Annex 1: Older Peoples Inpatient Services Review – Options Appraisal - Version 4

Paper coproduced by – Dr Diarmid Sinclair (Chief Medical Officer); Steve Forsyth (Chief Nurse); Dr Judith Graham (Director for Psychological Professionals and Therapies). Paper also consulted with all Care Group Quads via CLE distribution. Feedback also obtained to contribute to V4 of the paper from Dr Arty Das (Medical Director RCG), Dr Gemma Graham (Director for Psychological Professionals and Consultant Psychologist Specialising in Older Age Psychology), Dr Rebecca Humphries (Community Lead Consultant – RCG) (via the HQTC), Dr John Bottomly (Old Age Psychiatry Consultant); Paula Thompson (Service Manager – Acute Services Doncaster); Catherine Collins (Matron- Acute Services Rotherham), and the patient flow team. Additionally, the paper was discussed and contributed to at the High-Quality Therapeutic Care Taskforce on 12/2/25 and the Clinical Leadership Executive Group on the 19/2/25.

Situation

Within our Trust Strategy Promise 4 is focussed upon our bed-base service provision. Through pre-discussions in terms of our inpatient task force, issues have been raised in terms of the consistency of our older people's inpatient services. This issue has been brought into sharper focus with the temporary ward closure in Rotherham Care Group in terms of medical staffing in the inpatient older peoples services.

On the 23rd of December 2024 due to a medical staffing situation, resulting in no Consultant Psychiatrist cover for the Brambles Older Persons ward in Rotherham, a decision was reached to temporarily close this ward and support patients previously in this ward in other parts of the service. There are many actions which the care group explored to avoid this action, however the lack of cover resulted in the options being limited.

This paper has two purposes, to explore options in terms of enabling consistency for older adult's inpatient care at RDaSH and as a part of this resolving the temporary solution put in place regarding Rotherham Older Peoples Inpatient Services.

Background

There are different models of inpatient older people's services which are permittable in terms of National Guidance, in terms of both regulatory bodies and professional bodies. This enables some organisational flexibility in terms of the way that inpatient older people's services are delivered. The joint commissioning panel for mental health (2013) recommends in its guidance for commissioners of older people's mental health services that: -

- *inpatient services that specifically meet the needs of older people and are separate from wards for adults of working age.*
- *where possible, separate ward space for functional and organic disorder*
- *gender separation guidance for inpatient services being properly applied*.

The Royal College of Psychiatrists Standards for Older Adult Mental Health Services 5th Edition state that:

- Wards that admit patients living with dementia should have a dementia-friendly environment/layout
- All staff working with people living with dementia should receive specialist training in dementia care and working with behaviour that challenges
- An MDT should be available that is able to consider diagnoses of depression, dementia, and delirium

The standards do not reference requiring separate wards for organic and functional patients.

Within RDaSH we have differing configurations of inpatient older people's services which will be expanded upon in the section below.

Assessment

At RDaSH, what is important to us is to explore care being provided at home and in local neighbourhoods where possible to do so. We want to ensure that medium and long-term care should be located where it is readily accessible to our communities, because this is supportive of effective long terms recover. In the Trust we provide older peoples mental health services in all 3 localities, the bed ratio and type of provision is summerised on the next page:-

- **North Lincolnshire** – In North Lincolnshire we have one Older Peoples Mental Health ward (Laurel Ward) with 13 beds, for a population of 169,700 people. The ward is a mixed ward (Single Sex Rooms with en-

suite bathrooms – adhering to NHSE Single Sex Accommodation Guidance). The ward supports people with both functional and organic mental health problems. The ward layout is in such a way that enables separate spaces for people with dementia/organic mental health problems and people with functional mental health problems – adhering to national recommendations.

- **In Doncaster** - In Doncaster we have one Older Peoples Mental Health ward (Windermere) with 20 beds, for a population of 308,100 people. The ward is a mixed ward (Single Sex Rooms with en-suite bathrooms – adhering to NHSE Single Sex Accommodation Guidance). The ward supports people with both functional and organic mental health problems. The ward is managed is in such a way that enables separate spaces for people with dementia/organic mental health problems and people with functional mental health problems – however building changes are recommended to strengthen this environmental support.

- **In Rotherham** – In Rotherham we have two Older Peoples Mental Health wards (Brambles and Glades) with a total of 30 beds, for a population of 265,800. One ward supports people with organic mental health problems and the other people with functional mental health problems (i.e. depression, psychosis). One of the wards (Brambles) is temporarily closed as described at the start of the paper. Both wards are mixed wards (Single Sex Rooms with en-suite bathrooms – adhering to NHSE Single Sex Accommodation Guidance).

Across Trust Considerations: -

- Our bed distribution does not align with the population sizes we serve.
- The age boundaries of care are debated at a local and national level, with frailty models being discussed at a high prevalence
- There are national and local debates about the effects of mixed organic and functional ward bases. Where there is research it seems to have been looking at the impact on the quality of dementia care (i.e. Gondhalekar, 2022) and is based on a small sample. It is therefore difficult to argue either way based on evidence alone. Whilst some reviews (although limited) are indicative of better experience for patients on separate wards, there are also examples of mixed wards working well – although around 11% of MH trusts have mixed wards at the current time.
- Our recent occupancy rate for our older people's wards varies between 40-60% across trust, please see 3 tables below for expanded data in relation to this.

Table 1 – Occupancy levels (%)

	Doncaster			Rotherham					North Lincs	
	Brodsworth	Cusworth	Windermere	Kingfisher	Sandpiper	Osprey	Brambles	Glade	Mulberry	Laurel
Sep-23	105.00%	105.00%	85.00%	100.00%	94.44%	94.74%	86.67%	73.33%	100.00%	100.00%
Oct-23	102.26%	101.13%	78.87%	81.94%	99.10%	100.72%	87.31%	64.73%	103.80%	81.39%
Nov-23	100.50%	101.00%	81.50%	91.33%	99.07%	101.30%	78.89%	53.33%	102.15%	95.38%
Dec-23	101.29%	100.64%	44.52%	87.74%	96.77%	99.64%	69.89%	60.00%	104.93%	99.01%
Jan-24	102.10%	101.29%	42.90%	91.61%	106.63%	99.10%	69.03%	56.77%	104.36%	85.86%
Feb-24	105.00%	102.75%	51.72%	97.24%	100.77%	100.38%	77.93%	62.76%	104.04%	79.84%
Mar-24	98.87%	102.10%	49.52%	85.26%	100.00%	99.46%	72.69%	61.29%	100.57%	68.49%
Apr-24	100.00%	100.50%	67.83%	74.00%	97.96%	99.26%	81.78%	86.44%	105.10%	58.97%
May-24	100.65%	99.52%	70.97%	69.43%	97.31%	100.00%	72.79%	82.58%	96.49%	65.51%
Jun-24	101.67%	103.00%	70.50%	72.67%	98.34%	97.04%	86.44%	85.33%	99.81%	68.54%
Jul-24	102.90%	100.48%	68.39%	89.03%	98.75%	99.28%	84.06%	70.11%	95.34%	63.61%
Aug-24	100.81%	99.84%	68.71%	80.00%	97.13%	97.13%	87.96%	80.65%	97.34%	66.25%
Sep-24	101.00%	100.00%	67.67%	78.00%	94.81%	95.93%	90.22%	74.89%	108.63%	71.03%

The length of bed stay differs significantly in our different localities as outlined in table 2 on the next page:-

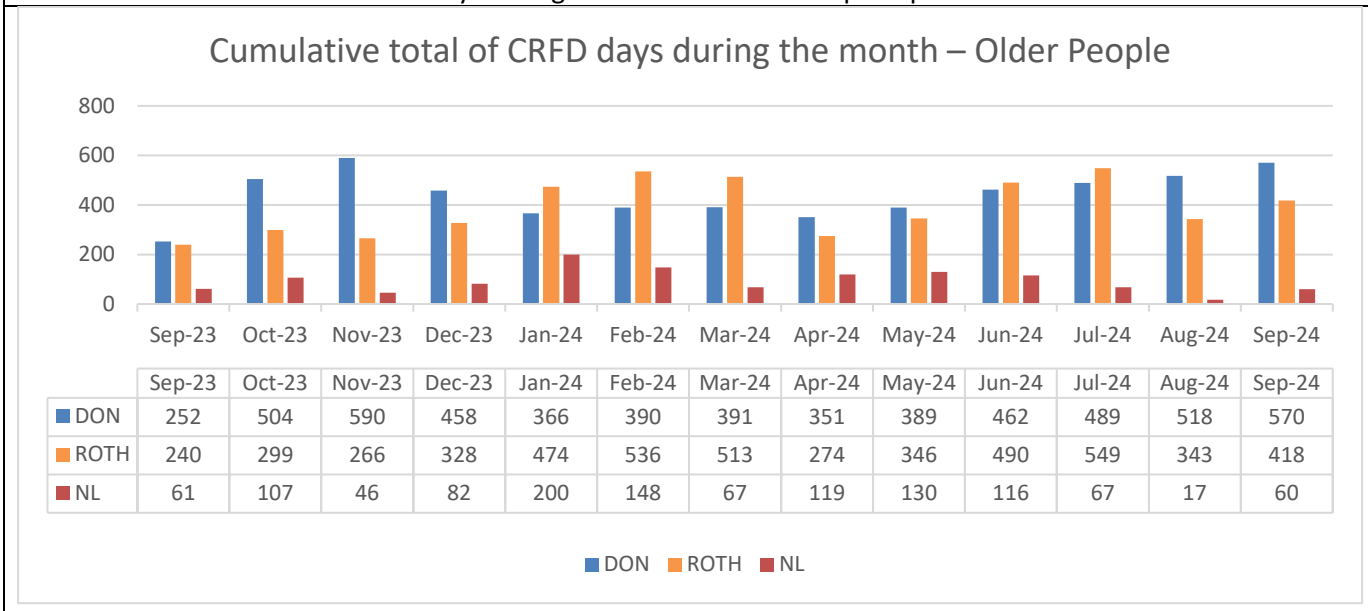
Table 2 – Length of Stay

	ALOS - On discharge (days)							
	Doncaster			Rotherham			North Lincolnshire	
	PICU	Acute	Older Peoples	PICU	Acute	Older Peoples	Acute	Older Peoples
Sep-23	25.86	29.48	23.5	21.88	20.5	50.43	27.86	35.38
Oct-23	2	36.33	34.15	32.27	36.33	140.22	18	31.33
Nov-23	27.3	60.7	60.75	4	67.5	19.34	31.41	716.5
Dec-23	13.6	40.35	42.71	14.06	35.49	67.5	27.18	66.25
Jan-24	24.78	55.62	37.1	6.83	37.55	60.75	19.6	90.33
Feb-24	14.44	75	37.4	57.5	30.43	78.71	39.46	42.38
Mar-24	15.38	33.86	34.22	17.69	51.73	102.82	47.89	59.57
Apr-24	31.67	52.22	25.63	15.27	43.44	70.75	25.25	69.5
May-24	18	40.33	29.63	13.55	44.66	29.94	18.88	32
Jun-24	30.6	33.12	46	13	55.16	46.75	18.15	27.44
Jul-24	22.86	44.5	25.78	20.33	47.23	43.12	19.21	46.43
Aug-24	10.85	50.32	27.44	0	15.42	56.33	24.64	19.46
Sep-24	8.79	23.74	31.45	33	26.36	60	20.7	30.83

*It should be noted that Windermere Ward has catered for 2 people in EoL and one person with MOJ restrictions in the period listed, which has contributed to an average longer length of bed stay.

The cumulative total CRFD days during the month differs significantly in our different localities as outlined in table 3 below. This information should firstly be considered in terms of both the occupancy rate, should CRFD days reduce as per national and local policy. And secondly, considerations should be given in terms of whether low occupancy level and increased availability of beds means that people stay in hospital longer and are admitted more frequently than in other specialities/localities, which in itself is researched to have iatrogenic effects.

Table 3 - Cumulative total of CRFD days during the month – Older People Inpatient Services



	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
DON	252	504	590	458	366	390	391	351	389	462	489	518	570
ROTH	240	299	266	328	474	536	513	274	346	490	549	343	418
NL	61	107	46	82	200	148	67	119	130	116	67	17	60

Options

The Trust strategy contains a series of promises aligned with RDaSH Trust Strategic Objectives 3 & 4 related to high quality therapeutic care, with a particular focus on bed-based care and community driven care. Decoding that language, these commitments go beyond the traditional NHS idea of inpatients, to include those currently, or in the

future looked after in residential spaces, either owned by the Trust or by partners. Implicitly, and building on a lack of outcome data or other quality metrics, no assumption is made that presently we do or do not deliver high quality care; mindful of long stays and iatrogenic effects, as well as a CQC rating of Requires Improvement, the following options are to be considered: -

Option 1 – Stay with the same configuration or beds across the Trust, and as a part of this re-open Brambles Ward after the period of temporary closure.

The benefits of this option: -

- It would retain a familiar model for staff and patients
- it would retain a 2-ward structure in Rotherham, and without any environmental changes would therefore enable separation of older adults who have functional and organic mental health problems.
- Care for older adults would remain in the 'place' that they live.
- Staff would retain the same working patterns.

The risks of this option: -

- Ward beds remain underutilised, with additional staffing and associated cost retained (the additional costs are available in terms of NHSP shift cancelled with the temporary closure of the OP ward in Rotherham and also medical agency costs).
- Staffing the number of older peoples wards we have, particularly in relation to a Responsible Clinician has proven problematic, even when high-cost options have been pursued.
- Additional staff (NHSP, overtime and agency) has been used when all wards were open.
- The current and past Trust occupancy levels do not warrant the whole bed base to be open.
- The number of older adults' beds offered in Rotherham would remain significantly different, per head of population from other places served in the Trust.

Option 2 – Move to a single ward older persons model in all 'place based' areas in the Trust.

The benefits of this option: -

- All 'place based' areas of the Trust would have comparable ratio of beds per head of population. This would mean that beds would be utilised rather than remaining empty.
- All 'place based' areas of the Trust would have a comparable impatient provision model, in terms of having a mixed wards with environmental safeguards in order to meet National OP standards.
- Staffing would be permanently released in not reopening the Brambles ward in Rotherham which may prove beneficial if deployed to both older people's inpatient and community services across RDaSH due to redeployment opportunities.
- An in-reach model may be considered in Rotherham, which is in place in North Lincolnshire and being worked towards in Doncaster. This would enable consistent models of care across Trust and may support the reduction in length of stay in Doncaster and Rotherham, to meet North Lincolnshire standards. This shortened length of stay would be beneficial for patient well-being and recovery.
- Each of the older people's inpatient services would benefit from a multi-professional approved clinician model due to both medical and non-medical AC/RCs in each area. Meaning care can be personalised to specialism and patient need.
- The staff release from the permanent ward closure in Rotherham would not only fill vacancies but would provide options to enhance 'out of hours' services for older people in the community, which would support a community driven model.

The risks of this option: -

- environmental changes would be required to adhere to national guidance in terms of the compartmentalisation of ward areas which support people who have functional and organic mental health problems. This cost has been considered in Doncaster but will need to be considered in Rotherham.
- Staff will be displaced from Rotherham inpatient services on a permanent bases, and although there will be opportunities due to vacancy levels in the community and inpatient services in Doncaster, other opportunities for staff may be further away from their current stated base of work.

- Some staff have expressed some criticism about not having separate 'functional' and 'organic' wards, acknowledging it is permitted in national models if separate day and sleeping spaces are accommodated. This may result in staff leaving the service.
- Risks of patient and carer feedback being negative in terms of the change in model, this is most likely with those patients and carers who have experienced the previous care model.

Option 2b – This takes the principles of options 2 above, but in terms of the Rotherham ward proposes the Rotherham Older Peoples ward older adult ward be relocated the services to Swallownest Court rather than the Woodlands.

*Point to note. The Woodlands service in Rotherham not only hosts the 2 older peoples inpatient services, but also the home treatment services and also ECT services.

** From 2/4/24-1/11/24 13 patients have been provided with Electroconvulsive therapy (ECT) in total from the Woodlands Service – 8 Rotherham patients, 3 Doncaster patients, 1 patient from Wathwood Hospital and 1 patient from North Lincolnshire. The increased use of ECT as a treatment is noted in this paper, but not expanded upon as this is not the core focus of the paper.

The benefits of this option: -

- it would retain a ward structure in Rotherham which would enable older people to be as close to home as possible.
- The spare/empty ward in Swallownest Court could have environmental changes to enable separation of older adults who have functional and organic mental health problems prior to the move, to minimise any disruption.
- Being onsite with other inpatient wards would enable flexibility of staff if required. This is the same as the model that is in place in Doncaster and North Lincolnshire where staff from adult mental health wards are on the same geographical site and therefore can assist and support during break times, if there are incidents and also to support increased need situations.
- The older people's services in Rotherham would be nearer to the PICU and Section 136 suite which would be beneficial for older people who may require this service. This would also be aligned with the geographical location of the North Lincolnshire and Doncaster services.
- This would enable all inpatient services to be on the same site as the care group senior leadership team, which is aligned to the design in the two other Trust 'place based' services.

The risks of this option: -

- The location is further away from acute services for older adults who may be more prone to physical health difficulties.
- The location is currently not designed for specialist older people's services.
- There would be some colleague issues in terms of moving the base of work that must be considered (clinical and support service staff – such as administrators and domestic staff)
- There would need to be considerations regarding the ECT suite considering the current alignment and resource sharing with the inpatient services.

Option 2c – To progress a single area/ ward option, with expanded numbers of beds, and environmental adjustments.

The benefits of this option: -

- All 'place based' areas of the Trust would have comparable ratio of beds per head of population. This would mean that beds would be utilised rather than remaining empty.
- All 'place based' areas of the Trust would have a comparable impatient provision model, in terms of having a mixed wards with environmental safeguards in order to meet National OP standards.
- The number of extra beds required would need to be defined by both retrospective analysis in terms of occupancy data but also consideration of population data and predictive modelling. The number is therefore not defined in this paper but is likely to be <5.
- With expanding the number of beds there would be an increased staffing model on the wards needed, however not all of the staffing resource released from the closure of the Brambles ward would be required, and therefore some funds would be released which would be reinvested in an enhanced community older people services provision.

- The environmental changes required would be to all 3 localities and requests would be to fund from capital budgets. The environmental changes would include –
    - ward separation points (enabling a 2 in one ward approach) with concertina doors meaning the number of beds open to support people with functional or organic mental health problems can be flexed to the needs of the population, as there is not always a 50/50 split in each locality.
    - A low stimulus environment in the organic part of the ward, this should have appropriate decoration, and safety equipment, as well as being designed in such a way that diurnal variation can be well supported and also that relatives can visit if safe to do so.
    - Some areas in the ward may cater for communal activities, but there should be provision for separate lounges for people and also a low stimulus dining area specifically in terms of the organic side of the ward.
    - As well as the environmental changes, upskilling of staff should be in focus so that staff can develop specialist skills but also the flexibility to work across the areas due to the complexity and often comorbidity of illnesses that patients presents with, this includes skilling up in how to support frailty, physical health issues and also behavioural difficulties as well as mental illness.

The risks of this option: -

- The environmental changes would take a little time to be put in place, due to building requirements, therefore interim support (including wards to decant to) would be required.
- Data would be required to reflect upon bed usage and also predictive modelling to ensure the number of additional beds was adequate for not only the current population, but also to future proof, at least for the next 3 years.
- Not all staff that are currently temporarily displaced from Rotherham inpatient services will gain an inpatient role in the new proposed model, although there will be enhanced opportunities for them than provided in options 2a, 2b or 3.
- Some staff have expressed some criticism about not having separate 'functional' and 'organic' wards, acknowledging it is permitted in national model This may result in staff leaving the service.
- Risks of patient and carer feedback being negative in terms of the change in model, this is most likely with those patients and carers who have experienced the previous care model.

Option 3 – Reduce to one older person's role per locality based on bed occupancy. Analyse occupancy rates split between functional and organic diagnosis, and purpose certain older adult wards in the Trust for organic mental health problems and certain for functional mental health problems. This would turn the older people's inpatients service into a Trust wide rather than 'place based' provision.

The benefits of this option: -

- It would enable wards specifically focussed upon organic mental health and functional mental health, which is aligned with national guidance.
- Capacity and demand would be better matched due to a ward closure, considering overall occupancy levels.

The risks of this option: -

- We may have more people with a stated need for either organic or functional mental health problems than stated bed allocation, which would be problematic and may mean out of area placements.
- Our older people would often be displaced from the 'place' in which they live. This would result in more travel for their family/ carers when visiting and also for the community care team that are supporting.
- The job plans for our consultants would need to change focussed on speciality and the community in reach model would have greater geographical challenges.

Option 4 – Retain a one ward older adult structure in each area and consider a 'virtual ward' option for older people with organic mental health problems.

The benefits of this option: -

- It would retain a ward structure in each 'place' which would enable older people to be as close to home as possible.
- It would retain a model which supports the separation of people with functional and organic mental health problems.
- We run virtual ward offers elsewhere in the Trust which are successful.
- Specialist Nursing home facilities in the community may offer good partnership options to host the virtual ward.
- We would be able to staff the virtual ward with some of the staff from the inpatient service that has been closed.
- AC/RC responsibility for 'virtual ward' patients may be supported by community consultants or inpatient consultants providing flexibility.
- A care home support/liaison team model may be considered, that again differs in different parts of the Trust.

The risks of this option: -

- Partner agencies may not wish to join.
- There may be different costs associated with the partnership model.
- Some patients may require a more intensive facility. However, if this happens the PICU or out of area facilities that are currently used with older people who have additional needs may be considered as an option.
- It should be noted that the treatment powers of the Mental Health Act in hospital are significantly different to the treatment powers of the Mental Capacity Act which would need to be used on a virtual ward.

Recommendation (s)

For the Clinical Leadership Executive to not, discuss the contents of the paper and contribute to the next and final version of the paper. The final version of the paper will be taken to the Trust Board of Directors for decision in March 2025.

- Please note that People and OD considerations/ plans will require progressing once a preferred option has been identified.
- Please note that all options are being costed by the Trust finance team.
- Please note that a QSIA and EIA will be required once a final / preferred option is selected.
  Please note that if a mixed ward option is pursued (either as a temporary or permanent measure), Dr Gemma Graham has explained that she both has specialist expertise and also national links with other organisations who have mixed ward models and has said that she is therefore able to support a developmental programme for RDaSH staff which would enable the mixed ward model to be more effective, including education and focus on topics including:- Separate spaces; Staff competencies; Distinct pathways / agreed models; environment and access to therapeutic activities specific to each group; Clinical leads for dementia and OP mental health for each ward; and Contingencies / pathways for patients with dementia who present with highly complex and potentially risky behaviours (require higher staffing ratios, intensive interventions and risk traumatising 'functional mental health' patients etc.

Annex 2 – Considerations from Rotherham Care Group SLT

Whilst it may seem skewed to include the RCG SLT opinions and concerns, but not stakeholders be assured considerations from North Lincolnshire, Doncaster and also backbone services, are included as the feedback has supported the option recommended in the paper.

The rational for providing this annex is because of the specific concerns raised by the Rotherham Care Group SLT, and because this is the care group where the bed base will see the most substantive change in terms of the inpatient services provided.

The different model options that are detailed in the annex have differing levels of support. The preferred option has been selected after considering all peoples input and suggestions. It is acknowledged that it is not the preferred option of all who have been consulted about the change. However, it is the option that is advocated by many; is clinically associated with practice guidance; provides care closest to home for our older adults and is also cost effective in the current climate.

The Rotherham Care Group are most affected by the inpatient remodelling part of this proposal, in so specific meetings have been held with the care group, the report author and the Chief Operating Officer. In these meetings the following points have been raised to note as part of these considerations –

- The RCG teams preferred option is to reopen the brambles ward. They do not however have a savings plan in terms of the deficit cost and acknowledged that the occupancy levels do not reflect a inpatient demand that warrants reopening all 15 beds.

- The RCG have stated that their second preference is option is 2c – which is a mixed-ward provision but with 3-5 more beds. There is a provision in Rotherham that would provide a ward base with the requisite increased number of beds (Goldcrest Ward, which is currently closed has 19 beds, which would enable an extra 4 beds from the brambles provision) however this is not purpose built for older people and therefore this is not the care groups preferred option.

- The savings and investment monies require full definition prior to the full detail of the enhanced community care option.

- The potential for a High Dependancyt Unit (HDU) has been discussed in Rotherham and this is linked with both the Rotherham savings plan and the future use of the Goldcrest bed base. Although no investment with the ‘place’ or ICB partners has yet been gained in terms of this facility, the care group has asked that the interdependencies are taken into consideration.

- The care group has raised that the future as the older people’s population rises nationally there will need to be a consideration about the bed base in the Trust. This is acknowledged as not only an issue for Rotherham, but also the whole Trust. This is one of the reasons that an enhanced community care option and the consideration for future ‘virtual ward’ provision is detailed in Annex 1.

Appendix 2 : Environment appendix

Steve Forsyth, Chief Nursing Officer

Windermere Lodge – Brief review of the Organic/ Functional patient care and provision in the current environment

Including Glade and Laurel wards.

Windermere Lodge is currently a 20-bed mixed sex inpatient facility for the admission and treatment of older adults who have a diagnosis of organic illness and/or functional mental ill health. The ward admitted both male and females with both diagnoses approx.10 years ago when the neighbouring ward (Coniston) closed.

The ward is symmetrical from a bird's eye view (bow tie shape), as in the diagram below highlights how the ward is divided into a male and female corridor.

The ward has a circular design and offers minimal restriction of movement throughout the ward, enabling people to walk with purpose and to manage times of increased activity, such as sundowning.

Proposal dividing the ward into two distinct areas by diagnosis (not gender) Organic/Functional

A ward visits and review has been undertaken by the area Matron, DoN Backbone Services, CNO and Matron PD&RRI. The visit explored the practicalities of separating the physical environment to create two ward areas.

Benefits	Challenges
• **Specialist care** - Each area would be able to operate a specialist environment to promote care to each patient Organic/ functional ill health. • **Levels of ability for activity** – This would enable specific focus rather than accommodating a mixed ward.	• **Clinical Room** – There is only one clinic room that cannot be separated. Therefore, consideration would need to be made in replicating this on each side of the ward. Access is needed to essential equipment on each side of the ward, and this would need duplicating, i.e. Resus equipment

Benefits	Challenges
• **Functional/ Organic diagnosis** – The split would enable a focus on each patient group individually. Experience indicates that people with a functional diagnosis may get reduced input due to the behaviours that challenge from an organic presentation. • Lower stimulus environment.	• **Containment and space** – The ward currently have a linked corridor configuration that accommodates 'purposeful walking' enables patients with limited capacity to engage in 'work mode', with a freedom throughout the ward. Splitting the ward would mean the area spread for walking would be limited. • **Incident management** – The separation of the ward would be similar to that of creating 'hot' and 'cold' spaces as during the global pandemic (Covid-19). This confinement the ward staff report a perception of an increase in incidents relating to violence and aggression. This data would need to be reviewed and tested along with the data around the recent separation of the environment for an EOL patient which was perceived by the ward to have had a negative effect on patients on the ward removing the ability to walk freely around the circumference of the ward. • **Staffing** – Due to the split into two separate environments it is anticipated that there would be a need to increase the safer staffing establishment to accommodate the division, incurring further cost. The rationale for this would be the requirements for that care environment would potentially absorb the already established staffing group. • **EMSA** – There would be a breach in this policy due to the layout of bedrooms on each corridor and the mixed sex position. 5 bedrooms on each side there would inevitably be some bedrooms opposite each other with mixed sex. • **Access to outdoor space –** There would need to be two separate outdoor spaces. The front garden area would need to be developed to accommodate this. • **Access and egress –** Two separate access/egress to the ward areas would need to be created and management of this.

Other considerations -

There are three care groups that have older adult inpatient services. Each of the other two care groups have a mixed Organic/ Functional illness care ward. This is since the emergency and urgent closure of Brambles Ward at the Woodlands, Rotherham. This was an emergency closure that was undertaken due to patient and staff safety, at the end of December 2024.

Laurel ward since opening 2011/12 in North Lincolnshire has always had a ward that has admitted people with an organic or functional mental illness and is a mixed sex ward.

Windermere is as described in this paper

- Staffing Establishment would need to be reviewed for each separate area, if there was to be a separation in the ward area to ensure this was not an area that became isolated, secluded and created further inherent and residual risks.

The current safe staffing establishment:

Windermere 20 beds

Early 2 Registered 4 Unregistered

Late 2 Registered 4 Unregistered

Night 2 Registered 4 Unregistered

Laurel 13 beds

Early Registered 2 Unregistered 2

Late 2 Registered 2 Unregistered 2

Nights 1 Registered 3 Unregistered

Glade 15 beds

Early Registered 3 Unregistered

Late 2 Registered 3 Unregistered

Night 1 Registered 3 Unregistered – Urgent closure of Brambles will require review of Registered night to ensure that breaks are covered ND Meagan McNaney meeting with 2 x ward managers.

- Therapeutic Observations and zonal observations need reconsideration, alongside the EToC work currently being undertaken nationally, included in the scope must be to describe how these historic type observations, support therapeutic activities, quality/safety and impact on safe staffing.

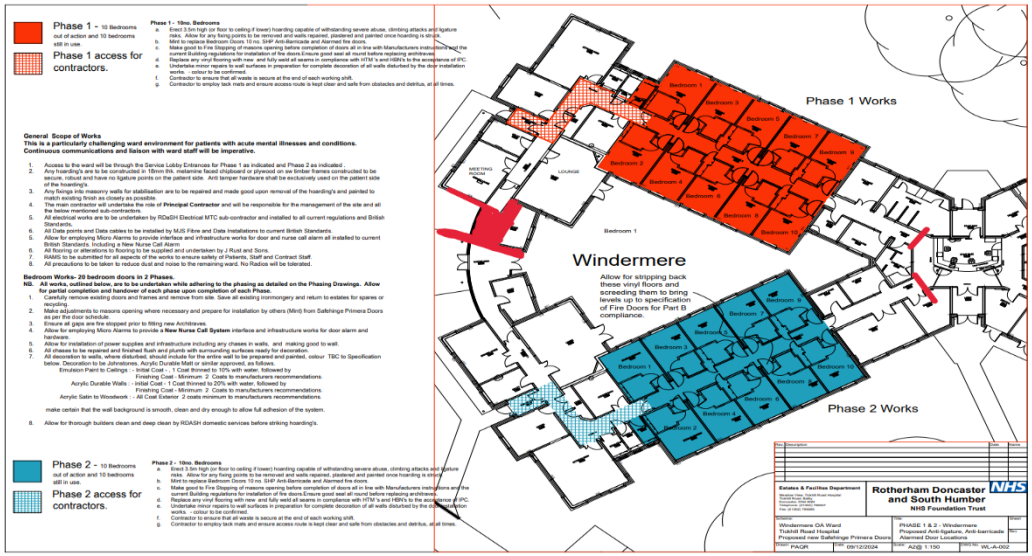
It is recommended this takes place for Windermere, as this review and release would create 72 staffing hours per 24h period day/night which will undoubtedly increase the therapeutic activity both on the ward and off the ward (utilisation of outdoor gardens and spaces – facilitated S17 leave, informal, group activities). Whilst not a feature of this paper, adult inpatient wards, it is recommended this is also reviewed for both Brodsworth and Cusworth wards.

Appropriate use of oxevision, CCTV, new doors in older adults and staffing hours removed from untherapeutic zonal observations would provide support to manage activities, levels of stimulus, create the ability to utilise other areas of the ward, lounge, activities room, dining areas to support meal times, garden time, family visits and explore other therapeutic activities within the current ward layout/environment.

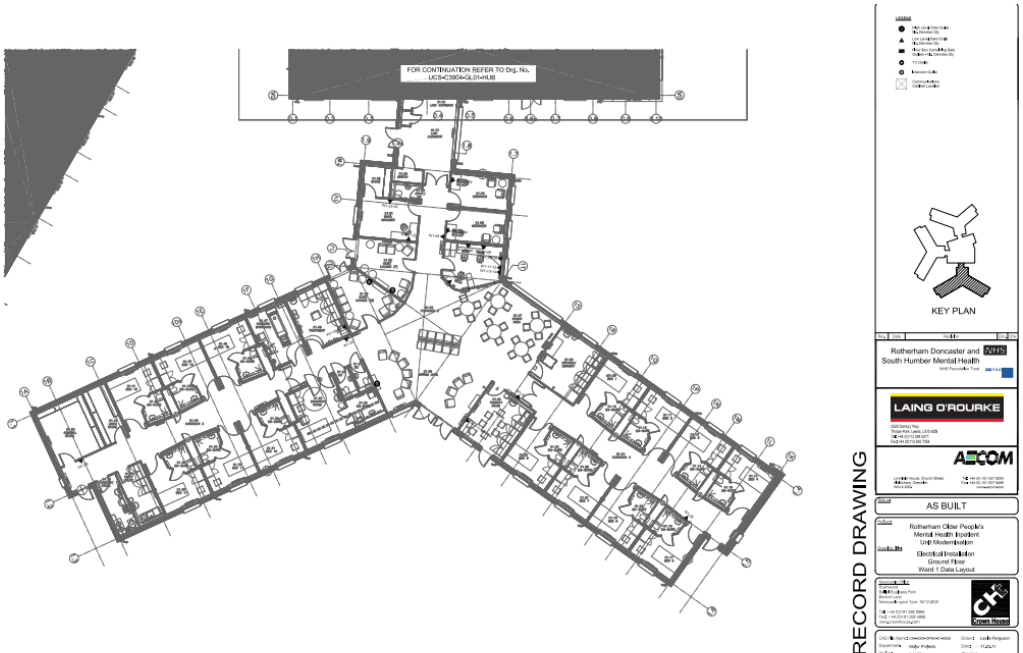
This could include upgrading areas of the ward to become areas that are low stimulus and/or a bedroom/s that could support an older adult with higher dependency needs for both mental and physical health. This must include the support of John's campaign, the dementia friendly hospital charter (with its 7 key principles and goals), the National Dementia Action Alliance, continuation of the Butterfly scheme, Dementia friends and the Public Health Wales guidelines for their hospital charter for people with Dementia.

Therefore, it is recommended that, there is no separation of wards based on a person diagnoses, currently the wards separate patients by gender only (male/female). Separation and segregation as we know can enhance stigma, depersonalise care and can lead to language that dehumanises, none of which is acceptable or in line with our trust values.

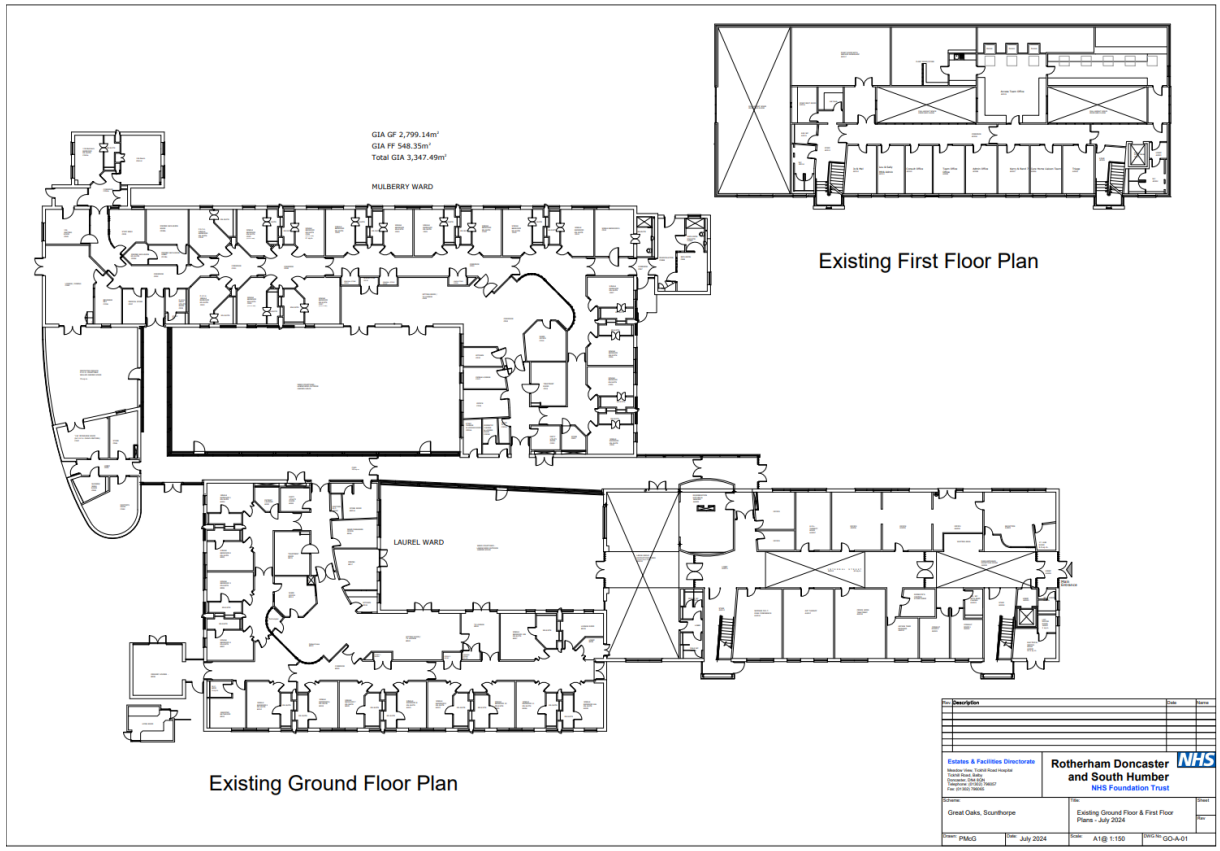
Floor plan Windermere



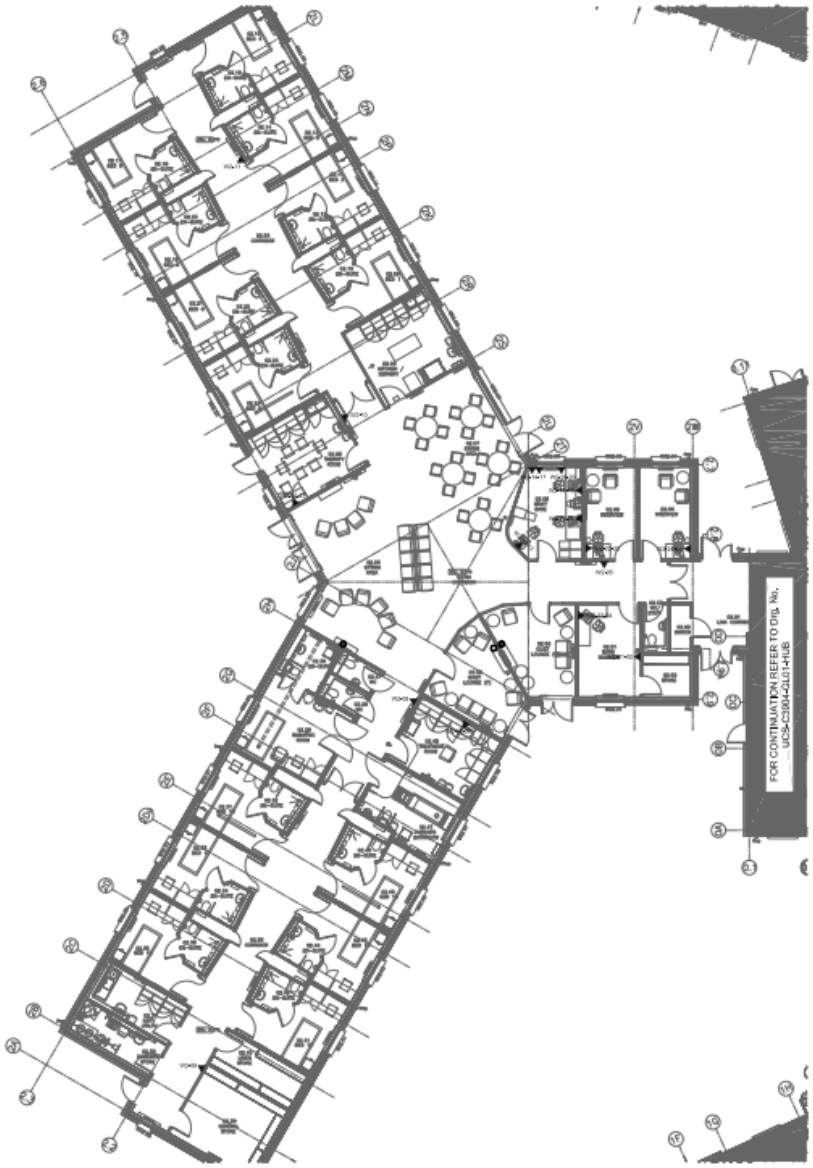
Floor plan Brambles

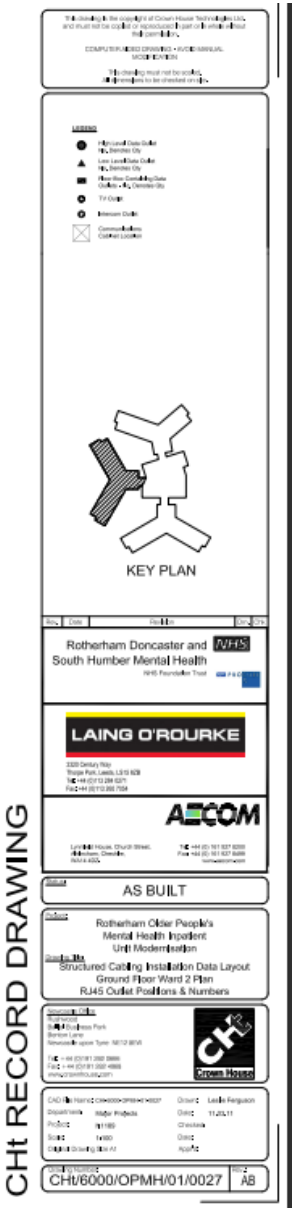


Floor Plan Great Oaks (Laurel – bottom drawing)



Floor plan Glades





Rotherham Doncaster and South Humber NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT

Care Group / Corporate Services:	**Service:**	☑
Care group Acute and Community Mental Health Directorates	**Policy:**	☐
Name of Service/Title of Policy or Strategy, Name of Event:	**Strategy:**	☐
Older Peoples Services across Trust	**Event:**	☐
Equality Impact Assessment Undertaken by:	**Date undertaken:**	
Dr Judith Graham (Director for Psychological Professionals and Therapies)	04/03/2025	

Questions

1. **What are the main aims and purposes of the Policy / Service / Strategy or Event?**

The purposes of the service change to a three-site mixed ward model for older people's service at RDaSH, with an enhanced community care provision. This proposal is aligned with our Trust Strategy, with specific focus on Strategic Objectives 2 and 3.

2. **Who is involved in delivering the service, implementing the policy or strategy / organising the event? (i.e., partnerships, stakeholders, or agencies)**

- Direct Delivery - The older adult inpatient services in Rotherham, Doncaster and North Lincolnshire. (Discussion through delegated representatives in CLE)
- Direct Delivery - The older people's community mental health services in Rotherham, Doncaster and North Lincolnshire. (Discussion through delegated representatives in CLE)
- Stakeholders – patients and families. (Discussion through delegated representative in CLE)
- Partners/ agencies – Local Authority (part of the discussions through HQTC group)

3. **What information, data or experience can you draw on to provide an indication of the potential inclusive / exclusive results of delivering this service or event / implementing the policy or strategy? Consider the impact on different groups of people and the different needs of people with protected characteristics in relation to this policy / service / strategy or event.**

Inpatient information - Currently 2 out of the 3 RDaSH inpatient older peoples sites mixed ward model for older people's inpatient care – this proposal is to align the 3rd Care Group.

Community information – an enhanced community response has been identified as important by Trust experts and all care groups, the changes in the inpatient services suggested will release resources to fund the enhanced community offer. There is no other budget stream which can do this and care groups are struggling to find the savings to meet the budgets set.

National evidence in terms of older peoples mental health care have been considered and are included in the options appraisal which accompanies this EIA, and therefore this information should be read in conjunction with this EIA.

Protected Characteristics	Positive Impact	Negative Impact	Evidence for Impact
Age	☑	☐	The proposed model retains an age defined model which specialises focus upon older people. There is no proposition to merge adult and older adult services.
Disability	☐	☑	In having mixed wards there is a mixture of people with different diagnosis on each ward. Patients presenting with dementia, or functional illness, will have an overlap in symptoms and presentations. Therefore, this advocates the 'mixed ward' approach we are advocating. We are also advocating development of staff to support people with different presentations and also environmental changes to enable different spaces for people with differing needs aligned with Royal College of Psychiatry guidance.
Gender reassignment	☐	☐	No changes that impact this area identified
Marriage and civil partnership	☐	☐	No changes that impact this area identified
Pregnancy and maternity	☐	☐	No changes that impact this area identified
Race	☐	☐	No changes that impact this area identified
Religion or belief	☐	☐	No changes that impact this area identified
Sex	☐	☐	It has been raised during discussion that there is a potential impact for male and female inpatient split. However, all RDaSH wards are single occupancy bedrooms with en suite bathrooms, that are non-gender specific. Therefore, the changes proposed would not impact in terms of 'males being in female identified bedrooms' as the bedroom occupancy is under the control of the ward staff and therefore the management of male/ female separation in this area would be expected to be the same as on all mental health inpatient areas at RDaSH.
Sexual orientation	☐	☐	No changes that impact this area identified
Disadvantaged groups	☐	☐	No changes that impact this area identified
Carers	☐	☐	Older people more often have carer/ relative/ family involvement differently from younger adults. Therefore this change may effect carers in terms of a change in care experience (positively, in relation to an enhanced community care provision, and potentially negatively if there is a need to have a bed in another part of the Trust due to capacity issues) this will be monitored and individual support plans put in place if effects/risks are seen/ identified.

4. What positive impacts are there for this policy / service / strategy or event to better meet the needs of people with protected characteristics?

- An enhanced community care provision, enabling more people to stay closer to home or in their own home.
- A consistent inpatient provision, no matter which of the geographies of the Trust that a person resides in.
- Staff opportunities for development in their area of specialism.

If there are no negative impacts skip to point 7.

5. What action would be needed to ensure the policy / service / strategy or event overcomes:

- Discriminatory negative impacts
- Exclusion

Opportunities for promoting equality and inclusion should be considered when failing to meet the needs of people with protected characteristics.

There are 3 areas identified above which require consider

Age – there is a retention of an age-appropriate model, but there is also a proposed enhancement of a community service which should help prevent admission in some cases and reduce length of bed stay. KPIs will be in place as defined below to monitor the needs and outcomes in terms of age.

Disability - A mixed ward model is permitted in National Guidance; however, it is recognised that although the move to a mixed provision in Rotherham is aligned with our other RDaSH inpatient sites it is the less common option nationally and regionally. The experience of this change in provision will therefore be monitored in terms of risk and patient experience. Also, the environment in the Rotherham ward has not been designed through a dementia specific lens and therefore requires risk assessment and also monitoring in terms of individual risk.

Carers – It is expected that work enhancing the community provision should enable people to be cared for closer to home, this is then anticipated to have a positive effect on carers. If inpatient admission is however required, that we will monitor if there is any impact in terms of patients needing to transition into beds in Doncaster or North Lincolnshire related to capacity. Where this is the case then individual carer support plans would be put in place that support communication and travel to visit loved ones.

*Additional point raised at CLE 18/3/25 - It has been raised during discussion that there is a potential impact for male and female inpatient split. However, all RDaSH wards are single occupancy bedrooms with en suite bathrooms, that are non-gender specific. Therefore, the changes proposed would not impact in terms of 'males being in female identified bedrooms' as the bedroom occupancy is under the control of the ward staff and therefore the management of male/ female separation in this area would be expected to be the same as on all mental health inpatient areas at RDaSH.

6. Recommended steps to avoid discrimination and ensure opportunities for promoting equality and inclusion are maximised.

Impact identified	Action required/explanation if none taken	Lead responsible for overseeing actions	Timescales	Costs (where applicable)
Increased community provision for older people (across trust)	Monitor admission rates Monitor Length of Stay (LoS) Monitor caseload	Community Matron & Service Manager	9 months with evaluation entered at 12 months	Not applicable, expected as part of routine work
Increased risk in terms of mixed occupancy, with previously being a separate functional and organic provision (Rotherham only)	Environmental risk assessment Monitor patient incidents Spend time with Doncaster and NL inpatient leads who both moved from a separate to mixed ward provision.	Inpatient Matron and Service Manager Rotherham	9 months with evaluation entered at 12 months	Not applicable, expected as part of routine work.

Staff knowledge base and confidence in working on mixed ward (Rotherham only)	Training needs analysis – discussion with staff Delivery of training sessions in handover and on half day learn sessions. Inclusion of subject matter experts from backbone services (i.e. adjusted RRI for people with cognitive impairment)	Inpatient Matron and Service Manager Rotherham. For education – older people's specialists in Trust	3 months with existing staff, then integrated into new starter induction *specific work will be required in terms of AC/RC on the ward areas, linked together to work towards a reduced length of bed stay in Rotherham, as this is an outlier in terms of all RDaSH services	Time costs – training would be expected by internal older people's specialists Time from L&D trainers
Carer support if capacity is taken in Rotherham and patient is moved to NL or Doncaster	Individual Carer Assessment Travel support plan Communication support plan (i.e. via IPAD as used in some of the Doncaster rehab wards) Carer experience	Inpatient Matron and Service Managers in all sites (although Rotherham would be the originating area, other care group staff would need to contribute to the assessments).	With immediate effect With summary and review in care group business meetings and delivery review.	There may be costs in terms of supported travel costs or device costs.
Patient experience of enhanced community and mixed inpatient ward	Via patient Via ward meetings Via discharge questionnaires Via Care Opinion	Inpatient Matron and Service Manager Rotherham. Support from N&F backbone patient experience team.	With immediate effect With summary and review in care group business meetings and delivery review.	Not applicable, expected as part of routine work
Out of Area Placements	Via occupancy and flow monitoring as with adult inpatient services at the current time.	Patient flow team	With immediate effect	Not applicable, expected as part of routine work
Staff experience of enhanced community and mixed inpatient ward	Via staff / team meetings and 1:1s Via pulse surveys	Matron and Service Manages. Support from POD backbone services re pulse check.	With immediate effect With summary and review in care group business meetings and delivery review.	Not applicable, expected as part of routine work
Male / Female occupancy levels	All RDaSH mental health wards are mixed sex wards, adhering to single sex occupancy guidance by having single bedrooms with en suite bathroom facilities. Therefore, ward staff must ensure patients are cohorted on admission to support safety. There are no specific male and female bedrooms,	Staff Nurses, Ward Managers	With immediate effect	Not applicable, part of routine work

	therefore it is the staff who have the responsibility to allocate an appropriate bedroom for admissions, as with all other mental health wards across the RDaSH footprint.			

7. What arrangements are going to be made to monitor and review the adverse impact in the future?

How the equality impact of the policy/service/strategy/event will be monitored?	• Daily via clinical teams • Via care group directorate governance • Via trustwide delivery reviews • Patient and staff experience monitoring
Frequency of monitoring?	• Daily – clinical team • Monthly care group governance • Bimonthly – delivery reviews • Annual review of change • Patients experience monitoring reports (N&F) • Staff experience pulse checks and survey (POD)
How the monitoring results will be used and where they will be published?	• Directorate minutes • Delivery review data and out briefs • Clinical Leadership Executive (CLE) updates • Patient Experience reports – Q&S sub-CLE group • Staff Experience reports – P&T sub-CLE group
Who will be responsible for reviewing monitoring results and initiating further action where required?	• Matrons & Service Managers at a delivery level • Quadrumvirates at a Care Group level • Joint work between N&F and Care Groups • Joint work between POD and Care Groups
Any changes that have been made to remove or reduce any negative impacts as a result of conducting the equality impact assessment?	• Engagement with staff side colleagues • Engagement with internal and external stakeholders via HQTC taskforce • Engagement with clinical and managerial leads through Clinical Leadership Executive.
Any action points should be included in Care Group / Corporate action plans, with monitoring and review processes.	Not at this time

8. Is further work / consultation required? If yes, please explain how this is to be carried out and the time frame for completion.

Yes ☐ No ☑

This depends upon the option that is chosen at the Board of Directors meeting in March 2025.If option 2 is chosen, the consultation process will be linked with staff change.

Although these are not the preferred options presented - if options 3 or 4 are decided upon these will require a public consultation.

This Equality Impact Assessment will need to be reviewed in line with any changes made to the policy, service, strategy, or event.

Name of lead:	**Head of service:**
Dr Judith Graham	Not applicable – applies to multiple services
Designation:	**Signature:**
Director for Psychological Professionals and Therapies	
Signature:	**Date:**
JSC Graham	

Once completed and signed by your head of service or manager, the Equality Impact Assessment is ready for review. Please send it to the relevant group for consultation. Information about the consultation process can be found in the Equality Impact Assessment Toolkit and Policy and Procedural Documents (Development and Management) Policy.

QSIA Checklist

Quality & Safety Impact Assessment Toolkit

Title	Name of Lead	Executive Sponsor / Clinical Lead
Older People's Mental Health Services Across Trust	Dr Sinclair (CMO) Steve Forsyth (CNO) Dr Graham (Director for Psychological Professionals & Therapies)	Toby Lewis (Chief Executive Officer)

Description
Please provide a brief description, what is its purpose, what is the problem you hope to solve, what is hoped to be achieved, what are the key actions, how will the benefit be seen?
The purposes of the QSIA is to focus upon the service change to a three-site mixed ward model for older people's service at RDaSH, with an enhanced community care provision. This proposal is aligned with our Trust Strategy, with specific focus on Strategic Objectives 2 and 3. This QSIA should be read in conjunction with the analysis and recommendations paper reviewed through the High-Quality Therapeutic Care (HQTC) Task force meetings in Q4 24/25; through the Clinical Leadership Executive meetings in January and February 2025 and also through the Board of Directors meeting in March 2025. This QSIA should also be read in conjunction with the paper and associated QSIA from the emergency closure of Glade ward in January 2025.

Has this QSIA been completed in collaboration with the clinical team that the project will affect?	
Yes ☒	No ☐
Different models of care and options have been considered in the following meetings and with the following people. The different model options are detailed in the paper referenced in the above section. The preferred option has been selected after considering all peoples input and suggestions. It is acknowledged that it is not the preferred option of all who have been consulted about the change. However, it is the option that is advocated by many; is clinically associated with practice guidance; provides care closest to home for our older adults and is also cost effective in the current climate. *List Names & Job Titles:* • Clinical Leadership Executive (representatives from all care groups, backbone directorates and also lived experience partners – ToR has full name list) • High Quality Therapeutic Care (HQTC) taskforce - (representatives from all clinical specialisms; care groups; backbone directorates; local authority and peer support workers – ToR has full name list) • Trust Consultants Committee – (shared by Chief Medical Officer to all Consultant Psychiatrists in the Trust) • Care Group – shared with all care groups for discussion with staff in relevant areas.	

Equality Impacts
Has an Equality Impact Assessment (EIA) been completed? **If Yes** – Please briefly describe any impacts that have been identified **If No** – Please explain why an EIA was not applicable
Yes. There are 3 areas identified which require consideration, these are - **Age** – there is a retention of an age-appropriate model, but there is also a proposed enhancement of a community service which should help prevent admission in some cases and reduce length of bed stay. KPIs will be in place as defined below to monitor the needs and outcomes in terms of age. **Disability** - A mixed ward model is permitted in National Guidance; however, it is recognised that although the move to a mixed provision in Rotherham is aligned with our other RDaSH inpatient sites it is the less common option nationally and regionally. The experience of this change in provision will therefore be monitored in terms of risk and patient experience. Also, the environment in the Rotherham ward has not been designed through a dementia specific lens and therefore requires risk assessment and also monitoring in terms of individual risk. **Carers** – It is expected that work enhancing the community provision should enable people to be cared for closer to home, this is then anticipated to have a positive effect on carers. If inpatient admission is however required, that we will monitor if there is any impact in terms of patients needing to transition into beds in Doncaster or North Lincolnshire related to capacity. Where this is the case then individual carer support plans would be put in place that support communication and travel to visit loved ones. Within the EIA there is also an action plan and set of governance arrangements detailed in order to have oversight and manage the risks. *When the EIA and QSIA were considered in the clinical leadership executive meeting on the 18/3/25, there was a request to detail the potential risk and risk management regarding gender split and occupancy. This has been added to the EIA, and considered by the Clinical Executives, with this outcome detailed in the action plan - *All RDaSH mental health wards are mixed sex wards, adhering to single sex occupancy guidance by having single bedrooms with en suite bathroom facilities. Therefore, ward staff must ensure patients are cohorted on admission to support safety. There are no specific male and female bedrooms, therefore it is the staff who have the responsibility to allocate an appropriate bedroom for admissions, as with all other mental health wards across the RDaSH footprint.*

Savings Programme Specific Questions

Workforce Implications *Does the change impact individuals or positions? Please describe any workforce implications to aid the HR support requirements.*		
Whole Time Equivalent Impacted	*59 Headcount* *(this includes brambles and glades staff but does not include students or volunteers who support the ward indirectly)*	
Consultation required	Yes ☒	No ☒
The option 2 recommendation brings workforce/staffing implications, related to the permanent closure of Glade and the redeployment options for staff offered in terms of the enhanced community provision.		

Given the recommendation for the one ward model based in the Rotherham locality, this would result in a change management process for Rotherham colleagues. The colleagues affected by the change management process would differ based on whether option 2a or 2b or 2c is progressed.

Irrespective of the option, the Trust will comply with our change management consultation processes and seek to minimise any anxiety which affected colleagues may face as a result of the change management process.

Any consultation would be for a minimum of a 30-day period and the Trust would seek to redeploy all colleagues to suitable alternative employment opportunities within the Trust, recognising the additional posts which will be available as part of the community investment.

Area of Quality	Question	Examples	Tick Impact			Description of Impact	Quality Metric	
			Positive	Neutral	Negative		*Quality or performance metric to be monitored to assess impact*	Threshold for escalation
Patient Safety	Could this impact on patient safety?	*Incidents* *Avoidable falls* *Increased ligature risk* *Pressure ulcers* *Environment changes*	☒	☐	☒	Inpatient environmental changes – in permanently using a mixed ward provision in Rotherham. However, this change is aligned with the model progressed in North Lincolnshire and Doncaster and risks are managed. Community Changes – these are expected to have positive impacts upon patient safety in terms of reducing admissions; reducing length of stay in Rotherham specifically (to align with the wider Trust) and enhancing patient, carer and community support.	It is expected that the Rotherham team works with the Doncaster and North Lincolnshire teams who have already undertaken this change and have good risk management plans in process. Patient experience Staff experience	IQPR thresholds for safety metrics
Clinical Effectiveness	Could this impact on clinical outcomes?	*Quality standards* *Avoidable admissions* *Patients, carers & public engagement* *Length of stays*	☒	☐	☒	It is expected that the LoS should reduce, aligned with other areas in the Trust. If this is the case, (as the bed stay modelling in the associated paper shows) then there is sufficient inpatient capacity across Trust and in Rotherham to manage the demand upon the service. The proposed model aims to improve community care provision with the reinvestment or resource that comes from bed base realignment which will then support enhanced community care packages	Admission and discharge data across Trust Out of area placement data Length of stay data Patient and carer experience data Avoidable admissions data	IQPR thresholds for safety metrics

Area of Quality	Question	Examples	*Tick Impact*			Description of Impact	Quality Metric	
			Positive	Neutral	Negative		*Quality or performance metric to be monitored to assess impact*	Threshold for escalation
Caring	Could this impact on patient care and experience?	*Delayed discharges* *Out of area placements* *Other patient flow aspects* *Complaints or compliments*	☒	☐	☒	The enhanced community care provision is aimed at improving the care that older people receive in their own home. This is also aimed at being able to support more people at home and therefore reducing the number of admissions. The additional impact of an enhanced community care package is that patients and families can be supported to return home sooner if admitted. This will have an impact on length of stay. In terms of the inpatient bed realignment, there is the potential for people to be supported in other areas of the Trust. This mirrors the model in adult mental health provision. Should this arise it may have a negative impact on patient and carer experience.	Patient contacts Carer contacts/ assessments Carer travelling experience/ support if patient placed outside Rotherham Patient feedback Carer Feedback Staff Feedback LoS data	IQPR thresholds for safety metrics Patient Flow Escalation processes
Responsive	Could this scheme impact on timeliness of treatment or performance standards?	*Access to treatments* *Waiting times for diagnosis* *Waiting times for treatment* *Annual review compliance*	☒	☒	☐	The increased community care provision is likely to increase community responsiveness and therefore reduce waits. The reduced bed-base in Rotherham, will impact upon care and therefore beds may need to be utilised in other parts of the Trust, if length of stay and admission rates are not reduced in line with other areas of the Trust.	Length of Stay Out of Area Placements	IQPR thresholds for safety metrics Patient Flow Escalation processes

Area of Quality	Question	Examples	*Tick Impact*			Description of Impact	Quality Metric	
			Positive	Neutral	Negative		*Quality or performance metric to be monitored to assess impact*	Threshold for escalation
Well Led	Could this scheme impact on the financial position of the Trust, staff experience, equality and diversity, or Trust reputation?	*Income or expenditure* *Workforce turnover* *Staff working practices* *Training compliance* *Workforce capability & skills* *Impact on other healthcare services*	☐	☐	☐	Redeployment of staff will support other areas of the trust where there are staffing challenges and vacancies will be considered. In addition, there will be staff opportunities for people to move from specialist inpatient to community older people's services. However, some costs could be seen in terms of increased travel costs for relatives, patients and staff. Staff side engagement in terms of the programme of work is progressing	Staff change monitoring procedures Patients experience monitoring Carer experience monitoring	

To be completed by QSIA Panel:

Approval Status	Name	Signature	Date
QSIA Panel Chair:			
Is a full QSIA required	*(Yes / No)*		