



Thames Valley and Wessex
Adult Secure
Provider Collaborative

For Me Adult Secure Provider Collaborative



Commissioning Strategy 2023-2033





A thank you to our contributors!

In the spirit of co-production, we were very keen to involve our patients and teams in the production of this strategy. In the first instance, we conducted small group discussions and interviews, as well as a series of workshops focused on key priorities for our Provider Collaborative (PC) going forward; we featured patient videos in all our engagement sessions, and we have represented patient voices directly in this document. We wanted to go further to make this feel like a strategy that could be owned throughout our services.

One way in which we felt there was an opportunity to broaden involvement was to engage patients and staff in the development of the artwork you will see throughout this document. Inspired by the themes of working together, recovery, and nature, we have been impressed and overwhelmed by the skill and thoughtful reflection shown in the submissions we received. The creativity shown has brought our wards and teams together to produce beautiful artwork like you see here.

Confidentiality provisions prevent us from giving named credit within this document, but we would like to formally thank all our contributors; the effort has been immense, and you have greatly influenced the tone and themes throughout this document.

While leaders within the system play a crucial role in steering and guiding the strategy's delivery, the ultimate success will be determined by our staff and patients.



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A word from our leadership

Dear Provider Collaborative Patients, Teams and Partners,

We are delighted to share with you the combined efforts of our year's work, assessing the future needs of the service and working with you all to understand how best to meet these needs. It has been a privilege to work with you all throughout this process; you have approached the significant challenge of distilling 10 years of service wide priorities into tangible actions, with enthusiasm and pragmatism.

It is no surprise that we find ourselves in the enviable position of having clear patient focused goals for the next five years. It is aligned with the extraordinary efforts that teams throughout the Provider Collaborative make every day. We provide services to some of the most challenging and vulnerable individuals in the Thames Valley and Wessex region and you often put the needs of those in our care, their families and our communities well ahead of your own. We are all grateful for that and would like to commit to improving staff experience as a core priority for the coming years. Investment in learning, development and training, the right well-being facilities and a commitment to more peer support are all key priorities for our partners secure services over the next 2 years. The Provider Collaborative will fully lend its influence and resources to local developments that improve staff well-being.

We see this strategy as an opportunity to pause and reflect on all the hard work that has led to the significant success of our For Me Provider Collaborative since our inception. Our excellent financial performance, and significant repatriation gains, are testament to our shared commitment to quality and collaboration. We have maintained steadfast focus on achieving the best possible outcomes for a complex and challenging patient group. It



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Director of Secure Mental Health



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has not always been easy; professionalism and a commitment to transparency in decision making is as critical now as when we began this Provider Collaborative journey. With this in mind, we are now taking a bold step of co-signing this strategy, and the partnership commitments herein, to demonstrate a reinvigorated commitment to collaboration and partnership working going forwards.

We have reaped the rewards of a robust approach to case review and clinical led decision making, allowing us the financial headway to invest in new models of care, pathways and facilities. Renewed enthusiasm for innovation is now required to drive forward the next phase of development. We have opportunity to take a strategic view on building better local Women's Services, meeting the needs of our Neurodiverse patients, managing transitions between services better and addressing the growing pressure that frailty and patients with additional physical health needs pose on our services. We want to shift from reactive demand management to proactive planning and preventative approaches. We remain focussed on removing inequitable barriers to access secure services and improving discharge planning.

We are excited to continue this journey of improvement and collaboration together and once again offer our sincerest thanks for your commitment, humour and unwavering collaborative spirit. We look forward to hearing all of your thoughts on how we put this strategy into action.



Our commitments to work together

We have heard through the engagement phase of developing this strategy that the PC does not always work in the way that we hoped it would. There are some areas of perceived inequity between member organisations and services, as well as ways in which we could work together better.

In contrast we are all very much aligned in our values as organisations and teams, so we have decided to make a public commitment to achieving a common set of goals over the coming years.

These commitments were developed collaboratively across all partner organisations, and have been formally cosigned as part of this strategy.

When discussing the commitments with our teams we have noted a number of key feedback themes:

- We need to make sure the commissioning environment does not constrain our ability to deliver
- Partners agreed that all contribution should be proportionate and align with local capacity
- We should avoid any systematic duplication
- Collaboration and trust must be priorities
- We must tackle cultural barriers
- We must learn from and share both lessons learnt from things that may go wrong, as well as best practice and exemplar models.

Oxford Health
NHS Foundation Trust

Berkshire Healthcare
NHS Foundation Trust

Central and North West London
NHS Foundation Trust

Dorset Healthcare University
NHS Foundation Trust

Elysium
Healthcare

Hampshire and Isle of Wight Healthcare
NHS Foundation Trust

The Priory Group

Provider Collaborative Partnership Commitments

We will ensure appropriate parity of contractual terms for all providers and foster supportive partnership approach to addressing any identified shortfalls in quality and occupancy

We/I commit to fostering a culture of trust and collaboration between the member organisations and its clinical teams in particular; this will culminate in stronger system wide relationships

We/I will reflect the principles of a recovery focused pathway and least restrictive approaches in our day-to-day decision making

We/I will be a constructive and collaborative agent within the Provider Collaborative; ensuring appropriate representation at key meetings and committees

We/I will work proactively to unblock barriers to access in secure services and discharge pathways

We/I will support efforts to provide patients with the best possible care in a suitable location, as close to their home as is feasible

We/I will be open and transparent in our approach to sharing learning where things have gone wrong or near misses have occurred; focused on promoting a culture of learning from harm or potential harm. We will also take steps to collaborate on emerging best practice and things that have worked well

We/I will ensure that every possible effort is made to provide equitable access to care, decision making and patient outcomes regardless of age, race, gender, orientation, disability and/or clinical presentation

We/I will actively empower our workforce to grow and lead decision making; enabling skills development and championing well-being for all staff regardless of where they are based. We will facilitate shared learning and peer relationship development with this principle in mind

We/I will make every effort to secure sponsorship for critical infrastructure investment, as and when these are identified as priorities for the Provider Collaborative

We/I will make proportionate allocation of time and internal resources to support Provider Collaborative collaboration and the co-production agenda

Figure 1 - For Me Provider Collaborative Partnership Commitments

Our Core 10 Year Strategy to 2033

Better lives for our patients, our staff and our communities

We want to ensure our partnership approach to delivering the roles and responsibilities of the Provider Collaborative aligns with our goals of improving the lives of our patients and the experience of our staff. The core aims of the Provider Collaborative are to:

- Improve secure care pathways for care closer to home and in the least restrictive setting
- Improve experience, making sure we involve people in service review and design, and listen to their views
- Focus on the prevention of secure inpatient admission, so people are only admitted to hospital where clinically appropriate
- Invest in new services and better community facilities, to improve 'step-down' (rehabilitation) and to reduce the length of stays
- Work as a system, redesigning our services to fit the needs of people and support recovery
- Increase our focus on prevention, recovery and self-care.

People who use these services and the clinicians, in partnership, will continue to have influence and involvement in the delivery of their services. This, in turn, will mean that the Provider Collaborative can reinvest funding into improved community services and care pathways for people and their families.

This strategy is the culmination of an extensive period of analysis and engagement across our provider network. We have heard the views of our patients and staff and want to set out how we will work to improve services for everyone within our care over the next ten years. This is the beginning of a journey towards improved collaboration, and we hope this serves as a live framework that can continue to be refined and evolve to meet future needs.

Practices and Behaviours

We recognise that before we can work towards challenging changes in our facilities and clinical models we can and should do more to foster functional collaboration between teams at all levels of our organisations. This will require us to build trust between organisational

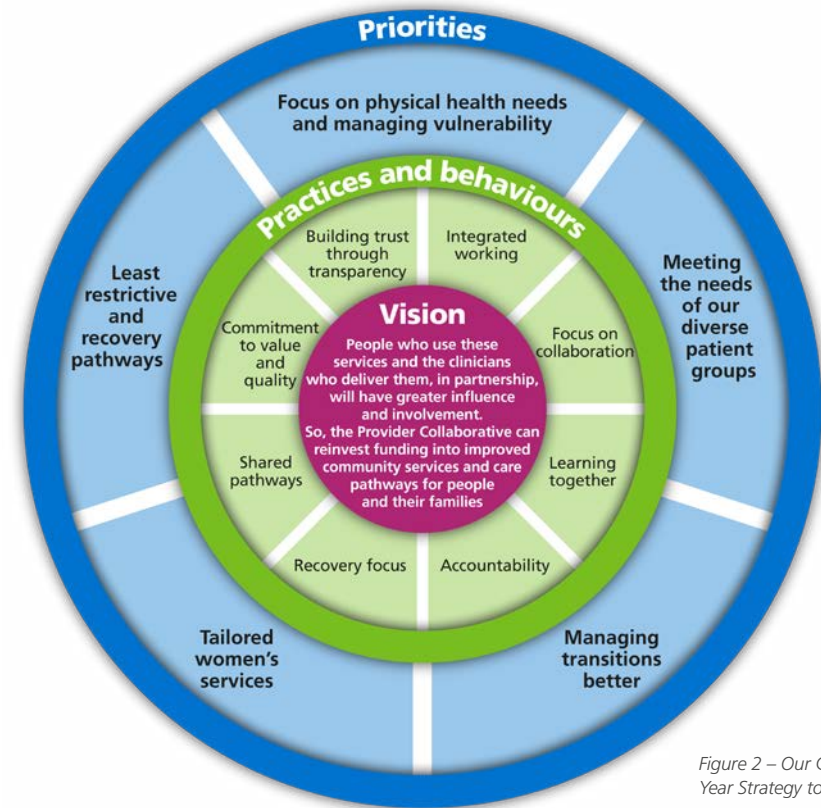


Figure 2 – Our Core 10 Year Strategy to 2033

boundaries and protect our clinician's development time. We will empower them to work together more, sharing best practice and working through challenges in patient care. We will hold each other accountable regarding our ongoing commitment to patient recovery and least restrictive practice; even when this is challenging. We will also support each other when our services are in crisis or not meeting the standards we expect.

Priority Developments and Enablers

The themes and deliverables summarised within our strategic priorities above are described in more detail in section 2 of this strategy. Whilst we will likely deliver a wider range of change, improvements and commissioning led innovation over the next 10 years, we feel it is important that we align our activities with one of these high priority themes.

These priorities can then provide a consistent framework for investment decisions and service change decisions going forwards. Activities to deliver each of these priorities are already underway (examples include FIND teams and community discharge investments) and will be built upon in the first year of the strategy delivery period.

Our Strategy on a Page

The graphic (right) represents the key themes and features of our strategy, showing the significant interdependencies and relationships between the key aims. We hope to align all priority workstreams within the strategy, with one of 6 working principles: User voice and experience, timely access, equality, clinical expertise, partnership and collaboration and least restrictive support in recovery.

The detailed approaches to delivering improved practices, and our priority developments, are set out in section 2 of our strategy. Some of the milestones and outcomes are summarised here to give a sense of the scale of what we have planned. This is a long-term commitment that will require the support of all partners and significant investment, but we strongly believe that this will help to achieve a significant positive step-change for many of our patients, the working life of our teams and the security of our communities.

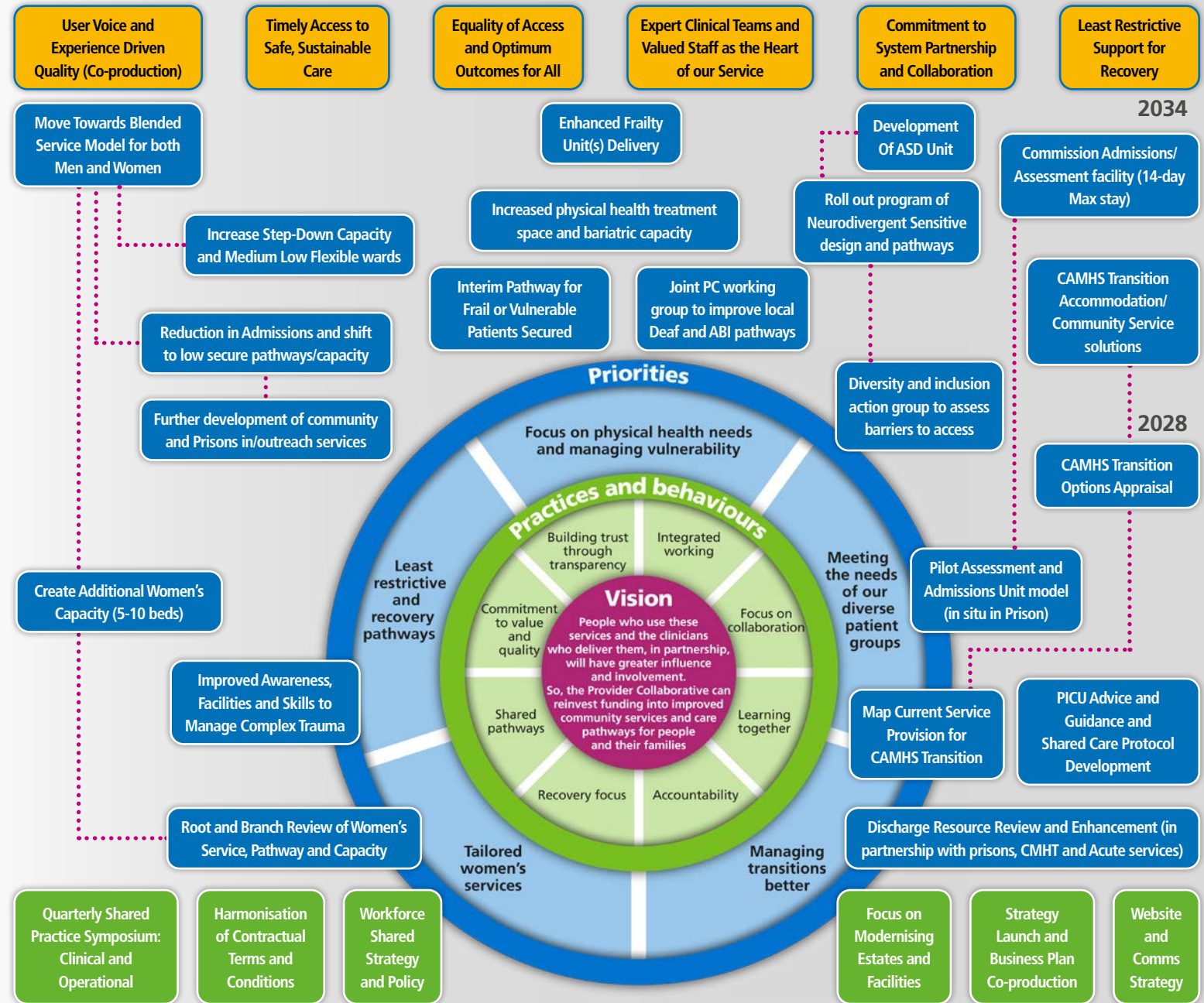
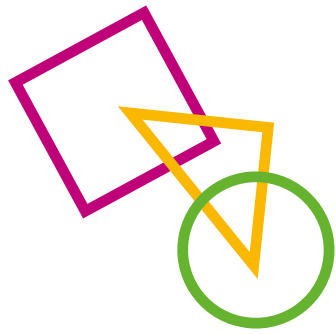


Figure 3 – Our Core 10 Year Strategy to 2033 in detail



Our patients' voices



What we have heard through local patient and carer discussions:

I need quiet reflection spaces to deal with challenging feelings and my trauma. Away from the noise and activity of the ward

I want my voice to matter

We need things to do to make our day to day lives meaningful and give things to work towards

We need more support for patients like me with ASD and ADHD

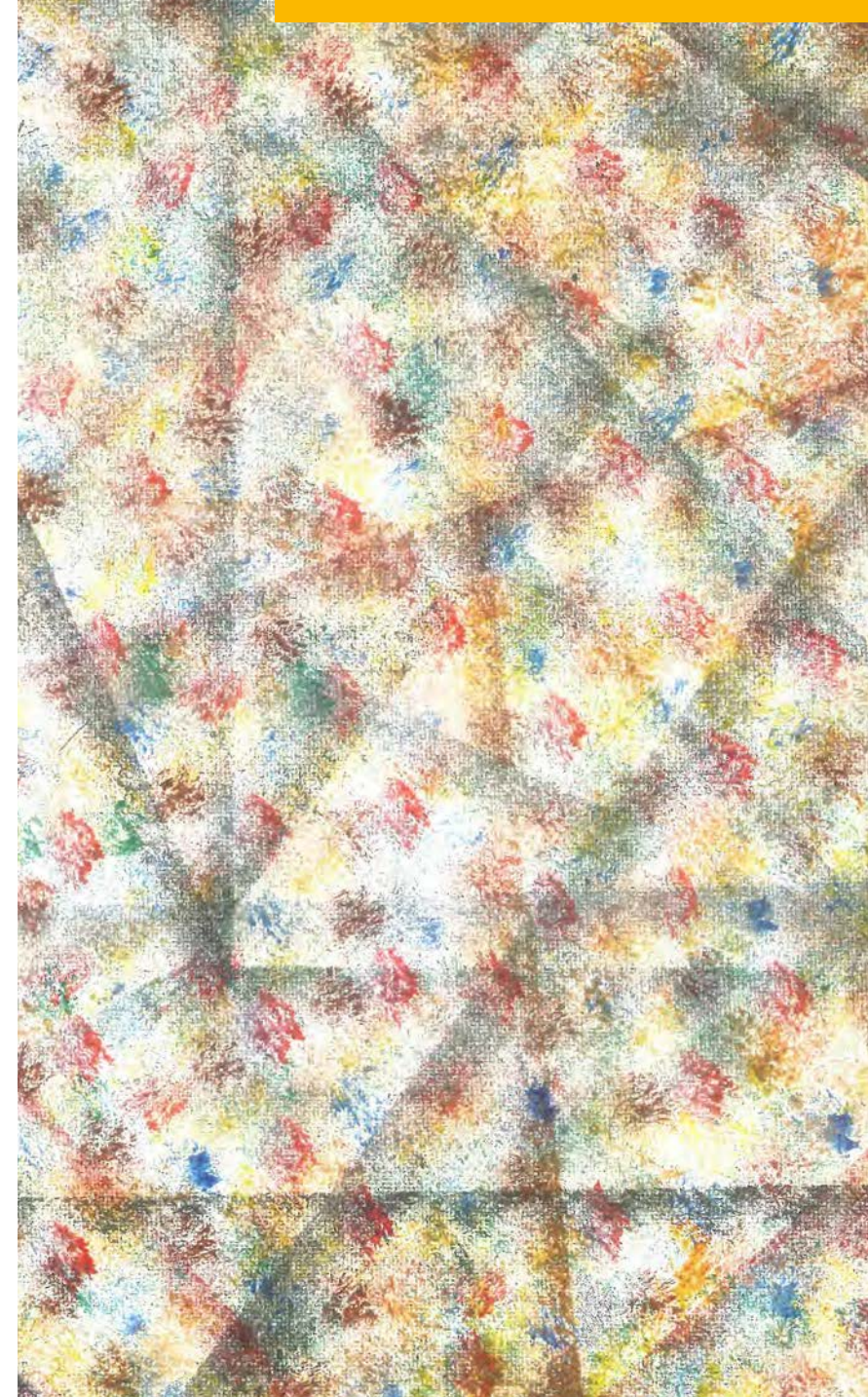
I expect honesty activity of the ward from staff about my treatment and likelihood of going home

I want to be able to speak to a member of staff when I am in crisis

I want to know when I will be able to leave

I want to develop skills and exercise when I want not when it's convenient

Could you do more to work with schools and young people before they end up in your services later in life?



Section 1: Understanding our future service needs and priorities

How we developed the evidence for our Commissioning Strategy

The illustration on the right shows the 4-stage process undertaken in order to develop this Commissioning Strategy. This includes

1. Gathering baseline information and stakeholder interviews and engagement
2. Refining and agreeing on local planning assumptions and modelling
3. Collaborative strategy development – applying the above to inform future provision including scoping of potential future service options and prioritisation
4. Commissioning strategy development – bringing together all the above and planning future service provision including specifications of services and new models of care.

In this section we will explore some of the insights generated by the Strategic Needs Analysis (SNA) undertaken earlier this year and the corresponding modelling of the future bed requirements (this correlates to Steps 1 and 2 in the illustration). The SNA was an essential step to understanding the service needs and priorities. This section also summarises the planning assumptions and modelling work performed, and the outputs of that work.

The options for development are introduced at the end of this section and explored in more detail over the next section. The final outputs and priorities (in line with Steps 3 and 4 of the illustration) will emerge later in the document.

We will begin by summarising the findings from the SNA which began in 2022, and proceeded to the development of the commissioning strategy which was undertaken between March and October 2023.

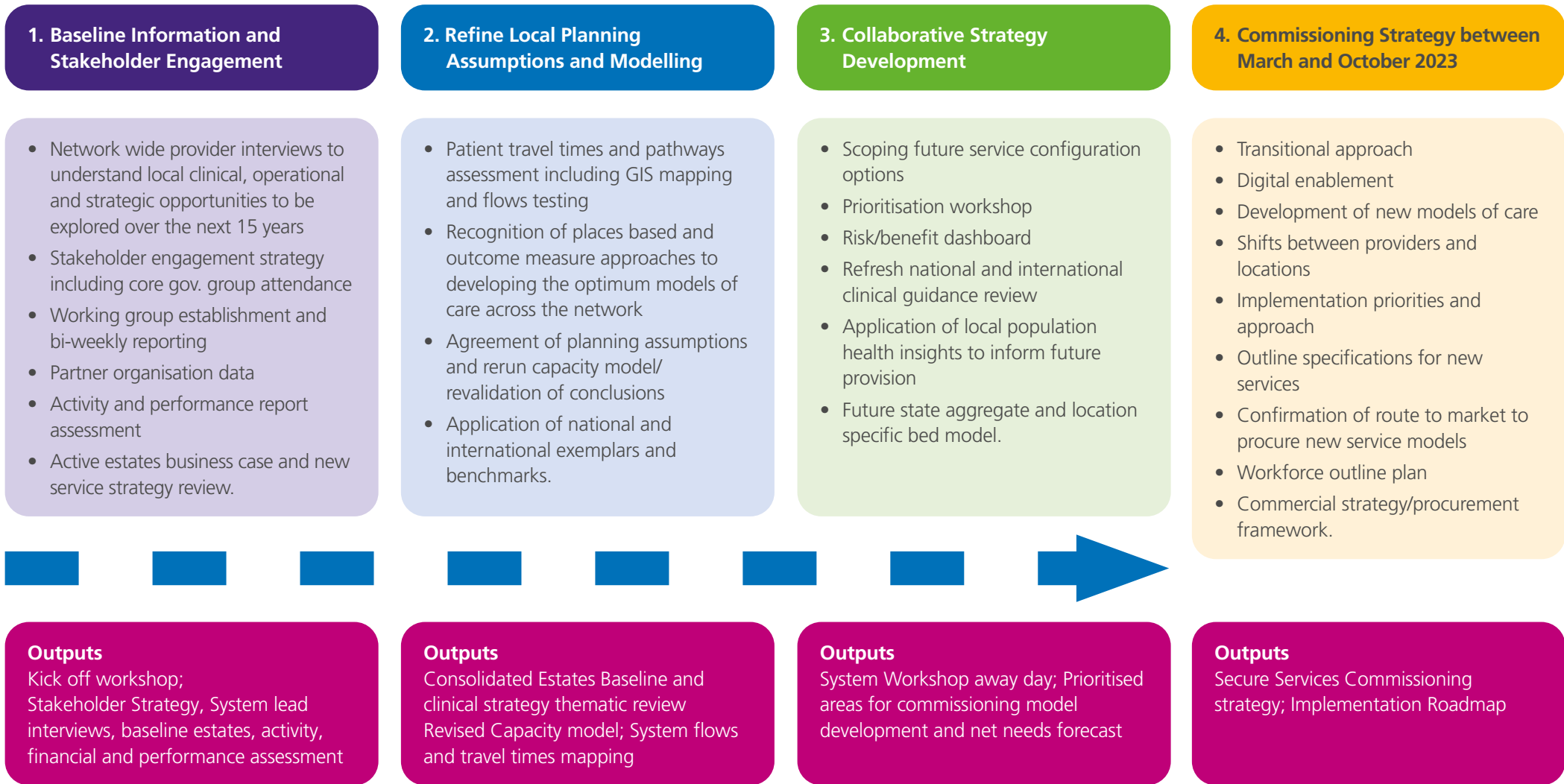
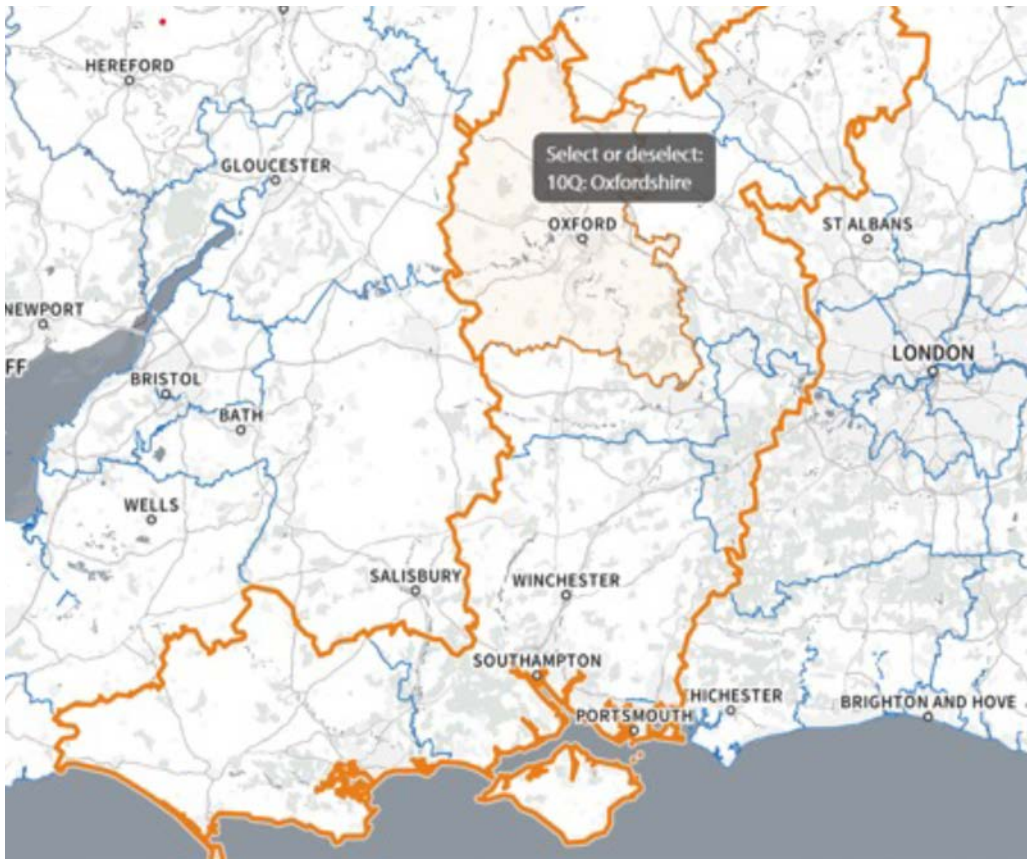


Figure 4 – Illustration of 4 stage process to formation of the PC Commissioning Strategy

Introduction to the Provider Collaborative

The Thames Valley & Wessex Adult Secure Provider Collaborative, now known as For Me, took over responsibility for the care pathways, budget and services for specialised mental health, learning disability and autism across the Thames Valley and Wessex region in 2021.



The Provider Collaborative membership have focused on delivery of a mandate to ensure people who use specialised mental health, learning disability and autism services are no longer only able to access care many miles from their home and families. Historically these patients would also spend longer in hospital because of the way services were organised

The **For Me Provider Collaborative** covers the geographical regions outlined in the map shown. This goes from the West end of Dorset and to the North end of Milton Keynes areas, as shown.

The Provider Collaborative (PC) is made up of a number of NHS organisations and independent providers, these are the following:

- Oxford Health NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- Elysium Healthcare

- Hampshire and Isle of Wight Healthcare NHS Foundation Trust
- The Priory Group.

The core services that were in scope for this commissioning strategy include:

- Male and Female Adult Services
- Medium and Low Secure Secure Mental Health (High Secure activity captured in baseline data set has been excluded) and Learning Disability, Autism Spectrum Disorder
- Additionally, responsibility for nationally commissioned highly specialist placements including Acquired Brain Injury, Deaf and Women's Enhanced Medium Secure services
- Step down and acute services.

We have also explored the relational aspects of services such as Tier 4 CAMHS, Prison, Community Mental Health and Psychiatric Intensive Care services.

Figure 5 – For Me Provider Collaborative geographical regions

Strategic Needs Analysis

What do our services need to deliver in the future?

Steps for the Strategic Needs Analysis (SNA)

A Strategic Needs Analysis has been undertaken which included the steps (as shown in the illustration):

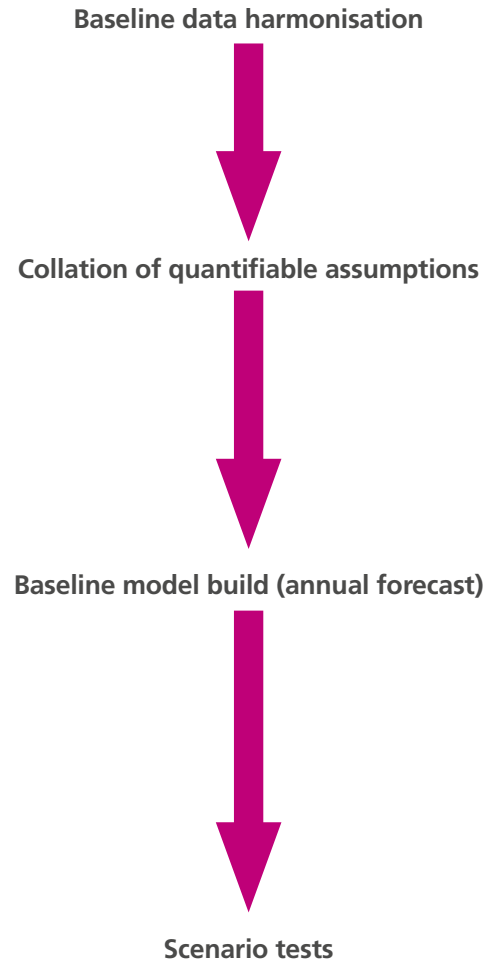
1. Undertaking a baseline assessment to understand current bed capacity and utilisation and activity
2. Trends analysis, for example including length of stay trends and identifying areas of need
3. Assumption development – defining core capacity assumptions for modelling through detailed analysis and stakeholder engagement
4. Model build – original build of activity and capacity future forecasting model built during SNA process; adjustment of core assumptions during commissioning strategy development
5. Confirm approach to quantifying demand for new or reconfigured services through scenario generation.

This approach enabled us to generate an objective evidence-based understanding of likely trends in future service demand. Whilst this is not an exact science, by testing what the determinants of service demand are we have been able to form confident conclusions about how this may change in the future.

The SNA was a high complex undertaking due to the range of over 100 assumptions and parameters that were applied to the final bed model. As a network, and a specialist service, it was important to apply a degree of fixed boundaries to ensure the analysis generated a robust conclusion. For this reason, flows were not changed materially in the forecast, and changes in activity and demand were applied proportionately to all providers.



Findings from the SNA are based on a comprehensive collation of baseline service activity and capacity data, a rigorous assessment of nation and local population insights and input from a range of system stakeholders regarding local patient needs.



- 2022/23 period
- All reported bed days
- Reported by service, location, gender and referral route.

- Split between activity and capacity assumption entry sheets
- Single uplift for unmet need
- Per annum% change for demographic factors.

- Translating forecast annual bed days into optimum bed capacity
- Maintain existing patient flows
- Assessment of proportion of local versus nationally commissioned capacity, out of area activity and variation between estimated requirement.

- Quantifiable revisions to activity and flows based on concept of “closest suitable provider”
- Identification of bed numbers, variation from current bed stock and correlated impact on the future bed requirement for the Provider Collaborative.

Summary Local and International Assessment

Analysis of National and International empirical trends

A number of interesting insights can be drawn from national empirical trends in secure mental health:

- There is highly correlated increases in relation to psychosis diagnosis, and admissions to Medium and Low secure facilities **with homelessness, benefits claim, substance misuse and long-term joblessness**
- There is significant **increase in transfers from prison nationally** but also a reduction in assessments/in prison treatment - This has been factored into the demand levers in the capacity model as discussed later.

The following trends have been identified by observing international comparators:

- There is significant international variation in access and accommodation standards
- The UK has higher than average beds at Low, Medium and High secure levels. It also has higher than average use of restraint, and conversely lower than average rates of seclusion
- England and Wales reported lower nurse/therapist to patients' ratios, and significantly **lower than benchmark Psychiatry workforce** at 6 per 100,000 population.

These international benchmarks have been reviewed in line with local models of care and it was felt that local length of stay and referrals patterns appear to be more indicative of future demand, therefore the international benchmark bed numbers have not been applied for future forecasting in this case.

Local health trend analysis

The local health needs of the Provider Collaborative have been analysed, as shown in the population health profiles for each of the 5 ICBs of the PC. Summary conclusions on core factors observed across the system have been drawn, and include the following:

- There is an increasing population - up to 10.5% population increase in all people (aged 15 upwards) in some areas, with an average 15-year population growth across the system of 6%

- Aging population: Up to 32.4% increase in older adults over 15-year forecast, particularly High in Slough, Milton Keynes and Isle of Wight
- There are increasing levels of rural poverty
- There is an increasing prevalence of all mental health diagnosis
- There are increases in reported diagnosis of BPD, Depression and ASD in women
- There is significant increase in obesity, cardiovascular and renal disease in all local authority areas
- Significant progress has been made in smoking cessation
- The Adult Psychiatric Morbidity Survey is next due to report in 2023, in 2014 it showed a **12% increase in the reported incidence of severe/acute mental health symptoms**
- 10% of women surveyed reported severe symptoms compared to 6% of men
- There is significantly higher rates of males in secure admissions so wider mental health prevalence trends are not indicative of the future non-demographic demand growth
- The Recorded Rates of Severe and Long-Term Mental Health (2018) showed Southampton and Portsmouth reporting significantly higher rates of common mental health conditions (19% vs national average of 16.7%)
- It also showed pockets of significantly higher incidence (in Hampshire and Isle of Wight) than national benchmarks, and significantly higher incidence than national benchmarked rates of mental health in over 65's, in Southampton.

The insight from this analysis of local trends has informed an uplift in the modelling based on downstream activity increases in the future. It has also shown that we are also likely to retain the most accessible model by developing new capacity within the Hampshire and/or Southampton area.



Population health profile - Hampshire and Isle of Wight ICB

The following population health profiles were undertaken as the first step of the SNA, to understand the local population health needs and priorities. The Provider Collaborative includes services across 5 Integrated Care Boards (ICBs) and the population profiles were done on an ICB basis.

Provider	Site	Type
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	Southfields	Low secure secure mental health inpatient unit for adults.
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	Ravenwood House	Medium secure unit for adults with serious mental illness
The Priory Group	Mildmay Oaks	Low secure and locked in-patient rehabilitation service
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	Ashford Unit (Community Secures Team)	Medium secure Learning Disabilities Residential Unit

Relevant health and well-being status of the population

Mental Health

12.6% of the population are recorded with depression, 1.7% new diagnosis. Prevalence has increased significantly year on year since 2012/13.

0.89% have a serious mental illness, prevalence has remained stable over the last 3 years.

Obesity

Obesity is a priority for the ICB, accounting for the second highest QOF recorded prevalence rate. Targeted weight management support is key especially in obese people with Type 2 diabetes or hypertension and the challenge of keeping people active and eating healthily is a concern.

63% of adults are classed as overweight or obese in Hampshire and 59% of adults are classed as overweight or obese in the Isle of Wight.

Learning disabilities

The Isle of Wight has more people with learning disabilities know to their GPs than most comparator areas. The number of people, aged 18 to 64 with learning disabilities is falling, while the number of older people with learning disabilities is increasing.

The number of people on the Island, aged 18 to 64 predicted to have a learning disability is expected to reduce over the next 18 years from 1,862 in 2017 to 1,778 by 2035, a reduction of 4.5%. At the same time, the number of people aged 65 and over with a learning disability is expected to increase from 797 to 1,115, an increase of 40%.

Smoking

Current smoking prevalence in adults:

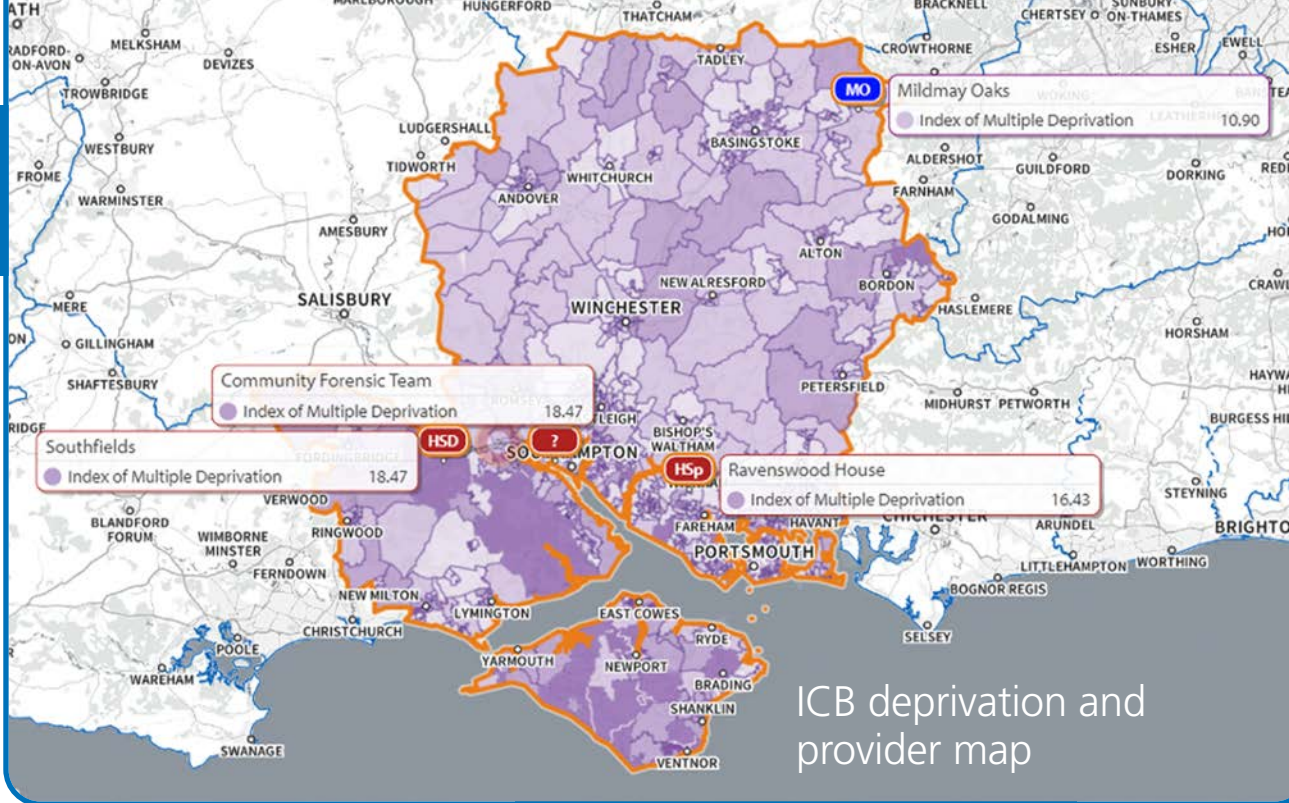
Hampshire – 8%

Isle of Wight – 11.8%

Drugs alcohol and liver disease

Drug misuse is a significant cause of disability, and is the fourth ranked cause of death in 15-49 year olds in Hampshire. In adults, admissions for alcohol-related conditions (using the narrow definition) have remained stable between 2016 and 2021. The areas with higher rates of admissions across Hampshire are Basingstoke and Deane, Eastleigh and Test Valley, although all areas are below the national average. Nationally the same trend has been observed and Hampshire was significantly below the England rate, until 2020/21 when it became slightly higher.

Figure 7 – Hampshire and Isle of Wight ICB population health profile



ICB deprivation and provider map

Population health profile - Hampshire and Isle of Wight ICB – continued

Population growth

Hampshire and IOW ICB Population Growth Table 5-Year Intervals		
Year	Population	Population Growth (%) from baseline (2022)
2022	1,679,916	
2027	1,727,476	2.83%
2032	1,765,935	5.12%
2037	1,786,922	6.37%

Population growth - 15-Year Population forecasting for this ICB showed a 6.4% increase in the overall population with a 21.7% increase in the older adults. As seen in the population distribution table below the majority of this growth comes from those over 80. A breakdown of growth at 5 yearly intervals shows a steady increase in line with expectation.

Hampshire and IOW ICB Population Distribution Table				
Age	15-19	20-59	60-79	80+
2022	117,401	1,009,946	432,090	120,479
2037	118,160	996,351	490,305	182,106
Change	759	-13,596	58,215	61,628
% Change	0.65%	-1.35%	13.47%	51.15%

Deprivation

The ICB has an average deprivation score of 17.28, the England wide average score is 21.67.

Unemployment

In England the proportion of adults claiming Universal Credit has declined after a sharp increase during the COVID -19 pandemic, to 3.9% in May 2022. The rate in Hampshire was lower at 2.3%, however there were variations across the area with Gosport and Havant showing the highest rates (3.6%) and Hart the lowest (1.5%).

Depression and personal well-being

Local depression prevalence (12.4%) has increased similarly along with national rates (12.3%) for 2020/21, 209,167 people are on the register. In Southampton the areas with the highest level of mental well-being vulnerability were the more deprived areas of the city centre and areas with more students. The overall pattern of mental health vulnerability in Hampshire shows those living in central urban areas have higher mental well-being vulnerability than those in rural areas.

Population health profile - Dorset ICB

The following population health profiles were undertaken as the first step of the SNA, to understand the local population health needs and priorities.

Provider	Site	Type
Dorset Healthcare University Locally NHS FT	St Ann's Hospital	Mixed service hospital

Relevant health and well-being status of the population

Mental Health

Depression and anxiety prevalence across Dorset has been increasing, alongside rates of referrals to psychological therapies.

Prevalence data suggests that, whilst better than average, 13% of adults are experiencing anxiety or depression, and 8% long-term mental health problems.

Obesity

In 2019/20 66% of adults were overweight or obese.

The prevalence of excess weight and obesity in Dorset is similar to England for adults – this figure is still of concern.

Learning disabilities

There are more people with a learning disability living in Weymouth than the next 3 areas combined (Dorchester, Wareham and Christchurch).

Smoking

Smoking prevalence in adults (18+) in Dorset is 8.6%, better than England (12.1%) and one of the lowest in the South West. Smoking attributed hospital admissions of 1,040 per 100,000 population, better than England (1,398 per 100,000), with a recent decreasing trend.

Drugs, alcohol and liver disease

Admission episodes for alcohol-specific conditions for Dorset 521 per 100,000 population, better than England (587 per 100,000). In Dorset key statistics around drug use are similar to or lower than the England rate – with 4.6 per 1,000 deaths from drug misuse and 42.13 per 100,000 hospital admissions due to drug poisoning.

Admission episodes for alcohol-specific conditions for BCP 807 per 100,000 population, worse than England (587 per 100,000).

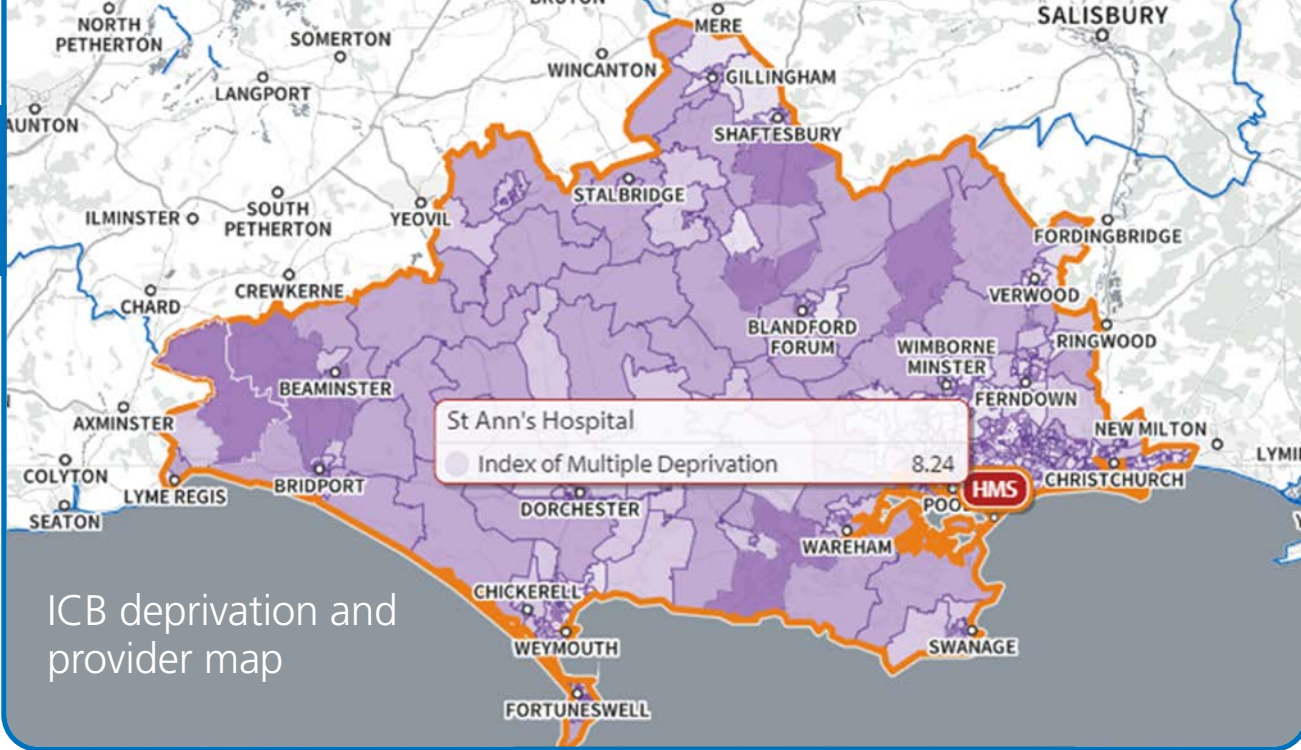


Figure 8 – Dorset ICB population health profile

Population health profile - Dorset ICB – continued

Population growth

Dorset ICB Population Growth Table 5-Year Intervals		
Year	Population	Population Growth (%) from baseline (2022)
2022	706,782	
2027	727,183	2.89%
2032	743,325	5.17%
2037	751,451	6.32%

15-Year Population forecasting for this ICB showed a **6.3% increase in the overall population with a 22.2% increase in the older adults**. As seen in the population distribution table, once age bands were analysed further we can see the majority of this pressure comes from the population over 80. A breakdown of growth at 5 yearly intervals shows a steady increase in line with expectation.

Dorset ICB Population Distribution Table				
Age	15-19	20-59	60-79	80+
2022	44,710	383,148	214,747	64,177
2037	44,773	365,859	245,922	94,897
Change	63	-17,289	31,175	30,720
% Change	0.14%	-4.51%	14.52%	47.87%

Deprivation

Deprivation - The ICB has an average deprivation score of 16.99, the England wide average score is 21.67.

Unemployment

In England the proportion of adults claiming Universal Credit has declined after a sharp increase during the COVID -19 pandemic, to 3.9% in May 2022. The rate in Dorset was lower at 3.6%

Depression and personal well-being

In Dorset the suicide rate for both males and females is similar to the England average (pre-pandemic measures). However, emergency hospital admissions for intentional self-harm are above average and there has been no change to the trend. Additionally, the rate of emergency hospital admissions and hospital stays for intentional self-harm are above the England rate. Depression and anxiety prevalence for BCP, Dorset, the South West and England is shown below.

Provider	BCP	Dorset	South West	England
Depression and anxiety prevalence (% on GP register 18+)	10.8	11.0	11.2	10.7

Population health profile - Frimley ICB

The following population health profiles were undertaken as the first step of the SNA, to understand the local population health needs and priorities.

There are no providers within Frimley ICB. Below are some examples of sites:

Cygnnet Hospital	Woodlands House	Chichester Secure Centre
Brockfield House	Thornford Park	Marlborough House

Relevant health and well-being status of the population

Mental Health

The latest Personal Social Services Survey of Adult carers (2022) recorded the following issues:

- Mental Health - Eight per cent of respondents reported that they have a mental health problem or illness
- Physical disability – 20 per cent reported that they have a physical impairment or disability
- Sensory impairment – 16 per cent reported that they have sight or hearing loss
- Estimated percentage of population with post traumatic stress disorder is higher in Surrey than England 3.11 vs 3.02
- There are an estimated 151,000 people aged 16 years and over in Hampshire with a common mental health disorder with 24,500 people aged over 65 years.

Obesity

62% of adults aged 18 and over are classed as obese in Slough

Learning disabilities

84% of adults (who are known to their local council, who are recorded as living in their own home or with their family) have a learning disability in Slough 4.21 people per 1000 population have a learning disability in Bracknell Forest.

Smoking

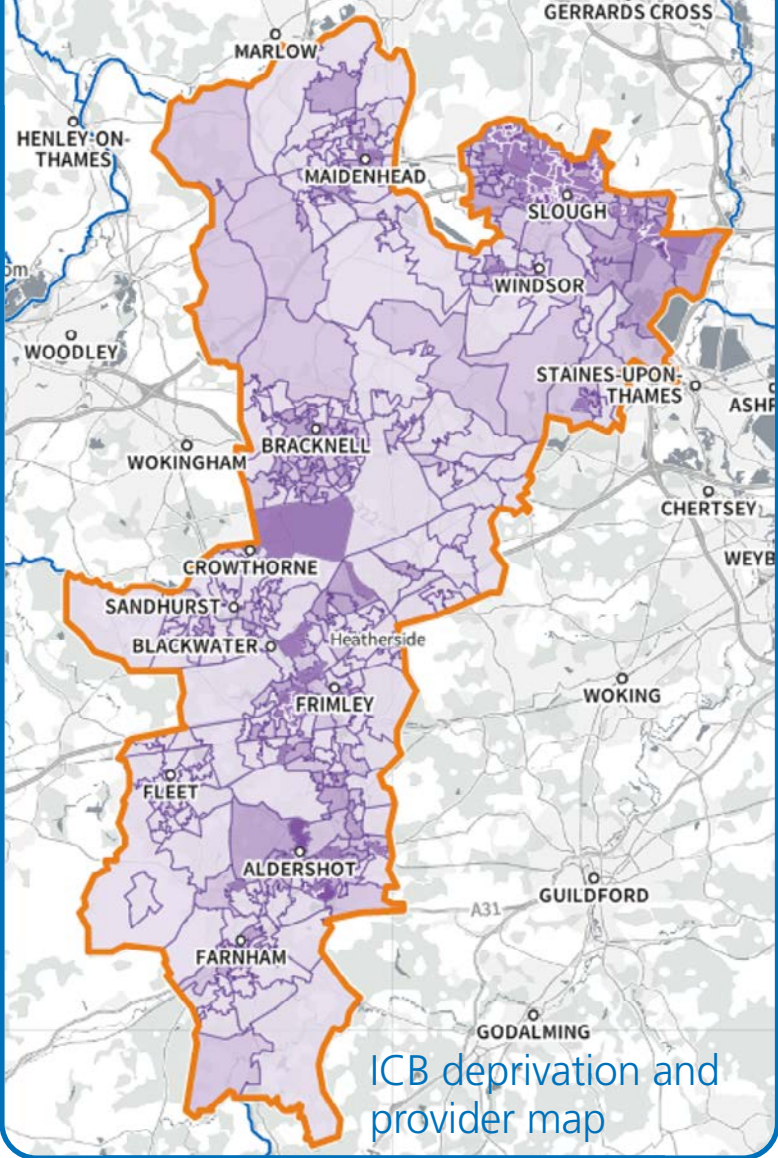
Current prevalence levels for some of the areas:

- Slough – 15%
- Bracknell Forest – 16%
- Hampshire – 8%

Drugs, alcohol and liver disease/other disease

- The number of people with long term conditions is increasing – the main health problems and causes of death include heart disease, stroke, diabetes and COPD.
- Comorbidity relates to the presence of more than one disorder. In the last 12 months just over a quarter of adults (27.7%) reported having at least one of the five chronic physical conditions in addition to a mental health disorder. High blood pressure was the most common, followed by asthma, diabetes, and cancer.
- Drug misuse is a significant cause of disability, and is the fourth ranked cause of death in 15-49 year olds in Hampshire.

Figure 9 – Frimley ICB population health profile



ICB deprivation and provider map

Deprivation

The ICB has an average deprivation score of 12.32, the England wide average score is 21.67.

Unemployment

In England the proportion of adults claiming Universal Credit has declined after a sharp increase during the COVID -19 pandemic, to 3.9% in May 2022. The rate in Hampshire was lower at 1.3%,

Depression and personal well-being

Feelings of low worth were higher in men; inactive or unemployed people; people from all Black ethnic groups; people with fair, poor or very poor health, and; people aged 45-59 and aged 80+.

Feelings of unhappiness were higher in women; inactive or unemployed people; people with fair, poor or very poor health, and; people aged 45-59.

Feelings of anxiety were higher in women; inactive or unemployed people; people with fair, poor or very poor health, and; people aged 40-59. Anxiety was higher than the England average for people working part-time, but not significantly so.

Across Hampshire trends suggest that population well-being has worsened slightly over the last few years.

Population health profile - Frimley ICB – continued

Population growth

Frimley ICB Population Growth Table 5-Year Intervals		
Year	Population	Population Growth (%) from baseline (2022)
2022	1,639,383	
2027	1,683,360	2.68%
2032	1,714,763	4.60%
2037	1,732,808	5.70%

Population growth - 15-Year Population forecasting for this ICB showed a **5.7% increase in the overall population with a 22.5% increase in the older adults.** As seen in the population distribution table below, once age bands were analysed further we can see the majority of this pressure comes from the population over 80. A breakdown of growth at 5 yearly intervals shows a steady increase in line with expectation.

Frimley ICB Population Distribution Table				
Age	15-19	20-59	60-79	80+
2022	113,305	985,162	421,719	119,197
2037	111,988	958,460	481,891	180,469
Change	-1,317	-26,702	60,172	61,273
% Change	-1.16%	-2.71%	14.27%	51.40%

Population health profile - Buckinghamshire, Oxfordshire and Berkshire West ICB

The following population health profiles were undertaken as the first step of the SNA, to understand the local population health needs and priorities.

Provider	Site	Type
Oxford Health NHS FT	Littlemore Mental Health Centre	MH Centre
Elysium Healthcare	Thornford Park	Private Hospital

Relevant health and well-being status of the population

Mental Health

- Mental health rates of diagnosis and referrals increased by 0.7% from 2019-20 and 2021-22, in 2020-21 there were 79,244 patients (aged 18 or over) with a diagnosis of depression registered by Oxfordshire's GP practices
- Depression and anxiety is more common in people with persistent pain. For example, around 14% of the population suffer with a musculoskeletal condition
- 12.6% of people aged 18 or over are on the depression disease register at GP Practices in Buckinghamshire
- The self reported well-being and mental health score (particularly high anxiety) is higher (26.2) across the ICB compared to the South East (23.6) and England score (24.2)
- Between 2019 and 2021 there were 181 deaths from suicide in Oxfordshire, 76% of these were male. The rate of suicide in Oxfordshire is similar to the rate in England generally. Amongst the most common causes were alcohol and chronic physical health conditions.

Learning disabilities

Over two thirds (68%) of adults on Oxfordshire GP practice Learning Disabilities registers were measured as overweight or obese, 10 percentage points above the general adult population.

77% of adults (who are known to their local council, who are recorded as living in their own home or with their family) have a learning disability in West Berkshire.

Obesity

- Over half of Oxfordshire adults are classified as overweight or obese (58%).
- Prevalence is higher in males, older people, some ethnic groups and more deprived areas.
- % obesity ratios in adults (over 18) per area are:
 - 21% Buckinghamshire
 - 63% Reading
 - 61% West Berkshire
 - 60% Wokingham

Smoking

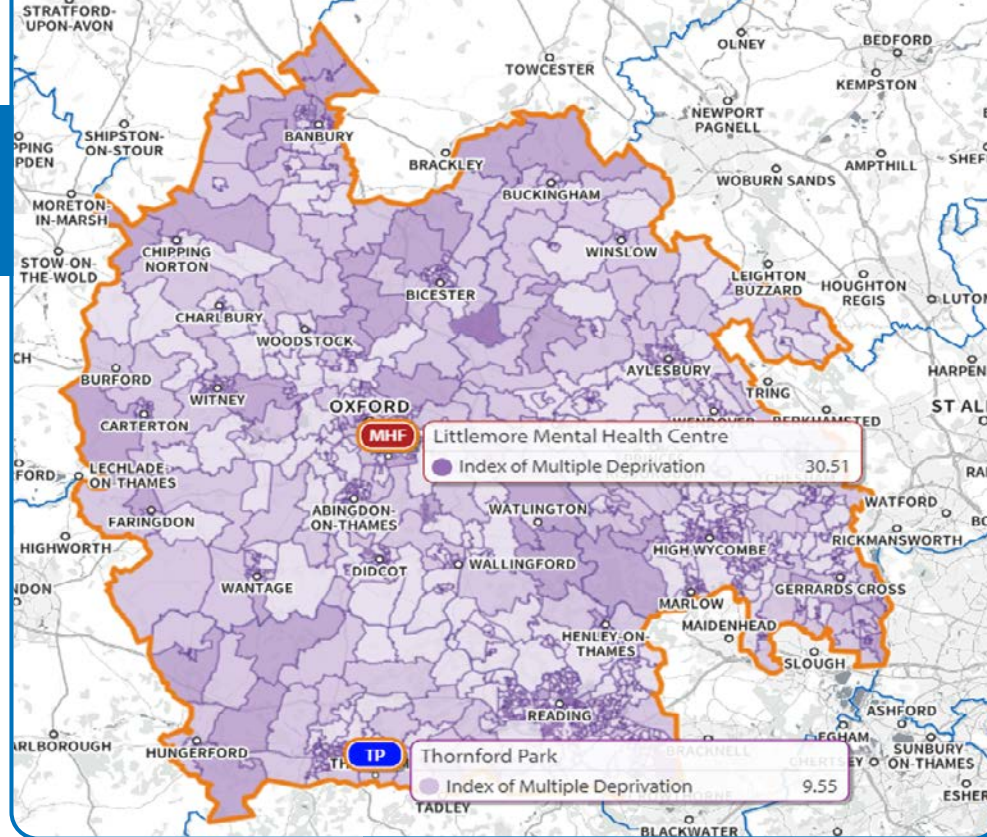
People with severe mental illness are more likely to smoke and more heavily than the general population (estimated at between 50% and 70%) and may be at increased risk of smoking-related illness (estimated at 50%).

Drugs, alcohol and liver disease

1 in 25 (3.7%) people aged 16-59 years reported taking a Class A drug in the last year, following a generally upward trend since 2011-12. 13% of women and 23% of men aged 65 – 74 years drink alcohol on five or more days a week although generally hospital admissions from alcohol related illness are lower than average for England

Figure 10 – Buckinghamshire, Oxfordshire and Berkshire West ICB population health profile

Population health profile - Buckinghamshire, Oxfordshire and Berkshire West ICB – continued



Population growth

Buckinghamshire, Oxfordshire and Berkshire West ICB Population Growth Table 5-Year Intervals

Year	Population	Population Growth (%) from baseline (2022)
2022	1,429,010	
2027	1473986.7	3.15%
2032	1508093.5	5.53%
2037	1527533.6	6.89%

15-Year Population forecasting for this ICB showed a **6.9% increase in the overall population with a 24.5% increase in the older adults**. As seen in the population distribution table, once age bands were analysed further we can see the majority of this pressure comes from the population over 80. A breakdown of growth at 5 yearly intervals shows a steady increase in line with expectation.

Bucks, Oxford, Berks ICB Population Distribution Table

Age	15-19	20-59	60-79	80+
2022	105,734	892,364	336,176	94,736
2037	108,039	882,364	394,440	142,235
Change	2,305	-9,544	58,264	47,499
% Change	2.18	-1.07	17.33	50.14

Deprivation

The ICB has an average deprivation score of 11.23, the England wide average score is 21.67. However, the darker the purple shading on the map above shows the areas of greater deprivation. Littlemore MHC is in area of high deprivation compared to most other ICB areas.

Unemployment

ONS shows a decline in the rate of employment from 2019 to 2021 although not by a significant amount.

Depression and personal well-being

Depression has increased by over 7,000 cases from 2019 – 2021, this illness being counted as one of the four conditions above the England average in the area and the 2nd highest number of patients (79,244) with the illness after hypertension. Personal well-being measure have shown declines, the mean score for “worthwhile” “happiness” and “life satisfaction” have each decreased by 3% whilst anxiety levels continue to increase and remain above the England average.

Population health profile - Bedford, Luton and Milton Keynes (BLMK) ICB

The following population health profiles were undertaken as the first step of the SNA, to understand the local population health needs and priorities.

Provider	Site	Type
Elysium Healthcare	Chadwick Lodge	Independent sector: Low and Medium Secure units
Oxford Health NHSFT	Marlborough House	Medium Secure unit for Mental Illness

Relevant health and well-being status of the population

Mental Health

Depression:

- SHAPE database shows that the recorded prevalence of patients with depression expressed as a percentage of the practice (18+) list size for 2021 is 10.92% for the region (The England average is 12.64%), this is comprised of
 - Bedfordshire 12.1%
 - Luton 8.76%
 - Milton Keynes (10.94% for Milton Keynes where provider services are located) for 2021 – 2022

Patients with issues with mental well-being

Overall for the ICB is 0.91% of the catchment population, this is against an average for England of 1%. This is comprised of

- 0.73% for Milton Keynes
- 0.94% for Bedford
- 1.06 Luton (Higher than the England average)

Obesity

- 9.06% of patients in the catchment area are registered as obese, this is slightly under the England average of 10.11%, this is comprised of
 - 8.17% Milton Keynes
 - 9.16% Bedford
 - 9.73% Luton

Learning disabilities

- The % of patients for the ICB with registered learning disabilities is 0.5%, just under the England average of .56%, this is comprised of
 - 0.45% - Milton Keynes
 - 0.48% - Bedford
 - 0.57% - Luton

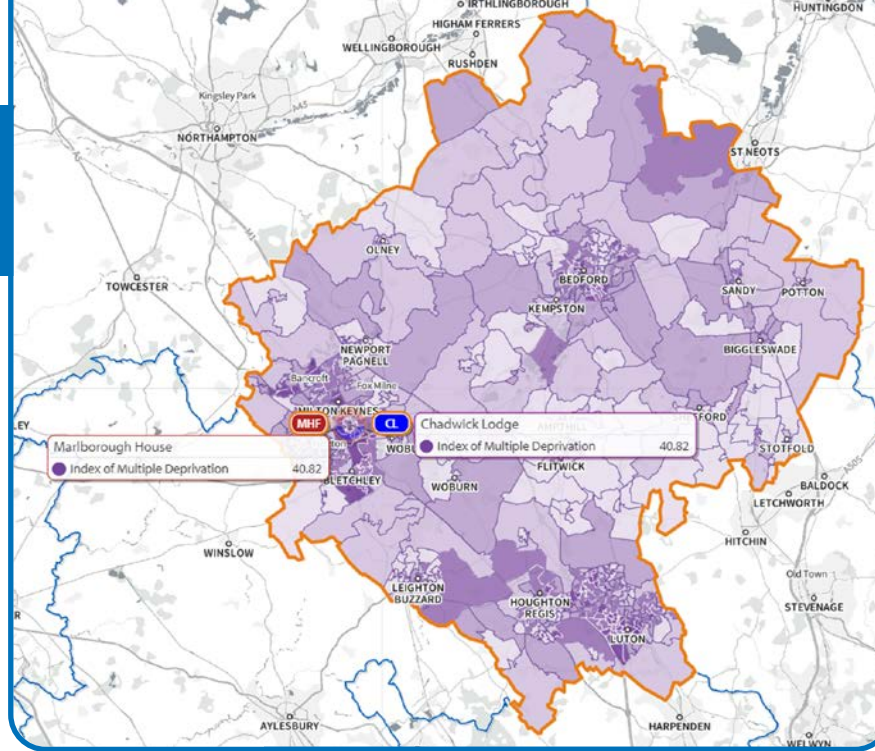
Smoking

People with severe mental illness are more likely to smoke and more heavily than the general population (estimated at between 50% and 70%) and may be at increased risk of smoking-related illness (estimated at 50%). 14.9% of people smoke in the overall area (2020 – 2021), an increase of 0.6% increase from the previous year.

Drugs, alcohol and liver disease

The rate for alcohol-related harm hospital admissions is 621, better than the average for England. This represents 1,489 admissions per year.

Figure 11 –Bedford, Luton and Milton Keynes ICB population health profile



Population health profile - Bedfordshire, Luton and Milton Keynes ICB – continued

Population growth

BLMK ICB Population Growth Table
5-Year Intervals

Year	Population	Population Growth (%) from baseline (2022)
2022	215,461	
2027	222,968	3.48%
2032	227,718	5.69%
2037	230,452	6.96%

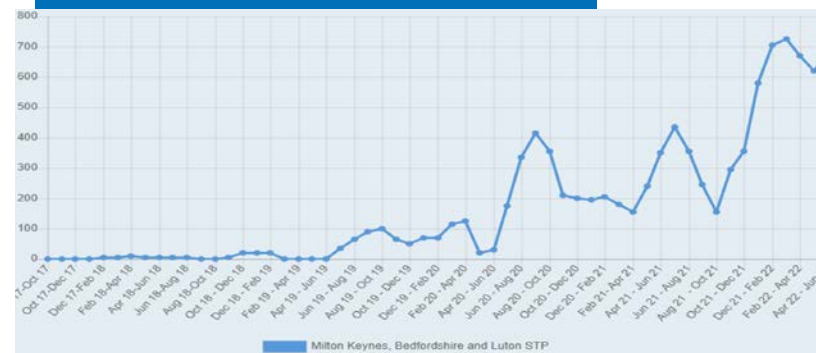
Inappropriate out of area placements

In the three months to June 2022, there were 680 inappropriate out of area placement days across BLMK compared to 350 in the corresponding period to June 2021. This is a 94.3% increase compared to a 12.1% decrease when looking at the same two periods in England overall.

The ambition to eliminate inappropriate out of area placements for adult acute inpatients is to continue to be a focus through the period of the Locally Commissioned Long Term Plan.

Deprivation: BLMK ICB has an average deprivation score of 18.2, the England wide average score is 21.67. The darker the purple shading on the map to the right, the higher the deprivation score. **It should be noted that there are 9 wards within Milton Keynes which are in the 10% most deprived in England.**

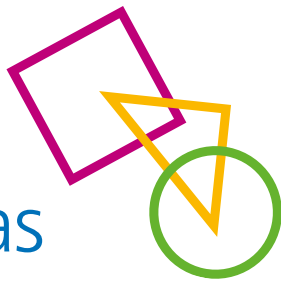
Unemployment: 3.6% of people in BLMK are unemployed (3.9% in Milton Keynes, 3.6% Bedford and Luton 5.7%).



15-Year Population forecasting for this ICB showed a **7% increase in the overall population with a 29% increase in the older adults.** As seen in the population distribution table, once age bands were analysed further we can see the majority of this pressure comes from the population over 80. A breakdown of growth at 5 yearly intervals shows a steady increase in line with expectation.

BLMK ICB Population Distribution Table

Age	15-19	20-59	60-79	80+
2022	15,962	143,495	46,108	9,896
2037	15,899	142,280	54,476	17,798
Change	-63	-1,215	8,368	7,902
% Change	-0.40	-0.85	18.15	79.84



Identified priority areas

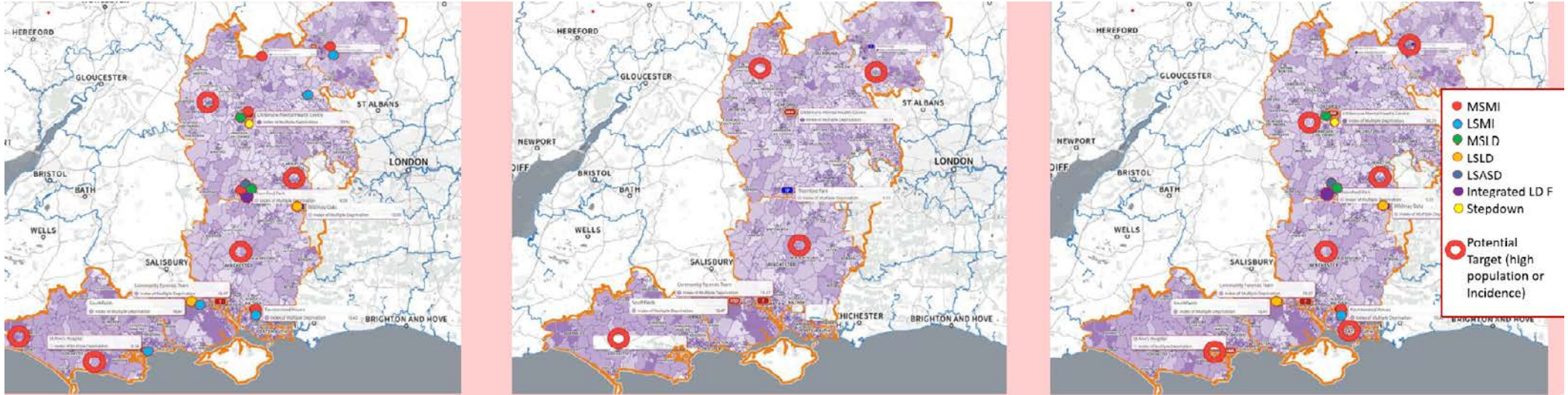


Figure 12- Maps showing locations of catchment services, women's services and LD and ASD services and target areas (Key on right)

The above maps shows the PC Catchment Service locations.

When reviewing the overall provision of adult services, there does appear to be an adverse correlation between index of deprivation and service availability.

The red targets have been placed at the identified areas of potentially unmet need, particularly the West of Dorset where there is a recognised gap in local service provision.

The above map shows the Local Women's Pathway Provider locations.

A key finding from the SNA was that women are 3.5 x more likely to be placed out of area.

This map shows the women's provider locations - Women are much more likely to travel out of area, but we can see from this map that even within area the services are very dispersed.

The above map shows the Learning Disability (LD) and Autism Spectrum Disorder (ASD) Service Provider locations.

The service provision for ASD services is very sparse as this is still a relatively novel and specialist area. We will be focusing more resource in this area in the future recognising the exponential increase in neurodiverse diagnostic groups.

The distribution for LD service provision is relatively good. This is in line with the fact community-based care for LD patients is being prioritised in line with the AT (Assuring Transformation) national strategy, to place LD patients out of acute care and into the community.

Analysis of bed utilisation and capacity data

Analysis of bed days activity data – Conclusions

The baseline bed days activity data has been analysed at a specialty and provider level, to ascertain both trends in length of stay and any shifts in flows into or out of the collaborative provider catchment area.

The identified trends from analysis include the following:

- There has been substantial reduction in Occupied Bed Days (OBDs) over 4-year period in line with reducing length of stay and static numbers of episodes of care
- The total admitted patient numbers have remained consistent over time, in line with minimal changes in local bed capacity over the period
- The most significant source of demand remains medium secure male mental health activity
- There have been significant increases in locally commissioned in-area activity which now accounts for 72% of the commissioned bed days, this aligns with local repatriation strategies and there is higher than recommended bed capacity utilisation in these locally commissioned providers
- The total number of bed days in low secure and medium secure are both decreasing. When looking at this as a percentage of all the bed days, the proportion of low secure bed days has increased whereas the proportion of medium secure bed days has decreased, showing a shift towards lower acuity care pathways
- The total number of bed days across WEMSS, ABI, Deaf, and ASD is a very small proportion of the overall bed days, so we would need to explore with other provider collaboratives to create a specialist facility for these patients.

Current local bed utilisation analysis

Analysis of the historical activity and corresponding bed utilisation within the collaborative provider environment has been performed. This analysis has shown the following:

- Bed utilisation has fallen from 86% to 55% between 2019 and 2021
- Nationally commissioned beds account for the majority of the under-utilisation (this is nationally commissioned and so cost neutral)
- Locally commissioned utilisation, more relevant in this assessment, at 85% overall
- Locally Commissioned Low secure Mental illness capacity is persistently above optimal utilisation (reaching 102% in 2022)
- Out of area activity has fallen from 23% of the bed days in 2018 to 13% of the activity in 2022, although female transfers out remain higher and so should be a priority for repatriation (41 beds equivalent)
- Stepdown capacity is persistently highly or over utilised and so should be explored as a growth area.

Out of area bed requirement analysis

Analysis has been performed, looking at the distribution of out of area bed day activity and corresponding equivalent bed capacity requirement between 2012 and 2022. The key observations regarding this data are as follows:

- There is a substantial reduction in out of area beds (reduction by over 50%)
- The largest number are female beds in all categories and low secure capacity (aligning with in area capacity challenges highlighted before)
- Out of area activity has fallen from 23% of the bed days in 2018 to 13% of the activity in 2022. Although female transfers out remain higher and so should be a priority for repatriation. The mixed proportion is so low that the capacity commissioned out of area is not significant overall.

Summary For Me Activity inc AT (all settings)

	2018/19	2019/20	2020/21	2021/22
Total OBDs in year	134480	126171	118213	110880
No of patients	514	514	514	514

Table 1 - Reduction in Occupied Bed Day numbers

Analysis of bed utilisation and capacity data

Length of Stay trends analysis

The average length of stay trends (year on year average LOS) have been analysed, service by service. The following observations have been made:

- There is a high degree of year-on-year variation in service average length of stay but there is a discernible downward trend in all services. This can be seen from the data in the table showing average LoS in days
- It is likely that annual reductions in length of stay of this magnitude will be short-lived, as these are attributable to the establishment of the Provider Collaborative and targeted interventions over the period
- Therefore, a diminishing rate of reduction in length of stay has been applied across the longer-term activity forecast (more details following later in this section)
- If patients with multiple admissions are discounted from analysis, the average LoS increases. This can be seen from the table showing average LoS excluding discharged patients (multiple short episodes of care)
- The minimum length of stay outside of NCF was 66 days in 2021/22, this had increased from the previous year
- The longest admission duration in years is around 26 years, (shown in the table showing maximum LOS).

Referral trends and out of area activity analysis

- The referrals data set out in the figure 13 to the right is based on a low number of system-wide referrals reported between 2020 and the present day. Overall referral rates persistently fell during the recorded period. The rate of conversion from referral to admission reduced sharply between 50% in 2020, to 33% in 2021 and then began to climb again to 41% in 2022.

This represents very limited data on referral trends currently. Additional provider and gatekeeper assessor engagement is required to determine if this is the whole picture with regards to secure service demand.

Out of area and Non-Clinical Flow trends analysis

- An assessment of historical rates of out of area (OOA) activity and referral outside of NCF was carried out

- Sometimes it is the right thing for patients to be cared for away from their home. This is considered to be Natural Clinical Flow. Reasons include the terms of their sentence or a need for physical distance from disruptive influences
- The For Me PC have a significant impact in reducing out of area referrals for bed capacity challenge alone, and in this way has achieved extremely low Non Clinical Flow rates
- For this reason, the model hasn't assumed any significant reduction in Non Clinical Flow
- Overall, out of area referrals are low and they have been reducing over the last 5 years, but there is a general view that there is limited opportunity to reduce them much further. Out of area referrals will continue to decline but not to the rate we have seen to date
- The modelling of out of area activity has been reduced at a diminishing rate in the model.

Average length of admission (days)	Year			
	19/20	20/21	21/22	22/23
Place outside of NCF	1536	1660	1599	1312
Within NCF	1220	1128	1004	910
Average	1310	1258	1139	996

Table 2 - Average LoS in days

Average length of admission (days)	Year			
	19/20	20/21	21/22	22/23
Place outside of NCF	2396	2099	1835	1431
Within NCF	2079	1720	1223	968
Average	2178	1826	1368	1075

Table 3 - Average LoS in days excluding discharged patients (multiple short episodes of care)

Max length of Admission (years)	Year			
	19/20	20/21	21/22	22/23
Place outside of NCF	24.32	24.32	24.32	24.32
Within NCF	26.79	26.79	26.79	26.79
Average	26.79	26.79	26.79	26.79

Table 4 - Maximum LoS in years

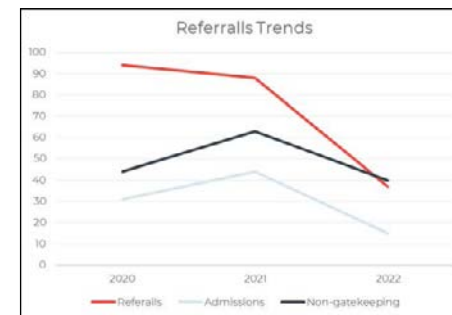


Figure 13 - Referrals Trends

Although referral trends are coming down, we need to do more to understand referrals patterns

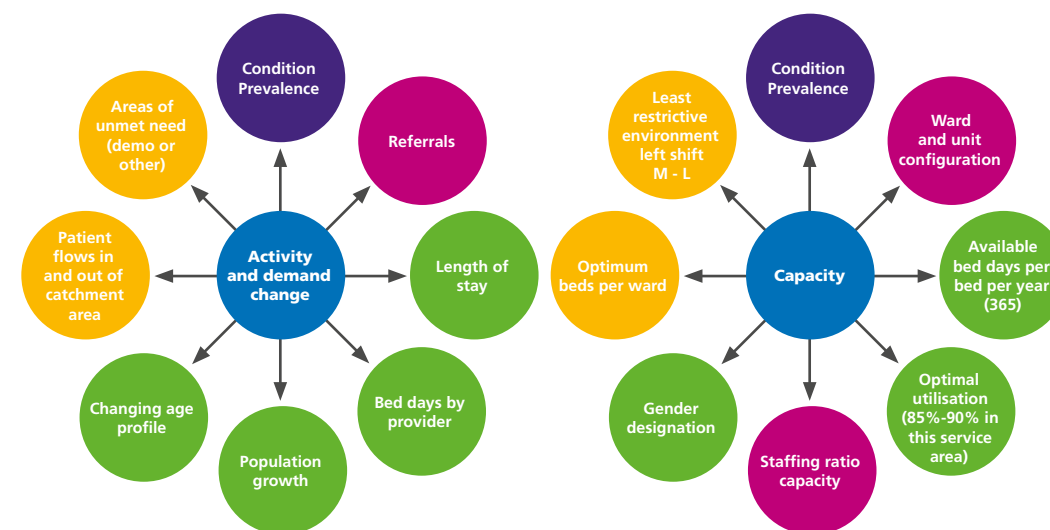
Bed capacity modelling approach

Methodology

The methodology for the bed modelling process can be seen in the adjacent illustration, key steps include:

1. Gathering baseline bed data and analysing data for trends and patterns (as explored earlier in this section)
2. Assumption development – this was undertaken with a small reference group from Provider Collaborative leadership and reviewed by local clinical teams. The full details of assumptions and outputs of modelling can be found in the capacity forecast report/ SNA document
3. Building the baseline model – Using approximately 120 activity and capacity-based assumptions to generate a future forecast on bed capacity requirements for the Provider Collaborative on a year-by-year basis
4. Scenario tests – working out how many beds would be needed for potential flow variations generated as a result of new models of care.

Of note, assumptions have been translated from identified best practice and local insights regarding optimal operational efficiency. Activity growth has not been applied on an age-adjusted basis, per standard healthcare planning (HCP) methodology. This is because the majority of the activity is within a narrow age band. The bed day baseline dataset is not linked to specific patient episodes at this stage, which would be required to undertake age or ethnicity-based activity assessment. Although there was scope to create age/gender adjusted profiles, this would be to average length of stay, but this was not felt to be an accurate indicator over a single year period. The conclusions do have a degree of subjectivity, as with any forecasting model so should be viewed as an estimate of future activity trends; subject to periodic review and revision going forwards.



What drives changes in activity and demand?

What drives changes in capacity?

Figure 14 – Illustration of bed capacity drivers

Factors considered when building capacity model

When you build a capacity model it is important to consider what is likely to impact on future activity, and how that activity will be accommodated. There are numerous components that have been assessed and integrated into the model to give the best possible chance of an accurate forecast.

The diagrams shown set out the areas explored by the project team when building a comprehensive evidence base for the future required bed capacity requirements, within the system. Assumptions related to each of these factors have been calculated on the following basis:

- Green - calculated based on historical trends and evidence
- Yellow - estimated and modelled
- Magenta - remain unchanged as we cannot accurately predict changes in this area.

Planning assumptions

Overarching general planning assumptions and constraints

The following assumptions form the framework for the capacity model. Assumptions have been generated through both stakeholder engagement and desktop analysis. The core scope and capacity calculation parameters are set out below. This forms the most significant set of assumptions but there are 150 further parameters applied in the model. These are set out fully in the SNA.

Core assumptions

The minimum turn-around-time for accommodation between discharge and new admission, is 12-hours

There will be 355 available bed days for year. This is to account for maintenance, deep cleaning and patient moves/leave

There are no automatic readmissions, self-referrals or carer-initiated admissions outside of the gatekeeper process

Out of area referrals are to be minimised but are likely to be at least 15% of the total activity due to the exclusion zones set at sentencing, removal from disruptive groups and family factors

The Non-Clinical Flow (NCF) rate is to be maintained below 0.5% of the total activity

Periods of day release will not lead to that bed being available for other referrals

There are no patients with 0 days Length of Stay, there is a minimum admission period of 24 hours

All patients are 18 or over and accommodated in gender-segregated units

Analysis identifies trends in admissions, average Length of Stay and annual discharges by patient cohort

Forecast bed capacity is presented as at 5-year (2028), 10-year (2033) and 15-year (2038) planning thresholds and for the following subtypes of spaces:

- Medium Secure
- Low Secure
- Flexible Designation
- Frailty-enabledSpaces - utilise age as proxy with uplift for physical health comorbidities in the younger cohorts
- Mental illness, Learning disability and Autistic spectrum disorder subtypes.

There is no short-stay/assessment model at present, as all referrals are managed by a gatekeeper assessment model i.e. all admissions are classed as Planned, even in the case of failed discharges where the community team/probation services recommend a return to secure services due to the risk of re-offending.

Table 5 – Core capacity modelling planning assumptions



Planning assumptions

Other non-demographic assumptions

Table 6 sets out an ambition to move to lower acuity balance across all clinical providers. There is scope to include a further left shift from secure services to community management, but this is likely to be a core contributor to Length of Stay trends and so has not been included at this stage to avoid double counting the benefit.

Length of Stay Trends and Forecast

To understand future demand trends in Length of Stay, we have analysed the historical data trends (as discussed earlier) and then considered what may happen to LoS in the future, on a service-by-service basis. The providers within the PC have been able to make extraordinary reductions in Length of Stay over the past 3 years.

This is equivalent to over 25% reductions on average and much higher in some service lines. Recognising the impact of proactive interventions is likely to have diminishing benefit over time, the following LoS reductions have been applied to the forecast bed days for these services on a 5-yearly basis. These assumptions will need to be tested and reviewed periodically.

This proxy 5-, 10- and 15-year estimate has been developed in recognition that historical length of stay improvements are likely to diminish over time. It takes into account the summary impact of patient planned interventions and proactive discharge planning, as well as investment in robust rehabilitation and community pathways.

Assumption applied in the modelling on the percentage change due to forecast shift from Medium Secure to Low Secure pathways			
Shift from Medium Secure to Low Secure pathways	2027/8	2032/3	2037/8
Low Secure Learning Disability	5%	5.10%	2.53%
Low Secure Mental Illness	10%	5.10%	2.53%
Medium Secure Learning Disability	-8%	-6.10%	-2.53%
Medium Secure Mental Illness	-15%	-8.10%	-2.53%

Table 6 - Assumptions on forecasted shift from medium to low secure pathways

Assumption applied in the modelling on the percentage change due to forecast Length of Stay reductions			
Service	5 year average reduction in bed days: 2029	10 year diminishing reduction in bed days: 2033	15 year diminishing reduction in bed days: 2038
Low Secure Male Learning Disability	-2.12%	-0.71%	-0.35%
Female Mental Illness	-19.16%	-6.39%	-3.19%
Low Secure Male Mental Illness	-7.73%	-2.58%	-1.29%
Low Secure Male Personality Disorder	-4.57%	-1.52%	-0.76%
Medium Secure Male Learning Disability	-8.98%	-2.99%	-1.50%
Medium Secure Male Mental Illness	-8.33%	-2.78%	-1.39%
WEMSS(increase based on historical trends)	4.96%	1.65%	0.83%
Average across all services (including those provided by other providers)	-9.39%	-3.13%	-1.57%

Table 7 - Assumptions on forecast Length of Stay reductions (likely diminishing benefit over time, these assumptions will need to be reviewed and tested periodically)

Planning assumptions

Other non-demographic demand assumptions

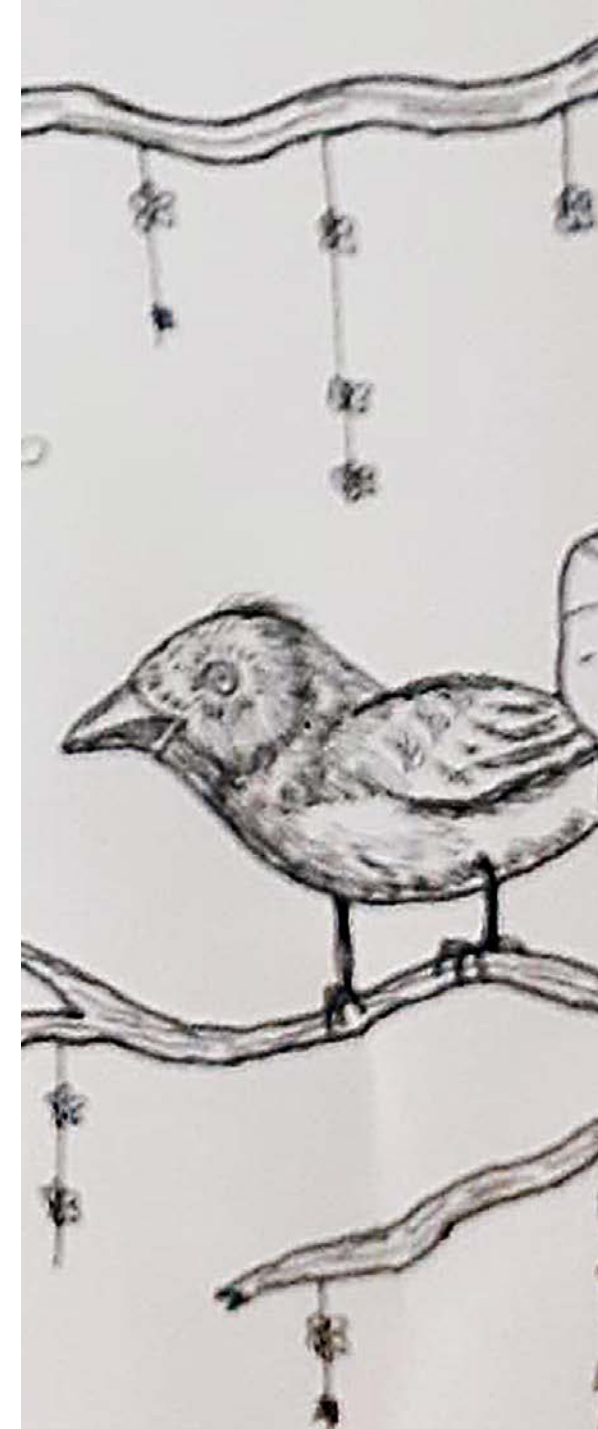
The table shown here summarises some of the applied factors that could impact on net uncontrolled demand for secure services locally. Factors such as unmet need are applied at either a diminishing annual rate or as a one-off uplift in the case of the ethnicity profile.

It is possible that the annual 5% uplift (falling to 2% PA after 5 years) estimated for future flows from prison could be less in practice. This is linked to the identified significant historical diminishing trends in referrals that have recently started to rise sharply. It is hypothesised that limited access to patients over the Covid -19 pandemic period might have translated to high levels of pent-up demand. This assumption should be tested annually, and the modelling conclusions revised accordingly if this does not manifest as predicted.

Summary assumptions applied in the modelling on the percentage change for the following non-demographic factors

Planning assumptions for the following non-demographic changes	Summary Assumption Applied	2023	2027/8	2032/3	2037/8
Increasing prevalence in serious mental health conditions	3% per annum growth in Demand (half of rate of prevalence increase overall)		15.93% five-year increase	15.93% five-year increase	15.93% five-year increase
Increasing prevalence due to the evidence of unmet need in Learning disability and Autism Spectrum Disorder	2% per annum extraordinary growth in these presentations		10.41% five-year increase	10.41% five-year increase	10.41% five-year increase
Increasing referrals expected through prison/ versus non-prison referral routes (based on evidence of likely unmet need due to the reduced referral rates via these routes)	5% per annum, falling to 2% per annum		18.24% five-year increase	10.41% five-year increase	10.41% five-year increase
Increasing prevalence due to unmet need from the evidence of under-representation of ethnic minorities (male only)		4.50% One off increase			
Reduced out of area CCG referrals into the PC (the out of area activity is currently 17% of the female activity and 25% of the male activity)	Male (in-area only)		-2.00%	-2.00%	-2.00%
	Female (in-area only)		-1.50%	-1.50%	-1.50%

Table 8 - Non-demographic assumptions



Bed capacity forecast summary

The table below sets out a high-level summary of our predicted bed requirements up until 2038. The Strategic Needs Analysis presents this requirement at both an organisational and unit level, but we have only set out the variable requirements at a pan-Provider Collaborative specialty level as an indication of overall activity trends. "Mixed" beds on this occasion

should be viewed as of undefined gender and not necessarily beds that are jointly occupied by men and women. Step down and specialist units are scoped based on a genderless activity set at this point and so the actual split between male and female beds will require refinement as part of the specification development process

Specialty	Bed days baseline inc AT				Baseline beds required				Beds available				2038 beds required				Variance				NHS Provider Bed Shortfall
	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total	
AS Low Secure ASD	1926	0	0	1926	7	0	0	7	0	0	0	6	-6	0	0	-6	-6	0	0	-6	
AS Low Secure LD	5522	617	0	6139	19	2	0	21	28	0	0	23	8	-3	0	5	8	-3	0	5	-3
AS Low Secure MI	33251	13515	0	46766	107	44	0	151	190	64	0	159	74	21	0	95	74	21	0	95	-2
AS Medium Secure LD	3458	0	0	3458	12	0	0	12	10	0	0	16	-6	0	0	-6	-6	0	0	-6	-4
AS Medium Secure MI	39792	617	0	40410	127	2	0	129	164	30	0	120	49	25	0	74	49	25	0	74	-3
Step Down Mixed	0	0	4464	4464	0	0	14	14	0	0	15	17	0	0	-2	-2	0	0	-2	-2	-3
												0	0	0	0	0	0	0	0	0	
Total In area Provision	83949	14749	4464	103162	272	48	14	334	392	94	15	501	273	51	17	341	119	43	-2	160	-15

Table 9 - Proportionate growth/reductions applied across all demographic and non-demographic factors on a provider basis, some targeted reduction in out of area placements and length of stay – 2023 Baseline

Summary Features

- The current baseline activity for this model is the occupied bed days for 2022-23 period by organisation and by service line
- All demographic and non-demographic assumptions applied regarding future demand, length of stay, service acuity shift and addressing areas of potentially unmet need as per those summarised on previous pages
- Existing flows were maintained to current organisations
- Out of Area activity consolidated into single service line bed requirements; reducing to 14% future bed base and Non-Clinical Flow maintained at current low levels
- This results in a baseline local bed requirement of 334 beds (assuming a reduction in target occupancy to 90%) against a combined total available bed stock of 501 beds.
- **With no changes to services or referral flows, the total 15-year bed capacity requirement for the Provider Collaborative is estimated to be 341 beds in area and with 41 beds out of area by 2038**
- **This represents a net additional locally commissioned bed requirement of 41 beds mixed between medium and low secure and a corresponding significant shift of up to 20 additional Nationally Commissioned beds**
- **If flows continue as currently mapped this could lead to a significant shortfall of 15 locally commissioned low secure NHS beds.**

Bed capacity forecast summary out of area beds

The table below sets out the potential out of area bed requirement in the event no further substantial repatriation efforts are feasible outside of natural clinical flow. This is a significantly higher number than the number of patients in out of area beds at the time of drafting this strategy (11 patients as of November 2023). There are 3 factors that have led to this disparity:

1. Significant very recent reduction in out of area activity that undermines the legitimacy of baseline year data as an indicator of future demand
2. All beds are rounded up to whole beds as a part of the modelling process and this creates a disproportionately high number of beds when developing assumptions around a very small number of beds days overall
3. The future bed model is focused on the bed requirement where no further repatriation is possible. The final planned bed strategy on the following page sets out the interventions that could reduce this out of area activity by up to 50%.

Specialty	Bed days baseline inc AT				Baseline beds required				2038 beds required			
	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total
ABI & Deaf	1370	0	0	1370	6	0	0	6	6	0	0	6
AS Low Secure MI	2412	1513	0	3925	9	6	0	15	8	7	0	15
AS Low Secure LD	2180	4	0	2184	8	1	0	9	6	1	0	7
AS Low Secure ASD	367	0	0	367	3	0	0	3	2	0	0	2
AS Medium Secure MI	276	1148	0	1424	1	6	0	7	1	5	0	6
AS Medium Secure LD	737	6	0	742	4	1	0	5	2	1	0	3
WEMS	0	483	0	483	0	2	0	2	0	2	0	2
Total In area Provision	7342	3154	0	10496	31	16	0	47	25	16	0	41

Table 10 - Opportunities for Local Service Development and Pathways- 2023 Baseline Out of Area Activity and Capacity Forecast

Summary opportunities

As it stands there is almost no out of area associated with Non-Clinical Flow (NCF), however:

- There is an option to reduce low secure activity further through targeted community in-reach and secure clinical lead advice and guidance model non-secure providers
- There is an option to repatriate up to half of women's activity through blended service model (WEMSS Consultation Dependant) reducing out of area by up to 8 Beds
- The development of an ASD specialist unit with a consolidation of these patients in a single unit would reduce out of area activity up to 10 Beds.
- Option to develop Frailty Unit for over 65 and patients with significant physical impairment due to physical health co-morbidities (estimated 22 Beds); reducing out of area by 4 Beds.
- Development of Acquired Brain injury and/or Deaf Facility of up to 6-10 beds (if shared with other PCs) would create a system wide improvement in local access.

Forecast phased bed changes to 2038

We have applied the wider strategic plans the Provider Collaborative has for changing our models of care, the table below sets out the detail of how the interventions we have planned will affect our bed requirements going forwards. These assumptions will need to be validated by piloting the models planned and auditing existing patient pathways to test the true requirements. If the Provider Collaborative can successfully implement additional low secure, women's, ASD and frailty beds there is scope to reduce forecast out of area placements by over 50%. Beds highlighted in blue are virtual pilots and bed numbers in magenta indicate fully implemented new models of care.

Specialty	OOA Bed Reduction: -4 Beds				OOA Reduction: Beds				OOA Reduction: Beds				OOA Reduction: -20				-22 Beds			
	Current Local Beds Available				Baseline 2024 Beds Required				2026 Beds planned				2028 Beds planned				2033 Beds planned			
	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total	M	F	Mix	Total
AS Low Secure ASD	0	0	0	0	7			7	7			7			12	12			10	10
AS Low Secure LD	28	0	0	28	19	4		23	22	6		28	24	2		26	18	1		19
AS Low Secure MI	190	64	0	254	107	44		151	114	46		160	114	32		146	112	20		132
AS Medium Secure LD	10	0	0	10	12			12	16			16	18			18	17			17
AS Medium Secure MI	164	30	0	194	127	2		129	124			124	120			120	100			100
Step Down Mixed	0	0	15	15			14	14			12	12			16	16			16	16
Frailty and/or Shared ABI-Deaf Unit (Virtual Pilot)				0				0	4	1		5	6	3		9			20	20
Integrated women's unit				0				0				0		16		16		30		30
Admissions/Assessment Beds (Virtual Pilot)					4	1		5			8	8			8	8			8	8
Transitional Care Accommodation (Virtual Pilot)								0	2	2		4	4	4		8	8			10
Total in area provision	392	94	15	501	276	51	14	341	289	55	55	364	286	57	36	379	255	53	54	362

Table 11 - Phased commissioning plan

Phased bed capacity plan

Overall, these new models of care slightly increase our local bed numbers to 362 in total, but these are not all secure beds (transitional and assessment beds are additional to existing pathway provision) and the net reduction in out of area beds is substantially higher. The steps to working towards these bed number are as follows:

- **In year 1** - we will make a substantial investment in increasing our step-down capacity to accommodate an overall reduction in average bed occupancy to 90%
- **By year 3** - we will have developed new models of care for frailty and transitional accommodation for young people. We will also have opened our assessment and treatment facility; focused on prison pathways initially with 16 week capped admission time
- **After 5 years** -16 new blended specialist women's beds commissioned sustainably within the Provider Collaborative and we will be commissioning up to 9 frailty beds to meet growing demand
- **Within 10 years we will have reduced our potential Out of Area capacity by 22 beds through a fully implemented rebalancing of our existing capacity and planned new models of care.**

Key observations and options for development

Key observations

There has been excellent performance evident to date within the Provider Collaborative, as shown by the following key observations:

- There has been a significant demonstrable reduction in overall and service line specific Length of Stays (LoS), particularly in the For Me Provider Collaborative commissioned providers
- There is evidence of proactively reducing acuity, as an adherence to least restrictive practice, through shift of medium secure to low secure activity, as well as increasing propensity to support patients through community secure models, in both prisons and outside of prisons
- There have been extraordinary reductions in both out of area and non-clinical flow placements, the latter is now at less than 0.5% of activity
- There is also evidence of reducing acuity overall, with a significant reduction in Learning Disability commissioned capacity, in line with the NHS Long Term Plan Assuring Transformation ambitions to reduce inpatient numbers and reduce length of stay.

Key conclusions on future bed capacity requirements

At this point the system level bed capacity is broadly sufficient across the provider network to accommodate up to 15 years growth in future demand however, not all beds are in the right place or at the right level of acuity and Locally Commissioned providers are already experiencing capacity challenges that are likely to get worse (net shortfall of up to 57-129 beds by 2037).

All providers will play a part in delivering a future sustainable model of care as the modelling indicates that decommissioning a service would put unfeasible demand pressure on other providers in the network.

Other key conclusions

- There are currently pockets of lower utilisation in Nationally Commissioned beds, but as these are not block funded by the Provider Collaborative; this does not affect network costs

- We have identified the following inequity in out of area referrals that we will be exploring further to be priorities to be addressed through this strategy:
 - Women are more than three times more likely to be placed out of area
 - Currently twice as likely to be placed in out of area or to a Nationally Commissioned provider if frail or elderly.

Options for development

The priority pathways/services that have been identified for consideration and development within the strategy are shown in the table below. Section 2 of this Strategy Document explores in further detail how we intend to develop services in each of these priority areas.

Options for development	Further details on page:
Blended Women's services and capacity within PC catchment (10-15 Beds)	39
Prisons Admission and General Assessment Model (8 Beds)	42
Community and PICU in/outreach secure advice and guidance service (Shared care contracts)	40
ASD sympathetic design and management	41
CAMHS and Transitional care model (outreach/secure accommodation solution not inpatient beds)	42
Multi-PC Solution for Frailty (up to 20 beds demand forecast)	43
Shared training and development models including collaborative peer review/regular clinical team in person MDT sessions	45

Table 12 – Options for development



Section 2: Our Strategy Themes

Women's services

Least restrictive and recovery

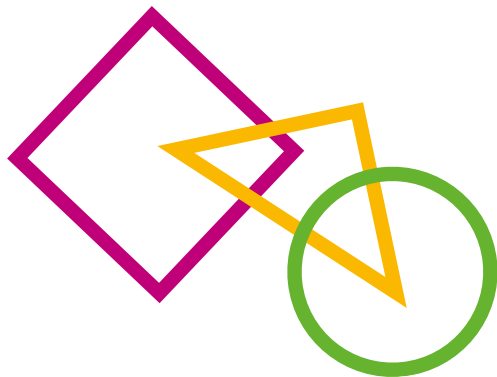
Diverse patient groups

Managing transitions better

Improved access and decisions

Physical health and vulnerability

Integrated working



Overview, scope and cross-cutting themes

Introduction

This section of the strategy sets out the key priority themes we have chosen to focus on in the medium and long term. These were developed based on the feedback of our patients, staff and partners over a significant period of engagement through existing forums, interviews and workshops. This thematic work should enable the 10 year bed commissioning plan set out in section 1 of this strategy.

The themes have been collated into 7 distinct areas of work to allow us to prioritise our supportive work and plan how we will allocate resources in support of achieving these aims.

In this section we will articulate what we learnt over the course of developing the strategy, summarise where

we want to be in the future, and what we will do to get there; as well as highlighting some of the risks and challenges we may need to overcome to achieve our goals in each area. The scope of the core strategy is mainly focused on adult secure mental health services but there are some new services and transitional pathways with other services explored to achieve better delivery, access and outcomes at all stages of the patient journey.

The engagement process highlighted a wide variety of priority interventions, some of which do not neatly align with our core themes. None of this valuable feedback should be lost and so we have summarised the wider areas where we will continue to focus our attention below:

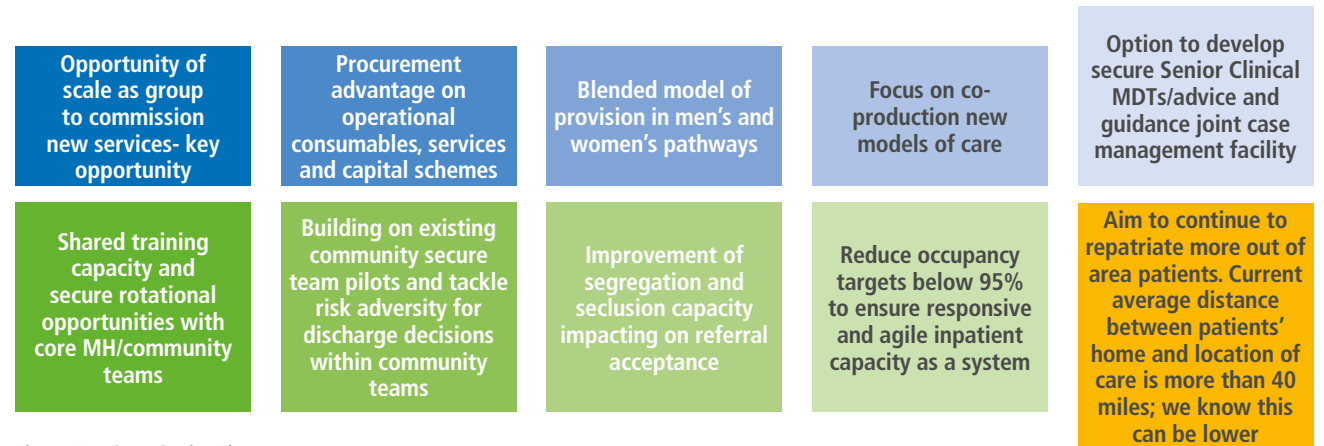


Figure 14 – Cross Cutting Themes

Women's Services

Developing a tailored local service offer

We heard...

Women's services are in a process of change; the general capacity constraints, consultation regarding the future of the WEMS service and increasingly complex needs demonstrated by this patient group are all areas of interest and concern. The impact of best practice guidance on managing complex trauma also demonstrate the need for improvement in our services.

We saw...

Despite the lower numbers of female patients overall, women are 3.5 times more likely to be referred into services outside of the Provider Collaborative. Female wards also have inconsistent quality support spaces and accommodation in different locations within the Provider Collaborative.

We predict...

That we will need to grow our female capacity with a focus on blended services and greater breadth of clinical capability to manage complex trauma, serious self-harm including disordered eating and potentially safe and sensitive solutions for accommodating transgender patients in the future.

Our strategy

We aim to offer women the same access locally as men. We will ensure facilities are tailored to the needs of this group; with accommodation that minimises the risk of self-harm and a tailored community offer to respond to the needs of those with complex trauma. Women can expect a renewed focus on family support and tailored care to meet their needs.

Action now

Before we invest in wholesale service change, we are going to review the women's service offer across the whole pathway. We want to understand what this service currently looks like in the community, through to support to prison services and the role of the Female Psychiatric Intensive Care Units (PICUs). We will take a pathway review approach and host a development session to identify the root cause of service challenge and access barriers. We will take a co-production approach to developing new pathways and interventions speaking to current and past patients about how they feel things could have been better.

Within 2 years

Once the true level of unmet need has been confirmed we will move forward with commissioning between 5-10 additional female beds. Complimentary investment in expert clinicians to deliver enhanced preventative community pathways will also be prioritised.

In the longer term

We will deliver a Women's Services Transformation Programme that aims to improve all aspects of our women's services; culminating in the delivery of an exemplar women's facility that delivers enhanced clinical facilities to manage self-harm and disordered eating, sustainable staffing models with additional specialist expertise in complex trauma and family centric facility design.



Risks and challenges

- Complex package of care requirement for women with co-morbidities including eating disorders and self-harm
- Need to tailor ward sizes to 12 patients or less may be difficult to staff and/or fund
- Requirement to develop specialist workforce with skills expertise in trauma pathways and women's' care
- Addressing access challenges for patients in the Dorset areas
- Need to confirm the future of the WEMS service and potential flexible commissioning model for community services
- Establishing the degree of unmet need in the community and prison service.

Least Restrictive and Recovery Pathways

Shift to lower security and community models of care

We heard...

Some patients would have equal benefit from community pathways both in prison and outside of custodial settings. Our leads have seen a persistent widening in the scope of referrals for secure admissions. This is further compounded by differing levels of focus on recovery once patients are admitted. Secure services cannot become the default location of care for complex or disruptive individuals.

We saw...

We have made significant progress to date in discharging patients whose risk profile no longer merits inpatient care. We have been able to develop excellent community pilot models, and these are delivering significant system benefits. We have been able to shift the balance of our inpatient accommodation by creating more low secure capacity.

We predict...

We can do more to prevent admissions and reduce length of stay by working more closely with our wider mental health service partners. By sharing risk and proactively planning for discharge from a much earlier stage in the patient journey we can achieve better outcomes for our patients.

Our strategy

We recognise our patients have a right to expect the least restrictive model of care that is feasible. We are committed to ensuring that secure inpatient care will be a service of last resort; only for the most complex and high-risk secure patients. We believe our patients history should not be the only determinant of their future. The degree of restriction we place on individual liberties should always be a carefully considered balance of risk, safety and exploration of the opportunities for meaningful recovery.

We will support partners throughout the system in managing low to moderate risk patients outside of restrictive setting where possible. All patients in our care will be subject to regular proactive review to ensure patients who are suitable for low secure or even conditional discharge are moved to these settings. Recovery should be our foremost priority once we have achieved a stabilisation of condition. We recognise that our patients' journeys are often not linear, but we will commit to challenging ourselves to maintain our recovery focus even when patients experience setbacks and become seriously unwell. Lastly seclusion and long-term segregation decisions, outside of short-term acute episodes, should be treated with rigorous challenge and discussion across multidisciplinary teams. Staffing and facilities to promote de-escalation should be the priority.

Action now

Continue to undertake periodic review of patients in admitted care to proactively identify patients who could be moved from medium to low secure accommodation. Ensure all patients have a recovery plan with clearly documented milestones in place. Scope opportunities to enhance discharge planning digital resources. Establish formal local review of seclusion and segregation decision making.

Within 2 years

Ensure all Provider Collaborative regions have a harmonised standard

Risks and challenges

- Capacity challenges and persistent workforce shortages in general mental health and prison services will continue to place pressure on the service
- General erosion of confidence managing patients with offending history outside of a secure setting
- Increasing complexity of balancing public safety against patient personal rights and freedoms
- Need to grow secure community teams over time as limited specialist resource currently available
- Inadequate de-escalation spaces within many of our facilities drive risk averse seclusion decisions.



of community secure resources. This should include specialist secure outreach teams to support prisons and PICU services. Rotational training models co-developed with wider mental health services to increase awareness of secure service practice and risk in general mental health teams. Lastly, we will invest in our descalation facilities and quiet spaces to reduce the requirement for segregation and seclusion.

In the longer term

Move towards blended care models for both male and female patients; with the flexibility in inpatient environments to adopt fluid approaches to restrictive practice.

Meeting the Needs of Our Diverse Patient Groups

Including Learning Disability and Autism Spectrum Disorder Supportive Models of Care

We heard...

Of a growing concern regarding the suitability of existing service and facilities to provide optimal care for diverse groups. In addition to better accommodation for women and older people, there is a view that additional/enhanced accommodation is required to meet the needs of increasingly neurodiverse patients.

We saw...

Evidence of systemic under representation of ethnic minorities both within referred and accepted patient groups. Whilst the root cause of the misalignment with mental health prevalence, prison population and violent offender demography is not clear this merits further exploration.

We predict...

Unmet need in non-white patient groups. We also believe there will be a persistent increase in demand (requiring specialist service adaptation) for patients with presenting neurodiversity and mild to moderate learning disability as comorbidities. We believe adaptation will be required to sensitively, yet safely, meet the accommodation preferences of transgender patients (national guidance pending).

Our strategy

We have committed to ensuring that every possible effort is made to provide equitable access to care, decision making and patient outcomes regardless of age, race, gender, orientation, disability and/or clinical presentation. Whilst we are confident that our services and teams broadly align with these values, patient presentation and clinical best practice in this area are constantly evolving. We cannot be complacent and so responding to the needs of our diverse patient groups will remain at the forefront of our priorities as we implement our strategy.

Action now

We will nominate a Provider Collaborative diversity, equality and inclusion (DEQ&I) advocate to explore employee attitudes and identify any potential sources of bias (unconscious or otherwise). Proactive engagement with referring agencies will be undertaken to test if there is underlying unmet need within ethnic minority groups. This senior DEQ&I lead will establish a cross Provider Collaborative working group to objectively assess the current cultures and behaviours of our teams (and patients).

Within 2 years

- Develop an equality and inclusion strategy to highlight effective ways to improve diversity awareness, equitably meet the needs of all protected groups and confirm any local training and process interventions required
- Undertake a programme of environmental adaptation in our patient areas to minimise adverse sensory impacts and provide ASD and ADHD sensitive facilities and services
- Confirm Provider Collaborative wide transgender patient accommodation policies and underpinning operating procedures; aligned with national guidance.

In the longer term

- Develop and commission specialist ASD unit to meet specialist patient needs.
- Proactively review our current Learning Disability capacity and continue to align with the principles of Assuring Transformation; most notably focused on supporting these patients to transition into community support where feasible to do so.



Risks and challenges

- We do not fully understand the root cause for the evident lack of diversity in our patient groups. This may be attributable to partner referrals and/or relate to geographic variation in demography
- Staff have reported historical incidences of racial abuse by patients. This should be addressed robustly through staff well-being workstreams and progress with tackling these behaviours reviewed through the Equality and Inclusion working group
- There is persistent tension between respecting the individual right of patients to self-identify and consequential duty of care to other vulnerable patients within our facilities. We will seek national clarification, and where possible, align our approach with our partners in the prison service.

Managing Transitions, Access and Shared Care better

Facilitation of timely assessment, movement between services and supporting our partners better (including CAMHS, Prison, PICU and Discharge)

We heard...

That our referring partners in prisons and PICUs don't always feel that admissions occur in a timely fashion. Clinicians felt that there are persistent barriers to discharge ranging from suitable accommodation through to community team confidence to manage patient related risk outside of a secure environment. There is no good pathway solution for high risk Tier 4 CAMHS patients when they approach 18 years of age.

We saw...

Frustration that patients that were not accepted due to unsuitability, then had to be re-referred to PICU or other services; delaying interventions; Challenge of operating with 95% occupancy pan PC- providers have limited ability to be responsive and agile in meeting variable demand.

We predict...

Sharp increase in prison referrals; particularly due to pent-up COVID demand and unmet need within new diagnosed neurodiverse populations. Increasing multi-morbidity presentations.; particularly younger PD/ED/ASD/LD presentations.

Our strategy

We know we can do better to be more responsive to changing patient and partner organisation needs in this area. Our single point of access and FIND models have been highly successful in improving our ability to assess, admit and ultimately discharge patients. In contrast there are still system level barriers to accommodating patients with short term assessment needs, as well as those who would benefit from transitional packages of care prior to discharge.

Recognising that our patients can experience their highest levels of uncertainty, and consequentially a risk of escalating symptoms, at times of transition we need to make sure our models of care are adaptable and responsive to their needs. These may require novel working practices and additional non-secure managed accommodation.

Action now

- We know a key barrier to timely admission of accepted patients, is a systemic under provision of de-escalation, seclusion and long-term segregation facilities. This is already a key priority that we have allocated capital grants to address, but there is likely to be wider investment required
- Consideration of piloting a virtual prison assessment ward within secure mental health accommodation (develop clinical specification/tariff)
- Cross sector working group on younger persons service model.

Within 2 years

- Significant increase in supportive rehabilitation step down capacity (at least 10 transitional beds/accommodation solutions) to maximise changes of successful discharge
- Work towards a maximum 90% occupancy model to allow for improved time between acceptance and admission

- Establish secure advice and guidance service, with scope to virtually admit patients for review or enter shared care arrangements with community teams.

In the longer term

- Supervised residential discharge/step down facility options delivery
- CAMHS/Adolescent transitional supervised accommodation commissioned
- Commission Prisons Assessment/Admissions ward with capped 16 week stay.



Risks and challenges

- Commissioning constraints are restrictive and don't enable shared management of complex patients
- ICB Commissioning priorities unclear in this area but greater integration with Local Authority services should be a positive enabler for solutions in this area
- Specialist Clinical Workforce Sustainability: Speculative service development should not undermine core workforce
- We need to continue to raise awareness among community and prison teams that historical secure admissions and/or violent offending are not automatic indicators for patient acceptance in secure services.

Focus on Physical Health Needs and Managing Vulnerability

The facilities to provide safe and supportive care for increasing Frailty and Acquired Brain Injury

We heard...

Older patients with physical health needs are often only cared for via ad-hoc arrangements, such as end of life pathways. It is a growing concern that as patients become increasingly frail and vulnerable (often not at a particularly old age due to historical factors), the capacity to meet their needs is limited within the Provider Collaborative.

We saw...

Our wards are not all compatible with caring for patients who are physically unwell or increasingly frail. We do not have universal physical health skills and space and there are very limited bariatric accommodation solutions. Lastly increased incidence of physical health comorbidities and self harm.

We predict...

There will be a substantial increase in the average age of our long term admitted patient groups. Demographic factors and improved life expectancy will play a significant part increasing the wider complexity of patient physical health needs. Many of our patients are known to have higher than average BMI due to both medication and lifestyle factors and the need for bariatric facilities and equipment will continue to rise based on national trends.

Our strategy

We want to ensure that we are meeting all the needs of our patients, not just focusing on their mental health recovery journey. A balanced approach to primary prevention and lifestyle interventions should be tempered with a realistic understanding of the physical frailty many of our patients develop relatively early in life.

We want patients to receive parity of esteem and the same quality of healthcare they would reasonably expect were they not living in secure accommodation. Treatment spaces, adaptive ward environments and a focus on developing the wider diagnostic and medical skills our staff require for future-proof models of care are among our key priorities for the next 5 years.

Action now

Develop a specification for the optimal model of care for vulnerable/frail patients with additional physical health needs. This work should involve the wider geographical area beyond our Provider Collaborative boundaries and should include exploratory discussions regarding specialist ABI needs. In parallel we will undertake an assessment of our physical health facilities and workforce capability to develop a targeted investment plan to augment our ability to meet physical health needs within best practice models of care.

Within 2 years

- Virtual frailty unit development by cohorting frail or physically unwell patients in a single facility
- Business case for Enhanced Frailty Unit.

In the Longer Term

- Fully operational Frailty unit by 2028
- All inpatient wards to include at least 1 bariatric room and bathroom with adaptation to meet needs of patients who may historically have required hospital admission for non-specialist treatment.

- Every unit to have at least 2 HBN compliant treatment suites; discontinuing health interventions including wound care, medical consultations and physical health assessments in patient bedrooms by 2026
- Delivery of Deaf-ABI commissioning strategy focused on repatriation of out of area patients (Joint Provider Collaborative working).



Risks and challenges

- Requires significant investment in both our physical estates and specialist clinical roles.
- Commissioning structure and tariffs do not currently align with the delivery of this specialist model; particularly if the services planned will be for multiple PCs
- Balance of managing risk and ensuring dignity should be carefully considered for palliative patients with limited discharge prospects
- Workforce intensity required for patients requiring regular transfer to hospital for treatment, admission and/or review
- Need to ensure vulnerable patients do not become targets for other patients (cohorting benefit).

Integrated Working and Collaboration

Facilitating shared patient care, joint-learning and a sustainable constructive partnership environment

We heard...

Our services remain a key shared priority but our partnership approach needs to evolve. Whilst the will for joint working has increased over recent years there are limited forums for clinical and operational teams to work together. Historical cynicism and mistrust between partners have proved challenging to address.

We saw...

Pockets of promising best practice such as the Provider Collaborative partnership structures and shared Safeguarding Leads group. Single digital structures, rationalised reporting and system wide capital investment approaches, are all constructive steps forward. Unfortunately, there is still too much focus on local autonomy and cost pressures rather than a true system wide partnership approach to sustainable care delivery.

We predict...

There is significant untapped opportunity to work together to deliver better shared outcomes for our patients and improved models of support for our staff.

Our strategy

We will seek to establish a culture of collaboration and team work across all secure mental health services. We will align our behaviours with the agreed partnership commitments and seek to develop trust and empathy between services, teams and professionals. Our senior team will lead by example, highlighting our common values and challenges and every member of staff will be afforded opportunities to share experience and collaborate with their peer group across the network.

Action now

This strategy is the first tangible step to progressing increased integration. The working groups that will be required to deliver this strategy will all feature equitable representation from our member organisations. We are revising our governance structures to ensure that the principles of equal representation are lived in practice for all organisations. We will establish a clinical symposium programme with 4 planned CPD meetings annually; focused on case study based learning, rapid improvement events and guest speakers from academic and national bodies. All teams should be encouraged to participate on a rotational basis recognising local service pressures will play a part in our ability to release staff to participate.

Within 2 years

To ensure we operate in a climate of trust and fairness; we will take steps to ensure that all Provider Collaborative members will be subject to parity of commissioning and contractual terms. We are aware that there will always be some disparity in benefits allocation (formally agreed risk-gain share), however the tariff for day rates and financial penalties applied to organisations should be the same.

In the longer term

We will focus on developing interactive digital solutions to support real time collaboration and relationship building. We will seek to

facilitate cross-organisational communication; sharing our challenges and success in secure digital environments. These systems will adhere to information governance and patient confidentiality constraints. We will engage with teams on an ongoing basis to better understand the barriers to collaboration and highlight the benefits in terms of improved patient care and staff moral. If there are financial challenges to releasing staff to work across the Provider Collaborative we will work with organisations to support with the costs of backfilling key clinical staff.



Risks and challenges

- Current contractual and commissioning models set at a national model and so work will be required to influence changes to prevent disincentivising patient share care agreements
- Time and commitment required to build strong relationships in the long term could prove challenging but there are significant economic, sustainability and service quality benefits so this should be a local and PC wide priority.

Enablers to delivering the strategy

Section 3: Making it happen

What do we need to do to ensure the successful implementation of our strategy?

There are some key building blocks we will need to put in place to ensure the successful realisation of our strategy. The costs of delivering these enablers will be shared throughout the collaborative but there is a recognition that most of the investment will be focused on our provider membership.

Fostering a Culture of Collaboration	<p>To build trust across the PC we know we must lead by example in creating a culture where collaboration can thrive. This will require protected time for our teams to work together on shared goals and behavioural change at all levels of the PC. We are not in competition as organisations so we must make every effort to break down the historical barrier to collaboration. Our staff should feel part of a single team with shared values, whilst being able to maintain focus on local needs and priorities when required.</p>
Promoting Innovation, Research and Continuous Culture of Quality Improvement	<p>We will establish an Improvement, Innovation and Quality group who will take forward a mandate of developing local research on best practice, sharing exemplar programmes and providing a forum to test complex patient care scenarios and gain support. Meeting quarterly, this group will engage with wider NHS support functions to develop a programme of QI skills development; whilst also building on existing relationships with the academic community to research emerging trends in secure patient presentation and care.</p>
Improving Our Estates and Facilities	<p>We recognise that the greatest source of risk to the sustainability of our service is the inadequate size and condition of our older estates. We will continue to support capital investment as a collective group and will publish a supportive estates strategy by the end of 2024 to guide our work. Local organisations will continue to retain responsibility for the quality of their accommodation, but the PC will take a supportive role in securing national investment wherever it can.</p>
Streamlining Reporting and Performance	<p>We have recognised the feedback from our members that there is currently pockets of duplication between PC, organisational and national reporting requirements. Our finance and performance committee will work with NHSE and our member organisations to develop a single succinct reporting format to support a meaningful dialogue on performance. This will focus on identifying opportunities for service improvement and early risk identification, rather than any form of punitive contractual penalties.</p>
Workforce Recruitment, Retention and Skills Development	<p>Our greatest asset is our highly expert workforce, but we know that this is a diminishing resource. We will appoint a workforce lead to support the development of a PC workforce strategy to deliver:</p> <ul style="list-style-type: none"> • Sustainable workforce capacity and training pipeline for the next 10 years • Holistic approach to training and skills sharing across the provider network • Improved focus on staff well-being and working experience; including the provision of a wider range of well-being resources for staff experiencing the adverse impacts of working in this area.
Focus on Partnership with Prisons and the Department of Justice	<p>Engagement and service development in partnership with these key stakeholders continues to be our key priority. We must build on our shared values to create a more open collaborative approach to decision making. We recognise there is a wider capacity crisis in some prisons and so want to make sure our ability to be responsive to these partners needs is enabled by regular dialogue on emerging needs and pressures.</p>
Investing in Digital Innovation	<p>We have seen the potential of implementing a single point of access system through Cambio and need to work through the access challenges that a single platform presents. We also need to expand our routes to support for our partner agencies; exploring a secure services advice and guidance model that allows partners to access senior expertise. We will also explore digital therapeutic tools as an aid to enrichment for our patients. There are numerous emerging digital tools for therapy that we will evaluate in terms of secure safety and compliance and trial across our providers. Lastly all of our facilities will continue to explore the opportunities for digital innovation in operational management and share learning on successes and challenges throughout the PC.</p>

Strategic Road Map

How we will phase our investment and developments over time (including scheduled review of strategic aims)

Theme	Year 1	Year 2	Year 5	Year 10
Developing the Provider Collaborative	Commence quarterly partner quality symposium	Align with ICB commissioning priorities	Single policy library	Single induction programme for clinical teams
	Engagement and coproduction workplan	Shared workforce strategy	Agreed harmonised contractual terms implemented to all providers	Workforce rotational programme
Women's Services	Pathway review of women's services	Renewed focus on family support	Focus on least restrictive care and recovery pathways	Women's services transformation programme and additional services
		Create additional women's capacity (5-10 beds)	Move towards blended service model	Delivery of an exemplar women's facility
Least restrictive and recovery	Discharge planning process review	Community secure services pan-pc equitable provision	Pilot PICU outreach team	Blended care and virtual admission pilots
	Digital discharge package development	Seclusion and segregation utilisation audit	Continue shift towards lower acuity pathways	Increase step down capacity and medium-low flexible wards
Diverse patient groups	DEQ&I advocate and working group	Targeted workplan to address access challenges	Transgender operating model agreed and implemented	Ongoing focus on tailored individualised care in least restrictive environment
		ASD accommodation compliance audit and adaptation programme	ASD specialist unit commissioned	
Improving transitions, access and decision making	Seclusion and segregation business case development	Young Persons' Transitional Model Programme	Commission additional step-down capacity	Admissions and assessment ward delivery
	Virtual assessment model pilot	Establish formal A&G service and shared care commissioning solution	Adjust occupancy to 90% average across pc settings	Commission young persons unit
Physical health and frailty		Anp development programme	Frailty Unit business case and virtual pilot	Frailty Unit commissioned
	Physical health treatment capacity, facilities and clinical skills audit	Increased bariatric capacity (1 room per ward)	Reviews and adaptation of physical health facilities in all units	Deaf-ABI repatriation strategy
Business plan development	Strategy launch	Strategy review point	Strategy review point	

Governance and Operations

How we will adapt our structures to deliver the strategy

In the development of this strategy, we took the opportunity to look closely at our own structures and processes. Two things became evident:

1. That we could do more to facilitate building relationships across our network through informal groups and action learning approaches
2. That there was an opportunity to streamline our governance and minimise operational pressures on key leads by cutting out any duplication in reporting and historical meetings that are no longer focused on progressing the key needs of our services.

The governance structure set out in figure 15 details how we plan to continue to satisfy our statutory responsibilities as a commissioner whilst augmenting our structures and processes to embed a partnership culture that is focused on engagement, coproduction and embedding the growing culture of continuous improvement. This will enable us to work together better, balancing our assurance function against a focus on multidisciplinary working and collaboration. We will also be utilising the soft launch of this strategy in all our provider locations to continue the momentum we have generated for increased informal collaboration and integrated working.

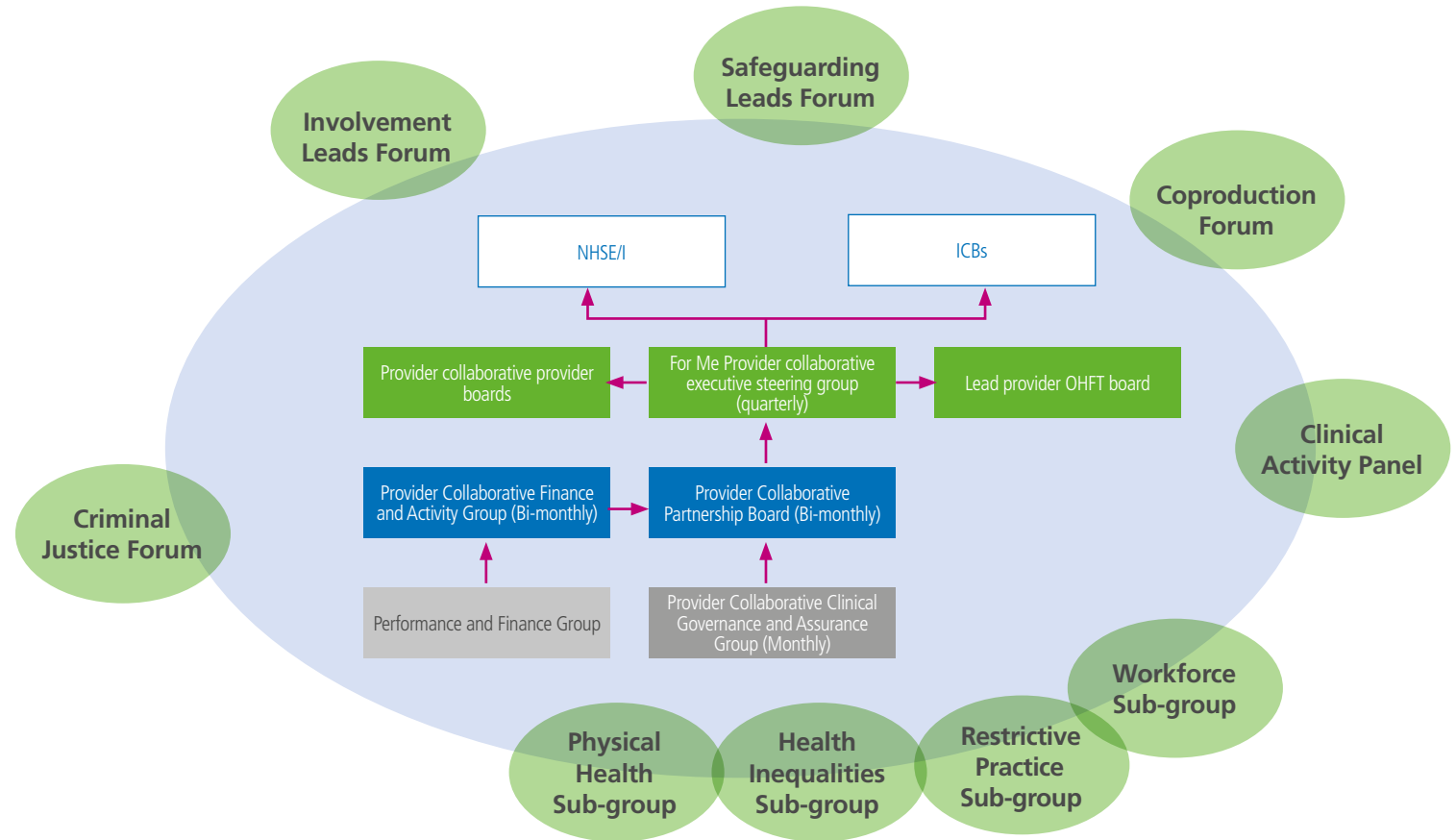
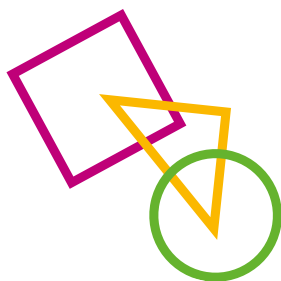


Figure 15 Provider Collaborative Governance Structure

Financial approaches and Impacts



We are currently in the process of developing a detailed plan of indicative forecast service costs based on average Overall Bed Days rates. As discussions are currently ongoing regarding the model for future rates and contractual terms, we are unable to accurately forecast annual service operational commissioning budgets associated with this strategy at this stage. The implementation plan for this strategy will include a 3- and 5-year cost forecast that details the financial model for all activity including the future planned models of care such as:

- Indication of cost profile for additional specialist facilities (Frailty, Women’s and ASD)
- Management of transitional model cost for CAMHS (secure housing solution sits with Local Authority).

These service models are subject to bespoke commissioning arrangements that are currently under development and so the aim is to have robust financial plan in place by April 2024.



Non-Operational Intervention	Year of Implementation	Estimate Cost (Per Annum)
Workforce Development Lead	2024	c£50-60k
PC Wide Estates Quality and Condition Audit and Strategy	2024	£70k
Women’s Pathway and Service Specification development	2024	£25-25k
LD/ASD Baseline Compliance review and Action plan	2024	£18k
Physical Health Capacity and Environmental Quality Review	2024	£28k
Digital Discharge Package Development	2024	TBC
Virtual Assessment Model Pilot	2024	£120k
DEQ&I Advocate and working group	2024	TBC
Expansion of Community service offer	2025 Onwards	TBC
Transgender Operating Model Agreed and Implemented	2025	£80K
ASD Facilities Audit and Development Programme	2025	£225k
Adjust occupancy to 90% average across PC settings	2026	TBC
Harmonisation of provider terms and conditions	2026	TBC
Increased Bariatric capacity (1 room per ward)	2025-2026	c£350k per facility

Table 13 – Investment Plan

Next steps and Development of Our Business Plan

Priority 1

- **Publish and secure buy-in**

Ensure that wider partners are engaged and focus on strategic engagement plans

Priority 2

- **Agree roles and responsibilities**

Confirm who will provide oversight and assurance regarding progress

Priority 3

- **Focus on delivery**

Confirm the systems, resources and structures are in place to achieve the strategy

Our business plan development

Once we have secured buy-in across all our partners for this strategy we will immediately go on to develop our 2-year business plan. This will set out the underpinning SMART objectives for delivery during FY24-25 and FY25-26; getting us on our way to achieving this strategy.

- This will be developed and agreed by January 2024 and ratified by partnership board no later than March 2024
- We will continue our coproduction approach and ensure the objectives in the plan align with the local priorities of our partners, as well as addressing patient needs
- The business plan should provide a detailed guide for how we address the overarching challenges set out in this strategy
- Once approved the progress against this plan, as well as any key strategic enablers, will be reported on quarterly to NHS England.

Getting everyone involved

The success of this strategy is contingent on everyone from our patients to our leaders rolling up their sleeves and getting involved. We cannot make big changes without our staff, carers and partners being empowered to participate in the changes we have planned.

The first step of securing this participation will be a programme of launch events in March and April next year (2024). We will be coming to visit many of your services and facilities to explore what this strategy will mean for you all in practice.

We will also be working with teams to identify staff and patient champions to join the delivery board for the strategy to ensure that all of your voices continue to be a key part of making this strategy a reality.





This Commissioning Strategy and further information can be downloaded from:

twwadultsecurepc.nhs.uk/our-commissioning-strategy

Commissioning Strategy 2023-2033

