carers and service users
16/02/2023	13	East Staffordshire District Patient Engagement Group	Patient representatives of East Staffordshire GP surgeries.
21/02/2023	2	Heart of Tamworth Sacred Heart Church	Volunteers
22/02/2023	7	Warm Space, Wilnecote Church, Wilnecote, Tamworth	General public, carer
23/02/2023	6	Burton Albion Hub – Community Champion Health and Wellbeing Fair	Community Champions, NHS employee and general public
27/02/2023	1	Bancroft Community Centre	Volunteer
27/02/2023	8	Open Door CIC, Lichfield	Service users
28/02/2023	7	Uttoxeter Heath Community Centre – Warm Welcome and Food Bank	General public and service users
28/02/20233	1	Uttoxeter Heath Community Centre – Warm Welcome and Food Bank	Member of public
01/03/2023	2	Uttoxeter Community Centre – Food Bank and Men's Group	Carer and member of public
03/03/2023	2	Lichfield Cathedral	Parishioners
07/03/2023	1	Heart of Tamworth Community Shop and Hot Café	Member of public
07/03/2023	2	Heart of Tamworth Sacred Heart Church	Volunteers
15/03/2023	1	Heart of Tamworth Sacred Heart Church	Member of public
15/03/2023	1	Support Staffordshire	Burton Hope Homeless Charity (based in Burton upon Trent) – community worker / volunteer
17/03/2023	1	Our Smiley Space, Tamworth – Neurodiverse charity	Volunteer
15/03/2023	4	Trent and Dove Housing Mental Health Working Group	Service users
23/03/2023	1	Communities Together Tamworth	Staff
29/03/2023	1	Serco – justice and immigration company supporting refugees in Tamworth and Burton hotels	Refugee and Asylum partnership
Total	*81*		

3.2.6.2 Online events

The purpose of the online events was to present the key messages of the consultation and gain feedback from participants on the different components of the proposal using a Jamboard (an anonymised method of leaving notes and comments). Events were conducted using Microsoft Teams and members of the clinical team were present to answer questions and listen to participants' feedback.

Event 1 was planned for Friday 2 March 2023. Although a small number of people had registered for this event, none attended. The team ensured that all who had registered were offered an opportunity to join the next event and were sent a link to the online survey as well.

Event 2 was held on 9 March 2023 and had six participants.

During the event, participants used the breakout sessions and the Q&A to give us feedback and ask questions about the consultation and the proposal. Jamboards were the key mechanism for recording and collating feedback. The themes from the comments and information on the Jamboard have been included in this report, along with the feedback and questions captured from the TEAMS chat during the event.

Table 12. Online event agenda

Section	agenda
1	**Presentation:** Why are we reviewing our local hospital mental health services?
2	**Presentation:** community support for mental health needs
3	**Breakout:** gathering views on the community-based model for mental health needs
4	**Presentation:** the community model for dementia care
5	**Breakout:** gathering views on the community-based model for dementia care
6	**Presentation:** the proposal for delivering inpatient mental health services
7	**Breakout:** gathering views for delivering inpatient mental health services
8	**Q&A**
9	Closing remarks

3.2.6.3 Drop-in roadshows

The initial plan was for five drop-in events, to give the consultation a presence in places with high footfall in the Tamworth, Lichfield and Burton areas.

The aim was to engage with the public about the proposal and to promote the survey, encouraging people to use it to give their feedback.

During the consultation, in response to feedback, including feedback from an MP, two more drop-in events in Tamworth were added. These were at the Ankerside Shopping Centre and the Coton Centre (an evening event). This gave the Tamworth community further opportunities to give their views on the consultation.

Table 13. Location and date of the drop-in roadshows

Date	Venue	Estimated attendees	Interactions
16/02/23	St George's Hospital	0	No staff attended but we received feedback that a thorough process of engaging with staff had already taken place, so this session was intended to ensure we were visible to any other staff who had further questions or queries
23/02/23	Lichfield Library	15–20	A small number of people engaged and took surveys to complete or information to help them engage online
06/03/23	Tamworth Asda	15–20	A high engagement rate with many people coming to talk to the team. Some participants had either been service users or were carers.A number of people took surveys to complete or information about the online sessions
10/03/23	Burton Library	1–2	The event ran on a day with high snowfall and genearl bad weather, so the venue was very quiet. We spoke to some staff but no members of the public
16/03/23	Ankerside Shopping Centre, Tamworth	7–10	We engaged with men and women aged between 25 and 70 – all of whom were willing to share their views on their experiences and on mental health provision in Tamworth
17/03/23	Burton Asda	9–12	Mostly women between 25 and 75. Two were users of mental health services, one was a carer and six were members of the public who were interested in the consultation for various reasons
21/03/23	Coton Centre, Tamworth	8–10	Approximately 10 people attended the session to talk to us about the consultation. These were a mix of carers and patients

A range rather than an exact number is given for attendance at drop-in roadshows because of the difficulty in recording an exact number in high-footfall areas.

3.2.6.4 Targeted workshops

Six targeted workshops were organised. The Communications and Engagement team worked with existing groups from specific communities to organise the sessions, where they intended to deliver a presentation and receive feedback. It became clear that the method of delivering the workshops could be adapted to better meet the needs of some attendees. This meant that in some sessions the message was delivered through targeted conversation, rather than using the original presentation, but feedback was still gathered via notes and completed surveys.

The team engaged with the communities of Tamworth, Burton and Lichfield. They specifically engaged with groups of people who had experienced mental health issues and challenges – either themselves or as carers. The team also worked with groups who support people experiencing dementia or caring for someone with the condition.

The groups the team attended included:

- Burton Caribbean Association, which runs community groups for local people who have dementia or mental health conditions, are carers, or feel isolated/lonely
- Better Way Recovery, a Lichfield-based group for people who are addicted to alcohol, drugs or have serious mental health conditions
- The Rotary Club, which hosts a regular Memory Café for people with dementia and their family and carers

- MIND invited the consultation team to their arts and crafts group for people who have mental health conditions and/or learning disabilities.

Working with these groups, the team were able to talk to people who had experience of inpatient mental health services – either personally, as family or friends, or as carers. The events are listed below.

Table 14. information about the targeted workshops

Date	Group	Attendees	Demographics	Needs
09/02/2023	Burton Caribbean Association	12	Black, Afro-Caribbean men and women aged 50–80	Dementia patients and those with experience of severe mental health conditions; elderly carers; retired NHS staff
21/02/2023	Rotary Club Carers+ Café	30	Mix of black and white men and women aged 50 and over	Dementia patients; elderly carers
27/02/2023	Better Way Recovery	18	Mix of men and women, mix of ages, mostly white British, but with some other ethnicities	Experience of severe mental health conditions and mental health issues – vulnerable due to drug and alcohol addiction
02/03/2023	Lichfield Memory Café	40	Predominantly white men and women, some from ethnic minority groups, aged 50 and over	Dementia patients and carers
14/03/2023	Tamworth Memory Café	25	Predominantly white men and women, some from ethnic minority groups, aged 50 and over	Dementia patients and carers
22/03/2023	Burton MIND arts club	8	White men and women, mainly women aged 30–55	People with some minor learning disabilities and mental health issues

3.2.7 Attendance at additional meetings and events

3.2.7.1 Lichfield Overview and Scrutiny Committee

Lichfield Overview and Scrutiny Committee asked to engage with the consultation team about the consultation and the proposal. The team gave a presentation to the committee at a meeting on 16 March 2023 and received a copy of the minutes of the meeting.

3.2.7.2 League of Friends Robert Peel Hospital meeting

The League of Friends at Robert Peel Community Hospital, Tamworth, asked for the chance to engage with the consultation team about the consultation and the proposal. The team gave a presentation on 20 March 2023 to the League of Friends' board.

3.3 The midpoint review

In line with good practice, the Communications and Engagement team conducted a midpoint review of the consultation on Tuesday 7 March 2023 and recommendations were made to the IMHS Steering Committee for consideration on Friday 10 March 2023.

The review looked at evidence of the consultation data, as of 7 March 2023, including:

- Findings and themes that had emerged from the survey and events up to that date
- An overview of the events and promotional activities delivered up to that date
- Information on gaps identified and key learnings at that point in time
- Recommendations for the IMHS Steering Committee on possible changes to the communications and engagement plan for the final weeks of the consultation.

Overall, the review found the consultation was delivering to plan. However, it highlighted a few areas in which the team should adapt the plan and subsequent activities for the remainder of the consultation. These were areas where the team had identified gaps of knowledge/reach, where they would need to focus their attention and resources.

An action plan was drawn up to address these gaps and the review made a number of recommendations.

- Provide Support Staffordshire with additional income to focus on the specific cohorts highlighted in the action plan
- Continue to adapt communications (face-to-face and online) to communicate the consultation effectively to audiences
- Continue to adapt and be flexible to meet the needs of audiences in remaining planned activities.

Following the midpoint review, the key changes to activities were:

- Support Staffordshire re-focused their activity to include engaging with:
    - people experiencing homelessness
    - workers in a homelessness charity
    - a representative of an LGBTQ+ charity supporting people who are neurodiverse
    - housing association tenants who have experienced mental health issues
    - a representative of a group supporting refugees and asylum seekers.
- An additional drop-in roadshow event was delivered in Tamworth, at the Ankerside Shopping Centre on 16 March, allowing local people a further opportunity to engage with the consultation
- Social media activity increased, with the George Bryan Centre name used in posts to attract attention
- Additional press activity was scheduled to highlight the survey and its closing date
- The team continued to be flexible in meeting the needs of audiences in all remaining activities.

4 Approach to analysis and presentation of findings

This section outlines how the feedback gathered from the activities outlined in the communications and involvement section above has been analysed and presented in this report of findings.

The feedback captured during the consultation can be grouped into two categories: 'structured' feedback and 'unstructured' feedback.

Structured feedback is where consultation participants provided specific responses to a series of pre-defined questions. This type of feedback was received from the consultation survey and the engagement sessions with specific communities led by Support Staffordshire.

Participants were asked specific questions so they could share their feedback on the following areas:

- Experience of mental health services
- The community model for severe mental illness
- The model for dementia healthcare services
- The proposal for delivering inpatient mental health services
- Travel and access
- Technology

Unstructured feedback is where consultation participants were given the opportunity to freely share their views on any element of the consultation. This type of feedback was received from the online events, targeted workshops and drop-in roadshows, and was collated by the team managing the consultation

The unstructured feedback also includes feedback received through correspondence and social media channels.

4.1 Analysing the feedback

This section outlines how all the feedback has been analysed to include it in the report of findings.

4.1.1 Consultation survey

The consultation survey used a combination of 'open' free-text questions for respondents to make written comments, and 'closed' questions where respondents 'ticked' their response from a set of pre-set responses. Closed question responses are shown as percentages. These may not add up to 100% due to rounding or respondents being able to select multiple options.

The 'base' figure refers to how many respondents answered each question. When completing the survey not all respondents answered every survey question. This means that the base size may change between questions.

Open responses received to the survey have been read and coded into themes. This is a subjective process, where the responses to each open question are read and the key

themes (codes) identified to create a code frame. The code frame is then used to code all responses to that question, by assigning responses to codes.

In the findings section, the survey responses are broken down to show how different sub-groups have responded. For each 'closed' question, tables are presented showing the following:

- The overall response to the questions
- How different respondent types answered
- How people from different parts of Staffordshire and Stoke-on-Trent responded.

Additionally, for each 'closed' question any significant differences across the following sub-groups have been included: service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

Significance testing was undertaken to identify whether the differences in sub-group responses were as a result that is not attributed to chance. Significance testing compares how different sub-groups have responded. For example, the proportion of males agreeing, compared to females, gives an indication as to whether the difference between the two sub-groups is down to chance (i.e. not significant) or not (i.e. significant). Significance testing is not the reporting of instances where large proportions of a sub-group have all answered in the same way (for example, 95% of 20 to 24-year-olds agreed). When conducting significance testing, sub-group base sizes play a key role. If two sub-groups with large base sizes are compared, what may appear as a small percentage difference could be significant. Alternatively, if the base size of sub-groups is small, what may appear as a large percentage difference may not be significant. Although significance testing has been undertaken across all characteristics and reported here, please note that some base sizes are small.

4.1.2 Event feedback

All the event feedback received has been analysed using the same method as per the 'open' questions in the consultation survey. All the feedback gathered at the events has been read and coded into themes and these are presented in this report of findings. For the event feedback presented, the base refers to the total number of feedback notes submitted by facilitators / note-takers in response to each question across all the events.

4.1.3 Correspondence

The correspondence received during this involvement exercise consists of 47 social media posts and three pieces of correspondence received via email. The social media posts and email correspondence have been analysed using the same method as per the 'open' questions in the survey. All the feedback has been read and coded into themes and these are presented in this report of findings.

5 Demographic profiling

This section presents a combined demographic profile of consultation survey respondents and engagement event participants. Please see the Appendix for a profile of just the survey respondents or event participants.

5.1 Respondent type

98 (91%) participants were responding to the consultation as individuals, while 10 (9%) were providing a formal response from an organisation.

Table 15 shows the different respondent types participating in the consultation.

Table 15. As an individual responding to this questionnaire which of the following best applies to you? Please tick one only.

	No.	%
Another member of the public	35	35%
User of mental health services	32	33%
Carer	14	14%
From a non-health voluntary group, charity or organisation	8	8%
From a health-related group, charity or organisation	5	5%
NHS employee	4	4%
From another public sector organisation	1	2%
Base	*99*	

The base refers to the number of responses received to this question in the survey and those completing the event participant demographic profiling questionnaire. All these profiling questions were voluntary, meaning survey respondents and event participants were able to skip those they did not wish to answer. Also, event participants did not have to complete the demographic profiling questionnaire if they did not wish to.

Those individuals responding from a health-related group, charity or organisation, from a non-health voluntary group, charity or organisation, or from another public sector organisation stated they were from the following organisations:

- Dementia Care
- Early Help Team
- League of Friends of the Tamworth Hospitals
- Lichfield Cathedral
- Sacred Heart Church
- Self-employed carer
- Serco
- Tamworth Borough Council
- Yoxall and Area Patient Participation Group (YAPP).

Table 16 shows the different types of organisations a formal response was received from.

Table 16. As an organisation responding to this questionnaire which of the following best applies to you? Please tick one only.

	No.	%
Formal response on behalf of a non-health related voluntary group, charity or organisation	4	44%
Formal response on behalf of a health-related group, charity or organisation	2	22%
Formal response on behalf of another public sector organisation	1	11%
Other	2	22%
Base	*9*	

The base refers to the number of responses received to this question in the survey and those completing the event participant demographic profiling questionnaire. All these profiling questions were voluntary, meaning survey respondents and event participants were able to skip those they did not wish to answer. Also, event participants did not have to complete the demographic profiling questionnaire if they did not wish to.

Specifically, the organisations submitting a formal response to the consultation through the survey and participation at the events included:

- Balance Street Patient Participation Group
- Burton Hope
- Changes Tamworth
- Member of Parliament for Tamworth
- Communities Together Tamworth
- Friends of Robert Peel Hospital charity
- Healthwatch Staffordshire
- Our Smiley Space
- Staffordshire Baby Bank
- Uttoxeter Heath Community Centre

5.2 Demographic profiling

Table 17 presents a demographic profiling of survey respondents and engagement event participants.

Table 17. Demographic profiling – survey respondents and engagement event participants

Ethnicity			Sexual orientation		
White: British	94	88%	Heterosexual	90	84%
White: Irish	-	-	Gay	3	3%
White: Gypsy or traveller	-	-	Bisexual	3	3%
White: Other	1	1%	Asexual	2	2%
Mixed: White and Black Caribbean	1	1%	Lesbian	1	1%
Mixed: White and Black African	-	-	Prefer not to say	8	7%
Mixed: White and Asian	-	-	*Base*	*107*	
Mixed: Other	2	2%	Relationship status		
Asian/Asian British: Indian	-	-	Married	45	42%
Asian/Asian British: Pakistani	2	2%	Single	27	25%
Asian/Asian British: Bangladeshi	-	-	Divorced	9	8%
Asian/Asian British: Chinese	-	-	Lives with partner	9	8%
Asian/Asian British: Other	-	-	Widowed	8	7%
Black/Black British: African	-	-	Separated	1	1%
Black/Black British: Caribbean	1	-	Civil partnership	1	1%
Black/Black British: Other	-	-	Other	2	2%
Other ethnic group: Arab	-	-	Prefer not to say	6	6%
Any other ethnic group	1	1%	*Base*	*108*	
Prefer not to say	5	5%	Pregnant currently		
Base	*107*		No	102	94%
Age category			Yes	1	1%
16 - 19	-	-	Prefer not to say	5	5%
20 - 24	4	4%	*Base*	*108*	
25 - 29	5	5%	Recently given birth		
30 - 34	7	7%	No	100	94%
35 - 39	6	6%	Yes	1	1%
40 - 44	5	5%	Prefer not to say	5	5%
45 - 49	13	12%	*Base*	*106*	
50 - 54	16	15%	Health problem or disability		
55 - 59	4	4%	Yes, limited a lot	18	17%
60 - 64	12	11%	Yes, limited a little	26	24%

65 - 69	8	8%	No	57	53%
70 - 74	9	9%	Prefer not to say	6	6%
75 - 79	11	10%	*Base*	*107*	
80 and over	2	2%	Disability		
Prefer not to say	3	3%	No disability	50	46%
Base	*105*		Mental health condition	29	27%
Religion			Physical disability	4	4%
Christian	61	57%	Learning disability or difficulty	6	6%
No religion	33	31%	Long-term illness	5	5%
Muslim	2	2%	Sensory disability	4	4%
Buddhist	1	1%	Other	2	2%
Hindu	-	-	Prefer not to say	11	10%
Jewish	-	-	*Base*	*108*	
Sikh	-	-	Carer		
Any other religion	2	2%	Yes - young person(s) aged under 24	18	17%
Prefer not to say	8	7%	Yes - adult(s) aged 25 to 49	13	12%
Base	*107*		Yes - person(s) aged over 50 years	19	18%
Sex			No	53	50%
Female	72	67%	Prefer not to say	11	10%
Male	32	30%	*Base*	*105*	
Intersex	-	-	Access to car		
Prefer not to say	4	4%	Yes, and I drive	79	75%
Other	-	-	Yes, but I don't drive	2	2%
Base	*108*		No, I don't have access to a car	24	23%
Armed services			*Base*	*105*	
No	95	8%			
Yes	5	5%			
Prefer not to say	7	7%			
Base	*107*				

The base refers to the number of responses received to this question in the survey and those completing the event participant demographic profiling questionnaire. All these profiling questions were voluntary, meaning survey respondents and event participants were able to skip those they did not wish to answer. Also, event participants did not have to complete the demographic profiling questionnaire if they did not wish to.

5.3 Geographical profiling

Figure 4 maps the location of consultation survey respondents and engagement event participants. The map has been created using the postcode shared by participants.

Figure 4. Map of survey respondents and event participants. Base 38 (survey respondents); 54 (engagement event participants)

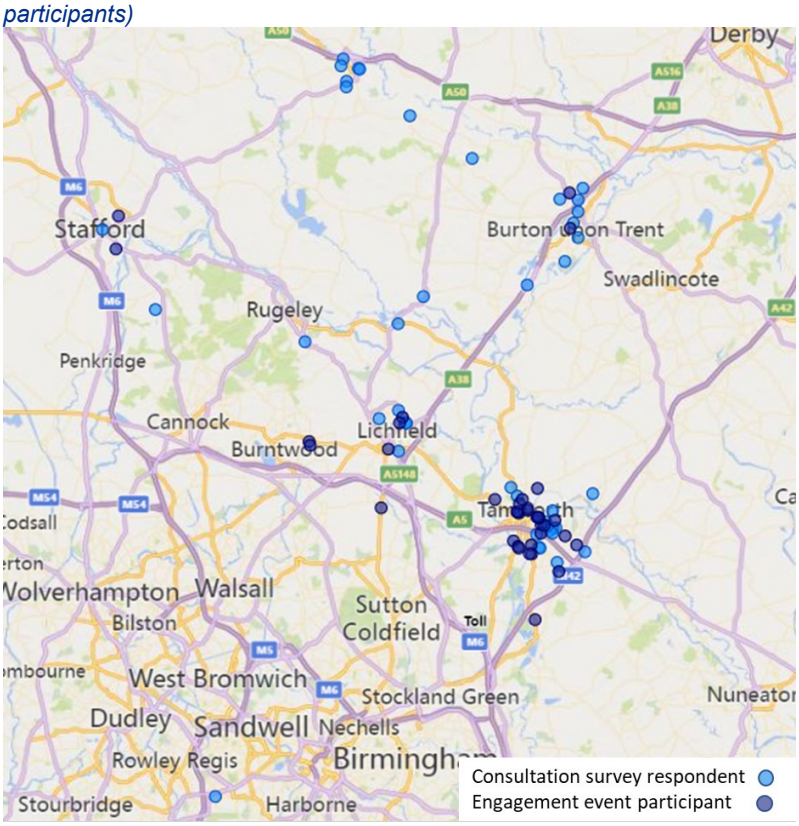


Table 18 shows the different local authority area consultation survey respondents and engagement participants were responding from.

Table 18.Local authority – survey respondents and engagement events with specific communities' participants combined

Local authority	No.	%
Tamworth	45	41%
East Staffordshire	20	18%
Lichfield	17	15%
Stafford	3	3%
Stoke-on-Trent	1	1%
South Staffordshire	1	1%
North Warwickshire	2	2%
North Wales	1	1%
Hart	1	1%
Birmingham	1	1%
No postcode provided	18	16%
Base	*110*	

The base refers to the number of responses received to this question in the survey and those completing the event participant demographic profiling questionnaire. All these profiling questions were voluntary, meaning survey respondents and event participants were able to skip those they did not wish to answer. Also, event participants did not have to complete the demographic profiling questionnaire if they did not wish to.

5.3.1 Index of Multiple Deprivation (IMD)

Table 19 shows the IMD decile of survey respondents' and event participants' postcodes. The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation for small areas in England. The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). Deciles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into 10 equal groups. These range from the most deprived 10% of neighbourhoods nationally (decile 1) to the least deprived 10% (decile 10).

Table 19. IMD breakdown – survey respondents and engagement events with specific communities' participants combined

IMD decile	No.	%
1 – Most deprived decile	13	12%
2	11	10%
3	2	2%
4	12	11%
5	11	10%
6	12	11%
7	10	9%
8	8	7%
9	9	8%
10 – Least deprived decile	4	4%
No postcode provided	18	16%
Base	*110*	

The base refers to the number of responses received to this question in the survey and those completing the event participant demographic profiling questionnaire. All these profiling questions were voluntary, meaning survey respondents and event participants were able to skip those they did not wish to answer. Also, event participants did not have to complete the demographic profiling questionnaire if they did not wish to.

6 Findings

This section presents the feedback gathered from the consultation survey, engagement events with specific communities, online events, targeted focus groups, drop-in roadshows and correspondence.

The feedback is split into two parts: presentation of the 'structured' feedback and presentation of the 'unstructured' feedback.

The 'structured' feedback was collated from the consultation survey and engagement sessions with specific communities. The feedback is split into the following sections:

- Experience of mental health services
- Feedback on the community model for severe mental illness
- Feedback on the model for dementia healthcare services
- Feedback on the proposal for delivering inpatient mental health services
- Feedback on travel and access
- Feedback on technology
- Suggestions about how inpatient mental health services could be provided.

The 'unstructured' feedback was collated from the online events, drop-in roadshows, targeted workshops, additional meetings and reports received and correspondence. The feedback is split into the following sections:

- Findings from the online events, targeted workshops and roadshows
- Findings from the correspondence
- Additional views and considerations.

6.1 Experience of mental health services

This section presents consultation survey respondents' experience of mental health services. The feedback relates specifically to the George Bryan Centre, St George's Hospital, Stafford, and community mental health services.

Tables 20 and 21 show the responses to the consultation survey question: Which of the following mental healthcare services have you used or experienced? 22 (49%) respondents said they had used or experienced community mental health services, 13 (29%) had used or experienced the George Bryan Centre, and 8 (18%) had used or experienced St George's Hospital, Stafford. However, 15 (33%) respondents said they had not used or experienced any of these services.

Table 20. Which of the following mental healthcare services have you used or experienced? Breakdown: Respondent type.

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Community mental health services	22	49%	15	79%	3	18%	2	50%	1	50%	1	33%	-	-
George Bryan Centre	13	29%	6	32%	3	18%	1	25%	2	100%	1	33%	-	-

St George's Hospital, Stafford	8	18%	5	26%	-	-	2	50	1	50%	-	-	-	-
None of the above	15	33%	1	5%	11	65%	2	50%	-	-	1	33%	-	-
Base	*45*		*15*		*17*		*4*		*2*		*3*		*-*	

Table 21. Which of the following mental healthcare services have you used or experienced? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Community mental health services	22	49%	7	33%	5	63%	2	100%	1	100%	1	50%	6	60%
George Bryan Centre	13	29%	4	19%	1	13%	-	-	-	-	1	50%	7	70%
St George's Hospital, Stafford	8	18%	1	5%	1	13%	2	100%	-	-	1	50%	3	30%
None of the above	15	33%	10	48%	2	25%	-	-	-	-	1	50%	1	10%
Base	*45*		*21*		*8*		*2*		*1*		*2*		*10*	

One response was received from outside the Staffordshire and Stoke-on-Trent area. The respondent stated they had not used or experienced any of these services.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.1.1 Significant differences across respondent groups

Respondent type

- A significantly higher proportion of users of mental health services (15 / 79%) stated they had used or experienced community mental health services, compared to members of the public (3 / 18%)
- A significantly higher proportion of members of the public (11 / 65%) stated they had not used or experienced any of these services, compared to users of mental health services (1 / 5%)

Disability

- A significantly higher proportion of consultation survey respondents stating they had a mental health condition (11 / 79%) said they had used or experienced community mental health services, compared to those stating they did not have a disability (5 / 26%)
- A significantly higher proportion of respondents stating they did not have a disability (9 / 47%) said they had not used or experienced any of these services, compared to those stating they had a mental health condition (1 / 7%)

Local authority

- A significantly higher proportion of respondents from the Stafford area (2 / 100%) stated they used St George's Hospital, compared to those responding from the Tamworth area (1 / 5%)

There were no significant difference in the following sub-groups: ethnicity, age, sex, sexual orientation, pregnancy, maternity, limitation in day-to-day activities, carers and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

The following sections present a more detailed view of consultation survey respondent's experiences of these services.

6.2 Experience of mental health services previously provided at the George Bryan Centre

Consultation survey respondents were asked the following questions:

- In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on?
- Which wing of the George Bryan Centre were you in?
- Which period would you like to provide feedback on?
- Please tell us about your experience of the George Bryan Centre below.
- Where do you work now?

Tables 22, 23 and 24 show the response to the consultation survey question: In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on? Most respondents stated they experienced the George Bryan Centre as a patient (5 / 39%), or as a carer or support worker for a patient (5 / 39%).

Table 22. In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
As a patient	5	39%	5	83%	-	-	-	-	-	-	-	-	-	-
As a carer or support worker for a patient	5	39%	1	17%	2	67%	1	100%	1	50%	-	-	-	-
As a provider of a service to a patient	2	15%	-	-	1	33%	-	-	-	-	1	100%	-	-
As a member of staff	1	8%	-	-	-	-	-	-	1	50%	-	-	-	-
Base	*13*		*6*		*3*		*1*		*2*		*1*		*-*	

Table 23. In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%

As a patient	5	39%	3	50%	5	39%	1	25%	-	-
As a carer or support worker for a patient	5	39%	2	33%	5	39%	2	50%	-	-
As a provider of a service to a patient	2	15%	-	-	2	15%	-	-	-	-
As a member of staff	1	8%	1	17%	1	8%	1	25%	-	-
Base	*13*		*6*		*13*		*4*		*-*	

Table 24. In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
As a patient	5	39%	2	50%	-	-	-	-	-	-	-	-	3	43%
As a carer or support worker for a patient	5	39%	2	50%	-	-	-	-	-	-	1	100%	2	29%
As a provider of a service to a patient	2	15%	-	-	1	100%	-	-	-	-	-	-	1	14%
As a member of staff	1	8%	-	-	-	-	-	-	-	-	-	-	1	14%
Base	*13*		*4*		*1*		*-*		*-*		*1*		*7*	

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents that make up that cohort.

6.2.1 Significant differences across respondent groups

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Those who had experienced the George Bryan Centre as patients were asked which wing they were in. All 5 (100%) patients stated they were in the west wing, which was for those aged under 65.

Respondents were asked which period they wanted to share their feedback on. 12 (100%) respondents stated their feedback relates to the period before and during March 2019, while 2 (17%) respondents stated their feedback relates to the period after March 2019.

Respondents were asked: Please tell us about your experience of the George Bryan Centre. 13 responses were received. The main theme areas were quality of care, staff, cost and efficiency, and access.

Overall, the top three sub-themes were:

1. Quality of care – The quality of care provided was good (5 / 39%)
2. Staff – Staff were caring and professional (3 / 23%)

3. Quality of care – The quality of care provided was poor (2 / 15%); Staff – Staffing levels were not sufficient (2 / 15%); Quality of care – The quality of care provided was poor (2 / 11%)

Table 25 presents the full list of themes.

Table 25. Please tell us about your experience of the George Bryan Centre below.

Sentiment	Main theme	Sub-theme	No.	%
Positive	Quality of care	The quality of care provided was good	5	38%
Positive	Staff	Staff were caring and professional	3	23%
Negative	Quality of care	The quality of care provided was poor	2	15%
Negative	Staff	Staffing levels were not sufficient	2	15%
Negative	Cost and efficiency	The centre was poorly managed	1	8%
Positive	Quality of care	The centre provided essential services	1	8%
Negative	Access	Concern over current location of inpatient mental health services (for example, long travel, poor public transport)	1	8%
Positive	Access	Services were accessible	1	8%
Neutral	General	Other	2	15%
Base			*13*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.2.2 Top theme by respondent group

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Quality of care – The quality of care provided was good (3 / 50%)
- **Another member of the public:** Limited feedback received
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** No feedback received

Service type

- **George Bryan Centre:** Quality of care – The quality of care provided was good (5 / 42%)
- **St George's Hospital, Stafford:** Quality of care – The quality of care provided was good (2 / 50%); Quality of care – The quality of care provided was poor (2 / 50%)
- **Community mental health services:** Quality of care – The quality of care provided was good (3 / 43%)
- **None of the above:** No feedback received

Ethnicity

- **White:** Quality of care – The quality of care provided was good (5 / 42%)
- **Prefer not to say:** Limited feedback received

Age

- **Under 45:** Limited feedback received
- **45 to 59:** Quality of care – The quality of care provided was good (2 / 50%); Staff – Staff were caring and professional (2 / 50%)
- **60 and over:** Quality of care – The quality of care provided was good (3 / 50%)

Sex

- **Male:** Staff – Staff were caring and professional (3 / 75%)
- **Female:** Quality of care – The quality of care provided was good (4 / 57)

Sexual orientation

- **Heterosexual:** Quality of care – The quality of care provided was good (4 / 40%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Limited feedback provided

Pregnancy

- **Yes:** No feedback received
- **No:** Quality of care – The quality of care provided was good (5 / 46%)

Maternity

- **Yes:** Limited feedback received
- **No:** Quality of care – The quality of care provided was good (5 / 50%)

Disability

- **No disability:** Quality of care – The quality of care provided was good (2 / 29%); Staff – Staff were caring and professional (2 / 29%)
- **Physical disability:** No feedback received
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Limited feedback received
- **Learning disability or difficulty:** No feedback received
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Quality of care – The quality of care provided was good (2 / 50%); Staff – Staff were caring and professional (2 / 50%)
- **No:** Quality of care – The quality of care provided was good (3 / 43%)

Carer

- **Yes – Carer:** Quality of care – The quality of care provided was good (3 / 60%);
- **No:** Staff – Staff were caring and professional (3 / 50%)

Local authority

- **East Staffordshire:** Limited feedback provided
- **Lichfield:** Limited feedback provided
- **Stafford:** No feedback received
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** Quality of care – The quality of care provided was good (2 / 50%)
- **No postcode provided:** Quality of care – The quality of care provided was good (2 / 33%); Staff – Staff were caring and professional (2 / 33%); Quality of care – The quality of care provided was poor (2 / 33%)

Index of Multiple Deprivation

- **Most deprived deciles (1-5):** Quality of care – The quality of care provided was good (2 / 50%)
- **Least deprived deciles (6-10):** Limited feedback provided
- **No postcode provided:** Quality of care – The quality of care provided was good (2 / 33%); Staff – Staff were caring and professional (2 / 33%); Quality of care – The quality of care provided was poor (2 / 33%)

Of the two respondents stating they were a member of staff at the George Bryan Centre, 1 (50%) is now working in community mental health services and 1 (50%) is working in another setting.

6.3 Experience of St George's Hospital, Stafford

This section presents the findings from the following consultation survey questions:

- In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on?
- Which period would you like to provide feedback on?
- Please tell us about your experience of St George's Hospital, Stafford, below.

Tables 26, 27 and 28 show the response to the consultation survey question: In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on? Most respondents stated they experienced St George's Hospital as a patient (4 / 50%), while 3 (38%) experienced it as a carer or support worker for a patient.

Table 26. In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
As a patient	4	50%	4	80%	-	-	-	-	-	-	-	-	-	-
As a carer or support worker for a patient	3	38%	1	20%	-	-	2	100%	1	100%	-	-	-	-
As a member of staff	1	13%	-	-	-	-	-	-	-	-	-	-	-	-
As a provider of a service to a patient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Base	*8*		*5*		*-*		*2*		*1*		*-*		*-*	

Table 27. In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
As a patient	4	50%	3	43%	1	25%	4	50%	-	-
As a carer or support worker for a patient	3	38%	3	43%	2	50%	3	38%	-	-
As a member of staff	1	13%	1	14%	1	25%	1	13%	-	-
As a provider of a service to a patient	-	-	-	-	-	-	-	-	-	-
Base	*8*		*7*		*4*		*8*		*-*	

Table 28. In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
As a patient	4	50%	1	100%	-	-	2	100%	-	-	-	-	1	33%
As a carer or support worker for a patient	3	38%	-	-	1	100%	-	-	-	-	1	100%	1	33%
As a member of staff	1	13%	-	-	-	-	-	-	-	-	-	-	1	33%
As a provider of a service to a patient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Base	*8*		*1*		*1*		*2*		*-*		*1*		*3*	

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents that make up that cohort.

6.3.1 Significant differences across respondent groups

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were asked which period they wanted to share their feedback on. 5 (63%) respondents stated their feedback relates to the period before and during March 2019, while 4 (50%) respondents stated their feedback relates to the period after March 2019.

Consultation survey respondents were asked: Please tell us about your experience of St George's Hospital, Stafford, below. 9 responses were received. The main theme areas were staff, access, communication, and quality of care.

Overall, the top three sub-themes were:

1. Staff – Some staff were not professional and caring (3 / 33%); Staff – Staff were good (3 / 33%)
2. Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 22%)

Table 29 presents the full list of themes.

Table 29. Please tell us about your experience of St George's Hospital, Stafford below.

Sentiment	Main theme	Sub-theme	No.	%
Negative	Staff	Some staff were not professional and caring	3	33%
Positive	Staff	Staff were good	3	33%
Negative	Access	Concern over the location of St George's Hospital (for example, long travel, poor public transport)	2	22%
Negative	Communication	Staff do not listen to service users and their families	1	11%
Positive	General	Better experience at St George's Hospital than at the George Bryan Centre	1	11%
Negative	Quality of care	Concern over early discharge	1	11%
Positive	Quality of care	St George's Hospital provides a good service	1	11%
Neutral	General	No comment (for example, N/A)	2	22%
Base			*9*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents that make up that cohort.

6.3.2 Top theme by respondent group

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Staff – Some staff were not professional and caring (2 / 33%); Staff – Staff were good (2 / 33%); Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 33%)
- **Another member of the public:** No feedback received
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** No feedback received
- **Formal response from an organisation:** No feedback received

Service type

- **George Bryan Centre:** Limited feedback provided
- **St George's Hospital, Stafford:** Staff – Some staff were not professional and caring (3 / 38%); Staff – Staff were good (3 / 38%)
- **Community mental health services:** Staff – Some staff were not professional and caring (3 / 38%); Staff – Staff were good (3 / 38%)
- **None of the above:** No feedback received

Ethnicity

- **White:** Staff – Some staff were not professional and caring (2 / 25%); Staff – Staff were good (2 / 25%); Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 25%)

- **Prefer not to say:** Limited feedback received

Age

- **Under 45:** Limited feedback provided
- **45 to 59:** Staff – Some staff were not professional and caring (2 / 40%); Staff – Staff were good (2 / 40%)
- **60 and over:** Limited feedback received

Sex

- **Male:** Limited feedback received
- **Female:** Staff – Some staff were not professional and caring (2 / 33%); Staff – Staff were good (2 / 33%); Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 33%)

Sexual orientation

- **Heterosexual:** Staff – Some staff were not professional and caring (2 / 29%); Staff – Staff were good (2 / 29%); Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 29%)
- **Other (for example, gay, lesbian, bisexual, asexual):** No feedback received

Pregnancy

- **Yes:** No feedback received
- **No:** Staff – Some staff were not professional and caring (2 / 29%); Staff – Staff were good (2 / 29%); Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 29%)

Maternity

- **Yes:** No feedback received
- **No:** Staff – Some staff were not professional and caring (2 / 29%); Staff – Staff were good (2 / 29%); Access – Concern over the location of St George's Hospital (for example, long travel, poor public transport) (2 / 29%)

Disability

- **No disability:** Limited feedback received
- **Physical disability:** Limited feedback received
- **Sensory disability:** No feedback received
- **Mental health condition:** Staff – Some staff were not professional and caring (2 / 50%); Staff – Staff were good (2 / 50%)
- **Learning disability or difficulty:** No feedback received
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Limited feedback received
- **No:** Limited feedback received

Carer

- **Yes – Carer:** Staff – Some staff were not professional and caring (2 / 50%); Staff – Staff were good (2 / 50%)
- **No:** Limited feedback received

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Limited feedback received
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Limited feedback received
- **No postcode provided:** Limited feedback received

Index of Multiple Deprivation

- **Most deprived deciles (1-5):** Limited feedback received
- **Least deprived deciles (6-10):** Staff – Some staff were not professional and caring (2 / 50%); Staff – Staff were good (2 / 50%)
- **No postcode provided:** Limited feedback received

6.4 Experience of community mental health services

This section presents the findings from the following consultation survey questions:

- In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on?
- Which period would you like to provide feedback on?
- Please tell us about your experience of community mental health services below.

Tables 30, 31 and 32 show the response to the consultation survey question: In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on? Most respondents stated they had experienced community mental health services as patients (15 / 65%), while (6 / 26%) respondents stated they experienced it as a carer or support worker for patients.

Table 30. In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
As a patient	15	65%	14	88%	1	33%	-	-	-	-	-	-	-	-
As a carer or support worker for a patient	6	26%	2	13%	2	67%	2	100%	-	-	-	-	-	-
As a member of staff	2	9%	-	-	-	-	-	-	1	100%	1	100%	-	-
As a provider of a service to a patient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Base	*23*		*16*		*3*		*2*		*1*		*1*		*-*	

Table 31. In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
As a patient	15	62%	15	68%	3	43%	3	43%	-	-
As a carer or support worker for a patient	6	26%	5	23%	3	43%	3	43%	-	-
As a member of staff	2	9%	2	9%	1	14%	1	14%	-	-
As a provider of a service to a patient	-	-	-	-	-	-	-	-	-	-
Base	*23*		*22*		*7*		*7*		*-*	

Table 32. In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
As a patient	15	62%	6	75%	2	40%	2	100%	1	100%	-	-	4	67%
As a carer or support worker for a patient	6	26%	2	25%	2	40%	-	-	-	-	1	100%	1	17%
As a member of staff	2	9%	-	-	1	20%	-	-	-	-	-	-	1	17%
As a provider of a service to a patient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Base	*23*		*8*		*5*		*2*		*1*		*1*		*6*	

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents that make up that cohort.

6.4.1 Significant differences across respondent groups

Age

- A significantly higher proportion of respondents aged under 40 (5 / 100%) stated they had used or experienced community mental health services as a patient compared to respondents aged over 60 (1 / 17%)

Limitation in day-to-day activities

- A significant proportion of respondents who are limited in their day-to-day activities (9 / 90%) stated they had used or experienced community mental health services as a patient, compared to respondents who were not limited (3 / 33%)

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, sex, sexual orientation, pregnancy, maternity, disability, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were asked which period they wanted to share their feedback on. 3 (60%) respondents stated their feedback relates to the period before and during March 2019, while 3 (60%) respondents stated their feedback relates to the period after March 2019.

Consultation survey respondents were asked: Please tell us about your experience of community mental health services below. 20 responses were received. The main theme areas were quality of care, staff, access, awareness, service provision, estate and facilities and support for carers.

Overall, the top three sub-themes were:

1. Quality of care – The services provided were good (for example, ongoing support) (5 / 25%)
2. Staff – Staff were not caring and lack of knowledge (4 / 20%); Quality of care – Services provided were poor (for example, poorly organised) (4 / 20%)
3. Access – Waiting times for community services are too long (for example, too many cancellations) (3 / 15%); Quality of care – Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups) (3 / 15%)

Table 33 presents the full list of themes.

Table 33. Please tell us about your experience of community mental health services below.

Sentiment	Main theme	Sub-theme	No.	%
Positive	Quality of care	The services provided were good (for example, ongoing support)	5	25%
Negative	Staff	Staff were not caring and lack of knowledge	4	20%
Negative	Quality of care	Services provided were poor (for example, poorly organised)	4	20%
Negative	Access	Waiting times for community services are too long (for example, too many cancellations)	3	15%
Negative	Quality of care	Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups)	3	15%
Negative	Quality of care	Concern over poor planning of care plans	2	10%
Negative	Awareness	Concern over the lack of awareness of mental health services available in the community	2	10%
Negative	Service provision	Concern over the lack of community mental health services	2	10%
Negative	Estate and facilities	The building was outdated	1	5%
Negative	Quality of care	Concern over the lack of recognition and accommodation of neurodiverse conditions	1	5%
Positive	Support for carers	The support provided to carers and families was good	1	5%
Negative	Access	Location of services is not accessible	1	5%
Neutral	General	Other	2	10%
Base			*20*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.4.2 Top theme by respondent group

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Quality of care – The services provided were good (for example, ongoing support) (4 / 29%)
- **Another member of the public:** Access – Waiting times for community services are too long (for example, too many cancellations) (2 / 100%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** No feedback received

Service type

- **George Bryan Centre:** Quality of care – The services provided were good (for example, ongoing support) (2 / 33%); Staff – Staff were not caring and lack of knowledge (2 / 33%)
- **St George's Hospital, Stafford:** Staff – Staff were not caring and lack of knowledge (3 / 43%)
- **Community mental health services:** Quality of care – The services provided were good (for example, ongoing support) (4 / 21%); Staff – Staff were not caring and lack of knowledge (4 / 21%); Quality of care – Services provided were poor (for example, poorly organised) (4 / 21%)
- **None of the above:** No feedback received

Ethnicity

- **White:** Quality of care – The services provided were good (for example, ongoing support) (4 / 27%)
- **Prefer not to say:** Negative – Quality of care – Services provided were poor (for example, poorly organised) (2 / 67%)

Age

- **Under 45:** Limited feedback received
- **45 to 59:** Staff – Staff were not caring and lack of knowledge (2 / 33%)
- **60 and over:** Quality of care – The services provided were good (for example, ongoing support) (3 / 60%)

Sex

- **Male:** Limited feedback received
- **Female:** Quality of care – The services provided were good (for example, ongoing support) (4 / 29%)

Sexual orientation

- **Heterosexual:** Quality of care – The services provided were good (for example, ongoing support) (3 / 30%); Access – Waiting times for community services are too long (for example, too many cancellations) (3 / 30%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Limited feedback received

Pregnancy

- **Yes:** No feedback received
- **No:** Quality of care – The services provided were good (for example, ongoing support) (4 / 27%)

Maternity

- **Yes:** No feedback received
- **No:** Quality of care – The services provided were good (for example, ongoing support) (4 / 27%)

Disability

- **No disability:** Quality of care – The services provided were good (for example, ongoing support) (2 / 50%); Quality of care – Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups) (2 / 50%)
- **Physical disability:** Quality of care – Concern over poor planning of care plans (2 / 50%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Quality of care – The services provided were good (for example, ongoing support) (2 / 20%); Quality of care – Services provided were poor (for example, poorly organised) (2 / 20%); Access – Waiting times for community services are too long (for example, too many cancellations) (2 / 20%); Quality of care – Concern over poor planning of care plans (2 / 20%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Quality of care – Services provided were poor (for example, poorly organised) (2 / 22%); Quality of care – Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups) (2 / 22%); Quality of care – Concern over poor planning of care plans (2 / 22%)
- **No:** Quality of care – The services provided were good (for example, ongoing support) (4 / 57%)

Carer

- **Yes – Carer:** Quality of care – The services provided were good (for example, ongoing support) (3 / 25%); Access – Waiting times for community services are too long (for example, too many cancellations) (3 / 25%); Quality of care – Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups) (3 / 25%)
- **No:** Limited feedback received

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Access – Waiting times for community services are too long (for example, too many cancellations) (2 / 50%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Quality of care – The services provided were good (for example, ongoing support) (2 / 33%); Awareness – Concern over the lack of awareness of mental health

services available in the community (2 / 33%); Service provision – Concern over the lack of community mental health services (2 / 33%)

- **No postcode provided:** Quality of care – The services provided were good (for example, ongoing support) (2 / 33%); Staff – Staff were not caring and lack of knowledge (2 / 33%)

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- **Most deprived deciles (1-5):** Quality of care – The services provided were good (for example, ongoing support) (2 / 29%); Awareness – Concern over the lack of awareness of mental health services available in the community (2 / 29%); Service provision – Concern over the lack of community mental health services (2 / 29%)
- **Least deprived deciles (6-10):** Staff – Staff were not caring and lack of knowledge (2 / 29%); Quality of care – Services provided were poor (for example, poorly organised) (2 / 29%); Access – Waiting times for community services are too long (for example, too many cancellations) (2 / 29%); Quality of care – Concern over the lack of continuity and consistency in the care provided (for example, lack of follow-ups) (2/ 29%)
- **No postcode provided:** Quality of care – The services provided were good (for example, ongoing support) (2 / 33%); Staff – Staff were not caring and lack of knowledge (2 / 33%)

6.5 Feedback on the community model for severe mental illness

Table 34 shows the questions consultation survey respondents and participants in the engagement sessions with specific communities were asked.

Table 34. Survey and voluntary sector support groups' questions

Consultation survey	Engagement sessions with specific communities
To what extent do you think the care model is a good one?	To what extent do you think the care model is a good one? In your response, please explain what you like and what concerns you
Please explain the reason for your rating. *In your response, please explain what you like and what concerns you.*	Are there any groups that you think may be disadvantaged by this model? Please explain who, and why.
Are there any groups that you think may be disadvantaged by this model? *If yes, please explain who and why.*	Tell us if you think there are any better ways to provide these services.
Tell us if you think there are any better ways to provide these services.	

6.6 Feedback on the care model

6.6.1 Feedback from the consultation survey

Tables 35, 36 and 37 show the responses to the consultation survey question: To what extent do you think the care model is a good one? 28 (60%) respondents stated that the care model was poor / very poor, while 19 (40%) stated it was very good / good (19 / 40%).

Table 35. To what extent do you think the care model is a good one? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	6	13%	1	6%	1	6%	2	50%	1	50%	1	33%	-	-
Good	13	28%	9	50%	1	6%	1	25%	-	-	1	33%	1	50%
Neutral	10	21%	2	11%	6	35%	1	25%	1	50%	-	-	-	-
Poor	9	19%	1	6%	6	35%	-	-	-	-	-	-	1	50%
Very poor	9	19%	5	28%	3	18%	-	-	-	-	1	33%	-	-
Base	*47*		*18*		*17*		*4*		*2*		*3*		*2*	

Table 36. To what extent do you think the care model is a good one? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Very good	6	13%	2	9%	1	8%	-	-	3	21%
Good	13	28%	8	36%	3	23%	2	25%	1	7%
Neutral	10	21%	4	18%	4	31%	3	38%	4	29%
Poor	9	19%	2	9%	2	15%	1	13%	3	21%
Very poor	9	19%	6	27%	3	23%	2	25%	3	21%
Base	*47*		*22*		*13*		*8*		*14*	

Table 37. To what extent do you think the care model is a good one? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	6	13%	4	18%	1	11%	-	-	-	-	-	-	-	-
Good	13	28%	4	18%	4	44%	1	50%	1	100%	-	-	3	30%
Neutral	10	21%	4	18%	1	11%	-	-	-	-	1	50%	4	40%
Poor	9	19%	5	23%	1	11%	1	50%	-	-	-	-	2	20%
Very poor	9	19%	5	23%	2	22%	-	-	-	-	1	50%	1	10%
Base	*47*		*22*		*9*		*2*		*1*		*2*		*10*	

There was one additional response to this question by a respondent outside the Staffordshire and Stoke-on-Trent area. This respondent stated the care model was very good.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents that make up that cohort.

6.6.2 Significant differences across respondent groups

Respondent type

- A significantly higher proportion of carers (3 / 75%) and users of mental health services (10 / 56%) said the care model was good / very good, compared to members of the public (2 / 12%)
- A significantly higher proportion of members of the public said the care model was poor / very poor (15 / 88%) compared to users of mental health services (8 / 44%) and carers (1 / 25%)

There were no significant differences in the following sub-groups: service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were then asked to explain the rationale for their rating. 43 responses were received. The main theme areas were quality of care, service provision, staff, access, health and wellbeing, communication, demographics, model, specific groups, efficiency and awareness.

Overall, the top three sub-themes were:

1. Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (11 / 26%)
2. Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (9 / 21%)
3. Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (7 / 16%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (7 / 16%)

Table 38 presents the full list of themes.

Table 38. Please explain the reason for your rating

Sentiment	Main theme	Sub-theme	No.	%
Negative	Quality of care	Community care may not be suitable for everyone (for example, not safe, lack of monitoring)	11	26%
Observation	Service provision	Consider greater provision of mental health services locally (for example, Tamworth)	9	21%
Observation	Staff	Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level)	7	16%
Negative	Access	Concern over the location of inpatient mental health services (for example, long travel, poor public transport)	7	16%
Negative	Service provision	Concern that the closure of the George Bryan Centre disadvantages inpatients and their relatives	6	14%
Positive	Health and wellbeing	Being close to home is better for mental health patients than being in a hospital	5	12%
Positive	General	The care model is good (for example, makes sense)	4	9%
Observation	Quality of care	Ensure consistency and continuity of care (for example, ongoing support)	4	9%
Observation	Quality of care	Ensure that services meet individual needs of patients and their carers	4	9%
Positive	Quality of care	Centralised services are good	3	7%
Observation	Communication	Ensure appropriate communication between healthcare professionals, patients, their families and carers	3	7%
Observation	Model	Ensure appropriate implementation of the model	2	5%
Observation	Demographic	Consider the demographic profile of Tamworth	2	5%
Negative	Access	Concern over the long waiting times for mental health support	2	5%
Positive	Model	The new care model encourages partnership working	1	2%
Observation	Specific groups	Consider the needs of patients with long-term mental health illnesses	1	2%
Neutral	Communication	More detail about the model is required	1	2%
Observation	Service provision	Consider the need for out of hours support in the community	1	2%
Negative	Efficiency	Concern over the reliance on voluntary organisations	1	2%
Negative	Access	In practice, the pathway is not as smooth as described in the model	1	2%
Positive	Quality of care	The model helps to prevent hospital admission	1	2%
Negative	Quality of care	The model is about saving money and not improving the quality of care	1	2%
Observation	Awareness	Consider improving awareness about the support available in the community and how to access it	1	2%
Observation	Health and wellbeing	Consider the positive therapeutic effect of visitors on inpatients	1	2%
Observation	Support for carers	More support for carers is needed (for example, peer-support)	1	2%
Neutral	General	Other	3	7%
Base			*43*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.6.3 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** General – The care model is good (for example, makes sense) (4 / 24%)
- **Another member of the public:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (6 / 40%)
- **Carer:** Limited feedback provided
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (2 / 100%); Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (2 / 100%)

Service type

- **George Bryan Centre:** Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (4 / 33%)
- **St George's Hospital, Stafford:** Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (3 / 43%)
- **Community mental health services:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (5 / 25%)
- **None of the above:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (4 / 33%)

Ethnicity

- **White:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (9 / 24%)
- **Prefer not to say:** Negative – Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (3 / 75%)

Age

- **Under 45:** Health and wellbeing – Being close to home is better for mental health patients than being in a hospital (3 / 30%); General – The care model is good (for example, makes sense) (3 / 30%)
- **45 to 59:** Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (3 / 23%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (3 / 23%); Service provision – Concern that the closure of the George Bryan Centre disadvantages inpatients and their relatives (3 / 23%)
- **60 and over:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (6 / 40%)

Sex

- **Male:** Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (4 / 44%)

- **Female:** Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (8 / 28%)

Sexual orientation

- **Heterosexual:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (8 / 27%)
- **Other (for example, gay, lesbian, bisexual, asexual):** General – The care model is good (for example, makes sense) (2 / 40%)

Pregnancy

- **Yes:** No feedback received
- **No: Q**uality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (9 / 24%)

Maternity

- **Yes:** No feedback received
- **No:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (8 / 23%)

Disability

- **No disability:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (6 / 33%)
- **Physical disability:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (2 / 25%); Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (2 / 25%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (2 / 25%); General – The care model is good (for example, makes sense) (2 / 25%); Model – Ensure appropriate implementation of the model (2 / 25%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (3 / 25%); General – The care model is good (for example, makes sense) (3 / 25%)
- **Learning disability or difficulty:** General – The care model is good (for example, makes sense) (2 / 100%)
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (4 / 24%)
- **No:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (7 / 37%)

Carer

- **Yes – Carer:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (5 / 26%)
- **No:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (4 / 27%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (4 / 57%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback provided
- **Tamworth:** Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (6 / 29%)
- **No postcode provided:** Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (4 / 44%)

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- **Most deprived deciles (1-5):** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (4 / 24%); Service provision – Consider greater provision of mental health services locally (for example, Tamworth) (4 / 24%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (4 / 24%)
- **Least deprived deciles (6-10):** Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (5 / 29%)
- **No postcode provided:** Staff – Ensure appropriate staffing in the community (for example, knowledgeable staff, sufficient staffing level) (4 / 44%)

6.6.4 Feedback from the engagement sessions with specific communities

Table 39 shows the response to the question: To what extent do you think the care model is a good one? 33 responses were received. The main theme areas were service provision, access, health and wellbeing, quality of care, communication, cost and efficiency, support for carers, equality, staff, efficiency, collaboration, specific groups, model consultation, awareness and resources.

Overall, the top three sub-themes were:

1. Service provision – Consider the need for better mental health support locally (12 / 36%)
2. Access – In practice, the pathway is not as smooth as described in the model (5 / 15%); Health and wellbeing – Consider negative impact a lack of community support has on patients and their families (5 / 15%); General – The care model is good (5 / 15%)
3. Access – Concern over location of inpatient mental health services (for example, long travel, poor public transport) (4 / 12%); Quality of care – Concern over poor quality of care (for example, does not reflect patients' needs) (4 / 12%); Communication – More detail about the model is required (4 / 12%)

Table 39 presents the full list of themes.

Table 39. To what extent do you think the care model is a good one?

Sentiment	Main theme	Sub-theme	No.	%
Observation	Service provision	Consider the need for better mental health support locally	12	36%
Negative	Access	In practice, the pathway is not as smooth as described in the model	5	15%
Negative	Health and wellbeing	Consider negative impact a lack of community support has on patients and their families	5	15%
Positive	General	The care model is good	5	15%
Negative	Access	Concern over location of inpatient mental health services (for example, long travel, poor public transport)	4	12%
Negative	Quality of care	Concern over poor quality of care (for example, does not reflect patients' needs)	4	12%
Neutral	Communication	More detail about the model is required	4	12%
Negative	Cost and efficiency	Concern over the allocation of financial resources (for example, extra funding for community services)	3	9%
Negative	Support for carers	Concern over poor support for carers and families (for example, access to carer's allowance)	3	9%
Negative	Equality	Concern over the inequitable access to services (for example, postcode lottery)	3	9%
Negative	Access	Concern over poor access to GP (for example, long waiting time)	3	9%
Observation	Staff	Ensure sufficient staffing levels to provide community support	3	9%
Negative	Efficiency	Concern that St George's Hospital may not be able to cope with additional patients	2	6%
Observation	Collaboration	Consider the need for greater involvement and collaboration between hospital sites, service providers, local authorities and private sector organisations	2	6%
Positive	Access	Self-referrals work well	2	6%
Negative	Access	Concern over lack of face-to-face appointments	2	6%
Observation	Quality of care	Consider improving mental health support provided by GP	2	6%
Observation	Quality of care	Quality of care is more important than the location of services	2	6%
Positive	Access	The George Bryan Centre was accessible	2	6%
Observation	Specific groups	Consider the needs of people experiencing homelessness (for example, access to healthcare)	2	6%
Positive	Quality of care	New care model will help to improve patients' confidence	2	6%
Negative	Quality of care	St George's Hospital provided poor care (for example, inconsistent and rushed)	1	3%
Negative	Staff	Staff at St George's Hospital were unhelpful (for example, crisis team)	1	3%
Negative	Access	Waiting times for community services are too long	1	3%
Observation	Model	The new model is similar to the existing one	1	3%
Negative	Consultation	Concern that questions asked during the events could trigger former George Bryan Centre patients	1	3%
Negative	Access	The self-referral system does not work properly (for example, too many rejections)	1	3%
Negative	General	The care model is not a good idea	1	3%
Observation	Communication	Consider raising public awareness about the model	1	3%
Negative	Access	Concern over poor access to inpatient care	1	3%
Negative	Access	Lack of access resulted in support being sought privately	1	3%
Observation	Awareness	Consider improving awareness about support available in community	1	3%

Observation	Service provision	George Bryan Centre should be rebuilt	1	3%
Observation	Service provision	Charities working with mental health patients are good and should not be replaced	1	3%
Negative	Quality of care	Concern that the 24-hour helpline does not signpost to other services	1	3%
Negative	Quality of care	Concern over the lack of recognition and accommodation of Asperger's syndrome	1	3%
Negative	Quality of care	Concern that community services may not be suitable for some patients at risk of harming themselves or others	1	3%
Positive	Quality of care	Support provided in the community was good	1	3%
Positive	Model	New care model encourages partnership working	1	3%
Observation	Specific groups	Consider the specific needs of asylum seekers and refugees	1	3%
Observation	Resources	Ensure sufficient resources for St George's Hospital	1	3%
Positive	Quality of care	Quality of care provided by the NHS is good	1	3%
Positive	Staff	Having all staff in one place is good	1	3%
Negative	Efficiency	Concern over reliance on private and voluntary sector	1	3%
Base			*33*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.7 Groups that may be disadvantaged by this care model

6.7.1 Feedback from the consultation survey

Table 40 shows the response to the consultation survey question: Are there any groups that you think may be disadvantaged by this model? 40 responses were received. The main theme areas were specific groups, access, travel cost, technology, demographics, service provision and quality of care.

Overall, the top three sub-themes were:

1. Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (13 / 33%)
2. General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (12 / 30%)
3. Specific groups – Patients with serious mental health problems (for example, patients in crisis, with long-term conditions) (8 / 20%)

Table 40 presents the full list of themes.

Table 40. Are there any groups that you think may be disadvantaged by this model?

Main theme	Sub-theme	No.	%
Specific groups	Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people)	13	33%
General	Everyone could be disadvantaged by the model (for example, inpatients, visitors)	12	30%
Specific groups	Patients with serious mental health problems (for example, patients in crisis, with long-term conditions)	8	20%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	7	18%
Specific groups	Non-drivers	5	13%
Specific groups	Residents of Tamworth and Lichfield	3	8%
Specific groups	Inpatients who benefit from friends and relatives visiting them	3	8%
Travel cost	Concern over travel costs	2	5%
General	No groups would be disadvantaged	1	3%
Technology	People without access to the internet	1	3%
Demographic	Consider the demographic profile of Tamworth	1	3%
Service provision	Consider greater provision of mental health support locally (for example, Tamworth)	1	3%
Quality of care	Ensure consistency and continuity of care (for example, ongoing support)	1	3%
Specific groups	People experiencing homelessness	1	3%
General	Other	1	3%
Base		*40*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.7.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (4 / 29%)
- **Another member of the public:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (7 / 47%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (2 / 67%)
- **Formal response from an organisation:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (2 / 100%)

Service type

- **George Bryan Centre:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (4 / 33%)
- **St George's Hospital, Stafford:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (3 / 43%)

- **Community mental health services:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (9 / 47%)
- **None of the above:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (5 / 46%)

Ethnicity

- **White:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (12 / 34%)
- **Prefer not to say:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (3 / 75%)

Age

- **Under 45:** Specific groups – Patients with serious mental health problems (for example, patients in crisis, with long-term conditions) (4 / 44%)
- **45 to 59:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (5 / 39%)
- **60 and over:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (6 / 43%)

Sex

- **Male:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (4 / 44%)
- **Female:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (11 / 41%)

Sexual orientation

- **Heterosexual:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (10 / 36%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (2 / 40%)

Pregnancy

- **Yes:** No feedback received
- **No:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (13 / 37%)

Maternity

- **Yes:** Limited feedback received
- **No:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (13 / 39%)

Disability

- **No disability:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (8 / 44%)
- **Physical disability:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (4 / 57%)
- **Sensory disability:** Limited feedback provided

- **Mental health condition:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (4 / 36%)
- **Learning disability or difficulty:** Limited feedback provided
- **Other:** Limited feedback provided

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (6 / 40%)
- **No:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (8 / 42%)

Carer

- **Yes – Carer:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (8 / 44%)
- **No:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (5 / 36%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (4 / 57%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (6 / 30%)
- **No postcode provided:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (4 / 44%); General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (4 / 44%)

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- **Most deprived deciles (1-5):** General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (7 / 44%)
- **Least deprived deciles (6-10):** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (7 / 44%)
- **No postcode provided:** Specific groups – Vulnerable people who struggle to ask for support (for example, people with disabilities or social anxiety, older people) (4 / 44%); General – Everyone could be disadvantaged by the model (for example, inpatients, visitors) (4 / 44%)

6.7.3 Feedback from the engagement sessions with specific communities

Table 41 shows the response to the question: Are there any groups that you think may be disadvantaged by this model? 28 responses were received. The main theme areas were access, specific groups, travel cost, service provision, awareness, efficiency and communication.

Overall, the top three sub-themes were:

1. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (12 / 43%)
2. Specific groups – Everyone may be disadvantaged (for example, patients, carers, visitors) (7 / 25%)
3. Specific groups – Carers and family members would be negatively impacted (for example, visitors) (6 / 21%)

Table 41 presents the full list of themes.

Table 41. Are there any groups that you think may be disadvantaged by this model?

Main theme	Sub-theme	No.	%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	12	43%
Specific groups	Everyone may be disadvantaged (for example, patients, carers, visitors)	7	25%
Specific groups	Carers and family members would be negatively impacted (for example, visitors)	6	21%
Specific groups	Vulnerable groups will be disadvantaged (for example, older people, people with disability, BAME community)	5	18%
Travel cost	Concern over travel cost	5	18%
Service provision	Consider improving mental health services locally (for example, expand the Community Health Team)	3	11%
Specific groups	Non-drivers may be disadvantaged	3	11%
Access	Concern patients could be too ill to travel	2	7%
Specific groups	Inpatients benefit from seeing friends, relatives and carers	2	7%
Specific groups	People experiencing homelessness	2	7%
Specific groups	Concern around how these changes may impact George Bryan Centre patients	1	4%
Specific groups	Concern over poor access to inpatient mental health services for young people	1	4%
Awareness	Concern over the lack of awareness regarding mental health support available in the community	1	4%
Efficiency	Concern that St George's Hospital may not be able to cope with the additional patients	1	4%
Service provision	Concern over the lack of beds available for inpatient mental health services	1	4%
Specific groups	Concern that there is a lack of consideration for patients with certain neurodiverse conditions	1	4%
Specific groups	People at risk of harming themselves or others	1	4%
Communication	Ensure appropriate communication about the new care model	1	4%
Specific groups	Consider the specific needs of asylum seekers and refugees	1	4%
Service provision	Concern over the lack of acknowledgment of the role of the church in the provision of mental health support	1	4%
Specific groups	Concern that information about 16 to 18-year-old patients can be shared with the police	1	4%
Specific groups	Residents of Tamworth and Lichfield	1	4%
Base		28	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.8 Suggestions to improve the care model

6.8.1 Feedback from the consultation survey

Table 42 shows the response to the question: Tell us if you think there are any better ways to provide these services. 37 responses were received. The main theme areas were service provision, staff, estate and facilities, specific groups, quality of care, resources, collaboration, and cost and efficiency.

Overall, the top three sub-themes were:

1. Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (13 / 35%)
2. Service provision – Consider the provision of mental health services locally (for example, including inpatient services) (7 / 19%)
3. Staff – Ensure appropriate staffing (for example, trained staff, sufficient staffing levels) (4 / 11%)

Table 42 presents the full list of themes.

Table 42. Tell us if you think there are any better ways to provide these services.

Main theme	Sub-theme	No.	%
Service provision	Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire)	13	35%
Service provision	Consider the provision of mental health services locally (for example, including inpatient services)	7	19%
Staff	Ensure appropriate staffing (for example, trained staff, sufficient staffing levels)	4	11%
Estate and facilities	A purpose-built centre is needed	3	8%
Specific groups	Consider the needs of vulnerable people (for example, older people, people with disabilities, people from ethnic minority communities)	3	8%
Quality of care	Ensure consistency and continuity of care (for example, ongoing support)	3	8%
Resources	Ensure sufficient resources for mental health services	2	5%
Service provision	Consider reopening old facilities (for example, community day centres, psychiatric hospitals)	2	5%
Collaboration	Ensure greater collaboration and communication between different services	1	3%
Service provision	Consider the need for out of hours support in the community for people in crisis	1	3%
Cost and efficiency	Concern about how the savings from the George Bryan Centre have been allocated	1	3%
Staff	Consider training volunteers to provide mental health support	1	3%
Service provision	Provide daily support for people who cannot look after themselves (for example, cooking, cleaning)	1	3%
Quality of care	Better support for mental health patients is needed	1	3%
General	Other	4	11%
Base		*37*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.8.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 21%); Estate and facilities – A purpose-built centre is needed (3 / 21%)
- **Another member of the public:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 57%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Service provision – Consider the provision of mental health services locally (for example, including inpatient services) (2 / 100%)

Service type

- **George Bryan Centre:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (6 / 55%)
- **St George's Hospital, Stafford:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (2 / 25%); Staff – Ensure appropriate staffing (for example, trained staff, sufficient staffing levels) (2 / 25%)
- **Community mental health services:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 26%)
- **None of the above:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 56%)

Ethnicity

- **White:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (11 / 34%)
- **Prefer not to say:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (2 / 50%)

Age

- **Under 45:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (2 / 25%)
- **45 to 59:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 33%)
- **60 and over:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 39%)

Sex

- **Male:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 43%); Service provision – Consider the provision of mental health services locally (for example, including inpatient services) (3 / 43%)
- **Female:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 31%)

Sexual orientation

- **Heterosexual:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (10 / 39%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Limited feedback provided

Pregnancy

- **Yes:** No feedback received
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (11 / 34%)

Maternity

- **Yes:** No feedback received
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (11 / 36%)

Disability

- **No disability:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 47%)
- **Physical disability:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 43%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Estate and facilities – A purpose-built centre is needed (3 / 27%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (6 / 38%)
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 33%)

Carer

- **Yes – Carer:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 31%)
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (6 / 46%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Service provision – Consider the provision of mental health services locally (for example, including inpatient services) (3 / 43%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 50%)
- **No postcode provided:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 44%)

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- **Most deprived deciles (1-5):** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (6 / 46%)
- **Least deprived deciles (6-10):** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 20%); Service provision – Consider the provision of mental health services locally (for example, including inpatient services) (3 / 20%)
- **No postcode provided:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 44%)

6.8.3 Feedback from the engagement sessions with specific communities

Table 43 shows the response to the question: Tell us if you think there are any better ways to provide these services. 31 responses were received. The main theme areas were service provision, quality of care, awareness, staff, access, specific groups, financial support, collaboration, technology, resources, efficiency, consultation, equality, and cost and efficiency.

Overall, the top three sub-themes were:

1. Service provision – Consider greater provision of mental health support locally (for example, local drop-in centres) (7 / 23%)
2. Quality of care – Ensure that care reflects the individual needs of patients (6 / 19%)
3. Awareness – Consider raising awareness around mental health services available in the community and how to access them (5 / 16%)

Table 43 presents the full list of themes.

Table 43. Tell us if you think there are any better ways to provide these services.

Main theme	Sub-theme	No.	%
Service provision	Consider greater provision of mental health support locally (for example, local drop-in centres)	7	23%
Quality of care	Ensure that care reflects the individual needs of patients	6	19%
Awareness	Consider raising awareness around mental health services available in the community and how to access them	5	16%
Staff	Ensure appropriate staffing (for example, trained staff, sufficient staffing levels)	3	10%
Access	Consider improving access for visitors (for example, flexible visiting times, free parking)	3	10%
Access	Consider improving transport to these services by providing a bus for patients and visitors	2	6%
Specific groups	Consider the needs of vulnerable people (for example, older people, people with disability, BAME community)	2	6%
Quality of care	Consider the need for face-to-face care	2	6%
Service provision	Consider reopening the George Bryan Centre	2	6%
Access	Concern over having to travel further for mental health support (for example, seeing a specialist)	2	6%
Service provision	Consider improving the mental health support provided by GPs (for example, not suitable for everyone)	2	6%
Specific groups	Consider the needs of people experiencing homelessness (for example, access to healthcare)	2	6%
Financial support	Consider the need to financially support voluntary organisations (for example, Changes in Tamworth)	2	6%
Collaboration	Consider greater collaboration with patients' families	1	3%
Technology	Consider that not everyone has access to technology or knowledge how to use them	1	3%
Access	Concern over not being able to attend early appointments due to lack of transport	1	3%
Resources	Ensure sufficient financial resources	1	3%
Staff	Improve working conditions for carers and nurses	1	3%
Quality of care	Quality of care is more important than money	1	3%
Efficiency	Concern that appointments were held behind schedule	1	3%
Service provision	Concern over reduced number of inpatient beds	1	3%
Consultation	Consider greater promotion of this consultation	1	3%
Consultation	Concern over conducting engagement activities in a supermarket	1	3%
Service provision	Consider improving the level of support offered after discharge	1	3%
Equality	Concern over the inequitable access to services (for example, postcode lottery)	1	3%
Quality of care	Consider tackling the stigma around mental health illnesses	1	3%
Quality of care	Ensure appropriate signposting for patients	1	3%
Quality of care	Concern that community services may not be suitable for some patients	1	3%
Staff	Consider the need to train staff to recognise and address certain neurodiverse conditions	1	3%
Service provision	Consider the provision of befriending services	1	3%
Communication	Ensure appropriate communication and joined-up working between all stakeholders	1	3%
Specific groups	Consider the specific needs of asylum seekers and refugees	1	3%
Service provision	Concern over lack of acknowledgement for the church's role in providing mental health support	1	3%
Cost and efficiency	Concern over how the savings from the George Bryan Centre have been allocated	1	3%
General	No comments	1	3%
Base		*31*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement events with specific communities and not the number of participants engaged with, or the number of events delivered.

6.8.4 Additional feedback from other channels

As well as the feedback captured through the outlined channels, further feedback on the community model for severe mental illness was received through the following:

- March 2023 Overview and Scrutiny Committee meeting minutes
- Enter and view report from Healthwatch Staffordshire
- Healthwatch Staffordshire feedback on the consultation
- Additional, written feedback submitted during the engagement events

A summary of the themes raised has been presented below:

- Being able to offer a more personalised and integrated approach to supporting and treating service users locally, allows for more people to be managed at home successfully.
- The improvement of staff recruitment and retention has resulted in community services being delivered more consistently and effectively.
- It was acknowledged that inpatient admissions have been reducing over the last 18 months.
- It was commented that crisis teams do not meet their 4-hour response time target. A response time of over 8 hours was shared.
- It was commented that the helpline operates 24 hours, 7 days a week and is free from any phone. However, the need for greater promotion of the helpline was highlighted.
- The issue of staff shortage was raised.
- Suggestions were raised about providing services on the old George Bryan site to speed up the response times for those living in the Lichfield and Tamworth areas.
- It was commented that Cherry Orchard has been renovated for the delivery of community services and will be open towards the end of this year.
- The willingness of the voluntary and community sector to support service users in the community was highlighted. Additionally, there was acknowledgement of the role carers play to support their family members.

6.9 Feedback on the community model for dementia healthcare services

Table 44 shows the questions consultation survey respondents and participants in the engagement sessions with specific communities were asked.

Table 44. Survey and voluntary sector support group's questions

Survey questions	Engagement events with specific communities' questions
To what extent do you think the care model is a good one?	To what extent do you think the care model is a good one? In your response, please explain what you like and what concerns you.

Please explain the reason for your rating. *In your response, please explain what you like and what concerns you.*	Are there any groups that you think may be disadvantaged by this model? Please explain who, and why.
Are there any groups that you think may be disadvantaged by this model? *If yes, please explain who and why*	Tell us if you think there are any better ways to provide these services.
Tell us if you think there are any better ways to provide these services.	

6.10 Feedback on the care model

6.10.1 Feedback from the consultation survey

Consultation survey respondents were asked: To what extent do you think the care model is a good one? Tables 45, 46 and 47 shows that 20 (44%) respondents stated that the care model for dementia was very good / good compared to 10 (22%) respondents who stated that the care model was poor / very poor.

Table 45. To what extent do you think the care model is a good one? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	7	15%	3	18%	1	6%	2	50%	1	50%	-	-	-	-
Good	13	28%	5	29%	3	18%	1	25%	1	50%	2	67%	1	50%
Neutral	16	35%	6	35%	7	41%	1	25%	-	-	1	33%	1	50%
Poor	6	13%	-	-	5	29%	-	-	-	-	-	-	-	-
Very poor	4	9%	3	18%	1	6%	-	-	-	-	-	-	-	-
Base	*46*		*17*		*17*		*4*		*2*		*3*		*2*	

Table 46. To what extent do you think the care model is a good one? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Very good	7	15%	3	14%	2	15%	2	25%	3	21%
Good	13	28%	7	33%	5	39%	2	25%	1	7%
Neutral	16	35%	8	38%	3	23%	4	50%	6	43%
Poor	6	13%	-	-	2	15%	-	-	3	21%
Very poor	4	9%	3	14%	1	8%	-	-	1	7%
Base	*46*		*21*		*13*		*8*		*14*	

Table 47. To what extent do you think the care model is a good one? Breakdown: Local authority

			Local authority											
	No.	%	Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	7	15%	4	18%	-	-	1	50%	-	-	1	50%	-	-
Good	13	28%	6	27%	3	33%	-	-	1	100%	-	-	3	33%
Neutral	16	35%	4	18%	6	67%	1	50%	-	-	1	50%	4	44%
Poor	6	13%	4	18%	-	-	-	-	-	-	-	-	2	22%
Very poor	4	9%	4	18%	-	-	-	-	-	-	-	-	-	-
Base	*46*		*22*		*9*		*2*		*1*		*2*		*9*	

There was one additional response to this question by a respondent outside of the Staffordshire and Stoke-on-Trent area. This respondent stated the care model is very good.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.10.2 Significant differences across respondent groups

Local authority

- A significantly higher proportion of consultation survey respondents from the Lichfield area (6 / 67%) stated the care model for dementia is neutral, compared to those in the Tamworth area (4 / 18%).

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were then asked to explain the rationale for the rating they gave. 36 responses were received. The main theme areas were health and wellbeing, service provision, safety, quality of care, access, cost and efficiency, model, communication, and staff.

Overall, the top three sub-themes were:

1. Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (13 / 36%)
2. Service provision – Consider the need for more local inpatient units and hospitals (3 / 8%)
3. Safety – Concern over the safety and security of patients with dementia (for example, lack of supervision in the community) (2 / 6%); Quality of care – Concern that community care may not reflect the needs of patients with dementia (2 / 6%); Service provision – Consider improving the level of support offered in the community after discharge (for example, respite care facilities) (2 / 6%); Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (2 / 6%); Service provision – Consider the need for home visits (2 / 6%); Cost and efficiency – More funding for mental health services is needed (2 / 6%);

Service provision – Concern over the reduced number of inpatient beds (2 / 6%);
Model – The care model puts more pressure on carers (2 / 6%)

Table 48 presents the full list of themes.

Table 48. Please explain the reason for your rating.

Sentiment	Main theme	Sub-theme	No.	%
Positive	Health and wellbeing	Being close to home or at home is better for patients with dementia than being in a hospital	13	36%
Observation	Service provision	Consider the need for more local inpatient units and hospitals	3	8%
Negative	Safety	Concern over the safety and security of patients with dementia (for example, lack of supervision in the community)	2	6%
Negative	Quality of care	Concern that community care may not reflect the needs of patients with dementia	2	6%
Observation	Service provision	Consider improving the level of support offered in the community after discharge (for example, respite care facilities)	2	6%
Negative	Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	2	6%
Observation	Service provision	Consider the need for home visits	2	6%
Observation	Cost and efficiency	More funding for mental health services is needed	2	6%
Negative	Service provision	Concern over the reduced number of inpatient beds	2	6%
Negative	Model	The care model puts more pressure on carers	2	6%
Observation	Service provision	Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire)	1	3%
Negative	Communication	Concern that the views of Tamworth and Lichfield residents have not been considered	1	3%
Observation	Communication	Ensure appropriate communication between healthcare professionals and families or carers of patients with dementia	1	3%
Negative	Staff	Concern over filling staffing gaps with volunteers	1	3%
Negative	Model	Concern over the lack of clarity on how the care model integrates with social care services	1	3%
Observation	Service provision	Consider improving out of hours support for patients and carers	1	3%
Negative	Service provision	Concern over the lack of voluntary sector support in Tamworth	1	3%
Neutral	General	No comment (for example, as above)	2	6%
Neutral	General	Other	3	8%
Base			*36*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.10.3 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (6 / 46%)

- **Another member of the public:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (4 / 29%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (3 / 30%)
- **St George's Hospital, Stafford:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (2 / 29%)
- **Community mental health services:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (7 / 41%)
- **None of the above:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (3 / 27%)

Ethnicity

- **White:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (11 / 34%)
- **Prefer not to say:** Positive – Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (2 / 50%); Negative – Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (2 / 50%)

Age

- **Under 45:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (5 / 63%)
- **45 to 59:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (4 / 31%)
- **60 and over:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (3 / 25%)

Sex

- **Male:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (3 / 33%)
- **Female:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (9 / 39%)

Sexual orientation

- **Heterosexual:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (9 / 35%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (2 / 50%)

Pregnancy

- **Yes:** No feedback received

- **No:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (11 / 36%)

Maternity

- **Yes:** Limited feedback received
- **No:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (10 / 35%)

Disability

- **No disability:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (4 / 24%)
- **Physical disability:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (4 / 57%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (5 / 50%)
- **Learning disability or difficulty:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (2 / 100%)
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (6 / 46%)
- **No:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (6 / 32%)

Carer

- **Yes – Carer:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (7 / 47%)
- **No:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (5 / 36%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Limited feedback received
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (10 / 50%)
- **No postcode provided:** Observation – Service provision – Consider the need for more local inpatient units and hospitals (2 / 33%)

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- **Most deprived deciles (1-5):** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (8 / 50%)
- **Least deprived deciles (6-10):** Health and wellbeing – Being close to home or at home is better for patients with dementia than being in a hospital (5 / 36%)
- **No postcode provided:** Observation – Service provision – Consider the need for more local inpatient units and hospitals (2 / 33%)

6.10.4 Feedback from the engagement sessions with specific communities

Participants were asked: To what extent do you think the care model is a good one? 33 responses were received. The main theme areas were health and wellbeing, safety, staff, awareness, quality of care, service provision, communication, support for carers, model, cost and efficiency, and engagement.

Overall, the top three sub-themes were:

1. Health and wellbeing – Being close to home is better for patients with dementia than being in a hospital (7 / 21%)
2. General – The new care model is good (6 / 18%)
3. Safety – Concern over the safety and security of patients with dementia (for example, lack of supervision in community) (5 / 15%)

Table 49 presents the full list of themes.

Table 49. To what extent do you think the care model is a good one?

Sentiment	Main theme	Sub-theme	No.	%
Positive	Health and wellbeing	Being close to home is better for patients with dementia than being in a hospital	7	21%
Positive	General	The new care model is good	6	18%
Negative	Safety	Concern over the safety and security of patients with dementia (for example, lack of supervision in community)	5	15%
Observation	Staff	Consider the need for appropriate staffing (for example, trained staff, sufficient staffing level)	4	12%
Negative	Awareness	Concern over the lack of awareness of dementia care services available in the community (for example, GPs may not be aware)	4	12%
Negative	Quality of care	Concern over the lack of support from community services	4	12%
Observation	Service provision	Consider the need for local hospitals to support patients with dementia who cannot cope at home	4	12%
Positive	Service provision	Dementia Cafés and local groups in churches provide good support	3	9%
Observation	Service provision	Ensure that support in the community is readily available	3	9%
Observation	Communication	Consider using different channels of communication to engage with service users, their families and carers (for example, use leaflet, social media)	3	9%
Negative	Support for carers	Concern over the lack of support for families and carers supporting patients with dementia	2	6%
Observation	Support for carers	Consider the need for greater recognition of carers in the model	2	6%
Negative	Service provision	Concern over insufficient support from paid carers (for example, very short visits)	2	6%
Negative	Quality of care	Concern that the model may have a negative impact on quality of dementia care	1	3%
Observation	Model	The new model is similar to the existing model	1	3%
Negative	Cost and efficiency	Concern over the lack of clarity around the allocation of financial resources (for example, extra funding for community services)	1	3%
Observation	Quality of care	Hospitals are more suitable for patients with dementia than nursing homes	1	3%
Observation	Quality of care	Consider individual needs of patients	1	3%

Observation	Communication	Ensure appropriate communication between healthcare professionals and families or carers of patients with dementia	1	3%
Negative	Quality of care	Quality of care in Queen's Hospital Burton is poor	1	3%
Negative	Specific groups	Concern the care model does not consider patients with certain neurodiverse conditions	1	3%
Neutral	Communication	More detail about the model is required	1	3%
Observation	Model	Ensure carers support the care model	1	3%
Observation	Engagement	It is important for people to share their experiences	1	3%
Neutral	General	No comment (for example, as above, no experience to comment)	8	24%
Base			*33*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.11 Groups that may be disadvantaged by this care model

6.11.1 Feedback from the consultation survey

Consultation survey respondents were asked: Are there any groups that you think may be disadvantaged by this model? 25 responses were received. The main theme areas were specific groups, access, staff, and service provision.

Overall, the top three sub-themes were:

1. Specific groups – All patients with dementia (8 / 32%)
2. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (5 / 20%)
3. Specific groups – Residents of Tamworth and Lichfield (4 / 16%)

Table 50 presents the full list of themes.

Table 50. Are there any groups that you think may be disadvantaged by this model?

Main theme	Sub-theme	No.	%
Specific groups	All patients with dementia	8	32%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	5	20%
Specific groups	Residents of Tamworth and Lichfield	4	16%
Specific groups	Patients who need inpatient care	3	12%
Specific groups	Vulnerable groups (for example, older people, people who are isolated)	3	12%
Specific groups	Patients without family, friends or social care support	2	8%
Specific groups	People from minority communities (for example, linguistic and cultural barriers)	2	8%
Specific groups	Consider the needs of patients with dementia experiencing homelessness	1	4%
Specific groups	Carers and family members	1	4%
Specific groups	Non-drivers	1	4%
Specific groups	People without access to a phone	1	4%
Staff	Concern over the lack of mental health staff	1	4%
Service provision	Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire)	1	4%

Service provision	Consider the need for greater social support (for example, walking and get together groups)	1	4%
General	No comment (for example, as above)	2	8%
Base		*25*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.11.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Specific groups – People from minority communities (for example, linguistic and cultural barriers) (2 / 22%)
- **Another member of the public:** Specific groups – All patients with dementia (5 / 56%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Specific groups – All patients with dementia (2 / 25%); Specific groups – Residents of Tamworth and Lichfield (2 / 25%); Specific groups – Patients who need inpatient care (2 / 25%)
- **St George's Hospital, Stafford:** Limited feedback received
- **Community mental health services:** Specific groups – All patients with dementia (3 / 27%)
- **None of the above:** Specific groups – All patients with dementia (3 / 38%)

Ethnicity

- **White:** Specific groups – All patients with dementia (7 / 32%)
- **Prefer not to say:** Limited feedback received

Age

- **Under 45:** Limited feedback received
- **45 to 59:** Specific groups – All patients with dementia (3 / 30%); Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (3 / 30%); Specific groups – Residents of Tamworth and Lichfield (3 / 30%)
- **60 and over:** Specific groups – All patients with dementia (4 / 44%)

Sex

- **Male:** Specific groups – Residents of Tamworth and Lichfield (2 / 40%)
- **Female:** Specific groups – All patients with dementia (6 / 35%)

Sexual orientation

- **Heterosexual:** Specific groups – All patients with dementia (5 / 28%)

- **Other (for example, gay, lesbian, bisexual, asexual):** Limited feedback provided

Pregnancy

- **Yes:** No feedback received
- **No:** Specific groups – All patients with dementia (6 / 29%)

Maternity

- **Yes:** No feedback received
- **No:** Specific groups – All patients with dementia (5 / 25%)

Disability

- **No disability:** Specific groups – All patients with dementia (4 / 36%)
- **Physical disability:** Specific groups – All patients with dementia (3 / 43%)
- **Sensory disability:** Specific groups – Vulnerable groups (for example, older people, people who are isolated) (2 / 100%)
- **Mental health condition:** Specific groups – People from minority communities (for example, linguistic and cultural barriers) (2 / 33%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Specific groups – All patients with dementia (4 / 40%)
- **No:** Specific groups – All patients with dementia (3 / 25%)

Carer

- **Yes – Carer:** Specific groups – All patients with dementia (4 / 36%)
- **No:** Specific groups – Residents of Tamworth and Lichfield (3 / 33%)

Local authority

- **East Staffordshire:** No feedback received
- **Lichfield:** Specific groups – All patients with dementia (2 / 40%); Specific groups – Vulnerable groups (for example, older people, people who are isolated) (2 / 40%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Specific groups – All patients with dementia (4 / 33%)
- **No postcode provided:** Specific groups – All patients with dementia (2 / 40%)

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- **Most deprived deciles (1-5):** Specific groups – All patients with dementia (4 / 40%)
- **Least deprived deciles (6-10):** Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (3 / 30%)
- **No postcode provided:** Specific groups – All patients with dementia (2 / 40%)

6.11.3 Feedback from the engagement sessions with specific communities

Participants were asked: Are there any groups that you think may be disadvantaged by this model? 30 responses were received. The main theme areas were, access, specific groups,

health and wellbeing, financial support, safety, support for carers, model, support, and travel cost.

Overall, the top three sub-themes were:

1. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (6 / 20%); Access – Concern over not being able to visit patients with dementia in hospital (for example, travel cost, too far to travel) (6 / 20%)
2. Specific groups – All patients with dementia (4 / 13%)
3. Specific groups – Everyone could be disadvantaged by the model (2 / 7%); Specific groups – Carers and family members could be negatively impacted (2 / 7%)

Table 51 presents the full list of themes.

Table 51. Are there any groups that you think may be disadvantaged by this model?

Main theme	Sub-theme	No.	%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	6	20%
Access	Concern over not being able to visit patients with dementia in hospital (for example, travel cost, too far to travel)	6	20%
Specific groups	All patients with dementia	4	13%
Specific groups	Everyone could be disadvantaged by the model	2	7%
Specific groups	Carers and family members could be negatively impacted	2	7%
Specific groups	Consider the needs of patients with dementia experiencing homelessness	2	7%
Health and wellbeing	Consider the positive therapeutic effect of patients with dementia being close to their family	1	3%
Financial support	Consider the need to financially support voluntary organisations (for example, church)	1	3%
Safety	Concern over the safety and security of patients with dementia in the community due to lack of supervision	1	3%
Support for carers	More support is required for families and carers that support patients with dementia	1	3%
Specific groups	People from minority communities may be disadvantaged (for example, linguistic and cultural barriers)	1	3%
Model	Concern over the lack of clarity on how the model fits for long-term care	1	3%
Support	Consider providing support to patients and their families during the transition to the implementation of the new care model	1	3%
Travel cost	Concern over travel cost	1	3%
Specific groups	Ensure the needs of people whose first language is not English are met (for example, access to translation services)	1	3%
General	No comments (for example, as above)	10	33%
Base		*30*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.12 Suggestions to improve the care model

6.12.1 Feedback from the consultation survey feedback

Consultation survey respondents were asked: Tell us if you think there are any better ways to provide these services.23 responses were received. The main theme areas were service

provision, access, support for carers, resources, communication, integration, staff and specific groups.

Overall, the top three sub-themes were:

1. Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 35%)
2. Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (6 / 26%)
3. Service provision – Consider the need for day hospitals/centres (3 / 13%)

Table 52 presents the full list of themes.

Table 52. Tell us if you think there are any better ways to provide these services.

Main theme	Sub-theme	No.	%
Service provision	Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire)	8	35%
Service provision	Consider the need for greater support provided locally (for example, including inpatient services)	6	26%
Service provision	Consider the need for day hospitals/centres	3	13%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	2	9%
Support for carers	More support is required for families and carers who support patients with dementia	2	9%
General	Other	1	4%
General	No comment (for example, as above)	1	4%
Resources	Concern over the limited number of beds in inpatient units	1	4%
Communication	Ensure appropriate communication between healthcare professionals and families or carers of patients with dementia	1	4%
Integration	Ensure greater integration between health and social care teams	1	4%
Staff	Ensure adequate staffing levels	1	4%
Access	Consider improving access for visitors (for example, flexible visiting times, free parking, transport)	1	4%
Specific groups	Consider the needs of Tamworth and Lichfield residents	1	4%
Service provision	Consider the need to have access to support in the community, 24 hours a day	1	4%
Base		*23*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.12.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (2 / 22%); Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (2 / 22%); Service provision – Consider the need for day hospitals/centres (2 / 22%)
- **Another member of the public:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 56%)
- **Carer:** No feedback received
- **NHS employee:** Limited feedback provided

- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback provided
- **Formal response from an organisation:** Limited feedback provided

Service type

- **George Bryan Centre:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 71%)
- **St George's Hospital, Stafford:** Limited feedback received
- **Community mental health services:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 30%); Service provision – Consider the need for day hospitals/centres (3 / 30%)
- **None of the above:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (2 / 33%); Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (2 / 33%)

Ethnicity

- **White:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 37%)
- **Prefer not to say:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (2 / 50%)

Age

- **Under 45:** Limited feedback received
- **45 to 59:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (3 / 43%)
- **60 and over:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 44%)

Sex

- **Male:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (3 / 60%)
- **Female:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 33%)

Sexual orientation

- **Heterosexual:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 44%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Limited feedback received

Pregnancy

- **Yes:** No feedback received
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 37%)

Maternity

- **Yes:** No feedback received
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 39%)

Disability

- **No disability:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 50%)
- **Physical disability:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (3 / 50%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (2 / 33%); Service provision – Consider the need for day hospitals/centres (2 / 33%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 36%); Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (4 / 36%)
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 33%)

Carer

- **Yes – Carer:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (4 / 50%)
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 50%)

Local authority

- **East Staffordshire:** No feedback received
- **Lichfield:** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (2 / 40%); Service provision – Consider the need for day hospitals/centres (2 / 40%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 50%)
- **No postcode provided:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 60%)

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- **Most deprived deciles (1-5):** Service provision – Consider the need for greater support provided locally (for example, including inpatient services) (4 / 40%)
- **Least deprived deciles (6-10):** Service provision – Consider the need for day hospitals/centres (3 / 38%)
- **No postcode provided:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 60%)

6.12.3 Feedback from the engagement sessions with specific communities

Participants were asked: Tell us if you think there are any better ways to provide these services. 31 responses were received. The main theme areas were access, service provision, quality of care, staff, financial support, awareness, communication, local characteristics, COVID-19, cost and efficiency, support for carers and specific groups.

Overall, the top three sub-themes were:

1. Access – Consider improving access for visitors (for example, flexible visiting times, free parking, transport) (6 / 19%); Service provision – Consider the need for greater support provided locally (6 / 19%)
2. Quality of care – Ensure the care provided is appropriate (for example, timely, continuity of care, reflects patient needs) (5 / 16%)
3. Staff – Ensure appropriate staffing levels in the community (for example, trained staff, sufficient staffing level, more permanent staff) (4 / 13%)

Table 53 presents the full list of themes.

Table 53. Tell us if you think there are any better ways to provide these services.

Main theme	Sub-theme	No.	%
Access	Consider improving access for visitors (for example, flexible visiting times, free parking, transport)	6	19%
Service provision	Consider the need for greater support provided locally	6	19%
Quality of care	Ensure the care provided is appropriate (for example, timely, continuity of care, reflects patient needs)	5	16%
Staff	Ensure appropriate staffing levels in the community (for example, trained staff, sufficient staffing level, more permanent staff)	4	13%
Financial support	Consider the need to financially support voluntary organisations (for example, church)	3	10%
Awareness	Concern over the lack of awareness of dementia care services available in the community (for example, GPs may not be aware)	3	10%
Access	Consider the need to improve the patient pathway (for example, make it faster)	2	6%
Communication	Ensure appropriate communication between healthcare professionals, patients, their families and carers	2	6%
Service provision	Recognise the support provided by local charities	1	3%
Quality of care	Ensure dementia care is tailored to individual needs	1	3%
Quality of care	Community care may not fit for patients with psychosis	1	3%
Quality of care	Ensure appropriate signposting for patients	1	3%
Service provision	Consider the need for a hospital in Tamworth	1	3%
Local characteristic	Consider the prevalence of mental health illnesses in Tamworth	1	3%
COVID-19	Consider the impact of COVID-19 on service provision	1	3%
Cost and efficiency	More clarity around the allocation of financial resources is needed	1	3%
Support for carers	More support is required for families and carers that support patients with dementia	1	3%
Cost and efficiency	Consider greater use of local facilities	1	3%
Specific groups	Consider the needs of homeless people (for example, access to healthcare)	1	3%
General	No comment (for example, as above)	9	29%
Base		*31*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.12.4 Additional feedback from other channels

As well as the feedback captured through the outlined channels, further feedback on the community model for dementia healthcare services was received through the following:

- March 2023 Overview and Scrutiny Committee meeting minutes
- Enter and view report from Healthwatch Staffordshire
- Healthwatch Staffordshire feedback on the consultation
- Additional, written feedback submitted during the engagement events.

A summary of the themes raised has been presented below:

- Concerns were raised around the availability of extra support for carers looking after patients with dementia at home
- Concerns were raised around the management of people with dementia who have challenging behaviour
- Consider the traumatic impact on patients with dementia of having to be transported to Stafford
- Concerns were raised around the availability, quality, and reliability of community care packages
- Concerns were raised around relying on the private sector to deliver long-term care for people with dementia
- The need for greater clarity on when Continuing Health Care applies to people with dementia was highlighted.

6.13 Feedback on the proposal for delivering inpatient mental health services

Table 54 shows the questions consultation survey respondents and participants in the engagement sessions with specific communities were asked.

Table 54. Survey and voluntary sector support groups' questions

Survey questions	Engagement events with specific communities' questions
To what extent do you think this proposal is a good solution?	To what extent do you think this proposal is a good solution? In your response, please explain what you like and what concerns you.
Please explain the reason for your rating. *In your response, please explain what you like and what concerns you.*	Are there any groups that you think may be disadvantaged by this model? Please explain who and why.
Are there any groups that you think may be disadvantaged by this proposal? *If yes, please explain who and why.*	Tell us if you think there are any better ways to deliver inpatient mental health services.
Tell us if you think there are any better ways to deliver inpatient mental health services.	

6.13.1 Feedback from the consultation survey

Consultation survey respondents were asked: To what extent do you think the care model is a good one? Tables 55, 56, and 57 show that 26 (59%) respondents stated that the care model in the proposal was poor / very poor, compared to 7 (15%) respondents who stated that the care model was very good / good.

Table 55. To what extent do you think the care model is a good one? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	1	2%	1	7%	-	-	-	-	-	-	-	-	-	-
Good	6	14%	2	13%	-	-	2	50%	-	-	2	67%	-	-
Neutral	11	25%	5	33%	3	18%	1	25%	1	50%	-	-	1	50%
Poor	11	25%	2	13%	6	35%	-	-	1	50%	-	-	1	50%
Very poor	15	34%	5	33%	8	47%	1	25%	-	-	1	33%	-	-
Base	*44*		*15*		*17*		*4*		*2*		*3*		*2*	

Table 56. To what extent do you think the care model is a good one? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Very good	1	2%	1	5%	-	-	-	-	-	
Good	6	14%	4	20%	1	9%	1	14%	1	7%
Neutral	11	25%	6	30%	3	27%	5	71%	2	14%
Poor	11	25%	4	20%	1	9%	-	-	4	29%
Very poor	15	34%	5	25%	6	55%	1	14%	7	50%
Base	*44*		*20*		*11*		*7*		*14*	

Table 57. To what extent do you think the care model is a good one? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very good	1	2%	1	5%	-	-	-	-	-	-	-	-	-	-
Good	6	14%	1	5%	3	33%	-	-	1	100%	-	-	1	11%
Neutral	11	25%	2	10%	3	33%	2	100%	-	-	-	-	4	44%
Poor	11	25%	9	43%	1	11%	-	-	-	-	1	100%	-	-
Very poor	15	34%	8	38%	2	22%	-	-	-	-	-	-	4	44%
Base	*44*		*21*		*9*		*2*		*1*		*1*		*9*	

There was one additional response to this question by a respondent outside the Staffordshire and Stoke-on-Trent area. This respondent stated the proposal was poor.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.13.2 Significant differences across respondent groups

Service type

- A significantly higher proportion of respondents who had not used any of the mental health services (11 / 79%) stated the proposal was poor or very poor, compared to those who had used or experienced St George's Hospital, Stafford (1 / 14%)

Local authority

- A significantly higher proportion of respondents from the Tamworth area (17 / 81%) stated that the proposal was poor / very poor, compared to those from the Lichfield area (3 / 33%)

There were no significant differences in the following sub-groups: respondent type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were then asked to explain the rationale for the rating they gave. 38 responses were received. The main theme areas were travel, specific groups, service provision, staff, health and wellbeing, demographics, quality of care, quality of services, communication, efficiency, travel cost and parking.

Overall, the top three sub-themes were:

1. Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (19 / 50%)
2. Specific groups – The proposal disadvantages inpatients, their carers and relatives (8 / 21%)
3. Service provision – Concern over the lack of inpatient beds available in the area (7 / 18%)

Table 58 presents the full list of themes.

Table 58. Please explain the reason for your rating.

Sentiment	Main theme	Sub-theme	No.	%
Negative	Travel	Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport)	19	50%
Negative	Specific groups	The proposal disadvantages inpatients, their carers and relatives	8	21%
Negative	Service provision	Concern over the lack of inpatient beds available in the area	7	18%
Observation	Staff	Ensure adequate staffing (for example, staffing level, trained staff)	6	16%
Observation	Service provision	Reopen the George Bryan Centre	5	13%
Observation	Health and wellbeing	Consider the positive therapeutic effect of visitors on inpatients	3	8%
Observation	Service provision	Consider the need for an inpatient ward in Tamworth	3	8%
Observation	Demographic	Consider the demographic profile of Tamworth	3	8%
Observation	Service provision	Consider provision of mental health services locally	2	5%
Positive	General	The proposal is a good solution	2	5%
Positive	Quality of care	The proposal helps to improve the quality of care	2	5%
Positive	Health and wellbeing	Being close to home is better for mental health patients than being in hospital	2	5%
Positive	Service provision	Community mental health services have been enhanced	1	3%
Negative	Specific groups	Concern over vulnerable groups being able to access hospital (for example, older people)	1	3%
Observation	Quality of services	Consider the need to enhance the crisis team (for example, better planning and training)	1	3%
Negative	Communication	Concern that the views of Tamworth and Lichfield residents have not been considered	1	3%
Negative	Quality of care	Concern over the lack of clarity on how community care has been enhanced in Tamworth	1	3%
Negative	Efficiency	Concern over the reliance on voluntary organisations	1	3%
Negative	Travel cost	Concern over travel costs	1	3%
Negative	Parking	Concern over parking at St George's Hospital	1	3%
Negative	Quality of care	Concern over the consistency and continuity of care (for example, aftercare)	1	3%
Observation	Service provision	Consider opening a male psychiatric ward in Tamworth as well as in Stafford	1	3%
Negative	Quality of care	The quality of care provided by St George's Hospital is poor	1	3%
Observation	Service provision	Having a separate dementia ward is beneficial	1	3%
Neutral	General	Other	3	8%
Base			*38*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.13.3 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (4 / 31%)

- **Another member of the public:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (10 / 59%)
- **Carer:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (2 / 100%)
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Observation – Staff – Ensure adequate staffing (for example, staffing level, trained staff) (2 / 100%)

Service type

- **George Bryan Centre:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (4 / 44%); Service provision – Reopen the George Bryan Centre (4 / 44%)
- **St George's Hospital, Stafford:** Staff – Ensure adequate staffing (for example, staffing level, trained staff) (2 / 50%)
- **Community mental health services:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (6 / 43%)
- **None of the above:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (10 / 71%)

Ethnicity

- **White:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (18 / 53%)
- **Prefer not to say:** Negative – Specific groups – The proposal disadvantages inpatients, their carers and relatives (2 / 67%)

Age

- **Under 45:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (6 / 55%)
- **45 to 59:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (7 / 64%)
- **60 and over:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (5 / 39%)

Sex

- **Male:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (8 / 80%)
- **Female:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (10 / 40%)

Sexual orientation

- **Heterosexual:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (16 / 55%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (2 / 50%)

Pregnancy

- **Yes:** No feedback received

- **No:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (18 / 53%)

Maternity

- **Yes:** Limited feedback received
- **No:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (17 / 53%)

Disability

- **No disability:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (11 / 61%)
- **Physical disability:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (4 / 50%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (4 / 36%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (7 / 47%)
- **No:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (10 / 56%)

Carer

- **Yes – Carer:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (8 / 57%)
- **No:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (9 / 53%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Staff – Ensure adequate staffing (for example, staffing level, trained staff) (3 / 50%)
- **Stafford:** Staff – Ensure adequate staffing (for example, staffing level, trained staff) (2 / 100%)
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (11 / 55%)
- **No postcode provided:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (3 / 43%)

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- **Most deprived deciles (1-5):** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (10 / 63%)
- **Least deprived deciles (6-10):** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (6 / 40%)
- **No postcode provided:** Travel – Concern over travel for visitors and patients (for example, distance and time from Tamworth, public transport) (3 / 43%)

6.13.4 Feedback from the engagement sessions with specific communities

Participants were asked: To what extent do you think this proposal is a good solution? 29 responses were received. The main theme areas were access, cost and efficiency, health and wellbeing, communication, estate and facilities, quality of care, proposal, resources, and specific groups.

Overall, the top three sub-themes were:

1. General – The proposal is not a good solution (for example, unrealistic) (5 / 17%)
2. Access – Concern over the location of the services (for example, too far to travel from some parts of Staffordshire) (4 / 14%)
3. Cost and efficiency – Concern over the lack of hospital beds to meet demand (3 / 10%)

Table 59 presents the full list of themes.

Table 59. To what extent do you think this proposal is a good solution?

Sentiment	Main theme	Sub-theme	No.	%
Negative	General	The proposal is not a good solution (for example, unrealistic)	5	17%
Negative	Access	Concern over the location of the services (for example, too far to travel from some parts of Staffordshire)	4	14%
Negative	Cost and efficiency	Concern over the lack of hospital beds to meet demand	3	10%
Negative	Health and wellbeing	The proposal could lead to more suicides	2	7%
Negative	Health and wellbeing	Consider the negative impact of a lack of local support available on the health and wellbeing of patients and their families	2	7%
Positive	General	Agreement with the proposal (for example, care model is good)	2	7%
Negative	Communication	Concern over poor communication between staff and patients (for example, staff do not listen)	1	3%
Negative	Access	The proposal makes it harder for people with severe mental health issues to access help	1	3%
Negative	Access	Concern over the lack of timely support	1	3%
Negative	Estate and facilities	St George's Hospital is not suitable for patients	1	3%
Neutral	Communication	More detail about the proposal is needed	1	3%
Observation	Quality of care	Quality of care is more important than the location of services	1	3%
Neutral	Proposal	The proposal is not new and reflects current service provision	1	3%
Observation	Resources	Consider different funding options to reopen the George Bryan Centre (for example, grants)	1	3%
Observation	Access	Consider options for Burton residents to access support in Derby	1	3%
Positive	Estate and facilities	The facilities at St George's Hospital are good	1	3%
Observation	Specific groups	Ensure the needs of people whose first language is not English are met	1	3%
Neutral	General	No comment (for example, as above)	14	48%
Base			*29*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.14 Groups that may be disadvantaged by the proposal

6.14.1 Feedback from the consultation survey

Consultation survey respondents were asked: Are there any groups that you think may be disadvantaged by this model? 29 responses were received. The main theme areas were specific groups, access, service provision, and cost and efficiency.

Overall, the top three sub-themes were:

1. Specific groups – Patients who need inpatient care (9 / 31%)
2. Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (6 / 21%); General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (6 / 21%)
3. Specific groups – Residents of Tamworth and Lichfield (5 / 17%)

Table 60 presents the full list of themes.

Table 60. Are there any groups that you think may be disadvantaged by this model?

Main theme	Sub-theme	No.	%
Specific groups	Patients who need inpatient care	9	31%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	6	21%
General	Everyone could be disadvantaged by the proposal (for example, patients, visitors)	6	21%
Specific groups	Residents of Tamworth and Lichfield	5	17%
Specific groups	Low-income families	4	14%
Service provision	Concern over the lack of inpatient beds available in the area	4	14%
Specific groups	Vulnerable people (for example, older people, people with social anxiety)	4	14%
Specific groups	Non-drivers	2	7%
Access	Concern over not being able to visit patients	2	7%
Access	Consider options for Tamworth residents to access mental health support in Birmingham	1	3%
Specific groups	Single parents	1	3%
Cost and efficiency	Concern over the poor insurance cover of the George Bryan Centre	1	3%
Specific groups	Anyone with mental health problems	1	3%
General	No groups would be disadvantaged	1	3%
Specific groups	People who don't have access to technology or knowledge of how to use it	1	3%
General	No comment (for example, as above)	1	3%
Base		*29*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.14.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Specific groups – Patients who need inpatient care (4 / 36%)
- **Another member of the public:** Specific groups – Patients who need inpatient care (4 / 31%)
- **Carer:** No feedback received
- **NHS employee:** No feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Specific groups – Patients who need inpatient care (3 / 43%)
- **St George's Hospital, Stafford:** Specific groups – Patients who need inpatient care (2 / 67%)
- **Community mental health services:** Specific groups – Patients who need inpatient care (3 / 25%); Specific groups – Residents of Tamworth and Lichfield (3 / 25%)
- **None of the above:** Specific groups – Patients who need inpatient care (3 / 33%); Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (3 / 33%)

Ethnicity

- **White:** Specific groups – Patients who need inpatient care (6 / 24%)
- **Prefer not to say:** Limited feedback received

Age

- **Under 45:** Specific groups – Patients who need inpatient care (3 / 43%); Service provision – Concern over the lack of inpatient beds available in the area (3 / 43%)
- **45 to 59:** Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (3 / 33%)
- **60 and over:** General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (5 / 50%)

Sex

- **Male:** Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (3 / 50%)
- **Female:** Specific groups – Patients who need inpatient care (5 / 25%); General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (5 / 25%)

Sexual orientation

- **Heterosexual:** Specific groups – Patients who need inpatient care (5 / 24%); General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (5 / 24%); Specific groups – Residents of Tamworth and Lichfield (5 / 24%)

- **Other (for example, gay, lesbian, bisexual, asexual):** Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (2 / 67%)

Pregnancy

- **Yes:** No feedback received
- **No:** Specific groups – Patients who need inpatient care (6 / 24%)

Maternity

- **Yes:** No feedback received
- **No:** Specific groups – Patients who need inpatient care (6 / 25%)

Disability

- **No disability:** Specific groups – Low-income families (3 / 25%); Specific groups – Vulnerable people (for example, older people, people with social anxiety) (3 / 25%)
- **Physical disability:** Specific groups – Patients who need inpatient care (3 / 50%)
- **Sensory disability:** Limited feedback provided
- **Mental health condition:** Specific groups – Patients who need inpatient care (3 / 33%); Service provision – Concern over the lack of inpatient beds available in the area (3 / 33%)
- **Learning disability or difficulty:** Limited feedback provided
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Specific groups – Patients who need inpatient care (5 / 42%)
- **No:** Specific groups – Low-income families (3 / 25%); Specific groups – Vulnerable people (for example, older people, people with social anxiety) (3 / 25%)

Carer

- **Yes – Carer:** Specific groups – Patients who need inpatient care (2 / 22%); Access – Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport) (2 / 22%); General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (2 / 22%); Specific groups – Residents of Tamworth and Lichfield (2 / 22%)
- **No:** Specific groups – Patients who need inpatient care (5 / 39%)

Local authority

- **East Staffordshire:** No feedback received
- **Lichfield:** General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (2 / 40%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** Limited feedback received
- **Tamworth:** Specific groups – Patients who need inpatient care (5 / 31%); Specific groups – Residents of Tamworth and Lichfield (5 / 31%)
- **No postcode provided:** Specific groups – Patients who need inpatient care (2 / 33%)

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- **Most deprived deciles (1-5):** Specific groups – Patients who need inpatient care (4 / 33%)

- **Least deprived deciles (6-10):** Specific groups – Patients who need inpatient care (3 / 27%); General – Everyone could be disadvantaged by the proposal (for example, patients, visitors) (3 / 27%); Specific groups – Residents of Tamworth and Lichfield (3 / 27%)
- **No postcode provided:** Specific groups – Patients who need inpatient care (2 / 33%)

6.14.3 Feedback from the engagement sessions with specific communities

Participants were asked: Are there any groups that you think may be disadvantaged by this model? 29 responses were received. The main theme areas were specific groups, travel cost, transport, and health and wellbeing.

Overall, the top three sub-themes were:

1. Specific groups – People who need to travel (for example, distance, poor public transport) (7 / 24%)
2. Specific groups – Non-drivers (4 / 14%)
3. Travel cost – Concern over the cost of travel (2 / 7%); Specific groups – Everyone could be disadvantaged (2 / 7%); Specific groups – People experiencing homelessness (2 / 7%)

Table 61 presents the full list of themes.

Table 61. Are there any groups that you think may be disadvantaged by this model?

Main theme	Sub-theme	No.	%
Specific groups	People who need to travel (for example, distance, poor public transport)	7	24%
Specific groups	Non-drivers	4	14%
Travel cost	Concern over the cost of travel	2	7%
Specific groups	Everyone could be disadvantaged	2	7%
Specific groups	People experiencing homelessness	2	7%
Specific groups	Vulnerable groups will be disadvantaged (for example, older people, people with disability, BAME community)	1	3%
Transport	Consider improving the provision of public transport between Tamworth and Stafford	1	3%
Specific groups	Carers and family members can be negatively impacted (for example, visitors)	1	3%
Health and wellbeing	Consider the negative impact of a lack of local support available on the health and wellbeing of patients and their families	1	3%
Specific groups	Consider the support for patients who need supervision while their medication is being adjusted	1	3%
General	No comment (for example, as above)	14	48%
Base		*29*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.15 Suggestions around how inpatient mental health services could be provided

6.15.1 Feedback from the consultation survey

Consultation survey respondents were asked: Tell us if you think there are any better ways to deliver inpatient mental health services. 35 responses were received. The main theme areas were service provision, cost and efficiency, access, quality of care, communication, and collaboration.

Overall, the top three sub-themes were:

1. Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (11 / 31%)
2. Service provision – Consider greater provision of mental health support locally (9 / 26%)
3. Service provision – More mental health units across the county are needed (3 / 9%); Cost and efficiency – Ensure sufficient funding for healthcare services (3 / 9%)

Table 62 presents the full list of themes.

Table 62. Tell us if you think there are any better ways to deliver inpatient mental health services.

Main theme	Sub-theme	No.	%
Service provision	Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire)	11	31%
Service provision	Consider greater provision of mental health support locally	9	26%
Service provision	More mental health units across the county are needed	3	9%
Cost and efficiency	Ensure sufficient funding for healthcare services	3	9%
Service provision	Consider the need for a larger mental health hospital in South Staffordshire	2	6%
Cost and efficiency	The proposal is the only workable option	1	3%
Access	Consider options for Tamworth and Lichfield residents to access mental health support in Birmingham	1	3%
Quality of care	Consider improving therapeutic support on wards	1	3%
Quality of care	Ensure the care provided reflects the individual needs of patients	1	3%
Communication	Listen to what patients say	1	3%
Cost and efficiency	Consider using the insurance money to restore the George Bryan Centre	1	3%
Collaboration	Consider the need for greater collaboration between hospital sites, service providers and charities	1	3%
General	No comment (for example, as above)	5	14%
General	Other	2	6%
Base		*35*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.15.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 33%)
- **Another member of the public:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (6 / 38%); Service provision – Consider greater provision of mental health support locally (6 / 38%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 44%)
- **St George's Hospital, Stafford:** Limited feedback received
- **Community mental health services:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 29%)
- **None of the above:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 39%)

Ethnicity

- **White:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 26%); Service provision – Consider greater provision of mental health support locally (8 / 26%)
- **Prefer not to say:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 75%)

Age

- **Under 45:** Service provision – Consider greater provision of mental health support locally (2 / 25%)
- **45 to 59:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 46%)
- **60 and over:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 23%); Service provision – Consider greater provision of mental health support locally (3 / 23%)

Sex

- **Male:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 44%)
- **Female:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 21%); Service provision – Consider greater provision of mental health support locally (5 / 21%)

Sexual orientation

- **Heterosexual:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 27%)

- **Other (for example, gay, lesbian, bisexual, asexual):** Service provision – Consider greater provision of mental health support locally (2 / 67%)

Pregnancy

- **Yes:** No feedback received
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 26%); Service provision – Consider greater provision of mental health support locally (8 / 26%)

Maternity

- **Yes:** Limited feedback received
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (8 / 28%); Service provision – Consider greater provision of mental health support locally (8 / 28%)

Disability

- **No disability:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 25%)
- **Physical disability:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 57%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Service provision – Consider greater provision of mental health support locally (3 / 33%)
- **Learning disability or difficulty:** No feedback received
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 39%)
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 24%)

Carer

- **Yes – Carer:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (4 / 29%); Service provision – Consider greater provision of mental health support locally (4 / 29%)
- **No:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (5 / 33%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 43%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 37%)
- **No postcode provided:** Service provision – Consider greater provision of mental health support locally (3 / 60%)

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- **Most deprived deciles (1-5):** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (7 / 41%)
- **Least deprived deciles (6-10):** Service provision – Reopen the George Bryan Centre (for example, provide services in the wing not affected by the fire) (3 / 23%)
- **No postcode provided:** Service provision – Consider greater provision of mental health support locally (3 / 60%)

6.15.3 Feedback from the engagement sessions with specific communities

Participants were asked: Tell us if you think there are any better ways to deliver inpatient mental health services. 25 responses were received. The main theme areas were service provision, estates and facilities, awareness, staff, technology, parking, access, quality of care and financial support.

Overall, the top three sub-themes were:

1. Service provision – Provide mental health services locally (6 / 24%)
2. Service provision – Reopen the George Bryan Centre (for example, rebuild it) (3 / 12%); Estate and facilities – Consider providing access to appropriate facilities for patients with mental health problems (for example, quiet room) (3 / 12%)

Table 63 presents the full list of themes.

Table 63. Tell us if you think there are any better ways to deliver inpatient mental health services.

Main theme	Sub-theme	No.	%
Service provision	Provide mental health services locally	6	24%
Service provision	Reopen the George Bryan Centre (for example, rebuild it)	3	12%
Estate and facilities	Consider providing access to appropriate facilities for patients with mental health problems (for example, quiet room, memory boxes)	3	12%
Service provision	Consider providing support following a crisis (for example, access to support groups)	1	4%
Awareness	Raise awareness of the support available and how to access it	1	4%
Staff	Consider additional training for staff (for example, suicide prevention training)	1	4%
General	The models do not reflect reality	1	4%
Technology	Technology cannot replace human contact	1	4%
Parking	Consider improving the parking for visitors	1	4%
Access	Consider the need for flexible visiting times	1	4%
General	There is no better way to deliver inpatient mental health services	1	4%
Staff	Ensure services are staffed appropriately with suitably trained staff	1	4%
Access	Consider improving access to mental health support	1	4%
Quality of care	Ensure the specific needs of people with neurodiverse conditions are met	1	4%
Financial support	Invest more money in mental health services	1	4%
Service provision	Reopen the Margaret Stanhope Centre	1	4%
General	No comment (for example, as above)	8	32%
Base		*25*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.15.4 Additional feedback from other channels

As well as the feedback captured through the outlined channels, further feedback on the proposal for delivering inpatient mental health services was received through the following:

- March 2023 Overview and Scrutiny Committee meeting minutes
- Enter and view report from Healthwatch Staffordshire
- Healthwatch Staffordshire feedback on the consultation
- Additional written feedback submitted during the engagement events.

A summary of the themes raised has been presented below:

- The need to travel to Stafford was highlighted as a disadvantage
- Transport is the major concern for those in Tamworth, due to lack of access to a car or bus stops near people's homes
- It is felt that elderly people would find travel difficult
- The Support Staffordshire Voluntary Driving Scheme was suggested as an option to help with the issue around travel
- The importance of family and friends being able to visit service users was highlighted
- The need for a patient transport service was highlighted
- Concerns were raised around whether St George's Hospital has sufficient capacity to meet demand
- The need for flexible visiting times at St George's Hospital was highlighted
- The need to improve visitor facilities was highlighted. For example, it was commented that the café and bistro are not open during the evening and on weekends It was suggested that vending machines are put in place for people to use when the café and bistro are closed
- Concerns were raised about the lack of parking available at St George's Hospital
- One service user commented that moving inpatient mental health services to St George's Hospital was a good idea
- It was commented that it would be hard for the public to accept the proposal
- It was commented that although digital technology may be suitable for some, there is a cohort of people who are digitally excluded and cannot use a computer without help
- Concerns were raised about the distance service users might have to travel on visits home as part of their recovery.

6.16Feedback on travel and access

Table 64 shows the questions consultation survey respondents and participants in the engagement sessions with specific communities were asked.

Table 64. Survey and voluntary sector support groups' questions

Survey questions	Engagement events with specific communities' questions
To what extent are you concerned about travel for visitors under this proposal? *Where 1 is very unconcerned and 5 is very concerned.*	Please explain to what extent you are concerned or unconcerned about travel for visitors under this proposal.

Please explain why you are concerned or unconcerned.	Tell us what support you think should be developed and provided for visitors. Please tell us if you think the support should be for a set period of time or up to a certain amount – for example, money or support level.
How do you think you will travel?	
In our proposals we are keen to include and develop support with travel for visitors. Tell us what support you think should be developed and provided for visitors. *Please tell us if you think the support should be for a set period of time or up to a certain amount, for example, money or support level.*	

6.16.1 Feedback on visitor travel

6.16.1.1 Feedback from the consultation survey

Consultation survey respondents were asked: To what extent are you concerned about travel for visitors under this proposal? Tables 65, 66 and 67 show that 40 (87%) respondents were concerned / very concerned about travel for visitors, compared to 3 (6%) respondents who were very unconcerned / unconcerned.

Table 65. To what extent are you concerned about travel for visitors under this proposal? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very unconcerned	2	4%	-	-	2	12%	-	-	-	-	-	-	-	-
Unconcerned	1	2%	-	-	-	-	-	-	-	-	-	-	-	-
Neither concerned nor unconcerned	3	7%	2	12%	-	-	1	25%	-	-	-	-	-	-
Concerned	12	26%	5	29%	3	18%	2	50%	1	50%	1	33%	-	-
Very concerned	28	61%	10	59%	12	71%	1	25%	1	50%	2	67%	2	100%
Base	*46*		*17*		*17*		*4*		*2*		*3*		*2*	

Table 66. To what extent are you concerned about travel for visitors under this proposal? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Very unconcerned	2	4%	1	5%	-	-	-	-	1	7%
Unconcerned	1	2%	-	-	-	-	-	-	-	-
Neither concerned nor unconcerned	3	7%	3	14%	-	-	1	13%	-	-
Concerned	12	26%	8	38%	4	33%	4	50%	3	20%
Very concerned	28	61%	9	43%	8	67%	3	38%	11	73%
Base	*46*		*21*		*12*		*8*		*15*	

Table 67. To what extent are you concerned about travel for visitors under this proposal? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Very unconcerned	2	4%	1	5%	-	-	-	-	-	-	1	50%	-	-
Unconcerned	1	2%	1	5%	-	-	-	-	-	-	-	-	-	-
Neither concerned nor unconcerned	3	7%	-	-	2	22%	-	-	1	100%	-	-	-	-
Concerned	12	26%	3	14%	3	33%	1	50%	-	-	1	50%	4	44%
Very concerned	28	61%	17	77%	4	44%	1	50%	-	-	-	-	5	56%
Base	*46*		*22*		*9*		*2*		*1*		*2*		*9*	

There was one additional response to this question by a respondent outside the Staffordshire and Stoke-on-Trent area. This respondent stated they are very concerned about travel for visitors.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.16.1.2 Significant differences across respondent groups

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were asked: Please explain why you are concerned or unconcerned about travel for visitors under this proposal. 39 responses were received. The main theme areas were travel, travel cost, health and wellbeing, specific groups, estate and facilities, service provision, proposal and access.

Overall, the top three sub-themes were:

1. Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (25 / 64%)
2. Travel cost – Concern over the travel cost (14 / 36%)
3. Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (10 / 26%)

Table 68 presents the full list of themes.

Table 68. Please explain why you are concerned or unconcerned.

Sentiment	Main theme	Sub-theme	No.	%
Negative	Travel	Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport)	25	64%
Negative	Travel cost	Concern over the travel cost	14	36%
Negative	Health and wellbeing	Concern over the negative impact on patients if they cannot see their relatives	10	26%
Negative	Specific groups	Concern that the needs of low-income families have not been considered	3	8%
Negative	Specific groups	The proposal disadvantages inpatients, their carers and relatives	3	8%
Observation	Estate and facilities	Utilise available local facilities for mental health services	2	5%
Negative	Service provision	Concern over the lack of inpatient beds available in the area	1	3%
Negative	Service provision	Concern over the lack of mental health services in the community	1	3%
Negative	Proposal	The proposal is about saving money and not improving services for people	1	3%
Positive	Access	St George's Hospital is closer than other hospitals	1	3%
Neutral	General	No comment (for example, as above)	1	3%
Neutral	General	Other	1	3%
Base			*39*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.16.1.3 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (9 / 64%)
- **Another member of the public:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (12 / 75%)
- **Carer:** Limited feedback provided
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (1 / 100%)

Service type

- **George Bryan Centre:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (6 / 60%)
- **St George's Hospital, Stafford:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (3 / 50%); Negative – Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (3 / 50%)

- **Community mental health services:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (10 / 63%)
- **None of the above:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (9 / 64%)

Ethnicity

- **White:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (22 / 65%)
- **Prefer not to say:** Negative – Specific groups – The proposal disadvantages inpatients, their carers and relatives (2 / 50%)

Age

- **Under 45:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (5 / 56%)
- **45 to 59:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (6 / 50%)
- **60 and over:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (11 / 79%)

Sex

- **Male:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (8 / 73%)
- **Female:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (14 / 58%)

Sexual orientation

- **Heterosexual:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (18 / 62%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (3 / 100%)

Pregnancy

- **Yes:** No feedback received
- **No:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (22 / 65%)

Maternity

- **Yes:** Limited feedback received
- **No:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (21 / 66%)

Disability

- **No disability:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (11 / 61%)
- **Physical disability:** Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (4 / 67%)
- **Sensory disability:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (2 / 100%); Travel cost –

Concern over the travel cost (2 / 100%); Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (2 / 100%)
- **Mental health condition:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (7 / 70%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (10 / 71%)
- **No:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (12 / 60%)

Carer

- **Yes – Carer:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (9 / 60%)
- **No:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (11 / 69%)

Local authority

- **East Staffordshire:** Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (2 / 100%)
- **Lichfield:** Travel cost – Concern over the travel cost (4 / 67%)
- **Stafford:** Health and wellbeing – Concern over the negative impact on patients if they cannot see their relatives (2 / 100%)
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (15 / 68%)
- **No postcode provided:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (5 / 71%)

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- **Most deprived deciles (1-5):** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (11 / 61%)
- **Least deprived deciles (6-10):** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (9 / 64%)
- **No postcode provided:** Travel – Concerns over the travel requirements for visitors and patients (for example, distance and time, public transport) (5 / 71%)

6.16.1.4 Feedback from the engagement sessions with specific communities

Participants were asked: Please explain to what extent you are concerned or unconcerned about travel for visitors under this proposal. 29 responses were received. The main theme areas were travel, travel cost, planning, access, specific groups, health and wellbeing, transport, estate and facilities and quality of care.

Overall, the top three sub-themes were:

1. Travel – Concern over travel for visitors and patients (for example, distance and time, public transport) (13 / 45%)
2. Travel cost – Concern over the cost of travel (4 / 14%)
3. Planning – Consider the need to align visiting times with public transport timetables (3 / 10%); Access – The proposal makes it challenging for patients and visitors to see each other (3 / 10%); Access – No concerns around travel (for example, can drive) (3 / 10%)

Table 69 presents the full list of themes.

Table 69. Please explain to what extent you are concerned or unconcerned about travel for visitors under this proposal.

Sentiment	Main theme	Sub-theme	No.	%
Negative	Travel	Concern over travel for visitors and patients (for example, distance and time, public transport)	13	45%
Negative	Travel cost	Concern over the cost of travel	4	14%
Observation	Planning	Consider the need to align visiting times with public transport timetables	3	10%
Negative	Access	The proposal makes it challenging for patients and visitors to see each other	3	10%
Neutral	Access	No concerns around travel (for example, can drive)	3	10%
Negative	Specific groups	The proposal disadvantages low-income families and children	2	7%
Negative	Access	Concern over the location of St George's Hospital	2	7%
Negative	Specific groups	Concern over the impact of the proposal on vulnerable people (for example, with limited mobility, recovering addicts)	2	7%
Negative	Specific groups	The proposal disadvantages non-drivers	2	7%
Negative	Health and wellbeing	Concern over the impact of travel on the health and wellbeing of patients and their families (for example, additional stress)	2	7%
Observation	Health and wellbeing	Consider the positive therapeutic effect of visitors on inpatients	1	3%
Negative	Transport	Concern over the lack of community transport services	1	3%
Positive	Access	St George's Hospital is easy to access	1	3%
Positive	Estate and facilities	The facilities for visitors at St George's Hospital are good (for example, café)	1	3%
Negative	Specific groups	Concern over access for homeless people	1	3%
Observation	Quality of care	Quality of care is more important than the location of services	1	3%
Neutral	General	No comment (for example, as above)	6	21%
Base			*29*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.16.2 Supporting travel for visitors

6.16.2.1 Feedback from the consultation survey

Consultation survey respondents were asked: In our proposals we are keen to include and develop support with travel for visitors. Tell us what support you think should be developed and provided for visitors. 36 responses were received. The main theme areas were travel support, financial support, service provision, process, support and access.

Overall, the top three sub-themes were:

1. Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (10 / 28%)
2. Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (9 / 25%)
3. Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (8 / 22%)

Table 70 presents the full list of themes.

Table 70. In our proposals we are keen to include and develop support with travel for visitors. Tell us what support you think should be developed and provided for visitors.

Main theme	Sub-theme	No.	%
Travel support	Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service)	10	28%
Financial support	Consider ongoing financial support until a patient returns home (for example, cover travel expenses)	9	25%
Service provision	Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire)	8	22%
Service provision	Spend the money to rebuild the George Bryan Centre instead of supporting patients to travel	4	11%
Support	Support should be provided for a set period	3	8%
Financial support	Financial support shouldn't be means tested	2	6%
Service provision	More inpatient beds are needed across Staffordshire	1	3%
Financial support	Petrol costs should be the same as the government rates	1	3%
Process	Ensure that the process of claiming financial support is clear and simple	1	3%
Support	Advice around how to support patients with mental health problems is needed	1	3%
Specific groups	Consider providing transport for disabled and elderly people	1	3%
Access	Concern over the location of inpatient mental health services (for example, long travel, poor public transport)	1	3%
Specific groups	Consider supporting volunteer drivers	1	3%
General	Other	3	8%
Base		*36*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.16.2.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (3 / 21%); Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (3 / 21%); Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (3 / 21%)
- **Another member of the public:** Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (5 / 38%)
- **Carer:** Limited feedback received

- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (2 / 25%); Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (2 / 25%); Service provision – Spend the money to rebuild the George Bryan Centre instead of supporting patients to travel (2 / 25%)
- **St George's Hospital, Stafford:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (2 / 33%)
- **Community mental health services:** Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (4 / 24%)
- **None of the above: Service provision –** Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (5 / 46%)

Ethnicity

- **White:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (9 / 29%)
- **Prefer not to say:** Service provision – Spend the money to rebuild the George Bryan Centre instead of supporting patients to travel (2 / 50%)

Age

- **Under 45:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (3 / 38%); Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (3 / 38%); Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (3 / 38%)
- **45 to 59:** Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (5 / 42%)
- **60 and over:** Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (3 / 25%)

Sex

- **Male:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (3 / 38%)
- **Female:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (6 / 25%); Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (6 / 25%); Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (6 / 25%)

Sexual orientation

- **Heterosexual:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (9 / 35%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (2 / 67%)

Pregnancy

- **Yes:** No feedback received
- **No:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (9 / 29%)

Maternity

- **Yes:** Limited feedback received
- **No:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (9 / 31%)

Disability

- **No disability:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (5 / 36%)
- **Physical disability:** Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (3 / 50%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (3 / 27%); Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (3 / 27%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (4 / 31%)
- **No:** Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (6 / 33%)

Carer

- **Yes – Carer:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (4 / 27%)
- **No:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (4 / 31%); Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (4 / 31%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (2 / 25%); Service provision – Consider greater provision of mental health support locally (for example, open hospital in south Staffordshire) (2 / 25%); Support – Support should be provided for a set period (2 / 25%)
- **Stafford:** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (2 / 100%)
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (7 / 35%)

- **Out of the area:** No feedback provided
- **No postcode provided:** Service provision – Spend the money to rebuild the George Bryan Centre instead of supporting patients to travel (2 / 40%)

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- **Most deprived deciles (1-5):** Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (7 / 41%)
- **Least deprived deciles (6-10):** Travel support – Consider providing affordable transport for visitors (for example, shuttle bus, private taxi service) (7 / 50%)
- **No postcode provided:** Service provision – Spend the money to rebuild the George Bryan Centre instead of supporting patients to travel (2 / 40%)

6.16.2.3 Feedback from the engagement sessions with specific communities

Participants were asked: Tell us what support you think should be developed and provided for visitors. 28 responses were received. The main theme areas were travel support, financial support, access, communication, estate and facilities, service provision, duration of support, parking, health and wellbeing, support, peer-support, travel cost and technology.

Overall, the top three sub-themes were:

1. Travel support – Consider providing transport for visitors (11 / 39%)
2. Financial support – Consider ongoing financial support until a patient returns home (for example, cover travel expenses) (8 / 29%)
3. Access – Consider the need to align visiting times with public transport timetables (6 / 21%)

Table 71 presents the full list of themes.

Table 71. Tell us what support do you think should be developed and provided for visitors.

Main theme	Sub-theme	No.	%
Travel support	Consider providing transport for visitors	11	39%
Financial support	Consider ongoing financial support until a patient returns home (for example, cover travel expenses)	8	29%
Access	Consider the need to align visiting times with public transport timetables	6	21%
Communication	Consider improving communication with patients' families and carers	4	14%
Estate and facilities	Ensure there are appropriate facilities for visitors (for example, access to refreshments, space for families with children)	4	14%
Service provision	Consider greater provision of mental health support locally	3	11%
Duration of support	Support should be in place as long as patients and their families need it	3	11%
Parking	Consider free parking for visitors	3	11%
Health and wellbeing	Consider the positive therapeutic effect of visitors on inpatients	2	7%
Support	Support should be timely	1	4%
Support	Consider the individual needs of patients and their family when providing support	1	4%
Access	Allow pets to visit	1	4%
Support	Consider the need to provide support following discharge	1	4%
Peer-support	Consider providing peer-support	1	4%
Access	Signpost to available services	1	4%

Travel cost	Proposed rates of 18p per mile is not enough to cover petrol	1	4%
General	Any support is good	1	4%
Technology	Consider that communication via technology may not be appropriate for some patients	1	4%
General	No comment	3	11%
Base		*28*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.16.3 Views on patient travel

6.16.3.1 Feedback from the consultation survey

Consultation survey respondents were asked: How do you think you will travel? 36 responses were received. The main theme areas were access, specific groups, travel cost and health and wellbeing.

Overall, the top three sub-themes were:

1. Access – By car (20 / 56%)
2. Access – Will not travel (for example, wouldn't be able) (7 / 19%)
3. Specific groups – Concerns for those who do not drive (5 / 14%)

Table 72 presents the full list of themes.

Table 72. How do you think you will travel?

Main theme	Sub-theme	No.	%
Access	By car	20	56%
Access	Will not travel (for example, wouldn't be able)	7	19%
Specific groups	Concerns for those who do not drive	5	14%
Access	By bus	4	11%
Specific groups	Consider the needs of vulnerable people	3	8%
Access	Concern over the location of inpatient mental health services (for example, too far to travel, poor public transport)	2	6%
Travel cost	Concern over travel costs	2	6%
Health and wellbeing	Concern over the negative impact on patients if they cannot see their relatives	2	6%
Access	Concern over increased traffic due to more people traveling	1	3%
Access	Rely on lifts from others	1	3%
Access	Using voluntary car services	1	3%
Access	Call an ambulance	1	3%
Access	By train	1	3%
General	No comments (for example, N/A)	3	8%
Base		*36*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.16.3.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Access – By car (7 / 50%)

- **Another member of the public:** Access – By car (6 / 43%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Access – By car (2 / 67%)
- **Formal response from an organisation:** Access – By car (2 / 100%)

Service type

- **George Bryan Centre:** Access – By car (4 / 50%)
- **St George's Hospital, Stafford:** Access – Will not travel (for example, wouldn't be able) (2 / 40%)
- **Community mental health services:** Access – By car (9 / 56%)
- **None of the above:** Access – By car (6 / 50%)

Ethnicity

- **White:** Access – By car (18 / 58%)
- **Prefer not to say:** Access – Will not travel (for example, wouldn't be able) (3 / 75%)

Age

- **Under 45:** Access – By car (5 / 63%)
- **45 to 59:** Access – By car (6 / 50%)
- **60 and over:** Access – By car (7 / 58%)

Sex

- **Male:** Access – By car (7 / 78%)
- **Female:** Access – By car (11 / 48%)

Sexual orientation

- **Heterosexual:** Access – By car (14 / 54%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Access – By car (2 / 67%)

Pregnancy

- **Yes:** No feedback received
- **No:** Access – By car (18 / 58%)

Maternity

- **Yes:** Limited feedback received
- **No:** Access – By car (16 / 55%)

Disability

- **No disability:** Access – By car (11 / 69%)
- **Physical disability:** Access – Will not travel (for example, wouldn't be able) (3 / 50%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Access – By car (6 / 60%)
- **Learning disability or difficulty:** Limited feedback received
- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Access – By car (4 / 31%); Access – Will not travel (for example, wouldn't be able) (4 / 31%)

- **No:** Access – By car (14 / 74%)

Carer

- **Yes – Carer:** Access – By car (7 / 50%)
- **No:** Access – By car (9 / 60%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Access – By car (6 / 86%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** Access – By car (11 / 52%)
- **Out of area:** No feedback received
- **No postcode provided:** Access – By car (3 / 60%)

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- **Most deprived deciles (1-5):** Access – By car (10 / 59%)
- **Least deprived deciles (6-10):** Access – By car (7 / 50%)
- **No postcode provided:** Access – By car (3 / 60%)

6.17 Feedback on technology

Table 73 shows the questions consultation survey respondents and participants in the engagement sessions with specific communities were asked.

Table 73. Survey and voluntary sector support group's questions

Survey questions	Engagement events with specific communities' questions
Do you have access to the internet?	What support, if any, should be offered to those wanting to contact someone in hospital using a device connected to the internet?
What type of device do you have?	
Does the device have a camera you can use while using your device to make a call?	
Could you use the device to contact someone in hospital?	
What support, if any, would you require to use the internet device to contact someone in hospital?	

6.17.1 Accessing technology

6.17.1.1 Feedback from the consultation survey

Consultation survey respondents were asked: Do you have access to the internet? Tables 74, 75 and 76 show that 42 (93%) respondents had access to the internet in their own home compared to 3 (7%) respondents who had no access to the internet.

Table 74. Do you have access to the internet? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
In your own home	42	93%	14	88%	17	100%	3	75%	2	100%	3	100%	2	100%
Another place	3	7%	2	13%	-	-	1	25%	-	-	-	-	-	-
No access	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Base	*45*		*16*		*17*		*4*		*2*		*3*		*2*	

Table 75. Do you have access to the internet? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
In your own home	42	93 %	19	95%	11	92%	6	75%	14	93%
Another place	3	7%	1	5%	1	8%	2	25%	1	7%
No access	-	-	-	-	-	-	-	-	-	-
Base	*45*		*20*		*12*		*8*		*15*	

Table 76. Do you have access to the internet? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
In your own home	42	93%	19	91%	9	100%	2	100%	1	100%	2	100%	8	89%
Another place	3	7%	2	10%	-	-	-	-	-	-	-	-	1	11%
No access	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Base	*45*		*21*		*9*		*2*		*1*		*2*		*9*	

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.17.1.2 Significant differences across respondent groups

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were asked: what type of device do you have? Tables 77, 78 and 79 show that most respondents used mobile phones (37 / 84%), laptop computers (25 / 57%) and tablet devices (15 / 34%).

Table 77. What type of device do you have? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Mobile phone	37	84%	13	81%	13	81%	3	75%	2	100%	3	100%	2	100%
Laptop computer	25	57%	8	50%	9	56%	1	25%	2	100%	3	100%	1	50%
Tablet device	15	34%	3	19%	9	56%	1	25%	-	-	1	33%	1	50%
Desktop computer	9	21%	1	6%	5	31%	-	-	1	50%	2	67%	-	-
I do not have access to any of these devices	2	5%	1	6%	-	-	1	25%	-	-	-	-	-	-
Base	*44*		*16*		*16*		*4*		*2*		*3*		*2*	

Table 78. What type of device do you have? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Mobile phone	37	84%	15	75%	8	67%	6	75%	14	100%
Laptop computer	25	57%	10	50%	6	50%	3	38%	9	64%
Tablet device	15	34%	5	25%	4	33%	1	13%	6	43%
Desktop computer	9	21%	2	10%	5	42%	-	-	3	21%
I do not have access to any of these devices	2	5%	2	10%	2	17%	1	13%	-	-
Base	*44*		*20*		*12*		*8*		*14*	

Table 79. What type of device do you have? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Mobile phone	37	84%	17	85%	8	89%	1	50%	1	100%	2	100%	7	78%
Laptop computer	25	57%	11	55%	5	56%	1	50%	1	100%	1	50%	6	67%
Tablet device	15	34%	6	30%	5	56%	-	-	-	-	1	50%	3	33%
Desktop computer	9	21%	2	10%	3	33%	-	-	-	-	1	50%	3	33%
I do not have access to any of these devices	2	5%	1	5%	-	-	-	-	-	-	-	-	1	11%
Base	*44*		*20*		*9*		*2*		*1*		*2*		*9*	

There was one additional response to this question by a respondent outside the Staffordshire and Stoke-on-Trent area. This respondent said they used a mobile phone.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.17.1.3 Significant differences across respondent groups

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were asked: Does the device have a camera you can use while using your device to make a call? Tables 80, 81 and 82 show that 36 (86%) respondents had a camera in their device that could be used while making a call, while 4 (10%) respondents did not have a camera on their device.

Table 80. Does the device have a camera you can use while using your device to make a call? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or organisation		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	36	86%	13	87%	12	75%	3	100%	2	100%	3	100%	2	100%
No	4	10%	1	7%	3	19%	-	-	-	-	-	-	-	-
Unsure	2	5%	1	7%	1	6%	-	-	-	-	-	-	-	-
Base	*42*		*15*		*16*		*3*		*2*		*3*		*2*	

Table 81. Does the device have a camera you can use while using your device to make a call? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Yes	36	86%	18	100%	8	80%	6	86%	11	79%
No	4	10%	-	-	1	10%	-	-	3	21%
Unsure	2	5%	-	-	1	10%	1	14%	-	-
Base	*42*		*18*		*10*		*7*		*14*	

Table 82. Does the device have a camera you can use while using your device to make a call? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	36	86%	15	79%	8	89%	2	100%	1	100%	2	100%	7	88%
No	4	10%	2	11%	1	11%	-	-	-	-	-	-	1	13%
Unsure	2	5%	2	11%	-	-	-	-	-	-	-	-	-	-
Base	*42*		*19*		*9*		*2*		*1*		*2*		*8*	

There was one additional response to this question by a respondent outside the Staffordshire and Stoke-on-Trent area. This respondent said their device had a camera.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.17.1.4 Significant differences across respondent groups

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, age, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

Consultation survey respondents were asked: Could you use the device to contact someone in hospital? Tables 83, 84 and 85 show that 27 (66%) respondents could easily use their device to contact someone in hospital, compared to 10 (24%) respondents who said that they could use their device to contact someone in hospital, but would need assistance.

Table 83. Could you use the device to contact someone in hospital? Breakdown: Respondent type

	No.	%	Respondent type											
			User of mental health services		Another member of the public		Carer		NHS employee		From a public / health related / non-health related charity or		A formal response from an organisation	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes, easily	27	66%	9	64%	9	56%	3	100%	2	100%	2	67%	1	50%
Yes, with assistance	10	24%	4	29%	4	25%	-	-	-	-	1	33%	1	50%
No	4	10%	1	7%	3	19%	-	-	-	-	-	-	-	-
Base	*41*		*14*		*16*		*3*		*2*		*3*		*2*	

Table 84. Could you use the device to contact someone in hospital? Breakdown: Service type

	No.	%	Service type							
			Community mental health services		George Bryan Centre		St George's Hospital, Stafford		None of the above	
			No.	%	No.	%	No.	%	No.	%
Yes, easily	27	66%	10	59%	7	70%	5	83%	10	71%
Yes, with assistance	10	24%	6	35%	-	-	-	-	3	21%
No	4	10%	1	6%	3	30%	1	17%	1	7%
Base	*41*		*17*		*10*		*6*		*14*	

Table 85. Could you use the device to contact someone in hospital? Breakdown: Local authority

	No.	%	Local authority											
			Tamworth		Lichfield		Stafford		Stoke-on-Trent		East Staffs		No postcode / unable to profile	
			No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes, easily	27	66%	13	68%	5	56%	1	100%	1	100%	1	50%	5	63%
Yes, with assistance	10	24%	5	26%	3	33%	-	-	-	-	1	50%	1	13%
No	4	10%	1	5%	1	11%	-	-	-	-	-	-	2	25%
Base	*41*		*19*		*9*		*1*		*1*		*2*		*8*	

There was one additional response to this question by a respondent outside the Staffordshire and Stoke-on-Trent area. This respondent said they could easily use their device to contact someone in hospital.

The base for the above tables refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer. The base for each subgroup in the table refers to the number of respondents in that cohort.

6.17.1.5 Significant differences across respondent groups

Age

- A significantly higher proportion of respondents aged 45 to 59 (11 / 97%) stated they could easily use their device to contact someone in hospital, compared to respondents aged over 60 (7 / 47%)

There was no significant difference in the following sub-groups: respondent type, service type, ethnicity, sex, sexual orientation, pregnancy, maternity, disability, limitation in day-to-day activities, carers, local authority, and Index of Multiple Deprivation.

For a full breakdown of the responses to this question by these groups and other groups please see the Excel Appendix data tables.

6.17.2 Supporting people with technology

6.17.2.1 Feedback from the consultation survey feedback

Consultation survey respondents were asked: What support, if any, would you require to use the internet device to contact someone in hospital? 30 responses were received. The main theme areas were technology, specific groups, support, COVID-19 and quality of care.

Overall, the top three sub-themes were:

1. Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (9 / 30%)
2. General – No support required (7 / 23%)
3. Specific groups – Consider the needs of older people (5 / 17%)

Table 86 presents the full list of themes.

Table 86. What support, if any, would you require to use the internet device to contact someone in hospital?

Main theme	Sub-theme	No.	%
Technology	Technology cannot replace human contact (for example, prefer face-to-face contact)	9	30%
General	No support required	7	23%
Specific groups	Consider the needs of older people	5	17%
Support	Will require a lot of support (for example, technical support)	3	10%
Technology	Consider that not everyone is tech savvy or has access to technology	3	10%
Technology	Concern over the reliability of technology (for example, quality of internet)	2	7%
COVID-19	Consider the advantages and disadvantages of people using technology during COVID-19	2	7%
Quality of care	Hard to assess virtually how patients are cared for	1	3%
Technology	Concern over access to devices and chargers	1	3%
Specific groups	Contact via technology is not appropriate for people with mental health problems	1	3%
Support	Support on how to set up a link for video conversations would be required	1	3%
Specific groups	Communication via technology may work for some patients	1	3%
Support	Support to connect device to the internet would be required	1	3%
General	No comment (for example, N/A)	1	3%
Base		*30*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.17.2.2 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (4 / 33%)
- **Another member of the public:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (4 / 36%)
- **Carer:** Limited feedback received
- **NHS employee:** Limited feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Specific groups – Consider the needs of older people (3 / 38%); Technology – Consider that not everyone is tech savvy or has access to technology (3 / 38%)
- **St George's Hospital, Stafford:** Limited feedback received

- **Community mental health services:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (4 / 25%)
- **None of the above:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (3 / 38%); General – No support required (3 / 38%)

Ethnicity

- **White:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (8 / 32%)
- **Prefer not to say:** Limited feedback received

Age

- **Under 45:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (3 / 43%)
- **45 to 59:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (3 / 50%)
- **60 and over:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (3 / 23%); General – No support required (3 / 23%); Support – Will require a lot of support (for example, technical support) (3 / 23%)

Sex

- **Male:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (4 / 50%)
- **Female:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (5 / 28%)

Sexual orientation

- **Heterosexual:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (7 / 35%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Limited feedback received

Pregnancy

- **Yes:** No feedback received
- **No:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (8 / 32%)

Maternity

- **Yes:** No feedback received
- **No:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (8 / 33%)

Disability

- **No disability:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (4 / 31%); General – No support required (4 / 31%)
- **Physical disability:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (2 / 67%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (5 / 63%)
- **Learning disability or difficulty:** Limited feedback received

- **Other:** Limited feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (6 / 60%)
- **No:** General – No support required (5 / 33%)

Carer

- **Yes – Carer:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (6 / 43%)
- **No:** Specific groups – Consider the needs of older people (3 / 33%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** General – No support required (3 / 43%)
- **Stafford:** Limited feedback received
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (6 / 40%)
- **Out of area:** No feedback received
- **No postcode provided:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (2 / 40%)

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- **Most deprived deciles (1-5):** General – No support required (4 / 31%)
- **Least deprived deciles (6-10):** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (5 / 42%)
- **No postcode provided:** Technology – Technology cannot replace human contact (for example, prefer face-to-face contact) (2 / 40%)

6.17.2.3 Feedback from the engagement sessions with specific communities

Participants were asked: What support, if any, should be offered to those wanting to contact someone in hospital using a device connected to the internet? 28 responses were received. The main theme areas were specific groups, technology, privacy, access, quality of care, training and cost and efficiency.

Overall, the top three sub-themes were:

1. Specific groups – Consider that not everyone is tech savvy (for example, older people) (11 / 39%)
2. Technology – Concerns around who will help patients with the technology (8 / 29%); General – This is a good idea (8 / 29%)
3. Specific groups – Contact via technology is not appropriate for people with dementia (6 / 21%)

Table 87 presents the full list of themes.

Table 87. What support, if any, should be offered to those wanting to contact someone in hospital using a device connected to the internet?

Main theme	Sub-theme	No.	%
Specific groups	Consider that not everyone is tech savvy (for example, older people)	11	39%
Technology	Concerns around who will help patients with the technology	8	29%
General	This is a good idea	8	29%
Specific groups	Contact via technology is not appropriate for people with dementia	6	21%
Technology	Technology cannot replace human contact (for example, prefer face-to-face contact)	5	18%
Specific groups	Consider that not everyone has access to technology	5	18%
Privacy	Concern over the availability of private spaces to talk to family and friends	2	7%
Access	Concern over the volume of devices available (for example, patients queuing to use them)	2	7%
Quality of care	A risk assessment is needed before implementing this idea	2	7%
Technology	Access to online care records helps for keeping families involved	1	4%
Technology	Video calls worked well during the pandemic	1	4%
Training	Consider providing training for patients to show them how to use the technology	1	4%
Cost and efficiency	Concern over the cost of devices	1	4%
Technology	Concern over safe access to the internet	1	4%
Specific groups	Consider the needs of those patients who do not have friends or family	1	4%
Specific groups	Consider the needs of patients with neuro diverse conditions	1	4%
Technology	Consider using technology to provide patients access to general educational courses to support their mental health	1	4%
General	No comment (for example, as above)	2	7%
Base		*28*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.18 Findings from the online events, targeted focus groups and drop-in roadshows

This section presents the analysis from the online event, six targeted workshops and seven drop-in roadshows. The feedback gathered at these events was 'unstructured', as participants were able to share their views on the care models and proposal without pre-defined questions to direct the discussions.

Facilitators were present at all these events and captured the feedback. Table 88 presents the analysis of this feedback, where it shows the full list of themes raised at these events. Please note that the figures in the table refer to the number of instances a specific theme was raised during the events, not how many participants raised the theme. This is because during the events, multiple participants may have raised the same theme, but the facilitator would have made note of it once.

Table 88 shows the themes specific to each care model, the proposal and general feedback grouped together.

When considering the feedback on the community model for severe mental illness, the main theme areas were awareness, staff, quality of care, health and wellbeing, support for carers, access, service provision, cost and efficiency, communication and collaboration.

The top three sub-themes around the community model for severe mental illness were:

1. Awareness – Consider improving awareness around the support available in the community and how to access it (7 / 8%)
2. Staff – Concern over inadequate staffing levels (6 / 7%)
3. Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (4 / 5%)

When considering the feedback on the community model for dementia healthcare services, the main theme areas were support for carers, awareness, quality of care, technology, access, safety, service provision, health and wellbeing, communication and staff.

The top three sub-themes around the community model for dementia healthcare services were:

1. Support for carers – Consider the need for greater support for carers (10 / 12%)
2. Awareness – Concern over the lack of awareness of dementia care services available in the community (for example, GPs may not be aware) (9 / 11%)
3. Quality of care – Consider the need for continuity of care for patients with dementia (3 / 4%); Technology – Contact via technology is not appropriate for people with dementia (3 / 4%)

When considering the feedback on the proposal for delivering inpatient mental health services, the main theme areas were access, specific groups, travel support, health and wellbeing, travel costs, technology, demographics, support for carers, integration, service provision, cost and efficiency, communication, estates and facilities and quality of care.

The top three sub-themes around the proposal for delivering inpatient mental health services were:

1. Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (10 / 12%)
2. Specific groups – Residents of Tamworth are disadvantaged by this proposal (5 / 6%); Travel support – Consider providing transport for patients and visitors (5 / 6%)
3. Access – The George Bryan Centre is accessible (4 / 5%); Health and wellbeing – Consider the positive therapeutic effect of visitors on inpatients (4 / 5%)

When considering the general feedback shared, the main theme areas were financial support, quality of services, cost and efficiency, quality of services, service provision, engagement, communication, staff and consultation.

The top three sub-themes from the general feedback shared were:

1. Financial support – Concern that Changes in Tamworth is not funded (7 / 8%)
2. Quality of services – Changes Tamworth provides good mental health support (for example, save lives) (6 / 7%); Cost and efficiency – Concern over the allocation of financial resources (for example, lack of funded service in Tamworth) (6 / 7%)
3. Quality of services – Consider improving mental health services (4 / 5%); Service provision – Consider greater provision of mental health services locally (for example, Burton, Lichfield, Tamworth) (4 / 5%)

Table 88. Findings from the online events, targeted focus groups and drop-in roadshows

Feedback area	Sentiment	Main theme	Sub theme	No.	%
Community model for severe mental illness	Observation	Awareness	Consider improving awareness around the support available in the community and how to access it	7	8%
	Negative	Staff	Concern over inadequate staffing levels	6	7%
	Negative	Quality of care	Community care may not be suitable for everyone (for example, not safe, lack of monitoring)	4	5%
	Positive	Health and wellbeing	Being close to home is better for mental health patients than being in a hospital	3	4%
	Observation	Support for carers	Consider the need for greater support for carers	3	4%
	Observation	Quality of care	Consider the need for continuity and consistency of care	3	4%
	Negative	Access	Concern over poor access to GPs (for example, long waiting time)	3	4%
	Negative	Service provision	Concern over the lack of community services	2	2%
	Negative	Cost and efficiency	Concern over the poor insurance cover of the George Bryan Centre	2	2%
	Positive	General	The care model is good	1	1%
	Negative	Access	Concern over travel to mental health services (for example, distance, transport)	1	1%
	Negative	Access	Concern over lack of face-to-face appointments	1	1%
	Observation	Service provision	Consider the need to access respite facilities for free	1	1%
	Negative	Access	In practice, the pathway is not as smooth as described in the model	1	1%
	Observation	Quality of care	Better Way Recovery provides good care for substance misuse and addiction patients	1	1%
	Negative	Quality of care	Concern over crisis response in the community	1	1%
	Positive	Access	The model supports quicker access to mental health services	1	1%
	Neutral	Communication	More clarity is needed around services provided in Cherry Orchard	1	1%
	Observation	Service provision	Consider provision of other services to boost mental health (for example, meditation, yoga)	1	1%
	Observation	Service provision	Consider providing a crisis café model at Cherry Orchard	1	1%
	Observation	Collaboration	Ensure appropriate collaboration between NHS services and charities	1	1%
	Observation	Quality of care	Consider improving mental health support provided by GPs	1	1%
	Negative	Access	Waiting times for community services are too long	1	1%
	Negative	Quality of care	Concern over the lack of support from community teams	1	1%
	Negative	Service provision	Concern over the lack of beds available for inpatient mental health services	1	1%
Community model for dementia healthcare services	Observation	Support for carers	Consider the need for greater support for carers	10	12%
	Negative	Awareness	Concern over the lack of awareness of dementia care services available in the community (for example, GPs may not be aware)	9	11%
	Observation	Quality of care	Consider the need for continuity of care for patients with dementia	3	4%
	Negative	Technology	Contact via technology is not appropriate for people with dementia	3	4%

	Negative	Access	Concern over travel to mental health services (for example, distance, transport)	2	2%
	Negative	Safety	Concern over the safety and security of patients with dementia (for example, lack of supervision in community)	2	2%
	Observation	Service provision	Consider improving out of hours support for patients and carers	2	2%
	Positive	Quality of care	The memory clinic at Amber House provides good support	2	2%
	Observation	Quality of care	Consider that different forms of dementia need different care	2	2%
	Observation	Access	Consider the need to access respite care (for example, outside of Staffordshire)	2	2%
	Positive	Health and wellbeing	Being close to home or at home is better for patients with dementia than being in a hospital	1	1%
	Observation	Communication	Ensure appropriate communication between healthcare professionals, patients, their families and carers (for example, listen, explain)	1	1%
	Observation	Quality of care	Consider tackling the stigma around dementia (for example, organise anti-stigma campaign)	1	1%
	Observation	Staff	Consider the need to train GPs in dementia-related issues	1	1%
Proposal for delivering inpatient mental health services	Negative	Access	Concern over the location of inpatient mental health services (for example, long travel, poor public transport)	10	12%
	Negative	Specific groups	Residents of Tamworth are disadvantaged by this proposal	5	6%
	Observation	Travel support	Consider providing transport for patients and visitors	5	6%
	Observation	Access	The George Bryan Centre is accessible	4	5%
	Observation	Health and wellbeing	Consider the positive therapeutic effect of visitors on inpatients	4	5%
	Negative	Travel cost	Concern over travel costs	3	4%
	Observation	Technology	Consider that not everyone is tech savvy (for example, elderly)	3	4%
	Observation	Technology	Technology cannot replace human contact (for example, prefer face-to-face contact)	3	4%
	Observation	Demographic	Consider the demographic profile of Tamworth	3	4%
	Negative	Travel cost	18p per mile for 12 months is insufficient support (for example, offer 45p a mile)	3	4%
	Negative	Support for carers	Concern over poor support for carers and families (for example, access to carer's allowance)	2	2%
	Observation	Integration	Greater integration between services is needed (for example, to provide care for substance misuse and addiction patients)	2	2%
	Cost and efficiency	Service provision	Rebuild the George Bryan Centre	2	2%
	Negative	Cost and efficiency	Concerns over the lack of funding for voluntary sector organisation which provide mental health services	2	2%
	Negative	Efficiency	Concern that St George's Hospital may not be able to meet demand	2	2%
	Neutral	Communication	More clarity around travel is needed (for example, around no right to appeal)	2	2%
	Positive	Quality of care	The George Bryan Centre provided good quality of care	2	2%
	Observation	Service provision	Concern over the uncertain future of the George Bryan Centre	1	1%

	Observation	Cost and efficiency	Funding should be used to improve mental health services and not to rebuild George Bryan Centre	1	1%
	Positive	Estate and facilities	St George's Hospital has better facilities	1	1%
	Positive	Staff	St George's Hospital has sufficient staffing levels	1	1%
	Observation	Estate and facilities	The George Bryan Centre had good facilities for patients (for example, homely environment)	1	1%
	Observation	Quality of care	Quality of care is more important than distance to travel	1	1%
	Negative	Specific groups	Vulnerable groups will be disadvantaged by the proposal (for example, elderly, disabled, BAME community)	1	1%
	Observation	Service provision	Consider the need for a hospital in Tamworth	1	1%
	Observation	Efficiency	Ensure effective monitoring of the implementation of the proposal	1	1%
	Observation	Travel support	Travel assistance should be in place for three years	1	1%
General	Negative	Financial support	Concern that Changes in Tamworth is not funded	7	8%
	Positive	Quality of services	Changes Tamworth provides good mental health support (for example, save lives)	6	7%
	Negative	Cost and efficiency	Concern over the allocation of financial resources (for example, lack of funded service in Tamworth)	6	7%
	Observation	Quality of services	Consider improving mental health services	4	5%
	Observation	Service provision	Consider greater provision of mental health services locally (for example, Burton, Lichfield, Tamworth)	4	5%
	Positive	Quality of services	Having good quality of services will avoid the need for inpatient services or crisis team for vulnerable patients	3	4%
	Negative	Quality of care	St George's Hospital provides poor care	3	4%
	Observation	Engagement	It is important for people to share their experiences	3	4%
	Negative	Service provision	Concern over reduction of mental health services (for example, more services are needed)	2	2%
	Observation	Communication	Ensure appropriate communication between healthcare professionals, patients, their families and carers	2	2%
	Negative	Staff	Staff at St George's Hospital were unhelpful	2	2%
	Observation	Quality of services	Learn from local charities on how to provide mental health services (for example, from Changes Tamworth)	1	1%
	Negative	Quality of care	Concern over early discharge	1	1%
	Observation	Communication	Consider using different types of communication depending on the needs of participants	1	1%
	Negative	Quality of care	Do not trust doctors	1	1%
	Negative	Quality of care	Concern over triage conducted by receptionists	1	1%
	Negative	Service provision	Concern over closing of NHS facilities	1	1%
	Communication	Communication	Consider using libraries to disseminate information about available support/services	1	1%

	Observation	Quality of care	Consider the need for more multidisciplinary teams to provide holistic care	1	1%
	Observation	Quality of care	Consider improving care during crisis to ensure that everyone is safe	1	1%
	Negative	Access	Concern over long waiting times for detox services	1	1%
	Negative	Staff	Concern over insecure staffing levels at St George's Hospital	1	1%
	Negative	Quality of care	Concern over poor care provided by crisis teams	1	1%
	Observation	Quality of care	Consider the need to prevent suicide in young men	1	1%
	Observation	Efficiency	Consider the need to implement the care models effectively (for example, have a clear timelines)	1	1%
	Negative	Service provision	Concern over insufficient support from paid carers (for example, very short visits)	1	1%
	Negative	Consultation	Concern over the poor communication of the consultation	1	1%
	Observation	Consultation	Consider the need to inform people about the outcome of the consultation (for example, if their feedback was taken on board)	1	1%
	Neutral	General	Other	8	10%
	Base			*83*	

The base refers to the number of facilitator feedback booklet / notes submitted by facilitators following the events

6.19Findings from the correspondence

This section presents the analysis from the three pieces of correspondence and 47 social media posts sharing feedback on the care models and proposal.

Table 89 shows the themes raised in the correspondence and social media posts specific to the community model for severe mental illness, the proposal for delivering inpatient mental health services and general feedback grouped together.

When considering the feedback around the community model for severe mental illness, the main theme areas were staff, access and quality of care.

The top sub-themes around the community model for severe mental illness were:

1. Access – Concern over poor access to GPs (for example, long waiting time) (2 / 4%)
2. Quality of care – Community care may not be suitable for everyone (for example, not safe, lack of monitoring) (2 / 4%)

When considering the feedback on the proposal for delivering inpatient mental health services, the main theme areas were access, health and wellbeing, consultation, service provision, the proposal and efficiency.

The top sub-themes around the proposal for delivering inpatient mental health services were:

1. Access – Concern over travelling to inpatient mental health services for patients and visitors (2 / 4%)
2. Health and wellbeing – Consider the positive therapeutic effect of visitors on inpatients (2 / 4%)
3. Consultation – Concern that the decision has already been made (2 / 4%)
4. Service provision – Concern over the closure of the George Bryan Centre (2 / 4%)
5. Service provision – Rebuild the George Bryan Centre (2 / 4%)

When considering the general feedback shared, the main theme areas were service provision, quality of care, efficiency, service provision, the consultation, access, cost and efficiency and COVID-19.

The top sub-themes from the general feedback shared were:

1. Observation – Service provision – Consider greater provision of inpatient mental health services locally (3 / 6%)
2. Negative – Service provision – Concern over the reduction of mental health facilities (for example, Margaret Stanhope Centre) (3 / 6%)
3. Observation – Consultation – Comment about the survey (for example, too lengthy, hard to find the link) (2 / 4%)

Table 89. Findings from the correspondence

Feedback area	Sentiment	Main theme	Sub theme	No.	%
Community model for severe mental illness	Negative	Access	Concern over poor access to GPs (for example, long waiting time)	2	4%
	Negative	Quality of care	Community care may not be suitable for everyone (for example, not safe, lack of monitoring)	2	4%
	Negative	Staff	Concern over inadequate staffing levels	1	2%
	Observation	Quality of care	Consider the need for continuity and consistency of care	1	2%
	Negative	Access	Concern over the lack of face-to-face appointments	1	2%
Proposal for delivering inpatient mental health services	Negative	Access	Concern over travelling to inpatient mental health services for patients and visitors	2	4%
	Observation	Health and wellbeing	Consider the positive therapeutic effect of visitors on inpatients	2	4%
	Negative	Consultation	Concern that the decision has already been made	2	4%
	Negative	Service provision	Concern over the closure of the George Bryan Centre	2	4%
	Observation	Service provision	Rebuild the George Bryan Centre	2	4%
	Observation	Service provision	Consider reopening both wards on the unit for working age adults	1	2%
	Negative	Proposal	Concern that the proposal does not consider the advantages of reopening the George Bryan Centre	1	2%
	Observation	Service provision	Concern over the uncertainty of the future of the George Bryan Centre	1	2%
	Observation	Quality of care	The George Bryan Centre provided poor quality of care	1	2%
	Negative	Efficiency	Concern that St George's Hospital may not be able to meet demand	1	2%
General	Observation	Service provision	Consider greater provision of inpatient mental health services locally	3	6%
	Negative	Service provision	Concern over the reduction of mental health facilities (for example, Margaret Stanhope Centre)	3	6%
	Observation	Consultation	Comment about the survey (for example, too lengthy, hard to find the link)	2	4%
	Observation	Access	Concern over not being able to use mental health services at neighbouring trusts	1	2%
	Negative	Consultation	Concern over the lack of access to consultation documents	1	2%
	Negative	Quality of care	Concern over the increased level of suicides	1	2%
	Negative	Cost and efficiency	Concern over the effective allocation of NHS financial resources	1	2%
	Observation	Quality of care	Concern over the lack of support for children with autism	1	2%
	Observation	COVID-19	Consider the impact of COVID-19 on mental health	1	2%
	General	General	Other	17	36%
	Base			*47*	

The base refers to the number of correspondence received. This includes, emails, letters and social media posts sharing feedback on the consultation.

6.20 Additional views and considerations

Table 90 shows the questions consultation survey respondents and participants of the engagement sessions with specific communities were asked.

Table 90. Survey and voluntary sector support group's questions

Survey questions	Engagement events with specific communities' questions
Finally, is there any other information you wish us to consider which you have not yet mentioned?	Any other comments

6.20.1 Consultation survey feedback

Respondents were asked: Finally, is there any other information you wish us to consider which you have not yet mentioned? 18 responses were received. The main theme areas were service provision, access, consultation, efficiency, demographics, staff, estate and facilities, specific groups, technology, quality of care, and health and wellbeing.

Overall, the top three sub-themes were:

1. Service provision – Reopen the George Bryan Centre (4 / 22%)
2. Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (3 / 17%)
3. Consultation – Concern over the poor advertisement of the consultation (2 / 11%); Efficiency – Consider the demand on mental health services (2 / 11%); Demographic – Consider the demographic profile of Tamworth and Lichfield (2 / 11%); Staff – Ensure services are staffed appropriately with suitably trained staff (2 / 11%)

Table 91 presents the full list of themes.

Table 91. Finally, is there any other information you wish us to consider which you have not yet mentioned?

Main theme	Sub-theme	No.	%
Service provision	Reopen the George Bryan Centre	4	22%
Access	Concern over the location of inpatient mental health services (for example, long travel, poor public transport)	3	17%
Consultation	Concern over the poor advertisement of the consultation	2	11%
Efficiency	Consider the demand on mental health services	2	11%
Demographic	Consider the demographic profile of Tamworth and Lichfield	2	11%
Staff	Ensure services are staffed appropriately with suitably trained staff	2	11%
Estate and facilities	The facilities at the Cherry Orchard Centre are dated	1	6%
Access	Consider options for Tamworth residents to access mental health support in other counties	1	6%
Specific groups	Consider the needs of families and friends	1	6%
Technology	Technology cannot replace human contact (for example, prefer face-to-face contact)	1	6%
Quality of care	Mental health support provided is poor	1	6%
Consultation	Concern that the survey is box ticking exercise	1	6%
Health and wellbeing	Consider the impact of the proposal on the health and wellbeing of patients and their families	1	6%
General	No comment	1	6%
General	Other	2	11%
Base		*18*	

The base refers to the number of responses received to this question in the survey, and not the total survey submissions (of which there were 48). All the questions in the survey were voluntary, meaning respondents were able to skip those they did not wish to answer.

6.20.1.1 Top themes by respondent groups

This section shows the top theme for each respondent group.

Respondent type

- **User of mental health services:** Limited feedback received
- **Another member of the public:** Service provision – Reopen the George Bryan Centre (3 / 43%)
- **Carer:** No feedback received
- **NHS employee:** No feedback received
- **Individual from another public sector organisation, health-related group or non-health related group or charity or organisation:** Limited feedback received
- **Formal response from an organisation:** Limited feedback received

Service type

- **George Bryan Centre:** Service provision – Reopen the George Bryan Centre (2 / 33%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (2 / 33%)
- **St George's Hospital, Stafford:** Limited feedback received
- **Community mental health services:** Limited feedback received
- **None of the above:** Service provision – Reopen the George Bryan Centre (2 / 33%)

Ethnicity

- **White:** Service provision – Reopen the George Bryan Centre (4 / 29%)
- **Prefer not to say:** Limited feedback received

Age

- **Under 45:** Limited feedback received
- **45 to 59:** Service provision – Reopen the George Bryan Centre (3 / 60%)
- **60 and over:** Limited feedback received

Sex

- **Male:** Service provision – Reopen the George Bryan Centre (2 / 33%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (2 / 33%)
- **Female:** Service provision – Reopen the George Bryan Centre (2 / 22%)

Sexual orientation

- **Heterosexual:** Service provision – Reopen the George Bryan Centre (3 / 28%)
- **Other (for example, gay, lesbian, bisexual, asexual):** Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (2 / 100%)

Pregnancy

- **Yes:** No feedback received
- **No:** Service provision – Reopen the George Bryan Centre (4 / 29%)

Maternity

- **Yes:** No feedback received
- **No:** No feedback received

Disability

- **No disability:** Service provision – Reopen the George Bryan Centre (2 / 29%)
- **Physical disability:** Service provision – Reopen the George Bryan Centre (2 / 50%)
- **Sensory disability:** Limited feedback received
- **Mental health condition:** Limited feedback received
- **Learning disability or difficulty:** Limited feedback received
- **Other:** No feedback received

Limitation in day-to-day activities

- **Yes, limited in day-to-day activities:** Service provision – Reopen the George Bryan Centre (3 / 38%); Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (3 / 38%)
- **No:** Staff – Ensure services are staffed appropriately with suitably trained staff (2 / 33%)

Carer

- **Yes – Carer:** Service provision – Reopen the George Bryan Centre (3 / 43%)
- **No:** Access – Concern over the location of inpatient mental health services (for example, long travel, poor public transport) (2 / 40%)

Local authority

- **East Staffordshire:** Limited feedback received
- **Lichfield:** Limited feedback received
- **Stafford:** No feedback received
- **Stoke-on-Trent:** No feedback received
- **Tamworth:** No feedback received
- **No postcode provided:** No feedback received

Index of Multiple Deprivation

- **Most deprived deciles (1-5):** Service provision – Reopen the George Bryan Centre (3 / 33%)
- **Least deprived deciles (6-10):** Limited feedback received
- **No postcode provided:** Limited feedback received

6.20.2 Engagement events with specific communities

Respondents were asked if they had any other comments. 19 responses were received. The main theme areas were access, quality of care, access to support, cost and efficiency, awareness, estate and facilities, communication, staff, consultation, service provision, travel cost, information, target, parking, efficiency, COVID-19, peer-support and collaboration.

Overall, the top three sub-themes were:

1. General – Concern the Tamworth community has been left behind (3 / 7%); Access – Concern over travel to mental health services (for example, distance, transport) (3 /

16%); Quality of care – Ensure the care provided reflects the individual needs of patients (3 / 16%)

2. Access to support – Concern over poor access to mental health support (2 / 10%); Cost and efficiency – Ensure sufficient funding for mental health services (2 / 10%); Quality of care – Consider the need for prevention and early intervention (for example, timely support from GP) (2 / 10%); Awareness – Consider improving awareness of support available in community (2 / 10%); Estate and facilities – Ensure appropriate facilities for visitors (for example, access to cafés over the weekend) (2 / 10%); Cost and efficiency – Concern over the allocation of financial resources (for example, extra funding for community services) (2 / 10%)

Table 92 presents the full list of themes.

Table 92. Any other comments.

Main theme	Sub-theme	No.	%
General	Concern the Tamworth community has been left behind	3	16%
Access	Concern over travel to mental health services (for example, distance, transport)	3	16%
Quality of care	Ensure the care provided reflects the individual needs of patients	3	16%
Access to support	Concern over poor access to mental health support	2	10%
Cost and efficiency	Ensure sufficient funding for mental health services	2	10%
Quality of care	Consider the need for prevention and early intervention (for example, timely support from GP)	2	10%
Awareness	Consider improving awareness of support available in community	2	10%
Estate and facilities	Ensure appropriate facilities for visitors (for example, access to cafés over the weekend)	2	10%
Cost and efficiency	Concern over the allocation of financial resources (for example, extra funding for community services)	2	10%
Communication	Consider improving communication with patient's families and carers (for example, listen)	1	5%
Staff	Ensure staff are easily recognisable in mental health facilities (for example, provide staff with uniforms)	1	5%
Consultation	Concern over the poor communication of the consultation	1	5%
Service provision	Mental health services should be provided locally	1	5%
Cost and efficiency	Ensure impact on wider services is considered (for example, impact on police, ambulance)	1	5%
Travel cost	Proposed rates of 18p per mile is not enough to cover petrol	1	5%
Estate and facilities	Consider if available local buildings can be utilised for mental health services	1	5%
Service provision	Concern that the impact of previous closures of services was not considered	1	5%
Information	More information about the support available for unregistered carers is needed	1	5%
Quality of care	Concern over the decreased quality of care	1	5%
Target	Concern over the unrealistic targets set for the crisis team	1	5%
Access	Consider the need for flexible visiting times	1	5%
Parking	Concern over parking in St George's Hospital	1	5%
Efficiency	Concern that St George's Hospital may not be able to meet demand	1	5%
COVID-19	Consider the impact of COVID-19 on mental health	1	5%
Peer-support	Peer-support is useful	1	5%
Collaboration	Greater collaboration and communication between services is needed	1	5%
Communication	More detail about proposals is needed	1	5%

Specific groups	Ensure the needs of people whose first language is not English are met	1	5%
General	No comment	3	16%
General	Other	3	16%
Base		*19*	

The base refers to the number of responses received to this question in the facilitator feedback booklets submitted following engagement with specific communities and not the number of participants engaged with, or the number of events delivered.

6.20.3 Additional feedback from other channels

As well as the feedback captured through the outlined channels, further feedback on the care models and proposal was received through the following:

- March 2023 Overview and Scrutiny Committee meeting minutes
- Enter and view report from Healthwatch Staffordshire
- Healthwatch Staffordshire feedback on the consultation
- Additional, written feedback submitted during the engagement events.

A summary of the themes raised has been presented below:

- Attempted suicides and deaths among children were increasing, therefore there is a need to make this a priority area
- Concerns were shared around the allocation of £10 million announced by the government for suicide prevention and support
- It was commented that CAMHS are not highly effective in providing support due to long waiting times
- During the pandemic, the NHS provided more training and expanded the CAMHS teams across the district, which made them more accessible
- Concerns around staffing levels were shared
- The enter and view report from Healthwatch Staffordshire highlighted that integrated mental health teams demonstrate considerable progress in meeting the challenges of moving from a diagnosis-led service to an approach that is needs-led
- The need to increase public awareness on how to access mental health services locally was highlighted
- It was also commented that up-to-date, comprehensive information on support available to service users and carers from the point of diagnosis is needed. This could be co-produced with local groups
- Ensure that information about access to out-of-hours support is readily available
- The need for more work on prevention was highlighted
- The need for more support for people with organic mental health issues and their carers was highlighted
- Ensure that primary care (including social prescribers) and out-of-hours medical services are fully aware of the routes into support.

7 Conclusion

The findings of this report summarise the feedback collected through various channels during the engagement phase of this consultation, between 9 February and 23 March 2023. The findings are based on feedback received through the consultation survey, a range of engagement events and correspondence.

Consultation participants were asked to share their experience of using mental health services, and to share their views on the care model for severe mental illness, the care model for dementia and on the proposal for delivering inpatient mental health services.

7.1 Experience of using mental health services

22 (49%) consultation survey respondents said they had used or experienced community mental health services, 13 (29%) had used or experienced the George Bryan Centre and 8 (18%) had used or experienced St George's Hospital, Stafford. 15 (33%) said they had not used or experienced any of these services. Most of those using or experiencing these services did so as a patient.

7.2 Views on the community model for severe mental illness

28 (60%) consultation survey respondents said that the care model for severe mental illness was poor or very poor, while 19 (40%) said it was good or very good. The key reasons given for this response were:

Table 93. Views on the community model for severe mental illness

Positive themes	Negative themes	Neutral themes / suggestions
The care model is good	The pathway is not as smooth as described in the model	There is need for better local mental health support
Being close to home is better for mental health patients than being in a hospital	Concern over inadequate staffing levels	Consider the effect that a lack of community support has on patients and families
Centralised services are good	Community care may not be suitable for everyone	More detail about the model is required
	Better awareness of the services available in community	
	Concerns over difficulty in accessing GPs	

7.3 Views on the community model for dementia healthcare

10 (46%) stated that the care model for dementia healthcare was good or very good, while 8 (36%) said it was poor or very poor. The key reasons given for this response were:

Table 94. Views on the community model for dementia healthcare

Positive themes	Negative themes	Neutral themes / suggestions
The new care model is good	Concern over the safety and security of patients with dementia	More support for carers

Being close to home is better for patients with dementia	Lack of awareness of dementia care services available in community	Consider the need for continuity of care
Dementia cafés and local groups in churches provide good support	Contact via technology is not appropriate for patients with dementia	

7.4 Views on the proposal to deliver inpatient mental health services

26 (59%) consultation survey respondents said the proposal was poor or very poor, while 7 (15%) said it was good or very good. The key reasons given for this response were:

Table 95. Views on the proposal to deliver inpatient mental health services

Positive themes	Negative themes	Neutral themes / suggestions
The proposal is a good solution	The proposal is not a good solution	Consider providing transport for patients and visitors
The proposal helps to improve the quality of care	Concern over the location of the services	Consider the positive therapeutic effect of visitors on inpatients
	Concern over the lack of hospital beds to meet demand	Consider rebuilding the George Bryan Centre.
	Residents of Tamworth are disadvantaged by this proposal	
	Concern over travelling to inpatient mental health services	
	Concern that the decision has already been made	
	Concern over the closure of the George Bryan Centre	

When asked how to improve the delivery of mental health services, the key emerging themes were:

- Reopen the George Bryan Centre
- Need for greater provision of local mental health support
- More mental health units across the county
- Ensure there is sufficient funding for healthcare services
- Consider providing access to appropriate facilities for patients with mental health problems
- Need for a patient transport service
- Ensure family and friends are able to visit service users.

7.5 Views on travel

40 (87%) consultation survey respondents said they were concerned or very concerned about travel for visitors under this proposal, while 3 (6%) said they were unconcerned or very unconcerned. When asked what support should be provided for visitors, the key themes raised were:

- Consider providing affordable transport for visitors
- Ongoing financial support until patient returns home

- Provision of local mental health support
- Consider the need to align visiting times with public transport timetables.

7.6 Using technology

27 (66%) consultation survey respondents said they could easily use their device to contact someone in hospital, while 10 (24%) said they could use their device to contact someone in hospital but would need assistance. When asked what support is required to contact someone in hospital, the key themes raised were:

- Technology cannot replace human contact
- No support required
- Consider the needs of older people who have difficulties using technology
- Concerns around who will help patients with the technology
- The use of technology to contact someone in hospital is a good idea
- Contact via technology is not appropriate for people with dementia.

8 Appendix

8.1 Consultation survey respondent demographic profiling

8.1.1 Overview of survey respondents

This section presents a profile overview of survey respondents.

Table 96. Are you responding as:

	No.	%
An individual	44	96%
A formal response from an organisation	2	4%
Base	*46*	

Table 97. As an individual responding to this questionnaire which of the following best applies to you? Please tick one only.

	No.	%
User of mental health services	19	42%
Another member of the public	17	38%
Carer	4	9%
NHS employee	2	4%
From a non-health voluntary group, charity or organisation	2	4%
From a health-related group, charity or organisation	1	2%
From another public sector organisation	-	-
Base	*45*	

Table 98. As an organisation responding to this questionnaire which of the following best applies to you? Please tick one only.

	No.	%
Formal response on behalf of a health-related group, charity or organisation	1	50%
Formal response on behalf of an NHS organisation	-	-
Formal response on behalf of another public sector organisation		
Formal response on behalf of a non-health related voluntary group, charity or organisation	-	-
Other	1	50%
Base	*2*	

Table 99. 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.

	No.	%
Member of Parliament for Tamworth	1	20%
League of Friends of the Tamworth Hospitals	1	20%
Dementia Care	1	20%
Councillor at Tamworth Borough Council, Tamworth resident and friend of former patients	1	20%
Friends of Robert Peel Hospital Charity	1	20%
Base	*5*	

8.1.2 Demographic profiling

This section shows the demographic profiling of survey respondents.

Table 100. Demographic profiling – survey respondents

Ethnicity			**Sexual orientation**		
White: British	41	89%	Heterosexual	35	76%
White: Irish	-	-	Lesbian	1	2%
White: Gypsy or traveller	-	-	Gay	1	2%
White: Other	1	2%	Bisexual	2	4%
Mixed: White and Black Caribbean	-	-	Asexual	1	2%
Mixed: White and Black African	-	-	Prefer not to say	6	13%
Mixed: White and Asian	-	-	*Base*	*46*	
Mixed: Other	-	-	**Relationship status**		
Asian/Asian British: Indian	-	-	Married	21	45%
Asian/Asian British: Pakistani	-	-	Civil partnership	-	-
Asian/Asian British: Bangladeshi	-	-	Single	10	21%
Asian/Asian British: Chinese	-	-	Divorced	4	9%
Asian/Asian British: Other	-	-	Lives with partner	4	9%
Black/Black British: African	-	-	Separated	-	-
Black/Black British: Caribbean	-	-	Widowed	3	6%
Black/Black British: Other	-	-	Other	-	-
Other ethnic group: Arab	-	-	Prefer not to say	5	11%
Any other ethnic group	-	-	*Base*	*47*	
Prefer not to say	4	9%	**Pregnant currently**		
Base	*46*		Yes	-	-
Age category			No	42	89%
16 – 19	-	-	Prefer not to say	5	11%
20 – 24	2	4%	*Base*	*47*	
25 – 29	2	4%	**Recently given birth**		
30 – 34	2	4%	Yes	1	2%
35 – 39	3	7%	No	40	87%
40 – 44	2	4%	Prefer not to say	5	11%
45 – 49	8	17%	*Base*	*46*	
50 – 54	5	11%	**Health problem or disability**		
55 – 59	2	4%	Yes, limited a lot	5	11%
60 – 64	6	13%	Yes, limited a little	13	28%
65 – 69	2	4%	No	23	50%
70 – 74	4	9%	Prefer not to say	5	11%
75 – 79	3	7%	*Base*	*46*	
80 and over	2	4%	**Disability**		
Prefer not to say	3	7%	No disability	21	45%
Base	*46*		Physical disability	9	19%
Religion			Sensory disability	2	4%
No religion	19	40%	Mental health condition	14	30%
Christian	23	49%	Learning disability or difficulty	2	4%
Buddhist	-	-	Long-term illness	-	-
Hindu	-	-	Other	1	2%
Jewish	-	-	Prefer not to say	7	15%
Muslim	-	-	*Base*	*47*	
Sikh	-	-	**Carer**		
Any other religion	1	2%	Yes – young person(s) aged under 24	7	16%
Prefer not to say	4	9%	Yes – adult(s) aged 25 to 49	2	4%
Base	*47*		Yes – person(s) aged over 50 years	12	27%

Sex			No	19	42%
Male	11	23%	Prefer not to say	6	13%
Female	32	68%	*Base*	*45*	
Intersex	-	-	**Access to car**		
Prefer not to say	4	9%	Yes, and I drive	33	75%
Other	-	-	Yes, but I don't drive	-	-
Base	*47*		No, I don't have access to a car	11	25%
Armed services			*Base*	*44*	
Yes	3	7%			
No	37	80%			
Prefer not to say	6	13%			
Base	*46*				

8.1.3 Geographical profiling of engagement events with specific communities

This section presents a geographical profiling of consultation participants.

Figure 5.Map of survey respondents. Base 38.

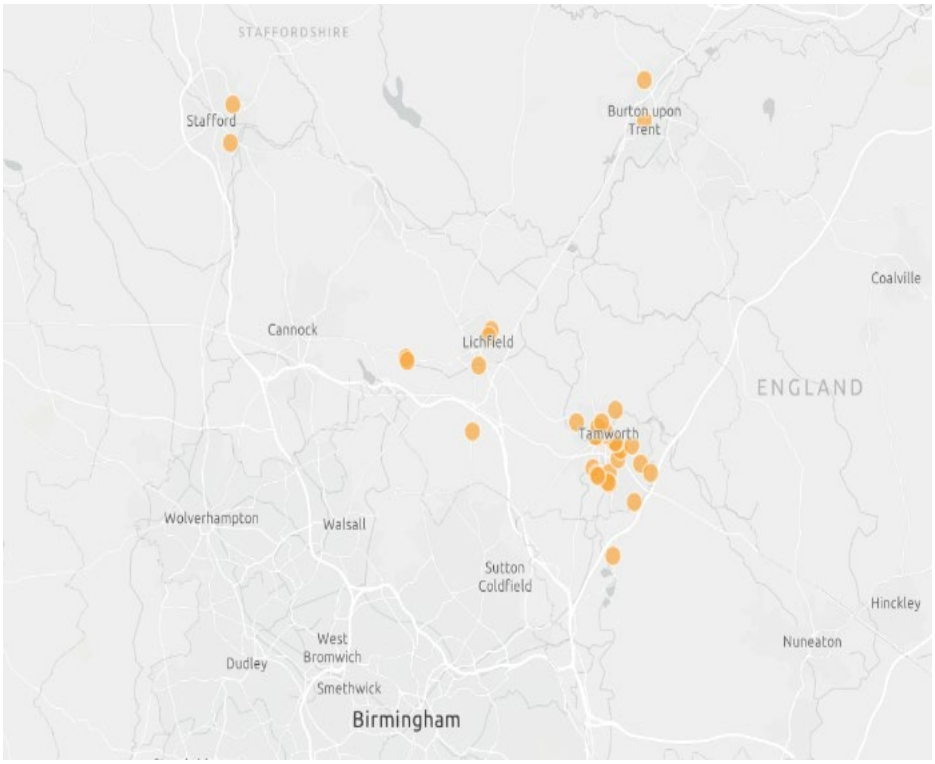

Table 101.Local authority – survey respondents

Local authority	No.	%
Tamworth	23	48%
Lichfield	9	19%
East Staffordshire	2	4%
Stafford	2	4%
North Wales	1	2%
Stoke-on-Trent	1	2%
No postcode provided	10	21%
Base	*48*	

Table 102 shows the level of deprivation of consultation participants. The Index of Multiple Deprivation is the official measure of relative deprivation for small areas in England, with the most deprived 10% of small areas categorised as '1' while the least deprived 10% of small areas are described as '10'.

Table 102. IMD breakdown – survey respondents

IMD decile	No.	%
1 – Most deprived decile	1	2%
2	8	17%
3	-	-
4	7	15%
5	5	10%
6	3	6%
7	7	15%
8	2	4%
9	5	10%
10 – Least deprived decile	-	-
No postcode provided	10	21%
Base	*48*	

8.2 Engagement event participant demographic profiling

8.2.1 Overview of engagement event participants

This section presents a profile overview of participants in engagement events with specific communities.

Table 103. Are you responding as:

	No.	%
An individual	54	87%
A formal response from an organisation	8	13%
Base	*62*	

Table 104. As an individual responding to this questionnaire which of the following best applies to you? Please tick one only.

	No.	%
Another member of the public	18	33%
User of mental health services	13	24%
Carer	10	19%
From a non-health voluntary group, charity or organisation	6	11%
From a health-related group, charity or organisation	4	7%
NHS employee	2	4%
From another public sector organisation	1	2%
Base	*54*	

Table 105. As an organisation responding to this questionnaire which of the following best applies to you? Please tick one only.

	No.	%
Formal response on behalf of a non-health related voluntary group, charity or organisation	4	57%

Formal response on behalf of another public sector organisation	1	14%
Formal response on behalf of a health-related group, charity or organisation	1	14%
Formal response on behalf of an NHS organisation	-	-
Other	1	14%
Base	*7*	

Table 106. 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.

	No.	%
Sacred Heart Church	2	13%
Changes Tamworth	1	6%
Volunteer at Sacred Heart Church	1	6%
Balance Street Patient Participation Group	1	6%
Early Help Team	1	6%
Healthwatch Staffordshire	1	6%
Lichfield Cathedral	1	6%
Uttoxeter Heath Community Centre	1	6%
Yoxall and Area Patient Participation Group	1	6%
Self-employed carer	1	6%
Burton Hope	1	6%
Our Smiley Space	1	6%
Communities Together Tamworth	1	6%
Staffs Baby Bank	1	6%
Serco	1	6%
Base	*16*	

8.2.2 Demographic profiling

This section shows the demographic profiling of participants in the engagement sessions with specific communities.

Table 107. Demographic profiling – Engagement sessions with specific communities

Ethnicity			**Sexual orientation**		
White: British	53	87%	Heterosexual	55	90%
White: Irish	-	-	Lesbian	-	-
White: Gypsy or traveller	-	-	Gay	2	3%
White: Other	-	-	Bisexual	1	2%
Mixed: White and Black Caribbean	1	2%	Asexual	1	2%
Mixed: White and Black African	-	-	Other	-	-
Mixed: White and Asian	-	-	Prefer not to say	2	3%
Mixed: Other	2	3%	*Base*	*61*	
Asian/Asian British: Indian	-	-	**Relationship status**		
Asian/Asian British: Pakistani	2	3%	Married	24	39%
Asian/Asian British: Bangladeshi	-	-	Civil partnership	1	2%
Asian/Asian British: Chinese	-	-	Single	17	28%
Asian/Asian British: Other	-	-	Divorced	5	8%
Black/Black British: African	-	-	Lives with partner	5	8%
Black/Black British: Caribbean	1	2%	Separated	1	2%
Black/Black British: Other	-	-	Widowed	5	8%
Other ethnic group: Arab	-	-	Other	2	3%
Any other ethnic group	1	2%	Prefer not to say	1	2%
Prefer not to say	1	2%	*Base*	*61*	
Base	*61*		**Pregnant currently**		
Age category			Yes	1	2%

16 – 19	-	-	No	60	98%
20 – 24	2	3%	Prefer not to say	-	-
25 – 29	3	5%	*Base*	*61*	
30 – 34	5	8%	**Recently given birth**		
35 – 39	3	5%	Yes	-	-
40 – 44	3	5%	No	60	100%
45 – 49	5	8%	Prefer not to say	-	-
50 – 54	11	18%	*Base*	*60*	
55 – 59	2	3%	**Health problem or disability**		
60 – 64	6	10%	Yes, limited a lot	13	21%
65 – 69	6	10%	Yes, limited a little	13	21%
70 – 74	5	8%	No	34	56%
75 – 79	8	13%	Prefer not to say	1	2%
80 and over	-	-	*Base*	*61*	
Prefer not to say	-	-	**Disability**		
Base	*59*		No disability	29	48
Religion			Physical disability	16	26%
No religion	14	23%	Sensory disability	2	3%
Christian	38	63%	Mental health need	15	25%
Buddhist	1	2%	Learning disability or difficulty	4	7%
Hindu	-	-	Long-term illness	5	8%
Jewish	-	-	Other	1	2%
Muslim	2	3%	Prefer not to say	4	7%
Sikh	-	-	*Base*	*61*	
Any other religion	1	2%	**Carer**		
Prefer not to say	4	7%	Yes – young person(s) aged under 24	5	8%
Base	*60*		Yes – adult(s) aged 25 to 49	11	18%
Sex			Yes – person(s) aged over 50 years	7	12%
Male	21	34%	No	34	57%
Female	40	66%	Prefer not to say	5	8%
Intersex	-	-	*Base*	*60*	
Prefer not to say	-	-	**Access to car**		
Other	-	-	Yes, and I drive	46	75%
Base	*61*		Yes, but I don't drive	2	3%
Armed services			No, I don't have access to a car	13	21%
Yes	2	3%	*Base*	*61*	
No	58	95%			
Prefer not to say	1	2%			
Base	*61*				

8.2.3 Geographical profiling of participants in the engagement sessions with specific communities

This section presents a geographical profiling of consultation participants.

Figure 6. Map of participants of engagement session with specific communities. Base 54.

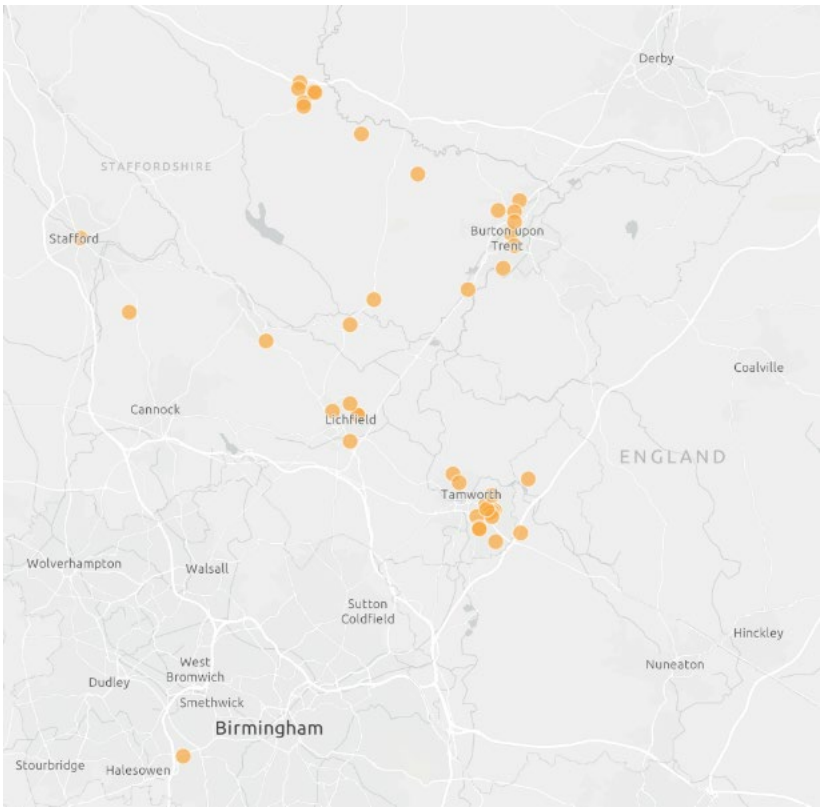

Table 108.Local authority – Engagement sessions with specific communities

Local authority	No.	%
Tamworth	22	35%
East Staffordshire	18	29%
Lichfield	8	13%
North Warwickshire	2	3%
Stafford	1	2%
South Staffordshire	1	2%
Hart	1	2%
Birmingham	1	2%
No postcode provided	8	13%
Postcode unable to be profiled	-	-
Base	*62*	

Table 109 shows the level of deprivation of consultation participants. The Index of Multiple Deprivation is the official measure of relative deprivation for small areas in England, with the most deprived 10% of small areas categorised as ‘1’ while the least deprived 10% of small areas are described as ‘10’.

Table 109. IMD breakdown – Engagement sessions with specific communities

IMD decile	No.	%
1 – Most deprived decile	12	19%
2	3	5%
3	2	3%
4	5	8%
5	6	10%
6	9	15%
7	3	5%
8	6	10%
9	4	6%
10 – Least deprived decile	4	6%
No postcode provided	8	13%
Postcode unable to be profiled	-	-
Base	*62*	

Appendix 3b **Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre**

Section 1: Tell us who you are and which mental health services you have experience of				
		Count	**Percent**	**Count & Percent**
Table 1	Are you responding as.	Link	Link	Link
Table 2	As an individual responding to this questionnaire, which of the following best applies to you?	Link	Link	Link
Table 3	As an organisation responding to this questionnaire, which of the following best applies to you?	Link	Link	Link
Table 4	Which of the following mental healthcare services have you used or experienced?	Link	Link	Link
Table 5	In what capacity did you experience the George Bryan Centre, which you have indicated that you would like to provide feedback on?	Link	Link	Link
Table 6	Which wing of the George Bryan Centre were you in?	Link	Link	Link
Table 7	Which period would you like to provide feedback on?	Link	Link	Link
Table 8	Please tell us about your experience of the George Bryan Centre below.	Link	Link	Link
Table 9	Where do you work now?	Link	Link	Link
Table 10	In what capacity did you experience St George's Hospital, Stafford, which you have indicated that you would like to provide feedback on?	Link	Link	Link
Table 11	Which period would you like to provide feedback on?	Link	Link	Link
Table 12	Please tell us about your experience of St George's Hospital, Stafford below.	Link	Link	Link
Table 13	In what capacity did you experience community mental health services, which you have indicated that you would like to provide feedback on?	Link	Link	Link
Table 14	Which period would you like to provide feedback on?	Link	Link	Link
Table 15	Please tell us about your experience of community mental health services below.	Link	Link	Link
Section 2: a community model for severe mental illness				
Table 16	To what extent do you think the care model is a good one?	Link	Link	Link
Table 17	Please explain the reason for your rating.	Link	Link	Link
Table 18	Are there any groups that you think may be disadvantaged by this model?	Link	Link	Link

Table 19	Tell us if you think there are any better ways to provide these services.	Link	Link	Link
Section 3: a community model for dementia healthcare services				
Table 20	To what extent do you think the care model is a good one?	Link	Link	Link
Table 21	Please explain the reason for your rating.	Link	Link	Link
Table 22	Are there any groups that you think may be disadvantaged by this model?	Link	Link	Link
Table 23	Tell us if you think there are any better ways to provide these services.	LInk	LInk	LInk
Section 4: proposal for delivering inpatient mental health services				
Table 24	To what extent do you think this proposal is a good solution?	Link	Link	Link
Table 25	Please explain the reason for your rating. I	Link	Link	Link
Table 26	Are there any groups that you think may be disadvantaged by this proposal?	Link	Link	Link
Table 27	To what extent are you concerned about travel for visitors under this proposal?	Link	Link	Link
Table 28	Please explain why you are concerned or unconcerned.	Link	Link	Link
Table 29	How do you think you will travel?	Link	Link	Link
Table 30	Do you have access to the internet?	Link	Link	Link
Table 31	What type of device do you have?	Link	Link	Link
Table 32	Does the device have a camera you can use while using your device to make a call?	Link	Link	Link
Table 33	Could you use the device to contact someone in hospital?	Link	Link	Link
Table 34	What support, if any, would you require to use the internet device to contact someone in hospital?	Link	Link	Link
Table 35	In our proposals we are keen to include and develop support with travel for visitors. Tell us what support you think should be developed and provided for visitors.	Link	Link	Link
Table 36	Tell us if you think there are any better ways to deliver inpatient mental health services.	Link	Link	Link
Table 37	Finally, is there any other information you wish us to consider which you have not yet mentioned?	Link	Link	Link
Section 5: About you				
Table 38	What is your ethnic group?	Link	Link	Link
Table 39	How old are you?	Link	Link	Link
Table 40	What is your religion or belief?	Link	Link	Link
Table 41	How do you identify?	Link	Link	Link
Table 42	What is your sexual orientation?	Link	Link	Link
Table 43	What is your relationship status?	Link	Link	Link
Table 44	Are you pregnant at this time?	Link	Link	Link
Table 45	Have you recently given birth? (within the last 26-week period)	Link	Link	Link
Table 46	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?	Link	Link	Link

Table 47	Do you consider yourself to have a disability?	Link	Link	Link
Table 48	Do you provide care for someone?	Link	Link	Link
Table 49	Have you ever served in the armed services?	Link	Link	Link
Table 50	Do you have access to a car?	Link	Link	Link
Table 51	Local Authority	Link	Link	Link
Table 52	Index Multiple Deprivation	Link	Link	Link

NHS Staffordshire and Stoke-on-Trent Integrated Care Board
and Midlands Partnership University NHS Foundation Trust

Equality and Health Inequalities Impact and Risk Assessment (EHIIRA)

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

1. Assessment Overview

Name of organisation: **Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)**

Assessment Lead Contact: **Kathryn Whitfield, Transformation Programme Manager**

Responsible Director/Board Member for this assessment:

Helen Slater, Associate Director of Transformation

Other contacts involved in undertaking this assessment:

Upkar Jheeta, Head of Mental Health Transformation, Midlands Partnership University Partnership NHS Foundation Trust (MPFT)

Start Date: **20/07/2023** **Completed Date:** **24/08/2023**

Who is impacted by this service / policy / decision?	Yes	No	Indirectly / Possibly
Patients / Service Users	☑	☐	☐
Carers or Family	☑	☐	☐
General Public	☐	☐	☑
Staff	☑	☐	☑
Partner Organisations	☐	☐	☑

Summary information of the service / policy / decision being assessed:

EHIIRAs have been completed for this programme previously, as the options appraisal process was taking place and to clearly articulate the impacts in a pre-consultation business case, which was presented to the Integrated Care Board (ICB) Board. The Board agreed with the recommendation set out in the pre-consultation business case to complete a six-week public consultation.

This consultation took place between February and March 2023. The Arden and Greater East Midlands Commissioning Support Unit (CSU) and the Midlands and Lancashire Commissioning Support Unit (MLCSU) were commissioned to produce a report of findings. This report has been formally received by the ICB and Midlands Partnership University NHS Foundation Trust (MPFT), and a decision-making business case (DMBC) is being developed. This EHIIRA will outline the feedback provided by the public and the mitigations that are in place to reduce the impact of the proposal, as set out in the DMBC.

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 MPFT made the decision later in February to temporarily close the remaining East Wing. The decision was enacted in April 2019 after patients were either discharged or transferred to the most appropriate care setting according to their needs. For some patients, this meant going 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. We have considered the findings from the public involvement and consultation, along with clinical evidence, while developing and reviewing proposals.

We used a series of technical events to consider proposals for change against a set of essential criteria: strategic fit, clinical safety, and meeting the needs of the local population. Two proposals were considered through most of the process. After listening to our clinicians, staff, service users, carers and representatives, and carefully considering their input, the outcome of the final stage of the process is that we believe only one of these proposals will deliver the standard of care required for local people. That proposal is to make permanent the service changes we made in 2019.

What are the aims and objectives of the service / policy / decision being assessed?

The service was commissioned to provide inpatient 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 of a currently commissioned service or an existing policy, what are the main changes proposed and what are the reasons for the review?

A technical event was held in December 2021 with 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 Healthwatch Staffordshire's southeast engagement officer. The group examined the progress of 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 and over with serious mental health needs

A key part of both proposals was the provision of a transformed community mental health offer, which included enhanced crisis home treatment with skilled older adult specialists, a nursing/therapy lead, and a 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, and the research showing that people with dementia thrive better if they remain in their home setting. The group considered that these factors meant that the beds provided in the East Wing for older adults 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 home.

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 Hospital 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 a 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 NHS Long Term Plan, 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 it would not support a high-quality service for this cohort of people. Without those 12 beds, the proposal for provision of beds in south east Staffordshire would only be for people aged 18 and over with serious mental health needs. Providing care to one ward of people in a standalone unit makes responding to medical and psychiatric emergencies difficult, which would put service users, visiting carers and staff at risk.

What engagement work is planned (or has already been carried out)? How will you involve people from protected characteristics, vulnerable groups, and groups that experience health inequalities to ensure that their views inform this decision-making process?

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 involvement exercise on 30 January 2020.

Sense check engagement

The COVID-19 pandemic delayed further involvement about the long-term solution for the services formerly provided at the George Bryan Centre. It was decided that the involvement process would re-start in autumn 2021.

Feedback was gathered through 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 2021, with paper versions 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 findings has been published and includes demographic information on respondents. **https://gettinginvolved.mpft.nhs.uk/george-bryan-centre-engagement**

Reference group (March 2022)

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

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

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

Decision to proceed to public consultation

The pre-consultation business case (PCBC) was presented to the ICB Board on 19 January 2023, along with a consultation plan and associated documents. These included the communications and involvement plan, approved by the ICB Quality and Safety Committee on 9 November 2022, and the draft consultation document, approved by the ICB Quality and Safety Committee on 14 December 2022. The ICB Board approved the PCBC and agreed to proceed to public consultation for a period of six weeks.

The public consultation ran from 9 February to 23 March 2023. Its aims were to:

- Explain the proposal, including:
    - setting out the context of national changes in best practice in mental healthcare and the clinical evidence supporting these changes
    - how the proposal had been reached and why a single viable proposal was being recommended
- Ask people their views on:
    - whether there were other ideas that had not been considered
    - any advantages or disadvantages that would need to be planned for, if the proposal is implemented
    - how to support people if the proposal is implemented, especially with travel.

Support Staffordshire

Support Staffordshire was commissioned to reach and engage with specific targeted communities during the consultation. The communities included:

- People of Eastern European, South Asian, Black (Afro-Caribbean) and mixed race ethnicities
- People in the most deprived areas – particularly in Lichfield, Burton and Tamworth
- Men aged 65 and over
- Women aged 25 to 44
- People experiencing homelessness
- Carers – particularly young carers
- People involved in substance misuse
- Lesbian, gay, bisexual, transgender, queer/questioning and other (LGBTQ+) groups
- People currently in the military and veterans.

Two members of the Support Staffordshire team attended facilitator training to enable them to deliver a range of focus groups and one-to-one interviews. Materials were adapted to meet their needs and specifications.

Support Staffordshire used the feedback mechanisms set up for the consultation to report findings from all their engagement sessions. They engaged with 81 participants between 9 February and 23 March 2023.

Following the six-week public consultation, the report of findings was received (**reports of findings**), and the feedback was considered and noted at a meeting of the transformation steering group on 9 June 2023. Prominent themes in the feedback were travel, use of technology, and support for carers. It was agreed that the feedback received did not suggest any new proposals which had not previously been considered. Therefore, one viable proposal remains – **centralising inpatient treatment at St George's Hospital in Stafford.**

It was agreed that impact assessments would be updated to reflect the feedback and any mitigations that have been implemented or are planned to reduce the impact of the proposal. It was agreed to progress to a decision-making business case (DMBC).

Is this proposal likely to affect health inequalities – either positively or negatively? YES ☑ / NO ☐

Please provide rationale for your answer below:

A cohort of patients and carers will be impacted by the 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 people who live in rural areas without good transport links and households without a car.

Previously, there were two potential sites in 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 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 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 home. MPFT will provide support for travel and the use of digital technology to support remote visiting.

MPFT has developed a standard operating procedure (SOP) to help those affected by the temporary closure of the George Bryan Centre. This is to help this group of family, friends and carers to visit and stay in touch with loved ones who have been admitted to St George's Hospital. The SOP includes some help with travelling costs for a limited time.

MPFT will also provide support in other ways:

- Being flexible about visiting times at St George's Hospital, to make it easier for those who use public transport, or who have work/other caring commitments.
- Supporting 'virtual visiting' – staying in touch through video calls. This includes making sure that patients and visitors have access to devices like tablets. MPFT's website has a page with support and guidance about digital skills: **www.mpft.nhs.uk/about-us/digital/training**

2. Evidence Section

What evidence have you considered to inform your decision-making within this assessment?

The more evidence you are able to provide in this section, the better informed your decision-making will be. Such evidence may include NICE guidance, clinical research, literature reviews, quality and performance data, workforce metrics, engagement findings, demographic data, community intelligence, health inequalities data (RightCare profiles, JSNA), etc.

- 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. National community mental health transformation programme details can be found at **https://www.england.nhs.uk/mental-health/adults/cmhs/**

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 can be found on the **Staffordshire and Stoke-on-Trent ICB 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**

The public consultation ran from 9 February to 23 March 2023. Its aims were to:

- Explain the proposal, including:
  - setting out the context of national changes in best practice in mental healthcare and the clinical evidence supporting these changes
  - how the proposal had been reached and why a single viable proposal was being recommended
- Ask people their views on:
  - whether there were other ideas that had not been considered
  - any advantages or disadvantages that would need to be planned for, if the proposal is implemented
  - how to support people if the proposal is implemented, especially with travel.

If this assessment relates to a policy / strategy, has an equality statement been added (or is it planned to be added) to the document? YES ☐ / NO ☑ / N/A ☐

If you have answered 'No', please explain why not:

Since the fire in early 2019, people who would previously have accessed mental health services at the George Bryan Centre have been provided with appropriate care, either by admission to the inpatient mental health beds at St George's Hospital in Stafford or by the transformed community mental health teams.

3. Impact Assessment

This section should record any identified and/or potential impacts on protected characteristic groups, groups experiencing health inequalities, and other groups at risk of experiencing poorer health outcomes. Both positive and negative impacts should be recorded for each of the groups defined below where applicable.

Think about any barriers to access, areas of inequity, and how different groups may be disproportionately impacted by this proposal. Conversely, think about how certain groups may benefit or see better health outcomes as a result of this proposal.

Protected Characteristics

Age	Positive impact	Negative impact	Neutral impact
Groups impacted may include young people, older people or working-age population.	☑	☐	☐

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

The transformation of community services takes into account the needs of young adults. 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 broad expertise (including a CAMHS service manager, an early intervention lead, youth participation leads, an Additional Roles Reimbursement Scheme (ARRS) practitioner with a specific focus on the 18–25 agenda, and involvement and co-production officer/s).

Disability	Positive impact	Negative impact	Neutral impact
Groups impacted may include people with physical / learning disabilities, long term conditions, or poor mental health	☑	☐	☐

For 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 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. It will remove the need to transfer patients between these sites to access appropriate therapy, leading to improved outcomes for these patients.

The service seeks to be inclusive by providing accessible information. This could include easy read documents, BSL or any other formats for people requiring additional communication support. MPFT have also produced a style guide to support health literacy issues.

Sexual Orientation	**Positive impact**	**Negative impact**	**Neutral impact**
Groups impacted may include gay / bisexual men, lesbian / bisexual women, or heterosexual people	☐	☐	☑

Both inpatient and community mental health services support patients from the LGBTQ+ community.

Gender Reassignment	**Positive impact**	**Negative impact**	**Neutral impact**
This includes people proposing to undergo, who are undergoing or have undergone gender reassignment.	☐	☐	☑

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 home and by clinicians who know them.

Sex (Gender)	**Positive impact**	**Negative impact**	**Neutral impact**
Groups impacted may include males or females – or specific gendered groups such as boys and girls.	☐	☐	☑

Acute adult mental health wards are mixed sex at St George's Hospital, as they were at the George Bryan Centre, so there is no change to this aspect of the 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. If a single-sex ward is required based on clinical need, then MPFT have access to male-only beds in the Psychiatric Intensive Care Unit (PICU) and female-only wards at the Redwoods Centre, but these occasions are rare.

Race	Positive impact	Negative impact	Neutral impact
Groups impacted may include different ethnicities, nationalities, national identities, and skin colours.	☐	☐	☑

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 (MPFT), which promote service user inclusion, dignity and respect.

The service seeks to be inclusive by using easy read documents, interpreter services, and materials in different languages.

Religion and Belief	Positive impact	Negative impact	Neutral impact
Groups impacted can include all recognised faith groups and those who do not follow any religion or belief system	☐	☐	☑

It would be expected that both inpatient and community mental health services support patients from all religions and/or beliefs. Staff will support the cultural beliefs of patients and carers/families. Staff would work under the values and behaviours of the Trust, which promote service user inclusion, dignity and respect.

Pregnancy and Maternity	Positive impact	Negative impact	Neutral impact
Groups impacted may include pregnant women, people on maternity leave and those caring for a new-born / young child	☐	☐	☑

Pregnant women will be supported throughout their inpatient stay at St George's Hospital. There is no change to service provision between the George Bryan Centre and St George's Hospital. No concerns have been raised through the engagement/patient feedback.

Marriage and Civil Partnerships	Positive impact	Negative impact	Neutral impact
This includes people within a formal legal partnership – same sex and opposite sex	☐	☐	☑

It would be expected that both inpatient and community mental health services support patients irrespective of marital status.

Inclusion Health Groups

The services we commission should be available to all and as inclusive as possible. Your proposal should also consider any other population groups that are (or are at risk of being) socially excluded. This can include carers, people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers and many other socially excluded groups.

Think about which other inclusion health groups may be impacted by your proposal. Select from the drop-down list in each section below or manually state which other socially excluded groups you are considering. Select the table and click the blue '+' symbol in the bottom right of the table to add more sections if required.

For more information about inclusion health groups, please refer to our EHIIRA Guidance document.

Carers	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☐	☑	☐

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 people who live in rural areas without good transport links and households without a car.

For 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 home.

At the reference group held in March 2022, attendees were asked if they could suggest potential mitigations related to this impact on patients and carers. The **full report of findings** from this reference group has been published. MPFT responded to the feedback by developing support in a number of areas.

MPFT has developed a standard operating procedure (SOP) to help those affected by the temporary closure of the George Bryan Centre. The purpose is to help this group of family, friends and carers to visit and stay in touch with loved ones who have been admitted to St George's Hospital. The SOP includes some help with travelling costs for a limited time.

MPFT will provide support in other ways:

- Being flexible about visiting times at St George's Hospital, to make it easier for those who use public transport, or who have work/other caring commitments
- Supporting 'virtual visiting' – staying in touch through video calls. This includes making sure that patients and visitors have access to devices like tablets. MPFT's website has a page with support and guidance about digital skills: **www.mpft.nhs.uk/about-us/digital/training**

Choose a group	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☐	☐	☐

Other - please state	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☐	☑	☐

Socio-economic deprivation

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 people who live in rural areas without good transport links, households without a car and those on low incomes. For 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 home.

At the reference group held in March 2022, attendees were asked if they could suggest potential mitigations related to this impact on patients and carers. This could include digital solutions for remote support from carers.

MPFT has developed a standard operating procedure (SOP) to help those affected by the temporary closure of the George Bryan Centre. This is to help this group of family, friends and carers to visit and stay in touch with loved ones who have been admitted to St George's Hospital. The SOP includes some help with travelling costs for a time-limited period.

MPFT provides support in other ways.

- Being flexible about visiting times at St George's Hospital, to make it easier for those who use public transport, or have work/other caring commitments
- Supporting 'virtual visiting' – staying in touch through video calls. This includes making sure that patients and visitors have access to devices like tablets. MPFT's website has a page with support and guidance about digital skills: **www.mpft.nhs.uk/about-us/digital/training**

Other - please state	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☑	☐	☐

Asylum seekers, People experiencing homelessness, sex workers, military veterans, rural communities

It would be expected that both inpatient and community mental health services support any patients based on need. MPFT are committed to working with groups that can struggle to access health care and an example of ongoing work is given below.

MPFT's discharge pathway is identifying some service users who have been admitted to an inpatient ward who do not have a place to live. These service users are referred to the council for housing support and the team:

- support them to obtain identification documents
- support them to access appropriate benefits
- discharge to emergency housing once confirmed by local authority
- arrange for food parcels to be delivered
- liaise with housing to resolve any issues that occur
- support them to complete housing assessment documents
- refer to lower-level supported accommodation, for example, Rethink Mental Illness, League of Friends
- employ recovery workers who can support people to get their own flat, to furnish the flat and support them with setting up paperwork.

Core20PLUS5

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system levels. The approach defines a target population cohort – the **'Core20PLUS'** – and identifies '5' areas of clinical focus requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMD)

PLUS refers to ICS-chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach.

The **5** areas of clinical focus are as follows:

1. **Maternity** – Ensuring continuity of care for 75% of women from ethnically diverse backgrounds and from the most deprived groups
2. **Severe mental illness** – Ensuring annual health checks for 60% of those living with SMI (bringing this in line with success seen in learning disabilities)
3. **Chronic respiratory disease –** A clear focus on COPD driving up uptake of COVID-19, flu and pneumonia vaccines
4. **Early cancer diagnosis** – Ensuring that 75% of cases are diagnosed at Stage 1 or Stage 2 by 2028
5. **Hypertension case-finding** – Allowing for interventions to optimise blood pressure and minimise risk of myocardial infarction and stroke.

More information about Core20PLUS5 can be found using the following link - https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Please record any identified or potential areas of impact – both positive and negative – for the target cohorts and any relevant clinical areas defined below and consider how your proposal may be able to contribute to making improvements in these priority areas.

Core20 - Deprivation	Positive impact	Negative impact	Neutral impact
The most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD).	☐	☐	☑

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 people who live in rural areas without good transport links, households without a car and those on low incomes. For 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 home.

At the reference group held in March 2022, attendees were asked if they could suggest potential mitigations related to this impact on patients and carers. This could include digital solutions for remote support from carers.

PLUS	Positive impact	Negative impact	Neutral impact
Any other locally determined population groups experiencing poor health outcomes – examples are listed above. **Please state which groups you are considering in your response.**	☐	☐	☑

Severe mental illness – Annual health checks for people with severe mental illness are completed in general practice, and therefore this proposal does not directly impact this metric.

Choose one of the five areas of clinical focus	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☐	☐	☐

No other areas of clinical focus applicable.

4. Compliance with Legal Duties

Has the organisation given due regard and consideration to the following areas?

Eliminating unlawful discrimination, harassment and victimisation

YES ☑ / NO ☐

Unlawful discrimination takes place when people are treated 'less favourably' due to having a protected characteristic.

Advancing equality of opportunity between people who share a protected characteristic and those who do not. YES ☑ / NO ☐

This means making sure that people are treated fairly and given equal access to opportunities and resources.

Fostering good relations between people who share a protected characteristic and those who do not. YES ☑ / NO ☐

This mean creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference.

Are there any Human Rights concerns? YES ☐ / NO ☑

If you have answered '**Yes**', please seek advice from the Inclusion Unit to discuss carrying out a specific Human Rights Assessment

Compliance with the NHS Standard Contract? YES ☑ / NO ☐

In relation to Service Condition SC13 which includes the NHS Accessible Information Standard

Please provide a supporting narrative to support your responses to the above questions: This section must be completed

Access to mental health services, both in the community and for inpatient beds, is provided on the basis of need. The proposed centralisation of inpatient beds at the St George's Hospital site provides equity of provision for all patients requiring inpatient care. Previously, inpatients at the 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.

5. Equality Related Risk

If you have identified an area of actual or potential equality-related risk due to your proposal, please use the matrix below to work out the risk score and tick the corresponding box. If the area of risk gives a score of 9 or above, this should be escalated using the organisation's risk management procedures.

Risk score is calculated as the likelihood of risk multiplied by the level of consequence.

For more information about how to calculate a risk score, please refer to the EHIIRA Guidance document.

Likelihood of risk ➔	RARE	UNLIKELY	POSSIBLE	LIKELY	HIGH
Level of consequence ↓	= 1	= 2	= 3	= 4	= 5
NEGLIGIBLE = 1	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
MINOR = 2	2 ☐	4 ☐	6 ☐	8 ☑	10 ☐
MODERATE = 3	3 ☐	6 ☐	9 ☐	12 ☐	15 ☐
MAJOR = 4	4 ☐	8 ☐	12 ☐	16 ☐	20 ☐
CATASTROPHIC = 5	5 ☐	10 ☐	15 ☐	20 ☐	25 ☐

Please provide a narrative to explain the risk score relating to your proposal:

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 home, rather than being admitted to an inpatient bed.

People on low income who claim certain benefits can reclaim transport costs to hospital, utilising MPFT's travel policy. MPFT staff will signpost people to any voluntary car schemes that are in place at the time. Digital solutions have also been implemented, following the successful use of technology throughout health and social care during the COVID-19 pandemic.

6. Equality Action Plan

Please outline any actions or recommendations arising from this assessment of the proposal.

A target completion date is required for all actions and recommendations

Action Required	Lead Person	Target Date	Further Comments
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

7. Approval

All EHIIRAs should have governance oversight via formal committee. Please provide details of the arrangements for formal approval below.

Name of formal committee approving this assessment: ICB Board

Date of committee meeting: 18/10/2023

Name of person completing this assessment: Kathryn Whitfield

Below fields to be completed by Inclusion Unit upon receiving assessment:

Date received by Inclusion Unit for assurance check: 22/08/2023

Name of Inclusion Unit Team Member completing assurance check: Dan Shackleston

Date of completed assurance check: 24/08/2023

8. What Next?

- Regularly review the action plan and update the EHIIRA accordingly.
- Save a finalised copy for your records and share via your governance pathways and with the Inclusion Unit.
- Follow any specialist advice or guidance from the In.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Quality Impact Assessment (QIA)

Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre

Title	**Inpatient mental health services previously provided at the George Bryan Centre – Older Adult Ward closure and implementation of an enhanced community offer**
Portfolio / Collaborative / Place	Mental Health Portfolio / Transformation
QIA reference number	QIA23-013
Date QIA started	17/07/23
Proposed Project Start Date	Programme in place – previous QIA 212 completed in 2022
Portfolio Director and Role	Nicola Bromage, Associate Director – Mental Health, Learning Disability and Autism and Children and Young People, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)
Clinical Lead and Role	Lisa Agell, Operations Director – Unplanned Care and Mental Health, Midlands Partnership University NHS Foundation Trust (MPFT)
Project Lead and Role	Helen Slater, Associate Director of Transformation – Staffordshire and Stoke-on-Trent ICB
Quality Lead and Role	Lee George, Associate Director – Quality Assurance and Improvement, Staffordshire and Stoke-on-Trent ICB
QIA Author and Role	Kathryn Whitfield, Transformation Programme Manager – Staffordshire and Stoke-on-Trent ICB
Summary of reason for QIA (max 200 words) • **Current state** • **Rationale for change** • **Proposed future state**	*Brief overview of the proposed service changes, including why this change is being proposed, the locations covered in the proposal, current state and proposed future state.* The George Bryan Centre in Tamworth provided an assessment, care and treatment service in a 19-bed ward (the West Wing) for adults aged 18–65 in an acute state of mental illness and a 12-bed mental health assessment and treatment service for older adults (aged 65+) with severe mental health problems, including dementia (the East Wing). Following a fire in February 2019, plans for enhanced community services were accelerated. The temporary solution was for adults with severe mental illness to be admitted to St George's Hospital in Stafford and for older adults with severe mental illness/ dementia cared for by the community team. Following a robust options appraisal process, in March 2022 a technical group agreed that the only viable proposal was to make permanent the service changes the Trust made in 2019. The ICB subsequently approved the pre-consultation business case (PCBC) that outlined the evidence and proposal and agreed to a six-week public consultation. The consultation built on relationships already established with stakeholders and used a range of methods to obtain feedback. Full details are available in the report of findings.

	Consultation feedback is anonymous, so it has been difficult to establish which participants had direct experience of the George Bryan Centre. However, one participant who gave feedback had been an inpatient at both centres and described them as 'night and day', highlighting their positive experience of St George's Hospital. Feedback from this consultation was received at a further technical group (June 2023), where no new proposals were suggested, and it was agreed the ICB could proceed to a decision-making business case (DMBC). This QIA will support that decision-making.
Key issues raised in QIA	Executive summary of key issues / risks once the QIA has been completed to ensure that these are highlighted to Decision Makers/Committees/Boards. Also include any key issues / risks that cannot be mitigated. Key themes that have emerged throughout public involvement and consultation have been: • Impact of travel for carers • The need for accessible technological solutions for remote visiting • Support for carers • Knowledge of how to access services. **Impact of travel** In the report of findings, one of the key themes related to the impact of travelling further to visit a loved one in St George's Hospital. As outlined in the decision-making business case, the clinical case for change outlines the benefits of consolidating inpatient beds and services at a single site, with more people being supported by the enhanced community offer. The impact of travel requirements is difficult to assess, as this is more likely to affect carers visiting the patient, and MPFT do not hold data on carers, who may not live with the patient. The move from bed-based care to community-based care also presents a challenge with data interpretation – patients who would have been admitted to the George Bryan Centre pre-fire are now more likely to receive community-based care, as admissions to inpatient beds are made only in those cases where a person cannot be safely cared for at home. In recommending the proposal to make permanent the inpatient mental health beds at St George's Hospital, MPFT have thought carefully about the potential disadvantage caused by travel difficulties for some patients and carers, both in terms of the cost and time for carers to travel for visits and for the patient, who may receive fewer visits as a result. • On balance, MPFT believe the following advantages mean this is the right way forward: • Our community mental health services are giving better support to people with severe mental illness in the community, so that fewer people need to stay in hospital. Through the right specialist treatment, hospital stays can be shorter, and people are helped to stay independent

- Better care through on-site access at St George's Hospital to a larger range of mental health specialists, more treatment options and activities, and the safer care that the facilities help provide
- MPFT are improving services to offer better support for people in crisis
- Analysis shows that, before February 2019, 75% of south east Staffordshire patients admitted for an inpatient mental health stay were admitted directly to St George's Hospital. This was because their illness was too serious for them to be treated at the George Bryan Centre.

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

As part of the consultation, MPFT asked for people's ideas and suggestions about how they can further support visitors to St George's Hospital. MPFT have reviewed these ideas and suggestions as part of finalising their travel standard operating procedure (SOP).

The visitors within scope of this SOP, and eligible to make a claim against it, are those who are visiting people who would previously been admitted to the George Bryan Centre, who have now been admitted to St George's Hospital, Stafford. Visitors must also be in receipt of a benefit or other financial support from the government.

In response to consultation feedback, MPFT have increased the amount per mile that can be claimed and clarified how people can claim back for using public transport. MPFT have outlined other ways they can support patients and carers:

- **Being flexible about visiting times** at St George's Hospital, to make it easier for people who use public transport and are reliant on the public transport timetable, or those carers who wish to visit after the working day or have other caring commitments at home
- **Supporting 'virtual visiting**' – staying in touch through video calls, which proved very successful during the COVID-19 pandemic. This includes making sure that patients and visitors have access to devices like tablets. MPFT's website has a page with support and guidance about digital skills: Digital Training and Support: Midlands Partnership Foundation Trust (mpft.nhs.uk)

Technological solutions for remote visiting

Following the public consultation, an update was received from MPFT regarding ongoing work to ensure that carers of patients on mental health inpatient wards are supported through a range of digital methods. These include:

- **Video calls:** carers can use video calling apps that they are already familiar with, such as WhatsApp, Facebook Messenger and FaceTime

- **KOMP:** a secure digital communication device that enables carers to engage with patients. Carers can use their own smartphones to access KOMP. MPFT staff are happy to support carers who want to use this assistive technology
- **MPFT Digital Angel IT project:** supports staff with new technology – increasing their confidence in using technology to support patients and carers. This also forms part of our Digital Strategy as outlined in the Transformation Plan section (see the enhanced digital strategy document)
- **Staff newsletter and ward manager meetings:** MPFT have created an inpatient staff newsletter and set up monthly ward manager meetings to ensure that key messages are cascaded to staff. This will form part of their communications plan.

MPFT are committed to providing carers with the support they need to stay connected with their loved ones who are on inpatient mental health wards. Digital technology can play a vital role in this, and MPFT are constantly looking for new ways to use technology to support carers. MPFT's digital strategy has a strong emphasis on inclusion and reducing inequalities. The Trust is committed to tailoring services based on people's digital communication preferences, their ability to access and use digital services, and their individual needs, including protected characteristics.

Accessing services

Although the proposal has not resulted in any impact on access to services, this was a prominent theme of feedback throughout involvement and consultation activity and one that MPFT are keen to address. MPFT and MLCSU will go back out to the community groups who engaged with us during the consultation to feed back on services. They will maintain an open dialogue with them regarding access to services.

MPFT understand that patients and carers may not always retain information on how to contact us. They have simplified the way that patients and carers can access our services and have a single point of contact via our adult mental health services across south Staffordshire. This point of contact will direct patients and carers to their named worker. They also work with Brighter Futures, who deliver the mental health helpline. This helpline is available for patients and carers who require non-urgent support.

MPFT regularly promote their Access number on social media, and it is on all leaflets and correspondence with service users.

The single point of access can direct and support people to VCSE services such as housing, financial wellbeing, social navigators, and substance misuse support.

The 24/7 open access, freephone urgent mental health helpline for all ages provided by MPFT is being developed to make these services accessible via NHS 111 (the caller would select the mental health option). There will be a soft launch in December 2023 and a formal launch in April 2024.

Supporting carers

The consultation received feedback about the need for greater support for carers. MPFT work with the Alzheimer's Society to support patients and carers post-diagnosis.

All information regarding MPFT services can be found on their website. MPFT are working with patients and carers to simplify the language used in information for patients and carers

MPFT are also working on a ‘message in a bottle’. This will contain useful information for patients and carers such as contact details for services

MPFT are improving partnerships with system partners such as Staffordshire County Council to improve and join up care for dementia patients and carers

The Hospital Avoidance team (HAT), which includes older adult specialists, gives support at home to help older people stay out of hospital. The team offers phone calls and home visits, and carers can call for help in a crisis

A new home sitting service is being developed to support carers who need a break during the evening or at weekends. The crisis team will refer patients to this service, which will give carers some much-needed time to themselves, while their loved one is looked after in their own home.

Risks that cannot be mitigated

The travel SOP was developed to support a cohort of visitors during the transition period of inpatient services moving from one location to another. For this reason, the claim period will be time limited from 1 September 2022 to 31 December 2023 (or on implementation of the long-term solution, whichever is first).

From 31 December 2023 (or the implementation of the long-term solution) this financial support will cease to be provided.

Like travelling for other specialist treatments, the proposed solution does potentially mean a longer journey for some visitors. MPFT recognise the important role visitors have for mental health patients and are balancing this against the need to deliver the best quality of care. The range of additional (non-financial) support will remain in place.

Ongoing monitoring

Due to some of the limitations in evidencing potential impacts, as outlined in the summary above, it has been agreed that, following any decision, the impacts will be monitored and formally reported to both the Mental Health Portfolio Board and the Quality and Safety Committee for the first 12 months following any decision. This is in addition to routine contractual monitoring.

Care Quality Commission (CQC) update

Following a focused unannounced inspection in November 2022, the Care Quality Commission (CQC) issued MPFT with a section 29A warning notice. MPFT developed an improvement plan, which is being monitored by its executive team, and has provided evidence of progress to the CQC. MPFT provide monthly updates to the System

	Quality Group. The improvement plan is a standing agenda item on the bimonthly Clinical Quality Review Meeting. In May 2023, the CQC published an inspection report rating MPFT's acute wards for adults of working age and psychiatric intensive care units as 'Inadequate'. This applied to both the safe and well-led domains, as well as the overall core service. This does not affect the overall Trust-wide rating, which remains 'Good'. (The full report is available online.) The CQC undertook a follow-up inspection on 27 and 28 June 2023. This was to review progress against the areas for improvement outlined in the warning notice. The Trust awaits the outcome. Partnership working remains in place between MPFT, Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB. The ICB are joining CQC assurance spot-check visits at St George's Hospital in collaboration with the Trust to provide assurance that improvement actions are embedded.

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Version control

Version Number	Date	Author	Summary of Changes
1	16/08/23	KW	Final QIA submitted for QIA Panel on 23/08/23
2	11/09/23	KW	Updated following QIA Panel
3	18/09/23	BR	Updated to include CQC update and link to PCBC. FINAL PDF.

Sign-off following completion of the Quality Impact Assessment on page 2 onwards

Quality Buddy Comments

Name and Role	Comments and Date
Lee George – Associate Director of Quality Assurance and Improvement	The proposal reflects the national strategy for mental health services, enhanced support within the community and local clinical opinion. Further, the proposal demonstrates increased resilience of the service and provision of additional support for service users. A significant amount of targeted engagement has been undertaken, however, there are limitations in the ability to evidence potential impacts based on the feedback and during the period of temporary closure following the fire. It is therefore recommended that following any decision the impacts are monitored and formally reported to both the Mental Health Portfolio Board and Quality and Safety Committee as part of routine reporting for the first 12 months. 16 August 2023

Safeguarding Lead Comments

Name and Role	Comments and Date
Heidi Watts – Deputy Designated Nurse for Safeguarding Adults	I can see that there has been a lot of consultation with the public for this decision including with hard-to-reach groups. It appears that there was a comprehensive review carried out by independent professionals which found that the change was in line with NICE guidance and the direction of travel for mental health treatment to be more community-based. There are some considerations relating to travel access for people's family / representatives and these need to continue to be monitored to ensure that people's right to family life are not impeded. MPFT have duties for safeguarding under the Care Act, in the terms of their CQC regulation and within the standard NHS contract. These are monitored through contractual and regulatory processes. MPFT must have policies, procedures and staff training in place to identify / prevent abuse of people with care and support needs who are unable to protect themselves. 16 August 2023

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Portfolio Director Comments

Name and Role	Comments and Date
Helen Slater – Associate Director of Transformation	As Associate Director of Transformation, I have been responsible for the service change process and the development of the Pre-consultation business case, which was assured by NHSE in January 2023 as per the Planning, Assuring and Delivering Service Change for Patients Guidance. Following this process, the ICB made the decision to proceed with a six-week consultation. The IMHS Steering Group has overseen the process for reviewing consultation feedback and development of impact assessments for the viable proposal. This QIA supports the decision-making business case, which will be subject to ICB Board in December 2023. Going forward, the responsibility for monitoring of the impact of the service change will sit with the Mental Health Portfolio. 16 August 2023

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Quality Impact Assessment (only complete applicable boxes)						
NQB* Domain	**Impact Considerations** **People working in systems deliver care that is…**	**Impacts** **(Positive / Neutral / Negative)**	**Describe the impacts of the proposal**	**Evidence and Rationale**	**Describe the metrics that are being monitored to evidence the impacts**	**RISK SCORE** **For any negative impacts provide: the mitigations and risk score** **(Likelihood x Consequence = Risk**)**
Safe	Delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.	**Positive**	Some of the benefits of this proposal to centralise inpatient mental health beds for serious mental illness have been: • Fewer emergency call-outs, reflective of a larger site with senior clinical back-up, more staff, and intensive psychiatric care facilities, which can manage crises more effectively • People who require an inpatient admission have been able to access appropriate treatments and therapeutic interventions that were not available in the George Bryan Centre • A centralised centre also results in more consistent and timely care provision, preventing the need for disruptive transfer between sites for intensive psychiatric care or to access therapeutic interventions	The proposal has been developed based on evidence and best practice, as outlined in the 'Effective' domain. Staff who provide therapeutic interventions are skilled and specialist, so it can be difficult to recruit and keep these staff when there are workforce challenges. It would be particularly hard to recruit to a smaller, isolated site. In a bigger hospital, they would work across wards as required. Additional interventions that are available at St George's Hospital that were not available at the George Bryan Centre include art therapy, music therapy and occupational therapy. Allied health professionals (AHPs) providing services such as art and music therapy or occupational therapy at St George's Hospital are able	MPFT are required to monitor and report on safe staffing numbers, to ensure there are sufficient staff on wards and that these numbers are reflective of the acuity of patients. Safer staffing reports are produced by the Nursing Directorate and reported to the Quality Governance Committee. Incidents, emergency call-outs and complaints are monitored. These are reviewed regularly by MPFT business support officers and escalated to operational leads, before being presented at the MPFT Mental Health Performance and Quality Group.	

Quality Impact Assessment (only complete applicable boxes)						
NQB* Domain	**Impact Considerations** **People working in systems deliver care that is…**	**Impacts** **(Positive / Neutral / Negative)**	**Describe the impacts of the proposal**	**Evidence and Rationale**	**Describe the metrics that are being monitored to evidence the impacts**	**RISK SCORE** **For any negative impacts provide:** **the mitigations and risk score** **(Likelihood x Consequence = Risk**)**
			• With more staff and a wider skill mix, it is easier at St George's Hospital to provide cover across different areas during times of operational pressure • Consultant on site at all times.	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.	More serious incidents reaching a certain threshold are presented to MPFT Quality Governance Committee and escalated to MPFT Board if appropriate.	
		Negative				

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Effective	Informed by consistent and up-to-date high-quality training, guidelines, and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit.	**Positive**	The national best practice for treating patients with serious mental illness (SMI) has moved from a bed-based model to a community-based model. Guidance: **Community-centred practice: applying All Our Health** The case for change for mental health services was clinically led and aligns with the national model. For people with dementia, evidence demonstrates that care at home or in the local community is preferred over bed-based care. (Evidence from **The dementia care pathway**) Following the fire, the existing community pathway was developed and further enhanced to support older adults by Older Adult teams treating patients in home settings in the community; this now includes: • Enhanced crisis home treatment with skilled, experienced older adult	**Treatment of patients with dementia** **Evidence from the dementia care pathway** (National Collaborating Centre for Mental Health, 2018) shows that hospital admissions can: • make the symptoms of dementia worse • permanently reduce the person's independence • make it more likely that the patient will be discharged into residential care and/or re-admitted to hospital. The dementia care pathway guidance says that, when a patient has to go into hospital, the stay should be as short as possible. Care should focus on helping people to live as well as possible at home, with support from health and social care, local authorities and/or voluntary groups. It should be person-centred, and could include things like: • extra-care housing and practical support, for example with transport	The Trust routinely monitors data including: • Numbers of admissions with dementia • Length of stay • Patient / user experience • Complaints / PALS.	

			specialists and Hospital Avoidance team • Addition of a nursing / therapy lead to ensure interventions are evidenced-based and focused on enabling people 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. **Inpatient beds for patients with severe mental illness** For people who need to be admitted, St George's Hospital offers a greater range of specialty services on one site, which patients can access. If they were in the George Bryan Centre, they would need to travel for approximately one hour to access these services at St George's Hospital.	• 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. 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 fewer patients admitted to St George's Hospital with dementia. 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.		
		Neutral	**SMI inpatient admissions**			

			For the cohort of people with the most 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 that can be offered in a larger hospital.			
		Negative	**Greater risk of health inequalities** Some patients and carers will have to travel further to visit a person who is admitted to St George's Hospital in Stafford.	Evidence shows that being in touch with family, carers and friends is beneficial to patients with severe mental illness. There could be more of an impact on people living in rural areas without good transport links, people without a car and those on low incomes – with a risk of greater risk of health inequalities for some patients. The impact of travel is difficult to assess, as this is more likely to affect carers who wish to visit the patient, and MPFT do not hold data on carers, who may live separately from the patient. The move from bed-based care to community-based care also presents a challenge with interpretation of the data – patients who would have been admitted to the George Bryan Centre pre-fire are now more likely to receive community-based care, as admissions to inpatient beds are made only in those cases where a person cannot be safely cared for at home.	MPFT have developed a standard operating procedure (SOP) to provide help with travelling costs for a time-limited period. The number of claims made against this policy for support with travel will be monitored by the Trust to assess the true level of impact.	**Risk Score = 6** 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. MPFT has outlined other ways they can support patients and carers: • Being flexible about visiting times at St George's Hospital, to make it easier for people who use public transport and are reliant on the public transport timetable, or those carers who wish to visit after the working day or have other caring commitments at home Supporting 'virtual visiting': • Video calls: carers can use video calling apps that they are already familiar with, such as WhatsApp, Facebook Messenger and FaceTime • KOMP: a secure digital communication device that

						carers can use to engage with patients. Carers can use their own smartphones to access KOMP. MPFT staff are happy to support carers who want to use this assistive technology • MPFT Digital Angel IT project: supports our staff with new technology – increasing their confidence in using technology to support patients and carers.

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Positive Experience	Responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable. Caring – delivered with compassion, dignity and mutual respect.	Positive	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. For example: • 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 • A new home sitting service is being developed to support carers who need a break during the evening or at weekends. The crisis team will refer patients to this service, which will give carers some much-needed time to themselves, while their loved one is looked after in their own home.	The main aim of these services is to address the social determinants of poor mental health, which cause or exacerbate a service user's experience of mental illness. For example: • The Lifestyle service 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 reduce social isolation • The Future Focus support service aims to support people to stay well in their recovery journey, using a person-centred and flexible approach. This support is offered alongside clinical interventions and continues to support the patient for up to 12 to 18 months after	Use of support services is monitored through monthly contract review meetings with VCSE partners and reported to the South Community Mental Health Framework (CMHF) delivery group and the system CMHF steering group. This ensures that services are being used effectively and that patients are receiving the support they need. In terms of personalised care, this is part of the third year of the transformation roadmap and MPFT are developing a new approach which replaces CPA. Service users have been involved in and co-produced all the changes MPFT intends to implement.	

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			There was positive feedback from some patients about the ability to visit Stafford town centre from St George's Hospital, promoting socialisation and independence during leave from the ward.	completion of clinical interventions • Housing support services provide a range of housing-related support, helping services users to access and navigate housing allocation processes and maximise their opportunities to live in areas that allow the best support their ongoing mental health needs • The out of hours home sitting service is for patients 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 can safely remain at home, or in an alternative environment, and provides support and respite to carers / relatives out of hours		

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				• Examples of case studies included in **<u>PCBC</u>** Section 3.4.8 how the wrap-around community service supports those with mental health needs.		
		Neutral				
		Negative	Some patients and carers will be impacted by having to travel further to visit a person who is admitted to a bed in St George's Hospital in Stafford. This could affect those who live in rural areas without good transport links, people without a car and those on low incomes. The impact of travel is difficult to assess, as this is more likely to affect carers who wish to visit the patient, and MPFT do not hold data on carers, who may live separately from the patient. The move from bed-based care to community-based care also presents a		The number of claims made against this policy for support with travel will be monitored by MPFT to assess the true level of impact.	**<u>Risk Score = 6</u>** 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. MPFT has developed a standard operating procedure (SOP) to provide help with travelling costs for a time-limited period. MPFT has identified other ways they can offer support:. • Being flexible about visiting times at St George's Hospital, to make it easier for people who use public transport and are reliant on

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			challenge with interpretation of the data – patients who would have been admitted to the George Bryan Centre pre-fire are now more likely to receive community-based care, as admissions to inpatient beds are made only in those cases where a person cannot be safely cared for at home. Travel has been raised as a concern in both 2019 and 2021 public involvement sessions and in the 2023 public consultation.			the public transport timetable, or those carers who wish to visit after the working day or have other caring commitments at home • Video calls: carers can use video calling apps that they are already familiar with, such as WhatsApp, Facebook Messenger and FaceTime • KOMP: a secure digital communication device that carers can use to engage with patients. Carers can use their own smartphones to access KOMP. MPFT staff are happy to support carers who want to use this assistive technology • MPFT Digital Angel IT project: supports our staff with new technology – increasing their confidence in using technology to support patients and carers.

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Well-Led	Driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.	**Positive**	The clinical model has been developed in line with national best practice for treating patients with SMI, which has moved from a **bed-based** model to a community-based model, and NICE guidance for treatment of people with dementia. Guidance: Community-centred practice: applying All Our Health	The clinical model that is outlined within the decision-making business case has been independently reviewed by the West Midlands Clinical Senate (WMCS). A copy of the report can be found at Midlands Clinical Senates – Clinical Reviews – Recent. The programme team is satisfied that the proposal meets the government's four tests applied to service change, and in addition, NHS England and NHS Improvement's (NHSEI) Patient Care (bed closure) Test.		
		Neutral				
		Negative				

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Sustainably Resourced	Focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment.	**Positive**	**Preventing readmissions** It is recognised that a patient being discharged from an inpatient mental health bed is at risk of readmission. MPFT have a dedicated discharge pathway, which provides intensive community support for four weeks post-discharge. This takes a person-centred approach and can include home visits, home cleaning and/or repairs, and support with food and utilities. Social care plays a key role in timely discharge and patients benefit from MPFT being an integrated social care and mental health provider. Older people with dementia are on a non-discharge pathway and therefore can access more intensive support if needed from a specialist Hospital Avoidance team. This helps people to stay safely at home and prevents admissions. 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 are required to monitor and report on safe staffing numbers, to ensure there are sufficient staff on wards and that these numbers are reflective of the acuity of patients. Safer staffing reports are produced by the Nursing Directorate and reported to the Quality Governance Committee. The use of agency and bank staff is also monitored, and the data presented to the MPFT People Committee for oversight. MPFT also monitor: • Readmission data for SMI • Length of stay • Out of area placements. These are reviewed regularly by MPFT business support officers and escalated to operational leads before being presented at the MPFT Mental Health Performance and Quality Group.	

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		Neutral				
		Negative				

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**ICB Risk Management Strategy IAN - ICB Risk Management Strategy - May 2023 (v2.8).pdf - Newer to Older (sharepoint.com)

NQB* Domain	Impact Considerations People working in systems deliver care that is…	Impacts (Positive / Neutral / Negative)	Describe the impacts of the proposal	Evidence and Rationale	Describe the metrics that are being monitored to evidence the impacts	RISK SCORE For any negative impacts provide: the mitigations and risk score (Likelihood x Consequence = Risk**)
Equitable	Everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.	**Positive**	The EIA identifies the protected characteristics of age and disability as the most likely to be impacted. People who require an inpatient admission have been able to access appropriate treatments and therapeutic interventions that were not available in the George Bryan Centre.	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. 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.		
		Neutral				

		Negative	Some patients and carers 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 people who live in rural areas without good transport links, people who would struggle 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. The impact of travel is difficult to assess, as this is more likely to affect carers who wish to visit the patient, and MPFT do not hold data on carers, who may live separately from the patient. The move from bed-based care to community-based care also presents a challenge with interpretation of the data – patients who would have been admitted to the George Bryan Centre pre-fire are now more likely to receive community-based care, as admissions to inpatient beds are made only in those cases where a person cannot be safely cared for at home.	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.	The number of claims made against this policy for support with travel will be monitored by MPFT to assess the true level of impact.	**Risk Score = 6** MPFT has developed a standard operating procedure (SOP) to provide help with travelling costs for a time-limited period. MPFT has identified other ways they can offer support: • Being flexible about visiting times at St George's Hospital, to make it easier for people who use public transport and are reliant on the public transport timetable, or those carers who wish to visit after the working day or have other caring commitments at home • Video calls: carers can use video calling apps that they are already familiar with, such as WhatsApp, Facebook Messenger and FaceTime • KOMP: a secure digital communication device that carers can use to engage with patients. Carers can use their own smartphones to access KOMP. MPFT staff are happy to support carers who want to use this assistive technology • MPFT Digital Angel IT project: supports our staff with new technology – increasing their confidence in using technology to support patients and carers.

*The National Quality Board (NQB, 2021) has refreshed its Shared Commitment to Quality to support those working in health and care systems. The publication provides a nationally-agreed definition of quality and a vision for how quality can be effectively delivered through ICSs **https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-refreshed-shared-commitment-to-quality.pdf**

ICB Risk Management Strategy **IAN - ICB Risk Management Strategy - May 2023 (v2.8).pdf - Newer to Older (sharepoint.com)

Screening criteria

To be completed by QIA Author

Question	Answer
Does the QIA document any level of risk (negative quality impact) that has been introduced by the 'business decision' and not mitigated?	Yes
Is the 'business decision' part of a formal (NHS England) service change proposal?	Yes
Does the 'business decision' increase the number of steps / handoffs within a single pathway and identify the potential for an associated increased risk?	No
Has the QIA author requested a QIA Panel discussion due to the level of perceived risk or other reasons e.g., potential media interest?	No

If 'yes' to any screening criteria, please include brief explanation:

The impact of additional travel for a cohort of patients and carers cannot be fully mitigated.

This QIA supports the decision-making business case on Inpatient mental health services previously provided at the George Bryan Centre – Older Adult Ward Closure and implementation of an Enhanced Community Offer, a service change proposal. The pre-consultation business case outlining the proposal has been assured by an NHSE Stage 2 panel as meeting the five tests of service change.

If all screening criteria are recorded as 'no':

The QIA can be signed-off without a QIA Panel (Gateway 1).

If a 'yes' has been recorded in any of the screening questions:

The QIA will be considered at a QIA Panel (Gateway 2).

*The National Quality Board (NQB, 2021) has refreshed its Shared Commitment to Quality to support those working in health and care systems. The publication provides a nationally-agreed definition of quality and a vision for how quality can be effectively delivered through ICSs https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-refreshed-shared-commitment-to-quality.pdf

Gateway control

To be completed by the Quality Assurance and Improvement Team

Gateway	Quality Lead	Comments and Date
Gateway 2	Becky Roberts, Senior Quality Improvement and Assurance Manager	According to the screening criteria this QIA is deemed to be a Gateway 2 QIA as it forms part of a formal NHSE Service Change proposal (DMCB). The QIA is to be discussed at the QIA Panel on 23/08/23. 16 August 2023

Final Version of QIA Emailed back to QIA Author and Portfolio Director

Date sent	

Gateway 2 ONLY – QIA Panel Feedback

To be completed by the Quality Assurance and Improvement Team

Date of QIA Panel	Feedback and Actions / Amendments	QIA requires resubmission
		Yes / No

Confirmation of Amendments by Quality Assurance and Improvement Team

Quality Lead	Date Confirmed

Final Version of QIA Emailed back to QIA Author and Portfolio Director

Date sent	

*The National Quality Board (NQB, 2021) has refreshed its Shared Commitment to Quality to support those working in health and care systems. The publication provides a nationally-agreed definition of quality and a vision for how quality can be effectively delivered through ICSs **https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-refreshed-shared-commitment-to-quality.pdf**

APPENDIX 1 - Quality Buddy QIA Template Checklist

Considerations for completing the Quality Impact Assessment. Remember to use evidence where possible.

National Quality Board (NQB) Domain	Considerations
Safe	Harm to patients, Incidents, Healthcare Associated Infections (HCAIs), Safeguarding of adults and children, including children and Young People (CYP) aged 0-25 with Special Educational Needs and Disabilities (SEND), and Vulnerable adults or children. Patient Safety Incident Response Framework (PSIRF).
Effective	Evidence based practice, NICE Guidance, Consistency/continuity of care, Continuous improvement, Wider determinants of health, Health inequalities and prevention, Improve outcomes in population health and healthcare.
Positive Experience	Patient / service user experience (complaints / PALS/ Surveys etc.), Hard to reach groups, Consent and confidentiality, Informed choice and care planning, Compassionate and personalised care, Physical environment or location and accessibility, Involvement of service users, patients, and carers.
Well-Led	Clinical leadership and engagement, Learning culture and continuous improvement, Governance, Staff experience.
Sustainably Resourced	Enhance productivity and value for money. Reducing waste and inefficiencies, adding value, Performance improvements, Pathway improvement, Supporting broader social and economic development.
Equitable	Tackle inequalities in outcomes, experience, and access, reducing variation, reducing health inequalities.

*The National Quality Board (NQB, 2021) has refreshed its Shared Commitment to Quality to support those working in health and care systems. The publication provides a nationally-agreed definition of quality and a vision for how quality can be effectively delivered through ICSs https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-refreshed-shared-commitment-to-quality.pdf

Staffordshire and Stoke-on-Trent care group

Standard Operating Procedure

Financial assistance for travel costs for visitors associated with the programme to find the long-term solution to the provision of mental health in-patient services in South East Staffordshire

Document Control Summary	
Status	New
Version	2.2
Author/Title	Upkar Jheeta/Head of Primary Care Development & MH Programme Lead (South Staffordshire)
Owner/Title	Jennie Collier/Managing Director
Approved by	
Ratified	
Related Trust strategy and/or strategic aims	
Implementation date	
Review date	
Keywords	
Associated policy or Standard Operating Procedure	

Contents

Introduction

The George Bryan Centre is just outside Tamworth in the Lichfield District Council area and served the population of south east Staffordshire; Burton upon Trent, Lichfield, Tamworth and surrounding areas.

It had two wards that provided assessment and treatment services for people with severe mental illness and dementia, including mood disorders, psychosis, anxiety and depression.

In February 2019, a fire destroyed one ward and the remaining ward was temporarily closed shortly afterwards, on safety grounds.

Since that time, people who have needed an inpatient bed were likely to be admitted to St George's Hospital in Stafford.

An enhanced community service is supporting people to remain in their own homes for longer.

A programme was established to find a long-term solution for the services formerly provided by the George Bryan Centre, which was paused to enable the NHS to respond to the COVID-19 pandemic.

During the COVID-19 pandemic, visiting a person in hospital was supported using a needs-led and risk-assessed approach and considered on a case by case basis.

Contact between those in hospital and people outside of hospital was maintained using digital technologies.

In September 2021, the programme to find the long-term solution to the provision of mental health in-patient services in South East Staffordshire was re-started.

During the engagement phase of the programme in 2019, 2021 and 2022, travel was a common theme. This included the need for some visitors having to travel further, the cost of travel and the availability of public transport.

Purpose

This Standard Operating Procedure (SOP) has been developed to provide financial assistance for those visitors who are directly affected by the programme to find the long-term solution to the provision of mental health in-patient services in South East Staffordshire and who will need support during the transition.

Scope

Those visitors eligible to make a claim

Those visitors within scope of this SOP, and eligible to make a claim against it, are those who are visiting people who would previously been admitted to the George Bryan Centre, that have now been admitted to St George's Hospital, Stafford.

This will be the decision of the responsible clinician and there will be no right of appeal.

When George Bryan Centre was open, one quarter (25%) of the total number of people admitted to a mental health inpatient bed from the area served by the George Bryan Centre were admitted there. Three quarters (75%) were admitted to somewhere that better met their needs.

Criteria for making a claim

- The visitor should live within south east Staffordshire
- The visitor is in receipt of a benefit or other financial support from the Government. A self-declaration will be required.

Claim period

To support the transition from moving the inpatient service from one location to another, the claim period will be time limited from 1 September 2022 to 31 December 2023 (or on implementation of the long-term solution, whichever is first).

How to make a claim

A visitor should make their claim via the Ward Manager who will ensure that they meet the above criteria.

Evidence of the expense incurred will need to be provided.

Reimbursement rate

If the visitor travelled by taxi, a maximum claim of £20 for a return journey will be reimbursed.

If the visitor has travelled by car, they will be able to claim fuel costs for the difference in the number of miles between their home address and the George Bryan Centre and their home and St George's Hospital.

The reimbursement rate will be 45 pence per mile.

The directions function on Google maps will be used to determine the number of miles. If more than one option is shown, the shortest route will be used. The mileage used to pay the first claim will be applied for each claim subsequent claim.

An example is shown below

Calais Road, Burton upon Trent – George Bryan Centre = 18.9 miles

(accessed 07.09.22: Calais Road, Burton-on-Trent to Plantation Ln, Tamworth - Google Maps)

Calais Road, Burton upon Trent – St George's Hospital = 26.7 miles

(accessed 07.09.22: Calais Road, Burton-on-Trent to St Georges Hospital - Google Maps)

26.7miles – 18.9miles = 7.8 miles.

7.8 miles there and 7.8 miles back.

This visitor will be able to claim 15.6 x 45p = £7.02

Other forms of support

MPFT is committed to supporting individuals with travel arrangements on a case-by-case basis.

Digital devices, including tablets, will be loaned to people on our wards to enable them to speak to people outside of hospital.

A dedicated webpage has been designed to support carers to use digital technology Digital Training and Support :: Midlands Partnership Foundation Trust (mpft.nhs.uk).

Staff are asked to promote this offer and to signpost to the resources.

There are currently several community and voluntary transport schemes running across Staffordshire. Staff are asked to signpost patients and visitors to the following information: Community and voluntary schemes - Staffordshire County Council

Roles and responsibilities

Ward managers - process travel claims in a timely manner.

Process for monitoring compliance and effectiveness

The director of unplanned care will monitor the appropriate ward budgets to check for expenditure against this SOP.

Equality analysis summary

The programme to find the long-term solution to the provision of mental health in-patient services in South East Staffordshire conducted an equality impact assessment (EIA) 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.

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 is shown on the following table

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%

The EIA identified 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.

What should I do if the SOP is not being followed?

Should you be concerned that this SOP is not being followed correctly please refer initially to your manager or their manager. If this is not effective refer to the freedom to speak up SOP for guidance; http://sp.mpft.nhs.uk/library/docs/Freedom%20to%20Speak%20Up%20SOP.pdf

AUGUST 2022

INPATIENT SERVICES FOR ADULTS AND OLDER ADULTS EXPERIENCING SEVERE MENTAL ILLNESS OR DEMENTIA LIVING IN SOUTH EAST STAFFORDSHIRE

WEST MIDLANDS CLINICAL SENATE REPORT AND RECOMMENDATIONS

1. Introduction

The clinical senate review of proposals for inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire was jointly commissioned by Staffordshire CCGs and Midlands Partnership NHS Foundation Trust. Chaired by Professor Neil Gittoes, the review was carried out by a panel of 13 experts from the West Midlands Clinical Senate, most of whom are practicing clinicians. The review took place on 10 June 2022.

The purpose of the review is to offer external clinical assurance on the proposal to provide acute mental health inpatient services for adults with severe mental illness and older adults with severe mental illness or dementia living in south east Staffordshire on a single site: St George's Hospital, Stafford. The clinical senate review and responses to the points raised in its recommendations form an essential part of the preparation for the stage two assurance checkpoint process as set out in NHS England's service change guidance: 'Planning, assuring and delivering service change for patients'.

The report contains five recommendations, which the programme has responded to below.

2 Programme response to recommendations

Recommendation	Programme response
Recommendation 1 - The current use of surplus dementia beds (average 5 out of 12 occupied) are being utilised by functional[1] adult mental health patients; this is considered sub-optimal practice and the panel recommended alternatives should be sought to prevent this from occurring and poor patient experiences for both patient groups.	The bed management function shows beds that are available to the system that a patient can be admitted to and this is a key part of managing patient flow and using resources effectively. The Five Year Forward View and the NHS LTP set out a clear directive that inappropriate out of area placements should be eliminated. Any vacant bed needs to be considered for residents of Staffordshire and Stoke-on-Trent, to avoid the negative impact of any out of area placement. Out of area placements are characterised by a lack of continuity which impacts on the delivery of a safe and effective acute mental health care pathway. Patients are admitted to MPFT and placed based on their needs not necessarily age as this is not always an indicator of frailty or vulnerability. This to ensure continuity of care is provided which is clinically preferable to admitting out of area. If a patient with functional mental illness is admitted to a dementia bed, as there is no Older Adult Acute bed available at that time, MPFT will aim to move the patient to the ward that is better placed to meet their needs as soon as a bed becomes available. While it is not ideal to mix patients in this way, the enhanced community offer aims to ensure that length of stay is kept to a minimum – MPFT is in upper quartile performance when benchmarked against similar trusts for length of stay. While it is not ideal to mix patients in this way, the enhanced community offer aims to ensure that length of stay is kept to a minimum. The Baswich and Bromely wards (older adult and dementia wards) consist of individual rooms with some shared bathroom facilities. These are not purpose built and MPFT are looking to enhance these environments as part of future capital programmes. While the environment may not be purpose built, care is improved from being on a centralised site, as additional needs of an individual or cohort of patients can be supported by flexing staff across wards as required.
Recommendation 2 - The panel recommend a review of the current Crisis Resolution and Home Treatment (CRHT) team to assure themselves	The CRHT is commissioned for all adults (18+) with no upper age limit and therefore there are no gaps to access. MPFT are working to recruit additional staff with older adult training. It is currently undertaking a review of older adult activity data from the past four years to inform the Trust on the resource required to further enhance this service. This

[1] The term 'functional' mental illness applies to mental disorders other than dementia and includes severe mental illness such as schizophrenia and bipolar mood disorder.

Recommendation	Programme response
that there are no barriers to older people accessing the service and that older peoples' needs would be met in the service. This is to ensure that patients that would have ordinarily been admitted to the George Bryan Centre and the dementia ward in Stafford will have alternative community provision for them.	review includes scoping what other trusts have in place and the evidence around CRHT for older people. Early indications from this review are that the home treatment element of the service could be strengthened for older people. MPFT is already working with the voluntary sector to enhance home support services.
Recommendation 3 - The panel recommend utilisation of both real time and process and outcome data are more widely used to both monitor and drive improvements. There is strong positive leadership at MPFT, which is enabling the transformations to take place, however, greater use of data will ensure these remain on track, with progress assessed regularly against a set of agreed process and outcome measures.	The response needs to respond to the following 3 areas: 1) *PROMS - Patient Reported Outcome Measures (PROMs) will be integral to the reporting about the delivery of patient centred care for all mental health services* The pre-consultation business case outlines outcome measures used within MPFT. MPFT has a working group comprising of clinical and BI colleagues meeting regularly to look at both PROMS and reporting needs to ensure that these recommendations are implemented. They also follow guidance from NHSE regarding PROMS and this is being monitored through current CQUIN. 2) *KPI's – the should develop a suite of process and outcome measures, the Trust will be able to monitor more closely the improvements being made and opportunities available. It will also support being able to benchmark performance to peers and enable the identification of unwarranted variation across services and corporate functions. An example on the day was whether the Trust had easy sight of the average wait times to access care in the community teams, with mixed replies being returned – there was no one clear answer or signpost provided.* The mental health outcomes the NHS commissions for are detailed in the pre-consultation business case at Appendices 5a to 5i.

Recommendation	Programme response
	These tables show how Staffordshire and Stoke-on-Trent's mental health services compare with those in the rest of the country. MH181 refers to the whole of Staffordshire and Stoke-on-Trent. 3) *Interoperability of systems - It was noted that digital integration is always a challenge when working across multiple services and organisations, but having appropriate access is imperative to ensure seamless care for patients.* VCSE (Voluntary, community and social enterprise) partner providers contracted by MPFT have been given access to MPFT clinical systems to avoid service users repeating their stories, to allow the updating of progress notes and the seamless transfer of care. We have initiated projects to improve interoperability with GP practices.
Recommendation 4 - The panel recommend engaging with operational and clinical colleagues to understand the need for community sites for staff to use as bases for clinics and to run events. This will support the focus of bringing care closer to home for patients.	Through our CMH transformation commitment we are working on delivering our services closer to home and within community settings. The community mental health team for south-east Staffordshire is based at the Sir Robert Peel hospital. There are mental health services available in Tamworth locality via a range of community venues. We have a solution to provide a Crisis Cafe in Tamworth as well as agreeing shared accommodation opportunities with community and voluntary sector partners. Tamworth Library and Humankind offices in Tamworth are venues that are currently used in the locality. We are delivering our memory services from a church building in Tamworth and holding service user group intervention sessions in local community buildings across the locality. Our integrated mental health teams and specialist pathways are identifying where they can take their services closer to home for service users by utilising alternative and local venues. MPFT is actively working towards bringing Cherry Orchard back online as an adult mental health community venue and the current plan is to deliver this by March 2023 (subject to planning).

Recommendation	Programme response
Recommendation 5 - The panel recommend a review of staffing shortages and recruitment and retention plans to ensure MPFT remains an employer of choice and does not see attrition at a level which will have a detrimental effect on patient care and safety. In addition, ensuring any risks are presented on the relevant risk registers	MH Workforce Strategic Approach v3 MPFT's workforce strategy is attached. It is recognised that recruiting staff is a major challenge. Nursing staff, including mental health nurses, are on the national shortage occupation list. Allied Health Professionals and Band 8A Psychologists are also on the shortage list. This challenge is recognised and is on MPFT's risk register. The strategy has been developed to mitigate this risk. In terms of recruitment to support sustainability, MPFT is currently running a huge recruitment drive. It has employed a talent acquisition specialist to support advertising and seek out people from different employment backgrounds, not just the NHS. There are also two members of staff dedicated to recruitment supporting the operational managers for services across community and inpatients. They are focusing on areas that have had the most challenge in terms of workforce replacement across the whole of mental health inpatient and community services. The transformation funding for the community model also provides more opportunities to contract the voluntary sector to work with the NHS in a more integrated way, working to service specifications and providing holistic non-clinical support in areas such as housing, finance and day-to-day living.

[1] The term 'functional' mental illness applies to mental disorders other than dementia and includes severe mental illness such as schizophrenia and bipolar mood disorder.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 07

Report to:	**Integrated Care Board**						
Date:	**21 December 2023**						
Title:	**Interim aligned assisted conception policy**						
Presenting Officer:	Paul Edmondson-Jones – Chief Medical Officer and Deputy CEO, Staffordshire and Stoke-on-Trent ICB.						
Author(s):	Helen Slater – Associate Director of Transformation, Gina Gill - Transformation Programme Lead, Staffordshire and Stoke-on-Trent ICB						
Document Type:	Policy		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☐	
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	YES					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* Impact is an anticipated net cost saving					
Appendices:	1. Draft interim assisted conception for infertility policy						

(1) Purpose of the Paper:
This report provides an update on the work completed to date to develop an interim aligned assisted conception policy as directed by the ICB Board in September 2022. The paper provides the recommended proposals including the impacts and financial implications identified for discussion and approval by the Board.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Finance and Performance Committee	05/12/2023
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	Involvement activity has been undertaken in line with the requirements of relevant legislation and good practice e.g. NHS Act 2006 Duty to involve, Equality Act 2010, Planning, assuring and delivering service change for patients (2018, inc. 2022 addendum)
CQC or Patient Safety	No
Financial (CFO-assured)	No
Sustainability	No

Workforce or Training	No
Equality & Diversity	No
Due Regard: Inequalities	No
Due Regard: wider effect	No

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why Not required for policy approval – no change to the way patient information is shared* *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☒	☐	☐	*Approved on 02/11/2023*
	QIA	☒	☐	☐	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on 26/09/2023
Has there been Public / Patient Involvement?		☒	☐	☐	Involvement activity undertaken as outlined within the paper.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☐
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

In July 2022, the Women's Health Strategy was published which stated an intention to initiate a national review of fertility provision. The ICB were reviewing proposals for this area at the time as part of the Clinical Policy Alignment programme. The strategy does not provide timelines for the completion of the review or for the release of further guidance and/or mandates.

As a result, the ICB at its Board meeting in September 2022, approved a recommendation to pause further work on the long-term proposals for assisted conception and develop a draft interim aligned policy, in place of the three separate CCG policies, whilst the ICB awaits further national guidance.

This paper outlines the involvement activity undertaken and the process through which the proposals and final recommendations were developed.

(7) Recommendations to Board / Committee:

The ICB Board Meeting is asked to:
BE ASSURED that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders.
NOTE the anticipated financial impact relating to the recommendations.
APPROVE the recommendation to implement the draft interim aligned assisted conception policy across Staffordshire and Stoke-on-Trent.

Assisted Conception for infertility: interim aligned policy
December 2023

1. Executive Summary

1.1. The Clinical Policy alignment programme (previously known as Difficult Decision) was launched in January 2020 and aimed to harmonise the eligibility criteria for five clinical areas across Staffordshire and Stoke-on-Trent. These were;

1.1.1. Assisted Conception
1.1.2. Hearing Loss in Adults
1.1.3. Male and Female Sterilisation
1.1.4. Breast Augmentation and Reconstruction
1.1.5. Removal of excess skin following significant weight loss.

1.2. Following an extensive involvement exercise, the ICB Board meeting on 22 September 2022 approved the proposals for Hearing Loss in Adults, Male and Female Sterilisation, Breast Augmentation and Reconstruction and Removal of excess skin.

1.3. Whilst developing the proposals for assisted conception services for infertility, the Women's Health Strategy (WHS) was released (published in July 2022 and revised in August 2022) which indicated that a review of fertility provision across the UK will be undertaken.

1.4. The strategy does not give an indication of whether ICBs will be expected to implement mandated access criteria however it is clear that the intention is to review geographic variation, address inequities of provision and remove any non-clinical criteria that is currently in place (for example, that people must not have children from previous relationships). There is an expectation that revised NICE guidance will be published in November 2024.

1.5. In light of the publication of the WHS, the ICB Board, during the meeting in September 2022 agreed to separate assisted conception from the wider clinical policy alignment programme and pause further work on the long-term proposals until further guidance is released.

1.6. As the ICB currently works to three different assisted conception policies dependent on where patients live, the September 2022 ICB Board meeting approved the recommendation to develop an interim aligned assisted conception policy for implementation whilst the ICB awaits further directives following the national review of service provision.

1.7. The scope of the policy review was to look at criteria that differs across the three policies retaining criteria that is already aligned and address only those criteria that differ and need to be aligned into a single policy across Staffordshire and Stoke-on-Trent.

1.8. A draft interim aligned policy was developed and patient and public views of the policy were sought through an involvement exercise that was completed in March 2023 in line

with the Integrated Care Board's Duty to Involve.[1] Significant involvement was undertaken through 2020 to 2022 and therefore the aim of this involvement exercise was to add to the feedback previously gathered.

1.9. During a technical event on 23 May 2023, the group formally received the report of findings following the involvement exercise and confirmed they were confident with the process that had been undertaken.

1.10. The group was also asked to consider whether any further involvement activity was required and to consider whether any changes to proposals were required in light of the feedback received. The group confirmed the involvement activity was sufficient and the ICB had reached out via the appropriate channels and received an appropriate level of feedback.

1.11. A series of working groups and technical events were convened in June and July 2023 to review and refine the policy proposals taking into consideration the recommendations from the clinical prioritisation process, the recommendations from the previous options appraisal process and the feedback received through the involvement within the agreed scope of aligning criteria that differs within the current policies and not implementing new criteria.

1.12. The draft interim aligned policy shared during the involvement has been amended to reflect the recommendations from the technical group for approval through the ICBs governance process.

1.13. A quality impact assessment (QIA) was completed for the draft interim aligned policy and was approved at panel on 26 September 2023. The panel recognised the positive impact of aligning criteria and eliminating variation across Staffordshire and Stoke-on-Trent. The panel noted there are both positive and negative impacts that have been taken into consideration through the involvement work and the technical events and appropriate mitigations had been identified through the assessment.

1.14. An equality impact assessment was completed for the draft interim aligned policy. The assessment recognised the positive impact of aligning criteria and eliminating variation across Staffordshire and Stoke-on-Trent. The assessment noted the need for further review in some areas but recognised that the scope of the work was to align criteria that differs, and a review of the entire policy would be undertaken when the updated NICE guidance is received and any national directives are issued.

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[1] The ICB has a statutory duty to involve patients and the public in the planning, development and delivery of local health services. The aim is to ensure the public receives meaningful information to make informed decisions and provide them with the mechanisms to get involved in the commissioning of local health services and influence ICB decisions at the level of participation they choose.

The public sector Equality Duty (2011) means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It also requires that public bodies have due regard to the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations between different people when carrying out their activities

1.15. No material workforce impact was identified through the process or within either the quality or equality impact assessments.

1.16. The anticipated financial impact associated with the draft interim aligned policy is an overall reduction in costs due to the nature of the proposals.

1.17. This paper was presented to the Finance and Performance Committee on 05 December 2023. The committee was assured that a robust process had been taken through the work programme and approved the recommendations within the paper.

1.18. This report provides an update on the work completed to date and the recommended proposals including the impacts and financial implication identified for discussion and approval by the Committee. The ICB Board meeting is asked to:

1.18.1. Be **ASSURED** that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders.

1.18.2. **NOTE** the anticipated financial impact relating to the recommendations.

1.18.3. **APPROVE** the recommendation to implement the draft interim aligned assisted conception policy across Staffordshire and Stoke-on-Trent.

2. Background and context

2.1. Introducing excluded or restricted criteria for any intervention are difficult decisions to make, which is why the ICB has a clinically led prioritisation process.

2.2. Inevitably, as some interventions/services score below the threshold for investment, difficult decisions have to be made; however, using a clinically led prioritisation process based on review of available scientific evidence of effectiveness ensures that where interventions are excluded from commissioning or, where they are prohibitively expensive or in limited supply, restrictive criteria are used to ensure that these interventions are reserved for those most likely to benefit.

2.3. The Integrated Care Board has a process for prioritising the use of the resources available to commission healthcare across Staffordshire and Stoke-on-Trent. This is set out in the Policy on the Prioritisation of Healthcare Resources[2].

2.4. The ICB has a group known as the Clinical Priorities Advisory Group (CPAG), which is a subcommittee of the Finance and Performance Committee. The membership consists of Clinicians, Medicines Optimisations Representatives and Consultant(s) in Public Health (the full terms of reference can be found in the Policy on the Prioritisation of Healthcare Resources). The group considers interventions and services which are referred from the commissioning team. This may be because there is a recognised unmet need and the ICB wishes to identify the best interventions to invest in or, as is the reason in this case, because there is a view that services need to be reviewed.

[2] The Policy on the Prioritisation of Healthcare Resources can be found on the IBC webpage Contents (icb.nhs.uk)

2.5. CPAG undertakes the ranking of healthcare interventions using a scoring system of criteria based on the Portsmouth Scorecard. Interventions are scored by the group against eight criteria that include:

- Strength and quality of evidence – how well does this treatment or service work?
- Magnitude of health improvement benefit for the patient group or population – to what extent does this intervention increase the health gain or life expectancy for the patients/population? Appraise outcome measures e.g. improvement in functionality or of clinical markers for the condition, Quality of Life (QoL), increase in health expectancy.
- Does the intervention prevent a condition or detect a condition which is not yet known (i.e. screening)?
- Supporting people with existing conditions - Does this intervention prevent or reduce complications in people with ongoing conditions?
- How cost effective is the intervention – how much health gain compared to the cost?
- Does it address health inequalities?
- Does it deliver national and/or local requirements/targets?

2.6. CPAG does not make decisions on whether a service should or should not be commissioned. The group makes recommendations which are reviewed by the commissioning teams and taken to the ICB Board meeting for discussion and approval.

2.7. As the policy explains there is a threshold score, and interventions scoring below the threshold will not be considered by the ICB for new investment and where already commissioned, current eligibility criteria will be subject to review.

2.8. This is particularly important given the ICB's challenged financial position and the need to balance the services that are commissioned against their statutory responsibilities to ensure that they operate within their defined budgets and achieve financial balance.

2.9. In 2019, the former six Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs) reviewed eligibility criteria for a range of interventions/procedures with the overarching aim of aligning criteria where there were differences across the CCGs and to review any outstanding recommendations from the CCGs CPAG.

2.10. Significant involvement was undertaken through 2020 to 2022 to develop and refine the proposals for the clinical areas under consideration and a number of proposals were approved at the ICB Board Meeting on 22 September 2023. Further detail of this work, including the report of finding from the public involvement can be found here Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

2.11. Whilst the team was in the process of developing this proposal, the WHS was published which indicated that a review of fertility provision across the UK will be undertaken.

2.12. The ICB review of assisted conception services included proposals to reduce to zero cycles of IVF as this service fell below the threshold for commissioning when considered by the former CCGs Clinical Priorities Advisory Group. The ICB Board

meeting therefore agreed to separate assisted conception from the wider clinical policy alignment programme and pause further work on the long-term proposals until further guidance is released. It is anticipated NICE guidance will be published in November 2024

2.13. As the ICB currently works to three different assisted conception policies dependent on where patients live, the ICB Board meeting approved the recommendation to develop an interim aligned assisted conception policy for implementation whilst the ICB awaits further directives following the national review of service provision.

3. Policy Development and public involvement

3.1. Following approval of recommendations at the ICB Board meeting, the project team, working with clinicians, began to review the current policies and recommended aligned criteria for a single ICB assisted conception policy.

3.2. A draft interim aligned policy was developed and patient and public views of the policy were sought through an involvement exercise that was completed in March 2023 in line with the Integrated Care Board's Duty to Involve (see section 1). Significant involvement was undertaken through 2020 to 2022 and therefore the aim of this involvement exercise was to add to the feedback previously gathered.

3.3. In late 2022, an involvement plan was developed. It set out the involvement aims as being:

3.3.1. to ask the public to view the draft interim aligned policy and comment on whether there was anything that hadn't already been taken into consideration from previous involvement

3.3.2. to ask the public if they could suggest mitigations for any issues they foresaw with the draft interim aligned policy

3.3.3. to communicate key messages about the draft interim aligned policy to the public.

3.4. The plan identified some key groups with protected characteristics that should be proactively engaged with as part of the involvement. This was based on the findings of a 2018 Equalities Impact Assessment on the overarching transformation programme in Staffordshire and Stoke-on-Trent, and a gap analysis that was carried out in 2021.

3.5. The plan set out that the involvement would run for three weeks and include:

3.5.1. an online survey

3.5.2. two online focus group sessions in March – one in the early afternoon and one in the early evening.

3.6. A report of findings was developed by the MLCSU following the involvement activity. A summary of the feedback is outlined below.

3.7. When considering the impact of the draft interim aligned policy, most respondents (102 / 95%) said it would have a negative, or very negative impact, on themselves or others. The key reasons given for this negative response were that:

- the impact of reducing the number of cycles and embryo transfers offered would be negative
- reducing the number of cycles offered goes against NICE guidelines
- the policy excludes specific groups, like same-sex couples, single women and patients with low AMH
- participants felt the policy was discriminatory/unfair
- the policy is not in line with other organisations/NICE guidelines.

3.8. Participants also expressed a need for greater understanding of the draft interim aligned policy, asking for more information around the types of embryo transfer available and how changes will be made in line with NICE guidance.

3.9. Participants made several suggestions about how to avoid the negative impacts. The most frequently mentioned suggestions were:

- providing the number of cycles in line with NICE guidelines
- making sure that the policy is inclusive and fair
- providing more cycles of IVF treatment
- ensuring the policy does not discriminate against certain groups, like same-sex couples, single women and patients with low AMH.

3.10. Further detail on the involvement activity and the full report of findings and summary report of findings can be found on the ICB's webpage Assisted Conception - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

3.11. During a technical event on 23 May 2023, the group formally received the report of findings following the involvement exercise and confirmed they were confident with the process that had been undertaken.

3.12. During the technical event, the group was asked to consider whether any further involvement activity was required and to consider whether any changes to proposals were required in light of the feedback received.

3.13. The group confirmed the involvement activity was sufficient and the ICB had reached out to the appropriate channels and received an appropriate level of feedback.

3.14. A series of working groups and technical events were convened in June and July 2023 to further review and refine the policy proposals taking into consideration the clinical prioritisation process, the recommendations from the previous options appraisal process and the feedback received through the involvement within the agreed scope of aligning criteria that differs within the current policies and not implementing new criteria.

3.15. When considering the proposals and the potential impact, the groups discussed feedback regarding the reduction in provision in some areas. For example, the proposal to reduce the number of cycles in Stoke-on-Trent to align with the other five areas. The groups did consider the potential to increase provision in some of these criteria. However assisted conception was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment. As a result the groups stated it would be inappropriate to increase provision where this applied to the majority

and it was recommended that the initial proposals for alignment were not amended in these areas.

3.16. The group also discussed areas where the ICB had received feedback on criteria but that were already aligned within the three policies. For example, the criteria for same sex male and female couples. The group recognised these areas required further review but as these are currently aligned the groups stated these are outside of scope of the current review and therefore recommended these criteria are not amended at this stage. The recommendation from the groups is that these areas are considered further during a wider review for a substantive policy, which may include further scoring by the ICBs CPAG, once national guidance is released.

3.17. The main area of concern within the public involvement feedback was regarding the number of cycles offered and what constitutes a full cycle e.g. the number of frozen embryo transfers per cycle. The draft interim aligned policy proposes offering one partial cycle of IVF with a fresh or frozen embryo transfer (a partial cycle is where the cycle does not include the transfer of all embryos created during that cycle). As a result, patients in Stoke-on-Trent will see a reduction in provision as currently patients receive two cycles with up to four embryo transfers per cycle.

3.18. The other five geographical areas currently offer one partial cycle with one embryo transfer only therefore there is no reduction in provision in these areas. Within North Staffordshire, the draft interim aligned policy is an improvement to provision where patients are currently only eligible for a fresh embryo transfer only, meaning patients who need a frozen embryo transfer, for example in cases of ovarian hyperstimulation syndrome, would not receive their partial cycle.

3.19. The groups discussed the potential to increase provision and level up to the policy in Stoke-on-Trent, however as this intervention fell below the threshold at Clinical Priorities Advisory Group (CPAG) and the Clinical Policy Alignment programme proposed offering zero cycles of IVF following the options appraisal process, the group stated it would be inappropriate to level up in five of six geographical areas.

3.20. Feedback from the public involvement also challenged the proposed storage time of resultant unused embryos. The ICB had originally proposed a one-year storage time but noted that three years storage is currently offered in the four former CCG areas where one fresh or frozen transfer is offered. The group therefore recommended the proposal is amended to three years funded storage to allow patients time to consider their options with regard to any stored embryos.

4. Summary of proposals

4.1. The draft interim aligned policy shared during the involvement has been amended to reflect the recommendations from the technical group for approval through the ICBs governance process.

4.2. Table 1 below outlines the policy proposals and the impact on each of the geographical areas across Staffordshire and Stoke-on-Trent.

4.2.1. Table 1: Summary of proposals

Proposed criteria	Impact		
	North Staffordshire	**Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsular, Stafford and Surrounds**	**Stoke-on-Trent**
Number of cycles: Commission one partial cycle using fresh or frozen embryo	Addition of frozen embryo transfer – currently commissions fresh embryo transfer only	Unchanged	Reduction from two cycles with up to one fresh and three frozen embryo transfers per cycle
Storage of gametes and embryos as part of IVF: Funded for up to three years.	Currently funded until the end of the year in which the first cycle is completed	Unchanged	Funded for 12 months
Previous IVF cycles: Where couples have previously self-funded, they may receive one NHS cycle provided they have not received more than two compete cycles of privately funded IVF	Currently not eligible where they have previously self-funded any IVF cycles	Unchanged	Currently not eligible where they have self-funded two cycles of IVF. If they have funded one cycle of IVF, they may receive one NHS-funded cycle.
Handling of existing frozen embryos from previous cycles: Criteria removed	Unchanged (not previously listed within the policy)	All stored and viable embryos must be used before a new cycle commences (includes embryos from self-funded cycles)	Unchanged (not previously listed within the policy)
IUI (intra-uterine insemination): Do not commission	Currently commissions three cycles of IUI (in place of IVF if requested)	Unchanged	Unchanged
Age: Women: 23–39 years old Men: no upper age limit	Women – increase in upper age limit from 35 to 39 Men – previous upper age limit of 55	Unchanged	Unchanged

Ovarian reserve: A threshold of AMH >3 will be applied to all women aged 35 or over for access to IVF treatment	Previously no requirement to measure ovarian reserve. However, the policy did not fund IVF where the woman was aged 35 or over.	Unchanged	Previously no requirement to measure ovarian reserve
Single infertile women: Do not commission	Currently, the same criteria is in place as for same-sex female couples. However, in practice the policy requires patients to be in a stable relationship and therefore single women cannot access treatment	Unchanged	Unchanged
Relationship status: Must be in a stable relationship and cohabiting for at least two years	Unchanged	Currently, must have been in a stable relationship for more than two years. Must have been trying to conceive for two years if woman is under 35, and one year if woman is over 35.	Currently, must have been in a stable relationship and cohabiting for at least one year
Duration of infertility: Failure to conceive within 12 months unless there is a known cause of infertility	Currently requires two years	Must have been trying to conceive for two years if woman is under 35, and one year if woman is over 35.	Unchanged
Investigations: Do not apply eligibility criteria	Investigations currently not commissioned if patients do not meet eligibility criteria for IVF	Unchanged	Unchanged
Donor eggs: Donor eggs commissioned in cases of premature ovarian failure, gonadal dysgenesis including Turner syndrome, bilateral oophorectomy, ovarian failure following chemotherapy or radiotherapy	Currently not commissioned within the policy	Unchanged	Currently not commissioned within the policy

Sperm washing: Sperm washing will be commissioned for couples where the male is HIV positive and either he is not compliant with HAART or his plasma viral load is 50 copies/ml or greater. A consultant in Genito Urinary Medicine or Infectious Diseases will be required to confirm the couples suitability for NHS fertility funding. In such cases, prior approval should be sought from the ICB and include all relevant clinical information. Sperm washing is not commissioned for men with hepatitis B or C. Treatment options to support conception should be discussed with patients in line with NICE Guidance (CG156)	Commissioned where the male is HIV positive, however criteria are not provided	Currently not listed in policy	Currently not commissioned
Criteria on alcohol consumption: Treatment may be postponed or denied on other medical grounds not explicitly covered in this document. Consideration should be given to reversible risk factors including lifestyle factors[10] such as excessive alcohol consumption, use of recreational drugs, excessive exercising (in males) prior to the patient being referred for any assisted conception or IVF treatment	Unchanged	Currently not listed within the policy	Currently requires couples to score less than 5 on the Audit C test

as these factors are detrimental to the success of the procedures.			
Welfare of the Child: Couples must conform to the statutory 'Welfare of the Child' requirements	Unchanged	Currently not listed in the policy	Unchanged
Patient registration status: The female patient must be registered with a GP within Staffordshire and Stoke-on-Trent ICB	Requires the female patient to be registered with a North Staffordshire CCG practice.	Not detailed in policy	Currently expects both patients to be registered within Stoke-on-Trent
IVF treatment for seriously injured veterans: Armed forces compensation scheme added as outside of scope of policy.	Currently states patients should receive 3 cycles in line with the Lord Boyce review of the armed forces compensation scheme.	Currently not listed in policy	Currently not listed in policy
Demonstrating infertility: people with a physical disability: Infertility is defined as the failure of a female of reproductive age to conceive after 1 year of regular unprotected vaginal intercourse, in the absence of any known medical cause of infertility. In circumstances	No criteria for patients with a disability who cannot demonstrate infertility through regular unprotected vaginal intercourse	Unchanged	No criteria for patients with a disability who cannot demonstrate infertility through regular unprotected vaginal intercourse

where the above definition cannot be applied (for example a same-sex female couple, infertility may be demonstrated by the failure to conceive after 6 cycles of self-funded donor insemination/IUI during the previous 12 months, undertaken at a Human Fertilisation and Embryology Authority (HFEA) licensed clinic, in the absence of any known reproductive pathology.			

4.3. The scope of the policy review was to align criteria that differs across the three policies that are currently in place. As a result, the above table identifies only the proposed changes to be included within an interim aligned policy. Where criteria are aligned across the three policies, this has not been included in the above table. The full interim aligned policy can be found in Appendix A.

5. Financial and activity implications.

5.1. A review of previous activity was undertaken to understand the financial implications of the recommended proposals.

5.2. Baseline data from 2018/19 is included in Table 2 below. To note, the activity represents the number of cycles undertaken during the year and not number of patients.

5.2.1. Table 2: Baseline activity

	North Staffordshire	Stoke-on-Trent	East Staffordshire	South East Staffordshire and Seisdon Peninsular	Cannock Chase	Stafford and Surrounds	Total
Activity (cycles)	31	64	38	36	20	27	216
Cost	£131,975	£281,409	£147,285	£129,662	£63,141	£122,480	£875,952

5.3. Throughout the involvement, activity data from 2018/19 was utilised due to the artificial suppression of activity through the pandemic and as a result of elective recovery following the pandemic.

5.4. Finance and activity data was retrieved from invoices submitted to the Oracle system during that period. The number of cycles was obtained through a review of all invoices received during the period.

5.5. Recent data (01 July 2022 – 30 June 2023) from the main provider of assisted conception services shows similar activity levels to that of 2018/19 however this has not been utilised as the data cannot be disaggregated by former CCG areas and cannot be used to support the financial modelling.

5.6. Overall, there is an expected cost reduction of £14,020. This is due to the increase in provision in some areas and the decrease in provision in other areas.

5.7. There is no expected financial impact for some elements due to the nature of the proposals. These have been outlined in table 3 below.

5.7.1. *Table 3: Neutral impact*

Criterion	Explanation

Previous IVF cycles	Within North Staffordshire, patients were declined NHS funded treatment if they have previously self-funded any cycles. The amended criterion allows for funding if patients have received up to two previous cycles. There is no evidence that patients have been declined treatment due to this criterion historically and therefore this amendment is not expected to affect activity levels.
Handling of existing frozen embryos	Within South Staffordshire patients were declined NHS funded treatment if they had stored embryos from previous cycles available. This criterion has been removed within the policy however the data review did not identify any patients that had been declined treatment for this reason and therefore no impact is anticipated.
IUI	While this was previously commissioned within North Staffordshire, activity has declined significantly over the years with only one IUI cycle being funded in the last 5 years. In addition, IUI was offered in place of an IVF cycle therefore the amended criterion is not expected to impact activity levels.
Single infertile women	Currently in North Staffordshire the same criteria is in place as for same-sex female couples. However, in practice the policy requires patients to be in a stable relationship and therefore single women have not been able to access treatment historically therefore this amendment is not expected to affect activity levels.
Relationship status	All policies required patients to be in a stable relationship, the amendment is regarding the duration of the relationship therefore there is no expected impact on activity.
Duration of infertility	Whilst the duration of unexplained infertility has been amended in one area, this is not expected to affect activity levels.
Investigations	The North Staffordshire policy states infertility investigations are not commissioned for those who do not meet the criteria for assisted conception IVF. It is assumed however that these patients accessed investigations via a gynaecology referral and therefore no impact is anticipated.
Alcohol consumption	The removal of the audit C test requirement is not expected to impact activity levels as the revised criterion retains the requirement for referrers to provide general advice on lifestyle factors such as smoking, excessive alcohol consumption and recreational drug use. In addition, there is no evidence that referrals have been rejected as a result of the audit c test.
Welfare of the child	Refers to generic advice that is included within the HFEA guidelines for all providers therefore this is not expected to affect activity levels.

Patient registration status	As a single ICB rather than individual ICBs this is not expected to affect activity levels.
IVF for seriously injured veterans	IVF for injured veterans has been provided via NHSE and the compensation scheme historically. This criterion confirms the process and is not expected to affect activity levels.
Sperm washing	While this is commissioned North Staffordshire and not other areas, no activity has been documented therefore minimal activity is expected.
Ovarian reserve	While the aligned policy introduces the requirement for a minimum ovarian reserve for females aged 36-39, there is no evidence that referrals have been rejected due to this criterion being in place in the south therefore no impact on activity is expected.
Demonstrating infertility	While the aligned policy introduces criteria for patients with a physical disability who cannot demonstrate infertility through regular unprotected vaginal intercourse, no activity in the South of the County (where this is currently commissioned) has been identified over the past 5 years. As a result, no impact on activity is expected.

5.8. The elements for which there is a financial impact are shown in Table 4 based on the proposed amendments. This largely relates to the change in number of cycles and embryo transfers for Stoke-on-Trent and the increase in the upper age limit within North Staffordshire.

5.8.1. Table 4: *anticipated financial impact*

Criterion	Activity variance	Cost variance (£)
Number of cycles	-16	(57,696)
Number of embryo transfers	-44	(40,040)
Embryo and gamete storage	79 (additional 2 years storage)	38,710
Upper age limit	10	36,060
Donor eggs	1	8,946
Total Change		**(14,020)**

5.9. Data quality has an impact on the financial predictions. This is due to inconsistencies in how each provider records their data and the lack of contracts and limited data reporting within North Staffordshire and Stoke-on-Trent. Any predictions are therefore made on the available data and the extrapolation of data to a wider cohort.

5.10. A review of historic Stoke-on-Trent invoice data shows that on average 25% of activity within the baseline is second new IVF cycles. This reduction has been applied to identify the number of cycles that will be removed in Stoke-on-Trent in line with the proposal to reduce provision to a single cycle.

5.11. Historic Stoke-on-Trent outcome data was utilised to identify the number of frozen embryo transfers that were funded within the period. The sample covered 26 cycles in total. This was extrapolated out to the total number of cycles per year to provide an estimate of the total frozen embryo transfers funded in Stoke-on-Trent that will be removed from the baseline due to the proposal to offer a single embryo transfer only.

5.12. The revised policy proposes extending embryo storage from one to three years in North Staffordshire and Stoke-on-Trent. Three years storage is currently funded for South Staffordshire. To calculate the activity increase, 16 cycles have been removed from the Stoke-on-Trent baseline (64) to account for second cycles that would no longer be funded under the revised policy. Once added to the cycles commissioned within North Staffordshire this results in 79 cycles where additional storage may be funded.

5.13. Data from a South Staffordshire information request was used to provide the age distribution of the female patients accessing IVF. This showed 25% of the cohort across 3 years of data was aged 36 and above. This increase was applied to the North Staffordshire cohort to understand the financial impact of increasing the upper age limit.

5.14. Due to the variation in costs per IVF cycle dependent on patient needs, an average cost of £3,606 per cycle has been used within the modelling.

6. Impact assessments

6.1. A quality impact assessment (QIA) was completed for the revised interim aligned policy and was approved at panel on 26 September 2023. The panel recognised the positive impact of aligning criteria and eliminating variation across Staffordshire and Stoke-on-Trent. The panel noted there are both positive and negative impacts that have been taken into consideration through the involvement work and the technical events and appropriate mitigations had been identified through the assessment.

6.2. An equality impact assessment was completed for the revised interim aligned policy and approved on 02 November 2023. The assessment recognised the positive impact of aligning criteria and eliminating variation across Staffordshire and Stoke-on-Trent. The assessment noted the need for further review in some areas but recognised that the scope of the work was to align criteria that differs and a review of the entire policy would be undertaken when the updated NICE guidance is received and any national directives are issued.

6.3. Within both assessments, emphasis was placed on the importance of good communication when implementing the policy to confirm what is commissioned and ensure patient expectations are not raised during their clinical pathway.

6.4. The ICB presented the report of findings to the Stoke-on-Trent Adult Social Care, Health Integration and Wellbeing Overview and Scrutiny Committee on 27 November 2023. During the meeting, members noted the potential mental health impact for those who may experience a reduction in service provision. As part of the implementation process, the ICB will need to ensure there is adequate signposting to relevant support where adverse impacts on mental health are identified.

6.5. No material workforce impacts were identified through the process or within either the quality or equality impact assessments.

7. Recommendations

7.1. The ICB Board meeting is asked to:

7.1.1. **BE ASSURED** that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders.

7.1.2. **NOTE** the anticipated financial impact relating to the recommendations.

7.1.3. **APPROVE** the recommendation to implement the draft interim aligned assisted conception policy across Staffordshire and Stoke-on-Trent

8. Next Steps

Activity	Date
Disseminate final interim assisted conception policy to key stakeholders e.g. General practice, secondary care providers, stakeholder identified through the involvement process.	December – January 2024
One month notice of policy change to providers	January 2024
Present final interim aligned policy to Staffordshire and Stoke-on-Trent HOSCs	January - February 2024
Implementation of final interim aligned policy following one month notice period	February 2024
Review contractual arrangements and procurement requirements. To note: any new contract award made after 1st January 2024 must be made under the new Provider Selection Regime[3]	February 2024 onwards

[3] NHS England » The Provider Selection Regime: draft statutory guidance

Commissioning Policy

Assisted Conception for infertility

Revised DRAFT

November 2023

Policy Folder & Policy Number	Commissioning
Version:	Revised DRAFT
Ratified by:	Integrated Care Board Meeting
Date ratified:	TBC
Name of originator/author:	Senior IFR/Improvement Manager
Name of responsible committee/individual:	Finance and Performance Committee
Date approved by Committee/individual	TBC
Date issued:	TBC
Review date:	December 2024
Date of first issue	Pre- April 2013
Target audience:	NHS and partnering agencies, health, and care professionals; general public

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
ICB clinical and programme leads	Internal working group	28 September 2022
ICB clinical and programme leads	Internal technical group	23 May 2023
ICB clinical and programme leads	Internal working group	09 June 2023
ICB clinical and programme leads	Internal working group	13 June 2023
ICB clinical and programme leads	Internal technical group	18 July 2023

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
Finance and Performance Committee	TBC

VERSION CONTROL

Version	Version/Description of amendments	Date	Author/amended by
DRAFT	Alignment of former CCG policies into single ICB interim policy	February 2023	Gina Gill Jackie Newman
Revised draft	Revisions to aligned interim policy	November 2023	Gina Gill

Impact Assessments – available on request

	Stage	Complete	Comments
Equality Impact Assessment	1	26/09/2023	Assessment approved
Quality Impact Assessment	1	02/11/2023	Assessment approved
Privacy Impact Assessment	N/A		

Version Number	Date	Outline of Amendments
Initial Draft	February 2023	Amalgamation of the following assisted conception policies: • Commissioning Policy for In Vitro Fertilisation (IVF)/Intracytoplasmic Sperm Injection (ICSI) within Tertiary Infertility – Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds Clinical Commissioning Groups • Commissioning Policy for Assisted Conception – Stoke-on-Trent Clinical Commissioning Group • Infertility and Assisted Reproduction Commissioning Policy and Eligibility Criteria – North Staffordshire clinical Commissioning Group
Revised Draft	November 2023	Revised criteria for the following: • Donor Eggs • Alcohol Consumption • Storage of gametes and embryos as part of IVF • Handling of existing frozen embryos from previous cycles • Sperm Washing • Identified cause/duration of infertility • Appendix A (removed) Abbreviations and Definitions updated Update to reflect outcome of impact assessments.

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1. Abbreviations and definitions

Blastocyst	A stage within embryo development – this is usually 5 to 7 days after an egg has been fertilised
BMI	Body Mass Index – this is calculated by you weight in kilograms divided by the square of your height in meters
CCG	Clinical Commissioning Group - The organisation previously responsible for funding and planning local NHS services which was replaced by ICBs on 01 July 2022
Cryopreservation	The freezing and storage of eggs, sperm or embryos for future use in assisted conception treatment cycles
Cycle	A treatment cycle of IVF which may include ovulation induction, egg retrieval, fertilisation and embryo transfer. Full cycle: includes the above plus the transfer of all embryos created during that cycle. Partial cycle: where a cycle does not include the transfer of all embryos created during that cycle.
DI	Donor Insemination
Embryo	An egg fertilised by sperm which is in the early stage of development.
Fertility Preservation	Involves storing egg, sperm or embryos with the aim of having biological children in the future.
Gamete	Male (sperm) or female (egg) reproductive cells
GUM	Genito Urinary Medicine
HAART	Highly Active Antiretriviral Therapy – a medication regime used to manage and treat HIV
Hepatitis	Hepatitis is an inflammation of the liver that is caused by a variety of infectious viruses and noninfectious agents leading to a range of health problems. In this document hepatitis refers to inflammation caused by strains of the hepatitis virus, referred to as types A,B,C,D and E.
HFEA	Human Fertilisation and Embryology Authority – UK's independent regulator overseeing the use of gametes and embryos in fertility treatment and research
HIV	Human immunodeficiency virus
ICSI	Intracytoplasmic Sperm Injection – a single sperm is injected into the egg
ICB	Integrated Care Board – The organisation responsible for funding and planning local NHS services.
IFR	Individual Funding Request – The ICBs process for applications for services/treatments that are not routinely commissioned. Patients must demonstrate exceptionality to secure funding.
Infertility	In the absence of known reproductive pathology, infertility is defined as failure to conceive after regular unprotected sexual intercourse. Infertility can be defined as primary, for people who have never conceived, or secondary, for people who have previously

	conceived
IUI	Intra-Uterine insemination – insemination of sperms into a woman's uterus
IVF	In Vitro fertilisation – patients eggs and her partners sperm are collected and placed together within a laboratory setting to achieve fertilisation outside of the body. The embryos produced are then transferred to the female patient.
NHS England	The organization that provides national leadership for the NHS and is responsible for funding and planning some complex and specialised services
NICE	National Institute of Health and Care Excellence – an independent organisation responsible for providing evidence based national guidance on promoting good health and preventing and treating ill health
Oocyte	A female reproductive cell (an egg)
Ovarian Reserve	This indicates the amount of eggs a female has remaining in the ovaries for pregnancy
Ovulation	Ovulation is when a mature egg is released from the ovary.
Ovulation Induction	Hormone therapy that can help females ovulate if this does not happen naturally or where this happens irregularly.
PGD	Pre-implantation Genetic Diagnosis
SET	Single Embryo Transfer
SSR	Surgical Sperm Retrieval – a surgical process to extract sperm in men who do not release these naturally in their ejaculate

2. Introduction

2.1. This policy sets out the criteria for access to specialist fertility services for the population of Staffordshire and Stoke-on-Trent, specifically the entitlement to In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI). Access to fertility services is governed by the same principles of all other services, namely clinical effectiveness, cost effectiveness and the outcomes of the ICB's annual Joint Strategic Needs Assessment.

2.2. The main aim of this policy is to assist couples with primary infertility as diagnosed by a clinician and is based on the principles that fertility services must be commissioned from centres with better than national average rates and that the patient eligibility criteria should reflect the highest probability of success from assisted conception techniques in line with the clinical evidence base.

2.3. The intention of this policy is to set out the commissioning arrangements for fertility services in a manner that is clear, fair and transparent, and the criteria has been developed in line with clinical evidence taking in account the success rates of fertility treatments and the impact that different factors have on this. This paper should be read in conjunction with the following supporting evidence:

- The National Institute for Health and Care Excellence (NICE) Clinical Guideline CG156 'Fertility problems: assessment and treatment' (2013) available on their website at Overview | Fertility problems: assessment and treatment | Guidance | NICE
- The Human Fertilisation and Embryology Authority (HFEA) document 'The Possible Best Start to Life' (2007) Our campaign to reduce multiple births | HFEA
- The Human Fertilisation and Embryology Authority Act 2008 Human Fertilisation and Embryology Act 2008 (legislation.gov.uk)
- The Human Fertilisation and Embryology Authority Code of practice 2021 Code of Practice 9th edition – revised October 2021 (hfea.gov.uk)
- The National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary: Infertility (2018) Infertility | Health topics A to Z | CKS | NICE

3. Scope

3.1. Within scope of the policy

3.1.1. This policy sets out the eligibility criteria for access to specialist fertility services within tertiary care only. Further detail on the wider care pathway is included in section 5.

3.1.2. This policy is specifically for those couples with primary infertility, where neither member of the relationship has a living child from their current or any previous relationships, regardless of whether the child resides with them or not. This includes any legally adopted child within their current or previous relationships but does not include any foster children.

3.1.3. Staffordshire and Stoke-on-Trent ICB will fund the following assisted conception techniques regulated by the HFEA for patients who meet the eligibility criteria

outlined in section 6;

3.1.3.1. In Vitro Fertilisation (IVF)

3.1.3.2. Intracytoplasmic Sperm Injection (ICSI)

3.1.3.3. Gamete and embryo cryopreservation

3.2. Outside of scope of the policy

3.2.1. This policy does not cover armed forces personnel and their families who are eligible for funding via NHS England[1].

3.2.2. Armed forces personnel who are in receipt of compensation for loss of fertility (received as a result of service/partner of same) and require access to assisted conception treatments are covered under the armed forces compensation scheme awards and outside of the scope of this policy.[2] .

3.2.3. In general, patients who are subject to the immigration surcharge are not eligible for NHS-funded assisted conception services. Providers are expected to comply with government guidance regarding these patients.[3]

3.2.4. Pre-implantation genetic diagnosis (PGD) is not covered by this policy as it is the commissioning responsibility of NHS England,[4]

3.2.5. The eligibility criteria do not apply to the use of assisted conception techniques other than infertility, for example in families with serious inherited diseases where IVF is used to screen out embryos carrying the disease or to preserve fertility for someone about to undergo treatment that may render them infertile.

3.2.6. Surgical Sperm retrieval is not covered by this policy as it is the commissioning responsibility of NHS England[5]

3.2.7. This policy will not provide fertility treatment for couples where their infertility arises wholly or partly from sterilisation in either partner. Sterilisation is offered within the NHS as an irreversible method of contraception.

3.2.8. The revised NICE Clinical Guideline on fertility problems[6] states that there is no apparent health benefit from Intra Uterine Insemination (IUI) and there are potential risks associated with IUI both with and without stimulation when compared with expectant management (i.e. encouraging conception through unprotected vaginal intercourse). In light of this recommendation and the evidence of a poor response rate, the ICB will not fund IUI, either with or without ovarian stimulation. Cases may be considered via the ICB's Individual Funding Request route but must demonstrate robust, clinical exceptionality.

3.2.9. The eligibility criteria set out in section 6 only apply to access to assisted

[1] NHS commissioning » Health and Justice and Armed Forces service specific policies (england.nhs.uk)
[2] Armed Forces Compensation Scheme (AFCS) - GOV.UK (www.gov.uk)
[3] Overseas NHS visitors: implementing the charging regulations - GOV.UK (www.gov.uk)
[4] NHS commissioning » E09. Specialised women's services (england.nhs.uk)
[5] NHS commissioning » Specialised Cancer Surgery (england.nhs.uk)
[6] Overview | Fertility problems: assessment and treatment | Guidance | NICE

conception services. There are no restrictions for patients requiring fertility investigations in secondary care.

4. Epidemiology[7]

4.1. Infertility is defined as the period of time people have been trying to conceive without success after which formal investigation is justified and possible treatment implemented.

4.2. Fertility problems are common in the UK and affect around one in seven couples. It is estimated that 84% of couples will conceive within one year if they do not use contraception and have regular sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate of c.92%). The remaining 8% of couples will be unable to conceive without medical intervention and will be considered to be infertile.

4.3. The main causes of infertility in the UK are (percentage figures indicate approximate prevalence):

- unexplained infertility (no identified male or female cause 25%)
- ovulatory disorders (25%)
- tubal damage (20%)
- factors in the male causing infertility (30%)
- uterine or peritoneal disorders (10%).

4.4. In about 40% of infertility cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role. Given the range of causes of fertility problems, the provision of appropriate investigations is critical. These investigations include semen analysis; assessment of ovulation, tubal damage and uterine abnormalities; and screening for infections such as *Chlamydia trachomatis* and susceptibility to rubella.

4.5. Infertility can be defined as primary, i.e. for people who have never conceived, or secondary, for people who have previously conceived.

5. Care Pathway

5.1. Treatment for infertility problems should include drugs, surgery, lifestyle advice and assisted conception techniques such as IVF. Counselling should also be offered in relation to the impact that this treatment can have on a couple's life.

5.2. The care pathway for infertility begins in primary care where the first stage of treatment generally comprises the provision of counselling and lifestyle advice to increase the chance of conception happening naturally (expectant management). If this is not effective, initial assessment such as semen analysis should take place.

5.3. If appropriate, the couple may then be referred to secondary care services where further investigations will be carried out and, potentially, treatment offered, such as hormonal drugs to stimulate ovulation. If this is unsuccessful or inappropriate and the couple satisfy

[7] Causes of infertility | Background information | Infertility | CKS | NICE

the ICB's eligibility criteria, they may be referred to tertiary care for assessment for assisted conception techniques such as IVF and ICSI.

5.4. Tertiary services include ICSI and IVF. All tertiary centres providing this service must be licensed with the HFEA in order to be commissioned under this policy. Other assisted reproduction and fertility services are not routinely commissioned.

6. General Access criteria for infertility services

6.1. Couples should only be referred into tertiary care for assisted conception treatment if they meet all the eligibility criteria listed below and when all appropriate tests and investigations have been successfully completed in primary care and in secondary care in line with NICE CG156[8].

6.2. Referrers must ensure patients are aware of the requirements for initial investigations and potential secondary care treatment and the timing implications of these. These stages may take up to 12 months before a referral to tertiary services can be completed. Referrers must be aware that if these early stages are not initiated with sufficient time prior to the woman's 39th birthday, patients may be ineligible for tertiary services.

6.3. Couples who do not meet the eligibility criteria but may have exceptional clinical circumstances should submit their requests for consideration of funding through the ICB's Individual Funding Requests (IFR) process[9].

6.4. The referring clinician must ensure that patients are aware of the implications of IVF/ICSI treatment, and the commitment required, before making a referral to tertiary care for assisted conception. If there is any doubt over the couple's ability to make the necessary commitment to comply with the treatment regime, they must be referred for counselling, in the first instance, to establish whether assisted conception is appropriate for them.

Criteria	Description
1. Female's Age	Any treatment cycle will not be commenced if the patient is less than 23 years of age but a referral into tertiary care must be made before the female reaches her 39th birthday. Females aged 35 – 39 years will be offered treatment **provided** their predicted ovarian reserve is found to be satisfactory, since this provides useful information regarding likely response to treatment. Although there is continuing debate around the most effective test, AMH is the test of choice for many providers since it has been found to be reliable and can be performed at any stage of the cycle. An AMH >3 will be required for all females 35 years or over for access to IVF treatment. Females who are likely to be above the age of 39 at the point of entering tertiary care may be referred for tests/investigations in secondary care but should be advised that it is unlikely they will be

[8] Overview | Fertility problems: assessment and treatment | Guidance | NICE

[9] Individual Funding Requests - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

	eligible for NHS funded IVF/ICSI in tertiary care due to the time required for any secondary care tests and/or treatments. It is the responsibility of service providers to ensure that couples meeting the eligibility criteria have been referred into tertiary care for their IVF/ICSI treatment **before the 39th birthday** of the female undergoing treatment. If the patient does not undergo their treatment within the 6 months following their 39th birthday they will no longer be eligible for NHS funding.
2. Female's Body Mass Index (BMI)	Obesity and smoking reduce fertility and increase risks to mother and baby during pregnancy. The woman should have a BMI between 19 and 30 (measured in a clinical setting) at the time of commencing treatment within tertiary care. Females who are overweight or underweight will be offered referral to dieticians/lifestyle interventions in order to improve their BMI. A BMI below 30 is a requirement as there is evidence to show that oocyte collection rates are significantly lower and early pregnancy loss rates are significantly higher, in females with BMI of 30 or more, compared with those with BMI less than 30. Females with a BMI of less than 19 and greater than 30 will not be funded.
3. Male's age	There is no upper age limit for the male partner as there is limited evidence to suggest sperm quality deteriorates with age.
4. Identified cause/duration of infertility	Couples who have an identified medical cause for their fertility problems OR have infertility of at least 1 year duration The aim of this policy is to assist people with primary infertility. Therefore patients with secondary infertility (i.e. where someone has had one or more pregnancies in the past) will not be eligible for NHS funded assisted conception Infertility is defined as the failure of a female of reproductive age to conceive after 1 year of regular unprotected vaginal intercourse, in the absence of any known medical cause of infertility. In circumstances where the above definition cannot be applied in: • same sex female couples, • those unable to have vaginal intercourse due to a clinically diagnosed physical disability Infertility may be demonstrated by the failure to conceive after 6 cycles of self-funded donor insemination/IUI during the previous 12 months, undertaken at a Human Fertilisation and Embryology Authority (HFEA) licensed clinic, in the absence of any known reproductive pathology.

	• For same sex female couples, where only one partner is infertile, clinicians should discuss the possibility of the other partner trying to conceive before proceeding to interventions involving the infertile partner • The ICB will **not** routinely fund donor sperm but will fund the associated IVF/ICSI treatment for patients meeting the eligibility criteria within this policy. Patients wishing to access donor sperm treatments must fund this themselves and are advised to check with the assisted conception provider to ensure HFEA guidelines are met before accessing donated sperms • For patients who have been having regular unprotected sexual intercourse with a male for a minimum of 1 year in an attempt to conceive would have to have medical proof that the male had no fertility issues prior to commencing on an infertility pathway. **Same sex male couples** Same sex male couples will not be able to access fertility treatment within their relationship but may be eligible for some assistance if there are medical infertility issues in both partners and both partners fit the above criteria for funding. These cases will considered via the Individual Funding Request process on the basis of exceptionality.
5. Previous IVF Treatment	Where couples have previously self-funded, they may receive 1 NHS cycle provided they have not received more than 2 complete cycles of privately funded treatment The partner of a prospective mother who has undertaken NHS funded fertility treatment, whether successful or not, will be deemed to have received their entitlement to NHS funded fertility treatment upon completion of this cycle and will not be eligible for additional cycles with their partner **or** any future partners. This is not applicable where same–sex couples or couples with a physical disability have self-funded donor insemination/IUI for the purpose of demonstrating infertility in line with criterion 4 above.
6. Previous sterilisation	Couples are ineligible if previous sterilisation has taken place in either partner, even if it has been reversed
7. Relationship	Couples should be in a stable relationship of at least two years duration and should be married, or cohabiting, with each other. Couples should also be seen together within primary, secondary and tertiary services as fertility treatment concerns both partners. The referring clinician must ensure that couples are aware of the implications of IVF treatment and the commitments required before making a referral for assisted conception.
8. GP Registration	The female partner must be registered with a Staffordshire and

	Stoke-on-Trent ICB General Practice.
9. Parental status	Couples must not have a living child from their current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationship. Once accepted for treatment, should a child be adopted or a pregnancy leads to a live birth the couple will no longer be eligible for treatment. Foster children are not included within this criterion
10. Smoking Status	Where couples smoke, only those who agree to take part in a supportive programme of smoking cessation will be accepted on any assisted conception or IVF waiting list and should be non-smoking for at least 28 days at the time of commencing investigations within secondary care. Patients must continue to be non-smoking throughout treatment within tertiary care. Providers may obtain evidence through testing, and confirmation from each partner. Providers will also include this undertaking on the consent form and ask each partner to acknowledge that smoking will result either in cessation of treatment or treatment costs being applied.
11. Lifestyle factors	Women who are trying to become pregnant should be informed not to drink more than 1 or 2 units of alcohol once or twice per week and to avoid episodes of intoxication. This will reduce the risk of alcohol related harm in a developing foetus. Men should be informed that excessive alcohol intake is detrimental to semen quality. Treatment may be postponed or denied on other medical grounds not explicitly covered in this document. Consideration should be given to reversible risk factors including lifestyle factors[10] such as excessive alcohol consumption, use of recreational drugs, excessive exercising (in males) prior to the patient being referred for any assisted conception or IVF treatment as these factors are detrimental to the success of the procedures.
12. Child welfare	The welfare of any resulting child is paramount. In order to take into account the welfare of the child, consideration should be given to factors that are likely to cause serious psychological or medical harm to the child that is born. Consideration should be given to any alcohol or substance misuse by the couple. The above are a requirement of the HFEA and the following HFEA guidance should be used when making these decisions: Read the Code of Practice

[10] Causes of infertility | Background information | Infertility | CKS | NICE

	| HFEA
13. Sperm washing	Sperm washing will be commissioned for couples where the male is HIV positive and either he is not compliant with HAART or his plasma viral load is 50 copies/ml or greater. A consultant in Genito Urinary Medicine or Infectious Diseases will be required to confirm the couples suitability for NHS fertility funding. In such cases, prior approval should be sought from the ICB and include all relevant clinical information. Sperm washing is not commissioned for men with hepatitis B or C. Treatment options to support conception should be discussed with patients in line with NICE Guidance (CG156)

7. Commissioned Services

7.1. IVF/ICSI

7.1.1. Staffordshire and Stoke-on-Trent ICB will commission ONE funded partial cycle of IVF/ICSI for couples with unexplained fertility, mild endometriosis or mild male factor infertility taking into account patient choice.

7.1.2. One partial cycle of IVF/ICSI treatment is defined as one fresh cycle including ovulation induction, egg retrieval, fertilisation and one embryo transfer where viable embryos are available. A cycle includes appropriate diagnostic tests, scans and pharmacological therapy.

7.1.3. As part of the partial cycle, the ICB will fund either one fresh, blastocyst or frozen transfer.

7.1.4. Where no viable embryos are available for transfer, a partial cycle is deemed complete following egg retrieval.

7.1.5. The ICB will not fund any subsequent frozen embryo transfers following the initial fresh, blastocyst or frozen embryo transfer.

7.2. Cancelled Cycles

7.2.1. A cancelled cycle is defined by NICE as ‘egg collection not undertaken’. Where IVF is charged by providers as an inclusive price, a cancelled cycle will not be charged. Couples will be eligible for one cancelled cycle as part of their NHS treatment where the cycle is cancelled for medical reasons. Cycles cancelled for social reasons are considered a treatment attempt and no further cycles will be funded.

7.3. Donor Sperm

7.3.1. The ICB will not routinely fund donor sperm but will fund the associated IVF/ICSI treatment in line with the eligibility criteria within this policy providing the sperms meet the criteria set out by the treating provider unit. Patients wishing to access donor sperm treatments must make their own arrangements but are advised to check with the treating provider unit to ensure HFEA guidelines before accessing donated sperms.

7.4. Donor Eggs

7.4.1. Oocyte donation may be commissioned as part of a cycle in cases where it is clinically appropriate;

7.4.1.1. Prematrue ovarian failure

7.4.1.2. Gonadal dysgenesis including Turner Syndrome

7.4.1.3. Bilateral oophorectomy

7.4.1.4. Ovarian failure following chemotherapy or radiotherapy

7.4.2. NHS funding would not normally be available for women outside these groups who do not respond to follicular stimulation

7.4.3. Oocyte donations will be sourced by the provider

7.5. Surgical Sperm Retrieval

7.5.1. Surgical sperm retrieval (SSR) is the funding responsibility of NHSE and therefore will not be funded by the ICB[11].

7.6. Egg and Sperm Storage

7.6.1. Embryo and gamete storage will be funded for patients fitting the ICB's eligibility criteria and undergoing NHS funded assisted reproduction treatment in line with this policy for a total of 3 years. Costs relating to the continued storage of the embryos beyond the initial 3 years of cryopreservation will become the responsibility of the patients.

7.6.2. The ICB will not separately fund any additional cycles of IVF/ICSI or frozen embryo transfers to utilise stored embryos or gametes following the completion of patients' NHS funded partial cycle.

7.7. Fertility Preservation

7.7.1. Cryopreservation of gametes will be available to all patients undergoing medical treatment that may render them infertile. Any funding requests for cryopreservation will be subject to prior approval. There is no lower age for eligibility under these circumstances. The ICB will pay for storage for a maximum of 5 years. After this period, patients wishing to continue to store may self-fund in line with HEFA Guidance.

7.7.2. Freezing method - Where oocytes are being preserved, the ICB will only fund freezing by vitrification. Other methods of freezing oocytes are not routinely funded.

[11] NHS commissioning » Specialised Cancer Surgery (england.nhs.uk)

7.7.3. Patients wishing to use stored gametes must meet the eligibility criteria within this policy at the time of application for assisted conception in an NHS setting.

7.8. Single Embryo Transfer

7.8.1. Multiple Births are associated with greater risk to mothers and children and the HFEA therefore recommends that steps are taken by providers to minimise multiple births.

7.8.2. Patients will receive a single embryo transfer (whether fresh or frozen) in line with NICE guidance, unless there is a clear clinical justification for not doing so. A maximum of 2 embryos will be transferred per procedure (either fresh or frozen).

7.8.3. For females aged between 37-39 years double embryo transfer may be considered if no top-quality embryo is available.

7.8.4. All providers are required to have a multiple birth minimisation strategy in line with the HFEA Code of Practice[12], .

7.9. Surrogacy

7.9.1. Surrogacy will not be routinely funded by the ICB. Cases will be considered via the ICB's Individual Funding Request route and must demonstrate exceptionality.

7.10. Risks associated with assisted conception methods

7.10.1. Risks such as the chance of multiple pregnancies and a slightly higher risk of ectopic pregnancy should be clearly explained to couples prior to them deciding to embark on any assisted reproduction pathway.

7.11. Armed Forces Covenant

7.11.1. Staffordshire and Stoke-on-Trent has signed the Armed Forces Covenant which 'sets a framework for how the Armed Forces Community can expect to be treated' but recognises that 'it is not possible to specify in detail how it should be applied in every case and at every time'.

7.11.2. The Covenant states that "special consideration" for accessing services may be "appropriate in some cases, especially for those who have given most such as the injured and the bereaved". Where veterans do not meet the criteria for treatment as outlined within this policy, clinicians should seek prior approval from the ICB where consideration will be given to applications in line with the Covenant.

[12] Code of Practice 9th edition – revised October 2021 (hfea.gov.uk)

Bibliography

Cannock Chase Clinical Commissioning Group, East Staffordshire Clinical Commissioning Group, South East Staffordshire and Seisdon Peninsular Clinical Commissioning Group and Stafford and Surrounds Clinical Commissioning Group (CCG) (2019) *Commissioning policy for In Vitro Fertilisation (IVF)/Intracytoplasmic Sperm Injection (ICSI) within Tertiary Infertility.* Available at: Our publications and policies - Staffordshire and Stoke-on-Trent (icb.nhs.uk) (Accessed 27 February 2023)

Department of Health (2023) *Guidance on implementing the overseas visitor charging regulations.* Available at: Overseas NHS visitors: implementing the charging regulations - GOV.UK (www.gov.uk) (Accessed 24 February 2023)

Department of Health (2009) *Regulated Fertility Services: A commissioning aid.* Available at [ARCHIVED CONTENT] Regulated fertility services: a commissioning aid - June 2009 : Department of Health - Publications (nationalarchives.gov.uk) (Accessed 24 February 2023)

Human Fertilisation and Embryology Authority (HFEA) (2021) *Code of practice.* 9th edn. Available at: Read the Code of Practice | HFEA (Accessed 24 February 2023)

Ministry of Defence (2022) *Armed Forces Compensation Scheme.* Available at: Armed Forces Compensation Scheme (AFCS) - GOV.UK (www.gov.uk) (Accessed 24 February 2023)

National Institute for Health and Care Excellence (NICE) (2017) *Fertility problems: assessment and treatment.* Clinical guideline [CG156]. Available at: Overview | Fertility problems: assessment and treatment | Guidance | NICE (Accessed 24 February 2023)

National Institute for Health and Care Excellence (NICE) (2018) *Infertility.* Clinical Knowledge Summary. Available at: Infertility | Health topics A to Z | CKS | NICE. (Accessed 24 February 2023)

NHS England (2014) *Clinical Commissioning Policy: Assisted Conception.* Available at: NHS commissioning » Health and Justice and Armed Forces service specific policies (england.nhs.uk) (Accessed 24 February 2023)

NHS England (2014) *Clinical Commissioning Policy: Pre-implantation Genetic Diagnosis (PGD)* Available at: NHS commissioning » E09. Specialised women's services (england.nhs.uk) (Accessed 24 February 2023)

NHS England (2016) *Surgical sperm retrieval for male infertility.* Available at: NHS commissioning » Specialised Cancer Surgery (england.nhs.uk) (Accessed 24 February 2023)

North Central London Integrated Care Board (ICB) (2022) *Fertility Policy*. Available at: Fertility Services - North Central London Integrated Care System (nclhealthandcare.org.uk) (Accessed 27 February 2023)

North Staffordshire Clinical Commissioning Group (CCG) (2020) *Infertility and Assisted Reproduction Commissioning Policy and eligibility Criteria.* Available at: Our publications and policies - Staffordshire and Stoke-on-Trent (icb.nhs.uk) (Accessed 27 February 2023)

Schmidt L. Infertility and assisted Reproduction in Denmark. Epidemiology and psychosocial consequences. Dan Med Bull. (2006) Nov;53 (4):390-417

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) (2022) *Individual funding Request Policy.* Available at: Our publications and policies - Staffordshire and Stoke-on-Trent (icb.nhs.uk) (Accessed 24 February 2023)

Stoke-on-Trent Clinical Commissioning Group (CCG) (2022) *Commissioning policy for assisted conception.* Available at: Our publications and policies - Staffordshire and Stoke-on-Trent (icb.nhs.uk) (Accessed 27 February 2023)

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 08

Report to:	**Integrated Care Board**					
Date:	**21 December 2023**					
Title:	**SSOT Quality Strategy**					
Presenting Officer:	J Spencer					
Author(s):	Cath Marsland					
Document Type:	Strategy					
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☒	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Draft Quality Strategy Delivery Plan for info					

(1) Purpose of the Paper:
SSOT three year Quality Strategy for Approval following stakeholder and public consultation. Approved at Quality and Safety Committee Nov 2023 for Ratification here.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Quality and Safety Committee	08/11/2023
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	Quality is the golden thread that runs through the ICB legal requirements
CQC or Patient Safety	Demonstrates Commitment to and journey to improve patient safety and experience
Financial (CFO-assured)	None known
Sustainability	Encourages working collectively and sustainably
Workforce or Training	Implications on training already agreed PSIRF
Equality & Diversity	Is system wide for all users
Due Regard: Inequalities	nil
Due Regard: wider effect	nil

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☒	☐	☐	Public sharing of document in draft for comment

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

Quality Strategy developed by ICB and NHS partners for approval. Decribes quality aims for next three years.
Associated delivery plan which will be taken to QSC for approval Febuary 24 and for ratification to Board March 24
Quality Strategy will be required to be addd to ICB Public facing page.

(7) Recommendations to Board / Committee:

Request for ratification as a Strategy

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

ICB Quality Strategy 2023 - 2026

"Quality must be the organising principle of our health and care service."

National Quality Board 2016

October 2023

Table of Contents

1.Introduction

The **Staffordshire and Stoke on Trent Integrated Care Board** was formed on a statutory basis by the **Staffordshire and Stoke-on-Trent Integrated Care System**.

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) brings together a range of partners who are responsible for planning and delivering health and care and for improving the lives of people who live and work in our area. The ICS is the geographical area in which health and care organisations work together.

The purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare.
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money.
- help the NHS support broader social and economic development.

The Health and Care Act 2022 created a statutory basis for ICSs by creating a statutory Integrated Care Partnership (ICP) and an NHS Integrated Care Board (ICB) for each ICS. The formation of an Integrated Care System (ICS) leads to an expectation of a strong and effective care system, which sees partners working together to meet health and care needs across the county.

The Staffordshire and Stoke on Trent Integrated Care Board (ICB) holds responsibility for planning NHS services, including those previously planned by Clinical Commissioning Groups (CCGs), managing the NHS budget, and arranging for the provision of health services.

The national definition of an Integrated Care Board (ICB) is a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.

This system wide ICB working extends the definition of quality across all partner services and facilitates a focussed and robust emphasis on quality, viewed through a population health and health inequalities lens. It also affords the opportunity for a greater focus on Quality Improvement (QI) activities and joint accountability for the quality and safety of services.

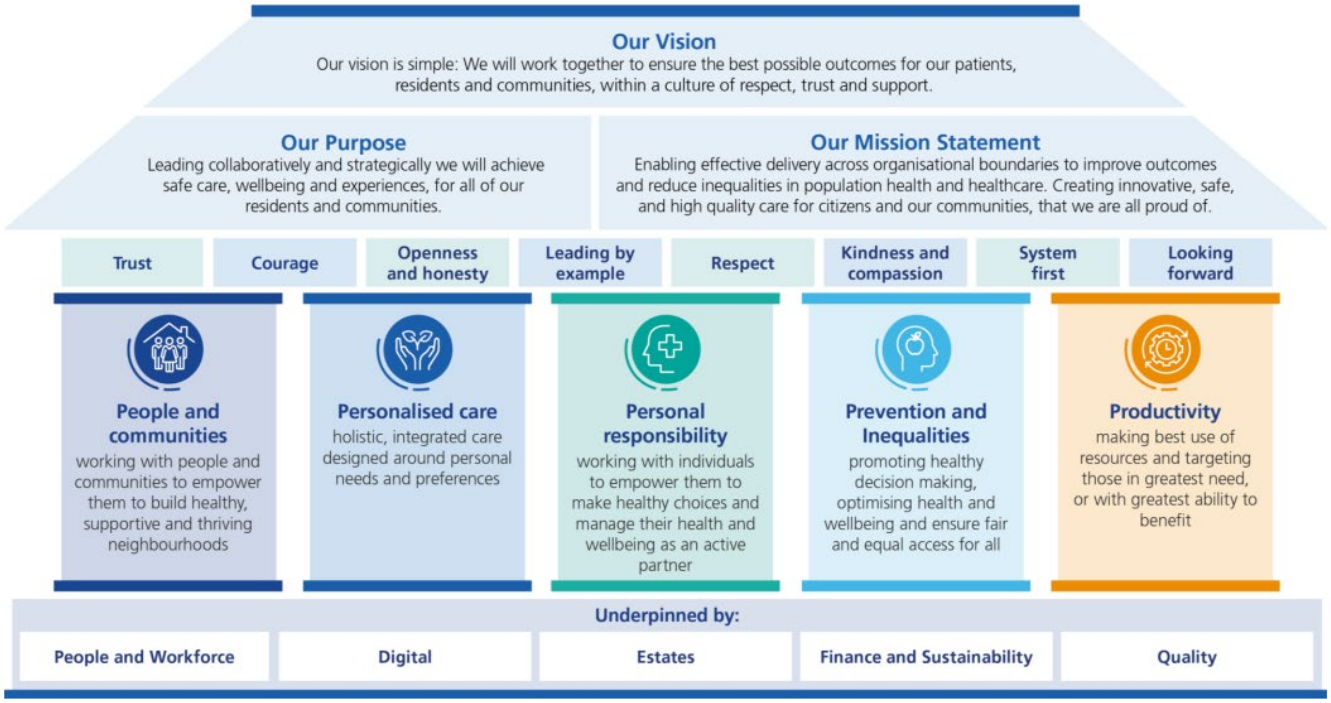
The ICB in Staffordshire and Stoke-on-Trent must ensure high quality care whilst achieving the best possible health outcomes for the population it serves, and all within an agreed financial envelope. The ICB, through its strategies and committees, needs to be assured that the management assurance systems are operating effectively and not be the assurance system itself.

High quality care continues to be defined as care that is safe, effective and provides a good patient experience.

2.Our Vision, Values and Objectives

2a. ICB Mission, Vision and Purpose

2b. ICB Strategy on a Page



NHS Staffordshire and Stoke-on-Trent Integrated Care Board

2c ICS Joint Forward Plan

This plan outlines the joint ambitions of partners, which both respond to and support the joint health and wellbeing strategies of our two upper tier local authority partners (Staffordshire County Council and Stoke-on-Trent City Council), and the integrated care partnership strategy. We are clear that achieving the ambitions in this plan will need us all to work together differently, as we continue to shift our focus from treatment to prevention, support people to make healthy choices, improve our services and the way we provide care. https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/plans-and-strategies/joint-forward-plan-final-11-07-23/?layout=default

2d. ICB Quality Ambition and Vision

The ICB Quality Strategy has been designed to complement the overarching ambitions of the ICS priorities and the ICS Joint Forward Plan with quality and safety being the golden thread running through them all. The quadruple aims of the ICB are:

- **Improve Population Health and Wellbeing Outcomes**
- **Address inequalities, experience and outcomes from health and social care services.**
- **Achieve a sustainable and resilient integrated care system.**
- **Working in partnership with communities to achieve social, economic, and environmental community development.**

The key clinical priorities of the quality strategy are to address and work to improve:

- **Any growing health inequalities.**
- **An increasing population of people with complex health and care needs.**
- **An increasing demand on primary care and variation in access**
- **An increasing unplanned and emergency care demand**
- **The recovery of elective and cancer care services**

Staffordshire and Stoke-on-Trent ICB are committed to high quality delivery of the priorities set out and intend to achieve this by:

- **Ensuring quality is everyone's business.**
- **Being committed to working closely with all system partners and stakeholders.**
- **Ensuring the best possible outcomes and experience for all our patients, their families, and carers.**

The Staffordshire and Stoke on Trent Integrated Care Board's vision for quality is to ensure that services provided are safe, effective, and meet the needs of the population, providing the best experience and outcomes possible.

This Quality Strategy has been developed to ensure it adheres to the requirements detailed by the National Quality Board in their shared commitment to quality document.

This Strategy has also aimed to align closely with the aims of the three NHS Provider within the ICB.

University Hospital North Midlands NHS Trust

https://www.uhnm.nhs.uk/about-us/our-organisation/

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

North Staffordshire Combined Healthcare NHS Trust

https://www.combined.nhs.uk/we-are-proud-to-launch-our-new-trust-strategy/

Midlands Partnership University NHS Foundation Trust

https://www.mpft.nhs.uk/about-us/quality

3. Quality Strategy Summary 2023 - 2026

Quality Ambition and Vision

Quality Outcome	What will this look like?	How will we do this?	How will we know?
People with lived experience are actively involved in service design, development, delivery, and evaluation.	People with relevant lived experience, carers and communities participate in shaping what quality and what safety looks like. Opportunities are given to people to work alongside system providers as mutual, reciprocal partners, with their expertise being fully recognised, in shaping the design of services.	Implementation of patient safety partners across the system. People are working in partnership, at the earliest opportunity, to shape priority programmes within the ICB. Increasing the opportunity for our region's population to engage in research and shape health and care research needs.	People with lived experience and communities have increased confidence in services demonstrated by co-designed satisfaction metrics. People are consistently involved in all elements of service design, delivery, evaluation, and implementation of best evidence throughout. Communities are actively engaged in co-production - programmes are co-produced with people from relevant protected characteristic groups and those who face health inequalities.
The promotion of safe care ensuring care is of a high quality, safe and accessible to all our population.	We will work to continually improve the reliability and effectiveness of our clinical systems and processes. We will learn when things go wrong and, will ensure that learning is shared across system partners to maximise opportunities to improve safety for users.	Implementation and embedding of NHS Patient Safety Strategy and other relevant quality and safety requirements.	System partners work together to share learning and drive improvement and innovation. Improved safety culture measurement.

Quality Ambition and Vision

Quality Outcome	What will this look like?	How will we do this?	How will we know?
Improving staff experience	A culture of transparent sharing and learning. Staff have the time and tools to deliver safe care and feel valued and empowered.	Consistent training for staff across system in relation to all recommended quality tools and processes e.g., Patient Safety Incident Response Framework (PSIRF). Continued Implementation of Freedom to Speak Up across the system. Monitored and managed post staff survey action plans. (ICS People Plan and NHS Long term Workforce plan)	Improved staff survey results showing that staff feel empowered to deliver safe care in a just and inclusive organisation. Improved key workforce metrics around workforce. Evidence of celebrating success and shared learning. Staff leading on innovation.
A shared system approach to quality and safety	Collaborative working towards quality across the system. An understanding of what quality looks like with a mutual approach to sharing and escalation of quality concerns and need for focus via QI.	Joined up Risk Management Approach. System Quality Group. (Embedded) Shared learning events. Quality focus in all delivery portfolios.	Strong and transparent relationships Robust identification of quality issues for improvement. Quality oversight arrangements functioning effectively. Shared intelligence. Shared Safety Culture.

Quality Ambition and Vision

Quality Outcome	What will this look like?	How will we do this?	How will we know?
Fair and equitable services for all, building a system for the future.	**Reducing health inequalities and variation especially as there are multiple diversities in population and cultures. Close Working within ICB inequalities agenda.**	**Embed a system oversight framework to ensure that equality and quality are the central principles in how health and care services are designed and delivered.**	**An embedded QIA approach based on learning from previous experience, best practice, and benchmarking.** **Evidenced learning from a robust Learning from Lives and Deaths (LeDeR) Programme**
We will drive the provision of quality services through a high-quality programme of research and continuous quality improvement.	Within the system our aligned Quality Improvement principles will guide change at all levels. Through the development of a collaborative integrated research and innovation partnership, we will develop the capacity and capability for evidence-based health and care. System collaboration will generate new learning and insights that will shape how we deliver services and continuously improve	The ICS will agree and develop a jointly owned improvement programme guided by those that use our services, led by staff, and aligned to the ICS priorities. We will build capacity and capability to practice Quality Improvement and Research & Innovation at all levels within the ICB. Develop an infrastructure that supports engagement in research for staff and communities where through routine transparent sharing we will learn from each other and continuously improve.	By monitoring data and insights from feedback our improvement programme will be focussed on what is important to our population. Our ICS Quality Improvement principles will be routinely used to tackle strategic priorities and quality challenges at all levels. Our Staff will feel confident and competent to be involved in research and Quality. Improvement and learning from training opportunities and improvement work is shared. With Collaborative research proposals co-developed with system partners and our communities.

4. Quality Strategy Delivery Plan

A comprehensive Quality Strategy Delivery Plan will be developed following stakeholder and staff engagement to determine the detailed actions required to achieve the aims of the Quality Strategy. This plan will be an addition to this strategy and will be used as a marker for achievements and presented to the Quality and Safety Committee bi-monthly to demonstrate adherence with actions required and any blocks to achieving the aims of the strategy.

5. Quality Risk Escalation

The National Quality Board sets out that:

> *It is crucial that NHSE regional and national teams adopt a system-first approach wherever possible when managing risks. Risks should be managed as close to the point of care as possible, where successful mitigation is not possible then escalation and management at the next level occurs as linked to the designated risk framework and overseen by the ICS. However, as the Guidance on System Quality Groups made clear, there will be situations in which NHSE and other regulators have the right to intervene, particularly if there are complex, significant and/or recurrent risks.*

The Quality Risk Response Process below sets out how any quality concerns and risks will be managed within the ICB in collaboration with NHS England (NHSE) and wider partners.

This approach will be based upon three main levels of assurance and support from the NHSE Regions and ICB partners. The levels will apply to all the different geographies e.g., Place, Neighbourhoods, pathways, and journeys of care.

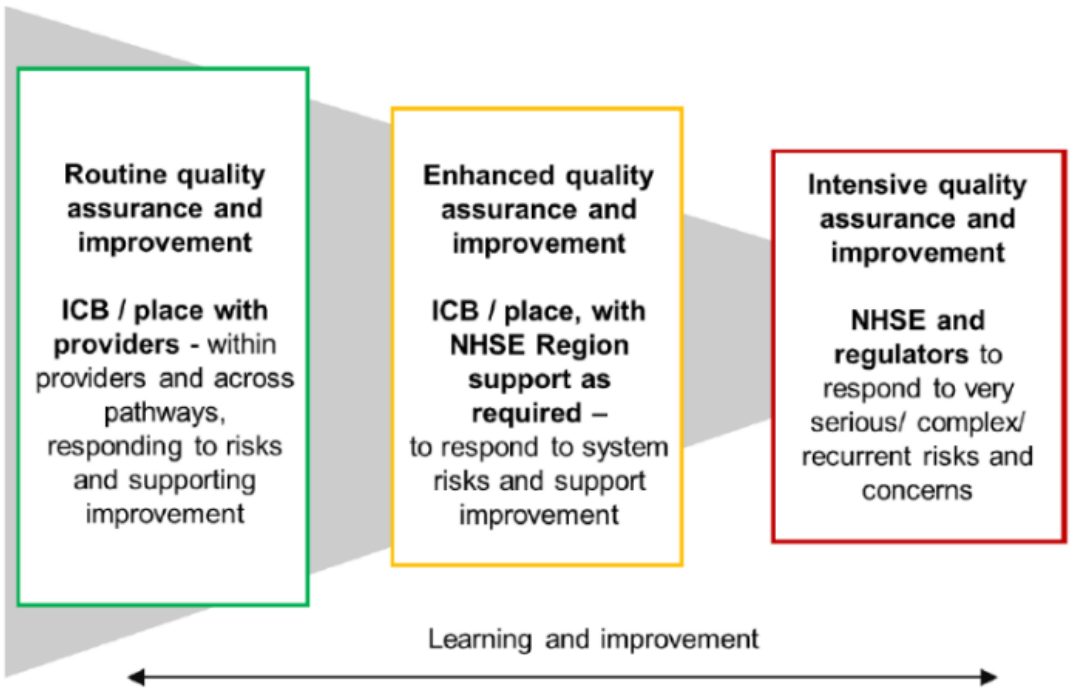


Table 1

5a. **Routine Quality Assurance**

Led by provider/ ICB Business as usual activity and reporting within providers (including independent sector providers), provider collaboratives/networks for service delivery, place-based structures, ICB/ICSs, including independent providers, provider collaboratives and networks.

This process will be monitored by the ICB System Quality Group with reporting to ICB Quality and Safety Committee. Types of monitoring include CQRMs, quality visits, review of data and information including complaints and regular triangulation of quality, performance, and patient experience data.

ICB Executive Owner *ICB Chief Nursing and Therapies Officer*

5b. **Enhanced Quality Assurance**

Led by provider/ ICB in most circumstances implemented when concerns/ risks are identified that require more frequent and intensive oversight to gain confidence that care is of sufficient and consistent quality, that action/ improvement plans are leading to the desired outcome and that the improvements in care are sustained.

May include regulatory action, including enforcement action (aligned with NHSOF segment 3) and contractual actions (e.g., service development and improvement plans, suspension of service, termination of contract).

The enhanced approach will be agreed and supported by Regional NHSE teams, based on the risk profile and support needs.

This process will be monitored via ICB System Quality Group with reporting to ICB Quality and Safety Committee and be supported by Regional NHSE Teams. Types of monitoring include Rapid Quality Review Meetings.

ICB Executive Owner *ICB Chief Nursing and Therapies Officer.*

5c. **Intensive Quality Assurance and Improvement**

Led by NHSE and other regulators implemented as a last resort when there are very significant, complex, or recurrent risks, which require mandated or immediate support from NHSE for recovery and improvement, including support through the Recovery Support Programme, or from wider regulators.

The intensive approach must be agreed based on the risk profile and support needs within the ICB. This assurance level covers previous NHSE Risk Summits.

This process will be supported via ICB System Quality Group with reporting to ICB Quality and Safety Committee and be Led by Regional NHSE Teams.

Please note: As NHSE delegate more to ICBs, ICBs will take an increased lead on Intensive Quality Assurance and Improvement.

ICB Executive Owner *ICB Chief Nursing and Therapies Officer*

6. Monitoring

The ICB Quality Strategy will be reviewed annually by the System Quality Group to ensure adhere to its requirements and the ICB Quality Strategy Delivery plan will be monitored to ensure actions are completed as required. Reporting of the actions from the Delivery plan will be undertaken to the ICB System Quality Group with exceptions and concerns escalated to the ICB Quality and Safety Committee.

Appendix 1

Quality Strategy on a Page

Our Quality Vision is to ensure that services provided are safe, effective, and meet the needs of the population, providing the best experience and outcomes possible.

The clinical priorities of the quality strategy are to address and work to improve quality in:

Health inequalities.	An increasing population of people with complex health and care needs	An increasing demand on primary care and variation in access	An increasing unplanned and emergency care demand	The recovery of elective and cancer care services

Quality Outcomes

People with lived experience are actively involved in service design, development, delivery, and evaluation.

So:

Reducing health inequalities and variation especially as there are multiple diversities in population and cultures.

The promotion of safe care ensuring care is of a high quality, safe and accessible to all our population.

So:

Aligned Quality Improvement principles will guide change at all levels.

We have capacity and capability for evidence-based health and care.

System collaboration will generate new learning and insights

Improving staff experience

So:

There is a culture of transparent sharing and learning.

Staff have the time and tools to deliver safe care and feel valued and empowered.

A shared system approach to quality and safety

So:

There is collaborative working towards quality across the system.

There is an understanding of what quality looks like with a mutual approach to sharing and escalation of quality concerns and focus on Quality Improvement

Fair and equitable services for all, building a system for the future.

So:

Reducing health inequalities and variation especially as there are multiple diversities in population and cultures.

We will drive the provision of quality services through a high-quality programme of research and continuous quality improvement.

So:
There are aligned Quality Improvement principles.

The development of develop the capacity and capability for evidence-based health and care.

System collaboration generates new learning & insights.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 09

Report to:	**Integrated Care Board**					
Date:	**21 December 2023**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Lynn Tolley, Acting Chief Nursing and Therapies Officer					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail December 2023.					

(1) Purpose of the Paper:
To provide assurance to the Integrated Care Board regarding the quality, safety, experience, and outcomes of services across the entire health economy.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
This paper is a combination of corresponding papers (D/S/I) presented and discussed at Quality and Safety Committee.	08/11/2023
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	Risks identified and managed via the Board Assurance Framework and Corporate Risk Register.
CQC or Patient Safety	Updates provided against relevant organisations. Continuous Quality Improvement update aligns to known links between providers and systems.
Financial (CFO-assured)	N/A
Sustainability	N/A
Workforce or Training	Details contained within the report relating to providers by exception.
Equality & Diversity	Details contained within the report.
Due Regard: Inequalities	Update contained within the report.

Due Regard: wider effect	Quality Impact Assessment update supports the ICB, and system partners, having due regard to all likely effects decisions.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

The paper summarises the items received by the Quality and Safety Committee (QSC) and the System Quality Group (SQG at the meetings held in November 2023. The Committee fulfilled its role as defined within its terms of reference. Where appropriate, actions and oversight arrangements are identified within Appendix A.

Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:

- Board Assurance Framework and Risk Register
- Local Maternity and Neonatal System
- Infection Prevention and Control
- Safeguarding Adults and Children
- Working with People and Communities
- Paediatric Audiology
- University Hospitals of Derby and Burton NHS Foundation Trust

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

- Receive this report and seek clarification and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Appendix A: Quality and Safety Report – Detail December 2023

1. Board Assurance Framework (BAF) and Risk Register

1.1 The Quality and Safety Committee (QSC) is responsible for overseeing BAF risks BAF3: Proactive and Needs Based Community Services, BAF4: Reducing Health Inequalities and BAF5: High Quality, Safe Care Outcomes. QSC members considered and discussed these risks and agreed that (i) the Risk Scores and Assurance Assessments are an accurate reflection of the position, and (ii) the actions identified are sufficient to either reduce the risk score towards target or to provide additional assurance.

1.2 QSC received the risk register for assurance. No new quality risks have been added. The committee agreed to the closure of two risks; Risk 081: Asylum Seekers and Refugees as the target risk score has been met and this is now considered an issue rather than a risk and Risk: 091: Care Home Standards as this is a duplicate of another risk. Further, Risk 108: Ivetsey Bank (Independent Hospital) decreased in residual risk score of as an action plan is now in place.

1.3 Risk 115: Looked After Children Initial/Review Health Assessment (IHA/RHA) Compliance was discussed and the committee increased the risk score to 20. The QSC received a paper outlining the work being undertaken by health and local authority providers. Including creation of a system wide dashboard illustrating an accurate system wide view of the risks and pressures in detail. Enabling a forensic view of where and why system pressures are occurring. The committee has asked for an update at the next meeting including details about longest waiters and an understanding of clinical risk.

2 Local Maternity and Neonatal System (LMNS)

2.1 The System Maternity Oversight and Assurance Group is established and includes representatives from the Maternity and Neonatal Voices Partnership and Care Quality Commission. All UHNM's maternity improvement actions have been aligned to each of the 4 Themes and 12 objectives in the Three-Year Maternity and Neonatal Delivery Plan 2023. In this way, rich discussions about innovation and improvements can be had that meet the requirements in the action plans, supporting RAG rating and the implementation of the actions in a meaningful way.

2.2 The ICB has been included in a pilot to appoint a Maternity and Neonatal Independent Senior Advocate, as a direct response to the Ockenden Report to support women and families who have experienced a traumatic episode. The ICB have appointed a very experienced neonatal nurse and trainer, who started in post in August 2023 and ensures independence from the local LMNS.

2.3 Operational pressures continue within all maternity and neonatal services providing care in Staffordshire and Stoke-on-Trent. UHNM and UHDB report positive recruitment programmes and are taking proactive action to attract midwives into their services. Primarily this will be newly qualified midwives in the Autumn but also includes international recruitment, for which UHNM have been commended. Trusts continue to work towards their birth rate plus establishment. Most staff will have commenced in post in October and through to the end of 2023.

2.4 Recently published Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries reports on data from 2021. It highlights that seven of the ten ICBs with crude neonatal mortality rates significantly higher than the 2021 UK average of 1.56 per 1000 live births, are in the Midlands. Staffordshire and Stoke-on-Trent ICB had the second highest rate at 2.6 and UHNM had a rate of 2.94. Locally, the UHNM Neonatal Improvement Group has been re-established as the Neonatal Improvement and Mortality Group. The agenda includes neonatal mortality, progress against Saving Babies Lives, the Neonatal Critical Care Review Action Plan and neonatal and neonatology staffing. Initial data for 2022 and 2023, which the Trust monitors and acts upon, demonstrates a decrease in neonatal deaths.

3. Infection Prevention and Control (IPC)

3.1 The ICB's Chief Medical Officer has now taken on the role of Director of Infection Prevention and Control (DIPC). The ICB's IPC leads continue to support system wide working, with weekly IPC meetings including representations from all NHS IPC teams, GP practice nurse facilitators and wider partners which allows early recognition of any issues or concerns and allows close working to support and enhance service delivery across the region.

3.2 At the close of Q2 2023/24, 242 cases of Clostridioides difficile Infection (CDI) have been reported related to the population of Staffordshire and Stoke-on-Trent against a combined threshold of 287 annual cases. This compares to 182 cases during the same period 2022/23. An increase of 60 cases. The UK Health Security Agency (UKHSA) epidemiological commentary (Oct 2023) for April-June 2023, noted a 30.5% increase in the count of all reported CDI cases compared to the same period of 2019 which is seen as a more typical period prior to the pandemic. In this same period community onset cases increased by 17.6%, with hospital onset cases increasing by 54.6%. UKHSA report the change to a steady increase in cases during the pandemic of major concern and currently being investigated. Local trusts have action plans in place and participate in regional work engaging with NHS England IPC colleagues.

4. Safeguarding Adults and Children

4.1 The ICB Safeguarding Team continue to support UHNM on delivering the maternity improvement actions for safeguarding training.

4.2 The annual Joint Safeguarding Self-Assessment Tool (JSSAT) has been sent to GP practices to complete. It is designed to help practices to understand where they are currently with applied knowledge, skills, process, and procedures relating to safeguarding. This self-assessment tool will allow the ICB Safeguarding Team to understand where more targeted support for practices may be required but also to honour some excellent safeguarding practice that we see across the region. The JSSAT and action plan will also be a powerful addition to their CQC safeguarding evidence folder.

5. Working with People and Communities

5.1 The ICB's approach to engagement is shaped by the Working with People and Communities Strategy and the core principals of engagement that were developed with the public. Overseen by the People and Communities Assembly, engagement activities held with patients, the public, partners, and staff include:

- Engagement workshops held with people with lived experience of learning disability and autism (LDA) to shape awareness campaign. Concept developed and launched at the LDA Programme Board. Communications and engagement plan developed to deliver the campaign.
- Engagement completed with those in receipt of Continuing Healthcare or their families. Feedback analysed and Report of Findings shared with lead to support development of a system-wide policy.
- Maternity transformation recruiting to a patient panel and leaflets are starting to be distributed via partners.

6. Paediatric Audiology

6.1 NHS England conducted national Paediatric Audiology Hearing Service Review, identified significantly high risks specific to Visual Reinforcement Audiometry (VRA) and Auditory Brainstem Response (ABR) testing within UHNM and MPFT services. Joint NHS England and ICB peer review site visits took place in November 2023.

6.2 In response, a system 'Bronze Cell' has been established (meeting weekly initially). With the ICB's Chief Medical Officer, supported by the Director of Nursing – Quality Assurance and Improvement and the Patient Safety Specialist, assuming the SRO/Lead Clinician role. Progress has been made to deliver the immediate actions required. Work is underway to review clinical outcomes following VAR and ABR tests with external clinicians to ascertain the level of risk and impact upon children who have received hearing tests. UKAS Accreditation process to commence over the coming months.

7. University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

7.1 The Care Quality Commission (CQC) inspected the maternity service at Queens Hospital Burton and Royal Derby Hospital as part of their national maternity services inspection programme. Following CQC visits to the Derby and Burton sites in August 2023, the final report was published on 29th November 2023, confirming that the Safe and Well-led domains and overall service has been rated Inadequate. Further, section 29A warning notices have been issued.

7.2 The ICB receives regular updates from the Derby and Derbyshire ICB Chief Nurse and the Local Maternity and Neonatal System forums and groups.

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	5 December 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Risk Register	There are 27 risks on the System Risk Register of which, 19 are high scoring (12 and above) and there are 8 medium risks. The Committee approved: • The closure of Risk 131: Delivery of Ambulance Service Performance Standards • The closure of Risk 151: Phasing out of the Emergency Digital Integration by NHS England • The increase in risk score from 20 to 25 for Risk 111: Ambulance Handover Delays • The reduction in risk score from 25 to 20 for Risk 98: UEC Workforce/Staffing • The reduction in risk score from 16 to 12 for Risk 134: Totally PLC Sustainability. The Committee has good sight of the top risks for finance, performance and transformation.	Ambulance handover delays have increased as pressure in the system has risen during October and November. This risk was rated at 25 last winter and reduced to 20 in spring 2023.
Integrated System Performance and Programmes Highlight Report	The Committee noted the Month 6 performance position against the key metrics in the Operating Plan. The report contained: • An executive summary outlining key performance headlines and escalations • An overview of programme delivery and exceptions • A placemat that demonstrates at a high level key metrics and deliverables within the 2023/24 Operating Plan	

	• Exception reporting against our One Collective Aim and 4 System priorities. In addition to noting escalations around Urgent and Emergency Care, Planned Care and the impact of diverting SDF on mental health and learning disabilities, the Committee commented on the positive performance regarding Primary Care Access; reductions in emergency attendance for children and young people with long term conditions; and improved access to specialist perinatal community mental health services.	
Proposed System Plan Priorities	The paper set out the proposed 2024/25 System Plan Priorities which seek to strengthen the links between the ICP Strategy, the Joint Forward Plan and the Operational Plan. The Committee discussed the need to balance ensuring sustainable services with a focus on quality and safety and asked for some revisions in the wording to better reflect this balance.	
Elective Care/Elective Recovery Plan	The Committee discussed the current position for 104ww, 78ww and 65ww and the actions being taken to mitigate the position noting that despite progress being made, the rate of improvement has been hampered by the industrial action. The report also provided details on the long-waiters who receive elective care outside of the Staffordshire and Stoke-on-Trent System.	The Committee noted the following further/ongoing actions: • A refreshed route to zero for the 78ww cohort by the end of the financial year • The close monitoring of patients transferred to Nuffield • The focus on resolutions for challenged specialties • The Medefer contract is now live and supporting with outpatient activity • The maintained focus on productivity and on 'going further faster'.
System Finance Month 7 Report	At Month 7, we are reporting a year-to-date deficit position of £75.5m which is a £60.7m adverse variance against the £13.6m deficit plan. The System is no longer going to achieve a forecast breakeven position and a supplementary return detailing a £91.4m deficit System forecast has been submitted to NHSE. Capital is forecasted as expected however medium-term challenges remain and require national monies to achieve plan.	The Committee would like to highlight the deficit position at Month 7 and level of risk within the plan. The net risk is now being reported at £141m, demonstrating the size of the challenge and need for the System to deliver on the Recovery Plan. Given the seriousness of the position and financial scrutiny, a review of compliance with the self-imposed double lock has taken place. Included within the

		report was a flow chart providing clarity on the double lock process and a list of investments with the governance route evidencing compliance.
System Recovery Plan Update	The paper provided an update on how the System Recovery Programme is being implemented. The report included: • An executive summary highlighting which areas are progressing well and which require escalation • A RAG rating and supporting narrative for each of the products which make up the System Recovery Programme • The key risks affecting the programme and whether we have sufficient mitigations in place to reduce the risk score • The latest version of the recovery dashboard. The Committee noted: • For CHC costs out, we have delivered £10.6m savings in 2023/24, and identified a further £5m for in-year delivery. This equates to a £32m full year effect • The Tests of Change being run in the Frail Elderly Assessment Unit and Ward 80 at UHNM to support timely discharge are already starting to show positive outcomes • The End of Life offer to the system is on track to go live from 4 December and will deliver additional capacity as well as a more integrated service offer from existing providers • A dedicated session is planned for 15 December to examine how we need to change the Enhanced Health in Care Homes LES/DES for 2024/25. This is key to reducing ED attendances and hospital admissions for this patient cohort • The number of patients discharged onto Pathway 0 remains at 70% against a target of 80%. A more granular view and monitoring of the activities being undertaken is now required.	The Committee asked for further information on Virtual Ward roll out in the South West and Care Home projects in light of the red RAG status. The Committee questioned whether there was sufficient resource available to drive forward our ambitions around Care Homes.

System Surge Winter Plan Update	The report provided an assessment against the plan, the mitigations and escalated risks. Delayed mobilisation of additional capacity has led to an anticipated residual medical bed deficit in November of -64 beds against a forecast position of -39 at RSUH.	Good progress has been made on the System Escalation Plan. Patient flow out of D2A beds is having a significant impact on system UEC flow. Delays are linked to choice, assessment and funding delays.
Transformation Programmes Update	The paper provided the monthly overview of the clinical areas included within the System Transformation and Service Change Programme. Key updates for the Committee focused on maternity, the Cannock Transformation Programme and Urgent and Emergency Care – UTC Designation. The report also included the draft Monthly NHSE Service Change Return for submission in December.	
System Business Cases	As part of the double lock process, the following Business Cases had been discussed at SPG where it was agreed that they should proceed and be presented to the Committee for approval: • Front Line Digitalisation Business Case • Consultant Connect Year 4 Business Case • CHC Fast Track - End of Life Pathway Business Case	The committee approved the 3 Business Cases and welcomed the robust discussion and challenge that had taken place at SPG.
VCSE Healthy Communities Alliance	The report provided an introduction to The Healthy Communities VCSE Alliance and its position within the ICS structure. • The presentation highlighted the difficulties around contracting and procurement with the sector, the positive impact of the VCSE sector, the financial risks faced and proposed next steps to improve the relationship between the ICS and VCSE sector.	
ICS Oversight Framework Update	The Committee received for information the oversight letter following the System Review Meeting held on 2 November.	
PART B		
Risk Register	The Committee reviewed the 7 risks on the ICB Risk Register and approved: • The addition of new Risk 160: Wheelchair Service and new Risk 158: Financial Impact of the NHS 111 Regional Model The reduction in risk sore from 6 to 4	

	and closure of Risk 060: Confidential Meir Park.	
ICB Efficiency Performance	The paper reported on the achievement to date and the remedial actions being taken to manage any gaps in the delivery of the ICB's 2023/24 efficiency programme.	The Committee noted the improvement in the forecast outturn from £16.4m in Month 6 to £11.8m this month.
ICB Finance Report (Month 7)	The paper reported an ICB year-to-date deficit position of £70.2m against a planned deficit of £19.6m, creating an adverse variance to plan of £50.5m. The key risks to the position being ERF allocation, contract agreements and NHSE allocations were highlighted in the report. We continue to adopt a formal forecast of break-even for the year, following NHSE forecasting protocols, but following the submission of the £97.4m deficit on 22 November, we are anticipating imminent release of guidance allowing the ICB to move the risk position into the formal forecast.	FPC approved the ICB's Month 7 forecast position of breakeven and noted the level of unmitigated risk being reported.
Budget Setting Principles 2024/2025	The ICB have agreed budgets in place prior to the commencement of each financial year to ensure that the management team is operating within the Standing Financial Instructions (SFIs). The paper set out the framework and principles that will be applied in setting the ICB statutory body budgets for 2024/25 whilst being cognisant of the current uncertainties around planning.	FPC approved the budget setting approach outlined within the report.
ICB Procurement Operations Group Highlight Report	The paper reported the key activities being co-ordinated by the Procurement Operations Group and in particular the actions being taken to ensure the ICB is able to implement the new Provider Selection Regime regulations.	Non-Executive Director briefing to be arranged regarding the new Provider Selection Regime regulation.
Decision-making Business Case (DMBC) for the long-term solution for Inpatient Mental Health Services previously provided at the George Bryan Centre	The DMBC outlined the recommendation for the long-term solution for inpatient mental health services previously provided at the George Bryan Centre. The process to develop and assure the recommendation which adhered to NHSE guidelines, was detailed in the report.	The Committee: • agreed that the process has adhered to NHSE guidelines; • confirmed that the recommendation poses no risk to system finances; and • agreed that the DMBC can be presented to the ICB Board for decision making.
Integrated Community Equipment Service (ICES) Re-procurement	The paper described the aim and objectives of the ICES, updated Committee members on the completion of the contract novation, shared the legal view in terms of	FPC approved the proposed recommendation to commence a re-procurement exercise in the interim whilst the wider options appraisal is developed.

	compliance with the current Tomlin Order and provided an overview of current performance, activity, and finance (2023/24).	The lead for the re-procurement will be Stoke-on-Trent City Council. The current contract will be extended in line with the procurement and mobilisation plan whilst the re-procurement exercise is underway.
Interim Aligned Assisted Conception Policy	The report provided an update on the work completed to date to develop an interim aligned policy to replace the 3 separate CCGs' policies and provided recommended proposals. A national review of fertility provision is expected to result in revised NICE guidance in November 2024. The Committee emphasized that the scope of the policy review was to look at criteria that differs across the three CCG policies, retaining criteria that is already aligned and addressing only those criteria that differ.	FPC was assured that a robust process has been undertaken and that there is no adverse financial impact and agreed that the Policy be presented to this ICB Board meeting for decision making.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions that took place at the Committee. Specific risks highlighted above, and in the FPC Risk Register.