
OLDER PEOPLE'S MENTAL HEALTH TRANSFORMATION JOINT COMMITTEE

10.00 to 11.30 am, Monday 11 November 2024

Microsoft Teams Meeting

AGENDA

1. Welcome and Apologies
2. Declaration of Interests
3. Minutes of the Last Meeting – 17 June 2024 – **page 2**
4. Older People's Mental Health Inpatient Transformation Programme for Calderdale, Kirklees and Wakefield: Decision-Making Business Case – Vicky Dutchburn – **page 8**

OLDER PEOPLE'S MENTAL HEALTH TRANSFORMATION JOINT COMMITTEE

2.00 pm, Monday 17 June 2024

Microsoft Teams Meeting

MINUTES

Present	
Members	
Jo Bibby (JB) (in the chair)	Independent Chair, Calderdale
Stephen Hardy (SH)	Independent Non-Executive Member (Citizen Voice and Inclusion), Wakefield
Carol McKenna (CM)	Accountable Officer, Kirklees
Mel Brown (MB)	Director of System Reform and Integrated Care Partnerships, Wakefield
Attendees	
Penny Woodhead (PW)	Director of Nursing and Quality, Kirklees, Calderdale, Wakefield
Alison Croft (AC)	Deputy for Lesley Stokey, Place Lead for Finance, Calderdale
Karen Huntley (KH)	Healthwatch Representative
Vicky Dutchburn (VD)	Director of Operational Delivery and Performance
Neil Smurthwaite (NS)	Chief Finance Officer, Calderdale Cares
Professor Subha Thiyagesh (ST)	Chief Medical Officer, SWYPFT
Ryan Hunter (RH)	Ryan Hunter, Programme Manager, SWYPFT
Matthew Burns (MBu)	SWYPFT
Dawn Pearson (DP)	Associate Director Communication, Involvement, Equality and Inclusion
Fabian Csilla (FC)	SWYPFT
Nick Lamper (NL)	Governance Manager

Apologies	
Members	
Liz Mear (LM)	Independent Chair, Kirklees
Robin Tuddenham (RT)	Place Lead, Calderdale
Attendees	
Lesley Stokey (LS)	Place Lead for Finance, Calderdale

1. Welcome and Apologies

JB, in the chair, welcomed everyone to the meeting; apologies were submitted as set out above.

2. Declarations of Interest

No interests were declared by members of the committee. The interests of colleagues from SWYPFT as the provider of the service were acknowledged; their role at the meeting was to provide information but not participate in the decision making.

3 Accuracy of Minutes from 1 December 2023, Matters Arising, Action Log

The minutes of the meeting held on 1 December 2023 were **APPROVED** as a correct record, subject to checking and updating of the list of members present and those in attendance (and apologies) and reflecting that SH had chaired the meeting.

SH noted that part way through the consultation process there had been a progress report at a stakeholder event and some concerns had been raised, particularly in relation to Wakefield. VD advised that those concerns would be raised and addressed during the presentation of the report and the delivery of the presentation at this meeting.

The Older People's Mental Health Transformation Joint Committee then resolved:

"That the press and public be excluded from the meeting during the consideration of the remaining items of business as they contain confidential information as set out in the criteria published on the ICB's website, and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."

4. Older People's Mental Health Inpatient Transformation Programme for Calderdale, Kirklees and Wakefield

VD presented a report along with the following documents:-

- OPMH Inpatient Consultation – assurance of process report
- Older people's mental health inpatient services consultation report (independently produced)
- Equality Impact Assessment
- DRAFT post consultation plan: governance timetable

The first part of the meeting would deal with the assurance of the consultation process, and seek confirmation from the committee that it was assured on the delivery of that process.

The second part would cover the independent consultation report, EIA and forward timetable, with the committee's agreement being sought to share the full report and EIA publicly when ready.

RH and DP undertook a presentation detailing the process and documentation set out above.

SH observed that great efforts had been made to put the relevant information into the public domain and target specific groups, but noted that some of the outlets to which information had been sent had not initially displayed it. He asked whether it was possible to be sure that they had done so on the second push.

DP responded that there had been a call to action through the ICB to all partners, and colleagues had gone out to check that material was being displayed, as it was important to know the extent of the reach without public feedback. It had therefore been possible to build a reflective response of impact, geographically and demographically.

SH confirmed that he was satisfied that the process had been robust.

VD added that some mystery shopping had been undertaken by colleagues armed with extra leaflets; nowhere had been found not to be displaying the materials, although there had been a variety of ways in which they were being displayed. Additional materials had also been left in some places, at their request.

JB advised that, in respect of the Public Equality Duty, clarification had been issued in December in relation to the terms sex, gender and gender identity. This had been taken forward for future work. She added that an impressive number of people had engaged in the process and congratulated the team for the work undertaken.

The Older People's Mental Health Transformation Joint Committee:-

(1) Was **ASSURED** in respect of the consultation process and its delivery;

The Older People's Mental Health Transformation Joint Committee was **ASSURED** in respect of the consultation process and its delivery.

Continuing the presentation, RH set out the feedback on the most important elements, and VD advised that the travel and transport working group had been reestablished and considered a wealth of information that people had been prepared to share regarding solutions.

CM asked about the information given to respondents on value for money in relation to each of the options. RH responded that high level financial information had been

shared mapping costs of the different options. The full business case with a full breakdown had been available on the website.

VD added that, while these had not been true social value questions, there had been information on each option as per what had come out of the financial sub-group. That group had now been stood back up and had an initial meeting with NHSE. Much more detail would be included when a decision was made on which option to take forward.

MB stated that he would be keen to see a breakdown by place. VD and RH confirmed that this was in the presentation, which would be circulated following the meeting.

PW observed that mixed gender/sex accommodation had clearly come out as a theme from a causative care perspective. There was a need to describe the improvements and mitigating action around these concerns with a well-developed narrative. It was not just about being compliant with the legislation, but presenting back to the public on how it had been raised. JB asked what it was that had led to some of the services being categorised as mixed-sex; for instance, was it that shared communal areas had been misinterpreted as meaning beds were side-by-side? VD advised that this had been one of the areas which had quite quickly been included in the FAQs and it could be made more explicit in the final report. ST added that this had come up a number of times as there had been an assumption that people understood the terminology but then a realisation that it had not been made clear.; it would be ensured that the future narrative was really clear. RH advised that a small working group was reviewing the equality impact assessment and had been looking at the impact of mixed-sex wards. The group would tease out the mitigations for each department and ensure these were included. SH commented that it was not just the public and stakeholders who needed clarification as he, himself, had been unclear – so it would be important to be specific in any explanations. MBu clarified that there had never been a proposal of shared sleeping arrangements; the key would be in the sharing of the narrative.

The meeting was adjourned for a break at 3.20 pm and reconvened at 3.30 pm.

ST continued the presentation, reflecting on the findings, and DP presented those aspects relating to equality.

KH asked what correspondents had understood by the term single-sex ward and noted that, when the co-design work was done, certain groups had expressed a wish to be involved in this. MBu advised that, at public meetings, people had tended to be unable to differentiate between what a mental health ward and a general ward would look like. They had therefore tended to assume that mixed-sex wards included mixed-sex sleeping and bathing accommodation. VD advised that the FAQs had been repeatedly refreshed to reflect this misapprehension and she would also share the layout of words in future development work.

PW asked whether there had been ICB check-and-challenge conversations around the definitions in and understanding of the equality impact assessment, and VD confirmed that she was confident that this had been picked up in the next stages.

VD continued the presentation, focussing on the next steps, and posing the following three questions to the committee:-

- Looking at the findings of the independent report – is there anything you think the report has not considered or drawn out?
- Do you agree with the key considerations identified in the independent report of findings?
- Do you have anything to add in relation to the findings?

SH stated that he supported all the report's recommendations. He had a question about the availability of capital and asked whether the ICB had confirmed that the £8m was available. VD responded that the capital allocation in the business case was spread over two years and SWYPFT had stated that this was in the allocations.

MB asked about arrangement to feed back to the places on current progress and VD advised that there would be a need to feed back into their respective Quality and Finance and Performance Sub-Committees or equivalent. JB added that she had included an update on progress in a recent Chief Executive's Report.

NS advised that he was still worried about finance as he was not sure SWYPFT had got an allocation for the following year, as these were allocated one year at a time. He would be keen to see more confirmation about how this was prioritised and its current standing. It should be flagged as a big risk to the project. VD advised that this would be placed on the corporate risk register in the following cycle.

JB suggested that a breakdown by place as well as an overview and explanation of the term mixed-sex accommodation, and careful use of sex and gender terms, should be provided as the information moved into the public domain.

She also asked if there was an indication of when the new model may be in place.

VD advised that this had originally been intended to be towards the end of this year but this had moved slightly and would be reviewed as the process moved forward. It was intended to go live one year after the decision was taken.

The Older People's Mental Health Transformation Joint Committee:-

- (2) **ACCEPTED** the independent consultation report and EIA to be shared publicly when appropriate;
- (3) **ENDORSED** the plan to conclude governance; and
- (4) **AGREED** to review a series of questions and to feed into the deliberations.

5. Date of Next Meeting

The date of the next meeting would be set in due course, in consultation with members.

The meeting concluded at 11.30 am.

Meeting name:	Calderdale, Kirklees and Wakefield Older People's Mental Health Transformation Joint Committee
Agenda item number:	4
Meeting date:	11 November 2024
Report title:	Older People's Mental Health Inpatient Transformation Programme for Calderdale, Kirklees and Wakefield: Decision-Making Business Case
Report presented by:	Vicky Dutchburn, Director of Operational Delivery and Performance: Kirklees ICB: Senior Responsible Officer for older people's transformation, NHS West Yorkshire Integrated Care Board Professor Subha Thiyagesh, Chief medical officer, Consultant in psychiatry for older people and clinical lead for older people's transformation, South West Yorkshire Partnership NHS Foundation Trust Ryan Hunter, Programme Manager
Report approved by:	Vicky Dutchburn
Report prepared by:	Ryan Hunter, Programme Manager

Purpose and Action:			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/com- ment/discuss/escalate)	Information ☐
Previous considerations:			
In the formal meeting of 17 June 2024, the committee were asked to: - Assure the consultation process - Accept the independent consultation report and EIA for sharing publicly when appropriate. - Endorse the plan to conclude governance - Agree to review a series of questions and to feed into the deliberations. The committee confirmed the following statements: - Due regard to equality and diversity has been paid through the delivery of consultation activity, and in the independent report of findings. - Adequate time has been given for you to consider the responses contained in the independent report of findings. - The product of consultation has conscientiously taken into account all of the key themes that need to be considered. The Committee felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.			

The independent report demonstrates a full and comprehensive consultation was undertaken. The key themes, identified and considered in the report, fully reflect those areas the joint sub-committee expected to be included based on the consultation scope and plan. The Joint Sub-Committee noted the comprehensive consultation process and the mid point review process, which allowed for additional sessions to be included to extend the reach, where gaps were identified.

The Committee welcomed the emphasis placed on travel, transport and parking and noted the commitment to consider the implications on those people impacted by the proposed options and the ongoing work to co-produce potential solutions.

Executive summary and points for discussion:

This report provides an update in relation to the completed consultation process for the older peoples mental health inpatient transformation.

This report includes the preferred recommendation in relation to the outcome of the formal consultation process that has been undertaken, for future implementation.

The following papers are attached for consideration by the committee.

These are:

1. OPMH Inpatient Decision-Making Business Case
2. Supporting appendices
3. Summary presentation slides

Note: the equality impact assessment has been shared and reviewed at the previous governance and can be found via the link below:

[Older-Peoples-Mental-Health-Inpatient-Transformation-EIA-v8.0.pdf](#)

Note: as part of the governance process there are meetings being held with NHS England and the Joint Overview & scrutiny committee of Calderdale, Kirklees & Wakefield, ahead of the formal Joint ICB Committee. Outcome letters will be circulated to the joint ICB committee when available.

With which purpose(s) of an Integrated Care System does this report align?

- ☒ Improve healthcare outcomes for residents in their system
- ☒ Tackle inequalities in access, experience and outcomes
- ☒ Enhance productivity and value for money
- ☒ Support broader social and economic development

Recommendation(s):

The Older People's Mental Health Transformation Joint ICB Committee is asked to:

Be Assured of the process undertaken following the formal consultation, to reach the preferred recommendation of Option 1A

Approve the decision-making business case

Approve the preferred recommendation of option 1A for implementation.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
NA
Appendices:
Papers included: 1. OP Inpatient MH Decision Making Business Case v1.0 - Which includes: Appendix 1. Quality Impact Assessment Appendix 2. Travel Impact Assessment Appendix 3. Sustainability Impact Assessment Appendix 4. Review of strategies Appendix 5. Consultation plan Appendix 6. Feedback from JHOSC Appendix 7. Report of workshop Appendix 8. OPS Options and Recommendations Appendix 9. WY ICB OPMH Supporting Statement Appendix 10. Finance Supporting Statement Appendix 11. OPS Workstreams Post Decision 2. Summary Presentation: Recommendations for ICB committee.
Acronyms and abbreviations explained:
Covered in the report and business case

What are the implications for:

Residents and Communities	Covered in the business case
Quality and Safety	See appendix 1, Quality Impact Assessment
Equality, Diversity and Inclusion	See equality impact assessment: Older-Peoples-Mental-Health-Inpatient-Transformation-EIA-v8.0.pdf
Finances and Use of Resources	See finance section of decision making business case and Appendix 10, Finance Supporting statement
Regulation and Legal Requirements	The programme has followed all legal duties in line with NHSE major change programme framework and consultation legal duties.
Conflicts of Interest	None to note
Data Protection	None to note

Transformation and Innovation	See business case.
Environmental and Climate Change	See appendix 3, Sustainability Impact Assessment
Future Decisions and Policy Making	The programme has strong alignment with strategic priorities, see Appendix 4, review of strategies.
Citizen and Stakeholder Engagement	See consultation findings report: Older-peoples-mental-health-inpatient-services-consultation-report-v3.0.pdf and consultation review of process report was shared at the previous meeting.

1. Main Report Detail

- 1.1 The decision-making business case and appendices aim to do the following:
- Provide an overview and assurance of programme progress to date.
 - Clearly articulate the background and case for change of the programme.
 - Outline the options for change including the amendments /revisions made to the options following consideration of patient, public and staff feedback via the formal public consultation process.
 - Provide key additional assurances for the decision-making process from consultation deliberations, where required; and provide system and finance assurances.
 - Summarise the review of each option to inform decision-making, with recommendations.
- 1.2 The supporting slide set summarises the recent activity of the decision-making process and the proposed recommendation of the preferred option 1A to implement in the business case.
- 1.3 As part of the governance process there are meetings being held with NHS England and the Joint Overview & scrutiny committee of Calderdale, Kirklees & Wakefield, ahead of the formal Joint ICB Committee. Outcome letters will be circulated to the joint ICB committee when available.

2. Next Steps

- 2.1 Communication to staff and stakeholders
- 2.2 Staff consultation with staff most impacted by decision.
- 2.3 Detailed implementation planning

3. Recommendations

- 3.1 The Older People's Mental Health Transformation Joint ICB Committee is asked to:
- Be Assured of the process undertaken following the formal consultation, to reach the preferred recommendation of Option 1A
 - Approve the decision-making business case
 - Approve the preferred recommendation of option 1A for implementation.

4. Appendices

OP Inpatient MH Decision Making Business Case v1.0

Appendix 1. Quality Impact Assessment

Appendix 2. Travel Impact Assessment

Appendix 3. Sustainability Impact Assessment

Appendix 4. Review of strategies

Appendix 5. Consultation plan

Appendix 6. Feedback from JHOSC

Appendix 7. Report of workshop

Appendix 8. OPS Options and Recommendations

Appendix 9. WY ICB OPMH Supporting Statement

Appendix 10. Finance Supporting Statement

Appendix 11. OPS Workstreams Post Decision

Summary Presentation: Recommendations for ICB committee.

Older People's Inpatient Transformation Programme
Decision Making Business Case

October 2024

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

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1 Executive Summary

1.1 The need for change and the aims of the report

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides community, mental health and learning disability services to 1.22m people across Barnsley, Calderdale, Kirklees and Wakefield. These include mental health services for older people. Following improvements to community services the focus of this programme is on making changes and improvements to the inpatient service.

There is a compelling need to change this part of the system:

- At the moment, most of our older people's mental health inpatient wards are mixed, which means people with dementia and people with functional mental health needs share the same ward space.
- The clinical and personal needs of people living with dementia or a functional mental health need are different. Sharing a ward space often means that they do not get the appropriate specialist care that they should.
- In the current model services are run from an isolated site in the Wakefield district, which means risks need to be mitigated on an ongoing basis to keep the service safe.

We know from all our work and engagement that continuing with our current model is not a viable clinical option for the older people who need our care and support. It is not in line with best practice, does not meet the needs of either patient group nor does it address the challenges we face with some of our current estate.

Creating separate wards for people with dementia, and people with functional mental health needs will help us give the right type of care and support on all our older people's inpatient mental health wards. It means that people will be admitted to the right place, first time, which means they are less likely to need to move wards during their stay and can be discharged sooner. Most other Trusts already work in this way.

An additional benefit of a transformed service is that all options align hospital wards to other acute mental health hospital sites and reduce the risks of the isolated site.

Our pre-consultation business case explored multiple options for creating a specialist service which gives older people the most appropriate evidence based and best practice inpatient care to a high standard.

The scope of the programme is the wards in Calderdale, Kirklees and Wakefield as Barnsley operates the only exclusive functional ward on the Trust footprint and does not commission dementia beds – so the system in Barnsley will not change.

To aid the decision-making process, this decision-making report aims to do the following:

- Provide an overview of programme progress to date.

- Clearly articulate the background and case for change of the programme.
- Outline the options for change including changes made in light of patient, public and staff feedback via the formal public consultation process.
- Provide key additional assurances for the decision-making process from consultation deliberations, where required; and provide system and finance assurances.
- Summarise the review of each option to inform decision-making, with recommendations.

This executive summary provides an overview of the progress, more detail can be found in the main report including links to published reports.

1.2 Engagement and consultation

Engagement and consultation took place over three phases, the first being the broader engagement phase, followed by pre-consultation engagement and then formal public consultation. Each stage of the process was supported by an equality impact assessment (EIA).

The initial engagement took place over several years in each of our local places of Barnsley, Calderdale, Kirklees and Wakefield, where we spoke to a range of stakeholders, staff, public and voluntary and community sector representatives. Through conversations it was identified that the transformation of inpatient services would only be possible if the initial focus was on improvements to community services to support care closer to home.

This initial engagement focussed on challenges with the current model, helped inform early options development and collect patient, family and carer experiences of people accessing our wards which would be the next stage of transformation. Progress on this work was further paused during the pandemic.

Following the pandemic, the pre-consultation engagement phase was once again mobilised, using what we already had gathered, with a clear focus on stakeholder engagement to help identify and support the development of viable mental health inpatient service options for older people. At this stage, it was identified that any developments would only impact people from Calderdale, Kirklees and Wakefield only. Barnsley remained informed but out of scope.

The options were developed in a clinically led way, using a quality impact assessment and all insight from the engagement stage to inform the criteria. All options were reviewed through several stages and in partnership approaches.

A plan was developed to deliver a public consultation period for the programme, which ran for 12 weeks, from 5th January to 29th March 2024. This was to ensure there was adequate time for the proposals and issues to be considered and responded to, as per Gunning Principle that “adequate time must be given for consideration and response”. The approach to consultation was co-designed with expert advice from leads across each of our places and tested through scrutiny to ensure the approach could reach the intended audience using a variety of approaches, including groups identified in the EIA.

As the proposals were complex, the consultation material ensured that information was accessible, easy to read and understand used a range of formats and approaches. This ensured sufficient reasons were put forward for the proposal “to allow for intelligent consideration and response” which is one of the four Gunning Principles tests.

Following the consultation, all of the public feedback was independently analysed and published in a report of findings in July 2024.

The report of findings and EIA were both considered during summer 2024 as part of a deliberation process. This included sharing the information with Joint Health Overview and Scrutiny Committee (JHOSC), Healthwatch, Integrated Care Board for West Yorkshire and NHS England. A stakeholder event in August 2024 which focussed on the findings, concluded the consultation process.

1.3 Summary of the options

Clinically-led design teams developed potential options for change as part of the programme, informed by the engagement with patients, family, carers, and other stakeholders, and overseen by clinical and non-clinical leaders from Integrated Care Boards, and the Foundation Trust. A long list of multiple options was developed and assessed against 5 criteria (quality of care, access to care, deliverability and sustainability, co-dependencies with other strategies, value for money) which resulted in a small number of potentially viable options to take to consultation.

The options were reviewed by a Clinical Senate, tested via public workshops through 2022 and finalised in a stakeholder workshop in May 2023.

The options agreed to take to consultation were:

1. A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield.

There are two ways that this could be done:

- a. with additional functional bed capacity at the Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 single gender wards across the 26 beds.
- b. with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward.

And:

2. A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees.

This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beechdale would be functional wards.

1.4 Consultation findings

In total, we received 1,697 responses to the consultation, comprising of 1,554 survey responses, 21 advocacy organisation-led involvement survey responses, 6 correspondence, 110 pieces of feedback from event participants, and 6 pieces of feedback from social media channels. The demographic profile of respondents was reflective of the combined total population of Calderdale, Kirklees and Wakefield.

People were asked a series of questions in relation to the care of patients as well as value for money of the options. When comparing the level of agreement with each statement across the 3 options. The table below shows agreement with all 4 statements is highest for option 1a, and lowest for option 1b.

Comparing the level of agreement to each option

-	Strongly agree / agree	Not sure	Disagree / strongly disagree	Base
Improve care for people living with dementia				
Option 1a	82%	11%	8%	1160
Option 1b	58%	18%	24%	1149
Option 2	75%	12%	13%	1138
Improve care for people living with a functional mental health need				
Option 1a	80%	13%	7%	1158
Option 1b	56%	19%	25%	1149
Option 2	75%	14%	11%	1136
Offer the right care for patients with mental health needs				
Option 1a	79%	14%	7%	1156
Option 1b	51%	24%	25%	1145
Option 2	70%	18%	12%	1138
Services offer value for money				
Option 1a	65%	26%	8%	1153
Option 1b	46%	32%	23%	1142
Option 2	61%	26%	14%	1133

All places have the same overall ranking, though with different profiles – for example, the gap is narrower between the 3 options in Calderdale than elsewhere.

When considering the feedback by the different equality characteristics, the levels of agreement across most groups is highest for option 1a, followed by option 2 and 1b.

In summary, the consultation feedback shows the most important factors and key considerations are:

- the provision of single-gender wards with high levels of disagreement in response to mixed-gender wards
- the location of services and the potential impact this could have on the ability of patients and carers to travel
- the impact on carers, family members and visitors to support patients
- the staffing requirements for these revised services

- the quality of care provided to patients – with respondents highlighting the need for care to be provided closer to home and in a safe, supportive environment.

Of the 3 proposed options, **the highest levels of agreement are in response to option 1a** and lowest levels of agreement are in response to option 1b among participants for improving care for people living with dementia and functional mental health needs.

1.5 Deliberations on the findings from formal consultation

The Joint Health and Overview Scrutiny Committee (JHOSC) concluded that the consultation report of findings had reflected the key themes. They stated that the report “demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation”.

The Committee also flagged importance of travel and transport in considerations, welcoming “the emphasis placed on transport, travel and parking, and notes the commitment to consider the implications on those people impacted by the proposed options”.

The Joint Integrated Care Board (ICB) committee confirmed their view that the “key themes, identified and considered in the report, fully reflect those areas the joint sub-committee expected to be included based on the consultation scope and plan.”

A stakeholder workshop on 23 August 2024, demonstrated support that the findings and feedback were both comprehensive and thorough. There was also positive feedback that travel and transport had been identified early and enthusiasm to ensure that solutions are found.

1.6 Post consultation option evaluation

A further process to evaluate all the proposed options followed the deliberation of consultation findings. The five evaluation categories were the same categories used to identify options prior to formal consultation. The final evaluation took place using a partnership approach.

The criteria are outlined below:

- Quality of Care
- Access to Care
- Deliverability and sustainability
- Co-dependencies with other strategies
- Value for Money

As well as the consultation findings, updated impact assessments for Equality and Sustainability were used alongside the quality impact assessment to support the options review. The findings from this approach were:

Quality: Following the review, it was found that **Option 1a** is the strongest option from a quality, and equality, perspective. **Option 1b** received negative feedback in relation to the

lack of single gender wards for functional needs. Following consideration, this led to option 1a quality score increasing, whilst option 1b was reduced and option 2 did not change.

Access: Option 2 would lead to a greater access impact in terms of travel and has a lower number of dementia beds. These items were considered in the previous options appraisal and therefore access scores did not change.

Following review, the assessment and scores for deliverability and sustainability, co-dependencies with other strategies, and Value for Money did not change.

The table below shows the weighted scores of options following the review of findings:

	Option	Quality Domains				Total quality score	Value for Money	Total
		Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	70	30	100
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21 rescored to 24	14	6	8	49	19.2	72.2
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15 rescored to 12	8	4	5	32	21.6	50.6
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18 no change	12	6	8	44	19.2	63.2

Based on the updated findings of the consultation and impact assessments, the overall ranking hasn't changed but some scores have. Out of a weighted total of 100, the 3 options now scored as follows:

- Option 1A: 72.2
- Option 1B: 50.6
- Option 2: 63.2

Though some scores to the options appraisal were changed as a result of consultation, the findings supported the previous analysis and options appraisal that has taken place, **with option 1A ranking highest** and being the most appropriate option to take forward to implementation.

1.7 System prioritisation

The programme has been prioritised from both a system and a capital perspective.

The West Yorkshire Mental Health and Learning Disabilities Partnership has endorsed the priority of the programme, stating that it is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme.

The recommended option has been fully costed and the capital forecast factors in inflation and optimism bias.

South West Yorkshire Partnership Foundation Trust (SWYPFT) has confirmed that the OPS inpatient transformation scheme is their capital priority as identified in their Trust Estate Strategy. Based upon current agreed capital allocation methodology this is contained within the SWYPFT allocation. The capital programme is scheduled to accommodate this scheme without creating additional estates risks. The Trust will be using its own cash reserves and therefore does not require cash support from the ICB.

Jonathan Webb finance director for West Yorkshire ICB has confirmed system finance support for the programme, stating that “the agreed methodology for capital allocation would need to change from the current model to have a direct impact on other Trusts. During 2024/25, the WY infrastructure plan has been developed and agreed, with this programme identified as a priority.

In late 2023, the NHS WY ICB confirmed prioritisation of this scheme from a system capital & estates perspective. This was on the basis that the forecast capital expenditure for the programme is £8.2m and will be spent across the 2024/25 and 2025/26 financial years.

In 2024, wider system challenges have emerged. However, based on proposed costs remaining as planned, it is our expectation that SWYPFT will receive the capital allocation they require to deliver the programme, factoring in their prioritisation of the programme and plans to spread costs across financial years.

The ICB is committed to delivering MHIS in line with NHSE expectations. The ICB can confirm that this is our priority for funding future MHIS and forms the basis of financial planning.

The Trust has confirmed that it is continuing to develop its medium-term financial sustainability plan, in line with the wider development within the ICB, and is taking actions to ensure delivery of this and the 24 / 25 in year breakeven target”.

1.8 Implementation considerations

A number of mitigations have been identified for the new model of care and for the recommended option. These include:

- support for people to travel who are impacted as a result of the changes;
- improvements to ward environments that factor in the needs of differing protected groups and working groups to ensure inclusive approaches are taken;
- partnership working to facilitate new pathways of care across places,
- staff support,
- implementing creative solutions,
- green travel solutions and energy efficient building works in line with the green plan.

A Travel and Transport working group was established in 2024 with a mix of carers, governors, SWYPFT and ICB staff. It was tasked with making recommendations to support family, carers and loved ones that have difficulty travelling to a transformed model, considering feedback from the public consultation and agreeing principles for when support is needed as a result of the transformed model.

The group has recommended the implementation of a visitor support pathway for a 5-year period, which would take a needs based and personalised approach to supporting people impacted by changes. This has a range of features and aims to:

- Provide guidance on travel, provided by the wards.
- Ensure flexible visiting is adopted.
- Offer digital solutions.
- Factor in needs of carers, for example the triangle of care model and principles.
- Work with partners including the Combined Authority to influence improvements public transport solutions that better link hospitals and improve ease of public transport journeys.
- Ensure there is a failsafe / contingency in place for essential visitors such as carers / next of kin that are unable to visit as a result of changes made which factor in the visitors financial circumstances, ease of travel and disability/frailty. This could include volunteer drivers, VCSE support or paid taxis.

1.9 Recommendations

There is a clear and thorough evidence and rationale to make the following recommendations:

- That option 1A is endorsed for implementation.
- That commitment is made to progressing solutions identified, particularly for people impacted by travel and transport.

Also, that agreement is reached to approve the formation of an implementation team reporting to the programme board, SYYPFT Executive Management Team / Trust Board and the Joint Integrated Care Board Committee to feedback on the implementation process.

2 The case for change

2.1 Introduction and Background

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides community, mental health and learning disability services to 1.22m people across Barnsley, Calderdale, Kirklees and Wakefield. Part of the service offer includes mental health services for older people. Following improvements to community services the focus of this programme is on making changes and improvements to the inpatient model.

The acute mental health inpatient services are provided as follows:

- In Calderdale, **Beechdale** is a 16 bedded, mixed gender and mixed needs, functional and dementia ward at the Dales in Halifax, which is located on the site of Calderdale Royal Hospital.
- In Kirklees, **Ward 19** constitutes 2 x 15 bedded single gender wards, both mixed functional and dementia needs, on the site of Dewsbury and District Hospital.
- **Wakefield** currently has 2 wards, Crofton on the Fieldhead site and the Poplars, at Hemsworth. **Crofton** is a 16 bed, mixed gender, mixed functional and dementia acute needs ward. The **Poplars** is a mixed gender ward for people with dementia. People accessing services at the Poplars generally transfer to the ward after an admission to Crofton. The Poplars ward has been operating as a 12 bedded ward for several years.
- **Willow ward** on the Kendray site in Barnsley is the only exclusively functional only ward on the trust footprint and is a 10 bed, mixed gender ward.

In Barnsley there are no plans to change how the Willow Ward operates as Barnsley does not commission an inpatient unit for people with dementia. The number of people with dementia from Barnsley requiring an inpatient bed is small and so a spot purchase budget is in place should someone require an admission. Although Barnsley is an interested stakeholder, the impact on people from Barnsley is very limited.

The map below shows the services that are in scope the programme:



Activity on the programme has been progressed in partnership between South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and the Integrated Care Board (ICB) to explore how to improve mental health services for older adults.

More background and governance context can be found the [pre consultation business case](#).

2.2 The case for change

As set out in the [pre consultation business case](#), there is a compelling need to change the current system.

At the moment, most of our older people's mental health inpatient wards are mixed, which means people with dementia and people with functional mental health needs share the same ward space.

In line with best practice, mixed needs wards do not help us provide the best possible care or support the wellbeing of our patients, because:

- the clinical and personal needs of patients can be very different
- activities are not stimulating and appropriate for all patients
- the ward environment does not help patients be independent
- there is more chance of incidents
- the space could be used better to support therapies, safety and wellbeing for all our patients.

A person's experience of living with dementia or a functional mental health need is very individual. Each day may feel very different, and the care and support needed to best support a person should be tailored and personalised. Factors such as a person's environment, and specialist activities really matter in managing wellbeing and a person's condition.

It is important that all our patients get the right care in a safe and supportive environment. We know that the clinical and personal needs of people living with dementia or a functional mental health need are different. Sharing a ward space often means that they do not get the appropriate specialist care that they should.

Creating separate wards for people with dementia, and people with functional mental health needs will help us give the right type of care and support on all our older people's inpatient mental health wards. It means that people will be admitted to the right place, first time, which means they are less likely to need to move wards during their stay and can be discharged sooner.

An improved model can improve care, wellbeing, and give a better experience for our inpatients, carers, families and staff.

2.3 Strategic context

Best practice guidance highlighted in the [pre consultation business case](#), is that there should be specialist inpatient wards for people living with dementia and dedicated wards for people with functional mental health and this is common in other older people's mental health inpatient wards in the NHS.

National guidance sets out the context for delivery of acute inpatient care, from delivering care via purposeful admissions, therapeutic inpatient care, and proactive discharge planning, through to guidance on appropriate ward sizes (15 beds).

The West Yorkshire ICB also sets in its vision when local and specialist inpatient care should be delivered. It states that "if you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible and that access to care is equal for all. Local hospitals will be supported by centres of excellence for services such as cancer, vascular (arteries and veins), stroke and complex mental health. They will deliver world class care and push the boundaries of research and innovation".

2.4 Clinical safety and quality

The [pre-consultation business case](#) clearly identified that change is required to maintain clinical safety and quality.

As well as not delivering an optimal model of care, challenges with the current system include an isolated ward in Wakefield, the Poplars, which due to location has issues admitting a high level of acuity and access to timely support when required and challenges at this site have been flagged by CQC.

Whilst patients are on the wards, the aim is to have one single ward stay and not to move people from ward to ward in different hospitals as a single stay. Whilst the Trust works hard to minimise the impact of moving patients between wards this is not always possible and data shows that around 40% of patients with dementia experience ward moves as part of their inpatient stay. Risks associated with multiple ward stays include impairing continuity of care, preventing the development and utilisation of therapeutic relationships, increasing risk due to change of environment and unnecessarily extends the Length of Stay.

Data shows the average length of stay of people with dementia who have one ward stay is 69 days, compared with 126 for people that have more than 1 ward stay.

Some ward environments are challenging. Beechdale ward in Calderdale, for example, has narrow winding corridors and issues with staff line of sight on the ward and the mix of people with dementia and functional needs is a challenge to manage on an ongoing basis.

2.5 Workforce

As outlined in the [pre-consultation business case](#), detailed consideration has been given to the support staff required to enable the right therapeutic environment, on both dementia and functional wards, using clinical and operational staff and best practice models to support design.

The programme team engaged with other Trusts that have specialist needs based models to understand the different levels and roles of staff required in a more specialist service. We also used the Mental Health Optimal Staffing Tool (MHOST), which was developed with NHS Improvement, Imperial College London and 26 different Trusts and is the most evidence-based tool available, to model required staffing levels.

The workforce plan for this programme aligns with the NHS Long Term Workforce plan (NHSE 2023), which sets out a robust and effective plan to ensure we have the right number of people, with the right skills and support in place to be able to deliver the kind of care people need and the areas in the workforce plan that are to train, retain and reform.

The proposed models will expand on the NHSE workforce plan recommendations for reform, by increasing the number of nursing associate roles and Advanced Clinical Practitioner roles. This will lead to alternative career progression pathways to attract and retain staff.

The NHS People Plan (NHSE 2020) is reflected in the SWYPT workforce strategy of making this a Great Place to Work with a focus on:

- **Growing Our Workforce and Working Differently.** Ethical international recruitment for nursing and medical roles, redesigning core workforce to offer more flexible working roles, local recruitment to reflect the demographics of our local communities' new clinical roles to develop potential and effective staff engagement.

- **Looking After Our People.** Civility and Respect Model implemented to reduce bullying and harassment, ensuring clear and progressive career pathways, established health and wellbeing programmes and revising managers and leadership development pathways.
- **Inclusive and Compassionate.** Race Forward to develop an action plan, effective and efficient deployment of staff through the rollout of Safe Care, supporting a speak up culture and engaging and listening to feedback and development and implementation of the Trust's Talent Management Plan.

The proposals in the workforce model developed for this programme aligns with these principles.

2.6 Financial case

The [pre consultation business case](#) set out the financial requirements for the model and options to take into consultation. Whilst there are clear inefficiencies in the current model, for example, linked with overstaffing at an isolated site and lengths of stay for people moving wards, there is also a requirement to invest into a new model. The investment includes capital for a new ward on the Fieldhead hospital site so that the Trust can cease operating at an isolated site, and staffing into the specialist dementia service, where a higher level of support will be needed.

This means there is investment required to deliver the new service model.

However, the NHS as a whole currently faces many financial challenges. Recognising the priority of the programme and need to make these improvements a series of principles were agreed to support the programme. These were:

1. That SWYPFT will continue to contribute the difference in value of the total Commissioning budget 'v' total actual spend.
2. That the capital investment is within the SWYPFT capital allocation (noting the risk presented by any potential changes to ICB capital allocation methodologies) and that the Older People Mental Health inpatient programme is prioritised within the Trust Estates Strategy.
This has been confirmed by the West Yorkshire ICB finance director, Jonathan Webb, who wrote "The NHS WY ICB can confirm prioritisation of this scheme from a system capital & estates perspective. This is on the basis that the forecast capital expenditure for the programme is £8.2m and will be spent across the 2024/25 and 2025/26 financial years. SWYPFT has confirmed that it will prioritise this programme from within its expected operational capital allocation."
3. That the revenue costs will be phased, in agreement between system partners, with current modelled part year effect costs from 2025 / 26.
4. That we, as system partners, agree that if Mental Health Investment Standard funding continues we agree that in the Older Peoples transformation programme is initially prioritised to meet the revenue costs over the agreed period.
5. That SWYPFT and ICB will risk share any increases in costs that emerge as a direct result of the programme.

6. That if we agree to the above principles, SWYPFT will help manage any other business case / investment requests. (as Older Peoples Services (OPS) transformation will be the agreed priority (resulting in opportunity costs)).
7. That we discuss and confirm the above within West Yorkshire in terms of investment spend.

The [pre consultation business case](#) has more information on the financial requirements of the model and further details can also be found in section 6 of this document.

3 Decision making context and progress to consultation

3.1 Pre consultation engagement

Engagement and consultation took place over three phases, the first being the broader engagement phase, followed by pre-consultation engagement and then formal public consultation. Each stage of the process supported by an equality impact assessment (EIA).

The timeframes have taken longer than initially expected with early thinking and broader engagement taking place from 2015 onwards. However, there has been 2 periods where work on the inpatient programme was paused. In 2019 work was paused on inpatient developments while changes and improvements were made to community models. Work commenced again in early 2020 but was paused further due to the Covid-19 pandemic. It recommenced in 2021 before moving forward at a faster pace from 2022.

The initial engagement took place over several years in each of our local places of Barnsley, Calderdale, Kirklees and Wakefield, where we spoke to a range of stakeholders, staff, public and voluntary and community sector representatives. Through conversations it was identified that the transformation of inpatient services would only be possible if the initial focus was on improvements to community services to support care closer to home.

This initial engagement focussed on challenges with the current model, helped inform early options development and collect patient, family and carer experiences of people accessing our wards which would be the next stage of transformation.

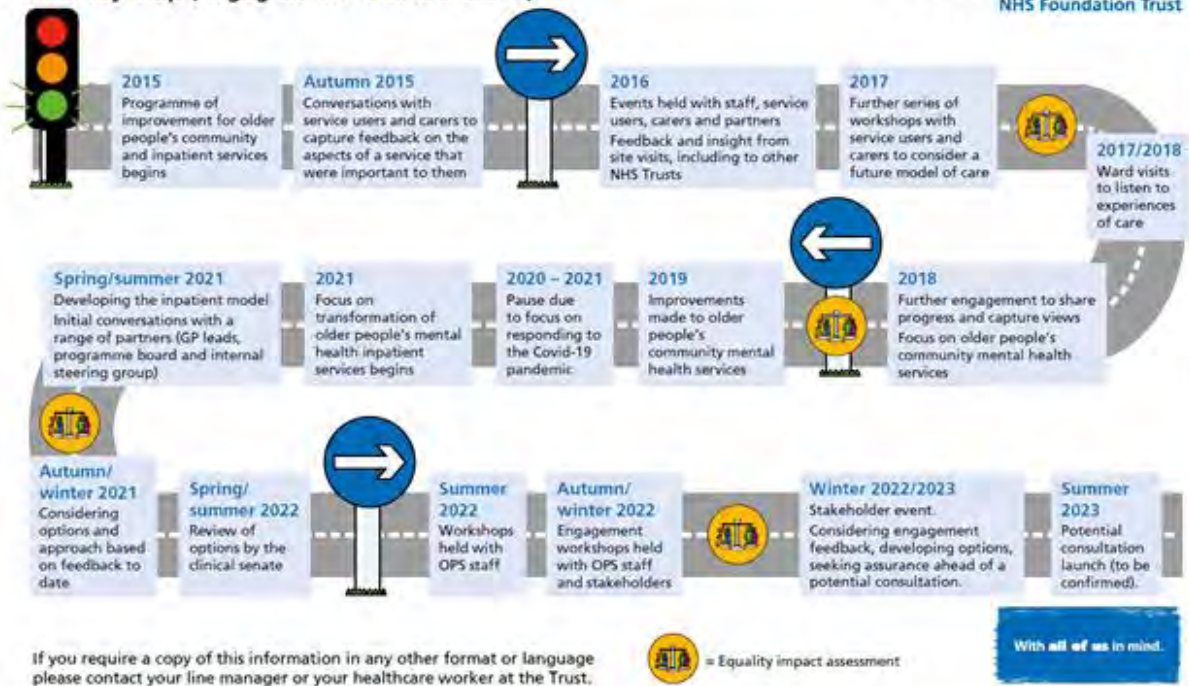
Following the pandemic, the pre-consultation engagement phase was mobilised, using what intelligence we already had gathered, with a clear focus on stakeholder engagement to help identify and support the development of viable mental health inpatient service options for older people. At this stage, it was identified that any developments would only impact people from Calderdale, Kirklees and Wakefield only. Barnsley remained informed but out of scope.

Staff, patient, carer, public and wider stakeholder engagement has been central to the development of the options. The approach has used best practice approaches to ensure a range of stakeholders have helped to co-design and inform the development of options.

The diagram below shows the high-level timeline of the development of work across the programme:

Older people's mental health inpatient services transformation

Journey map (engagement to consultation)



Through this period, we spoke to around 1000 people across a whole range of stakeholders including the patients on the wards and their family and carers, clinical staff and a range of partners.

The feedback gathered through this exercise was used initially to help design the high-level model and options, with option development being clinically led and then we tested the options developed with a range of stakeholders via workshops and events.

More information is in the [pre consultation business case](#).

3.2 Options development

Clinically-led design teams developed potential options for change as part of the programme, informed by the pre-consultation process including engagement with patients, family, carers, and other stakeholders, and overseen by clinical and non-clinical leaders from Integrated Change Boards, and the Foundation Trust. A long list of multiple options was developed and assessed against criteria, which resulted in a small number of potentially viable options to take to consultation.

The SWYPFT Trust template for options appraisal was used for the options review process. Specific detail was added to each section based on the quality requirements to deliver the vision for the model. Key feedback from patients, family and carers as well as key considerations highlighted in the quality and equality impact assessments were factored into.

As such, the options have been developed with the voice of staff and people who use services to ensure their voice and influence is part of the process *and* assessed using criteria that a wide range of stakeholders informed.

The domains were also weighted, with 70% allocated to quality domains and 30% to value for money to ensure that quality domains are the most heavily weighted but also that affordability and value of the options is fully factored in.

Criteria:

- Quality of Care 30%
- Access to Care 20%
- Deliverability and sustainability 10%
- Co-dependencies with other strategies 10%
- Value for Money 30%

The criteria process and options that were felt to be clinically viable would then be assessed against the other criteria. To be above the bar to progress, the option must score 4 or above for each quality and access criteria.

Agreed scoring for the quality domains were:

Score	Description	Viability
10	meets fully and exceeds requirements	Viable
9	Fully meets requirements	Viable
8	meets the vast majority of requirements	Viable
7	meets the vast majority of requirements with additional work required	Viable
6	meets most with more work required	Viable
5	meets most but a key area not met	Viable but further considerations of how to improve the key area should be considered
4	meets some parts not others with key areas not met	Viable – but sub optimal and need to consider how to improve model
3	limited criteria met with several key areas not met or one significant risk	Not currently viable – need to consider whether any changes could make the option viable
2	meets very few criteria well with many key areas not met / significant risks	Not viable
1	does not meet criteria	Not viable

Options were scored then weighted to result in a total score of from 100.

All the options were reviewed by the Clinical Senate, an independent advisory body, see section below for more information, and several options were removed as they did not meet clinical criteria. The Clinical Senate endorsed a shortlist of options which were then tested at

public workshops through 2022 and finalised in a stakeholder workshop in May 2023. More detail on these can be found the [pre-consultation business case](#) and the 2022 engagement is published [here](#).

The table below summarises the overall scoring across the domains when weighted (for example, 8 out of 10 for quality would be weighted to 24 (out of 30)). This is based on the work done through to May 2023 to inform which options should be taken into public consultation. The fields highlighted in red indicate where an option fell short of the required level based on key criteria:

	Quality Domains				Total quality score	Value for Money	Total
Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
	30	20	10	10	70	30	100
No change	12	8	2.5	4	26.5	25.2	51.7
W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15	8	4	5	32	21.6	53.6
W19 dementia unit, 2 extra beds at Crofton, 1 at Beechdale, Poplars not in this model	18	6	2.5	4	30.5	18.0	48.5
W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21	14	6	8	49	19.2	68.2
Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	44	19.2	63.2

The options appraisal found the following options were potentially viable. These are summarised below:

1. A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield.

There are two ways that this could be done:

- b. with additional functional bed capacity at the Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 wards across the 26 beds.

- c. with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward.

And:

2. A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees. This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beechdale would be functional wards.

The detailed process followed can be found in the [pre consultation business case](#).

3.3 Independent advice and assurance

Following the development of the list of potential options, the programme team invited the North East and Yorkshire Clinical Senate to review the options and proposals in 2022. Clinical Senates are independent non-statutory advisory bodies established to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change and service reconfiguration are clinically sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

The Clinical Senate were fully supportive of proposals and strongly agreed that patients with functional needs and dementia should be cared for in separate distinct dedicated units. Summary of findings from the Clinical Senate include:

- The Clinical Senate were fully supportive of proposals, and “strongly concurs that patients with functional and organic disease should be cared for in separate distinct dedicated units”.
- The Trust were “commended on the way in which they have developed options to significantly improve the care of older adults with both organic and functional mental health needs”.
- “The Clinical Senate commends the immense amount of work done over the years and that the programme team has worked hard at the Older Person’s Services programme”.
- The review panel was “impressed by the commitment and enthusiasm shown by so many of the staff in all the current inpatient units”.
- They also found that maintaining the current model is not a viable option.

Prior to moving into consultation NHSE assured the pre consultation business case in a letter from Richard Barker CBE, NHSE Regional Director, (North East and Yorkshire):

“A clear case for change has been demonstrated by the programme team and NHSE recognises the clinical quality and experience challenges posed by the mixed-needs nature of the current five older people’s inpatient wards. It is evident that the Trust is fast becoming an outlier in maintaining this model and the system has demonstrated that the proposals

stand to enhance staff specialist skills and improved ward environments for patients, likely to lead to less pharmaceutical intervention, fewer ward transfers and shorter lengths of stay.

NHSE acknowledges that the isolated nature of the Poplars site has been raised in both Care Quality Commission and Northern England Clinical Senate (2022) reports, presenting some risks around staffing and access to out of hours' assessments."

"The ICB has confirmed that it will prioritise the proposed changes from a capital and estates expenditure perspective, with capital costs to be met by SWYPFT's 2024/25 and 2025/26 operational CDEL capital allocations. However further assurance is required to demonstrate that this scheme is prioritised for system capital across all conflicting priorities in West Yorkshire, not limited to place. Prioritisation continues to apply within the wider system mental health context, where there are competing priorities and pressures on the system CDEL capital budget."

More information on the Clinical Senate review and NHSE assurance can be found in the [pre consultation business case](#).

3.4 Risk and impact assessments

A series of impact assessments were established to support the process of developing and shortlisting options. These assessments have been updated in 2024 to inform decision making and will be further reviewed to support implementation.

Identifying and reducing health inequalities in access, experience and outcomes is essential to the delivery of high quality, mental health care. From the outset of the programme, the **Equality Impact Assessment** (EIA) has been established and maintained, with the aim to ensure that all mental health care is responsive to the strengths and needs of each individual and community's identity and culture. Not only are there moral, legal, and economic imperatives for advancing equality, but learning and collaborating with all sections of society provides a valuable opportunity to innovate and enhance the way we provide care.

The most up to date equality impact assessment can be found [here](#).

Other impact assessments included:

A clinically led **Quality Impact Assessment** (QIA) has been a continuous process to ensure that possible or actual service developments and cost improvement programmes are assessed, the potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way. The most up to date QIA can be found in appendix 1.

A **Travel Impact Assessment** (TIA) was established to consider the potential impacts of changes on patients, visitors and staff for each of the options developed. This includes detailed transport analysis to understand what the likely impact is on people from different parts of the Trust footprint that may need to travel to visit a family member or a loved one. The most up to date TIA can be found in appendix 2.

The **Sustainability Impact Assessment** (SIA) was developed using recommended sustainability impact assessment provided by West Yorkshire ICB sustainability lead, to enable scrutiny of the potential impact of the options for this transformation as part of the SWYPFT strategic approach to the environment supported by the Trusts Social Responsibility and Sustainability (SRS) strategy, Trust Green Plan and the Estates strategy. The most up to date SIA can be found in appendix 3.

In addition, a document was established to review alignment of the model and options with national, regional and local strategies. This can be found in appendix 4.

Alongside the impact assessments a robust risk assessment process has taken place with risks identified through impact assessments and through consultation identified and appropriate mitigations established.

4 Consultation process

4.1 Consultation plan

A consultation plan was developed in partnership with subject matter experts from across the ICB who lead on involvement, communication, and equality, which included the consultation approach and mandate. The approach to consultation was co-designed with expert advice from leads across each of our places and tested through scrutiny to ensure the approach could reach the intended audience using a variety of approaches, including groups identified in the [EIA](#).

The consultation approach and mandate set out how the consultation would satisfy the key tests for both consultation and equality, which are the Gunning and Brown Principles. See appendix 5 for the consultation plan.

The public consultation was set for a period of 12 weeks to ensure there was adequate time for the proposals and issues to be considered and responded to, as per Gunning Principle that “adequate time must be given for consideration and response”.

As the proposals were complex, the consultation material ensured that information was accessible, easy to read and understand used a range of formats and approaches. This ensured sufficient reasons were put forward for the proposal “to allow for intelligent consideration and response” which is one of the four Gunning Principles tests.

4.2 Consultation activity

The public consultation took place between Friday 5 January and Friday 29th March 2024.

A multi-faceted approach was taken to ensure that the consultation had a wide reach in terms of geographic spread, engaging with people with protected characteristics, the use of different types of media and approaches to engage with people.

Information distributed through the consultation included:

- More than 15,000 direct communications (letters, emails and text messages) were sent at key milestones to patients, staff working in older people’s mental health services, trust members and a range of other key stakeholders.
- A range of materials were printed and distributed across many community sites including thousands of consultation documents and summary documents, surveys, posters, and leaflets.
- A dedicated website was established to be a single source of information.
- A communication toolkit was developed for partner organisations. This included social media messaging and imagery, digital screens, newsletter copy, website copy and a link to a dedicated resources area on the consultation website where digital versions of information could be downloaded.
- A video was created explaining the rationale for the consultation and the options as well as an animation describing the different options. These were published on the

consultation website, used in the consultation events and posted on social media. The consultation video and animation included subtitles and a transcript.

- Easy read materials were produced, text only webpages of the consultation documents were created for use with assistive software, a British Sign Language (BSL) version and transcript of the video and animation were made, translations of documents were made available on request and information was published to accessible standards. All consultation materials included a phone number to support those who did not have digital access, where they were able to contact the team managing the consultation and obtain any information they required. Additionally, all consultation materials stated information could be requested in other formats.
- A number of media releases were circulated to support the launch, and the consultation was reported in local newspapers, as well as several radio interviews, and promoted widely across social media.
- Information about the consultation was regularly shared in bulletins and newsletters by the Trust and partner organisations. This included bulletins to staff, GP practices, and newsletters aimed at the public.

Through the consultation, programme team met and engaged with hundreds of people at public events, roadshows, and meetings, both with people in the community and with stakeholders.

The programme team worked closely with partners in the voluntary and community sector, partnering with VCSE organisations to raise awareness and gather views from communities across Calderdale, Kirklees and Wakefield, and in particular help to gather feedback from seldom heard groups. Partnering with advocacy organisations, the trust and ICB were able to reach current patients.

The consultation included events held in community venues widely across Calderdale, Kirklees and Wakefield. Events were run in the evening, at weekends, and online, to help ensure that people had the opportunity to attend.

A key focus of the consultation was to gather information via a survey. This was available online and 8,000 copies were printed and distributed.

As well as this, feedback was sought using:

- a feedback capture form for people attending events
- a contact phone number and email address
- social media
- responses from key partner organisations.

An independently chaired midpoint review took place on 12 February 2024, just under halfway through the 12-week consultation period, with a range of stakeholders attending including members of the Joint Health Overview and Scrutiny Committee, the Joint ICB Committee and Trust Governors.

The purpose of the midpoint review was to assess how well we have consulted to date to ensure we provided the best opportunities for people to have their say. The midpoint review

helped measure the plan against metrics, ensure the programme was reaching and consulting the right people and identify activity required through the second half of the consultation.

4.3 Responses to the consultation

In total there were 1,697 responses to the consultation, comprising of 1,554 survey responses, 21 advocacy organisation-led involvement survey responses, 6 correspondence, 110 pieces of feedback from event participants, and 6 pieces of feedback from social media channels:



Below is an overview of the geographical and demographic profile of the consultation survey respondents:

- **Geography:** 536 (34%) respondents were from the Kirklees area, 288 (19%) were from the Calderdale area and 172 (11%) were from the Wakefield area
- **Sex:** 769 (67%) said they were female, 327 (29%) were male and 6 (1%) were non-binary
- **Age:** 9 (1%) respondents said they were under 18, 286 (25%) were 18 to 39, 410 (36%) were 40 to 59, 285 (25%) were 60 to 79 and 47 (4%) were 80 and over
- **Country of birth:** 963 (85%) respondents said they were born in the United Kingdom and 103 (9%) said they were born in another country
- **Religion:** 432 (38%) respondents said they were Muslim, 376 (33%) were Christian, 19 (2%) were Hindu, 9 (1%) were Sikh, 8 (1%) were Buddhist, 5 (0.4%) were Jewish and 219 (19%) said they did not have a religious affiliation
- **Ethnicity:** The majority of people taking part in the consultation were from the following ethnicities: White British (542 / 48%), Pakistani (371 / 33%), Indian (61 / 5%), Bangladeshi (17 / 2%), Caribbean (15 / 1%), African (12 / 1%) and White Irish (11 / 1%)
- **Disability:** 830 (74%) respondents said they did not have any disabilities while 238 (21%) said they did have a disability
- **Long-term conditions, impairments or illnesses:** 206 (25%) respondents said they had a mental health condition, 201 (24%) had a long-term condition, 163 (20%) had a physical or mobility impairment, 85 (10%) had a hearing impairment, 38 (5%) had a neurodivergent condition, 32 (4%) had a sight impairment, 16 (2%) had issues

with learning, understanding, concentrating or memory, and 153 (18%) said they did not have a disability

- **Carers:** 729 (66%) respondents said they were not carers, while 335 (30%) said they were carers
- **Sexual orientation:** 930 (84%) respondents said they were heterosexual, 17 (2%) were gay, 17 (2%) were lesbian, 16 (1%) were bisexual / pansexual and 3 (0.3%) were asexual
- **Transgender:** of all the survey respondents, 5 said they were transgender
- **Cost of living:** 65 (6%) respondents said they were very comfortable, 373 (33%) were quite comfortable, 322 (29%) were just getting by and 247 (22%) were really struggling
- **Pregnant or recently given birth:** 33 (3%) respondents said they were currently pregnant or had recently given birth. 1,062 (93%) said they were not pregnant, nor had they given birth recently
- **Parent / primary carer of children:** 322 (30%) respondents said they were parents or the primary carers of children, 737 (69%) said they were not
- **Relationship status:** 597 (57%) respondents said they were married or in a civil partnership, 219 (21%) were single, 81 (8%) lived with a partner and 76 (7%) were widowed
- **Deprivation:** 521 (34%) respondents were from postcode areas where less than 40% of the locality are from the most deprived deciles, 168 (11%) were from postcode areas where 40% to 49% of the locality are from the most deprived deciles and 339 (22%) were from postcode areas where more than 50% of the locality are from the most deprived deciles.

4.4 Post consultation Assurance

The ICB joint committee reviewed the consultation activity and reach against the plan in June 2024 and confirmed that it was assured of the consultation process.

An independently produced report of the consultation findings was published on 17 July 2024 and a workshop held 5 weeks later, on 23 August, with a range of stakeholders to test, review and reflect on the findings.

In this period, feedback was also sought from key stakeholders, including holding a Joint Health Overview and Scrutiny (JHOSC) meeting held on 15 August 2024, on assurance of the consultation process and equality impact assessment.

The Committee confirmed that they felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.

“Members of the JHOSC were provided with the consultation report and the EIA on the 17 July 2024, and although these documents ran to nearly 500 pages, sufficient time was allowed prior to the formal meeting of the JHOSC on the 15 August 2024. A presentation at Committee was helpful in segmenting key points whilst maintaining a necessary overview to allow meaningful discussion, questions and comment.”

See appendix 6 for feedback from JHOSC.

The ICB committee also found that due regard has been paid to equality and diversity through the delivery of consultation activity, and in the independent report of findings and adequate time had been given for you to consider the responses contained in the independent report of findings.

5 Options Appraisal

5.1 Options summary

The options shortlist for consultation are set out below:

Summary of consultation options

	Option 1		Option 2
The dementia service	• A dementia service on Ward 19, Dewsbury and District Hospital • 2 separate male and female wards • 30 beds		• A dementia service on Crofton Ward, Fieldhead Hospital, Wakefield • 2 separate male and female wards • 26 beds
The functional mental health needs service	Option 1a	Option 1b	
	• On Crofton Ward, Fieldhead Hospital, Wakefield, 2 separate male and female wards, 26 beds, and, • On Beechdale Ward, Calderdale Royal Hospital, 1 mixed-gender ward, 16 beds • There would be 42 beds for a functional mental health needs service in total.	• On Crofton Ward, Fieldhead Hospital, Wakefield, 1 mixed-gender ward, 22 beds, and, • On Beechdale Ward, Calderdale Royal Hospital, 1 mixed-gender ward, 16 beds • There would be 38 beds for a functional mental health needs service in total • This is 4 fewer beds than in option 1(a) • There would be only mixed-gender wards for functional mental health needs.	• On Ward 19, Dewsbury and District Hospital, 2 separate male and female wards, 30 beds, and, • On Beechdale Ward, Calderdale Royal Hospital, a mixed-gender ward, 16 beds. • There would be 46 beds for a functional mental health needs service in total.
Total beds	72	68	72
Cost to set up	£8.2 million	£5.5 million	£8.2 million
Cost to run each year	£9.1 million	£8.2 million	£9.3 million

5.2 Consultation findings

The consultation responses were analysed independently of the programme, by NHS Arden and Greater East Midlands Commissioning Support Unit (CSU) and NHS Midlands and Lancashire CSU. The CSU used their analysis to produce the report of findings of the consultation.

The following sections summarises key findings reported. The full report can be found [here](#).

5.2.1 Feedback on proposed options:

People were asked 4 questions about each option and whether it would:

- improve care for people living with dementia
- improve care for people living with a functional mental health need
- offer the right care for patients with mental health needs
- offer value for money

When comparing the level of agreement with each statement across the 3 options, The table below shows agreement with all 4 statements is highest for option 1a, and lowest for option 1b.

Comparing the level of agreement to each option

-	Strongly agree / agree	Not sure	Disagree / strongly disagree	Base
Improve care for people living with dementia				
Option 1a	82%	11%	8%	1160
Option 1b	58%	18%	24%	1149
Option 2	75%	12%	13%	1138
Improve care for people living with a functional mental health need				
Option 1a	80%	13%	7%	1158
Option 1b	56%	19%	25%	1149
Option 2	75%	14%	11%	1136
Offer the right care for patients with mental health needs				
Option 1a	79%	14%	7%	1156
Option 1b	51%	24%	25%	1145
Option 2	70%	18%	12%	1138
Services offer value for money				
Option 1a	65%	26%	8%	1153
Option 1b	46%	32%	23%	1142
Option 2	61%	26%	14%	1133

5.2.2 Place Analysis

All places have the same overall ranking, though with different profiles – for example, the gap is narrower between the 3 options in Calderdale than elsewhere – tables can be found in the full consultation report of findings.

5.2.3 Other Consultation Feedback

When thinking about older people's mental health services, the most important factors highlighted by respondents were being cared for as close to home as possible (363 / 32%) and being cared for in a safe supported environment (355 / 31%).

661 (59%) respondents said they felt the Trust had considered everything around sustainability and environmental impacts when considering the proposals. However, 240

(21%) respondents felt they had not, and these respondents were invited to share their rationale. The top themes raised were:

- Neutral – Transport – Consider the impact of travel (e.g. mileage, transport links, costs) (35 / 17%)
- Negative – Transport – Consider the environmental implications of travelling long distances (24 / 12%)
- Negative – General – Environmental impact has not been considered (e.g. long-term effects) (23 / 11%).

When asked if there was anything further to consider for the proposals the top themes raised were:

- Neutral – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (40 / 12%)
- Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport, ability of person travelling, environmental impact) (38 / 12%)
- Neutral – Quality of care – Consider the needs of individuals to give the best care (23 / 7%).

5.2.4 Travel and Transport Consultation Findings:

Most respondents said they expect to travel up to 45 minutes for both specialist inpatient dementia care (1011 / 88%) and for functional inpatient mental health care (1016 / 89%).

The top 3 options for transportation were driving a petrol / diesel car (582 / 50%), walking (368 / 32%) and travelling by bus (364 / 31%). And, when asked if there was anything else that should be considered around making travel easier, the top themes raised were:

- Neutral – Transport – Parking should be free (149 / 29%)
- Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%)
- Neutral – Transport – Consider providing a free local bus / shuttle bus service (111 / 21%).

5.2.5 Conclusions of consultation findings:

5.2.5.1 Feedback on option 1a

Most respondents strongly agreed or agreed that this option would improve care for people living with dementia (946 / 82%), would improve care for people living with a functional mental health need (929 / 80%), would offer the right care for patients with mental health needs (909 / 79%) and would offer value for money (755 / 65%). The top themes raised by survey respondents about this option were:

- Neutral – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (98 / 27%)
- Positive – Access – Option 1a is a good option (46 / 13%)
- Positive – Quality of care – Separating dementia and functional mental health needs services would be beneficial (39 / 11%).

5.2.5.2 Feedback on option 1b

Around half of respondents strongly agreed or agreed that it would improve care for people living with dementia (661 / 58%), would improve care for people living with a functional mental health need (645 / 56%), would offer the right care for patients with mental health needs (588 / 51%) and would offer value for money (520 / 46%). The top themes raised by survey respondents about this option were:

- Negative – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (203 / 47%)
- Negative – Access – Option 1b is not a good option (36 / 8%)
- Negative – Quality of care – Concern over the reduction of beds (33 / 8%).

5.2.5.3 Feedback on option 2

Most respondents strongly agreed or agreed that it would improve care for people living with dementia (850 / 75%), would improve care for people living with a functional mental health need (854 / 75%), would offer the right care for patients with mental health needs (802 / 70%), and would offer value for money (690 / 61%). The top themes raised by survey respondents about this option were:

- Neutral – Quality of care – Wards should be single-gender / disagreement with mixed-gender wards (56 / 18%)
- Positive – General – Option 2 is a good option (38 / 12%)
- Negative – Finance – This is not a cost-effective option (28 / 9%).

In summary, the consultation feedback shows the most important factors and key considerations are around:

- the provision of single-gender wards with high levels of disagreement in response to mixed-gender wards
- the location of services and the potential impact this could have on the ability of patients and carers to travel
- the impact on carers, family members and visitors to support patients
- the staffing requirements for these revised services
- the quality of care provided to patients – with respondents highlighting the need for care to be provided closer to home and in a safe, supportive environment.

Of the 3 proposed options, **the highest levels of agreement are in response to option 1a** and lowest levels of agreement are in response to option 1b among participants for improving care for people living with dementia and functional mental health needs.

More information can be found in the consultation report of findings.

5.3 Equality Impact

The consultation findings have been analysed in detail and used to update the impacts and mitigations required for all proposed options. This has ensured that any gaps in our understanding from previous involvement work continue to be highlighted and the actions required to address these impacts are understood.

When considering the feedback by the different equality characteristics, the levels of agreement across most groups is highest for option 1a, followed by option 2 and 1b.

Carers: Option 1a scored the highest with variations for option 2 with option 1b scoring the lowest.

Religion: Option 1a and option 2 (variations across faith groups) scored the highest with option 1b scoring the lowest.

Ethnicity: Option 1a and option 2 (variations across groups) scored the highest with option 1b scoring the lowest.

Disability: Option 1a scored the highest with variations for option 2 with option 1b scoring the lowest.

Age: Option 1a highest on all questions with some age variations. Under the age of 18 - option 2 was viewed as the best option to improve dementia care and best value for money. Over the age of 80 - option 2 would provide the best functional care.

Sexual orientation: Option 1a scored the highest.

Gender: Option 1a scored the highest on all questions relating to options.

Transgender: Option 1a scored the highest but option 1b scored joint highest on improving care for dementia and functional patients.

Consideration was also given to addressing inequalities, including a question about the impact of the cost of living.

Option 1a scored the highest with option 2 scoring joint highest for improving the care of people living with dementia for people who are really struggling.

Option 1a scored highest for all questions in the areas with most deprivations. Option 1b scored lowest for all questions.

The impacts and mitigations can be found in the [updated EIA](#).

5.4 Consultation deliberations

The joint health scrutiny committee confirmed key themes are adequately reflected in the consultation report of findings, and the report demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation.

The Committee also flagged importance of travel and transport in considerations, welcoming “the emphasis placed on transport, travel and parking and notes the commitment to consider

the implications on those people impacted by the proposed options. However, there is no indication in the consultation report as to how much weight the decision-maker will place on transport considerations, as opposed to clinical quality, for example. The Committee understands there will be conflicting views as the decision-maker seeks to balance 'trade offs' between local access and the provision of centralised specialist services".

The Joint ICB committee confirmed their view that the "key themes, identified and considered in the report, fully reflect those areas the joint sub-committee expected to be included based on the consultation scope and plan." They also welcomed the emphasis on travel and transport.

Similar themes were raised at the stakeholder workshop on 23 August, with strong support for the findings, feedback that there were comprehensive and thorough findings, positive feedback that travel and transport has been identified and a desire to ensure that solutions are found. Other key feedback related to factors that should be considered as the programme progresses toward implementation, such as pathways and partnership working including voluntary and community sector, creative solutions, ward environments and staffing.

A report of workshop including attendees and more detailed theming can be found in appendix 7.

5.5 Quality Impact Assessment of options

A quality impact assessment was established prior to consultation which supported the options development and shortlist of options for consultation. This was reviewed and updated in 2024 by a clinically led group, see appendix 1 for more information. All options deliver improvements across many quality domains.

Option 1B delivers fewer improvements and requires several more mitigations than either of the other options.

Key specific challenges with option 1B are:

- Functional mixed gender wards only, which would create a challenge for functional admissions that would benefit from gender specific ward environments.
- Large 22 bedded ward, much larger than ideal and requires staffing consideration and impacts on clinical and therapeutic environment.
- Reduced overall capacity.

Option 1A and option 2 have similar overall profiles but none of the 3 key challenges identified above with option 1B.

Option 2 would require additional considerations:

- Crofton ward better designed for functional needs (existing space) so would require additional adaption whilst option 1A would need less as the Ward 19 environment is well suited to people with dementia.
- Dementia bed numbers lower, at the low end of the acceptable range.

Options 1A and 1B has additional dementia beds compared but wouldn't have the gender flex that option 2 has with dementia beds.

All options would require the following mitigations:

- Improvements of ward environments, including development of some e/s at Ward 19.
- Support for visitors (see travel impact)
- Work on pathways with partner organisations

Therefore, option 1A and 2 deliver many quality improvements but option 1A would require fewer mitigations from a quality perspective.

5.6 Travel Impact

A travel impact assessment was undertaken prior to public consultation and reviewed and updated, factoring in the feedback from the consultation and the proposed mitigations. For the purposes of the Travel Impact Assessment (TIA), both options 1A and 1B are considered together given their geographical parallels.

The TIA found that both of the options will have some negative impact.

The highest numbers of people impacted will be essential visitors, carers and next of kin, of people admitted to wards, given that stays can range from 60 to 100 plus days.

Some staff will be impacted as a result of the transformation, most notably staff based at the Poplars ward in Hemsworth.

There will be limited impact for patients, some functional patients will have ward leave prior to discharge and this might be further to travel from home. The Trust has policies and procedures to support people to access this and impact therefore will be very limited.

Visitor travel:

Feedback from the consultation showed that a high proportion of carers of people with dementia had access to cars. Analysis of car travel impact shows that the majority of people would be able to travel within the expected travel time, as established via the consultation questions on travel, for the most part, though some distances and journeys will be long.

Therefore, while essential visitors will be impacted in both options, in terms of driving time and driving distance, for the majority, people able to drive will be able to access services.

However, data in the travel impact assessment shows that some next of kin / carer visitors will rely on public transport and that in either option there will be a negative impact.

There will be slightly more people negatively impacted in option 2 than option 1 and the impact will be higher for people from Calderdale with dementia. People from South Kirklees with dementia would not be impacted with option 1 and would have a negative impact overall with option 2.

In terms of parking, whichever option is implemented, some people from Wakefield will be admitted elsewhere and be subject to car parking charges. The net impact of car parking is neutral though for any option as some people outside of Wakefield will be admitted to Fieldhead, with free parking.

Staff impact:

There will be some impact on staff for either option, with staff in Poplars impacted. Analysis in 2023 found that Poplars was a similar distance on average to Fieldhead overall from staff's home but that staff in lower pay bands were more likely to live closer to the Poplars. Some staff might wish to relocate to ward 19 in either option. Whilst further overall, 40% of staff were similar distance / closer to Ward 19.

Summary:

Option 1 would have negative impacts for some visitors which is likely to make travel difficult, with solutions required. Option 2 would have negative impacts for more people and those impacts would be greater, given the distances – meaning more people would require solutions and those solution might be more difficult.

The TIA and travel and transport working group have established a series of improvements that could support people visiting who are impacted by the change.

A staff consultation will be established post decision to include focus on staff directly impacted.

5.7 Sustainability Impact

All options will deliver / enable benefits in terms of in terms of pharmacy, technology, improved estate at the Fieldhead site.

Option 1B has a smaller estates footprint so lower carbon footprint.

All options will benefit from not having the isolated site and extra travel associated with it (for example, pharmacy, acute hospital admissions and transfers).

All options do lead to extra travel for visitors and there will be some additional travel for visitors in option 2 over either option 1A and 1B.

5.8 Alignment with strategies

To support the review of options for the pre-consultation business case, a full assessment took place of how each option adhered to relevant national, regional and local strategies. This was updated in 2024 to reflect any new strategies or guidance.

Findings were that Options 1A and 2 remained very closely aligned with best practice and regional / national strategies, in terms of models of care and delivering in a specialist environment.

In terms of regional / local strategies, all options align with ICB aims around specialist MH inpatient care and aligns well with acute hospital aspirations, for example Mid Yorkshire's aim for delivery of centres of excellence models and aligning their older people's wards in Wakefield and Dewsbury.

Option 1B does not align with national guidance on ward sizes but does for many other elements.

5.9 Review of all findings and recommendations

To evaluate the different options, five evaluation categories were determined and evaluated prior to the public consultation. This evaluation took place in a partnership approach.

Key feedback that we'd heard from patients, family and carers as well as key considerations highlighted in the quality and equality impact assessments were factored into each category. The criteria are outlined below:

- Quality of Care
- Access to Care
- Deliverability and sustainability
- Co-dependencies with other strategies
- Value for Money

No other options were identified during formal consultation.

As part of the decision-making process, consideration was be given by the programme board as to whether the options assessment remained viable. The original options appraisal and rationale were reviewed. The review to reach a recommended option used the same criteria to rescore.

Updated information used included:

- Quality Impact Assessment
- Travel Impact Assessment
- Sustainability Impact Assessment
- Strategic Alignment Assessment
- VfM assessment

- Equality Impact Assessment – updated post consultation
- Consultation findings, including independent report of findings, the feedback from key stakeholders and the stakeholder workshop outputs.

Each of these documents was considered in detail for impact against the different domains and found the following:

5.9.1 Quality Domain

Option 1a is the strongest option from an equality perspective. 1a Gives the best option for more people over a greater span of time. **1a – increased score from 7 to 8.**

Option 1b received negative feedback in relation to the lack of single gender wards for functional needs.

- No single gender option for functional needs if a patient wants or requires this.
- Inequality of access – this maintains a barrier of access, but 1a and 2 offer options to address the barrier as they include a single gender functional ward.
- Score for option **1b reduced from 5 to 4 in quality** as it means that there is more than one key area that can't be met: though mitigations could be put in place to manage, this is sub optimal.

Option 2 – no change.

People with functional needs more likely to benefit from en-suite but no / very limited access to this in option 2. Option 1a has no/very limited en-suites for dementia, but patients with dementia more likely to need bathroom/bathing support.

5.9.2 Access Domain

Calderdale most impacted by the options and there is a greater impact with option 2. Extra travel for option 2 raised as key specific negative themes by people in Calderdale:

- This option will create difficulties around transport for patients, carers and families (14 / 19%)
- Locations are hard for patients, families and carers to reach (9 / 12%)

The updated Travel Impact Assessment identified that whilst all options created extra travel, the overall impact of option 2 is greater (more people impacted and a bigger impact for those that are).

Consultation theme in relation to access: the lower number of dementia beds in option 2 and whether there is capacity to meet demand.

Consideration was given as to whether the access score for option 2 should be reduced but these issues were identified in 2023 options assessment and scored accordingly then.

For criteria of access for **1a, 1b, and 2 options scores remain the same.** No additional considerations.

5.9.3 Sustainability

The focus of the sustainability criteria was primarily on whether each solution could be sustained for a period of up to 10 years and there was nothing new to indicate a change to scores based on these criteria

5.9.4 Strategic Alignment

Following review there no significant changes to policy or strategies that would impact on the proposed transformation. Both option 1a and 2 scored well from strategic perspective and therefore there was no new information to date that changes the assessment.

5.9.5 Value for Money

Whilst it was noted though that option 1b was not recognised as offering the same value for money in the consultation feedback compared to other options, even though it is lower cost., the assessment rating did not change as the costs and other factors considers in the value for money assessment remained the same.

5.9.6 Updated options matrix

The table below shows the revised scores following the review of findings:

	Option	Quality Domains				Total quality score	Value for Money	Total
		Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	70	30	100
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21 rescored to 24	14	6	8	49	19.2	72.2
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15 rescored to 12	8	4	5	32	21.6	50.6
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18 no change	12	6	8	44	19.2	63.2

Based on the updated findings of the consultation and impact assessments, the overall ranking hasn't changed but some scores have. Out of a weighted total of 100, the 3 options now scored as follows:

- Option 1A: 72.2
- Option 1B: 50.6
- Option 2: 63.2

Though some scores to the options appraisal were changed as a result of consultation, the findings supported the previous analysis and options appraisal that has taken place, **with option 1A ranking highest** and being the most appropriate option to take forward to implementation.

For more information see appendix 8, options and recommendations.

6 System prioritisation and financial assurance

6.1 NHSE Requirements

NHSE acknowledged prior to consultation that the ICB has confirmed that it will prioritise the proposed changes from a capital and estates expenditure perspective, with capital costs to be met by SWYPFT's 2024/25 and 2025/26 operational CDEL capital allocations. However, they sought further assurance prior to decision making business case demonstrate that this scheme is prioritised for system capital across all conflicting priorities in West Yorkshire

Further to this, NHSE requested the following information in place pre decision.

Financial plan

Evidence documents:

- Draft finance chapter of business case
- SWYPFT Medium term Financial Plan

Key content:

- Complete picture of costs with total costs and funding sources and applicable increases e.g., in contingencies, agenda for change pay increases since PCBC was published and impact on both provider and commissioner budgets/bottom lines
- Detail of workforce costs (WTE increase, timeline and on-going impact on revenue position), including contingencies if recruitment plans aren't fulfilled
- Incorporation of stranded costs and associated revenue costs into the financial model but clarifying exactly what these costs are and their associated value.
- Detail of any transition costs
- Inflation calculations for both revenue and capital including appropriate, quantified tolerances and mitigations
- Evidence of how financial modelling aligns with workforce and capacity and demand modelling (and that growth has been considered in relation to the latter) ie: triangulation
- Comparison of proposed option's costs to business-as-usual costs from both a capital and revenue perspective
- Process for estimating optimism bias (use of external consultants with supporting documentation etc)
- Profiling of planned capital/revenue expenditure (£ per year) and how capital falls within CDEL allocations
- Description of governance for planned spend and sign up at all relevant levels (provider and commissioner, as well as system given that WY is now identified as a deficit system for 24/25). As such, confirmation required that the business case has gone through the ICS governance process and affordability has been confirmed by the system.
- Description of all capital/revenue risks with evidence that these are understood, owned, monitored and planned mitigations supported at a system level
- Poplars site – our understanding is that under the options being considered, this site will become vacant. Please detail what the Trust intends to do with this site and the financial impacts, along with relevant timelines e.g.: is the intention to sell the asset,

in which case a capital receipt will arise that requires to be factored into the business case financial modelling, if the site is to remain vacant then there will be on-going associated revenue costs to be factored into the business case financial modelling.

Strategic prioritisation:

Evidence documents:

- Letter of support from MH Provider Collab & Programme Board for the specific change proposals

Key content:

- Confirmation that the OPMH change proposals are viewed as a system priority for the collaborative/board
- Assurances that there has been an impact assessment and review undertaken collectively, within the system, that has considered and established the MH priorities for West Yorkshire and has thereby confirmed that this investment is indeed a priority, given the competing needs of other schemes to access CDEL.

System level controls/checks & balances

Evidence documents:

- Finance section and separate supporting letter/email from the system, which has been taken through ICS governance.

Key content:

- Description of additional financial controls/checks/governance that has been applied to change programme to reflect the now very different financial position of WY ICS, evidencing the need to assure the use of resources within the system.
- Evidence of considerations undertaken and that the planned spend remains supported at a system level, whilst also demonstrating how the business case will provide both financial sustainability and address the underlying financial deficit of the Trust.

6.2 Financial plan

6.2.1 Capital Costs:

Estimated capital financial values have been calculated in line with NHS standards and align with HM Treasury Green Book and NHS England and Department of Health and Social Care (DHSC) business case requirements and processes. As such each estimate includes optimism bias, inflationary assumptions and contingencies. The main cost of capital in the proposals is for the relocation of the isolated site, the Poplars, to be co-located with other wards. These costs will be updated and finalised following a procurement process post consultation.

The table below gives a high-level summary of capital costs:

Option	Description	Total Capital Cost	Comments

Option 1A	Model designed as part of an overall functional or dementia site	£8.2M	The 10-bed design would accommodate either of these proposed options, having a specialist dementia unit in Dewsbury or Wakefield.

There is a revenue implication for the model and the £8.2 capital option will add approximately £500K annual revenue costs.

Current planning assumptions are that capital costs will be spread across 2 financial years, 2024/25 and 2025/26, with work being complete in spring or summer 2025. These values are contained within the current SWYPFT capital allocations as part of the West Yorkshire ICB capital allocation process.

2024 / 25	2025 / 26
£2.5M	£5.7M

6.2.2 Workforce Modelling

The workforce section of the [pre consultation business case](#) covers the workforce modelling process in more detail, which has been clinically led by the programme clinical lead resource, supported by the establishment review lead resource for skills mixing on the wards and reviewed by the service managers.

The table below references SWYPFT Trust establishment review activity took place in early 2023, using the same MHOST data as was used for transformation modelling, to identify gaps between the existing staffing and required staffing for the existing model.

Summary of staff across models:

	Current Establishment	Proposed (establishment review)	Actual Use	Option 1A
Registered Nurse	70.24	80.62	61.67	75.88
Healthcare Assistant	84.61	99.04	122.4	114.84
Total	154.85	179.66	184.07	190.72

Option 1A does require some additional staffing resources above existing levels and levels proposed in the establishment review. This is because it brings the people with the highest dependency levels into one place to deliver *specialist* dementia care whilst the remaining functional wards will still need to operate at similar safe levels to the existing mixed needs wards.

Whilst this model does increase the staffing above current levels of use, the clinically led team that focussed on the required workforce believe that this increases the likelihood of being able to manage within established levels of staff.

Transforming to a specialist model could also lead to less people in the dementia unit being on high level of observations, reducing very long stays and therefore reducing demand for dementia beds. However, economies based on the option can't be expected immediately, which is why a robust staffing model is initially needed for dementia specialist ward, though the Trust will also try to carefully phase to the new model if possible.

6.2.3 Recruitment, training, and wider system impacts:

Staff recruitment would need to be phased in prior to the transformed model being fully implemented. The numbers required are relatively low in comparison to the overall staff base across SWYPFT and local partners. Recent recruitment drives into the Trust have had positive results and as such we believe that the ability to recruit into the workforce model carries low risk. Should this increase, there is the option to re-open the overseas recruitment programme that has been used in recent years by SWYPFT to fill vacancies for qualified nurses.

Although there could be some wider system impacts due to the transformation posts being new and attractive, the increase in posts involved are low compared to current use. This is unlikely to have significant clinical or financial impact on the wider system.

6.2.4 Overall costs of the proposed option:

The table below is the most recent revision of the costed option.

Option	19 Male	19 Female	Beechdale	Crofton	Poplars	Willow	Revenue for Capital	Total
	£K	£K	£K	£K	£K	£K	£K	£K
a. 2022/23 budget	1,093	1,094	1,083	1,162	1,275	980		6,688
b. 2022/23 actual	1,078	1,034	1,329	1,818	1,636	1,166		8,062
c. 2023/24 budget	1,168	1,175	1,146	1,214	1,352	968		7,023
No change (costed at current roster templates)	1,158	1,243	1,164	1,164	1,151	1,035		6,914
uplift /safer staffing	1,342	1,350	1,308	1,429	1,528	1,017		7,975
Option 1A) W19 dementia unit, 10 extra beds at Crofton, Poplars not in this model **	1,963	1,963	1,233	2,430	0	1,008	486	9,082

The proposed option 1A in the table above represents just over £1M increase above the actual rostered staff revenue spent in 2022/23, though is over £2M above the budget levels.

The costs in the table above, per ward, are staffing costs related only and are based on costed rota's in line with Trust standard costing principles. There are no assumed recurrent non pay cost changes in any scenario as no change in activity, and therefore variable costs, has been assumed. Fixed costs will remain the same with the exception of additional capital charges (depreciation and Public Dividend Capital) arising from the additional capital expenditure proposed. This is included in the revenue for capital column above.

From a SWYPFT perspective there will be no impact to Trust bottom line as costs, which are over and above existing SWYFPT costs, incurred will be funded by commissioners in line

with the partnership agreement set out in the agreed principles. These have been factored into commissioners medium planning arrangements.

Workforce modelling and costs continue to be reviewed. No fundamental differences have been identified as a result of this and costs will be finalised following the recommendation of and decision on the option to implement.

6.2.5 Financial engagement

Discussion on the **potential** financial elements has been undertaken via the programme board; there was a need to jointly develop the different service model options to enable indicative costings to be undertaken. This has considered both the revenue and capital consequences.

The discussions with stakeholders have confirmed the appropriateness of the costing process undertaken, the principles applied, the assumptions made (such as workforce modelling).

6.2.6 Timing

Current modelling assumptions are that a preferred model could be live from late in the financial year **2025 / 26**. It needs to be clear that this is an assumption and actual timing will be dependent on a number of factors which are dependent on the outcome of the public consultation including the agreement of a preferred option, decision to commence timelines, and triangulation with the capital programme scheduling.

Based on this, the system / commissioners have incorporated and prioritised funding from that point. Recruitment plans, and part year effects, profiling, etc, will be agreed with system partners once timescales are finalised.

6.2.7 Financial implications – revenue

Whilst the actual costs will depend on the decision on the recommended option, confirming of final staffing models and agreed national pay rates, the financial modelling, used to inform the preferred options to take to consultation, highlighted a current difference of £1.2m between current costs and the highest cost option (which is option 2). The difference to option 1A is £1.0m.

This is summarised in the table below and illustrates the mitigations that SWYPFT have included and the remaining funding gap:

Description / option	Cost £k	
Budgeted OPMH inpatient services 22 / 23	6,688	} SWYPFT mitigation £1,374k Already included in SWYPFT financial position
Actual Spend 22 / 23	8,062	
Option 1A	9,082	Modelled financial gap £1,020k

It is proposed that the additional cost would be apportioned between the three places (Calderdale, Kirklees and Wakefield using a methodology yet to be defined and agreed). No additional non pay or overheads have been included within the financial modelling. These are not expected to significantly change from current costs incurred.

6.2.8 Financial implications – capital

The capital cost has been incorporated into the SWYPFT capital programme which has been developed in support of the long-term Estates strategy. This will utilise SWYPFT capital allocations and cash reserves. The main risks relate to ensuring that the Trust capital allocation is maintained at an appropriate and sustainable level and also the opportunity cost; doing this scheme will mean that another programme cannot be completed at the same time.

The Trust Estates strategy has formed the basis for prioritisation of schemes within the capital programme. The potential capital works identified within this document have formed part of this programme and have been repeatedly included in indicative medium term Trust capital plans which have been periodically shared with the ICB. Other schemes have been profiled around the indicative timing of this programme; based on current modelling this does not wholly utilise the capital allocation in any given year allowing other works to be completed alongside this.

The NHS WYICB has confirmed prioritisation of this scheme from a system capital and estates perspective. This is on the basis that the forecast capital expenditure for the programme is £8.2m and will be spent across the 2024/25 and 2025/26 financial years. SWYPFT has confirmed that it will prioritise this programme from within its expected operational capital allocation. This programme is included within the WYICB 10 year infrastructure plan which is currently under development.

Business case guidance around contingency and optimism bias have been factored into the costed models. For example, 15% optimism bias is factored in at a cost of £1.07M. However, the programme team remain conscious of price volatility. Cost uncertainty is recognised and we are using the ProCure23 process for delivery in order to manage some of that volatility. As identified above the Trust does have the capacity to flex other capital scheme spend in year to mitigate against cost uncertainty.

6.2.9 Financial implications – opportunity cost

All parties recognise that there are limited resources within organisations, the overall system and that the financial position is becoming increasingly challenging (and is expected to increase further). As such prioritisation of investment (capital and revenue) will be required which in turn means that investment in other priorities will not be possible. At this stage those opportunities are not clearly articulated.

6.2.10 Financial implications – transition costs

There will potentially be a limited amount of transition resource required at time of go live and a period of up to 4 weeks where additional staffing is needed to manage the transition across sites. Based on previous experience of work at Fieldhead site this is an estimated £10-15K one off cost.

There may also be some staff relocation costs as a result of material changes to people's role and location. Data shows this could impact on 13 staff members from the Poplars site and the payment for excess journeys could cost up to £15K tapering down to £13K per annum for up to 4 years if all people are relocated to be based at Fieldhead. The actual cost could be lower if all staff do not relocate.

6.2.11 Financial implications – stranded costs

The impact on other organisations and partners has been considered as part of this programme especially as a number of the current services are provided in units leased from other local NHS Trusts. No other organisation is impacted or has any stranded costs as a result of any of the options. The Trust will follow the capital disposal process for the Poplars site should that be required following the public consultation, which involves the following:

- When a property is declared surplus to requirements, the Department of Health and NHS estates are informed and the property goes on the surplus register
- We would then ask if any public bodies want the property as a limited disposal and we are required to get a capital return which equates to the market value of the property.
- If no public body wants the property it is disposed of on the wider property market

Poplars disposal costs will be overall in the region of £10k based on the market value of circa £150k disposal will take approx. 12 months but this is market dependent.

Initial conversations have taken place with local partners about the future use of this site and how the site could be used as a local asset for health and care purposes. It is hoped that a solution to the use of the site can be found quickly. To note, this process would take place separately to the transformation programme.

Any receipts from the disposal will be returned into the overall Trust to be used in delivering services throughout the Trust.

6.2.12 Agreed principles:

Final values will be confirmed post consultation and post final cost review and the programme will continue to engage with partners and ensure that this is undertaken on an agreed open book basis for both costing methodologies and the underlying service modelling.

As covered, key principles that have been applied throughout across the partnership to ensure financial viability which include prioritisation of spend / funding and sharing of risk.

6.3 Strategic Prioritisation

The programme is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme.

A letter from Keir Shillaker, Programme Director: Mental Health, Learning Disability & Autism, West Yorkshire, confirms that business case for the development of specialist inpatient mental health services for older people is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme. It supports the ICB's overarching goals of improving outcomes, reducing inequalities, and enhancing the quality, accessibility and experience of mental health services for older adults, while also promoting sustainability and environmental responsibility.

The letter also states that the proposed specialist inpatient services will specifically benefit the populations and communities across Calderdale, Kirklees and Wakefield, addressing the identified clinical and quality gaps in specialist mental health provision for older adults in these places. However, this provision will also contribute to the overall enhancement of services across West Yorkshire, strengthening the region's ability to deliver high-quality, equitable care for older people with complex mental health needs.

See appendix 9 for more information.

6.4 System level controls/checks & balances

South West Yorkshire Partnership Foundation Trust (SWYPFT) has confirmed the following:

- That the OPS inpatient transformation scheme is their capital priority as identified in their Trust Estate Strategy. This forms the Trust key scheme within the developing WY ICB infrastructure plan.
- Based upon current agreed capital allocation methodology this is contained within the SWYPFT allocation. The capital programme is scheduled to accommodate this scheme without creating additional estates risks.
- The Trust will be using its own cash reserves and therefore does not require cash support from the ICB.

In addition, the West Yorkshire ICB finance director, Jonathan Webb, has confirmed the following statements (see appendix 10):

- The agreed methodology for capital allocation would need to change from the current model to have a direct impact on other Trusts.
- During 2024/25, the WY infrastructure plan has been developed and agreed, with this programme identified as a priority.

In late 2023, the NHS WY ICB confirmed prioritisation of this scheme from a system capital & estates perspective. This was on the basis that the forecast capital expenditure for the programme is £8.2m and will be spent across the 2024/25 and 2025/26 financial years.

In 2024, wider system challenges have emerged. However, based on proposed costs remaining as planned, it is our expectation that SWYPFT will receive the capital allocation they require to deliver the programme, factoring in their prioritisation of the programme and plans to spread costs across financial years.

The ICB is committed to delivering MHIS in line with NHSE expectations. The ICB can confirm that this is our priority for funding future MHIS and forms the basis of financial planning. As this will be apportioned across place it does not represent the entirety of the MHIS and will allow other investment.

The incremental revenue impact for SWYPFT and Calderdale, Kirklees and Wakefield place is c. £1m in total, which is approximately 5.1% of the WYICB MHIS growth for 2024/25.

The revenue costs will be phased, in agreement between system partners, with current modelled part year effect costs from 2025 / 26. As system partners, we have agreed that if Mental Health Investment Standard funding continues that the Older Peoples transformation programme is initially prioritised to meet the revenue costs over the agreed period. SWYPFT and ICB will risk share any increases in costs that emerge as a direct result of the programme.

The business case for the transformation evidences that the investment, whilst improving operational services, quality and safety, it also helps to mitigate a number of other risks including financial pressures arising from the current structure, in particular increasing costs associated with keeping patients with high acuity dementia safe in an isolated site. This will help support the overall financial sustainability for SWYPFT.

The Trust has confirmed that it is continuing to develop its medium-term financial sustainability plan, in line with the wider development within the ICB, and is taking actions to ensure delivery of this and the 24 / 25 in year breakeven target. This includes review and support of all guidance and advice.

7 Implementation considerations

7.1 Travel and Transport mitigations and actions

A working group was established in 2024 with a mix of carers, governors, SWYPFT and ICB staff. It was tasked with making recommendations to support family, carers and loved ones that have difficulty travelling to a transformed model, considering feedback from the public consultation and agreeing principles for when support is needed as a result of the transformed model.

From the findings of consultation and the evidence provided to the group, it was clear that some protected characteristics, and health inclusion groups may experience more of an impact than others when having to travel long distances, to unfamiliar places, or use public transport. The group identified these as: people who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties. The mitigations identified aim to address the issues for all groups identified but will benefit all patients, carers, and visitors impacted.

As such, the group has recommended the implementation of a visitor support pathway, which would take a needs based and personalised approach to supporting people impacted by changes, including:

- Provide guidance on travel by the wards.
- Ensure flexible visiting is adopted.
- Offer digital solutions.
- Factor in needs of carers, for example the triangle of care principles, carers' passports and carers' assessments.
- Work with partners including the Combined Authority to influence improvements public transport solutions that better link hospitals and improve ease of public transport journeys.
- Ensure there is a failsafe / contingency in place for essential visitors such as carers / next of kin that are unable to visit as a result of changes made which factor in the needs of the service user and the ability of next of kin to visit. This could include volunteer drivers, VCSE support or paid taxis.

If the measures above do not provide enough support to allow an essential carer to visit the ward, a range of circumstances will be considered including:

- Needs of service user – how beneficial visiting is, how frequently they would benefit from visits.
- Visitor circumstances:
 - If it requires a complex and long journey, for example, more than 1 change of public transport, or the journey takes over 1 hour.
 - If the visitor has disabilities or a condition, including frailty, that makes the journey difficult.
 - High cost of travel makes the journey unaffordable.

In these situations, where an essential visitor is unable to travel, it is proposed that the provider will work with the next of kin to capture the evidence of need and find a way to support the visitor to access the ward as appropriate.

It is proposed that the pathway is supported for a 5-year time period, with reviews factored in, potentially annually. 5-years would give the time for new ways of working to be fully embedded. The reviews would focus on access and usage of the pathway to ensure it is working effectively for people.

7.2 Equality Mitigations and Actions

The updated equality impact assessment includes an updated series of mitigations, factoring in feedback from the public consultation. The following are mitigations included in the equality impact assessment:

Consider improvements to ward 19 in relation to toilet and bathing facilities, factoring in patient and carer views, in particular in relation to options to add en-suite to any bedrooms on the site.

Ensure that options are in place to care for people from Calderdale and Kirklees admitted to Beechdale on a single gender ward in Wakefield if required.

As part of estates work consider décor, pictures and facilities to ensure inclusivity and consider arrangements for ablutions such as a Wudu. As part of implementation planning think about cultural approaches to cooking and storing food and menu choices and activity that consider diversity.

Ensure the Trust transgender policy is considered in the design and development of services. Further engage transgender groups to confirm design options and preferences.

Ensure environments meet the needs of people with a disability, considering flooring contrast, colour, lighting and accessible facilities and work with a range of disability groups to test out access

Staffing: Recruitment of staff representing a range of faith backgrounds and appropriate gender mix.

The equality impact assessment will continue to be reviewed and updated as the programme progresses towards implementation.

7.3 Quality Mitigations and Actions

The quality impact assessment identified potential mitigations linked to travel and toilet / bathroom facilities on ward 19 and some work should take place on general environment, in line with dementia design guidance.

In additional mitigations are required around pathways and partnership working across place.

Mitigations could include:

- An increased use in video conferencing for ward meetings to reduce travel impact.
- Reorganising ward reviews so that they are held on different days for each geographic area.
- A review of clinical pathways for patients admitted to general hospitals, to reduce the number of admissions to general hospitals

Further work to take place to focus on new ways of working.

Mitigations also may be required due to capacity limitations of having separate male and female needs-based wards. Mitigations would be to place someone in the next most appropriate ward, increasing observation levels while required, and further exploring whether any additional gender flex can be created.

7.4 Sustainability Impact Mitigations

A theme raised in the consultation was that although most respondents felt the Trust had considered everything around sustainability and environmental impacts, around 20% felt they had not and shared their rationale.

Every Trust is required to deliver a net zero carbon roadmap and activity in this programme will support the roadmap. All future reports to board on sustainability will be made available on the Trust website, which will fully explain rationale for sustainability activity, of which this programme will form part.

The building infrastructure for development work at Fieldhead will be in line with the green plan. We will continue to improve the energy efficiency of our buildings, equipment and practices as part of relocation and ensuring that all new buildings and refurbishments meet sustainability standards.

Visitor support solutions will be part of the active travel plan programme which explores all elements of green travel including increased support for electric vehicle use, for example more charging points, and use of public transport. Part of this includes exploring the potential for much improved public transport that better links hospitals and encourages people to use public transport rather than private transfer.

7.5 Other considerations identified

Other considerations identified, for example, via the consultation review workshop include:

- Partnership working – in particular with voluntary and community sector partners to improve patient pathways.
- Developing, using and optimising creative solutions

- Ensuring that there is a plan to support the staff through transition and staff wellbeing.

The mitigations identified across each impact assessment have been used to inform and drive the development of implementation planning and working group. Initial high level workstream plan and drivers can be found in appendix 11.

8 Recommendations

The programme has been on a journey for several years to reach a position where we are able to reach a recommendation on the preferred option, with mitigations, that have been robustly tested across a wide range of key stakeholders.

In presenting this business case, there have been conclusions throughout and based on the strong evidence and consistent feedback on options from a quality, equality and access perspective, the programme board make the following recommendations:

- That option 1A is endorsed for implementation.
- That commitment is made to progressing solutions identified, particularly for people impacted by travel and transport.

As well as these recommendations, ongoing governance and oversight will be required through to implementation and agreement is sought to approve the formation of an Implementation Team, reporting to the programme board, SYYPFT Executive Management Team / Trust Board and the Joint Integrated Care Board Committee on the implementation process.

9 List of appendices

Appendix 1. Quality Impact Assessment
Appendix 2. Travel Impact Assessment
Appendix 3. Sustainability Impact Assessment
Appendix 4. Review of strategies
Appendix 5. Consultation plan
Appendix 6. Feedback from JHOSC
Appendix 7. Report of workshop
Appendix 8. OPS Options and Recommendations
Appendix 9. WY ICB OPMH Supporting Statement
Appendix 10. Finance Supporting Statement
Appendix 11. OPS Workstreams Post Decision

9.1 Other documents for reference

Clink the links below to access other relevant documents referenced in this business case:

[Pre consultation business case](#)

[Independent report of consultation findings](#)

[Equality impact assessment](#)

[Transforming older people's inpatient mental health services – 2022 engagement](#)

Older People's Transformation Inpatient Model **Quality Impact Assessment**

Date

September 2024

Quality Impact Assessment

Title of scheme:	Overall Quality Impact	Positive (improved)	Neutral (maintained)	Negative (reduced)		
QIA OPS Inpatient MH Transformation		All options are positive overall, though there are several more mitigations required if option 1B is preferred to option 1A				
People involved in completing the QIA:						
Ryan Hunter. Gemma Hinchcliffe, Valerie Aguirregoicoa, Siobhan Dorotiak – review and support						
Lead person:						
Matthew Burns						

Brief description of scheme – (please embed business case or relevant proposal paper)

This is a QIA of the proposed options to take to consultation from the OPS Transformation Business Case for changes to the older people's mental health inpatient estate across Calderdale, Kirklees and Wakefield.

The current model of care is set out below:

- In Calderdale, Beechdale is a 16 bedded, mixed gender and mixed needs, functional and dementia ward at the Dales in Halifax, which is located on the site of Halifax Royal Hospital.
- Ward 19 constitutes 2 x 15 bedded single gender wards, both mixed functional and dementia needs, on the site of Dewsbury and District Hospital and people from Calderdale will often stay on this site in the current model.
- Wakefield currently has 2 wards, Crofton on the Fieldhead site and the Poplars, at Hemsworth. Crofton is a 16 bed, mixed gender, mixed functional and dementia acute needs ward. The Poplars is a mixed gender ward for people with dementia. People accessing services at the Poplars generally transfer to the ward after an admission to Crofton. It has been operating as a 12 bedded ward for several years.

Challenges of the current model:

There is strong evidence that the needs of the people with dementia and functional needs are different, and they do not mix well together. As our inpatient ward offer remains mostly mixed, the Trust has been developing a proposed clinical model to transform services.

The SWYPFT older people's wards only admit people with dementia who have very complex and challenging behaviours and need a hospital stay after all attempts have been made to support them in their own own/care home. The model of mixing people with dementia with other needs does often have a negative impact to people on the wards.

The behaviour of people with dementia on the wards can have a negative impact to people who might have anxiety or psychosis. People can be frightened and they might not engage as well on the wards because of this. Staff spend considerable time supporting the people with the most challenging behaviours and this can be at the expense of delivering therapeutic support to others.

The current model also leads to a number of other challenges such as an isolated ward which, due to location, has issues admitting a high level of acuity and access to timely support when required.

The current system leads to many people moving between wards, which has a negative impact on their wellbeing, impairs continuity of care, prevents best use of therapeutic interventions and leads to increased length of stay.

30% of people are admitted to a bed outside of their locality and 30% of people have more than one ward stay as part of their inpatient spell.

The current systems of care lead to many people having more than one stay. Operational and clinical staff have fed back that this can have a negative impact on people's wellbeing as it:

- Impairs continuity of care
- Prevents the development and utilisation of therapeutic relationships
- Hinders access by carers due to the geographical differences.
- Unnecessarily extends the Length of Stay
- Means there is an additional period of assessment while a new care team and the service user get to know each other
- Means an understanding of the wider multi professional team and their role in supporting care in the community has to be re-established.
- Means that relationships between the carer and the care team have to be re-established
- Leads to attitudes to risks being lowered while impact is re-evaluated
- Increases the risk due to the change of environment / change of staff, for example, can also lead to increased confusion when moving people. The changes can't always be mitigated and there can also be an impact on carers.

Features of the current system include:

- 4 of the 5 wards are mixed functional and dementia needs.
- Single sex accommodation guidance is met on all units except Poplars in Wakefield. Currently, 3 out of 5 of the wards are mixed gender, which can make clinical management an issue, especially for those patients with organic diagnosis.
- Services are local to place but site isolation of Poplars ward leads to challenges in terms of access to acute general hospital. The isolation of the Poplars ward creates issues in terms of access to cover, support in an emergency, shared facilities and medical out of hours support.
- There are challenges with some of the ward environments, notably Beechdale.
- There are very different pathways and stays across the Trust, particularly for people with dementia. Most people with dementia from Wakefield have more than 1 ward stay and a typical stay of well over 100 days. In Calderdale, around 50% of people with dementia have had more than one ward stay, and the length of stay is over 100 days on average.

More information on the challenges can be found the business case.

The business case also sets out the required clinical model which have been mapped against the quality domains in this QIA.

3 options are being assessed in this QIA:

1a A dedicated central specialised dementia unit developed on Ward 19 with additional functional bed capacity at the Crofton ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton would operate as 2 wards across the 26 beds.

1b A dedicated central specialised dementia unit developed on Ward 19 but with fewer beds being relocated to Crofton (6 in total), meaning that Crofton would operate a single 22 bedded mixed gender functional needs only ward.

2 Crofton being a 26-bed dementia unit (2 wards with 10 beds being relocated from Poplars), all other wards functional.

The Poplars site would not be in any of these proposed models, the service would be relocated and reconfigured in each option into the Fieldhead site and the wider model.

Quality Impact Assessment Tool

RATING	The assessment suggests that this the impact on quality is rated as follows
BLUE	Improves quality
GREEN	Neutral impact on quality
AMBER	Potential impact on quality. Requirement for mitigation and monitoring
RED	Likely impact on quality. Requires further work or substitution

The quality is assessed against the three options, where the impact is displayed under multiple options then it is thought to be applicable to all those options.

The table below has the summary assessment of each option against each domain and requirement:

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
SAFE	Improvement in the environment in which service users are treated	Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs.	IMPROVEMENT The options appraisal process found the W19 environment to be the best option in terms of a dementia	IMPROVEMENT Crofton dementia option would also improve the current model but there is no limited communal space; narrower corridors than W19, limited access to outside space.	IMPROVEMENT The options appraisal process found the W19 environment to be the best option in terms of a dementia
	Promotes a safe approach to service user care and/or helps to prevent harm to service users	A model with the best specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation. e.g., dedicated socialisation for people with similar needs.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
		Single Sex Accommodation	IMPROVEMENT	Minor Mitigation: Ligature light environment on Crofton - which works better for functional needs – adaptations would be required.	
		Wards sizes in line with or close to best practice guidance of 15 beds	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT BUT MITIGATIONS REQUIRED Issue with Poplars site resolved. All functional wards would be mixed sex.
	Supports a risk management and safety systems	Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
		Staffing to appropriate levels, in line with clinical need to support safety.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT BUT MITIGATIONS REQUIRED Mitigations due to increased ward size
	Takes account of the duty of 'due regard'		Due regard has been fully considered (please refer to Equality Impact Assessment for detail).		
	Impact on partner organisations and any aspects of shared risk	Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	IMPROVEMENTS BUT MITIGATIONS REQUIRED	IMPROVEMENTS BUT MITIGATIONS REQUIRED	IMPROVEMENTS BUT MITIGATIONS REQUIRED
EFFECTIVE	Supports staff in understanding their role in improving the service user experience	Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Reduces impact on variation in care provision.	Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Involves and engages service users, staff, public, people who use services and other stakeholders.	Stakeholders are involved in design and their input informs decision making.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Promotes positive outcomes of care.	Will deliver positive outcomes of care and allow for implementation of evidence-based practice.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT WITH MITIGATIONS REQUIRED: 22 bedded ward could have potential impacts on clinical and therapeutic engagement.
	Support services are aligned with pathways.	Clinical support staff teams and services, across pathways to work together to deliver safe, effective care	NEUTRAL IMPACT	NEUTRAL IMPACT	NEUTRAL IMPACT
		Non-clinical support staff teams and services, across pathways to work together to deliver safe, effective care	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Impact on eliminating inefficiency and waste by design	Patients received the right care at the right time. Pathway delays a minimised as much as possible.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
CARING	Allows staff time to care for people.	Ward staff who have skills, knowledge and experience that aligns to the patient specialism on their ward.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Services that have been co-produced.	Improvement has been co-produced with patients and carers.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
RESPON-SIVE	Improves the timeliness of any stage of the service user pathway.	Pathways that allow clinical interventions and discharge planning to happen as soon as clinically indicated.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Supports delivery of service performance and the principle of Right Care, Right Place, Right Time	Evidence that service users are in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
		That we have the right capacity in the system to meet the demand required, factoring in projected population increases.	NEUTRAL IMPACT/MITIGATION REQUIRED	MITIGATION REQUIRED Issue that this has lower dementia bed numbers	NEUTRAL IMPACT/MITIGATION REQUIRED
	Supports fair access and the principles of the Equality Delivery system	The service users, family and carers are able to access the service as needed.	MITIGATION REQUIRED	MITIGATION REQUIRED	MITIGATION REQUIRED
	Results in a more accessible service.	Service is accessible for families, carers and support services.	MITIGATION REQUIRED	MITIGATION REQUIRED	MITIGATION REQUIRED
	Impact on choice agenda	Provide patient choice wherever possible	NEUTRAL IMPACT	NEUTRAL IMPACT	NEUTRAL IMPACT
WELL LED	Aligns with trust vision, values, and strategic objectives	Objectives of the project align with the trusts.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT
	Takes account of the needs of service users, staff, public and other stakeholders	The needs of stakeholders are reflected in the design of the service.	IMPROVEMENT	IMPROVEMENT	IMPROVEMENT

The following table has the detailed rationale for each assessment:

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
SAFE	Improvement in the environment in which service users are treated	Separate wards for diagnosis - functional and organic, delivering the specialism to meet needs.	IMPROVEMENT ▪ The model takes on the evidenced based recommendation of separate wards for diagnosis - functional and dementia. ▪ This will improve socialisation, for example, dedicated socialisation for people with similar needs. ▪ There will be an appropriate environment for respective needs – i.e. dementia friendly and fit for purpose. ▪ The clinical senate strongly supported a model implemented based on needs:		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			<i>"The review team strongly concurs that patients with functional and organic disease should be cared for in separate distinct and dedicated units."</i> Feedback from stakeholder workshop in December 2022 also supports this: <i>There would be real positives in separating the services out and having a specialist dementia ward and the staffing of it, you can get the correct staff training/skills in place.</i> Data shows a much lower number of falls on the Trusts only functional only ward. Both models would be expected to reduce the overall number of falls across the system. We have had feedback from staff that functional patients can isolate themselves to their bedrooms because they may find being with dementia patients in communal areas difficult. This can lead to reduced mobility and increased falls risk. Dementia patients are also much more likely to fall due to neurological changes, difficulty in using aids and adaptations and fluctuating cognition, making care planning difficult. Separate spaces mean least restrictive environment for people with dementia. All our staff have undertaken the Oliver McGowan training which focusses on caring for somebody with learning difficulties (LD) in a mental health setting. We have considered how patients with a LD might be cared for in any new model. This would include placing the person in the most appropriate ward, dementia, functional or LD, with support from other specialist services as needed.		
			The options appraisal process found the W19 environment to be the best option in terms of a dementia appropriate with More space for movement; Wider corridors; Courtyard space; Each ward has access to lounges, dining room, OT room, garden conservatory; ECA. Less ligature safety compared with Crofton is better fit for dementia. But environment especially if a small number of en-suite could be added to that site.	The Crofton dementia option would also improve the current mixed environment with Ensuite; Large bathroom area with grab handles; More modern feel; Grab handles on corridors to reduce risk of falls; ECA. But there is not a lot of communal space; Narrower corridors than W19 – feels more like an acute setting; Limited access to outside space So, both options would improve quality compared to current model. Potential for small number of en-suite at Ward 19 for people with functional	The options appraisal process found the W19 environment to be the best option in terms of a dementia appropriate with More space for movement; Wider corridors; Courtyard space; Each ward has access to lounges, dining room, OT room, garden conservatory; ECA. Less ligature safety compared with Crofton is better fit for dementia. But environment especially if a small number of en-suite could be added to that site.

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
				needs should be explored if this option is taken forward.	
	Promotes a safe approach to service user care and/or helps to prevent harm to service users	A model with the best specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation. e.g., dedicated socialisation for people with similar needs.	IMPROVEMENT A specialist environment would improve safety of both functional and organic patient groups by removing interactions between the patient groups that could increase risk. Royal college states main problem with joint functional and dementia wards is that some patients with dementia tend to interfere and invade the personal space of other people - there is an history of examples of this. Specialist wards would remove or reduce the impact this has on patient experience. Specialist wards would also allow for staff to increase their specialist skills in dementia or functional illnesses, such as the CAMS suicide prevention training or dementia specific assessment skills. Previous training in similar areas has been undertaken but maintain the skill across the staff groups has proved difficult when ward staff have to care for a wide variety of patients. All wards would be co located with other mental health wards in all models. As well as being co-located (or nearby) to acute hospitals. This would allow for a quicker response from on call doctors and other staff in clinical emergencies. This is not currently the case as Poplars ward is not aligned to any trust or acute hospital site. In all models Beechdale ward would be a unit for functional mental health.		
				Minor Mitigation: Ligature light environment on Crofton - which work better for functional needs – adaptations would be required to existing site to make more dementia friendly.	
		Single Sex Accommodation	IMPROVEMENT We meet single sex accommodation guidelines in all options. This means that all bedrooms and sleeping areas are single sex. There are allocated bathrooms for each sex and a separate female lounge on mixed sex wards. There are mixed sex communal areas such as corridors and dining rooms on all mixed sex wards. It is recommended practice and preferable to have single sex wards.		
					IMPROVEMENT BUT MITIGATIONS REQUIRED Whilst this option would meet single sex accommodation guidelines, all wards for functional mental health would be mixed gender. This would limit how we are able to manage functional

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Due to symptoms of our patients conditions or other risks we may need to place a patient on a single sex ward. Currently we do not meet single sex accommodation guidelines on all wards.		patients where there is a clinical or safety concern around being on a mixed gender ward. Mitigations would depend on the nature of the clinical or safety issue, but this could include: • An increased level of observation, which would increase staffing costs and not promote a least restrictive approach. • Placing a patient with functional mental health needs on a dementia ward. Clinically this would not be the best practice as highlighted throughout this QIA. • Placing a patient in an out of area bed, which could lead to poorer clinical outcomes, increased travel time for carers and increased costs.
		Wards sizes in line with or close to best practice guidance of 15 beds	IMPROVEMENT Modelling (DH 2013) suggests 15 beds is an optimum size for clinical and therapeutic engagement. This option would have two 13 bed functional wards at Crofton, two 15 bed dementia wards at Ward 19 and one 16 bed functional ward at Beechdale.	IMPROVEMENT This option would have two 13 bed dementia wards at Crofton, two 15 bed functional wards at Ward 19 and one 16 bed functional ward at Beechdale.	MITIGATIONS REQUIRED This option would have two 15 bed dementia wards at ward 19, one 16 bed functional ward at Beechdale and would introduce a 22 bedded unit at Crofton ward, which is above the DoH recommendations of 15. There would need to be mitigations in place to minimise the impact this had

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
					on clinical and therapeutic engagements including increased staffing levels. Mitigations listed in relation to staffing levels and appropriate outcomes are also valid for this item (see below).
	Supports a risk management and safety systems	Environment and resourcing to minimise incidents and deliver improvements to clinical quality and safety whilst achieving standards.	IMPROVEMENT The current risk management of diagnostic groups differ, so the proposed model should help risk management strategies by separating the needs based groups and enabling more cohesive risk strategies to be designed. The clinical senate found in relation to options with a central dementia unit and service relocated from Poplars: ▪ Addresses the risks and issues associated with mixed wards. ▪ Mitigates the clinical risks attached to the current ways of working at The Poplars and on the Beechdale ward. Having separate dementia unit may be least restrictive for people.		
		Staffing to appropriate levels, in line with clinical need to support safety.	IMPROVEMENT It is an aspiration of a specialist model to improve demand for staffing across the models. There will be more than one registered nurse in all proposed staffing models. Currently there is a shortage of qualified members of staff, especially on a night shift where most of our wards have one registered nurse. This may also be having an impact on staff recruitment and retention. With new staffing models retention and recruitment could improve due to richer staffing models.		IMPROVEMENT BUT MITIGATIONS REQUIRED Mitigations could include: An increased level of observation, which would increase staffing costs and not promote a least restrictive approach. Admitting a functional patient to the Dales, Calderdale, when Fieldhead, Wakefield would be the usual (closest) admission ward. Which would increase travel time for carers. An ongoing review of the ward environment with considerations

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton									
					around staffing. Such as an increase in bank and agency staff, or providing cross cover from other wards. A review of support from Allied Health Professionals, with potential need for cross cover from other ward environments or extra recruitment, either in the short term (bank) or longer term.									
	Takes account of the duty of 'due regard'		Due regard has been fully considered (please refer to Equality Impact Assessment for detail).											
	Impact on partner organisations and any aspects of shared risk	Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	IMPROVEMENTS BUT MITIGATIONS REQUIRED Currently social care is aligned to services in each area, however there are still patients that are admitted and discharged from wards that are not in the same LA as their usual residence. Social workers will work across place boundaries in these cases and this practice is assisted by ward teams, including discharge coordinators. Conversations have been held with partner stakeholders through the development of the model, including LA and VCSE. There will be some impact on the third sector, but these will be limited. For example, advocacy will adapt to whatever structure is implemented. Local authorities have told us that they will be able to adapt their working practices to a specialist model though we did hear some concerns about travel impact for staff that are often working into the wards to facilitate discharge. This was raised as more of a concern for staff potentially from the west side of the Trust footprint if travelling to a dementia unit in Wakefield. Some issues raised with slight bed reduction – MY and Wakefield LA. Bed usage over the last 5 years does show that we can manage within the modelled numbers. The options 1A and 2 only reduce beds by 2 and the Trust has generally been managing within 72 through this period. Factoring in that over 40% of people with dementia have more than 1 stay and their LOS I nearly double does show that the system can manage within capacity. <table><tr><td></td><td>Functional (LOS)</td><td>Dementia (LOS)</td></tr><tr><td>1 stay</td><td>61</td><td>69</td></tr><tr><td>2 + stays</td><td>107</td><td>126</td></tr></table>				Functional (LOS)	Dementia (LOS)	1 stay	61	69	2 + stays	107	126
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DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Potential differences across options: There will be an impact on the need for YAS with the Dewsbury dementia option being on the site of Dewsbury District Hospital, meaning that dementia patients, who are more likely to fall could, in most instances receive general hospital care on the same site but we believe this impact is very small. We don't believe that there is likely to be any significant negative impact on the local general acute hospitals as a result of the options. A reduction in falls would hopefully reduce the numbers of general hospital admissions Note, there is also the informal arrangement with DDH geriatrician and ACP resource supporting physical health. There could be the opportunity to make more formal arrangements over time which would help support more people with physical needs without requiring a general hospital admission. The Fieldhead site is close to Pinderfields with nurse consultation – could explore linking in over time. The general hospitals have fed back that they have no plans for changes to their offer that will impact on an option. Mitigations could include: • An increased used in video conferencing for ward meetings to reduce travel impact. • Reorganising ward reviews so that they are held on different days for each geographic area. • A review of clinical pathways for patients admitted to general hospitals, to reduce the number of admissions to general hospitals.		
EFFECTIVE	Supports staff in understanding their role in improving the service user experience	Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care.	IMPROVEMENT The evidence gathered shows that the type of supervision, clinical intervention and workforce skills needed for the two groups may be quite different, evidenced in HEE older people's mental health competency framework which outlines different competencies for different specialisms. Psychology clinical leadership model, implemented on other specialist dementia wards, would be implemented on a specialist dementia ward. Staff will have a very well-defined remit of care in the proposed model. The various staff will have a clear understanding of expectations and appropriate / enhanced staffing levels should lead to a more sustainable service.		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Targeted approach to a singular client group rather than having to design activity for a number of clinical issues and activities. Current dilutes activity resource by having to do multiple things. Quote from the December 2022 event: <i>There would be real positives in separating the services out and having a specialist dementia ward and the staffing of it, you can get the correct staff training/skills in place.</i>		
	Reduces impact on variation in care provision.	Same care offer and pathway for people requiring an admission, ability to quickly stabilise people and facilitate timely discharge.	IMPROVEMENT Patients who need dementia beds will all access the same service, via a central unit. This will improve consistency of care. It is also envisioned that people who need functional mental health beds will have less ward stays as the clinical environment will be improved due to specialist wards. A set of standard operating procedures will be developed for functional and dementia beds to ensure consistency across the footprint to support enhancing quality of care and helping people recover. There is variation of offer in the current model at the Poplars due to the isolation – for example, staff cover issues.		
	Involves and engages service users, staff, public, people who use services and other stakeholders.	Stakeholders are involved in design and their input informs decision making.	IMPROVEMENT We have involved service users and staff in this model design, coproducing via a number of workshops and events (see business case for more evidence). We used the engagement to inform the options analysis criteria and options appraisal work. More information is in the business case. The formal consultation process has now taken place. We are listening and using feedback to inform the agreed model. We plan to continue to involve and engage, via the formal consultation process where will listen and use feedback to inform the agreed model.		
	Promotes positive outcomes of care.	Will deliver positive outcomes of care and allow for implementation of evidence-based practice.	IMPROVEMENT The clinical senate fed back: <i>It is well recognised that patients with organic disease benefit from a therapeutic environment dedicated solely to their needs. The same is true for patients with functional disease. National guidance and established practice in most centres has led to reconfiguration of services to achieve this. Maintaining mixed wards is thus not acceptable.</i>	IMPROVEMENT BUT WITH SOME MITIGATIONS REQUIRED: As other options but a 22 bedded ward could have potential impacts on clinical and therapeutic engagement. The impact of this on a 22 bedded ward is unknown but not thought to be optimal.	

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			The new model will provide a better environment through dedicated needs-based wards, tailored and appropriate therapeutic programmes. Specialist training will be provided to staff on the wards. Care would be more specialised to patients with functional/organic need to improve outcomes. This will be achieved not only by having a place that is specialised but also a group of staff, model of care and an environment that is specialised to organic/functional need.		Mitigations: - An increased level of observation, which would increase staffing costs and not promote a least restrictive approach. - Admitting a functional patient to the Dales, Calderdale, when Fieldhead, Wakefield would be the usual (closest) admission ward. Which would increase travel time for carers. - An ongoing review of the ward environment with considerations around staffing. Such as an increase in bank and agency staff, or providing cross cover from other wards. - A review of support from Allied Health Professionals, with potential need for cross cover from other ward environments or extra recruitment, either in the short term (bank) or longer term.
	Support services are aligned with pathways.	Clinical support staff teams and services, across pathways to work together to deliver safe, effective care	NEUTRAL IMPACT The model involves a shared bed base so will be bringing people together with shared objectives. A challenge will be in working across place boundaries so measures will need to be put in place to support staff working on a shared pathway across these geographic boundaries. For example, Kirklees Outreach Team (KOT) will need to reach more widely across wards. This will be covered in the standard operating procedures. The pathways in, out and through of the wards should improve as people will generally not be transferred from ward to ward as part of the pathway. Recent conversations with advocacy have confirmed that a revised model is likely to have a minimal impact on how they operate.		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			The reducing restrictive practice team, pharmacy and other centralised clinical support teams would also be better aligned to wards. Additional work and training needs for staff that involved with coordinating the patient journey will be needed. Time spent shadowing services across localities to better understand their pathways and build relationships will be needed for discharge coordinators and ward managers. Coordinating the ward review schedule to align with localities will also allow for a reduction in wasted time and duplication for teams in-reaching into the wards. Further consideration is needed for speciality services that will in reach into our wards, such as diabetes nurses or end of life care. There are cross boundary issues that exist in the current model that could be amplified by any of the proposed options.		
		Non-clinical support staff teams and services, across pathways to work together to deliver safe, effective care	IMPROVEMENT Alignment with other trust sights would improve access to estates, domestic, catering and other non clinical services. Improved access would provide better cover at busy times and improved support in an emergency (such as flooding, or supply chain issues).		
	Impact on eliminating inefficiency and waste by design	Patients received the right care at the right time. Pathway delays a minimised as much as possible.	IMPROVEMENT In this model, most patients will stay on the ward they're admitted to until ready to discharge. Currently around 30% of patients have more than one ward stay. Less ward stays will allow staff to plan for discharge as soon as is clinically indicated. Patients will also have access to appropriate therapies and interventions in a timelier manner, as separate organic and functional wards will have specialist staff who can focus solely on their needs. Will improve continuity of care as less need to hand over from ward to ward (also linked in patient safety). Opportunity to focus on improving pathways as part of implementation plan.		
CARING	Allows staff time to care for people.	Ward staff who have skills, knowledge and experience that	IMPROVEMENT Separate functional and dementia wards would mean that appropriate staffing based on people's needs.		

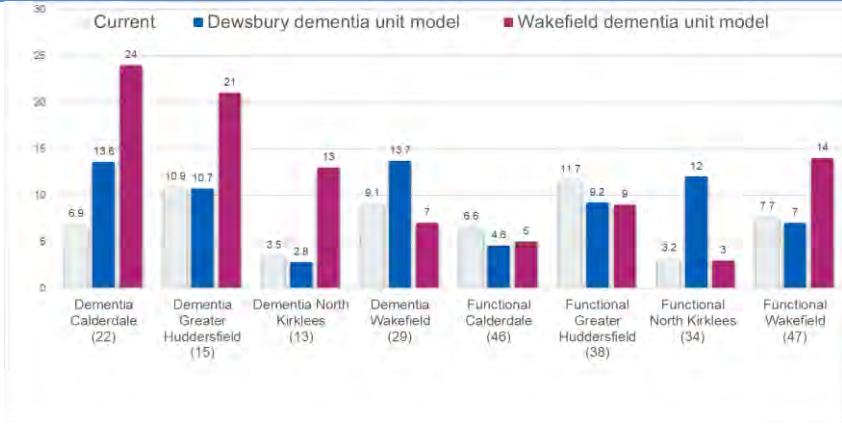
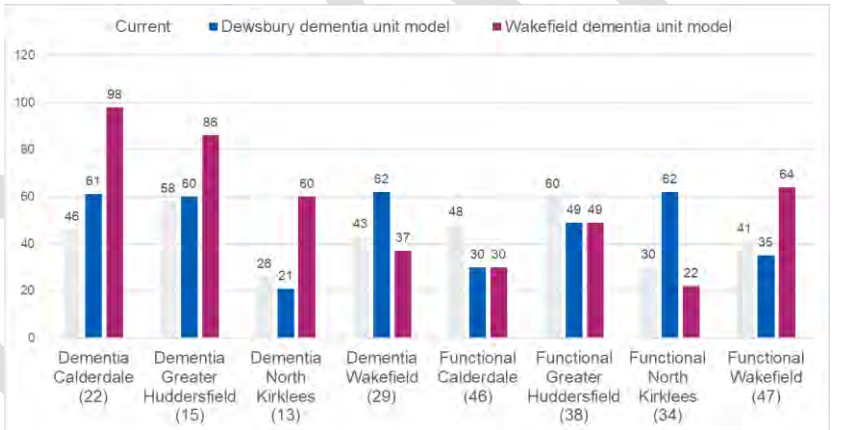
DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
		aligns to the patient specialism on their ward.	As covered above from the clinical senate: It is well recognised that patients with organic disease benefit from a therapeutic environment dedicated solely to their needs. The same is true for patients with functional disease. National guidance and established practice in most centres has led to reconfiguration of services to achieve this. Maintaining mixed wards is thus not acceptable. As cited in our evidence: Functional admissions will often have some accompanying psychosis and carry a high level of risk. Having separate specialist wards for people with functional needs allow the quality of therapies to be improved, enables staff to have the right skills on the wards. Having functional only units means that staff can dedicate their time to people with these needs. It means that they are not juggling needs of people with dementia who can often take a disproportionate amount of resource and support Separate need wards could lead to improvements in physical health care. A richer staffing model, with more overall staff and clinical specialists, like an extra ACP on the dementia unit, would give more time to care for some physical health issues and reduce transfers to acute hospitals.		
	Services that have been co-produced.	Improvement has been co-produced with patients and carers.	IMPROVEMENT Patients and carers will continue to give feedback through groups, friends and family feedback, complaints, compliments and serious incident reviews. This information is fed back to ward managers and quality leads. Involved service users and staff in this model design, coproducing via a number of workshops and events. We have used the feedback to inform the options development. The EIA focuses on the co-production that is required throughout service change, to reduce health inequalities and meet WRES and WDES standards. Feedback from consultation has been independently analysed and will be used to support deliberations and ensure the best option can be implemented.		
RESPON-SIVE	Improves the timeliness of any stage of the service user pathway.	Pathways that allow clinical interventions and discharge planning to happen as soon as clinically indicated.	IMPROVEMENT The dedicated function for each ward and improved therapeutic environment should reduce the time it takes to reduce levels of acuity, though work with local partners will also be required to ensure timely movement onto any further pathways. Feedback from partners is that working across place-based boundaries is not likely to have a negative impact on LOS, though at the December 2022 Event a potential impact of the changes was flagged and that it will be a challenge / barrier		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			to discharge especially for dementia patients who do not live in the local area. Each area has a way of doing things e.g. social services and will need to be streamlined. So, while a single streamlined ward stay does have the potential to improve the timeliness and reduce length of stays, we will need to ensure that the correct systems are put in place to support improved timeliness. A detailed operational plan will be established to support this.		
	Supports delivery of service performance and the principle of Right Care, Right Place, Right Time	Evidence that service users are in the most appropriate environment, receiving the most appropriate care and for the most appropriate length of time.	IMPROVEMENT The programme and changes will lead to various improvements in performance. Standard Operating Procedures should lead to more consistency in terms of service offered and could improve outcomes and Length of Stays, though there are some dependencies outside of this such as facilitated move on to the right accommodation. Programme team need to consider how they will measure service performance from a quality perspective and build this into operational planning element of the programme.		
		That we have the right capacity in the system to meet the demand required, factoring in projected population increases.	NEUTRAL IMPACT/MITIGATION REQUIRED See Appendix 1 for information on current bed use. There is also a potential capacity caps in both functional and organic beds as well as male and female beds. See Appendix 2 for a detailed breakdown of bed surge testing. This option has 30 dementia beds and 42 functional beds in the trust. Compared to 2040 demand modelling this option appears to have capacity for both organic and functional beds.	MITIGATION REQUIRED This option has 26 dementia beds and 46 functional beds in the trust. Compared to 2040 demand modelling this option may be leave slightly low capacity for organic beds but be a little over capacity for functional beds. This option will allow for significant gender flex on both functional and organic beds with functional beds being able to be up to a 15/31 male female split and dementia beds be a 8/18 split. Mitigations:	NEUTRAL IMPACT/MITIGATION REQUIRED This option has 30 dementia beds and 38 functional beds in the trust. Compared to 2040 demand modelling this option may have lower capacity for functional beds but has the right capacity for organic beds. There is a potential for difficulty with surges of male dementia bed demand. Potential mitigations have been discussed with estates colleagues and there will be options to add some limited gender flex in the dementia beds at ward 19.

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			There is a potential for difficulty with surges of male dementia bed demand. Potential mitigations have been discussed with estates colleagues and there will be options to add some limited gender flex in the dementia beds at ward 19. We don't feel this will have an impact on 12 hour A+E waits and out of area placements as older people's admissions tend to be by a more managed process and it is likely that we would find mitigations to caps in functional/organic male/female before admit patients in non SWYPT beds. Mitigations could include: • Exploring adding gender flexibility to the ward 19 estate. This has been discussed with Estates colleagues and this seems to be possible. • Admitting a male dementia patient to a female ward. This could mean increased levels of observation as certain ward areas would not be accessible to them, it could also mean a reduction female bed capacity to conform to single sex accommodation guidelines.	This may mean that a patient with dementia would have to be admitted to functional ward, which would not be clinically optimal.	Mitigations include: Exploring adding gender flexibility to the ward 19 estate. This has been discussed with Estates colleagues and this seems to be possible. Admitting a male dementia patient to a female ward. This could mean increased levels of observation as certain ward areas would not be accessible to them, it could also mean a reduction female bed capacity to conform to single sex accommodation guidelines.
	Supports fair access and the principles of the Equality	The service users, family and carers are able to access	MITIGATION REQUIRED Any centralisation of a service to create specialism is likely to involve additional travel impact for family and carers. It should not impact on the numbers of people requiring access to a bed.		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton																																				
	Delivery system	the service as needed.	The current model has challenges, for example, Poplars isn't very accessible at present, even for people within the Wakefield locality and is used by other parts of the Trust as part of the joined-up bed base. All sites in proposed models have good access to other acute sites. The findings from the consultation do show the people from more deprived areas and people who are more impacted by cost of living challenges are less likely to drive and therefore any visitor from a deprived area is more likely to be impacted by extra travel. A full Equality Impact Assessment and travel impact assessment is being undertaken which will consider any actions required to ensure the new system gives equal access to all. Impact of different options: The table below shows the public transport travel impact of people from the most deprived 20% areas (likely to impact on family and carers). The numbers in brackets show the average number of people per year from this population being admitted: <table><thead><tr><th>Location</th><th>Current</th><th>Dewsbury dementia unit model</th><th>Wakefield dementia unit model</th></tr></thead><tbody><tr><td>Dementia Calderdale (6)</td><td>32</td><td>69</td><td>96</td></tr><tr><td>Dementia Greater Huddersfield (<5)</td><td>52</td><td>50</td><td>76</td></tr><tr><td>Dementia North Kirklees (6)</td><td>18</td><td>16</td><td>56</td></tr><tr><td>Dementia Wakefield (9)</td><td>41</td><td>66</td><td>42</td></tr><tr><td>Functional Calderdale (12)</td><td>31</td><td>23</td><td>23</td></tr><tr><td>Functional Greater Huddersfield (8)</td><td>49</td><td>40</td><td>40</td></tr><tr><td>Functional North Kirklees (14)</td><td>24</td><td>60</td><td>22</td></tr><tr><td>Functional Wakefield (18)</td><td>40</td><td>36</td><td>64</td></tr></tbody></table> All options have a negative impact on people from the most deprived areas, with the Wakefield dementia option having a bigger impact on slightly more people. Mitigations will be similar for all options though the numbers of people likely to require mitigations will be higher for option 2 because of the additional travel impact.			Location	Current	Dewsbury dementia unit model	Wakefield dementia unit model	Dementia Calderdale (6)	32	69	96	Dementia Greater Huddersfield (<5)	52	50	76	Dementia North Kirklees (6)	18	16	56	Dementia Wakefield (9)	41	66	42	Functional Calderdale (12)	31	23	23	Functional Greater Huddersfield (8)	49	40	40	Functional North Kirklees (14)	24	60	22	Functional Wakefield (18)	40	36	64
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DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			Mitigations have been explored via a travel and transport working group. A key proposed mitigation involves the implementation of a visitor support pathway, which would be implemented for any of the options that are implemented. The pathway will consider impacts on people such as costs and people that might have difficulties with complex journeys, such as frail/elderly or people with disabilities. It will also include help and guidance for people on each ward. The travel and transport group have also developed a list of wider system improvements, for example, some of which require combined transport authority consideration. If some wider system improvements could be made it will reduce the numbers of people with travel challenges. With mitigations adopted the impact could become neutral in terms of travel because the people that require support to visit would receive it. More detailed mitigations are included in the travel and transport impact assessment.		
	Results in a more accessible service.	Service is accessible for families, carers and support services.	MITIGATION REQUIRED There will be some impact in terms of distance travelled to any specialist site for family and carers but the service users will be accessing better care and the model still delivers that care for all the people in the current model. Although current data shows 30 % of admissions are currently outside of people's locality meaning that there are challenges with access to the current model. Also challenges with accessibility to Poplars site, including staff challenges – for example medical cover. All sites in new function have good access to other acute sites. Travel impact analysis has been undertaken and options to support people who are impacted will be explored in a consultation before a final business case is completed. The table below shows the driving distance to each of the options (on average from each place):		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			 The table below shows the public transport time (on average). More detailed travel impact analysis is in the business case:  Mitigations will be similar for all options though the numbers of people likely to require mitigations will be higher for option 2 because of the additional travel impact. Mitigations have been explored via a travel and transport working group. A key proposed mitigation involves the implementation of a visitor support pathway, which would be implemented for any of the options that are implemented.		

DOMAIN	Assessment questions	Requirements	1a Dementia site Ward 19, 26 functional beds Crofton	2. Dementia site Crofton	1b Dementia site ward 19 with 22 functional beds at Crofton
			The pathway will consider impacts on people such as costs and people that might have difficulties with complex journeys, such as frail/elderly or people with disabilities. It will also include help and guidance for people on each ward. The travel and transport group have also developed a list of wider system improvements, for example, some of which require combined transport authority consideration. If some wider system improvements could be made it will reduce the numbers of people with travel challenges. With mitigations adopted the impact could become neutral in terms of travel because the people that require support to visit would receive it. More detailed mitigations are included in the travel and transport impact assessment.		
	Impact on choice agenda	Provide patient choice wherever possible	NEUTRAL IMPACT Choice is limited due to the nature of inpatient mental health. Choice would be offered where possible.		
WELL LED	Aligns with trust vision, values, and strategic objectives	Objectives of the project align with the trusts.	IMPROVEMENT The vision of the transformation sets out clear objectives that align to trust values – see project vision and objectives (shared with Service Users) in the business case. There is potential for improvement in the digital access to the wards,		
	Takes account of the needs of service users, staff, public and other stakeholders	The needs of stakeholders are reflected in the design of the service.	IMPROVEMENT A wide range of engagement has been held between 2015 and 2023 to ensure that these needs have been considered and factored into the design. Although much of the major public engagement was before 2020 a formal public consultation process will inform any future design of the options.		

Summary of mitigations:

The table below summarises that mitigations that would be required for each option.

Option	Theme	Mitigation
1a	SAFE: Environment	Potential for small number of en-suite at Ward 19 for people with dementia needs should be explored. General improvements as part of implementation plan to include: Ward 19 – space dedicated to more dementia specific activities such as reminiscence and sensory rooms. Signage and colour schemes review. Functional ward designed to maximise independence and engagement.
	SAFE: accessible services	Mitigations to include: • An increased used in video conferencing for ward meetings to reduce travel impact. • Reorganising ward reviews so that they are held on different days for each geographic area. • Designing new care pathways across specialist wards with social care colleagues (and other partners that could support pathways). • A review of clinical pathways for patients admitted to general hospitals, to reduce the number of admissions to general hospitals.
	RESPONSIVE: capacity to meet demand	Mitigations could include: • Targeted discharge planning and prioritisation to maintain capacity on both male and female wards for future admissions. • Internal processes to increase speed of clinical decision making and working alongside social services colleagues to reduce delays in allocation and assessment. • Admitting a male dementia patient to a female ward. This could mean increased levels of observation as certain ward areas would not be accessible to them, it could also mean a reduction female bed capacity to conform to single sex accommodation guidelines. • Exploring adding gender flexibility to the ward 19 estate – though limited rooms could be created with current layout.
	Equality: Access for carers	Mitigations have been explored via a travel and transport working group. A key proposed mitigation involves the implementation of a visitor support pathway, which would be implemented for any of the options that are implemented. The pathway will consider impacts on people such as costs and people that might have difficulties with complex journeys, such as frail/elderly or people with disabilities. It will also include help and guidance for people on each ward. The travel and transport group have also developed a list of wider system improvements, for example, some of which require combined transport authority consideration. If some wider system improvements could be made it will reduce the numbers of people with travel challenges. More detailed mitigations are included in the travel impact assessment.
1b	SAFE: Environment	Potential for small number of en-suite at Ward 19 for people with dementia needs should be explored if this option is taken forward.
	SAFE: Single sex accommodation	Mitigations would depend on the nature of the clinical or safety issue, but this could include:

Option	Theme	Mitigation
		- An increased level of observation, which would increase staffing costs and not promote a least restrictive approach. - Placing a patient with functional mental health needs on a dementia ward. Clinically this would not be the best practice as highlighted throughout this QIA. - Placing a patient in an out of area bed, which could lead to poorer clinical outcomes, increased travel time for carers and increased costs.
	SAFE: Ward sizes	There would need to be mitigations in place to minimise the impact this had on clinical and therapeutic engagements including increased staffing levels. Mitigations listed in relation to staffing levels and appropriate outcomes are also valid for this item (see below).
	SAFE: Staffing levels	Mitigations could include: An increased level of observation, which would increase staffing costs and not promote a least restrictive approach. Admitting a functional patient to the Dales, Calderdale, when Fieldhead, Wakefield would be the usual (closest) admission ward. Which would increase travel time for carers. An ongoing review of the ward environment with considerations around staffing. Such as an increase in bank and agency staff, or providing cross cover from other wards. A review of support from Allied Health Professionals, with potential need for cross cover from other ward environments or extra recruitment, either in the short term (bank) or longer term.
	SAFE: accessible services	Mitigations could include: - An increased used in video conferencing for ward meetings to reduce travel impact. - Reorganising ward reviews so that they are held on different days for each geographic area. - A review of clinical pathways for patients admitted to general hospitals, to reduce the number of admissions to general hospitals.
	EFFECTIVE: Positive outcomes	Mitigations: - An increased level of observation, which would increase staffing costs and not promote a least restrictive approach. - Admitting a functional patient to the Dales, Calderdale, when Fieldhead, Wakefield would be the usual (closest) admission ward. Which would increase travel time for carers. - An ongoing review of the ward environment with considerations around staffing. Such as an increase in bank and agency staff, or providing cross cover from other wards. - A review of support from Allied Health Professionals, with potential need for cross cover from other ward environments or extra recruitment, either in the short term (bank) or longer term
	RESPONSIVE: capacity to meet demand	Mitigations include: Exploring adding gender flexibility to the ward 19 estate. This has been discussed with Estates colleagues and this seems to be possible. Admitting a male dementia patient to a female ward. This could mean increased levels of observation as certain ward areas would not be accessible to them, it could also mean a reduction female bed capacity to conform to single sex accommodation guidelines.
	Equality: Access for carers	Mitigations have been explored via a travel and transport working group. A key proposed mitigation involves the implementation of a visitor support pathway, which would be implemented for any of the options that are implemented.

Option	Theme	Mitigation
		The pathway will consider impacts on people such as costs and people that might have difficulties with complex journeys, such as frail/elderly or people with disabilities. It will also include help and guidance for people on each ward. The travel and transport group have also developed a list of wider system improvements, for example, some of which require combined transport authority consideration. If some wider system improvements could be made it will reduce the numbers of people with travel challenges. More detailed mitigations are included in the travel impact assessment.
2	SAFE: Environment	Ligature light environment on Crofton - which work better for functional needs – adaptations would be required to existing site to make more dementia friendly. Potential for small number of en-suite at Ward 19 for people with functional needs should be explored if this option is taken forward.
	SAFE: accessible services	Mitigations could include: • An increased used in video conferencing for ward meetings to reduce travel impact. • Reorganising ward reviews so that they are held on different days for each geographic area. • A review of clinical pathways for patients admitted to general hospitals, to reduce the number of admissions to general hospitals.
	RESPONSIVE: capacity to meet demand	Mitigations: This may mean that a patient with dementia would have to be admitted to functional ward, which would not be clinically optimal.
	Equality: Access for carers	More people are likely to be impacted with option 2 than either option 1a or 1b. Mitigations have been explored via a travel and transport working group. A key proposed mitigation involves the implementation of a visitor support pathway, which would be implemented for any of the options that are implemented. The pathway will consider impacts on people such as costs and people that might have difficulties with complex journeys, such as frail/elderly or people with disabilities. It will also include help and guidance for people on each ward. The travel and transport group have also developed a list of wider system improvements, for example, some of which require combined transport authority consideration. If some wider system improvements could be made it will reduce the numbers of people with travel challenges. More detailed mitigations are included in the travel impact assessment.

Appendix 1

Our current ward beds allow us to have around 85% bed occupancy, which allows for surges in admissions and mostly avoids any delays in admission due to no beds being found in the trust. We have almost no out of area placements of our older adults inpatients.

Below is a table of our bed use over recent years:

Year	Total Available Beds	Occupied Bed Days Inc Leave	Occupancy Rate Inc Leave
2018	27010	22905	84.8%
2019	27010	23451	86.8%
2020	27084	22069	81.5%
2021	27010	24024	88.9%
2022	27010	23148	85.7%

This is split across condition and gender as follows:

	Female	Male
functional	59%	41%
organic	46%	54%
Grand Total	55%	45%

Populations projections from POPPI combines with the age profile of our patients allows us to project how many beds we may need in the future. The table below shows an increase of around 100 beds over the next 17 years, it is to be noted that previous population increases have not been realised in bed use. This may be because of improvements in care and support for mental health and improving lifestyle factors.

Condition	18-21	2025	2030	2035	2040
Dementia	93.2	105	112	125	131
Functional	202.6	217	239	259	267
Total	296	322	351	384	398

Demand modelling shows that we can expect to have the following occupied bed days (excluding leave) over the coming years. With a presumed reduction in length of stay and an increase in local population.

	2025	2030	2035	2040
Functional	32.7	36	39	40.2
Organic	23	27.4	27.4	28.7
Total	55.7	66.4	66.4	68.9

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Appendix 2

Surge Testing

The table below shows the day-by-day bed use, by functional and dementia/organic needs of people from Calderdale, Kirklees and Wakefield from 2018 to 2023, including leave:

Overall functional bed use:



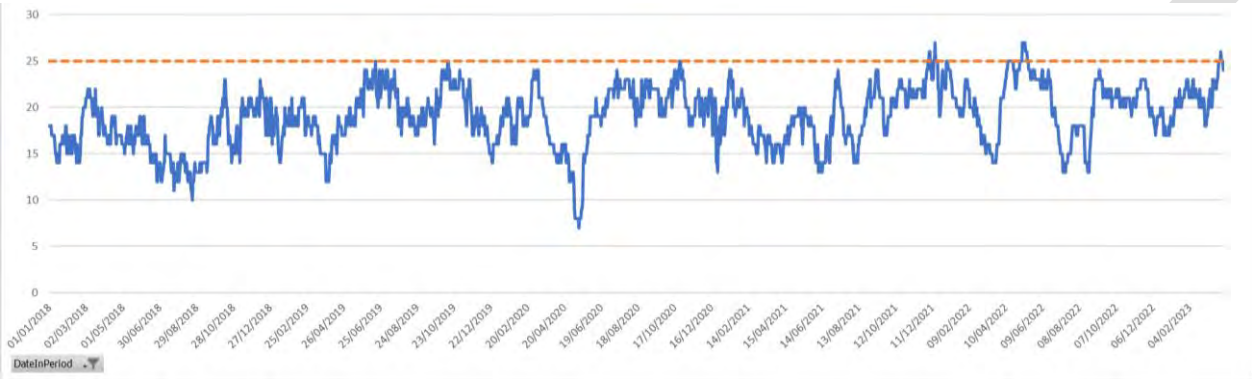
This shows that a model with around 40 beds overall should be enough for the vast majority of time.

The table below shows the overall dementia bed use:

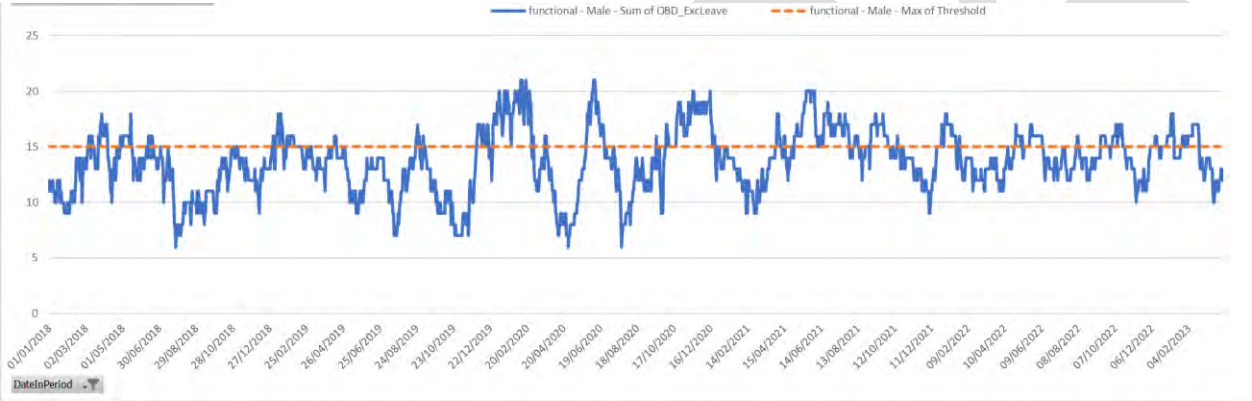


It shows that 30 beds is enough for the vast majority of time over the most recent 4 years, though there were several instances in 2018 and early 2019 where more than 30 beds were needed.

Functional female daily demand:



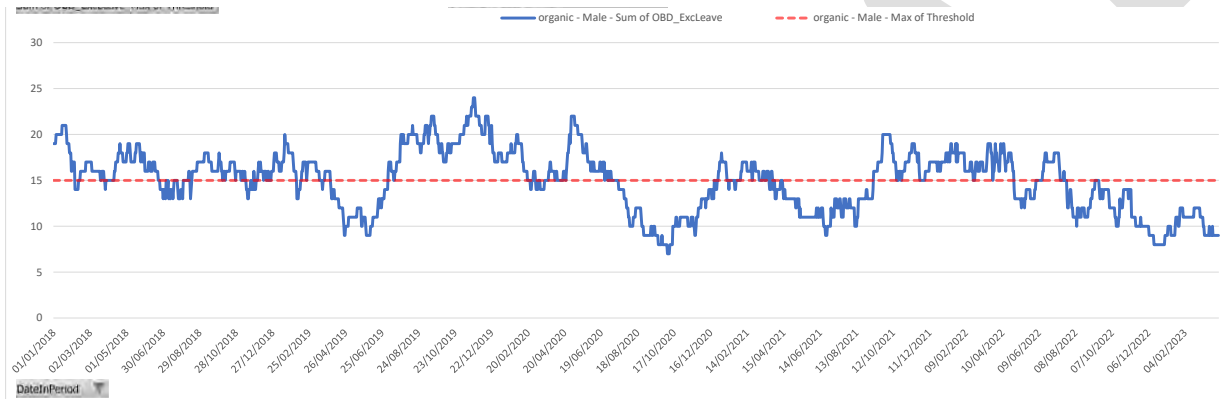
Functional male daily demand



Dementia Female:



Dementia Male:



Gender use:

- **Functional:** Whilst 40 beds is enough to meet overall demand for functional beds there appears to be an upper ceiling of around 25 female beds and 20 male beds in use.
- **Dementia:** Whilst 30 beds is enough to meet overall demand male use has often been above 15 but only rarely above 20. Female bed use has mostly been within 15 but has occasionally gone above.

Travel and transport – detailed impact assessment

September 2024

Updated post consultation

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1 Introduction

This travel and transport impact assessment includes detail of the travel and transport impact of the proposed OPS Inpatient Transformation options, including detailed methodology, additional data and place travel summary.

It includes updated findings from the public consultation held between 5 January and 29 March 2024.

From the outset of the programme, one of the major themes we have heard from across a range of stakeholders is the impact on travel of any potential changes.

A key consideration of any potential change is the impact on elderly family and carers who will play a key part in supporting the service user when they're admitted to a ward but might struggle to easily access transport to allow them to visit.

As such, the programme has undertaken a detailed transport analysis to understand what the likely impact is on people from different parts of the Trust footprint that may need to travel to visit a family member or a loved one.

Detailed travel impact analysis has been undertaken on the shortlisted options below. The table here shows both the option number proposed to be used in consultation and the option number that it was on the long-list:

New Option Reference	Description
1 a)	A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield with additional functional bed capacity at the Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 wards across the 26 beds.
1 b)	A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward.
2	A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees. This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beechdale would be functional wards.

High level analysis has been conducted for the other, discounted, options or close proxies of them and this can be found in the previous version, which formed part of the pre-consultation business case.

2 Travel Impact Methodology

The following methodology was used to consider the travel impact:

Location:

- Based on a person's home address prior to admission
- Assumes that supporting family members/carers live in the same locality.
- Uses discharge ward

Identification of those with functional and dementia/organic needs is based on diagnosis codes.

Travel time, distance and public transport:

- Uses origin and destination postcodes calculated using online maps/tools
- Estimates are based on one point in time and do not account for volume of traffic at various times in the day.
- Based on all stays over a 4-year period (from 2018/19 – 2021/22).

The following assumptions are made for the options where the central specialist dementia unit is at Ward 19, Dewsbury Hospital:

- All dementia admissions would be to Dewsbury Hospital
- Calderdale and Greater Huddersfield functional/other admissions go to the Beechdale Ward, Calderdale Hospital
- Wakefield and North Kirklees functional/other admissions go to the Crofton Ward, Fieldhead Hospital, Wakefield

The following assumptions are made for the option where the Central specialist dementia unit is at Crofton Ward, Fieldhead Hospital, Wakefield:

- All dementia admissions would be to Crofton Ward, Fieldhead Hospital, Wakefield
- Calderdale and Greater Huddersfield functional/other admissions go to the Beechdale Ward, Calderdale Hospital
- Wakefield and North Kirklees functional/other admissions go to Ward 19, Dewsbury Hospital

3 Travel impact – findings

The review of data shows that many people are already admitted outside of their locality. The table below shows that around 300 people were admitted outside of their home locality between 2018 and 2021, which accounts for just under 30% of all admissions:

	Grand Total
Calderdale	171
Kirklees	58
Wakefield	72
Grand Total	301

The data also shows that approximately 30% of people also have more than 1 ward stay as part of their spell (data from 2017/18 onwards):

Number of stays	1	2+	Total
functional	954	242	1196
dementia/organic	321	259	580
Grand Total	1275	501	1776

Many people have stays outside of their locality and many also have more than one ward stay in the current model. However, changing approaches to deliver a specialist model will have a further impact.

Many people move wards and because of this it is more challenging to analyse the impact and compare the travel implications of the multiple ward stays to a future model where we expect people to have just one ward stay.

A Power BI tool has been developed to support analysis of the data. The tool does allow analysis to be undertaken that focusses on different domains such as deprivation and ethnicity.

The travel impact analysis tool considers 970 inpatient spells, of which there were 1305 ward stays.

Whilst the tool has both ward stays and spells, this travel analysis focusses predominantly on the spell and the impact based on discharge ward. All analysis is based on the average numbers per year across the 4 financial years of data.

The travel impact analysis focusses predominantly on:

- Driving distances
- Driving times
- Public transport times

With all of the options for proposed changes, there would be a positive impact for some people. This is because 30% of admissions to older people's beds are outside of the home locality and, for example, people with functional needs in Calderdale would be very likely to be admitted to their local ward in a new model.

However, more family and carers will have further to travel if any specialist model is implemented. The negative impact is greater in the options where the dementia unit is in Wakefield compared to Dewsbury.

4 Analysis of ward stays and inpatient spells

The table below shows the average numbers of people per year in the analysis. The number of spells shows how many unique inpatient spells there were, whilst ward stays considers the total number of ward stays across these spells.

Need	Place and need	Spells	Ward Stays
Dementia	Calderdale	22	32
Dementia	Greater Huddersfield	15	16
Dementia	North Kirklees	13	15
Dementia	Wakefield	29	54

Functional	Calderdale	46	63
Functional	Greater Huddersfield	38	44
Functional	North Kirklees	34	40
Functional	Wakefield	47	62

The data below shows the number of spells and wards stays per year of the people from the 20% most deprived areas:

Need	Place and need	Spells	Ward Stays
Dementia	Calderdale	6	8
Dementia	Greater Huddersfield	<5	<5
Dementia	North Kirklees	6	7
Dementia	Wakefield	9	15
Functional	Calderdale	12	17
Functional	Greater Huddersfield	8	10
Functional	North Kirklees	14	16
Functional	Wakefield	18	24

There are very few spells for people with a BAME background per year. There are 5 functional spells per year on average from Greater Huddersfield. There are very few dementia stays of people from a BAME background across the whole system.

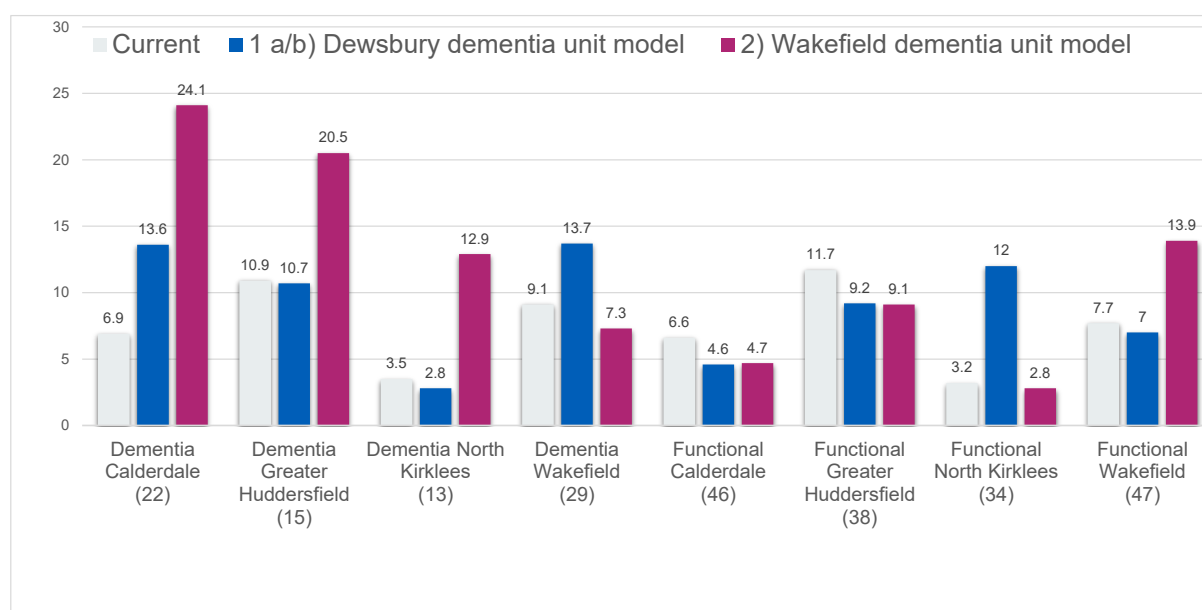
To note, where Wakefield is referenced, we mean the whole Wakefield district.

5 Impact on the overall population

The charts below show the average journey distances and times for travel by car to the current and proposed models.

Driving Distance:

The following chart shows the average driving distance based on inpatient spells (discharge ward): with the number of people impacted per in year brackets:



Summary:

If the dementia unit were in Dewsbury:

- The longest average travel distances would be people with dementia from Wakefield (29 people per year) and Calderdale (22 people) with 14-mile average journeys respectively.
- Functional admissions from North Kirklees (34 people) would also be an average of over 10 miles from home, as would dementia admissions from North Kirklees (13 people), though this would be a short average distance than the current model.

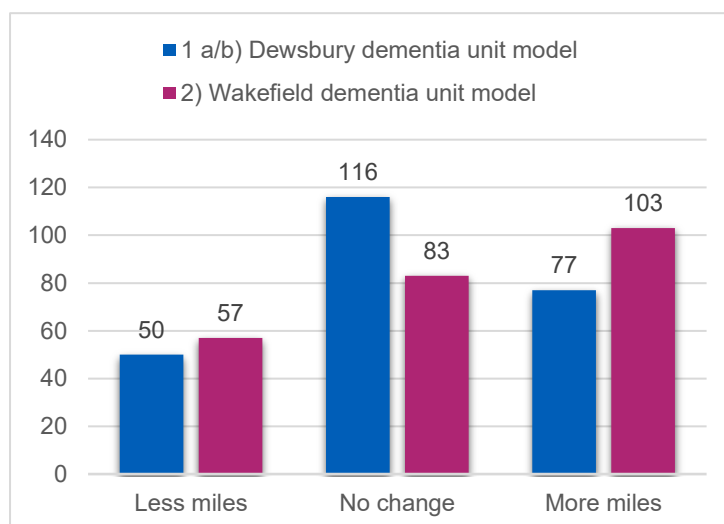
If the Dementia unit were in Wakefield:

- The longest average travel distances would be people with dementia from Calderdale (22 people per year) and Greater Huddersfield (15 people) with 24- and 21-mile average journeys respectively.
- 46 Functional admissions from Wakefield would have an average 14-mile journey from their home and 13 dementia admissions from North Kirklees would average 13 miles.

In both models some people would have less distance to travel. Most notably, people with functional needs from Calderdale who are often admitted outside of the place.

5.1 Driving distance – mean change per year:

The chart below shows the numbers of people that would be positively or negatively impacted in terms of driving distance of each option (based on discharge ward):



Considering individual stays and based on the discharge ward, in a model with a dementia unit in Dewsbury:

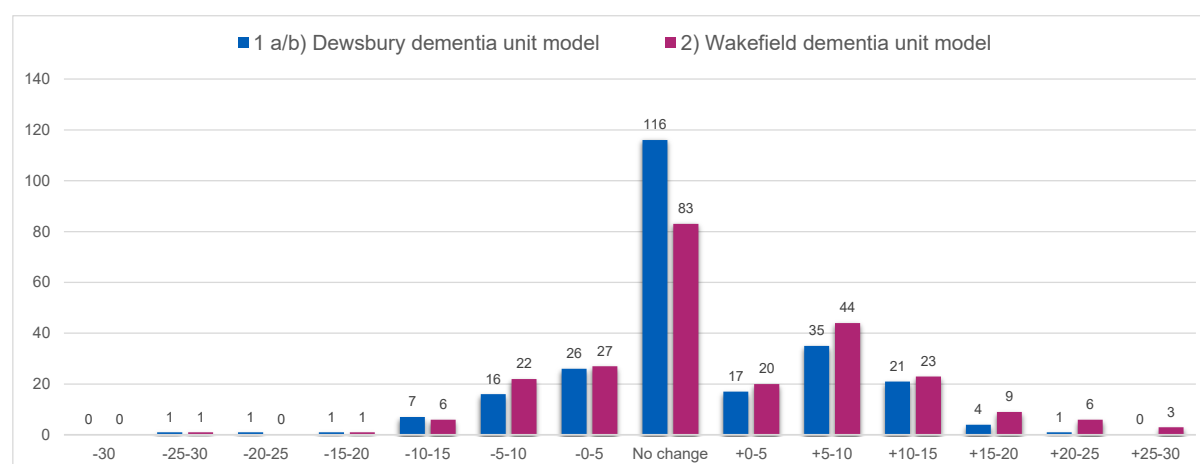
- 50 people would be closer home when discharged
- 116 people would be in the same place

- 77 would be discharged from a ward further away from their home.

Considering individual stays and based on the discharge ward, in a model with a dementia unit in Wakefield:

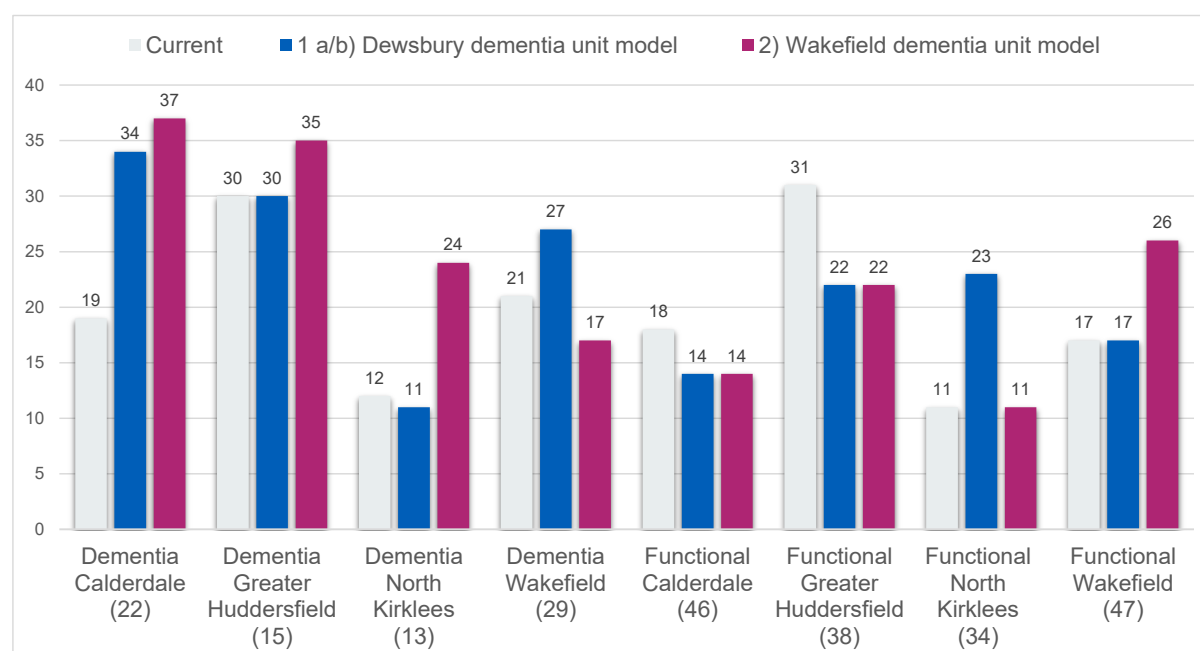
- 57 people would be closer home when discharged
- 83 people would be in the same place
- 103 would be discharged from a ward further away from their home.

Driving distance, grouped into miles:



5.2 Driving Travel Time Analysis

The table below shows the average driving time for each option (using discharge ward):



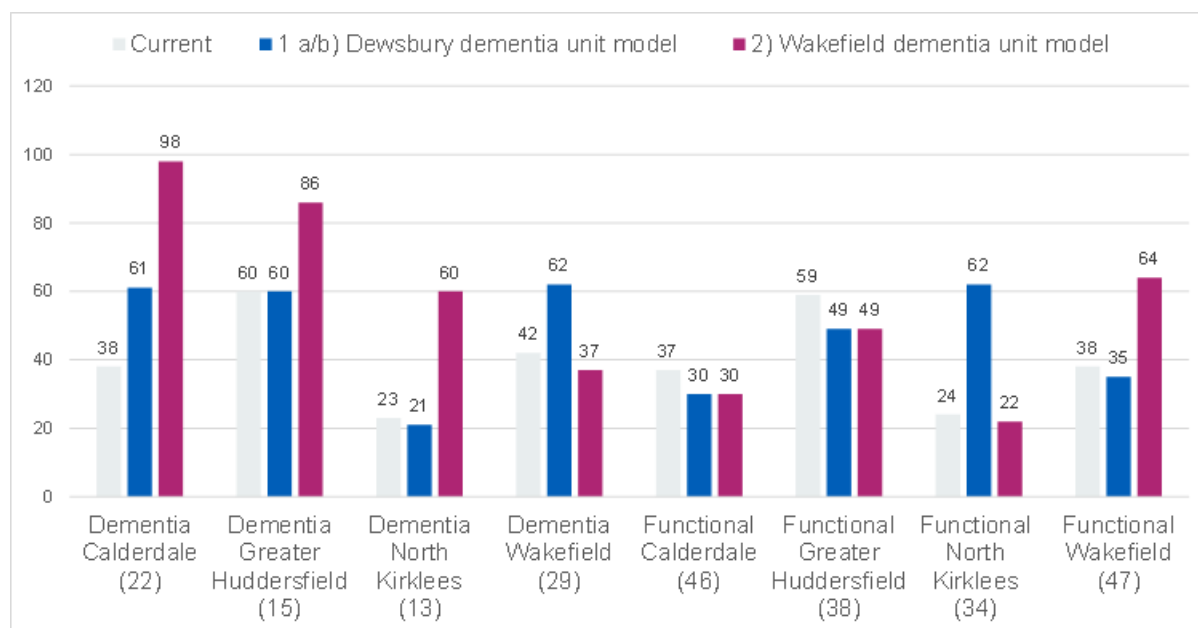
Whilst the travel distance analysis showed some big gaps between options, in particular if people from Calderdale and Greater Huddersfield had to travel to Wakefield for dementia care, the gap narrows in terms of driving times compared to driving distance. This is due to

the motorway and dual carriageway access to Wakefield which isn't available when accessing Dewsbury from the north or west.

5.3 Public Transport Times:

It is important to understand the impact from a public transport perspective, especially for family and carers who might need to use this service.

The data below shows the public transport times based on the proposed models, with the numbers of people impacted per year in brackets:



In both models there are 4 localities where the average public transport journey would be 1 hour plus.

The Wakefield dementia model would mean that people from Greater Huddersfield (15 people per year) and Calderdale (22 people) would be 86 and 98 minutes journey away respectively.

Average public transport journeys of people in the current model take 60 minutes for functional or organic admissions from Greater Huddersfield.

Places with long (around 1 hour or more) average public transport journeys in the current or future model:

Need	Place	Current (time mins)	1 a/b) Dementia unit in Dewsbury (time mins)	2) Dementia unit in Wakefield (time mins)
Dementia	Calderdale	38	61	98
Dementia	Greater Hudds	60	60	86
Dementia	North Kirklees	23	21	60
Dementia	Wakefield	42	62	37
Functional	Calderdale	37	30	30
Functional	Greater Hudds	59	49	49
Functional	North Kirklees	24	62	22
Functional	Wakefield	38	35	64

5.4 Some journeys from different places:

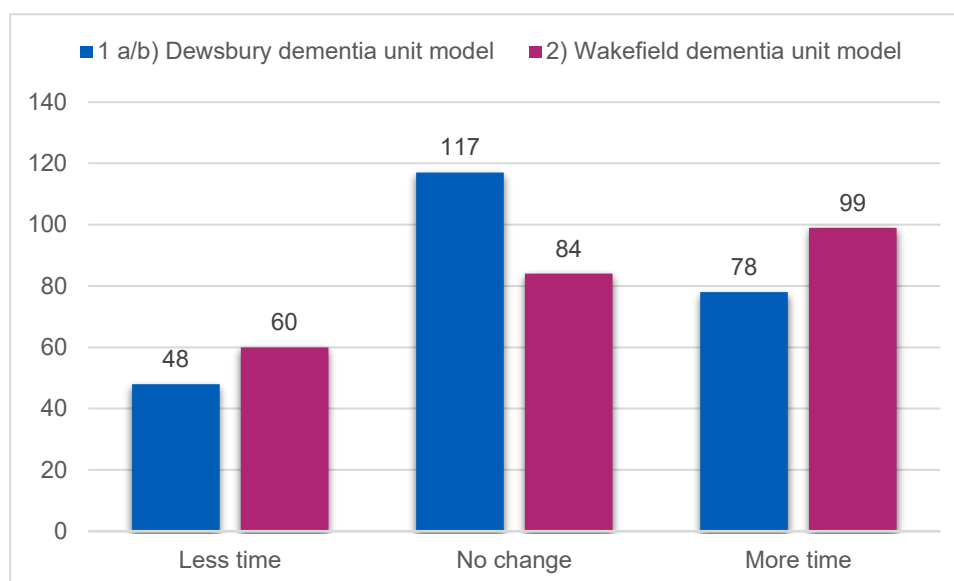
The following gives more of an indication of what some of the journey may be like (taken from WY Metro website journey planner in 2022 to arrive at destination at 1630):

	Day of travel	Dewsbury Hospital	Pinderfields Hospital (sited near Fieldhead)	Calderdale Royal
Kirklees Huddersfield	Weekdays	33 minutes via 1 train and 1 bus	74 minutes via 1 train & 2 buses	38 minutes via 1 bus
	Sundays	43 minutes via 1 train and 1 bus	94 minutes via 2 buses	36 minutes via 1 bus
Holmfirth	Weekdays	75 minutes via 2 buses, 1 train & 2 x 5 minute walks	87 minutes via 2 buses	80 minutes via 2 buses
	Sundays	82 minutes via 2 buses, 1 train & 2 x 5 minute walks	80 minutes via 2 buses	86 minutes via 2 buses
Slaithwaite train station	Weekdays	45 minutes via 2 trains, 1 bus & 1 x 5 minute walk	115 minutes via 3 trains & 1 bus	54 minutes via 1 train & 1 bus
	Sundays	66 minutes as above	115 minutes via 1 train & 1 bus	60 minutes via 1 train & 1 bus
Denby Dale	Weekdays	86 via 2 trains, 1 bus and 2 x 5 minute walks	66 minutes via 2 buses	66 minutes via 1 train & 1 bus
	Sundays	94 minutes as above	61 minutes via 2 buses	63 minutes via 1 train & 1 bus
Bradley	Weekdays	57 minutes via 2 or 3 buses & 5 minute walk	93 minutes via 3 buses	53 minutes via 2 buses
	Sundays	60 minutes as above	96 minutes via 3 buses, 1 train & 2 walks x 10 minutes	60 minutes via 2 buses
Mirfield	Weekdays	29 minutes via 2 buses & 1 x 5 minute walk	65 minutes via 1 train & 2 buses	51 minutes via 1 train & 1 bus
	Sundays	26 minutes as above	42 minutes via 1 train & 1 bus	48 minutes via 1 train & 1 bus
Cleckheaton	Weekdays	30 minutes via 1 or 2 buses & 1 x 7 or 17 minute walk	69 minutes via 2 buses	59 minutes via 1 train & 2 buses
	Sundays	25 minutes via 1 or 2 buses & 1 x 7 minute walk	75 minutes via 2 buses	50 minutes via 1 train & 2 buses
Birstall	Weekdays	62 minutes via 2 buses	66 minutes via 3 buses	85 minutes via 1 train & 2 buses
	Sundays	64 minutes as above	67 minutes via 3 buses	82 minutes via 1 train & 2 buses
Heckmondwike	Weekdays	14 minutes via 1 or 2 buses	50 minutes via 2 buses	81 minutes via 2 buses
	Sundays	10 minutes as above	58 minutes via 2 buses	59 minutes via 2 buses
Calderdale Halifax bus or train station	Weekdays	61 minutes via 1 train & 1 bus (from Cleckheaton)	86 minutes via 1 train & 2 buses	19 minutes via 1 bus
	Sundays	76 minutes via 2 or 3 buses (via Bradford) or via 2 trains (via Mirfield) & 1 bus	64 minutes via 1 train & 1 bus	13 minutes via 1 bus

	Day of travel	Dewsbury Hospital	Pinderfields Hospital (sited near Fieldhead)	Calderdale Royal
Hebden Bridge	Weekdays	54 minutes via 1 train & 1 bus (via Bradford)	97 minutes via 2 trains & 1 bus	36 minutes via 1 train & 1 bus
	Sundays	85 minutes via 1 train & 1 bus	107 minutes via 2 trains & 1 bus	30 minutes via 1 train & 1 bus
Elland	Weekdays	68 minutes via 2 buses & 1 train (via Huddersfield)	106 minutes via 2 trains & 2 buses	18 minutes via 1 bus
	Sundays	87 minutes via 2 buses (via Huddersfield) & 1 train	90 minutes via 2 trains & 2 buses	13 minutes via 1 bus
Brighouse	Weekdays	36 minutes via 1 train & 1 bus	72 minutes via 1 train & 2 buses	37 minutes via 1 bus
	Sundays	47 minutes via 2 trains & 1 bus	49 minutes via 1 train & 1 bus	35 minutes via 1 bus
Wakefield	Weekdays	55 minutes via 1 bus	14 minutes via 1 bus	89 minutes via 2 trains & 1 bus
	Sundays	42 - 55 minutes via 1 bus	16 minutes via 1 bus	90 minutes via 2 trains & 1 bus
Ossett	Weekdays	45 minutes via 2 buses	42 minutes via 2 buses	83 minutes via 2 buses & 1 train
	Sundays	45 minutes via 2 buses	46 minutes via 2 buses	103 minutes via 3 buses
Horbury	Weekdays	50 minutes via 2 buses	33 minutes via 2 buses	104 minutes via 2 trains
	Sundays	50 minutes via 2 buses	38 minutes via 2 buses	86 minutes via 2 buses
Castleford	Weekdays	73 minutes via 2 trains (via Leeds) & 1 bus	37 minutes via 1 bus	82 minutes via 2 trains & 1 bus
	Sundays	88 minutes via 3 buses (via Wakefield)	56 minutes via 2 buses	99 minutes via 2 trains
Hemsworth	Weekdays	91 minutes via 2 buses (via Wakefield)	50 minutes via 2 buses	114 minutes via 2 trains & 2 buses
	Sundays	90 minutes via 2 buses & 1 train (via Wakefield)	51 minutes via 2 buses	119 minutes via 2 trains & 2 buses
Pontefract	Weekdays	64 minutes via 1 bus	37 minutes via 1 bus	111 minutes via 2 trains & 2 buses
	Sundays	64 minutes via 1 bus	37 minutes via 1 bus	136 minutes via 2 trains & 2 buses

Public transport – summary of numbers of people that would have shorter or longer public transport journey:

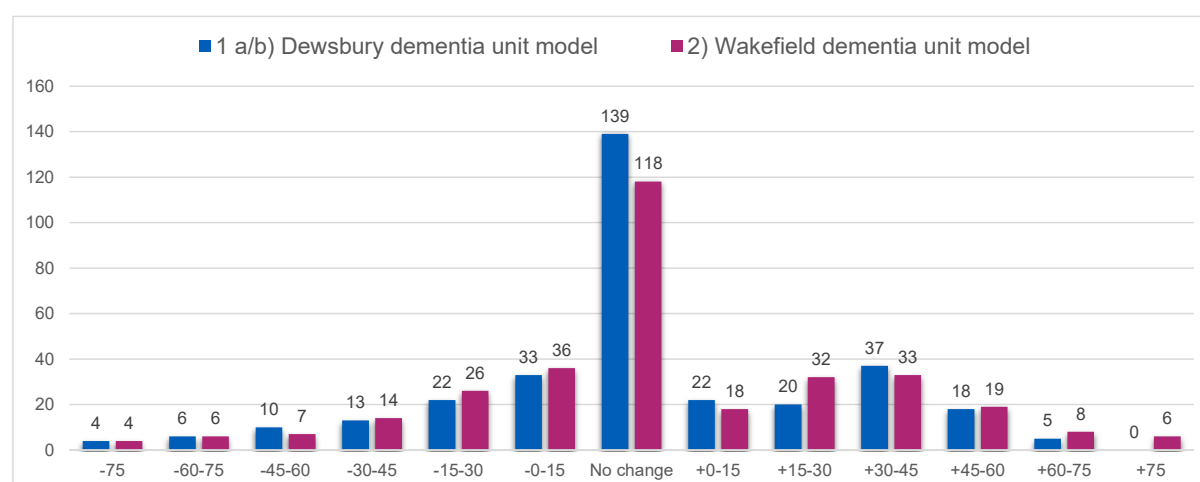
Discharge ward:



Overall, there would be an average of around 80 people per year that would have a longer journey with a dementia unit being in Dewsbury whilst around 100 people per year would have a longer journey to Wakefield.

With both models, some people would have a shorter journey, with the Wakefield dementia unit benefiting slightly more people (12 per year).

Public transport changes grouped:

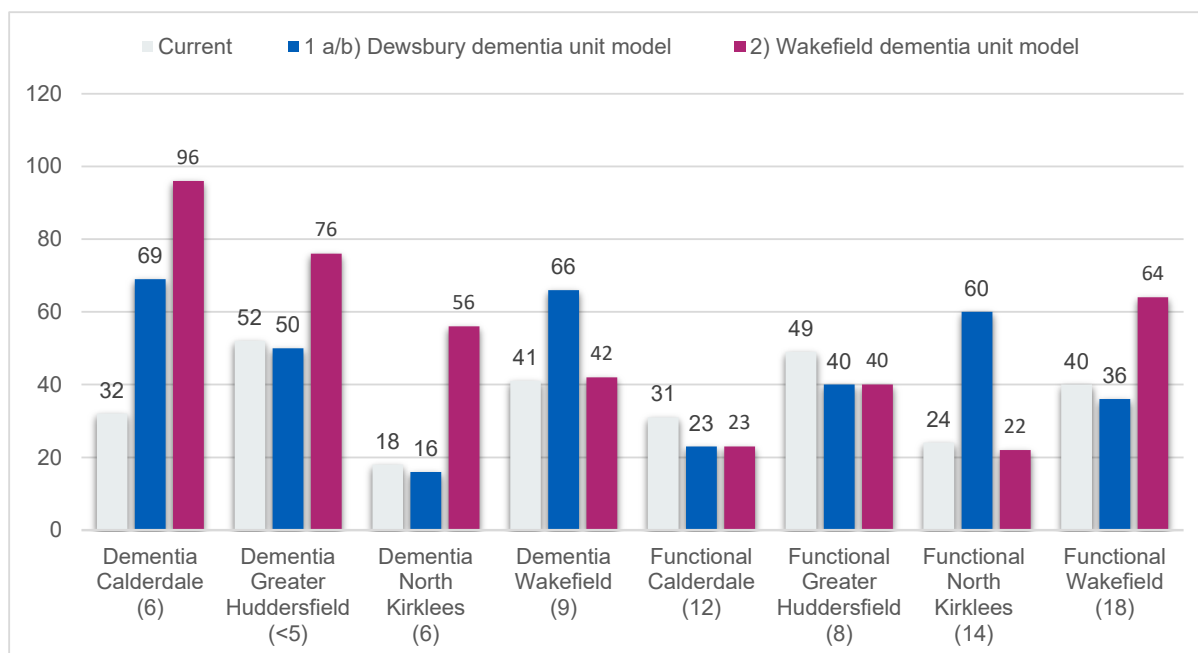


This shows the time difference between the current and future models and there are some journeys that would be over 1 hour more than the current journey. Around 14 people per year would have an extra hour or more to travel in the Wakefield dementia unit model (6 of these being 75 minutes +), whilst 4 people per year would need to travel an hour extra to access the model where Dewsbury has the dementia unit.

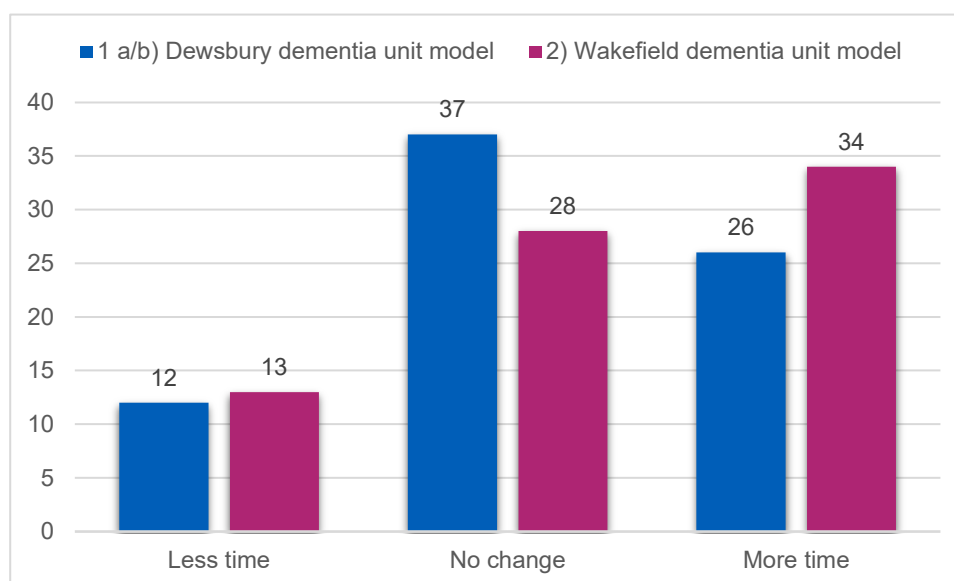
5.5 Analysis of impact on the 20% most deprived areas:

The following focusses specifically on the public transport impact of people in the most deprived areas, who are more likely to require use of this mode of transport.

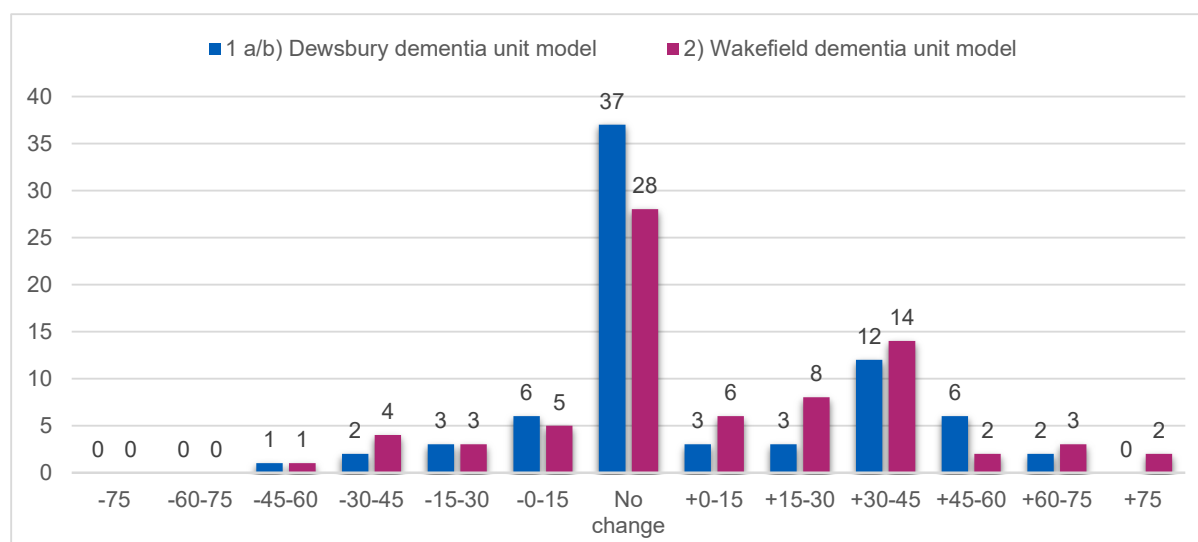
Inpatient spell (using discharge ward):



Public transport – numbers of people that are positively or negatively impacted per year (based on discharge ward):



Public transport times grouped:



When considering the data in terms of the 20% most deprived areas, it shows a similar impact in terms of time required to travel, proportion of people that travel less or more, and the profile of travel time grouped in comparison to the whole population, though the numbers are smaller.

Considerations:

- The numbers are small but not inconsiderable and we know the negative impact could be high on the small numbers of people that struggle to visit their loved ones.
- If the option chosen was the dementia unit in Wakefield a number of people would have significant public transport journeys to visit their loved ones, including journeys around 100 minutes from Calderdale to Wakefield and also very considerable times from Greater Huddersfield, North Kirklees, plus long Wakefield for functional admissions.
- Whilst not as high travel times there are still several significant typical (one hour plus) journeys for people travelling to a model with a dementia unit in Dewsbury, including people from Calderdale, Great Huddersfield and Wakefield, plus functional admissions from North Kirklees.
- There are clearly some considerable public transport times in the current model, regardless of any change. Greater Huddersfield does not have an inpatient facility so people from this area would have a long journey and factoring in the 30% of people are admitted outside of their locality.

5.6 Access for BAME populations

We know also that people from black and minority ethnic groups are more likely to be from deprived areas. However, there are very few admissions and especially low numbers of dementia admissions for people from a BAME background.

6 Public Transport costs

There are options available for people using public transport (Metro travel) within West Yorkshire. Currently (as of June 2024), people do not have to pay more than £2 for an adult single ticket or £4.50 for a Metro Card (MCard) day saver ticket for travel on any bus across West Yorkshire valid anytime. A weekender ticket costs £8.50 which can be bought on the

bus for unlimited bus travel from 6pm on Fridays until midnight on Sundays on any bus, anywhere in West Yorkshire.

People travelling by bus and train would pay £10.60 off-peak and £15.60 peak for a bus and rail day saver ticket across the West Yorkshire area.

Off-Peak Countywide Bus and Train tickets are valid on any bus from 09:30 and on any train from 09:30 to 16:01, and from 18:30, Monday to Friday, and all day at weekends and public holidays. A daily ticket is £9.50 or £4.80 (concessionary)

People who have reached the state pension age and are a permanent resident of West Yorkshire will qualify for a Senior Pass. A Senior Pass provides:

- Free, off-peak bus travel throughout England. Off-peak is after 9.30am Monday to Friday, and all day at weekends and Bank Holidays.
- Half-fare, off-peak train travel throughout West Yorkshire, for West Yorkshire residents. Off-peak is Monday to Friday after 09:30 until 16:00, then after 18:30. All day on weekends & public holidays. Anyone travelling by train during the weekday evening peak - 16:01 to 18:29 - will need to buy an Anytime Day Single or Anytime Day Return ticket. The half-fare only applies to travel within West Yorkshire. If part of the journey falls outside of West Yorkshire, full fare will be paid for that part of the journey.

As well as this, there is currently a **free public transport option** that could support part of our population with a bus that runs across the Mid Yorkshire Hospital footprint, from Pontefract to Pinderfields in Wakefield and Dewsbury Hospital.

Taxi fares

Travelling by taxi may be another option for some people if they are unable to use public transport or they are unable to drive. Some high-level analysis has been carried out on the cost of taxi journeys. See below for an example of taxi costs, from June 2023 (link: [Ossett to Dewsbury District Hospital \(rome2rio.com\)](https://www.rome2rio.com)):

From	Dewsbury Hospital	Fieldhead Hospital	Calderdale Royal
Ossett	£10 - £13	£14 - £17	£40 - £55
Hebden Bridge	£45 - £55	£70 - £90	£22 - £27
Huddersfield	£20 - £24	£45 - £60	£18 - £22
Pontefract	£35 - £45	£24 - £29	£75 - £95

7 Voluntary and Community Sector (VCSE) travel support

The VCSE can also offer an alternative transport option for people who have trouble in accessing other forms of transport to visit their loved one in hospital.

We do know that local transport offers do exist in place, often delivered through VCSE organisation but often these might be place based and for example, focussed on patients themselves rather than family or carers that need to visit.

Age UK [Transport services for the elderly and disabled | Age UK](https://www.ageuk.org.uk) and Calderdale Community Transport [Home \(ctcalderdale.co.uk\)](https://www.ctcalderdale.co.uk) offer older people support to arrange transport with a

local provider, such as Dial-a-Bus or the [Royal Voluntary Service](#) however, there may be a small charge to cover the cost of petrol.

The Trust does also currently work with service users and carers/families to find and access appropriate transport support, including supporting them to find public transport options and transport support through the VCSE sector.

8 Use of technology

There is a chat pad offer on every ward in the Trust which uses ZOOM and has been rolled out as a result of covid-19. People staying on the wards can ask to use the system to connect with loved ones, family, friends and carers. It can also be used to contact an advocate.

9 Parking charges

The table below summarises the parking charges of each site (as of December 2022)

Location	Hospital	Costs
Calderdale	The Dales Calderdale Royal Hospital	30 mins (free) Up to 2hrs (£3.00) Up to 4hrs (£5.00) Up to 6hrs (£6.00) Up to 24hrs (£8.00)
Kirklees	Priestley Unit (Dewsbury and District Hospital)	Less than 20 mins (free) Up to 1hr (£2.00) 1-2hrs (£2.80) 2-4hrs (£5.00) 4- 24hrs (£6.90)
Wakefield	Fieldhead Hospital The Poplars	Free

10 Summary of travel Impact

Whilst changing models would lead to a positive impact in terms of transport for some people, all proposed change options models have a negative overall impact on travel.

With a dementia unit in Wakefield (option 2), overall, more people would have to travel further than if the dementia unit were in Dewsbury.

In the Dewsbury (W19) dementia model option (1 a/b) there are on average 80 people a year who would have to travel further than now. In the Wakefield dementia model there would be around 100 people per year, though both would be offset by some people that would have shorter journeys.

Specifically, there is an additional negative impact for all people with dementia travelling from Calderdale. People from Calderdale who would rely on public transport if we had the specialist ward in Wakefield would face particularly long journeys.

There are some lengthy public transport times to Wakefield, in particular for people from Calderdale. They would have on average around 60 minutes travel to Dewsbury and 100 minutes to Wakefield.

However, there are also some longer public transport journeys in both models and the current model.

When looking at just the 20% most deprived areas, findings highlight:

- Around 25-35 people per year would have further to travel as a result of the changes.
- Around 6 people per year from Calderdale's most deprived areas will have a 70 minute public transport journey to Dewsbury and 95 minutes to Wakefield (on average).

Car travel **distance** is higher to a Wakefield Dementia model. So is car travel **time**, but the gap narrows as a result of motorway and dual carriageway access to Wakefield.

When factoring in car travel times, the longest average journey in either option is less than 40 minutes (from Calderdale to Wakefield). The longest average car journey with the Dewsbury dementia unit model is less than 35 minutes (Calderdale to Dewsbury). Some individual journeys will be longer as these represent averages.

Therefore, whilst some of the current public transport journeys clearly create challenges, people that can travel by car, on the whole, would not face exceptionally long journeys.

11 Staff Travel Impact

Staff travel impact will be considered in more detail in the formal consultation process and further in any subsequent staff consultation process that might lead to changes in staff terms and conditions.

Current staff roles are based on generic job descriptions that could apply to both functional and dementia wards. Feedback from informal conversations with staff members suggests that there may be a small proportion of people that would wish to move wards if it changed function. This too will be explored further in consultation.

The Poplars service is proposed to be relocated in any of the shortlisted options. This means there will be a travel impact on the 29 substantive staff (in post in July 2023) that are based on the Poplars wards.

Data based on the home addresses of staff show that on average the Poplars ward is 0.8 miles closer than Fieldhead Hospital from people's home address. 9 staff members would have 7 miles + further to travel to Fieldhead and would be entitled to excess travel support for 4 years. Fewer than 5 people would be between 4-7 miles further and would receive support for 18 months.

This assumes that most staff would wish to relocate to the Fieldhead site regardless of the option eventually taken forward for implementation. The average distance from home to Dewsbury, for example, is further overall than to Fieldhead though it is similar or shorter distance to Dewsbury for around 40% of the staff. So, depending on eventual preferred option and staff preference there could be opportunities for some staff to choose to relocate to Wakefield and others to Dewsbury.

11.1 Travel impact by payband

14 of the staff (July 2023) are payband 2 and 3 and these people are more likely to live closer to the ward. The average extra travel distance from the Poplars to Fieldhead is 3.1 miles for people from these paybands.

7 of 14 the people will have 7 miles + further to travel. Fewer than 5 staff members are closer to Fieldhead hospital and fewer than 5 would be further from Fieldhead but less than 3 miles further.

12 Place Travel impact

The following gives a more detailed breakdown of the potential place impact. Where there are fewer than 5 people per year information has been suppressed.

12.1 Calderdale Travel Impact:

We would expect most people with functional needs to be admitted to the Beechdale ward and these make up around 60% of the bed use. This means that around 60% of people from Calderdale would still be admitted locally. That environment would be the same as it is now, and whilst issues such as line of sight in the ward cannot be fixed, the patient group will benefit considerably by the specialism of functional only.

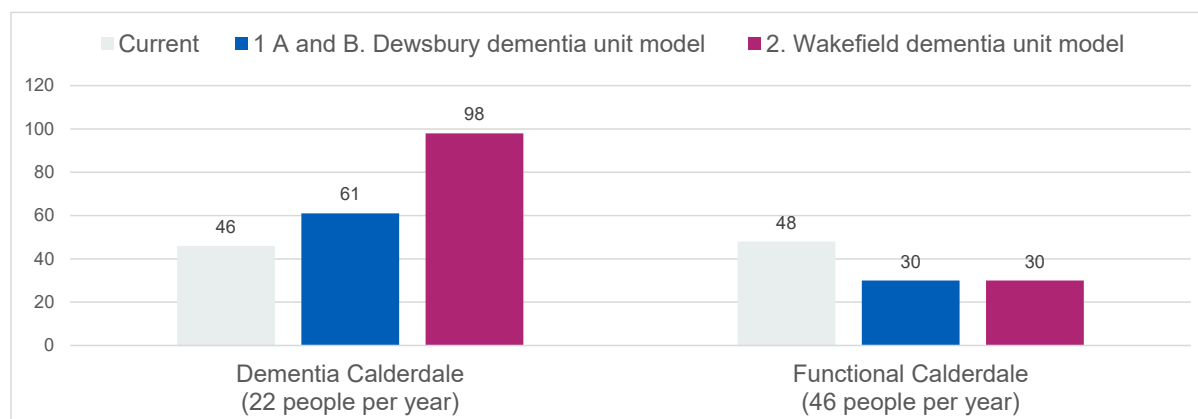
Around 40% of people requiring an inpatient stay from Calderdale will do so because of dementia and they will be admitted elsewhere in the proposals.

In options 1a and b, around 20 people per year with dementia will stay in Dewsbury and in option 2, those people would stay in Wakefield.

Because of the current people travelling outside of the locality, the overall travel impact of people in Calderdale is more limited.

The charts below show the travel time impact based on average public transport journeys for both dementia and functional admissions.

To note: the charts show the average public transport time of journey in minutes, the white bar being the current time, the blue bar being the average time expected for options 1a and b, and the purple bar being the expected journey time for option 2.



A key difference between options is the extra travel time required for people with dementia, who will have a longer journey to Wakefield.

Dementia Breakdown:

Travel Distance

Table summary of mean average distance:

Comparing numbers of inpatient spells based on discharge ward:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Distance
Calderdale	Dementia	Driving Distance	Discharge Ward	Current	22	6.9
Calderdale	Dementia	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	22	13.6
Calderdale	Dementia	Driving Distance	Discharge Ward	Wakefield Dementia Unit	22	23.9

Including all ward stay analysis:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Distance
Calderdale	Dementia	Driving Distance	Discharge Ward	Current	22	6.9
Calderdale	Dementia	Driving Distance	Non discharge ward	Current	10	16.2
Calderdale	Dementia	Driving Distance	Ward Stays	Current	32	9.8
Calderdale	Dementia	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	22	13.6
Calderdale	Dementia	Driving Distance	Discharge Ward	Wakefield Dementia Unit	22	23.9

Driving Distance for all people from Calderdale requiring a dementia admission.

The data shows:

- 22 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 6.9 miles.
- In a model where the specialist dementia unit were at Dewsbury this would increase to 13.6 miles
- At Wakefield it would be 23.9 miles on average.
- There were 32 ward stays on average across the 22 spells.
- The average distance from home of all ward stays is 9.8 miles.
- The 10 people (45%) that had more than one stay had a 16 mile average journey on their first part of the spell.

Driving Time Analysis

Comparing numbers of inpatient spells based on discharge ward:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Calderdale	Dementia	Driving Time	Discharge Ward	Current	22	19.0
Calderdale	Dementia	Driving Time	Discharge Ward	Dewsbury Dementia Unit	22	34.0
Calderdale	Dementia	Driving Time	Discharge Ward	Wakefield Dementia Unit	22	37.0

Including ward stay analysis:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Calderdale	Dementia	Driving Time	Discharge Ward	Current	22	19.0
Calderdale	Dementia	Driving Time	Non discharge ward	Current	10	35.0
Calderdale	Dementia	Driving Time	Ward Stays	Current	32	24.0
Calderdale	Dementia	Driving Time	Discharge Ward	Dewsbury Dementia Unit	22	34.0
Calderdale	Dementia	Driving Time	Discharge Ward	Wakefield Dementia Unit	22	37.0

- Just under 20 minutes driving time currently for people based on discharge ward.
- This would be 34 minutes on average to Dewsbury and 37 minutes to Wakefield.

- The 10 people (45%) that had more than one stay had a 35 minute average journey on their first part of the spell.

Public Transport Times

Comparing numbers of inpatient spells based on discharge ward:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Calderdale	Dementia	Public Transport Time	Discharge Ward	Current	22	38
Calderdale	Dementia	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	22	61
Calderdale	Dementia	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	22	98

Including ward stay analysis:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Calderdale	Dementia	Public Transport Time	Discharge Ward	Current	22	38
Calderdale	Dementia	Public Transport Time	Non discharge ward	Current	10	67
Calderdale	Dementia	Public Transport Time	Ward Stays	Current	32	47
Calderdale	Dementia	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	22	61
Calderdale	Dementia	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	22	98

- Just under 40 minutes average public transport time based on current discharge ward for 22 people per year.
- 10 people, 45%, with more than one stay – the average public transport journey would've been 67 minutes for the first part of their inpatient spell.
- Average public transport times for the 22 people to Dewsbury is 61 minutes, to Wakefield, 98 minutes.

Functional Impact – Calderdale

Driving Distance for all people from Calderdale requiring a functional admission.

Just considering discharge ward:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Calderdale	Functional	Driving Distance	Discharge Ward	Current	46	6.6
Calderdale	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	46	4.6
Calderdale	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	46	4.7

Including all ward stays:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Calderdale	Functional	Driving Distance	Discharge Ward	Current	46	6.6
Calderdale	Functional	Driving Distance	Non discharge ward	Current	17	15.9
Calderdale	Functional	Driving Distance	Ward Stays	Current	63	9.1
Calderdale	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	46	4.6
Calderdale	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	46	4.7

The data shows:

- 46 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 6.6 miles.
- There were 63 ward stays on average across the 46 spells.
- The average distance from home of all ward stays is 9.1 miles.
- The 17 people (37%) that had more than one stay had just under a 16 mile average journey on their first part of the spell.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Calderdale	Functional	Driving Time	Discharge Ward	Current	46	18.0
Calderdale	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	46	14.0
Calderdale	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	46	14.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Calderdale	Functional	Driving Time	Discharge Ward	Current	46	18.0
Calderdale	Functional	Driving Time	Non discharge ward	Current	17	36.5
Calderdale	Functional	Driving Time	Ward Stays	Current	63	23.0
Calderdale	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	46	14.0
Calderdale	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	46	14.0

- Just under 20 minutes driving time currently for people based on discharge ward.
- The 17 people (37%) that had more than one stay had a 37 minute average journey on their first part of the spell.

Public transport time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Calderdale	Functional	Public Transport Time	Discharge Ward	Current	46	37.0
Calderdale	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	46	30.0
Calderdale	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	46	30.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Calderdale	Functional	Public Transport Time	Discharge Ward	Current	46	37.0
Calderdale	Functional	Public Transport Time	Non discharge ward	Current	17	74.1
Calderdale	Functional	Public Transport Time	Ward Stays	Current	63	47.0
Calderdale	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	46	30.0
Calderdale	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	46	30.0

- Just under 40 minutes average public transport time based on current discharge ward for 46 people per year.
- 17 people, 37%, with more than one stay – the average public transport journey would've been just under 75 minutes for the first part of their inpatient spell.

12.2 Kirklees Travel Impact

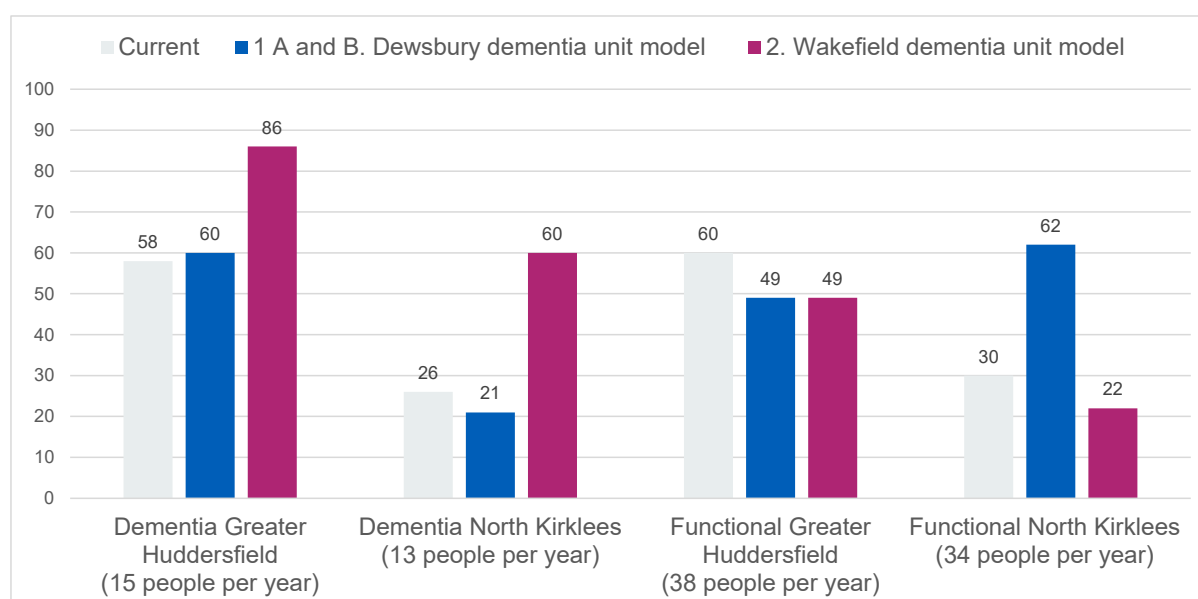
In option 1a and b functional service users will be admitted outside of Kirklees. People from North Kirklees would likely be admitted to Wakefield which would be further away than Dewsbury in the current model. People from Greater Huddersfield would be admitted to Calderdale, which, on average is a similar distance from Dewsbury where people are likely to be admitted in the current model. Because both options include more functional beds in Wakefield than Calderdale, it is possible that some people will require admissions into Wakefield.

People with dementia will be admitted locally.

The charts below show the public transport impact. It assumes that people from Greater Huddersfield are admitted to Calderdale and shows the biggest impact is on the functional stays from North Kirklees, which impact around 35 people per year who would have around an hour public transport journey to Wakefield:

In option 2, people with functional needs will be admitted locally but people with dementia will be admitted to Wakefield. This means that approximately 16 people per year from Greater Huddersfield would have an 85 minute journey on average, whilst around 15 people per year from North Kirklees would have an hour journey.

To note: the charts show the average public transport time of journey in minutes, the white bar being the current time, the blue bar being the average time expected for options 1a and b, and the purple bar being the expected journey time for option 2.



Greater Huddersfield - Dementia

Driving Distance

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Greater Hudds	Dementia	Driving Distance	Discharge Ward	Current	15	10.9
Greater Hudds	Dementia	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	15	10.7
Greater Hudds	Dementia	Driving Distance	Discharge Ward	Wakefield Dementia Unit	15	20.5

The table with all ward stays has not been included due to low numbers and therefore the additional data has been suppressed.

Driving Distance for all people from Greater Huddersfield requiring a dementia admission.

The data shows:

- 15 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 10.9 miles.
- In a model where the specialist dementia unit were at Dewsbury this would reduce to 10.7 miles
- At Wakefield it would be 20.5 miles on average.
- There were 16 ward stays on average across the 15 spells.
- The average distance from home of all ward stays is 11 miles.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Greater Hudds	Dementia	Driving Time	Discharge Ward	Current	15	30.0
Greater Hudds	Dementia	Driving Time	Discharge Ward	Dewsbury Dementia Unit	15	30.0
Greater Hudds	Dementia	Driving Time	Discharge Ward	Wakefield Dementia Unit	15	35.0

The table with all ward stays has not been included due to low numbers and therefore the additional data has been suppressed. 30 minutes driving time currently for people based on discharge ward.

- In a model where the dementia unit was in Dewsbury the driving time wouldn't change (30 minutes).
- If the dementia unit was in Wakefield this would increase to 35 minutes.

Public transport time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Greater Hudds	Dementia	Public Transport Time	Discharge Ward	Current	15	60.0
Greater Hudds	Dementia	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	15	60.0
Greater Hudds	Dementia	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	15	86.0

Table with all ward stays has not been included due to low numbers and therefore the additional data has been suppressed.

- 60 minutes is the average public transport time based on current discharge ward for 15 people per year.
- Average public transport times for the 15 people to travel to Dewsbury is 60 minutes and to Wakefield would be 86 minutes.

North Kirklees Dementia

Driving Distance

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
North Kirklees	Dementia	Driving Distance	Discharge Ward	Current	13	3.5
North Kirklees	Dementia	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	13	2.8
North Kirklees	Dementia	Driving Distance	Discharge Ward	Wakefield Dementia Unit	13	12.9

The table with all ward stays has not been included due to low numbers and therefore the additional data has been suppressed.

Driving Distance for all people from North Kirklees requiring a dementia admission.

The data shows:

- 13 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 3.5 miles.
- In a model where the specialist dementia unit were at Dewsbury this would reduce to 2.8 miles
- At Wakefield it would be 12.9 miles on average.
- There were 15 ward stays on average across the 13 spells.
- The average distance from home of all ward stays is 4.6 miles.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
North Kirklees	Dementia	Driving Time	Discharge Ward	Current	13	12.0
North Kirklees	Dementia	Driving Time	Discharge Ward	Dewsbury Dementia Unit	13	11.0
North Kirklees	Dementia	Driving Time	Discharge Ward	Wakefield Dementia Unit	13	24.0

The table with all ward stays has not been included due to low numbers and therefore the additional data has been suppressed.

- 12 minutes driving time currently for people based on discharge ward.
- This would be slightly reduced to 11 minutes on average if everyone with dementia were admitted to Dewsbury.
- It would be 24 minutes if everyone with dementia were admitted to Wakefield.

Public transport time

Just considering discharge ward

Table here

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
North Kirklees	Dementia	Public Transport Time	Discharge Ward	Current	13	23.0
North Kirklees	Dementia	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	13	21.0
North Kirklees	Dementia	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	13	60.0

The table with all ward stays has not been included due to low numbers and therefore the additional data has been suppressed.

- Just under 25 minutes average public transport time based on current discharge ward for 13 people per year.
- Average public transport times for the 13 people to Dewsbury is 21 minutes, to Wakefield 60 minutes.

Greater Huddersfield Functional

Driving Distance

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Greater Hudds	Functional	Driving Distance	Discharge Ward	Current	38	11.7
Greater Hudds	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	38	9.1
Greater Hudds	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	38	9.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Greater Hudds	Functional	Driving Distance	Discharge Ward	Current	38	11.7
Greater Hudds	Functional	Driving Distance	Non discharge ward	Current	6	13.2
Greater Hudds	Functional	Driving Distance	Ward Stays	Current	44	11.9
Greater Hudds	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	38	9.1
Greater Hudds	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	38	9.0

Driving Distance for all people from Greater Huddersfield requiring a functional admission.

The data shows:

- 38 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 11.7 miles.
- There were 44 ward stays on average across the 38 spells.
- The average distance from home of all ward stays is 11.9 miles.
- The 6 people per year (16%) that had more than one stay had a 13.2-mile average journey on their first part of the spell.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Greater Hudds	Functional	Driving Time	Discharge Ward	Current	38	31.0
Greater Hudds	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	38	22.0
Greater Hudds	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	38	22.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Greater Hudds	Functional	Driving Time	Discharge Ward	Current	38	31.0
Greater Hudds	Functional	Driving Time	Non discharge ward	Current	6	31.0
Greater Hudds	Functional	Driving Time	Ward Stays	Current	44	31.0
Greater Hudds	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	38	22.0
Greater Hudds	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	38	22.0

- 31 minutes average driving time currently for people from Greater Huddersfield based on both discharge ward and the average ward stay.
- This would reduce to an average 22 minutes if people are admitted to Calderdale.

Public transport time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Greater Hudds	Functional	Public Transport Time	Discharge Ward	Current	38	59.0
Greater Hudds	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	38	49.0
Greater Hudds	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	38	49.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Greater Hudds	Functional	Public Transport Time	Discharge Ward	Current	38	59.0
Greater Hudds	Functional	Public Transport Time	Non discharge ward	Current	6	66.3
Greater Hudds	Functional	Public Transport Time	Ward Stays	Current	44	60.0
Greater Hudds	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	38	49.0
Greater Hudds	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	38	49.0

- Just under 60 minutes average public transport time based on current discharge ward for 38 people per year.
- 6 people, 16%, with more than one stay – the average public transport journey would've been 67 minutes for the first part of their inpatient spell.
- The public transport times would reduce to around 50 minutes with either option if all people are admitted to Calderdale.

North Kirklees Functional

Driving Distance

Just considering discharge ward:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
North Kirklees	Functional	Driving Distance	Discharge Ward	Current	34	3.2
North Kirklees	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	34	12.0
North Kirklees	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	34	3.0

Including all ward stays:

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
North Kirklees	Functional	Driving Distance	Discharge Ward	Current	34	3.2
North Kirklees	Functional	Driving Distance	Non discharge ward	Current	6	9.2
North Kirklees	Functional	Driving Distance	Ward Stays	Current	40	4.1
North Kirklees	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	34	12.0
North Kirklees	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	34	3.0

Driving Distance for all people from North Kirklees requiring a functional admission.

The data shows:

- 34 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 3.2 miles.
- There were 40 ward stays on average across the 34 spells.
- The average distance from home of all ward stays is 4.1 miles.
- The 6 people (15%) that had more than one stay had a 9.2-mile average journey on their first part of the spell.
- If the dementia ward is in Dewsbury functional admissions will travel further, 12 miles on average.
- If the dementia admissions were in Wakefield, then functional admissions would be local, averaging 3 miles away.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
North Kirklees	Functional	Driving Time	Discharge Ward	Current	34	11.0
North Kirklees	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	34	23.0
North Kirklees	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	34	11.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
North Kirklees	Functional	Driving Time	Discharge Ward	Current	34	11.0
North Kirklees	Functional	Driving Time	Non discharge ward	Current	6	24.3
North Kirklees	Functional	Driving Time	Ward Stays	Current	40	13.0
North Kirklees	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	34	23.0
North Kirklees	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	34	11.0

- Just over 10 minutes driving time currently for people based on discharge ward.
- The 6 people (15%) that had more than one stay had just under a 25-minute average journey on their first part of the spell
- The average driving time from home of all ward stays is 13 minutes.
- If the dementia unit is in Dewsbury, people would be admitted to Wakefield with an average 23 minute driving time.
- If the dementia admissions were in Wakefield, then functional admissions would be local, averaging 11 minutes drive away.

Public transport time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
North Kirklees	Functional	Public Transport Time	Discharge Ward	Current	34	24.0
North Kirklees	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	34	62.0
North Kirklees	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	34	22.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
North Kirklees	Functional	Public Transport Time	Discharge Ward	Current	34	24.0
North Kirklees	Functional	Public Transport Time	Non discharge ward	Current	6	50.7
North Kirklees	Functional	Public Transport Time	Ward Stays	Current	40	28.0
North Kirklees	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	34	62.0
North Kirklees	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	34	22.0

- Just under 25 minutes average public transport time based on current discharge ward for 34 people per year.
- 6 people, 15%, with more than one stay – the average public transport journey would've been 51 minutes for the first part of their inpatient spell.
- The average public transport from home of all ward stays is 28 minutes.
- If the dementia unit is in Dewsbury, people would be admitted to Wakefield with an average 62-minute public transport time.
- If the dementia admissions were in Wakefield, then functional admissions would be local, averaging 22 minutes public transport journey.

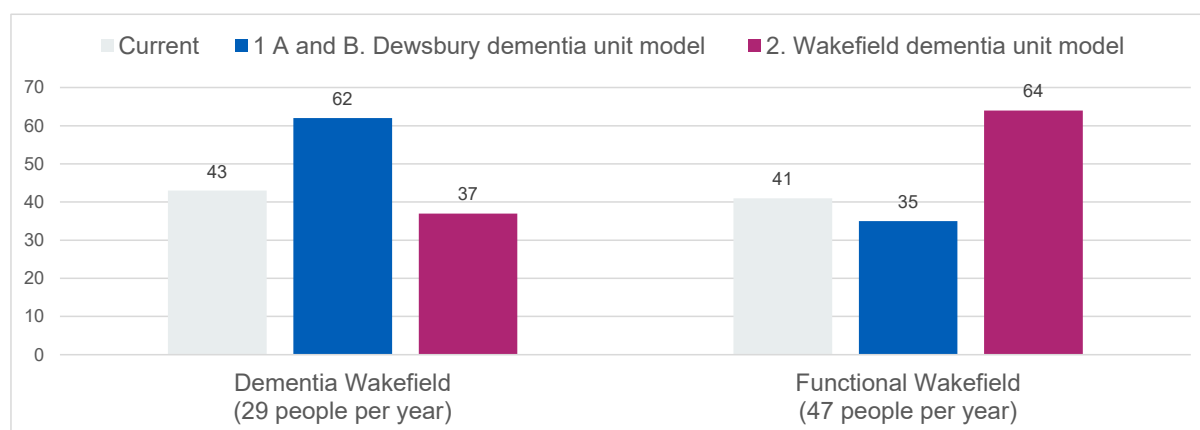
12.3 Wakefield Travel Impact

There will be a travel impact of both options, with either people with functional needs or dementia being admitted to Dewsbury, depending on which option is preferred.

Travel impact of options 1a and b, around 30 people per year would have a greater journey to Dewsbury.

Travel impact of option 2 around 50 people per year with functional needs would have greater journeys to Dewsbury.

To note: the charts show the average public transport time of journey in minutes, the white bar being the current time, the blue bar being the average time expected for options 1a and b, and the purple bar being the expected journey time for option 2.



Wakefield Dementia

Driving Distance

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Wakefield	Dementia	Driving Distance	Discharge Ward	Current	29	9.1
Wakefield	Dementia	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	29	13.7
Wakefield	Dementia	Driving Distance	Discharge Ward	Wakefield Dementia Unit	29	7.3

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Wakefield	Dementia	Driving Distance	Discharge Ward	Current	29	9.1
Wakefield	Dementia	Driving Distance	Non discharge ward	Current	25	8.7
Wakefield	Dementia	Driving Distance	Ward Stays	Current	54	8.9
Wakefield	Dementia	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	29	13.7
Wakefield	Dementia	Driving Distance	Discharge Ward	Wakefield Dementia Unit	29	7.3

Driving Distance for all people from Wakefield requiring a dementia admission.

The data shows:

- 29 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 9.1 miles.
- In a model where the specialist dementia unit were at Dewsbury this would increase to 13.7 miles
- At Wakefield it would be 7.3 miles on average.
- There were 54 ward stays on average across the 29 spells.
- The average distance from home of all ward stays is 8.9 miles.
- The 25 people (86%) that had more than one stay had 9 mile average journey on their first part of the spell.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Wakefield	Dementia	Driving Time	Discharge Ward	Current	29	21.0
Wakefield	Dementia	Driving Time	Discharge Ward	Dewsbury Dementia Unit	29	27.0
Wakefield	Dementia	Driving Time	Discharge Ward	Wakefield Dementia Unit	29	17.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Wakefield	Dementia	Driving Time	Discharge Ward	Current	29	21.0
Wakefield	Dementia	Driving Time	Non discharge ward	Current	25	18.8
Wakefield	Dementia	Driving Time	Ward Stays	Current	54	20.0
Wakefield	Dementia	Driving Time	Discharge Ward	Dewsbury Dementia Unit	29	27.0
Wakefield	Dementia	Driving Time	Discharge Ward	Wakefield Dementia Unit	29	17.0

- Just over 20 minutes driving time currently for people based on discharge ward.
- The 25 people (86%) that had more than one stay had a 19 minute average journey on their first part of the spell.
- The average drive time from home of all ward stays is 20 minutes.
- If the dementia unit is in Dewsbury, people from Wakefield would be admitted there with an average 27 minute drive.
- If the dementia admissions were in Wakefield then people would be admitted to Fieldhead hospital with a 17 minute drive on average.

Public transport time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Wakefield	Dementia	Public Transport Time	Discharge Ward	Current	29	42.0
Wakefield	Dementia	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	29	62.0
Wakefield	Dementia	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	29	37.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Wakefield	Dementia	Public Transport Time	Discharge Ward	Current	29	42.0
Wakefield	Dementia	Public Transport Time	Non discharge ward	Current	25	42.0
Wakefield	Dementia	Public Transport Time	Ward Stays	Current	54	42.0
Wakefield	Dementia	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	29	62.0
Wakefield	Dementia	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	29	37.0

- Just over 40 minutes average public transport time based on current discharge ward for 29 people per year, which is the same for all 54 ward stays.
- Average public transport times for the 29 people to Dewsbury is 62 minutes, to Wakefield, 37 minutes.
- If the dementia ward is in Dewsbury all people would be admitted to it at an average of 62 minutes public transport journey.
- If the dementia admissions were in Wakefield, the average public transport journey would be 37 minutes.

Wakefield Functional

Driving Distance

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Wakefield	Functional	Driving Distance	Discharge Ward	Current	47	7.7
Wakefield	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	47	7.0
Wakefield	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	47	13.9

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Distance
Wakefield	Functional	Driving Distance	Discharge Ward	Current	47	7.7
Wakefield	Functional	Driving Distance	Non discharge ward	Current	15	11.4
Wakefield	Functional	Driving Distance	Ward Stays	Current	62	8.6
Wakefield	Functional	Driving Distance	Discharge Ward	Dewsbury Dementia Unit	47	7.0
Wakefield	Functional	Driving Distance	Discharge Ward	Wakefield Dementia Unit	47	13.9

Driving Distance for all people from Wakefield requiring a functional admission.

The data shows:

- 47 people per year have an inpatient spell.
- Mean driving distance currently from home address based on discharge ward of the spell is 7.7 miles.
- There were 62 ward stays on average across the 47 spells.
- The average distance from home of all ward stays is 8.6 miles.
- The 15 people per year (32%) that had more than one stay had 11.4-mile average journey on their first part of the spell.

- If the dementia unit is in Dewsbury all admissions from Wakefield will be local, and the 47 stays will be 7 miles away, on average.
- If the dementia unit is in Wakefield, functional admission will be to North Kirklees, which average 14 miles away.

Driving Time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Wakefield	Functional	Driving Time	Discharge Ward	Current	47	17.0
Wakefield	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	47	17.0
Wakefield	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	47	26.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Average Time
Wakefield	Functional	Driving Time	Discharge Ward	Current	47	17.0
Wakefield	Functional	Driving Time	Non discharge ward	Current	15	25.3
Wakefield	Functional	Driving Time	Ward Stays	Current	62	19.0
Wakefield	Functional	Driving Time	Discharge Ward	Dewsbury Dementia Unit	47	17.0
Wakefield	Functional	Driving Time	Discharge Ward	Wakefield Dementia Unit	47	26.0

- 17 minutes driving time currently for people based on discharge ward.
- The 15 people (32%) that had more than one stay had a 25.3 minutes average journey on their first part of the spell.
- If the dementia unit is in Dewsbury, functional admission will be local in Wakefield with an average driving time of 17 minutes.
- If the dementia unit is in Wakefield, people will need to travel to Dewsbury with an average driving time of 26 minutes.

Public transport time

Just considering discharge ward

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Wakefield	Functional	Public Transport Time	Discharge Ward	Current	47	38.0
Wakefield	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	47	35.0
Wakefield	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	47	64.0

Including all ward stays

Place	Need	Indicator	Type	Model	Numbers of people or stays	Time
Wakefield	Functional	Public Transport Time	Discharge Ward	Current	47	38.0
Wakefield	Functional	Public Transport Time	Non discharge ward	Current	15	54.5
Wakefield	Functional	Public Transport Time	Ward Stays	Current	62	42.0
Wakefield	Functional	Public Transport Time	Discharge Ward	Dewsbury Dementia Unit	47	35.0
Wakefield	Functional	Public Transport Time	Discharge Ward	Wakefield Dementia Unit	47	64.0

- Just under 40 minutes average public transport time based on current discharge ward for 47 people per year.
- 15 people, 32%, with more than one stay – the average public transport journey would've been just under 55 minutes for the first part of their inpatient spell.
- If the dementia unit is in Dewsbury, then the 47 people will be admitted locally, with an average public transport time of 35 minutes.
- If the dementia unit is in Wakefield, people will need to travel to Dewsbury, at an average public transport journey time of 64 minutes.

13 Section 2: Consultation Findings

In total, 1,676 pieces of feedback were received to the consultation. This consisted of 1,554 responses to the consultation survey, 110 pieces of feedback from event participants, 6 pieces of feedback from social media posts and 6 pieces of correspondence by email and post.

13.1 Feedback on additional considerations

Transport ranked high in the themes raised by people in the consultation.

The top themes raised were:

- **Neutral – Transport – Consider the impact of travel (e.g. mileage, transport links, costs) (35 / 17%)**
- **Negative – Transport – Consider the environmental implications of travelling long distances (24 / 12%)**
- Negative – General – Environmental impact has not been considered (e.g. long-term effects) (23 / 11%)

When asked if there was anything further to consider for the proposals the top themes raised were:

- Neutral – Quality of Care – Wards should be single sex / disagreement with mixed sex wards (40 / 12%)
- **Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport, ability of person travelling, environmental impact) (38 / 12%)**
- Neutral – Quality of Care – Consider the needs of individuals to give the best care (23 / 7%)

13.2 Travel, transport and parking

Most respondents stated they expect to travel up to 45 minutes for both specialist inpatient dementia care (1011 / 88%) and for functional inpatient mental health care (1016 / 89%).

The top three options for transportation were driving a petrol / diesel car (582 / 50%), walking (368 / 32%) and by bus (364 / 31%). And, when asked if there was anything else that should be considered around making travel easier, the top themes raised were:

- Neutral – Transport – Parking should be free (149 / 29%)
- Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%)
- Neutral – Transport – Consider providing a free local bus / shuttle bus service (111 / 21%)

13.3 Geographical analysis

This section presents feedback on expected travel time and method of travel in the Kirklees, Wakefield and Calderdale areas.

Most of those responding from the Kirklees area stated they would expect to travel up to 45 minutes for specialist inpatient dementia care (465 / 88%) and for functional inpatient mental health care (469 / 89%). The top three options for transportation for those responding from the Kirklees area were driving a petrol / diesel car (278 / 52%), by bus (204 / 38%), and walking (156 / 29%).

Most of those responding from the Wakefield area stated they would expect to travel up to 45 minutes for specialist inpatient dementia care (150 / 88%) and for functional inpatient mental health care (145 / 88%). The top three options for transportation for respondents from the Wakefield area were driving a petrol / diesel car (113 / 66%), by bus (54 / 31%), and walking (29 / 17%).

Most of those responding from the Calderdale area stated they would expect to travel up to 45 minutes for specialist inpatient dementia care (268 / 94%) and for functional inpatient mental health care (266 / 94%). The top three options for transportation for respondents from the Calderdale area were by taxi (164 / 57%), walking (159 / 55%), and driving a petrol / diesel car (114 / 40%).

13.4 Travel access for different groups:

The table below shows the breakdown of responses by people that are carers of someone with dementia or functional mental health needs. This is important to consider because many of the people that have a travel impact by the proposals will be carers of someone with dementia or functional mental health needs.

	I care for someone living with dementia	I care for someone living with functional mental health needs
	123	64
I drive a petrol/ diesel car	66%	61%
Walk	20%	30%
Bus	33%	38%
Taxi	19%	28%
Train	15%	14%
Petrol/diesel car – as a passenger	9%	13%
Patient transport	7%	5%
I drive an electric/ hybrid car	9%	8%
Other, please tell us	3%	2%
Electric/hybrid car – as a passenger	4%	2%
Bicycle	4%	3%
Electric Bicycle	-	-
Motorbike	-	-
Drive	75%	69%
Passenger	13%	15%
Total drive or passenger	88%	84%

The table below shows the travel breakdown for people aged 80+:

	Aged 80+
	47
I drive a petrol/ diesel car	53%
Walk	19%

Bus	38%
Taxi	15%
Train	15%
Petrol/diesel car – as a passenger	19%
Patient transport	11%
I drive an electric/ hybrid car	6%
Other, please tell us	4%
Electric/hybrid car – as a passenger	6%
Bicycle	-
Electric Bicycle	-
Motorbike	2%
Drive	59%
Passenger	25%
Total drive or passenger	84%

For all of these groups, between 80% and 90% of people have access to a car, either as a driver or passenger.

For people aged over 80 the proportion that have access only as a passenger increases and it is possible that their loved one could be the person that drives, meaning that if their loved one was admitted they may no longer have access to a car as a passenger.

Data on other protected groups is available and being assessed via the equality impact assessment.

13.5 Considering themes raised in consultation

The following are the key themes that were raised in the public consultation:

- Parking should be free (149 / 29%)
- Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%)
- Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%)
- Consider providing a free local bus / shuttle bus service (111 / 21%)
- Parking should be available and accessible (92 / 18%)
- Consider the importance of parking facilities for patients / families and carers (49 / 9%)
- Ensure there are accessible, regular, and reliable public transport services available with minimal to no changes needed (64 / 12%)
- Consider how to provide the best travel solutions to support patients, families, and carers to access services (62 / 12%)
- Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (50 / 10%)
- Travel may be difficult for some groups (48 / 9%)

As well as these we also learned about people's expectations in terms of travel times and the modes of transport different groups of people currently use to travel.

13.6 Addressing inequalities – key themes raised

As part of the consultation, we sought feedback which can be traced back to the first 3 digits of an area postcode. This data can help to identify areas of deprivation at a macro level. Further detailed analysis by protected group using the deprivation questions and including carers can help inform impacts.

Key travel and transport themes raised by these groups were that parking should be free,

- **Just getting by:** Neutral – Transport – Parking should be free (58 / 34%).
- **Really struggling:** Neutral – Transport – Parking should be free (24 / 41%).

Deprivation:

- **Postcode sectors where 50% or more of the localities are comprised of wards that fall into the two most deprived deciles:** Neutral – Transport – Parking should be free (49 / 37%).

Modes of travel:

The consultation also explored methods of travel. It highlights that less people that are struggle / from more deprived postcodes are likely to drive – they are more likely to walk.

Driving

A significantly higher proportion of respondents who are quite comfortable (240 / 65%) travelled by driving a petrol / diesel car compared to respondents who are just getting by (162 / 51%), very comfortable (32 / 49%) and really struggling (79 / 32%).

A significantly higher proportion of respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (284 / 55%) and postcode areas where 40% to 49% of the locality are from the most deprived deciles (88 / 52%) travelled by driving a petrol / diesel car compared to respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (144 / 43%).

Walking

A significantly higher proportion of respondents who are really struggling (167 / 68%) travelled by walking compared to respondents who are just getting by (69 / 22%), quite comfortable (79 / 21%) and very comfortable (11 / 17%).

A significantly higher proportion of respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (157 / 46%) travelled by walking compared to respondents from other postcode areas.

Consultation theme:

Parking should be free (149 / 29%)

Considerations:

The table below shows the parking changes for a future model (2024 prices):

Location	Hospital	Costs
Calderdale	The Dales Calderdale Royal Hospital	30 mins (free) Up to 2hrs (£3.00) Up to 4hrs (£5.00) Up to 6hrs (£6.00) Up to 24hrs (£8.00)
Kirklees	Priestley Unit (Dewsbury and District Hospital)	Less than 20 mins (free) Up to 1hr (£2.00) 1-2hrs (£2.80) 2-4hrs (£5.00) 4- 24hrs (£6.90)
Wakefield	Fieldhead Hospital – Crofton Ward	Free

Parking is free for anyone visiting Fieldhead hospital but there are changes for visiting any of the other wards.

Consultation theme:

Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%)

Considerations:

Some elements of this theme are also reflected above in terms of parking. The costs of using public transport are set out below. The cost impact of public transport is reduced for older people but could be considerable for other people that use public transport and travel regularly

There are options available for people using public transport (Metro travel) within West Yorkshire. Currently (as of June 2024), people do not have to pay more than £2 for an adult single ticket or £4.50 for a Metro Card (MCard) day saver ticket for travel on any bus across West Yorkshire valid anytime. A weekender ticket costs £8.50 which can be bought on the bus for unlimited bus travel from 6pm on Fridays until midnight on Sundays on any bus, anywhere in West Yorkshire.

People travelling by bus and train would pay £10.60 off-peak and £15.60 peak for a bus and rail day saver ticket across the West Yorkshire area.

Off-Peak Countywide Bus and Train tickets are valid on any bus from 09:30 and on any train from 09:30 to 16:01, and from 18:30, Monday to Friday, and all day at weekends and public holidays. A daily ticket is £9.50 or £4.80 (concessionary)

People who have reached the state pension age and are a permanent resident of West Yorkshire will qualify for a Senior Pass. A Senior Pass provides:

- Free, off-peak bus travel throughout England. Off-peak is after 9.30am Monday to Friday, and all day at weekends and Bank Holidays.
- Half-fare, off-peak train travel throughout West Yorkshire, for West Yorkshire residents. Off-peak is Monday to Friday after 09:30 until 16:00, then after 18:30. All day on weekends & public holidays. Anyone travelling by train during the weekday evening peak - 16:01 to 18:29 - will need to buy an Anytime Day Single or Anytime Day Return ticket. The half-fare only applies to travel within West Yorkshire. If part of the journey falls outside of West Yorkshire, full fare will be paid for that part of the journey.

Consultation Theme:

Consider providing a free local bus / shuttle bus service (111 / 21%)

Consideration:

There is **currently** a free public transport option that could support part of our population with a bus that runs across the Mid Yorkshire Hospital footprint, from Pontefract to Pinderfields in Wakefield and Dewsbury Hospital.

The Pinderfields is close to Fieldhead Hospital, this service does not access Fieldhead Hospital in Wakefield. There is a 10 minute uphill walk from to Fieldhead Hospital and a busy road to cross.

There is no service to link Greater Huddersfield or Calderdale to Dewsbury or Wakefield.

Consultation Theme:

Parking should be available and accessible (92 / 18%)

Consider the importance of parking facilities for patients / families and carers (49 / 9%)

Consideration:

There is available/accessible parking at every site. Feedback is that this is much more difficult at the site of Calderdale Royal Hospital, where the Beechdale ward is located. However, work is ongoing on a multi-story car park which is scheduled to open in early 2026.

Consultation Theme:

Ensure there are accessible, regular, and reliable public transport services available with minimal to no changes needed (64 / 12%)

Consideration

We know that public transport journeys can be complex and if one part of a journey is delayed, this could have ramifications and cause delays to other parts of journeys.

Consultation Theme:

Consider how to provide the best travel solutions to support patients, families, and carers to access services (62 / 12%)

Consideration

We know that from time to time, people do struggle to travel to visit their loved ones. This happens in the current model and may be increased with changes.

Consultation Theme:

Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (50 / 10%)

Consideration

Linked to a theme above, we know that public transport journeys can be complex to our sites and if one part of a journey is delayed, this could have ramifications and cause delays to other parts of journeys.

Consultation Theme:

Travel may be difficult for some groups (48 / 9%)

Consideration:

We know that visitors of people on older people's wards can be elderly themselves, increased likelihood of frailty for example, and this can make journeys more difficult.

Consultation Theme:

Travel times: Most respondents stated they expect to travel up to 45 minutes for both specialist inpatient dementia care (1011 / 88%) and for functional inpatient mental health care (1016 / 89%).

Consideration:

The table below shows the average travel times for people that would travel by **public transport** (some people would have longer to travel).

It highlights the places where the average travel time is outside the 45 minutes:

Need	Place	Current (time mins)	1 a/b) Dementia unit in Dewsbury (time mins)	2) Dementia unit in Wakefield (time mins)
Dementia	Calderdale	38	61	98
Dementia	Greater Hudds	60	60	86
Dementia	North Kirklees	23	21	60
Dementia	Wakefield	42	62	37
Functional	Calderdale	37	30	30
Functional	Greater Hudds	59	49	49
Functional	North Kirklees	24	62	22
Functional	Wakefield	38	35	64

Of note, is that some of the current travel times are considerable, if people require public transport.

The table below shows the time take to travel by driving in all options. Although averages and some people take longer the vast majority of people that drive or have access to a car as a passenger will be able to visit within times that are considered acceptable.

Need	Place	Current (time mins)	1 a/b) Dementia unit in Dewsbury (time mins)	2) Dementia unit in Wakefield (time mins)
Dementia	Calderdale	19	34	37
Dementia	Greater Hudds	30	30	35
Dementia	North Kirklees	12	11	24
Dementia	Wakefield	21	27	17
Functional	Calderdale	18	14	14
Functional	Greater Hudds	31	22	22
Functional	North Kirklees	11	23	11
Functional	Wakefield	17	17	26

Consultation theme:

How people travel:

	1159
I drive a petrol/ diesel car	50%
Walk	32%
Bus	31%
Taxi	28%
Train	14%
Petrol/diesel car – as a passenger	11%
Patient transport	9%
I drive an electric/ hybrid car	6%
Other, please tell us	2%
Electric/hybrid car – as a passenger	2%
Bicycle	2%
Electric Bicycle	1%
Motorbike	0%

Of all people completing the survey, 56% of people drive and a further 13% of people have access to a car as a passenger.

Focussing on some groups that might be significantly impacted:

	I care for someone living with dementia	I care for someone living with functional mental health needs	Aged 80+
Drive	75%	69%	59%
Passenger	13%	15%	25%
Total drive or passenger	88%	84%	84%

As reflected above, for people aged over 80 the proportion that have access only as a passenger increases and it is possible that their loved one could be the person that drives, meaning that if their loved one was admitted, they may no longer have access to a car as a passenger.

Also, as people are able to tick more than one box in the consultation survey, it is also possible that the proportions of people that don't have access to a care from these groups are slightly higher.

Consideration:

A small but not inconsiderable proportion of people will be reliant on public transport to visit a loved one.

13.7 Numbers of people impacted by each option:

The percentage of people with car access in the table has been rounded down to try and ensure that we don't underestimate the numbers of next of kin visitors impacted by potential changes:

	Number of admissions per year	Car Access	No car access	Predicted numbers with car access	Predicted numbers without car access
Dementia Calderdale	22	85%	15%	19	3
Dementia Greater Huddersfield	15	85%	15%	13	2
Dementia North Kirklees	13	85%	15%	11	2
Dementia Wakefield	29	85%	15%	25	4
Functional Calderdale	46	80%	20%	37	9
Functional Greater Huddersfield	38	80%	20%	30	8
Functional North Kirklees	34	80%	20%	27	7
Functional Wakefield	47	80%	20%	38	9
Total	244			199	45

The data shows that potentially in the region of up to 50 people per year could be reliant on public transport.

For a group of these, the impact won't change / will be limited in either option.

Travel impact for each option:

Option 1:

	Predicted numbers with car access	Driving Time	Predicted numbers without car access	Public Transport time
Dementia Calderdale	19	34	3	61

Dementia Wakefield	25	27	4	62
Functional North Kirklees	27	23	7	62

Note: this assumes that people from Greater Huddersfield will be admitted to Beechdale, which overall is a similar travel time for people of Greater Huddersfield and an existing pathway for working aged adults from that place.

However, there will be more functional capacity at Wakefield. Importantly though, should someone from the west side of the Trust footprint be admitted to Wakefield, and this proves difficult travel for next of kin, there would be an opportunity to transfer the patient to Beechdale when a bed becomes available.

Practically, for those requiring public transport, some people from Wakefield district may be able to benefit from the free hospital bus that **currently** runs from Pontefract to Dewsbury via Pinderfields Hospital and vice versa from North Kirklees to Wakefield (accepting that the bus does not access the Fieldhead site).

There is a direct train from Todmorden, Hebden Bridge and Sowerby Bridge to Dewsbury that would help some people from Calderdale. However, there is still approximately 30 minutes uphill walk from Dewsbury station to Dewsbury Hospital, or a further bus journey.

Option 2:

	Predicted numbers with car access	Driving Time	Predicted numbers without car access	Public Transport time
Dementia Calderdale	19	37	3	98
Dementia Greater Huddersfield	13	35	2	86
Dementia North Kirklees	11	25	2	60
Functional Wakefield	38	27	9	64

As with option 1, for option 2 people from North Kirklees and Wakefield might be able to benefit from the free hospital bus. The journey from Calderdale and Kirklees to Wakefield via public transport will be long and complex for some people.

A key consideration of either option is that, so long as people have access to a car, travel times will, overall, be in line with the timings that people have said they're prepared to travel **for both options**.

There will be slightly more people impacted by option 2. For option 2, the impact is greater for those that will be reliant on public transport so there is likely to be more people that will either struggle to visit or will need support.

13.8 Proposed Mitigations

The Travel and Transport working group have been considering potential solutions to travel and transport challenges that emerge as a result of the transformed model. From the evidence provided to the group, it was clear that some protected characteristics, and health inclusion groups may experience more of an impact than others when having to travel long distances, to unfamiliar places, or use public transport. The group identified these as: people who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties. The mitigations in this report aim to address the issues for all groups identified but will benefit all patients, carers, and visitors.

A key recommendation is to implement a visitor support pathway. This will ensure that Trust is more systematic at being aware of potential travel problems and works with essential visitors to find solutions where visiting is more difficult. See appendix with process map for more information.

Visitor support pathway features the following:

- Help and guidance (non-financial) for people travelling to wards.
- Flexible visiting.
- Use of technology.
- Carer support – for example alignment with triangle of care.
- Working in partnership to make improvements to public transport, including potential access to Fieldhead Hospital.
- Failsafe in place for essential visitors (next of kin / carers) that are unable to visit follow other support and as a result of changes which could be a solution that involves financing. This could include volunteers, VCSE or failing their availability, private taxi hire.

Time period:

The travel and transport working group endorsed a 5 year time period for the visitor support pathway with potential reviews annually to check usage and adapt as appropriate. This would give the time needed for new ways of working to be fully embedded and allow for some ongoing review. If needed, there may be an option to retain some or all elements after 5 years but expectation is that it will be embedded in the system by that time.

More detail of travel impact and mitigations is set out on the table below:

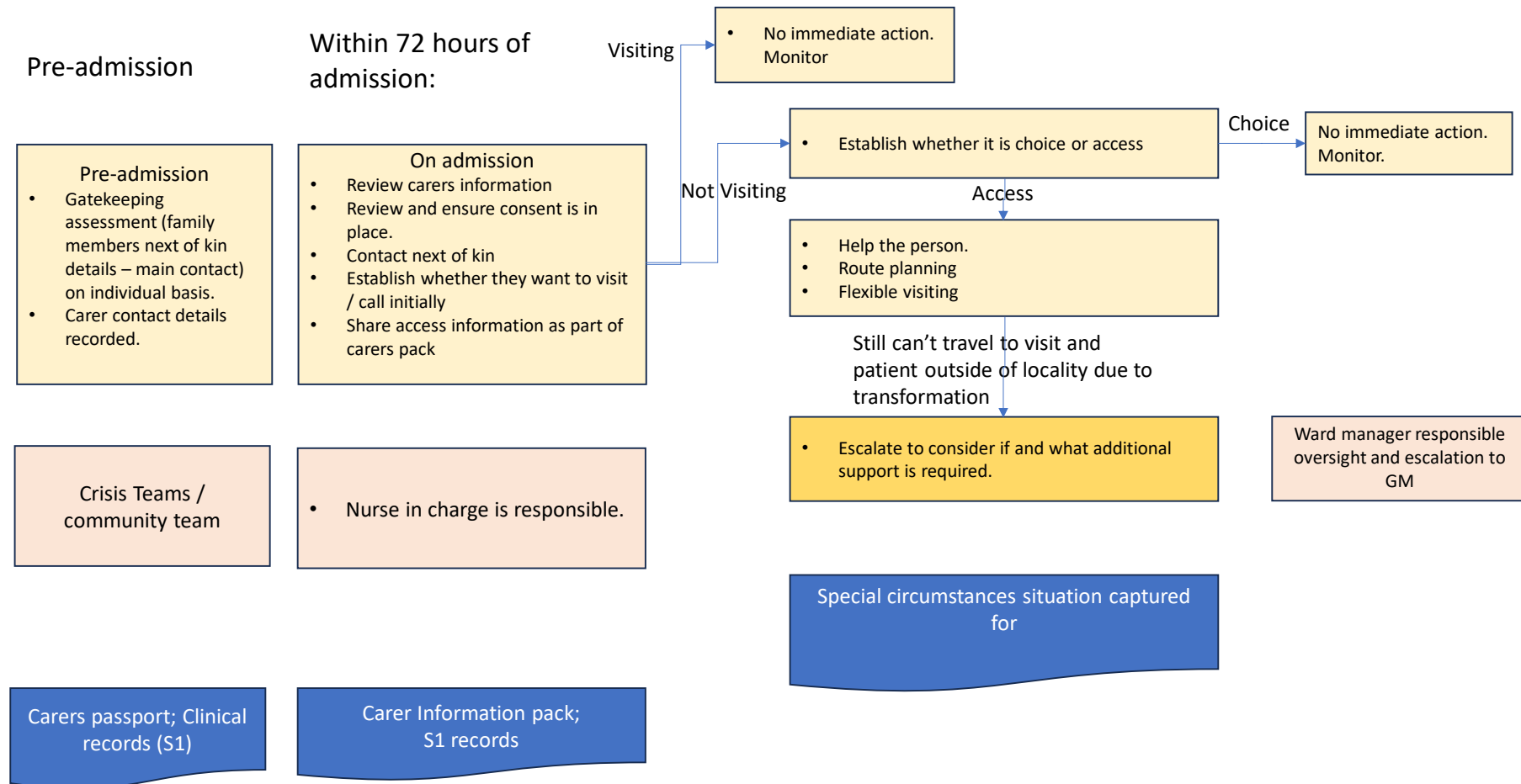
Theme	Transformation Impact	Equality and Health inequality group affected	Mitigations
Parking			
Parking should be free.	The net impact will be neutral but some people that currently would be admitted to a Wakefield ward will be admitted elsewhere and there will be a parking charge. Conversely, some people from other parts of the footprint will benefit from free parking at Wakefield.	Carers, people on low incomes or experiencing financial difficulty, people who do not qualify for disabled parking but have a disability or long-term condition that impacts travelling	Parking will be free to anyone visiting Fieldhead Hospital. Elsewhere, it is chargeable and the sites are not owned by South West Yorkshire Partnership, so it is outside the scope of the programme to change this.
Parking should be available and accessible.	No direct impact as a result of transformation, though we are aware of existing challenges at the Calderdale Royal Hospital site.	Carers, people on low incomes or experiencing financial difficulty, people who do not qualify for disabled parking but have a disability or long-term condition that impacts travelling	When the new multi-story car park in Calderdale opens, we expect that all sites will have appropriate parking facilities.
Consider the importance of parking facilities for patients / families and carers.			No direct mitigation is required on this, other than to keep a watching brief as part of the visitor support pathway.
Costs			
Consider the cost of travel, parking, and public transport.	The costs of travel have been considered in this impact assessment. There will be some cost increases as a result of	People who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people,	It is proposed that this forms part of the considerations of the visitor support pathway and costs will be considered if it becomes a barrier to essential visiting.

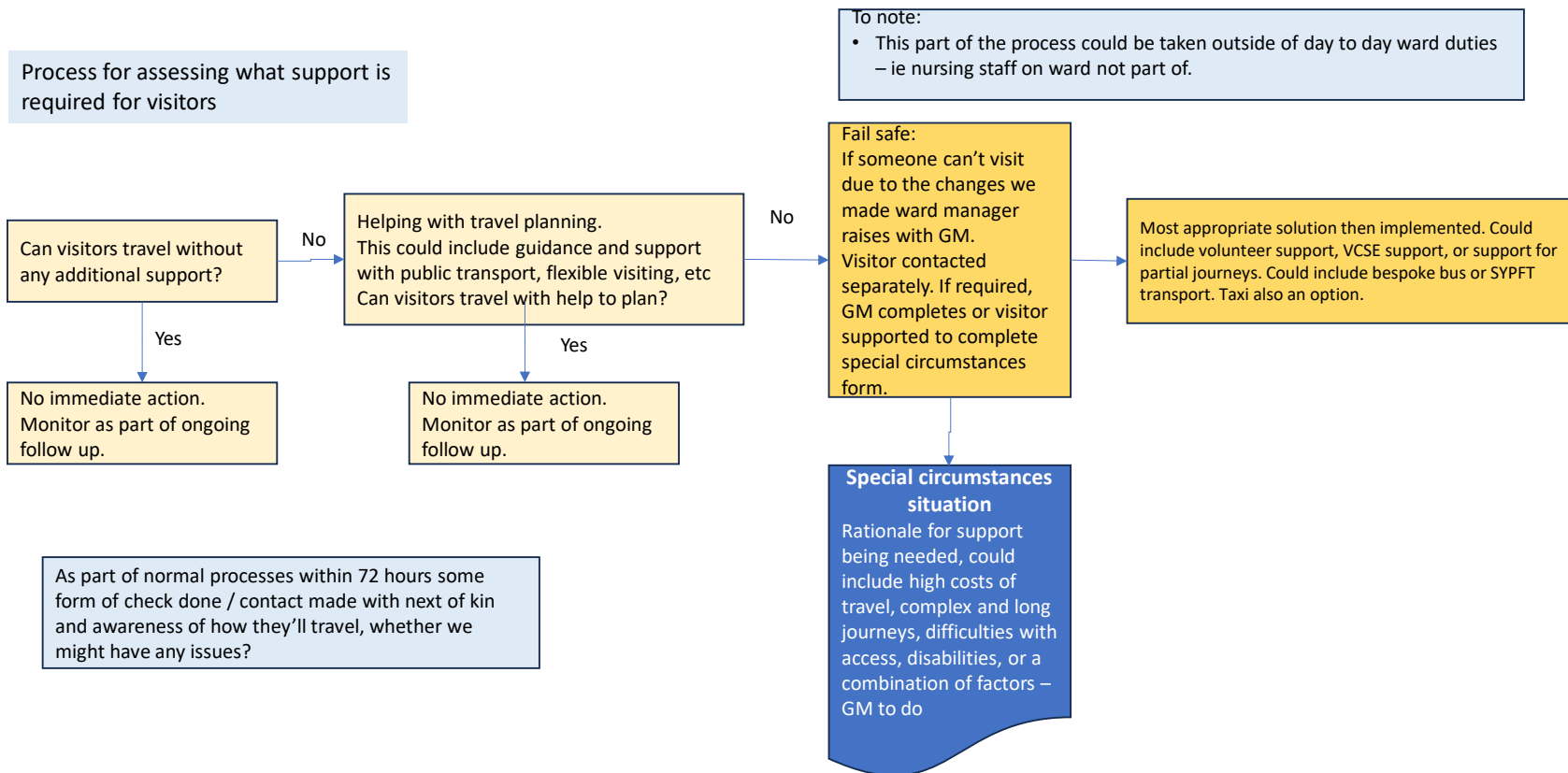
Theme	Transformation Impact	Equality and Health inequality group affected	Mitigations
	extra driving distances and longer public transport journeys. For many people, we hope that the costs of travel and transport will be affordable.	and people on low incomes or experiencing financial difficulties.	Use of digital technology could help some people, potentially supplementing some visits.
Availability, Accessibility and Ease of Public Transport			
Consider providing a free local bus / shuttle bus service.	No impact as a result of proposals, though we do know that this could lead to more people being admitted between Calderdale and Dewsbury and that these hospitals aren't serviced by free transport, whilst there currently is a free bus that runs across the Wakefield District Hospital footprint and to Dewsbury.	People who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties.	The programme team supports the principles of a free local bus / shuttle bus services. In particular, there are challenges linking Calderdale and Greater Huddersfield to Dewsbury. However, we also acknowledge that on its own, the changes of this programme will not create enough demand to warrant the commissioning of a bespoke service. The costs of such a service are estimated to be between £150-175K per annum. Our proposals are that this could be considered as part of wider system approaches and that we would flag the benefits of a shuttle bus for visitors to this model and ask that it is factored into considerations.

Theme	Transformation Impact	Equality and Health inequality group affected	Mitigations
			We would like to explore linking the free bus (113) that runs across the Mid Yorkshire hospital sites to the Fieldhead hospital site.
Ensure there are accessible, regular, and reliable public transport services available with minimal to no changes needed.	That there may be more people required to make lengthy and difficult public transport journeys in the new model to visit loved ones.	People who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties.	As part of the travel and transport group, activity has taken place to identify key areas where we feel improvements could be made to public transport. The key themes include: • Connectivity. • Access to toilets en route. • Routes to hospital. • Reliability. • Accessible information for people. • Support for people with disabilities and long-term conditions that impact on ability to travel. The programme team acknowledge that we are not directly able to or responsible for making any of these improvements, but we aim to work with the combined authority and will seek to feed this into other groups that have a focus on public transport. A direct mitigation is that these challenges will be factored into the visitor support pathway. So, as part of helping visitors to access the wards we will implement a travel guide that people can use and if travel does remain difficult, we will look at what
Consider the availability of public transport (e.g. frequency / time of day / location).		people who are disabled or have long term conditions, unpaid carers, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties.	
Consider the transportation difficulties for each location (e.g. distance, busy		Carers, people who are disabled or have long term conditions, some people from ethnic minority communities, older people, and people on low incomes	

Theme	Transformation Impact	Equality and Health inequality group affected	Mitigations
areas, availability of public transport)		or experiencing financial difficulties.	additional support we can give for people with special circumstances.
Travel may be difficult for some groups		Carers, people who are disabled or have long term conditions, some people from ethnic minority communities, older people, and people on low incomes or experiencing financial difficulties.	As part of this we will look to support people by offering flexible visiting hours and using digital technology for virtual visiting if/as appropriate.
Helping people			
Consider how to provide the best travel solutions to support patients, families, and carers to access services	As identified, some people will have longer and/or more expensive journeys to visit family and loved ones.		Implementation of the visitor support pathway will aim to find the best travel solutions for visitors, whilst improvement over time to public transport will hopefully further deliver better travel solutions for people. Digital solutions to support people will also be implemented, as will more flexible visiting hours across wards.

14 Appendix 1 – Visitor Support: Proposed Pathway





Follow up process

What's
required?

Review of visiting that is taking
place to be part of the Multi
Disciplinary Team review
(weekly ward round)

To note:

Ad hoc or short term support might be required if
family member / support becomes unavailable for
period of time
Also, support if major public transport issues occur
i.e. strike, weather condition, road closures leading
to public transport cancellation or delays.
As with other processes impact of transformation,
and escalation process be required.

Who is
responsible
and when?

Ward team - weekly

Information
recorded

MDT ward round information on
S1

15 Appendix 2: Public Transport themes identified by travel and transport working group:

Public Transport themes

ITEM	GENERAL THEMES
1.	Connectivity
2.	Access to toilets en route
3.	Routes to hospital
4.	Reliability
5.	Accessible information for people
6.	Support for people with disabilities and long-term conditions that impact on ability to travel

ITEM	SUB THEMES
1.	Connectivity: Being aware of where transport links and adjusting / being flexible for people on journeys with changes. Example: people don't need to wait 1 hour because their bus is delayed 5 minutes. Trains being part of the connectivity (not just busses).
2.	Toilet access: Toilets being available / toilets being free
3.	Routes to hospital: Hospitals are not the easiest place to get to. Busses going into hospital grounds. Town links to hospitals / town circular buses. Joining hospitals.
5.	Accessible information for other languages Accessible information for visually impaired Improved journey planning in one place, especially if people planning journeys across providers. Difficult to plan journeys in advance. Current system (moovit) not as good as old WY journey planner app.
6.	Limited timing of disabled bus passes.

ITEM	SPECIFIC THEMES
1.	Connectivity: Trains – any journey starting after 4.00pm is charged more including if people are delayed on a prior bus.
2.	Toilets: Dewsbury charge 20p, if people don't have change then this can be a problem. Radar keys – can these be made available for people to access toilets.
3.	Fieldhead link / bus into Fieldhead grounds. Link from Calderdale/ Huddersfield to Dewsbury
5.	Information on safe spaces for people travelling, when they're open, where they are, etc. Better travel assistance to certain places – ie Hospitals.

16 Appendix 3: Consultation survey feedback (excerpt from Consultation report)

16.1 Travel expectations to access services

Table 57 shows that most respondents expect to travel up to 45 minutes for specialist inpatient dementia care, with 679 (59%) saying they would travel up to 30 minutes and 332 (29%) saying they would travel between 30 and 45 minutes. When considering the responses across the geography, travel expectations were consistent across the Kirklees, Wakefield and Calderdale areas, with most respondents saying they would expect to travel up to 45 minutes.

Table 1. How long would you expect to travel for specialist inpatient dementia care?

-	Total – No.	Total - %	Kirklees	Wakefield	Calderdale	Other LAs	Unable to profile
	679	59%	58%	50%	75%	50%	43%
	332	29%	30%	38%	19%	28%	35%
	104	9%	9%	9%	5%	9%	17%
	32	3%	3%	3%	1%	13%	5%
	1147	-	529	170	284	32	132

Equalities analysis

This section presents significant differences across the protected demographic profiling characteristics and groups of most interest. Where groups are too small for significance testing the key reportable finding has been presented instead. For more information, see the reporting methodology section.

Respondent type:

Up to 30 minutes

- A significantly higher proportion of respondents who are living with functional mental health needs (65 / 72%), respondents living with dementia (21 / 68%), respondents who work for a voluntary or community organisation (100 / 61%), respondents who care for someone living with functional mental health needs (35 / 57%), respondents who work in social care, including care homes (26 / 53%) and those who care for someone living with dementia (64 / 52%) said that they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to a Governor or members of South West Yorkshire Partnership Foundation Trust (3 / 19%).
- A significantly higher proportion of respondents living with dementia (21 / 68%) and members of the public (393 / 66%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents working in healthcare (55 / 43%), staff working in older people's mental health services (37 / 37%) and Governors or members of South West Yorkshire Partnership Foundation Trust (3 / 19%).

Between 30 and 45 minutes

- A significantly higher proportion of respondents who previously cared for someone with dementia / functional mental health needs (4 / 50%), Governors or members of South West Yorkshire Partnership Foundation Trust (7 / 44%), respondents working in healthcare (56 / 44%), staff working in older people's mental health services (43 / 43%), respondents caring for someone living with dementia (42 / 34%), members of the public (151 / 25%), respondents who care for someone living with functional mental health needs (15 / 25%) and respondents who work for a voluntary or community organisation (41 / 25%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents living with functional mental health needs (13 / 14%).
- A significantly higher proportion of respondents who work in healthcare (56 / 44%) and members of staff working in older people's mental health services (43 / 43%) said they would expect to travel between 30 minutes and 45 minutes for specialist inpatient dementia care compared to respondents living with dementia (6 / 19%).

Between 45 and 60 minutes

- A significantly higher proportion of Governors or members of South West Yorkshire Partnership Foundation Trust (4 / 25%) and staff working in older people's mental health services (17 / 17%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to members of the public (40 / 7%).

Gender:

- There were no significant differences across the different gender cohorts. Similar proportions of male (287 / 89%) and female (672 / 88%) respondents said that they would expect to travel up to 45 minutes for specialist inpatient dementia care.

Age:

Up to 30 minutes

- A significantly higher proportion of respondents aged 40 to 59 (270 / 67%) and 18 to 39 (179 / 63%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents aged 60 to 79 (139 / 50%).

Between 30 and 45 minutes

- A significantly higher proportion of respondents aged 80 and over (20 / 45%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents aged 60 to 79 years (91 / 33%) and 40 to 59 (98 / 24%).
- A significantly higher proportion of respondents aged 80 and over (20 / 45%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents aged 18 to 39 (79 / 28%).

Religion:

Up to 30 minutes

- A significantly higher proportion of Muslim respondents (331 / 77%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to Christian respondents (188 / 51%), respondents with no religion (87 / 41%) and Buddhist respondents (3 / 38%).

Between 30 and 45 minutes

- A significantly higher proportion of Jewish respondents (3 / 60%), respondents with no religion (89 / 42%) and Christian respondents (113 / 36%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to Muslim respondents (71 / 16%).
- A significantly higher proportion of respondents with no religion (89 / 42%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to Hindu respondents (3 / 16%).

Between 45 and 60 minutes

- A significantly higher proportion of Buddhist respondents (3 / 38%), Hindu respondents (4 / 21%), respondents with no religion (27 / 13%) and Christian respondents (37 / 10%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to Muslim respondents (22 / 5%)

Ethnicity:

Up to 30 minutes

- A significantly higher proportion of Asian / Asian British respondents (341 / 76%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents from mixed / multiple ethnic backgrounds (9 / 47%), White British respondents (238 / 45%), White Gypsy or Irish Traveller or Roma respondents (2 / 29%) and White Irish respondents (3 / 27%).

Between 30 and 45 minutes

- A significantly higher proportion of White respondents from other backgrounds (4 / 67%), White Irish (6 / 55%) and White British respondents (217 / 41%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to Asian / Asian British respondents (69 / 15%).

Between 45 and 60 minutes

- A significantly higher proportion of respondents from mixed / multiple ethnic backgrounds (5 / 26%) and White British respondents (58 / 11%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to Asian / Asian British respondents (29 / 6%).

Over 60 minutes

- A significantly higher proportion of Black / African / Caribbean / Black British respondents (3 / 13%) said they would expect to travel over 60 minutes for specialist inpatient dementia care compared to Asian / Asian British respondents (9 / 2%).

Disability:

Up to 30 minutes

- A significantly higher proportion of disabled respondents (182 / 78%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to non-disabled respondents (439 / 54%).

Between 30 and 45 minutes

- A significantly higher proportion of non-disabled respondents (270 / 33%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to disabled respondents (37 / 16%).

Between 45 and 60 minutes

- A significantly higher proportion of non-disabled respondents (86 / 11%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to disabled respondents (10 / 4%).

Long-term conditions or illnesses:

Up to 30 minutes

- A significantly higher proportion of respondents with a mental health condition (155 / 76%), those with a long-term condition (142 / 72%), respondents with a physical or mobility impairment (105 / 67%), and respondents with a hearing impairment (46 / 56%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents who do not have a disability (62 / 41%).
- A significantly higher proportion of respondents with a mental health condition (155 / 76%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to neurodivergent respondents (22 / 58%), those with a hearing impairment (46 / 56%) and those who do not have a disability (62 / 41%).

Between 30 and 45 minutes

- A significantly higher proportion of respondents who do not have a disability (65 / 43%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents with a physical or mobility impairment (41 / 26%), respondents with a long-term condition (38 / 19%), respondents with a mental health condition (34 / 17%), and those with a sight impairment (5 / 16%).
- A significantly higher proportion of neurodivergent respondents (13 / 34%), respondents with a hearing impairment (26 / 32%) and those who have a physical or mobility impairment (41 / 26%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents with a mental health condition (34 / 17%).
- A significantly higher proportion of respondents with a hearing impairment (26 / 32%), said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents with a long-term condition (38 / 19%).

Between 45 and 60 minutes

- A significantly higher proportion of respondents who do not have a disability (20 / 13%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to respondents with a physical or mobility impairment (7 / 4%), those with a mental health condition (10 / 5%), and respondents with a long-term health condition (10 / 5%).

Carer

- A significantly higher proportion of respondents who are not carers (77 / 11%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to respondents who are carers (21 / 6%).

Sexual orientation:

- A significantly higher proportion of heterosexual respondents (557 / 61%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to bisexual / pansexual / asexual respondents (6 / 32%).

Transgender:

- A significantly higher proportion of transgender respondents (3 / 60%) agreed that they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to non-transgender respondents (88 / 9%).

Impact of the cost of living:

Up to 30 minutes

- A significantly higher proportion of respondents who are really struggling (209 / 85%) and those who are just getting by (202 / 64%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents who are quite comfortable (158 / 43%) and very comfortable (21 / 33%).

Between 30 and 45 minutes

- A significantly higher proportion of respondents who are quite comfortable (158 / 43%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents who are just getting by (88 / 28%) and really struggling (24 / 10%).
- A significantly higher proportion of respondents who are very comfortable (24 / 38%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents who are really struggling (24 / 10%).

Between 45 and 60 minutes

- A significantly higher proportion of respondents who are very comfortable (13 / 21%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to respondents who are quite comfortable (40 / 11%), just getting by (21 / 7%) and really struggling (9 / 4%).
- A significantly higher proportion of respondents who are quite comfortable (40 / 11%) agreed that they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to respondents who are really struggling (9 / 4%).

Over 60 minutes

- A significantly higher proportion of respondents who are very comfortable (5 / 8%) said they would expect to travel over 60 minutes for specialist inpatient dementia care compared to respondents who are just getting by (5 / 2%) and really struggling (3 / 1%).

Local authority area:

Up to 30 minutes

- A significantly higher proportion of respondents from the Calderdale area (213 / 75%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents from the Kirklees (308 / 58%) and Wakefield (85 / 50%) areas.

Between 30 and 45 minutes

- A significantly higher proportion of respondents from the Wakefield (65 / 38%) and Kirklees (157 / 30%) areas said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents from the Calderdale area (55 / 19%).

Between 45 and 60 minutes

- A significantly higher proportion of respondents from Kirklees area (49 / 9%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to respondents from the Calderdale area (14 / 5%).

Deprivation:

Up to 30 minutes

- A significantly higher proportion of respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (244 / 72%) said they would expect to travel up to 30 minutes for specialist inpatient dementia care compared to respondents from postcode areas where 40% to 49% of the locality are from the most deprived deciles (103 / 62%) and respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (275 / 54%).

Between 30 and 45 minutes

- A significantly higher proportion of respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (175 / 34%) said they would expect to travel between 30 and 45 minutes for specialist inpatient dementia care compared to respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (67 / 20%).

Between 45 and 60 minutes

- A significantly higher proportion of respondents from postcode areas where 40% to 49% of the locality are from the most deprived deciles (17 / 10%) and respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (47 / 9%) said they would expect to travel between 45 and 60 minutes for specialist inpatient dementia care compared to respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (17 / 5%).

For a full breakdown of the responses to this question by these groups and other groups please see the Excel data tables.

Additionally, Table 58 shows that most respondents expect to travel up to 45 minutes for functional inpatient mental health care, with 686 (60%) saying they would travel up to 30 minutes and 330 (29%) saying they would travel between 30 and 45 minutes. When considering the responses across the geography, travel expectations were consistent across the Kirklees, Wakefield and Calderdale areas with most people saying they would expect to travel up to 45 minutes.

Table 2. How long would you expect to travel for functional inpatient mental health care?

-	Total – No.	Total - %	Kirklees	Wakefield	Calderdale	Other LAs	Unable to profile
	686	60%	58%	52%	76%	63%	47%
	330	29%	31%	35%	18%	19%	37%
	87	8%	7%	8%	5%	16%	11%

	33	3%	3%	5%	0%	3%	5%
		-	524	167	282	32	131

Equalities analysis

This section presents significant differences across the protected demographic profiling characteristics and groups of most interest. Where groups are too small for significance testing the key reportable finding has been presented instead. For more information, see the reporting methodology section.

Respondent type:

Up to 30 minutes

- A significantly higher proportion of respondents living with dementia (23 / 77%), respondents living with functional mental health needs (62 / 70%) and members of the public (399 / 67%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents who care for someone living with dementia (62 / 53%), respondents who work in social care, including care homes (25 / 51%), staff working in older people's mental health services (46 / 46%), respondents who work in healthcare (57 / 45%), and Governors or members of South West Yorkshire Partnership (4 / 25%).
- A significantly higher proportion of respondents working for a voluntary or community organisation (103 / 62%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to staff working in older people's mental health services (46 / 46%) and respondents who work in healthcare (57 / 45%).
- A significantly higher proportion of respondents living with dementia (23 / 77%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents who know someone living with dementia / functional mental health needs (4 / 36%) and those who previously cared for someone with dementia / functional mental health needs (2 / 29%).
- A significantly higher proportion of respondents living with dementia (23 / 77%), respondents living with functional mental health needs (62 / 70%) and members of the public (399 / 67%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents who care for someone living with dementia (62 / 53%).

30 to 45 minutes

- A significantly higher proportion of respondents who work in healthcare (54 / 43%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents who work for a voluntary or community organisation (47 / 28%), members of the public (142 / 24%), respondents who care for someone living with functional mental health needs (16 / 25%), respondents living with dementia (6 / 20%), and respondents living with functional mental health needs (16 / 18%).
- A significantly higher proportion of respondents who work in healthcare (54 / 43%), staff working in older people's mental health services (36 / 36%) and respondents who care for someone living with dementia (43 / 36%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to members of the public (142 / 24%).
- A significantly higher proportion of respondents working in healthcare (54 / 43%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents who work for a voluntary or community organisation (47 / 28%).

- A significantly higher proportion of respondents who previously cared for someone with dementia / functional mental health needs (4 / 57%), Governors or members of South West Yorkshire Partnership Foundation Trust (7 / 44%), respondents who work in healthcare (54 / 43%), staff working in older people's mental health services (36 / 36%) and respondents who care for someone living with dementia (43 / 36%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents who are living with functional mental health needs (16 / 18%).

45 to 60 minutes

- A significantly higher proportion of staff working in older people's mental health services (14 / 14%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to respondents who work for a voluntary or community organisation (12 / 7%).

Over 60 minutes

- A significantly higher proportion of respondents living with functional mental health needs (7 / 8%) said they would expect to travel over 60 minutes for functional inpatient mental health care compared to respondents who work for a voluntary or community organisation (3 / 2%) and members of the public (12 / 2%).

Gender:

- There were no significant differences across the different gender cohorts. Similar proportions of male (293 / 91%) and female (669 / 89%) respondents said they would expect to travel up to 45 minutes for functional inpatient mental health care.

Age:

Up to 30 minutes

- A significantly higher proportion of respondents aged 40 to 59 years (278 / 69%) and 18 to 39 (190 / 66%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents aged 80 and over (23 / 52%) and 60 to 79 (129 / 48%).

30 to 45 minutes

- A significantly higher proportion of respondents aged 80 and over (21 / 48%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents aged 18 to 39 years (76 / 27%) and 40 to 59 (97 / 24%).
- A significantly higher proportion of respondents aged 80 and over (21 / 48%) and those aged 60 to 79 years (89 / 33%) agreed that they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents aged 40 to 59 (97 / 24%).

45 to 60 minutes

- A significantly higher proportion of respondents aged 60 to 79 years (37 / 14%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to respondents aged 40 to 59 (24 / 6%) and 18 to 39 (12 / 4%).

Over 60 minutes

- A significantly higher proportion of respondents aged 60 to 79 years (13 / 5%) agreed that they would expect to travel over 60 minutes for functional inpatient mental health care compared to respondents aged 40 to 59 years (6 / 1%).

Religion:

Up to 30 minutes

- A significantly higher proportion of Muslim respondents (336 / 78%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to Hindu respondents (10 / 53%), Christian respondents (180 / 50%), respondents with no religion (98 / 46%), and Jewish respondents (1 / 20%).

30 to 45 minutes

- A significantly higher proportion of respondents with no religion (82 / 38%) and Christian respondents (132 / 37%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to Muslim respondents (76 / 18%).

45 to 60 minutes

- A significantly higher proportion of Hindu respondents (3 / 16%), respondents with no religion (26 / 12%) and Christian respondents (36 / 10%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to Muslim respondents (9 / 2%).

Ethnicity:

Up to 30 minutes

- A significantly higher proportion of Asian / Asian British respondents (346 / 77%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to White British respondents (243 / 47%), respondents from mixed / multiple ethnic groups (8 / 42%), and White Irish respondents (4 / 36%).

30 to 45 minutes

- A significantly higher proportion of White Irish respondents (6 / 55%) and White British respondents (204 / 39%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to Asian / Asian British respondents (76 / 17%).

45 to 60 minutes

- A significantly higher proportion of respondents from mixed / multiple ethnic groups (3 / 16%) and White British respondents (60 / 11%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to Asian / Asian British respondents (15 / 3%).

Disability:

Up to 30 minutes

- A significantly higher proportion of disabled respondents (178 / 77%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to non-disabled respondents (456 / 56%).

30 to 45 minutes

- A significantly higher proportion of non-disabled respondents (263 / 32%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to disabled respondents (37 / 16%).

45 to 60 minutes

- A significantly higher proportion of non-disabled respondents (74 / 9%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to disabled respondents (9 / 4%).

Long-term conditions or illnesses:

Up to 30 minutes

- A significantly higher proportion of respondents with a learning, understanding, concentrating or memory impairment (14 / 88%), respondents with a mental health condition (160 / 78%) and those with a long-term condition (141 / 72%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents with a hearing impairment (45 / 56%).
- A significantly higher proportion of respondents with a learning, understanding, concentrating or memory impairment (14 / 88%), respondents with a mental health condition (160 / 78%), respondents with a long-term condition (141 / 72%), respondents with a physical or mobility impairment (105 / 69%) and respondents with a sight impairment (20 / 67%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents who do not have a disability (64 / 43%).
- A significantly higher proportion of respondents with a mental health condition (160 / 78%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to neurodivergent respondents (21 / 55%).

30 to 45 minutes

- A significantly higher proportion of respondents who do not have a disability (63 / 42%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents with a long-term condition (39 / 20%), respondents with a mental health condition (33 / 16%), and respondents with a learning, understanding, concentrating or memory impairment (12 / 6%).
- A significantly higher proportion of neurodivergent respondents (13 / 34%) and respondents with a hearing impairment (27 / 34%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents with a mental health condition (33 / 16%).
- A significantly higher proportion of respondents with a hearing impairment (27 / 34%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents with a long-term condition (39 / 20%).

45 to 60 minutes

- A significantly higher proportion of respondents who do not have a disability (22 / 15%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health

care compared to respondents with a physical or mobility impairment (9 / 6%) and respondents with a mental health condition (7 / 3%).

Carer

- A significantly higher proportion of respondents who are not carers (21 / 3%) said they would expect to travel over 60 minutes for functional inpatient mental health care compared to respondents who are carers (2 / 1%).

Sexual orientation:

- A significantly higher proportion of heterosexual respondents (566 / 62%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to bisexual / pansexual / asexual respondents (7 / 37%).

Transgender:

- There were no significant differences among this group. Of those responding to this question, 5 said they were transgender. 1 said they would expect to travel up to 30 minutes, 2 said they would expect to travel between 30 and 45 minutes, and 2 said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care.

Impact of the cost of living:

Up to 30 minutes

- A significantly higher proportion of respondents who are really struggling (210 / 85%) and those who are just getting by (199 / 64%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents who are quite comfortable (165 / 46%) and very comfortable (23 / 37%).

30 to 45 minutes

- A significantly higher proportion of respondents who are very comfortable (25 / 40%), quite comfortable (146 / 40%) and just getting by (90 / 29%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents who are really struggling (31 / 13%).

45 to 60 minutes

- A significantly higher proportion of respondents who are very comfortable (11 / 18%) and quite comfortable (41 / 11%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to respondents who are just getting by (16 / 5%) and really struggling (2 / 1%).

Local authority area:

Up to 30 minutes

- A significantly higher proportion of respondents from the Calderdale area (214 / 76%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents from the Kirklees (304 / 58%) and Wakefield (87 / 52%) areas.

30 to 45 minutes

- A significantly higher proportion of respondents from the Wakefield (58 / 35%) and Kirklees (165 / 31%) areas said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared to respondents from the Calderdale area (52 / 18%).



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Over 60 minutes

- A significantly higher proportion of respondents from the Wakefield (8 / 5%) and Kirklees (17 / 3%) areas said they would expect to travel over 60 minutes for functional inpatient mental health care compared to respondents from the Calderdale area (1 / 0.4%).

Deprivation:

Up to 30 minutes

- A significantly higher proportion of respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (246 / 73%) said they would expect to travel up to 30 minutes for functional inpatient mental health care compared to respondents from postcode areas where 40% to 49% of the locality are from the most deprived deciles (101 / 62%) and respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (278 / 55%).

30 to 45 minutes

- A significantly higher proportion of respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (166 / 33%) said they would expect to travel between 30 and 45 minutes for functional inpatient mental health care compared respondents from postcode areas where 40% to 49% of the locality are from the most deprived deciles (45 / 28%) and respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (70 / 21%).

45 to 60 minutes

- A significantly higher proportion of respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (50 / 10%) said they would expect to travel between 45 and 60 minutes for functional inpatient mental health care compared to respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (13 / 4%).

For a full breakdown of the responses to this question by these groups and other groups please see the Excel data tables.

16.1.1.1 Travel method and considerations

Table 59 shows that most respondents travel using a petrol / diesel car (582 / 50%), walking (368 / 32%) and by bus (364 / 31%). When considering the responses across the geography, most respondents from the Wakefield (113 / 66%) and Kirklees (278 / 52%) areas said they travel using a petrol / diesel car, while most respondents from the Calderdale area said they travel by taxi (164 / 57%).

Table 3. How do you travel?

-	Total – No.	Total - %	Kirklees	Wakefield	Calderdale	Other LAs	Unable to profile
I drive a petrol/ diesel car	582	50%	52%	66%	40%	34%	50%
Walk	368	32%	29%	17%	55%	3%	17%
Bus	364	31%	38%	31%	22%	13%	29%
Taxi	329	28%	20%	15%	57%	16%	20%
Train	168	14 %	16%	11%	14%	13%	14%
Petrol/diesel car – as a passenger	129	11%	15%	12%	7%	9%	6%
Patient transport	108	9%	3%	5%	27%	6%	3%
I drive an electric/ hybrid car	73	6%	7%	7%	3%	19%	6%
Electric/hybrid car – as a passenger	24	2%	3%	2%	-	3%	3%
Bicycle	21	2%	1%	2%	2%	3%	4%
Electric Bicycle	6	1%	1%	1%	1%	-	-
Motorbike	5	0.4%	1%	-	-	3%	1%
I drive a petrol/ diesel car	582	50%	52%	66%	40%	34%	50%
		-	534	172	288	32	133

Equalities analysis

This section presents significant differences across the protected demographic profiling characteristics and groups of most interest. Where groups are too small for significance testing the key reportable finding has been presented instead. For more information, see the reporting methodology section.

Respondent type:

Drive a petrol / diesel car

- A significantly higher proportion of Governors or members of South West Yorkshire Partnership Foundation Trust (12 / 75%), staff working in older people's mental health services (71 / 70%), respondents who care for someone living with dementia (81 / 66%), respondents who care for someone living with functional mental health needs (39 / 61%) and those who work in healthcare (71 / 56%) travel by driving a petrol / diesel car compared to members of the public (272 / 45%), respondents living with dementia (9 / 29%) and functional mental health needs (38 / 41%).
- A significantly higher proportion staff working in older people's mental health services (71 / 70%), and respondents who care for someone living with dementia (81 / 66%) travel by driving a petrol / diesel car compared to respondents who work for a voluntary or community organisation (82 / 50%).

- A significantly higher proportion of staff working in older people's mental health services (71 / 70%) travel by driving a petrol / diesel car compared to respondents who work in healthcare (71 / 56%), respondents who work in social care, including care homes (25 / 51%), respondents who work for a voluntary or community organisation (82 / 50%), members of the public (272 / 45%) and retired respondents (3 / 30%).

Walking

- A significantly higher proportion of members of the public (273 / 45%) travel by walking compared to respondents who care for someone living with dementia (25 / 20%), respondents who work in healthcare (20 / 16%) and staff working in older people's mental health services (8 / 8%).
- A significantly higher proportion of respondents who are living with functional mental health needs (34 / 37%) travel by walking compared to respondents who work for a voluntary or community organisation (57 / 35%), respondents who care for someone living with functional mental health needs (19 / 30%), respondents who care for someone living with dementia (25 / 20%), respondents who are living with dementia (6 / 19%), respondents who work in healthcare (20 / 16%), respondents who know someone living with dementia / functional mental health needs (1 / 9%), and members of staff working in older people's mental health services (8 / 8%).
- A significantly higher proportion of respondents who work in social care, including care homes (15 / 31%) travel by walking compared to respondents who work in healthcare (20 / 16%), and staff working in older people's mental health services (8 / 8%).
- A significantly higher proportion of respondents who are living with functional mental health needs (34 / 37%) and respondents who work for a voluntary or community organisation (57 / 35%), travel by walking compared to respondents who care for someone living with dementia (25 / 20%), respondents who work in healthcare (20 / 16%), staff working in older people's mental health services (8 / 8%).
- A significantly higher proportion of Governors or members of South West Yorkshire Partnership Foundation Trust (4 / 50%) travel by walking compared to respondents who work in healthcare (20 / 16%) and staff working in older people's mental health services (8 / 8%).

Bus

- A significantly higher proportion of Governors or members of South West Yorkshire Partnership Foundation Trust (8 / 50%), respondents who are living with functional mental health needs (45 / 49%), respondents who are living with dementia (13 / 42%), respondents who work in social care, including care homes (19 / 39%), respondents who care for someone living with functional mental health needs (24 / 38%), respondents who work for a voluntary or community organisation (61 / 37%) and members of the public (219 / 36%) travel by bus compared to respondents working in healthcare (27 / 21%) and staff working in older people's mental health services (17 / 17%).
- A significantly higher proportion of respondents who are living with functional mental health needs (45 / 49%) travel by bus compared to respondents who work for a voluntary or community organisation (61 / 37%), respondents who care for someone living with dementia (40 / 33%), respondents who work in healthcare (27 / 21%) and members of staff working in older people's mental health service (17 / 17%).

Taxi

- A significantly higher proportion of respondents living with functional mental health needs (27 / 29%) travel by taxi compared to staff working in older people's mental health services (12 / 12%).

- A significantly higher proportion of members of the public (226 / 37%) travel by taxi compared to respondents who care for someone living with dementia (23 / 19%).
- A significantly higher proportion of respondents who care for someone living with functional mental health needs (18 / 28%) travel by taxi compared to respondents who work in healthcare (20 / 16%) and staff working in older people's mental health services (12 / 12%).
- A significantly higher proportion of members of the public (226 / 37%) and respondents who work for a voluntary or community organisation (42 / 25%) travel by taxi compared to respondents who work in healthcare (20 / 16%).

Train

- A significantly higher proportion of Governors or members of South West Yorkshire Partnership Foundation Trust (5 / 31%) travel by train compared to staff working in older people's mental health services (10 / 10%).

Passenger in a petrol / diesel car

- A significantly higher proportion of respondents who are living with functional mental health needs (17 / 18%) travel as a passenger in a petrol / diesel car compared to staff working in older people's mental health services (8 / 8%).

Gender:

- When comparing the responses by this cohort a significantly higher proportion of female respondents said they travel using a petrol / diesel car (409 / 53%) and as a passenger in a petrol / diesel car (100 / 13%), compared to male respondents (drive: 148 / 45%, passenger: 24 / 7%).
- A significantly higher proportion of male respondents said they walk (133 / 41%), travel by taxi (113 / 35%) and use patient transport (50 / 15%) compared to female respondents (walk: 216 / 28%, taxi: 200 / 26%, patient transport: 54 / 7%).

Age:

Drive a petrol / diesel car

- A significantly higher proportion of respondents aged 60 to 79 (157 / 55%) and 40 to 59 (214 / 52%) travelled by driving a petrol / diesel car compared to respondents aged 18 to 39 (121 / 42%) and under 18 years (1 / 11%).

Walk

- A significantly higher proportion of respondents aged under 18 (8 / 89%) travelled by walking compared to respondents aged 40 to 59 (152 / 37%), 18 to 39 (100 / 35%), 60 to 79 (76 / 27%) and 80 and over (9 / 19%).

Bus

- A significantly higher proportion of respondents aged 60 to 79 (123 / 43%) travelled by bus compared to respondents aged 18 to 39 (82 / 29%) and 40 to 59 (98 / 24%).
- A significantly higher proportion of respondents aged 80 years and over (18 / 38%) travelled by bus compared to respondents aged 40 to 59 (98 / 24%).

Taxi

- A significantly higher proportion of respondents aged 40 to 59 (150 / 37%) and 18 to 39 (94 / 33%) travelled by taxi compared to respondents aged 60 to 79 (59 / 21%) and 80 and over (7 / 15%).

Train

- A significantly higher proportion of respondents aged 60 to 79 (53 / 19%) travelled by train compared to respondents aged 40 to 59 (52 / 13%).

Patient transport

- A significantly higher proportion of respondents aged 40 to 59 (60 / 15%) travelled by patient transport compared to respondents aged 60 to 79 (15 / 5%).

Religion:

Drive a petrol / diesel car

- A significantly higher proportion of respondents with no religion (139 / 63%) and Christian respondents (226 / 61%) travelled by driving a petrol / diesel car compared to Hindu (7 / 37%) and Muslim respondents (153 / 35%).

Walking

- A significantly higher proportion of Muslim respondents (205 / 48%) travelled by walking compared to respondents with no religion (49 / 22%), and Christian respondents (80 / 21%).

Bus

- A significantly higher proportion of respondents with no religion (81 / 37%) and Christian respondents (124 / 33%) travelled by bus compared to Muslim respondents (108 / 25%).

Taxi

- A significantly higher proportion of Muslim (206 / 48%) and Hindu respondents (7 / 37%) travelled by taxi compared to respondents with no religion (35 / 16%) and Christian respondents (59 / 16%).

Train

- A significantly higher proportion of respondents with no religion (50 / 23%) travelled by train compared to Christian respondents (44 / 12%) and Muslim respondents (51 / 12%).

Patient transport

- A significantly higher proportion of Muslim respondents (75 / 17%) travelled by patient transport compared to respondents with no religion (11 / 5%) and Christian respondents (17 / 5%).

Drive an electric / hybrid car

- A significantly higher proportion of Sikh respondents (2 / 22%), those with no religion (22 / 10%) and Christian respondents (30 / 8%) travelled using an electric / hybrid car compared to Muslim respondents (12 / 3%).

Bicycle

- A significantly higher proportion of respondents with no religion (10 / 5%) travelled by bicycle compared to Christian (5 / 1%) and Muslim respondents (5 / 1%).

Motorbike

- A significantly higher proportion of Sikh respondents (1 / 11%) travelled by motorbike compared to Christian (1 / 0.3%) and Muslim respondents (1 / 0.2%).

Ethnicity:

Drive a petrol / diesel car

- A significantly higher proportion of White British respondents (346 / 64%) travelled by driving a petrol / diesel car compared to Asian / Asian British (165 / 37%) and Chinese and other ethnic group respondents (4 / 29%).

Walk

- A significantly higher proportion of Asian / Asian British respondents (212 / 47%) travelled by walking compared to Black / African / Caribbean / Black British respondents (5 / 19%).
- A significantly higher proportion of Asian / Asian British respondents (212 / 47%) travelled by walking compared to White British respondents (104 / 19%).

Bus

- A significantly higher proportion of White respondents from other backgrounds (5 / 83%) travelled by bus compared to White British respondents (189 / 35%), respondents from mixed / multiple ethnic groups (5 / 26%) and Asian / Asian British (112 / 25%) respondents.

Taxi

- A significantly higher proportion of Asian / Asian British respondents (212 / 47%) travelled by taxi compared to respondents from mixed / multiple ethnic groups (3 / 16%), Chinese and other ethnic group respondents (2 / 14%), White British respondents (71 / 13%), and White Irish respondents (1 / 9%).
- A significantly higher proportion of Black / African / Caribbean / Black British respondents (10 / 37%) travelled by taxi compared to White British respondents (71 / 13%).

Train

- A significantly higher proportion of White British respondents (90 / 17%) travelled by train compared to Asian / Asian British respondents (50 / 11%).

Patient transport

- A significantly higher proportion of Asian / Asian British respondents (75 / 17%) travelled by patient transport compared to White British respondents (24 / 4%).

Drive an electric / hybrid car

- A significantly higher proportion of mixed / multiple ethnic group respondents (4 / 21%) travelled by driving an electric / hybrid car compared to White British (43 / 8%), and Asian / Asian British (15 / 3%) respondents.

Disability:

- When comparing the responses by this cohort a significantly higher proportion of respondents who did not have a disability said they travel by driving a petrol / diesel car (464 / 56%) and by bus (266 / 32%), compared to respondents with a disability (drive: 83 / 35%, bus: 59 / 25%).
- Whereas a significantly higher proportion of respondents with a disability said they walk (122 / 52%), travel by taxi (136 / 58%) and use patient transport (74 / 31%), compared to non-disabled respondents (walk: 218 / 26%, taxi: 160 / 19%, patient transport: 25 / 3%).

Long-term conditions or illnesses:

Drive a petrol / diesel car

- A significantly higher proportion of respondents who do not have a disability (106 / 69%) travelled by driving a petrol/ diesel car compared to respondents with a physical or mobility impairment (76 / 47%), hearing impairment (36 / 44%), neurodivergent respondents (16 / 42%), and learning, understanding, concentrating or memory impairments (5 / 31%).

Walk

- A significantly higher proportion of respondents with a mental health condition (118 / 57%) travelled by walking compared to respondents with a sight impairment (11 / 35%), physical or mobility impairment (49 / 30%), a hearing impairment (17 / 21%), and respondents who did not have a disability (20 / 13%).
- A significantly higher proportion of respondents with a long-term condition (94 / 47%) travelled by walking compared to respondents with a physical or mobility impairment (49 / 30%) and a hearing impairment (17 / 21%).
- A significantly higher proportion of neurodivergent respondents (15 / 39%) travelled by walking compared to respondents who did not have a disability (20 / 13%).

Bus

- A significantly higher proportion of respondents with a hearing impairment (36 / 44%) travelled by bus compared to respondents with a long-term condition (52 / 26%).
- A significantly higher proportion of neurodivergent respondents (18 / 47%) and those with a hearing impairment (36 / 44%) travelled by bus compared to respondents with a mental health condition (58 / 28%) and those who do not have a disability (32 / 21%).

Taxi

- A significantly higher proportion of respondents with a mental health condition (121 / 59%) and respondents with a physical or mobility impairment (66 / 41%) travelled by taxi compared to respondents with a hearing impairment (22 / 27%), neurodivergent respondents (8 / 21%) and respondents who do not have a disability (13 / 8%).
- A significantly higher proportion of respondents with learning, understanding, concentrating or memory impairments (9 / 56%) travelled by taxi compared to respondents with a hearing impairment (22 / 27%), and respondents who do not have a disability (13 / 8%).
- A significantly higher proportion of respondents with a sight impairment (13 / 42%) travelled by taxi compared to respondents who do not have a disability (13 / 8%).

- A significantly higher proportion of respondents with a mental health condition (121 / 59%) and respondents with a long-term condition (94 / 47%) travelled by taxi compared to respondents with a hearing impairment (22 / 27%) and neurodivergent respondents (8 / 21%).

Passenger in a petrol / diesel car

- A significantly higher proportion of respondents with a hearing impairment (19 / 23%) travelled as a passenger in a petrol / diesel car compared to respondents with a long-term condition (23 / 12%), respondents who do not have a disability (15 / 10%) and respondents with a mental health condition (20 / 10%).

Patient transport

- A significantly higher proportion of respondents with a long-term condition (67 / 34%), mental health condition (69 / 33%), learning, understanding, concentrating or memory impairment (2 / 13%), a physical or mobility impairment (18 / 11%), sight impairment (3 / 10%), neurodivergent respondents (3 / 8%), and respondents with a hearing impairment (6 / 7%) travelled by patient transport compared to respondents who did not have a disability (1 / 1%).

Drive an electric / hybrid car

- A significantly higher proportion of respondents who did not have a disability (22 / 14%) travelled as a driver in an electric / hybrid car compared to respondents with a long-term condition (11 / 6%), hearing impairment (4 / 5%), physical or mobility impairment (6 / 4%), and respondents with a mental health condition (4 / 2%).

Bicycle

- A significantly higher proportion of neurodivergent respondents (3 / 8%) travelled by bicycle compared to respondents with a long-term condition (1 / 1%) and respondents with a mental health condition (1 / 0.5%).

Carer

- When comparing the responses by this cohort a significantly higher proportion of respondents who are carers said they travel by driving a petrol / diesel car, compared to respondents who are not carers (205 / 61% vs. 341 / 47%).
- Whereas a significantly higher proportion of respondents who are not carers said they travel by train (117 / 16%) and using patient transport (80 / 11%), compared to respondents who are carers (travel by train: 37 / 11%), use patient transport: 19 / 6%).

Sexual orientation:

- A significantly higher proportion of gay / lesbian respondents (17 / 50%) travelled by bus compared to heterosexual respondents (274 / 30%).

Transgender:

- A significantly higher proportion of transgender respondents (5 / 100%) travelled by bus compared to non-transgender respondents (310 / 31%).
- A significantly higher proportion of transgender respondents (3 / 60%) travelled by train compared to non-transgender respondents (149 / 15%).

Impact of the cost of living:

Drive a petrol / diesel car

- A significantly higher proportion of respondents who are quite comfortable (240 / 65%) travelled by driving a petrol / diesel car compared to respondents who are just getting by (162 / 51%), very comfortable (32 / 49%) and really struggling (79 / 32%).

Walk

- A significantly higher proportion of respondents who are really struggling (167 / 68%) travelled by walking compared to respondents who are just getting by (69 / 22%), quite comfortable (79 / 21%) and very comfortable (11 / 17%).

Bus

- A significantly higher proportion of respondents who are just getting by (112 / 35%), and quite comfortable (120 / 32%) travelled by bus compared to respondents who are really struggling (57 / 23%).
- A significantly higher proportion of respondents who are just getting by (112 / 35%) travelled by bus compared to respondents who are very comfortable (14 / 22%).

Taxi

- A significantly higher proportion of respondents who are really struggling (158 / 64%) travelled by taxi compared to respondents who are just getting by (71 / 22%), very comfortable (12 / 18%) and quite comfortable (60 / 16%).

Train

- A significantly higher proportion of respondents who are quite comfortable (63 / 17%) travelled by train compared to respondents who are really struggling (25 / 10%).

Passenger in a petrol / diesel car

- A significantly higher proportion of respondents who are quite comfortable (47 / 13%) and just getting by (42 / 13%) travelled as a passenger in a petrol / diesel car compared to respondents who are really struggling (16 / 6%).

Patient transport

- A significantly higher proportion of respondents who are really struggling (69 / 28%) travelled by patient transport compared to respondents who are very comfortable (3 / 5%), just getting by (16 / 5%) and quite comfortable (9 / 2%).

Drive an electric / hybrid car

- A significantly higher proportion of respondents who are very comfortable (12 / 18%) travelled by driving an electric / hybrid car compared to respondents who are quite comfortable (25 / 7%), just getting by (17 / 5%) and really struggling (6 / 2%).
- A significantly higher proportion of respondents who are quite comfortable (25 / 7%) travelled by driving an electric / hybrid car compared to respondents who are really struggling (6 / 2%).

Motorbike

- A significantly higher proportion of respondents who are very comfortable (3 / 5%) travelled by motorbike compared to respondents who are just getting by (1 / 0.3%)

Local authority area:

Drive a petrol / diesel car

- A significantly higher proportion of respondents from the Wakefield area (113 / 66%) travelled by driving a petrol / diesel car compared to respondents from the Kirklees (278 / 52%) and Calderdale (114 / 40%) areas.

Walk

- A significantly higher proportion of respondents from the Calderdale area (159 / 55%) travelled by walking compared to respondents from the Kirklees (156 / 29%) and Wakefield (29 / 17%) areas.

Bus

- A significantly higher proportion of respondents from the Kirklees (204 / 38%) and Wakefield (54 / 31%) areas travelled by bus compared to respondents from the Calderdale area (63 / 22%).

Taxi

- A significantly higher proportion of respondents from the Calderdale area (164 / 57%) travelled by taxi compared to respondents from the Kirklees (108 / 20%) and Wakefield (25 / 15%) areas.

Passenger in a petrol / diesel car

- A significantly higher proportion of respondents from the Kirklees area (79 / 15%) travelled as a passenger in a petrol / diesel car compared to respondents from the Calderdale area (19 / 7%).

Patient transport

- A significantly higher proportion of respondents from the Calderdale area (79 / 27%) travelled by patient transport compared to respondents from the Wakefield (9 / 5%) and Kirklees (14 / 3%) areas.

Deprivation:

Drive a petrol / diesel car

- A significantly higher proportion of respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (284 / 55%) and postcode areas where 40% to 49% of the locality are from the most deprived deciles (88 / 52%) travelled by driving a petrol / diesel car compared to respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (144 / 43%).

Walk

- A significantly higher proportion of respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (157 / 46%) travelled by walking compared to respondents from postcode areas where 40% to 49% of the locality are from the most

deprived deciles (48 / 29%) and postcode areas where less than 40% of the locality are from the most deprived deciles (140 / 27%).

Taxi

- A significantly higher proportion of respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (140 / 41%) travelled by taxi compared to respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (131 / 25%) and postcode areas where 40% to 49% of the locality are from the most deprived deciles (31 / 18%).

Patient transport

- A significantly higher proportion of respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (50 / 15%) travelled by patient transport compared to respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (47 / 9%) and postcode areas where 40% to 49% of the locality are from the most deprived deciles (7 / 4%).

Drive an electric / hybrid car

- A significantly higher proportion of respondents from postcode areas where less than 40% of the locality are from the most deprived deciles (45 / 9%) travelled by driving an electric / hybrid car compared to respondents from postcode areas where more than 50% of the locality are from the most deprived deciles (12 / 4%).

For a full breakdown of the responses to this question by these groups and other groups please see the Excel data tables.

Respondents were asked if there was anything else that should be considered around making travel easier. This question received 522 responses. From these responses, 72 themes were raised, of which 7 were positive, 14 were negative and 51 were neutral. Overall, the top three sub-themes raised were:

- Neutral – Transport – Parking should be free (149 / 29%).
- Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (115 / 22%).
- Neutral – Transport – Consider providing a free local bus / shuttle bus service (111 / 21%).

Table 60 presents the full list of themes raised in response to this question by consultation survey respondents.

Table 4. Is there anything else you think we should consider about travel, transport, and parking and how easy it is for you to travel.

Sentiment	Main theme	Sub-theme	No.	%
Neutral	Transport	Parking should be free	149	29%
Neutral	Transport	Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours)	115	22%

Neutral	Transport	Consider providing a free local bus / shuttle bus service	111	21%
Neutral	Transport	Parking should be available and accessible	92	18%
Neutral	Transport	Ensure there are accessible, regular, and reliable public transport services available with minimal to no changes needed	64	12%
Neutral	Transport	Consider how to provide the best travel solutions to support patients, families, and carers to access services	62	12%
Neutral	Transport	Consider the availability of public transport (e.g. frequency / time of day / location)	51	10%
Neutral	Transport	Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport)	50	10%
Neutral	Transport	Consider the importance of parking facilities for patients / families and carers	49	9%
Neutral	Transport	Travel may be difficult for some groups (e.g. older people, those with a disability / mobility issues)	48	9%
Neutral	Transport	Consider patient transport services for those unable to use public transport	42	8%
Neutral	Transport	Transport options for patients, carers and family members should be considered (e.g. distance, cost, parking)	40	8%
Neutral	Access	Keep services local (e.g. maximum 30 minutes away from home)	34	7%
Negative	Access	Transport is a major barrier to access	29	6%
Negative	Transport	Consider improving parking at all facilities (e.g. Huddersfield, Calderdale)	14	3%
Neutral	Transport	Adequate disabled parking should be provided close to venues	13	2%
Neutral	Access	Consider providing facilities for carers and families to stay overnight	13	2%
Negative	Transport	Public transport is not reliable (e.g. in Dewsbury, Calderdale, Wakefield)	12	2%
Neutral	Workforce	Consider travel times and parking requirements for staff	12	2%
Neutral	Transport	Consider changing visiting times to avoid travel in peak times	11	2%
Neutral	Access	Consider longer visiting times	11	2%
Neutral	Transport	Consider providing support and guidance for travelling on public transport	10	2%
Neutral	Transport	Travelling by car is the only option to access services	7	1%
Neutral	Transport	Provide bus stops near hospital sites	6	1%
Neutral	Transport	No travel issues (e.g. have access to a car)	6	1%
Neutral	Transport	Consider the environmental impact of travel (e.g. inclement weather)	6	1%

Neutral	Transport	Transport and parking facilities should be safe (e.g. bigger parking spaces)	5	1%
Neutral	Transport	Consider ways to support funding for carer-specific transport (e.g. working with councils, rail and bus companies)	5	1%
Positive	Transport	The region has good transport links	5	1%
Negative	Transport	Concerns over parking and accessibility (e.g. Wakefield, Pinderfields)	4	1%
Negative	Transport	Concern around traffic and road congestion (e.g. around South Kirklees area)	4	1%
Neutral	Quality of care	Transport considerations should be balanced with the ability to provide reasonable clinical services as a baseline	4	1%
Neutral	Transport	Consider parking for electric vehicles	3	1%
Neutral	Access	Access ramps should be available for those with a disability / mobility issue	3	1%
Negative	Access	All locations are unsuitable for services	3	1%
Neutral	Finance	Consider additional financial support for those who require it	3	1%
Neutral	Transport	Consider that some people experience anxiety while travelling	2	0.4%
Negative	Transport	Transport to any site from Calderdale is difficult during the week	2	0.4%
Negative	Transport	Those who previously had free parking will now have to pay	2	0.4%
Negative	Transport	Cost of parking at Ward 19, Dewsbury and District Hospital	2	0.4%
Positive	Transport	Ward 19, Dewsbury and District Hospital has better transport links	2	0.4%
Positive	Transport	Parking facilities are good (e.g. Dewsbury)	2	0.4%
Positive	Transport	Parking at Crofton Ward, Fieldhead Hospital, Wakefield is currently free	2	0.4%
Neutral	Access	Reduce waiting times	2	0.4%
Negative	Access	Concern around the lack of services in Huddersfield	2	0.4%
Positive	Access	Using all three sites gives good geographical balance	2	0.4%
Neutral	Transport	Regional transport policies should be reviewed by the Government	1	0.2%
Neutral	Transport	Consider residential boundaries and jurisdictions when planning care settings	1	0.2%
Negative	Transport	Shortage of beds mean patients with functional mental health needs have to travel more	1	0.2%
Negative	Transport	Hemsworth is difficult to travel to and not close to hospitals	1	0.2%
Negative	Transport	Concern around travelling from the outskirts of Huddersfield to Wakefield	1	0.2%
Positive	Transport	There is a free bus (113) that runs from Pontefract Hospital, Pinderfields to Dewsbury	1	0.2%

Neutral	Access	Signs to direct patients, carers and families to wards should be clear and easy to read	1	0.2%
Neutral	Access	Ensure the chosen option for dementia results in services being provided centrally	1	0.2%
Neutral	Access	Consider working with VCSE / volunteer groups to provide carer support options	1	0.2%
Neutral	Access	Consider virtual consultations (e.g. using telemedicine with community team support)	1	0.2%
Neutral	Access	Consider providing translation services to prevent language barrier	1	0.2%
Neutral	Access	Consider patient support in Wakefield for those who live in Calderdale	1	0.2%
Neutral	Access	Consider intensive outpatient programme clinics (OIP)	1	0.2%
Neutral	Access	Consider improving access to the site for those who use train services	1	0.2%
Neutral	Access	Consider having all services at Dewsbury and District Hospital due to shuttle bus availability	1	0.2%
Positive	Access	Beechdale Ward, Calderdale Royal Hospital has special relative rooms where carers can stay overnight	1	0.2%
Neutral	Workforce	Consider the impact of staff travelling to and from work and how the carbon footprint can be reduced (e.g. car pool)	1	0.2%
Neutral	Workforce	Consider improving access to online platforms for staff (e.g. ensure staff have sufficient data allowance on laptops and mobile phones)	1	0.2%
Neutral	Workforce	Consider decreased staff availability due to travel	1	0.2%
Neutral	Quality of care	Environmental impact is not as important as functional mental health / dementia care	1	0.2%
Neutral	Quality of care	Consider shortening hospital stays by providing quick recoveries	1	0.2%
Neutral	Quality of care	Consider having gardens and facilities for patients, carers and families (e.g. therapy, bio walls to maximise green space)	1	0.2%
Neutral	Finance	Consider providing personalised budgets	1	0.2%
Neutral	Finance	Consider increased costs on team budgets due to travel and parking	1	0.2%
Negative	Finance	Ward 19, Dewsbury and District Hospital is expensive for patients, family and carers	1	0.2%
Neutral	General	No comment / unsure	29	6%
-	-	Base	522	-

Top themes for each respondent group

This section presents the top theme raised by each cohort in the sub-groups included in the equalities analysis.

Respondent type:

- **Member of the public:** Neutral – Transport – Parking should be free (76 / 30%).

- **Healthcare worker:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (18 / 30%).
- **Member of staff working in older people's mental health services:** Transport – Neutral - Consider the cost of travel, parking and public transport (e.g. cost should be low / subsidised, more parking hours) (10 / 23%).
- **Carer of someone living with dementia:** Neutral – Transport – Parking should be free (21 / 29%).
- **People living with functional mental health needs:** Neutral – Transport – Parking should be free (15 / 31%).
- **Voluntary or community organisation employee:** Neutral – Transport – Parking should be free (31 / 35%).
- **Carer for someone living with functional mental health needs:** Neutral – Transport – Parking should be free (9 / 28%).
- **Social care employee, including care homes:** Neutral – Transport – Parking should be free (4 / 31%), Neutral – Transport – Consider providing a free local bus / shuttle bus service (4 / 31%), Neutral – Transport – Consider how to provide the best travel solutions to support patients, families, and carers to access services (4 / 31%).
- **Governor or member of South West Yorkshire Partnership Foundation Trust:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (5 / 50%).
- **Person living with dementia:** Neutral – Transport – Parking should be free (5 / 42%), Neutral – Transport – Consider providing a free local bus / shuttle bus service (5 / 42%).
- **Previously cared for someone with dementia / functional mental health needs:** Neutral – Transport – Consider the availability of public transport (e.g. frequency / time of day / location) (3 / 38%), Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (3 / 38%).
- **I know someone living with dementia / functional mental health needs:** Neutral – Transport – Travel may be difficult for some groups (e.g. older people, those with a disability / mobility issues) (3 / 50%).
- **Retired:** Neutral – Transport – Consider how to provide the best travel solutions to support patients, families, and carers to access services (4 / 40%).
- **Person who attends a day care centre:** Neutral – Transport – Consider the availability of public transport (e.g. frequency / time of day / location) (2 / 25%).
- **Other:** Neutral – Transport – Consider how to provide the best travel solutions to support patients, families, and carers to access services (12 / 21%).

Gender:

- **Male:** Neutral – Transport – Parking should be free (28 / 25%), Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (28 / 25%).
- **Female:** Neutral – Transport – Parking should be free (116 / 31%).
- **Other:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (1 / 50%), Positive – Transport – Ward 19, Dewsbury and District Hospital has better transport link (1 / 50%).
- **Prefer not to say:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (6 / 38%).

Age:

- **Under 18:** No feedback received.
- **18 to 39:** Neutral – Transport – Parking should be free (30 / 35%).
- **40 to 59:** Neutral – Transport – Parking should be free (56 / 30%).
- **60 to 79:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (47 / 27%).
- **80 and over:** Neutral – Transport – Parking should be available and accessible (6 / 29%).
- **Prefer not to say:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (12 / 29%).

Religion:

- **No religion:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (32 / 28%).
- **Christian:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (54 / 26%).
- **Muslim:** Neutral – Transport – Parking should be free (59 / 44%).
- **Buddhist:** Neutral – Transport – Parking should be free (1 / 33%), Neutral – Transport – Ensure there are accessible, regular, and reliable public transport services available with minimal to no changes needed (1 / 33%), Neutral – Transport – Consider how to provide the best travel solutions to support patients, families, and carers to access services (1 / 33%), Neutral – Transport – Consider the availability of public transport (e.g. frequency / time of day / location) (1 / 33%), Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (1 / 33%), Neutral – Transport – Travel may be difficult for some groups (e.g. older people, those with a disability / mobility issues) (1 / 33%), Neutral – Transport – Transport options for patients, carers and family members should be considered (e.g. distance, cost, parking) (1 / 33%).
- **Hindu:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (5 / 63%).
- **Sikh:** Neutral – Transport – Parking should be free (2 / 67%).
- **Jewish:** Neutral – Transport – Parking should be free (1 / 33%), Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (1 / 33%), Neutral – Access – Keep services local (e.g. maximum 30 minutes away from home) (1 / 33%).
- **Other religion:** Neutral – Transport – Parking should be free (2 / 40%).
- **Prefer not to say:** Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (5 / 22%).

Ethnicity:

- **White – English/Welsh/Scottish/Northern Irish/British:** Neutral – Transport – Parking should be free (65 / 22%).
- **White – Irish:** Neutral – Transport – Parking should be free (2 / 29%), Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (2 / 29%), Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (2 / 29%).
- **White – Gypsy or Irish Traveller or Roma:** Neutral – Access – Consider longer visiting times (3 / 100%).
- **White – any other background:** Neutral – Transport – Parking should be free (1 / 33%), Neutral – Transport – Parking should be available and accessible (1 / 33%), Neutral – Transport – Ensure there are accessible, regular, and reliable public transport services

available with minimal to no changes needed (1 / 33%), Neutral – Transport – Consider how to provide the best travel solutions to support patients, families, and carers to access services (1 / 33%), Neutral – Transport – Consider the transportation difficulties for each location (e.g. distance, busy areas, availability of public transport) (1 / 33%), Neutral – Transport – Consider the importance of parking facilities for patients / families and carers (1 / 33%), Neutral – Transport – Consider patient transport services for those unable to use public transport (1 / 33%), Negative – Access – Transport is a major barrier to access (1 / 33%), Negative – Transport – Consider improving parking at all facilities (e.g. Huddersfield, Calderdale) (1 / 33%).

- **Mixed / multiple ethnic group:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (3 / 33%), Neutral – Transport – Consider providing a free local bus / shuttle bus service (3 / 33%).
- **Asian / Asian British:** Neutral – Transport – Parking should be free (66 / 47%).
- **Black / African / Caribbean / Black British:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (2 / 13%), Neutral – Transport – Consider how to provide the best travel solutions to support patients, families, and carers to access services (2 / 13%).
- **Chinese and other ethnic groups:** Neutral – Transport – Consider the cost of travel, parking and public transport (e.g. cost should be low / subsidised, more parking hours) (3 / 38%), Neutral – Transport – Consider providing a free local bus / shuttle bus service (3 / 38%), Neutral – Transport – Consider patient transport services for those unable to use public transport (3 / 38%).
- **Prefer not to say:** Neutral – Transport – Parking should be free (5 / 28%), Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (5 / 28%).

Disability:

- **Yes:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (17 / 22%).
- **No:** Neutral – Transport – Parking should be free (123 / 31%).
- **Prefer not to say:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (9 / 33%).

Long-term conditions or illnesses:

- **I do not have a disability:** Neutral – Transport – Parking should be free (22 / 26%).
- **Mental health condition:** Neutral – Transport – Parking should be free (18 / 27%).
- **Physical or mobility impairment:** Neutral – Transport – Parking should be free (20 / 27%), Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (20 / 27%).
- **Hearing impairment:** Neutral – Transport – Parking should be free (12 / 27%).
- **Neurodivergent conditions:** Neutral – Transport – Parking should be free (10 / 42%).
- **Sight impairment:** Neutral – Transport – Parking should be free (4 / 33%), Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (4 / 33%).
- **Learning, understanding, concentrating or memory:** Neutral – Transport – Consider the importance of parking facilities for patients / families and carers (3 / 50%).
- **Other:** Neutral – Transport – Parking should be free (15 / 27%).
- **Prefer not to say:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (20 / 38%).

Carer

- **Carer:** Neutral – Transport – Parking should be free (48 / 29%).
- **Not a carer:** Neutral – Transport – Parking should be free (89 / 29%).
- **Prefer not to say:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (6 / 30%), Neutral – Transport – Consider providing a free local bus / shuttle bus service (6 / 30%).

Sexual orientation:

- **Heterosexual / Straight:** Neutral – Transport – Parking should be free (127 / 30%).
- **Gay / Lesbian:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (4 / 29%).
- **Bisexual / Pansexual / Asexual:** Neutral – Transport – Travel may be difficult for some groups (e.g. older people, those with a disability / mobility issues) (3 / 38%), Neutral – Transport – Transport options for patients, carers and family members should be considered (e.g. distance, cost, parking) (3 / 38%).
- **Prefer not to say:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (12 / 23%).

Transgender:

- **Yes:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (1 / 50%), Positive – Transport – Ward 19, Dewsbury and District Hospital has better transport links (1 / 50%).
- **No:** Neutral – Transport – Parking should be free (132 / 29%).
- **Prefer not to say:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (8 / 30%).

Impact of the cost of living:

- **Very comfortable:** Neutral – Transport – Ensure there are accessible, regular, and reliable public transport services available with minimal to no changes needed (9 / 27%).
- **Quite comfortable:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (48 / 26%).
- **Just getting by:** Neutral – Transport – Parking should be free (58 / 34%).
- **Really struggling:** Neutral – Transport – Parking should be free (24 / 41%).
- **Don't know / prefer not to say:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (16 / 30%).

Local authority area:

- **Kirklees:** Neutral – Transport – Parking should be free (91 / 32%).
- **Wakefield:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (27 / 31%).
- **Calderdale:** Neutral – Transport – Parking should be free (31 / 32%).
- **Other local authority areas:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (4 / 29%).
- **Prefer not to say / no postcode provided / unable to profile:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (11 / 26%).

Deprivation:

- **Postcode sectors where 50% or more of the localities are comprised of wards that fall into the two most deprived deciles:** Neutral – Transport – Parking should be free (49 / 37%).
- **Postcode sectors where 40 to 49% of the localities are comprised of wards that fall into the two most deprived deciles:** Neutral – Transport – Parking should be free (39 / 44%).
- **Postcode sectors where less than 40% of the localities are comprised of wards that fall into the two most deprived deciles:** Neutral – Transport – Consider the cost of travel, parking, and public transport (e.g. cost should be low / subsidised, more parking hours) (69 / 27%).
- **No postcode provided / unable to profile:** Neutral – Transport – Consider providing a free local bus / shuttle bus service (11 / 26%).

16.2 Advocacy organisation-led engagement feedback

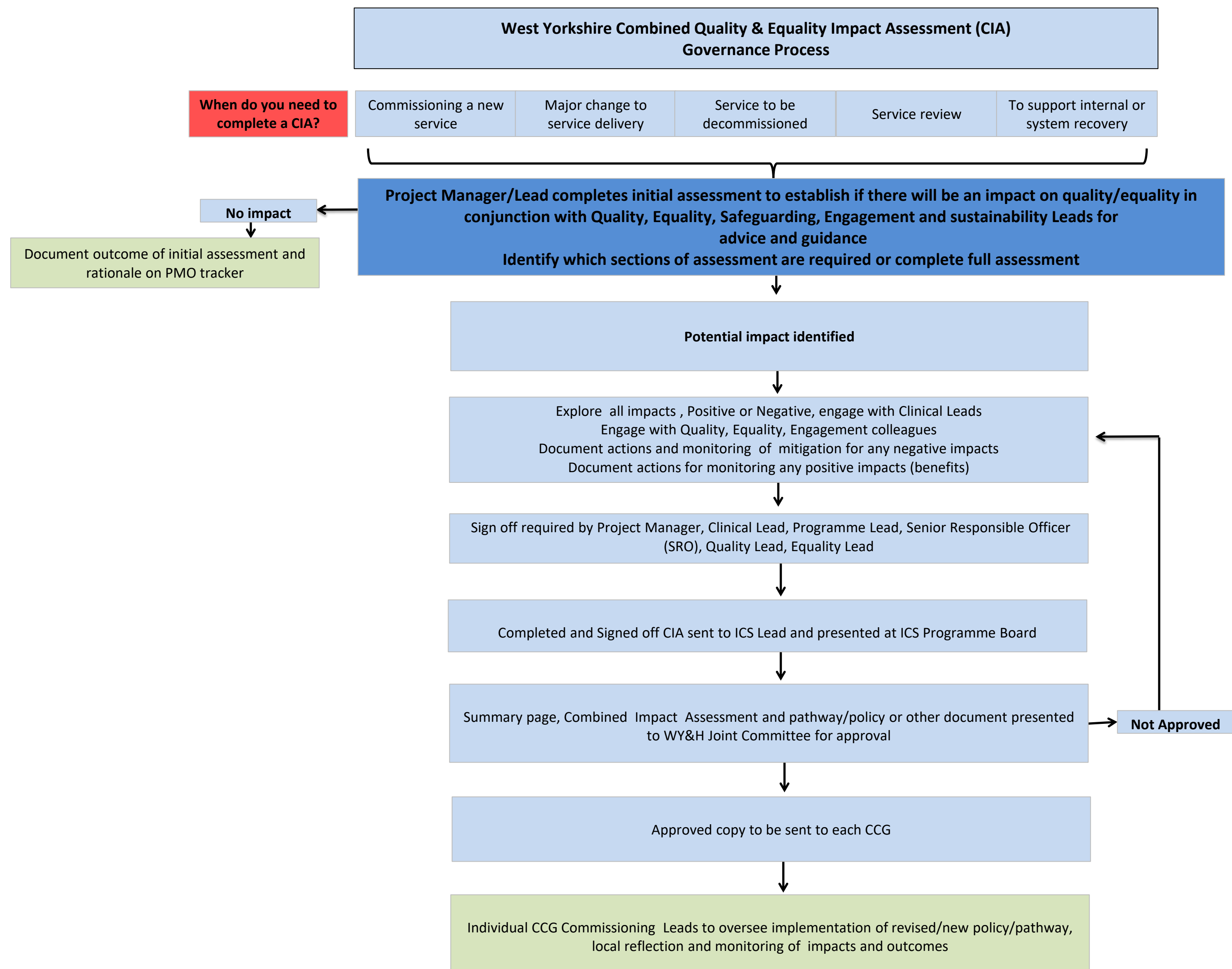
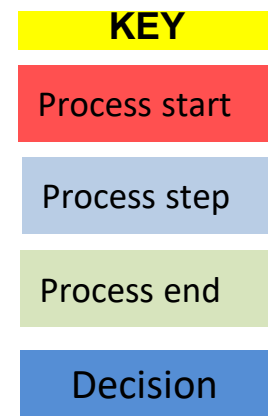
Advocacy services supported inpatients to respond to the consultation by providing information and / or communicating in a way that met the needs of each person. They ensured that all inpatients were approached and included, and that their capacity to be involved was assessed.

The advocacy services were delivered by different organisations, with Together UK providing advocacy in the Wakefield wards and Cloverleaf in Calderdale and Kirklees. Together UK provided a written summary of feedback – please see section 6.7 to view this. Cloverleaf used an adapted survey approach for people on the Calderdale and Kirklees wards – the feedback captured in this survey relating to travel and transport has been presented below.

10 (50%) service users would be willing to travel between 30 minutes and one hour to access services, while 9 (45%) said they would be willing to travel less than 30 minutes. Additionally, 1 person (5%) said they would be willing to travel over 1 hour.



**South West
Yorkshire Partnership**
NHS Foundation Trust



Sustainability assessment
Assessing sustainability and the social impacts alongside the financial business case is aligned with the legal requirements in the Public Services (Social Value) Act (2012)
The information below describes the proposed options for OPS inpatient transformation at a high level. Option one: A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury. There are two ways that this could be done: •Option 1a – with additional functional bed capacity at the Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 wards across the 26 beds. •Option 1b – with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward. Option two: A dedicated central specialised dementia unit developed on Crofton Ward. This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beechdale would be functional wards. From a sustainability perspective the options will have a very similar impact so have been assessed together, though potential minor differences such as net numbers impacted by travel, have been flagged in areas where the sustainability impact is uncertain or if you would like more information, please email frank.swinton@nhs.net

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative (Click on box to see prompts)	Positive Impact	Neutral Impact	Negative Impact	Opportunity/Consequence Rating	Consequence	Likelihood	Total Score
Technology	☒	☐	☐	Sustainability positive rating	2	5	10
Pharmaceuticals	☒	☐	☐	Sustainability negative rating	-1	5	-5
Transport	☐	☐	☒	*See Impact Matrix tab for guidance			
Supply/Purchasing	☐	☒	☐	*Link to sustainability guidance			
Waste	☒	☐	☐				
Green economy	☐	☒	☐				
Climate Change*	☐	☒	☐	* Link to climate change strategy			
Air Quality	☐	☒	☐	Consider what are the sustainability implications of continuing with business as usual or NOT taking the proposed changes?			
Housing	☐	☒	☐				
Green economy	☐	☒	☐				
Building: retrofit	☒	☐	☐				
Buildings: new	☐	☒	☐				
Energy (inc heat)	☐	☒	☐				
Green clinical pathways	☐	☐	☐				
Green social prescribing	☐	☒	☐				
Green social care	☐	☐	☐				
Green space	☐	☒	☐				
Other (please state below):							
Climate Change	☐	☒	☐				

Description of positive impacts (must include rationale and be evidence based)	How will these impacts be monitored
Technology - There is a chat pad offer on every ward in the Trust which uses ZOOM and has been rolled out as a result of covid-19. People staying on the wards can ask to use the system to connect with loved ones, family, friends and carers. It can also be used to contact an advocate. As well as using this, there may be opportunities to establish seperate video call rooms on the wards to support maintaining contact using technology. Technology can also be used to support services that might need to travel further, for example, social care liasion into a specialist dementia unit to facilitate discharge. From an infrastructure perspective there will be benefits to relocating Poplars service as there will be economies of scale with IT Hardware. There will be no extra hardware required to support extra staff footfall in a specialist dementia unit though wifi bandwidth may need to be increased.	Reports to track the amount of usage will be established
Pharmaceuticals - bringing the Poplars service into the Fieldhead site (proposed in all options) would support some streamlined pharmacy processes. There are regular journeys to the site to deliver medicine and pharmacy staff visits. There is also an expanded medicines stock list required and held on site due to the Poplars isolation that wouldn't be required as a result of bringing the service into Fieldhead. So, overall some limited benefits of Poplars coming onto the Fieldhead site	Tracking the amounts of stock per ward in the new model compared to the current one and tracking the numbers of saved journeys to the site.
Waste - moving from Poplars to developed site at Fieldhead should support waste reduction via better waste management practice. For example, effective use of energy and water as part of new build energy efficiency standards. The Poplars still has internal catering provision so a move would benefit in terms of food miles and staffing and potentially food waste.	Levels of food waste are monitored as part of regular reporting on the Trust Social Responsibility and Sustainability (SRS) strategy to the Trust board, OMG, EMT and SRS steering group.
Building Retrofit - estates strategy is to improve the energy efficiency of our buildings and equipment as part of relocation and ensuring that all new buildings and refurbishments meet sustainability standards. The building infrastructure for development work at Fieldhead will be in line with the green plan. We will continue to improve the energy efficiency of our buildings, equipment and practices as part of relocation and ensuring that all new buildings and refurbishments meet sustainability standards	The SRS reports monitor carbon reduction. The Green Plan documents how this will happen across the Trust. The Trust also reports carbon consumption through the Estates Reconciliation Information Collection (ERIC) return to NHSE

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Transport - depending on the option taken forward, between around 25 and 50 people per year will be admitted to a ward further from their home. This will create extra travel for family and carers travelling to visit and support the service user. Staff may be impacted by the options which involve Poplars service relocation but this is negligible with the average staff member living 1 mile closer to the Poplars than Fieldhead Hospital.	Visitor support solutions will be part of the active travel plan programme which explores all elements of green travel including increased support for electric vehicle use, for example more charging points, and use of public transport. Part of this includes exploring the potential for much improved public transport that better links hospitals and encourages people to use public transport rather than private transfer.	As part of implementation planning we'll be aiming to capture an understanding of how visitors travel and sustainability can be part of this	Post implementation	Operational lead

Sustainability guidance		
Areas to consider		
More info	Climate-change-and-sustainability-paper-october-2020.pdf	
Technology	Additional technology to reduce need for face to face contacts - e.g. telecare/telehealth and Technological developments to support sustainability, Note the danger of increasing loneliness/reducing social cohesion if we move too much to digital NHS Apps Models of care to deliver care closer to peoples homes. carbon footprint of needing lots of new hardware for tech solutions - Large footprint of data centres unless managed sustainably	- Increased
Pharmaceuticals	Value added from pharmaceuticals and technologies (medicines management, prescribing, and supply chains made on inhalers and anaesthetic gases (including nitrous oxide) Is there a green social prescribing alternative?	Specific gains to be
Transport	Impact on car based travel & parking: staff, patients, visitors and logistics (espeially the last mile logistics) Will it reduce 'care miles' to home Will it reduce repeat appointments Will it promote alternative modes of travel i.e. public transport and active travel (cycling/walking) Will it support more efficient use of cars i.e. car sharing, low emission vehicles, community transport, environmentally friendly fuels How will it affect access and travel needs for rural dwellers, vulnerable or disadvantaged groups Have the outcomes been considered via the HOTT (Health Outcomes of Travel Tool) Sustainable Development Unit - HOTT (Health Outcomes of Travel Tool)	
Supply/ Purchasing	Will it promote ethical purchasing of goods or services (e.g. increasing transparency of modern slavery in the supply chain globally) Will it support the local economy through local suppliers/regional supply chain, SMEs or engage with third sector or community groups? Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery in line with the Public Services (Social Value) Act 2012? Does it use suppliers who publish whole life cycle assessments of their products? Does it use suppliers who have broken environmental regulations within the last five years? Does it take into Public Services (Social Value) Act 2012 More info on sustainable procurement	
Waste	Will it reduce the amount of waste produced, environmental hazards and toxic materials for example by reducing PVC, antibiotic use, air pollution, noise, mining and deforestation? Will it reduce the amount of waste packaging (ie. Bin bags etc.) used? Will it reduce use of natural resources such as raw materials, embedded water, and energy to promote a circular economy? What is the impact on water consumption Are there any inefficiencies identified in the proposed model What is the impact on the demand and amount of recycling produced More info on waste	
Green Economy		
Climate Change	Contingency planning for extreme weather events i.e. flood/heat/snow etc Consider vulnerable groups/populations and migrations If impact can be quantified (i.e. reducing waste by X tons by 20XX) More info on climate change and impact	Food security
Buildings/Sites	Will it improve the resource efficiency of new or refurbished buildings (insulation, water, energy, density, use of existing buildings, designing for a longer lifespan)? Will the safety and security required for the new build/developments have any impact? Will landscaping be sympathetic and support the biodiversity of the locality? Will it improve green space and access to green space? Passivhaus, BREEAM Excellent or LEED Platinum standard? Will it employ local people? More info on buildings and energy management	Will it be built to
Other	Consider other impacts such as: Resilience and skills / Recruitment / Retention / Career pathways What the estimated carbon benefit (in terms of tCO ₂ e) from implementation of the project? implications of not making the change (continuing with business as usual?) What are the implications for building community/enhancing social cohesion?	What are the

Examples of things to guide choices for the Impact Matrix			
Positive	5	Excellence	Net positive carbon across all aspects of operation. True sustainable operation across multiple dimensions. Active travel as the default norm for staff, patients, visitors and deliveries. Self-generating biodiversity with unrestricted access to people and large fauna. Zero clinical waste production. No requirement for staff beyond the local community. SMEs used for all contracts.
	4	Major	Carbon neutral in all aspects of activity, including whole supply chain from cradle to cradle. Zero to landfill. Only zero emission vehicles allowed on site. Upstream and downstream flood alleviation programmes incorporating increases in biodiversity, green space and access to greenspace. Significant increase in local community cohesion and society inclusion in planning, ownership and operation.
	3	Moderate	Using mostly local SMEs, engaging the local population in design. Increase in green space or access to greenspace by >0.01 acres. Local flood management enhancement. New build or building renovation to Passivehaus, LEED Platinum, or BREEAM Excellent standard. Reduction in vehicle traffic on site by 30% in favour of active travel. Zero fossil fuel use.
	2	Minor	Using some local SME companies, increasing biodiversity, access to greenspace, reducing rainwater runoff. Increasing water, heat and energy efficiency of buildings. Promoting active travel.
	1	Negligible	Negligible improvement in biodiversity, carbon usage or social cohesion
Neutral	0	Neutral	No effect either positive or negative (See FS comment about removing this line)
Negative	-1	Negligible	Negligible negative impact on biodiversity, carbon usage or social cohesion.
	-2	Minor	Some effects on resilience such as increased water run-off, using some companies that don't pay their full share of UK tax
	-3	Moderate	Loss of greenspace and/or access to greenspace. Loss of opportunity for active travel. Increase in fossil fuel use.
	-4	Major	Significant (>0.01 acre) loss of greenspace, loss of access to greenspace, loss of biodiversity. Increased rain water runoff, reduction in efficiency of buildings in terms of heat, waste, water.
	-5	Excellence	Using firms that pay no UK tax, don't use local people for employment. Forcing people to travel by car, active promotion of fossil fuel use, manipulation of standards/loopholes. Loss of >0.1 acre greenspace or access to greenspace. Division of communities by physical or psychological means.

Likelihood		
0	Not applicable	
1	Rare	Not expected to occur for years. Will occur in exceptional
2	Unlikely	Expected to occur at least annually. Unlikely to occur.
3	Possible	Expected to occur at least monthly. Reasonable chance of
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More likely to occur than not.

Opportunity						Consequence						
Likelihood		5	4	3	2	1	0	-1	-2	-3	-4	-5
	5	25	20	15	10	5	0	-5	-10	-15	-20	-25
	4	20	16	12	8	4	0	-4	-8	-12	-16	-20
	3	15	12	9	6	3	0	-3	-6	-9	-12	-15
	2	10	8	6	4	2	0	-2	-4	-6	-8	-10
	1	5	4	3	2	1	0	-1	-2	-3	-4	-5
Category												
		Opportunity										
		Low - Moderate Risk										
		High Risk										

Opportunity and Consequence			
Impact	Score		The proposed change is anticipated to lead to the following level of opportunity and/or consequence:
Positive	5	Excellence	Multiple enhanced benefits including excellent improvement in access, experience and/or outcomes for all patients, families and carers. Outstanding reduction in health inequalities by narrowing the gap in access, experience and/or outcomes between people with protected characteristics and the general population. Leading to consistently improved standards of experience and an enhancement of public confidence, significant improvements to performance and an improved and sustainable workforce. Multiple enhanced benefits including excellent improvement in biodiversity, carbon usage or social cohesion
	4	Major	Major benefit leading to long term improvements and access, experience and /or outcomes for people with this protected characteristic. Major reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Benefits include improvements in management of patients with long term effects and compliance with national standards. Major benefit leading to long term improvements in biodiversity, carbon usage or social cohesion
	3	Moderate	Moderate benefits requiring professional intervention with moderate improvement in access, experience and /or outcomes for people with this protected characteristic. Moderate reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Moderate benefits to biodiversity, carbon usage or social cohesion
	2	Minor	Minor improvement in access, experience and /or outcomes for people with this protected characteristic. Minor reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Moderate benefits to biodiversity, carbon usage or social cohesion
	1	Negligible	Minimal benefit requiring no/minimal intervention or treatment. Negligible improvement in access, experience and /or outcomes for people with this protected characteristic. Negligible reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Negligible improvement in biodiversity, carbon usage or social cohesion
Neutral	0	Neutral	No effect either positive or negative
Negative	-1	Negligible	Negligible negative impact on access, experience and /or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry Negligible negative impact on biodiversity, carbon usage or social cohesion
	-2	Minor	Minor negative impact on access, experience and /or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal Minor negative impact on biodiversity, carbon usage or social cohesion
	-3	Moderate	Moderate negative impact on access, experience and /or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention. Moderate negative impact on biodiversity, carbon usage or social cohesion
	-4	Major	Major negative impact on access, experience and /or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury leading to long-term incapacity/disability Major negative impact on biodiversity, carbon usage or social cohesion
	-5	Catastrophic	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of experience and does not meet required standards Catastrophic negative impact on biodiversity, carbon usage or social cohesion

Engagement				
Definitions of reconfiguration proposals and stages of engagement/consultation				
Definition and examples of potential proposals	Stages of involvement, engagement and consultation			
	Informal Involvement	Engagement		Formal Consultation
				
Major Variation or Development Major service reconfiguration - changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service, arms length/move to CFT				Category 4 Formal consultation required (minimum of 12 weeks)
Significant variation or development Change in demand for specific services or modernisation of service. Examples: Changing provider of existing services, pathway redesign when the service could be needed by wide range of people			Category 3 Formal mechanisms established to ensure that patients/service users/carers and the public are engaged in planning and decision making. In most cases this means 12 weeks engagement period.	Information and evidence base
Minor Change Need for modernisation of services. Examples: Review of health visiting and district nursing, patient diaries		Category 2 More formalised structures in place to ensure that patients/service users/carers and patient groups views on the issue and potential solutions are sought	Information and evidence base	
Ongoing Development Proposals made as a result of routine patient/service user feedback. Examples: Proposal to extend or reduce opening hours	Category 1 Informal discussions with individual patients/service users/carers and patient groups on potential need for changes to services and solutions	Information and evidence base		

You will need to consult with the engagement lead to confirm the level of engagement or consultation required. Please use the Engagement Initial assessment form in the uploaded documents section to record your assessment. Examples of engagement planning templates will also be added to the uploaded documents section.

[Return to Part 1 - Initial Assessment tab](#)
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Older People's Mental Health Services Transformation - Inpatient Services Programme

Review of Strategies – Updated May 2024

Review of Strategies – May 2024

Following the review of options workshop on Tuesday 9 May 2023 a small subgroup reviewed the alignment with strategies domains scores and brought scores back to the programme board. This review took place with placed based leads from Kirklees ICB, Calderdale ICB, Wakefield ICB and the programme manager from SWYPFT.

Agreement was in place to revisit on completion of consultation process to factor in any new strategies that have emerged.

This is an update of the work from 2023, following the consultation process, to feed into the options deliberations in 2024.

Strategies

The main focus in this section is to ensure that the programme aligns (or isn't unaligned) to local, regional and national strategies.

Domain - strategies	What we need to measure against	Measures	Supporting information / comments
Alignment with strategies	Whether the model aligns with strategies.	• Demonstrates sufficient flexibility to align with and improve partnership working • Aligns with JNA • Maximise resilience to wider system • Estates strategy alignment	Strategy summaries (embedded below)

The following tables summarise the different strategies (that are now part of the draft business case), covering a table for national / regional / local strategies so alignment can be tested at each level. The table includes relevant elements from various strategic documents and summarise how well each option aligns.

National Strategies:

Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
National Picture NHSE, in their document, Acute Inpatient Mental Health Care for Adults and Older Adults: guidance to support timely access to high quality therapeutic care, close to home and in the least	National Context • Care is personalised • Admissions are timely and purposeful • Hospital stays are therapeutic • Discharge is timely and effective	Current stays can't be as therapeutic as they should be due to mix. Discharge,	Delivers in all options as the proposed new model of care supports all elements (these criteria are assessed in more detail in the QIA).		

Older People's Mental Health Services Transformation - Inpatient Services Programme

Review of Strategies – Updated May 2024

Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
restrictive setting possible (October 2022) have set out a vision for effective, good quality care in adult acute inpatient mental health services, which is based on 7 key principles:	- Services actively identify and address inequalities - Services grow and develop the acute inpatient workforce in line with national workforce profiles NHS England » Acute inpatient mental health care for adults and older adults	particularly dementia is not timely. Workforce has not grown and is inadequate.			
National	Clinical model, including royal college, Health Education England, analysis of predominant models suggest needs led specialism	Doesn't deliver the clinical model	Delivers in all options		
https://www.england.nhs.uk/commissioning/spec-services/highly-spec-services/	NHSE commissioning guidance sets out where specialised and highly specialised services should be used. NHS commissioning » Highly specialised services (england.nhs.uk) sets out that where highly specialist services are required and that centres of excellence should be considered where there are no more than 500 patients year. NHS commissioning » Specialised services (england.nhs.uk) describes the approach to specialist services, stating that “specialised services are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience.”	Doesn't deliver fully due to mixed needs	Delivers in all options – meets the principles of this as this system has around 300 people admitted per year – approximately 100 with dementia. Not a direct comparison but all options align with principles.		
NHS England » Culture of care standards for mental health inpatient services	Standards: all people (patients, staff and visitors) feel safe on the ward we respect and protect people's civil and human rights staff prioritise building therapeutic relationships to support patient safety people always receive a compassionate response when they feel unsafe the approach to safety is relational people's mental health and physical health needs are understood and met (see also Needs led) What these standards mean in practice: We take action to keep people (patients, staff and visitors) safe, protecting their physical, relational, emotional and cultural safety. We ensure people are safe from sexual and gender-based harm [10], and our facilities are safe for people at risk of harm to themselves or others. We believe people when they tell us they feel unsafe, or have	Whilst the Trust takes steps to deliver standards of care for service users it does it in spite of a current system that isn't configured in the best way to enable this.	All options deliver a model of care that better enable culture of care standard to be implemented. These features are explore more in the QIA. Option 1B would require further mitigations to mitigate around single sex needs. All wards in this model would meet mixed sex standard but	All options deliver a model of care that better enable culture of care standard to be implemented. These features are explore more in the QIA.	

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Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	experienced sexual or gender-based harm, and report incidents when they occur. We protect and value time to build meaningful therapeutic relationships with patients as we know this, over the use of surveillance technology, keeps them safe in everything we do. One-to-one observation can be a way to spend time and be with the person, thereby building a therapeutic relationship. Our focus is easing people's discomfort and distress, and we recognise that having someone to listen 24/7 can shift a person's perspective to one of hope for the future [11]. We are person centred [12] in our approach to safety. We ask patients and lived experience workers what makes them feel safe and what makes them feel unsafe on the ward; the former might include access to basic items such as a phone charger, hygiene products and information about the ward. We involve the person and their loved ones in safety planning. Where the person lacks the capacity to discuss what makes them feel safe, we seek information from their support network, patient record or community team, and listen to their feedback as we care for them.		there would be no single sex wards for people with functional needs.		
NHS England » Commissioning framework for mental health inpatient services	Care is personalised to people's individual needs, and mental health professionals work in partnership with people to provide choices about their care and treatment, and to reach shared decisions. Admissions are timely and purposeful. Hospital stays are therapeutic. Discharge is timely and effective. Care is joined up across the health and care system. Services actively identify and address inequalities that exist within their local inpatient pathway, in partnership with people from affected groups and communities. Services grow and develop the acute inpatient mental health workforce in line with national workforce profiles, so that inpatient services can offer a full range of multidisciplinary interventions and treatment. There is continuous improvement of the inpatient pathway <i>Four key principles</i> 1. Personalised care and shared decision making	As identified, the current model doesn't enable elements of care to be delivered as effectively as possible and requires ongoing mitigation – for example discharge not always being timely and not enabling the best environment for therapeutic interventions.	Improvements to therapeutic environment, timely discharges and skilled MDT workforce in all options.		

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Review of Strategies – Updated May 2024

Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	2. Trauma-informed care 3. Joined up partnership working 4. Care that advances health equality <i>Three key stages</i> <i>Purposeful admissions</i> <i>Therapeutic inpatient care</i> <i>Proactive discharge planning and effective post-discharge support</i> <i>Two key enablers</i> 1. A fully multidisciplinary, skilled and supported workforce. 2. Continuous improvement of the inpatient pathway. Using data, co-production and quality improvement methodology.				
Discharge from mental health inpatient settings - GOV.UK (www.gov.uk) https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings/discharge-from-mental-health-inpatient-settings	Good practice guidance for discharge and guidance for people with dementia that we need to factor into implementation design of model: This guidance applies to people with dementia who are discharged from mental health, learning disability or autism inpatient settings. This includes people admitted to specialist dementia inpatient services or a person with dementia (who may have a dual diagnosis of a mental health condition or learning disability) admitted to other mental health or learning disability inpatient services. All of the key principles in the section 'Principles for how NHS bodies and local authorities should work together' apply to people who are suspected of having or have received a diagnosis of dementia.	Applicable in all options.			
NHS Confed 2022/23 NHS priorities and operational planning guidance NHS Confederation	Transform and build community services' capacity to deliver more care at home and improve hospital discharge Exploit the potential of digital technologies to transform the delivery of care and patient outcomes	All options should allow this.			
National guidance on ward size	Modelling (DH 2013) suggests 15 beds is an optimum size for clinical and therapeutic engagement	In line	Well above proposed numbers of Crofton	In line	In line

Older People's Mental Health Services Transformation - Inpatient Services Programme

Review of Strategies – Updated May 2024

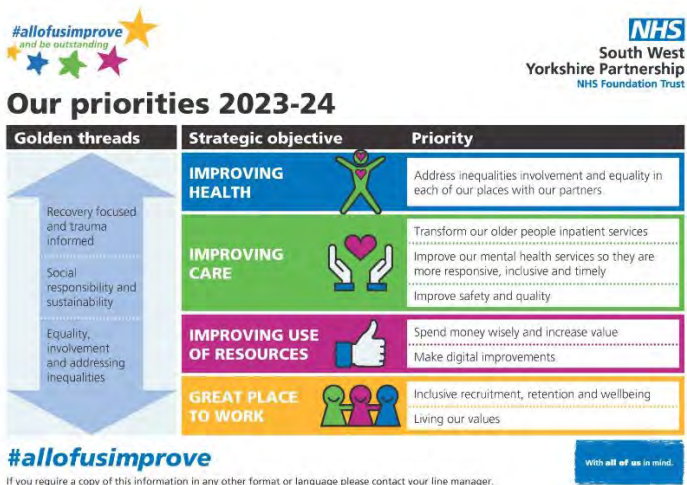
Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_03-01_Final.pdf			ward in the proposed option.		
National Strategies in pipeline:					
NHSE major conditions strategy	Key focus areas include: Dementia and Mental Health Background on: Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk) Systems will have to grapple with the complexity of integrating treatment, care and support into people's lives over the long term, with the likelihood of different periods of intensive support or treatment followed by periods where less support is needed, as well as moving between health and social care services.	Elements that would need to be factored into all options			

Regional and Local Strategies

Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
West Yorkshire ICB https://www.wypartnership.co.uk/application/files/6815/8451/9232/Better_Health_and_Wellbeing_for_Everyone.pdf	If you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible and that access to care is equal for all. Local hospitals will be supported by centres of excellence for services such as cancer, vascular (arteries and veins), stroke and complex mental		Delivers in all options		

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Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	health. They will deliver world class care and push the boundaries of research and innovation. In addition, the programme board has tested with the ICB several times and found that there is no activity planned regionally or in partner providers that would impact on the medium term options.				
SWYPFT Trust Priorities Trust Social responsibility and sustainability strategy 2022-27 Trust Estates Strategy (P317 via link below): Public-Agenda-and-papers-25.07.23.pdf (southwestyorkshire.nhs.uk)	Our strategic ambitions for 2023/24 are to: Our strategic ambitions set out what we want to achieve and be known for as an organisation. By fulfilling our objectives and achieving our priorities we will be: • A regional centre of excellence for learning disability, specialist and forensic mental health services • A trusted provider of general community and wellbeing services delivering integrated care • A strong partner in mental health and learning disability service provision across South Yorkshire and West Yorkshire • A trusted host or partner in our four local integrated care partnerships • A compassionate and innovative organisation with equality, co-production, recovery and creativity at its heart. 	Fails in quality and improving services	Transformation aligns with the Trust priorities. All transformation options need to be conscious of emissions of extra travel but overall impact is limited, especially factoring in impact of no longer having an isolated site and development of site in Wakefield. The options align well with the estates strategy, especially enhancing the service model, improving the quality of estate, meeting statutory requirements, helping deliver less stigmatising services through the needs based model and helping deliver a more sustainable model.		

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Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	SRS Strategy: Reduce direct CO2 emissions by 80% by 2028 (from 2013 baseline) and become net zero by 2040 (in line with the NHS target) Reduce energy consumption across our estate through changing behaviours, proactive management and investment in more efficient technology Reduce business miles travelled by staff and promote more sustainable methods of Transport including travel by service users, families, carers and friends Reduce emissions from transport, including miles travelled by staff and service users, families, carers and friends; and those for logistics. Examples could include reducing travel demand (e.g. online meetings and appointments) and promoting sustainable modes of transport such as active travel, public transport and electric vehicles. Estates Strategy: The estate must enhance and facilitate service models The quality of the estate must have a beneficial impact on staff and service All accommodation must meet accreditation and statutory requirements All accommodation for patients must be in appropriate, non-stigmatising locations All accommodation should be constantly reviewed in relation to the most effective service models. Wherever possible accommodation should enhance opportunities for the Trust Accommodation must provide value for money.				

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	The Trust should only own estate where this is an essential aspect of the service. All investment must be reviewed in relation to sustainability in the widest sense of the word.				
In pipeline: 2024-25 priorities Trust Strategy	Current 24/25 priorities awaiting final sign off but current indications are that this programme remains a priority and key focus area. Trust strategy in development through 2024.				
Wellbeing Strategy Calderdale - Living a Larger Life 2022-27	The Calderdale Wellbeing strategy 2022-2027 has 4 core areas, with Ageing Well particularly aligning to this population: The goal of aging well is that older people have strong social networks and live in vibrant communities, including an aim of increasing in the percentage of older people who agreed or strongly agreed that they felt they belonged to their immediate neighbourhood (to be measured in February 2022). It aims to develop and deliver community-based plans to achieve our four priority outcomes across the borough and in neighbourhoods Reviewed the inclusive economy strategic – does reference a specific travel challenge within Calderdale but nothing directly that could be linked to this. In the pipeline: Calderdale is currently in process of updating larger life strategy and the JNSA.	Whilst this has a clear local and neighbourhood focus there is no reference to when anyone need inpatient specialist care. As such there doesn't appear to be anything in this strategy that either supports or detracts from the OPS inpatient strategy. The inpatient model is for the very few people with highest need, it does mean options with an enhanced model the assessment and inpatient stay will decrease in time and mean that people are discharged back to place sooner.			
Kirklees strategy	KIRKLEES HEALTH AND WELLBEING STRATEGY 2022 – 2027 To achieve the 4 outcomes across the life course we will focus on 3 priorities MENTAL WELLBEING Our ambition is that everyone in Kirklees achieves good mental wellbeing and has a good quality of life with purpose and fulfilment throughout their lives.	The Kirklees health and care plan references this programme directly as one the key changes required to deliver improvements.			

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Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	HEALTHY PLACES Our ambition is that the physical and social infrastructure and environment supports people of all ages who live, work or study in Kirklees to maximise their health opportunities and to make the healthy choice the easy choice. CONNECTED CARE AND SUPPORT Our ambition is that organisations and professionals across the health and care system work together to ensure people are able to access the right care/support for their needs, when they need it, making the best use of all available resources. WHAT ARE LOCAL PARTNERS GOING TO DO Understand your responsibility around suicide prevention; undertake training to help reduce stigma and know what you can do to help ☐ We will recognise people as experts in their own mental wellbeing, work in partnership with them and support them to self-care ☐ We will work together so mental ill-health and physical ill-health are viewed equally 17 ☐ We will have good data, and use it and personal stories to understand people of all ages who live, work or study in Kirklees to inform evidence-based approaches to tackling mental wellbeing ☐ We will work together so support and services provided are easily accessible to meet the needs of those that require them the most and, where possible, are available in local communities The Kirklees Health and Care Plan references this programme as one its key changes to deliver improvements: • Implement transformation of older people's Inpatient services, following consultation • On-going implementation and transformation of older people's inpatient services				

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	In the pipeline: Kirklees is developing a strategic plan that will include dementia so no change from above. The JSNA is updating.				
Wakefield strategy	☐ We will ensure the whole health and care system works well together to help people live in good health for longer and reduce the need for people to be admitted to hospital. ☐ We will work with voluntary and community organisations to help people stay connected with their communities to prevent loneliness, which can affect people's mental and physical health and make them more dependent on services. ☐ We will also invest in technology to support people to live independently for longer, including aids to reduce the risk of injury caused by falls. ☐ We will enhance support to the thousands of informal carers in the district, including children and young people, to enable them to continue the vital role they play in looking after family members and friends with disabilities or health conditions. ☐ Intensive support to care homes and home care services that we put in place during the pandemic will continue and we will maintain housing support coordinators in hospitals to stop housing issues being a barrier to people being discharged. ☐ People will have more choice, control and support to live independently with less reliance on services. Where people do need support from services, health and care will be more joined up and organised around the needs and preferences of the individual, their carers and family. Mental ill-health is a concern for many people and suicide rates in the district are higher than the rest of the country, so we will invest time and money into helping people stay emotionally well, tackling the underlying causes of mental illness and supporting people who have mental health problems. In the pipeline, Wakefield is developing a roadmap that is community focussed.	Whilst this has a clear local and neighbourhood focus there is no reference to when anyone need inpatient specialist care. As such there doesn't appear to be anything in this strategy that either supports or detracts from the OPS inpatient strategy. The inpatient model is for the very few people with highest need, it does mean options with an enhanced model the assessment and inpatient stay will decrease in time and mean that people are discharged back to place sooner.			
CHFT (Acute Trust)	Within the strategic plan there is mention of a reconfiguration of clinical services by 2027.	The CHFT strategy flags the opportunity to transform services enabled by estate development			

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Document / Information		Key focus areas		Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	(NB It is important that local pathways reflect collaborative and partnership working to ensure that older people have access to the appropriate clinical services (mental or physical health or both) and that clinical teams work for the common purpose of providing holistic physical and mental health care appropriate to their assessed needs, regardless of their inpatient setting.)						
Mid Yorkshire (Acute Trust)	Services will be designed to provide and evidence excellent patient outcomes. This will include (where required) combining expertise from within the Trust and from our partners to establish joint working arrangements. Purpose-built facilities will be used to create centres of excellence and facilitate optimal clinical outcomes, patient safety and experience. Patients will be involved in co-designing what we do in the best interests of their individual care and that of the community. Dewsbury & District Hospital Dewsbury Hospital will continue to provide urgent and emergency care services through its Type-1 ED, CAU, and Dewsbury Acute Care of the Elderly Unit (DACE). Through this strategy, we will increase the provision of planned care services on the site and introduce specific centres of excellence. The Dewsbury site includes: • Emergency Department (ED) (Type-1) with Integrated GP Walk-in Centre • Acute Care of the Elderly Unit (DACE) • Palliative Care Day Support and Therapy Unit (Rosewood) Pinderfields Hospital, Wakefield – Major Acute Hospital Pinderfields Hospital is the acute and emergency care centre for the Trust. It is the focus of the main patient flows, particularly for sicker and more complex patients. This will continue and be enhanced through the delivery of this strategy.	Mid Yorks model aligns well with SWYPFT proposals for transformation, both in terms of delivery of centres of excellence models and aligning their older people’s wards in Wakefield and Dewsbury with our proposed wards in the Transformed model which by collaborative working will ensure patient flow is maintained. (NB It is important that local pathways reflect collaborative and partnership working to ensure that older people have access to the appropriate clinical services (mental or physical health or both) and that clinical teams work for the common purpose of providing holistic physical and mental health care appropriate to their assessed needs, regardless of their inpatient setting.)					

Older People's Mental Health Services Transformation - Inpatient Services Programme

Review of Strategies – Updated May 2024

Document / Information	Key focus areas	Option 1 No change	Option 1B Option 2	Option 1A Option 5	Option 2 Option 9
	The Pinderfields site includes: • Emergency Department (ED) (Type-1) – Adults and Paediatrics • Acute Care of the Elderly Unit (PACE) • Acute and Emergency Surgery • Acute Medical Services				

Summary scores

The table below summarises proposed revised scores following review and the rationale for any changes. It supports the previous analysis that options 5 and 9 do align well with strategies, though does propose increasing scores of option 2 and 3, acknowledging that the issues identified with these options do persist.

Number	Option	Co-Dependencies with other strategies (3 breakout groups)				
		Previous score	Agreed Y/N	Alternate suggested score	Agreed score	Key discussion points
NA	No Change	4	Y		4	No change scores 4 due to not delivering the key elements of a specialist model. Does support people in home locality but keeps people away from their community for longer. Option 1B does have one key area not met – the ward size which leads to a score of 5. Option 1A and 2 –align well with the vast majority of local, regional and national strategies. Sustainability impact is limited.
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards)	7	Y		8	
1B	W19 dementia unit, 6 extra beds at Crofton,	4	N	5	5	

Older People's Mental Health Services Transformation - Inpatient Services Programme
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Number	Option	Co-Dependencies with other strategies (3 breakout groups)				
		Previous score	Agreed Y/N	Alternate suggested score	Agreed score	Key discussion points
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	7	Y		8	

Older People's Mental Health Services Transformation - Inpatient Services Programme

Review of Strategies – Updated May 2024

Options Scoring Criteria

Score	Description	Summary	Viability
10	meets fully and exceeds	This gives us everything we'd expect from a model and more. A new build, for example, might allow an innovative environment that goes beyond some of our existing good practice models.	Viable
9	meets fully	This would fully meet requirements across all wards – for example, all wards would be en-suite, have good private space, strong male and female privacy etc.	Viable
8	meets the vast majority of requirements	This would meet the vast majority of requirements across all parts of the system. There might be some minor issues – for example meets single sex requirements but there is limited space for extra clinical activities – i.e. might be limited open space rooms.	Viable
7	meets the vast majority of requirements with additional work required	This could meet all but a small number of areas which could potentially be addressed over time without too much impact on the model – for example if not all bedrooms can be en-suite but that we can mitigate or wards with some space challenges, Single sex met, but needs management, etc.	Viable
6	meets most with more work required	Similar to above but there are more issues that require adjustments and management. For example, the overall environment is good, there are a few things that could be better across the system but we can still make it work safe and effectively	Viable
5	meets most but a key area not met	One of the key areas of delivery of the model can't be met. So this might be single sex accommodation can't be managed effectively everywhere or it might be delivery of the fully needs based model.	Viable but further considerations of how to improve the key area should be considered
4	meets some parts not others with key areas not met	This would be where a more than one key area can't be met. Viable but sub optimal. For VfM scoring any option that is financially viable would score 4 or above	Viable – but need to consider how to improve model
3	limited criteria met with several key areas not met or one significant risk	Where there are enough challenges that mean either the essence of a good service model can't be delivered or that something leads to a significant risk in the system. For VfM scoring this would be if we can't reach level of assurance that the models are financially viable.	Not currently viable – need to consider whether any changes could make the option viable
2	meets very few criteria well with many key areas not met / significant risks		Not viable
1	does not meet criteria		Not viable

Consultation plan

Older People's Mental Health Inpatient Service Transformation

Calderdale, Kirklees, and Wakefield

Version control			
Version	Name and title	Date	Status
V0.1	Dawn Pearson	5 May 2021	Initial draft
V0.2	CEE OPS steering group member comments	29 June 2021	Initial draft
V0.3	Dawn Pearson	July 2022	Updated
V0.4	Kamal Wrathall	January 2023	Updated
V0.5	CEE OPS steering group member comments	March 2023	updates
V0.6	OPS programme board comments	25 April 2023	updates
V0.7	CEE OPS steering group member comments	July 2023	updates
V0.8	Dawn Pearson and Ryan Hunter	Sept 2023	EIA alignment and delivery plans
V0.9	Sarah Mackenzie- Cooper	October 2023	updates
V0.10	Dawn Pearson	November 2023	Additional content
V0.11	Ryan Hunter	February 2024	Updated following midpoint review

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1 Introduction

The purpose of the document is to describe a process which will help South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) (referred to as 'The Trust') in partnership with Calderdale, Kirklees and Wakefield places and NHS West Yorkshire Integrated Commissioning Boards (ICB) consult on the future of older people mental health inpatient services for Calderdale, Kirklees, and Wakefield.

The plan describes the options and scope of the consultation including the approach we will take to deliver the consultation process. The plan also includes the communication materials and the process for ensuring due regard to equality is demonstrated throughout the process. The document includes:

- The background to this work
- What we already know
- The principles we should adopt to deliver the consultation across several local areas.
- The consultation approach and timescales
- How the information gathered from consultation will be used to inform a future service decision

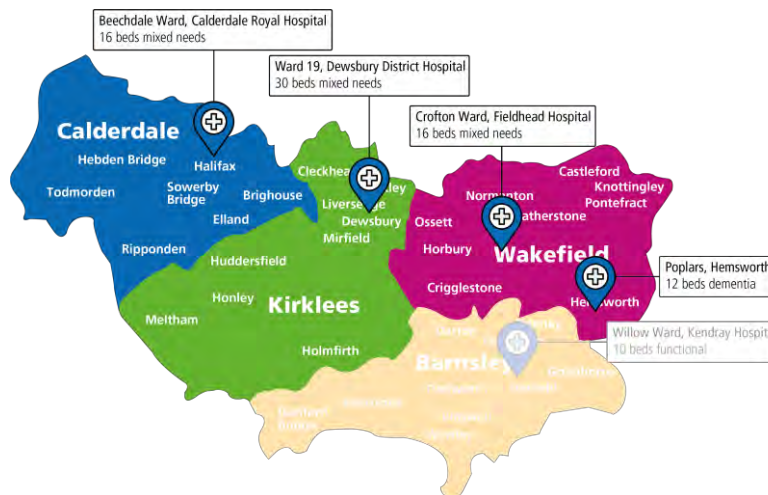
2 Background

The Trust alongside our partners and commissioners are reviewing how we provide mental health care for older people within our inpatient wards. This follows service improvements to our community mental health service in 2015.

In West Yorkshire, the Trust has five older people's mental health wards. These are:

- A ward in Halifax at Calderdale Royal Hospital (16 beds)
- Two wards in the Priestley Unit in Dewsbury, located in Dewsbury and District Hospital (30 beds; 15 male beds and 15 female beds)
- Two wards in the Wakefield district at Fieldhead Hospital (16 beds) and at The Poplars in Hemsworth (currently operating as 12 beds).

In South Yorkshire, the Trust has a ward for people with functional mental health needs (10 beds) at Kendray Hospital Barnsley, which we do not plan will change as part of this transformation.



There are two groups of older adults who use our inpatient wards. These are:

- People with needs such as dementia, and
- People with other mental health needs such as depression, anxiety, and psychosis (often referred to as functional needs).

Evidence shows that the care of people diagnosed with dementia, and people with functional needs is very different.

There are different types of supervision, clinical intervention, and workforce skills required to provide specialist care for people with dementia and people with functional needs. The living space, and the activities which are needed to effectively support and provide the best care for each group are also different.

People with dementia may require more specialist care and support. Currently, our wards support a mixture of mental health needs, which means that not everyone gets the specialist care they may need.

The CQC also highlighted the challenges of managing patients with dementia and functional needs on mixed wards during their visit in 2019.

We also face challenges with some current estate which does not provide an optimum layout for managing the care of people with dementia and functional needs on a mixed ward.

From a patient perspective, we know from previous engagement that patients, carers, and families also agree that specialist care would provide better outcomes for both groups of patients. (Add link to engagement report)

Therefore, we are looking at how we might separate care for people based on their needs, which is consistently regarded as a model of good practice.

3 The options

The two proposed options to create separate specialist wards are:

Option one: a specialised dementia unit at Ward 19, Dewsbury District Hospital.

There are two ways that this could be done:

- **Option 1a** – with an extra 10 beds at the Crofton Ward, Fieldhead Hospital for functional mental health needs. This would be two wards, one male and one female only, with 26 beds in total.
- **Option 1b** – with an extra 6 beds at the Crofton Ward, Fieldhead Hospital for functional mental health needs. This would be a single ward and mixed gender with 22 beds in total.

Option two: a specialised dementia unit on Crofton Ward, Fieldhead Hospital, Wakefield.

This would be a 26-bed dementia unit across two wards, with 10 beds being relocated from The Poplars, Hemsworth. Functional only wards would be located at Ward 19, Dewsbury District Hospital and Beechdale Ward, Calderdale Royal Hospital.

4 Legislation

The legislation we must adhere to and demonstrate to is set out below.

4.1 Health and Social Care Act 2022

In its responsibilities for public involvement and consultation under section 13Q of the National Health Service Act 2006, NHS England, and NHS West Yorkshire Integrated Care Boards (ICB) has a duty to consult individuals to whom services are being or may be provided, in the planning and development of commissioning arrangements for those services. The Act extends this to include “carers and representatives” of people receiving a service or who may do so. The extension of this duty is replicated in an equivalent duty on integrated care boards.

4.2 The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act - age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, and belief, sex, and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance ‘Equality of Opportunity’, and c) foster good relations. All public authorities have this duty so partners will need to be assured that “due regard” has been paid through the delivery of consultation activity, and in the review.

4.3 The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains several patient rights, which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

The consultation approach and mandate should also satisfy key tests. The test for both consultation and equality are set out below:

The **Brown Principles** for equality state an organisation must be aware of their duty set out below:

- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigor and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.

The 'Gunning Principles' state that:

- Consultation must take place when the proposal is still at a formative stage (i.e., no decision until the process has concluded)
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response (clearly describe the model, criteria used to determine the model and reasons)
- Adequate time must be given for consideration and response (the length of the consultation is important to ensure it allows for this)
- The product of consultation must be conscientiously taken into account (demonstrate clearly how the product of consultation has been considered)

5 Consultation mandate

We, South West Yorkshire Partnership NHS Foundation Trust and NHS West Yorkshire Integrated Care Board (ICB) want to understand views of the target audience set out in section 6 of the consultation plan concerning the transformation of older people mental health inpatient services so that South West Yorkshire Partnership NHS Foundation Trust can take into consideration the views of those consulted by Spring 2024, to make a decision on the future transformation of older people services which will be implemented across the geographical areas of Calderdale, Kirklees and Wakefield District.

6 Target audience

The key audiences and communities for this consultation will be the following groups in Calderdale, Kirklees, and Wakefield (EIA reference)

- Anyone currently using older people mental health inpatient services.
- Families, relatives, and carers of people who are currently using older people mental health inpatient services.
- Voluntary and community groups representing, supporting, or advocating for older people, carers and families.
- Staff with an interest in older people mental health services, from all health and social care sectors, including but not exclusive to hospital, community, local authority, and primary care.
- Key partners and stakeholders who have an interest in older people mental health services.
- Anyone with an interest in older people's mental health services
- People who are identified as future service users.

We do not plan change to services in Barnsley, but we will seek views from the following groups as Barnsley is within the Trust footprint:

- Key partners and stakeholders who have an interest in older people mental health services.
- Anyone with an interest in older people's mental health services
- People who are identified as future service users.

A more detailed stakeholder map can be found below. This will be monitored and reviewed regularly throughout consultation planning and delivery to ensure we are reaching the right audiences.

Participants	Key players
• South West Yorkshire Partnership NHS Foundation Trust staff • Overview and Scrutiny Committees - Barnsley, Calderdale, Kirklees, and Wakefield • Health and wellbeing boards - Barnsley, Calderdale, Kirklees, and Wakefield • NHS West Yorkshire ICB • Staff networks • Patients, families, carers, and members of the public	• South West Yorkshire Partnership NHS Foundation Trust executive management team and operational management group • NHS West Yorkshire ICB • NHS South Yorkshire ICB
Observers	Contributors

• Local media • Campaign groups • Community groups	• Primary care providers • Voluntary and community sector groups • Local Medical Committees • Local Pharmacy service providers via West Yorkshire Pharmacy services • Healthwatch organisations • Local authorities • Hospital trusts • MPs and local councillors • Care homes • West Yorkshire Police, South Yorkshire Police • Fire and rescue service • Yorkshire Ambulance Service • Education providers – including colleges and University of Huddersfield

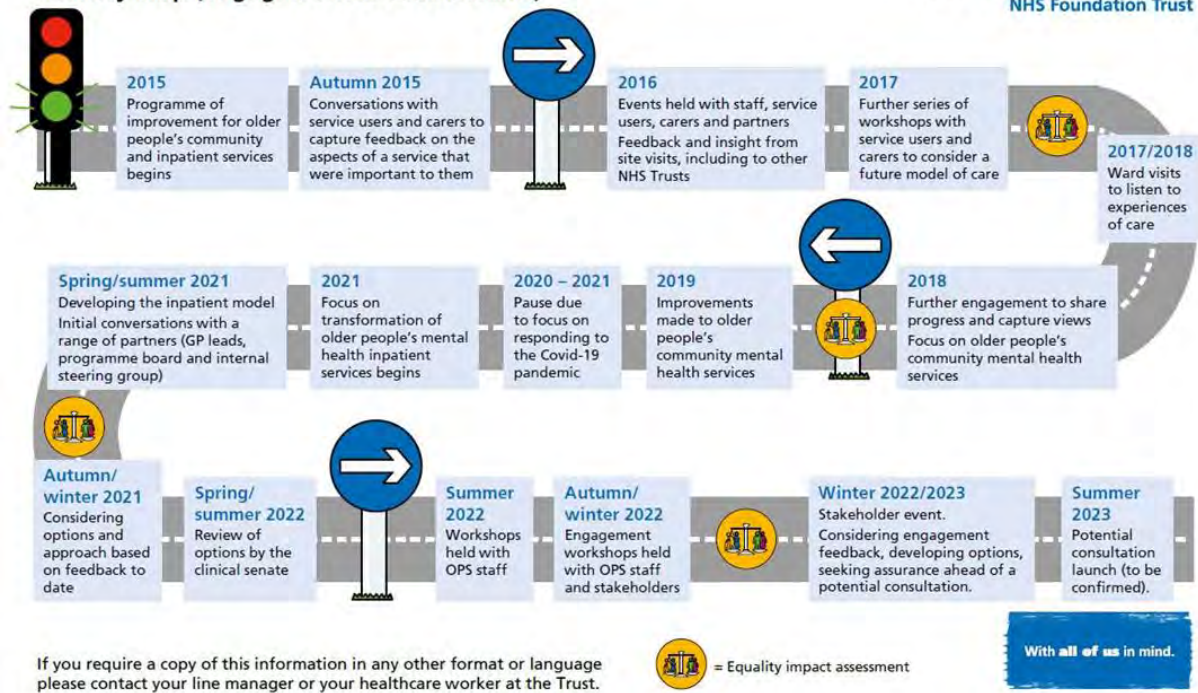
As part of our equality duty, we will ensure we consider equality and diversity at each stage in the consultation process. What this means in practice is that we will consider equality in the development of our plan to ensure we reach people identified in the target audience using an equality impact assessment. That we will ensure that we have a representative view which reflects the communities we serve so that we can make fair and informed decisions for everyone. To use the consultation process to identify any action required to mitigate any negative impacts or maximise any positive impacts on equality, and ensure we comply with our statutory responsibilities under the Equality Act 2010.

7 What do we already know

The Trust has already delivered several conversations across Barnsley, Calderdale, Kirklees, and Wakefield on older people inpatient services. This engagement has been captured into a report of findings. The journey to capturing views is highlighted below:

Older people's mental health inpatient services transformation

Journey map (engagement to consultation)



The findings collectively report on engagement from 2015 and all reports can be found here: [Transforming older people's inpatient mental health services - South West Yorkshire Partnership NHS Foundation Trust](#)

- Conversations with service users and carers in Autumn 2015 which captured feedback on the aspects of a service that were important to them.
- A range of mixed audience events which took place in March 2016. These events were attended by staff, service users, carers and partners.
- Feedback and insight from site visits including other NHS Trusts
- A further series of workshops with service users and carers which took place in May 2017. These workshops focussed on the consideration of a future model of care.
- Several ward visits which resulted in listening to current service user and carer accounts of care in the winter of 2017/2018.
- Further engagement took place in 2018 to share progress and capture views.

From all the engagement work which took place there were some key themes that started to emerge. These themes told us that.

- People were generally positive about the community proposals, and they prefer to be supported to have their **care closer** to home or in the home, for as long as possible.
- People were keen to ensure that the **hours of service were appropriate**, with extended hours available for people as needed.

- People were keen to ensure **dementia awareness within a care home** setting is built into a future model.
- People were positive about **benefits of a specialist dementia unit**.
- There were **concerns about potential extra travel for families**.

Following on for this work the engagement findings were used to inform the criteria to determine the options. Proposals were tested against a set of criteria informed by national guidance and clinical good practice. The engagement provided additional considerations for each of the criteria to ensure that the findings were used to inform the proposals. The criteria headings and 'what people told us' are set out below.

People told us what 'Good Quality Care' would like:

- Person centred.
- Good quality information available at each stage, not all at once
- Telling a story once
- A service that meets all cultural and religious needs – particularly South Asian
- More support and focus on families and carers.
- Improved access for carers so they can continue a caring role.
- Better communication between GP and specialist service
- Quality of assessment
- Being kept informed at each stage of the process.
- Quality of direct care and support
- Gender- Male/female privacy
- Continuity of care – seeing the same person
- A safe and supportive environment
- Physical and mental health needs are met.
- Maintaining independence and good health throughout the patient journey including admission and discharge
- Consistency in medication

People told us what 'Access to Care' means to them:

- Early intervention – help people understand the process to access services.
- Services that are responsive and accessible
- Access to the right person to receive the right treatment in the most appropriate setting.
- More support at the stage of diagnosis
- Minimise delays in care and ensuring the prompt action of staff.
- Distance to travel and transport routes
- Good access to travel, transport, and car parking
- Access to physical health care and other clinical support
- Access for carers which include flexible visiting times.
- Good care coordination – one person overseeing the patient journey.

People told us what 'Value for Money' means to them:

- Reimbursement of travel expenses if travelling further
- Explore the concept of funding a shuttle bus.

People told us what should be 'Delivered and Sustained':

- Safe, effective, and well led outcomes.

- Standard referral criteria
- Admiral nurses and nurse prescribing built into the model.
- Specialist dementia wards were seen as a good idea.

People told us what other factors we should consider:

- More links with local health and social care providers
- Physical, mental, and social care needs are met.
- Focus on care closer to home where possible – community hubs and clinics.
- Promoting an independent healthy, active lifestyle
- Supporting people at home
- Preventative approaches
- Involvement from the third sector

Previous engagement can demonstrate through equality monitoring that a range of views were gathered from a diverse audience. The equality monitoring from this engagement was captured separately to the feedback. We do know who we reached and will address any identified gaps through the consultation.

In addition, the Trust further involved key stakeholders in two events. The events and key themes are set out below.

7.1 October 2022 Workshop for health, social care, voluntary and community sector staff

A workshop was held in October 2022 to further involve health, social care, voluntary and community sector staff in the development of options. In total the event was attended by **50** health and social care staff from Barnsley, Calderdale, Kirklees, and Wakefield. The key themes for the event are summarised as:

- **Theme 1: Consider the travel impact of all options**, factoring in cost-of-living challenges and using travel impact analysis which should include travel by car and public transport.
- **Theme 2: Ensure we address inequalities** identified through the equality impact assessment in the development of options. This includes the impact on people who use services staff and carers.
- **Theme 3: Consider flow and length of stay** by considering potential solutions which enable a reduced length of stay and consider other developments which could support this ambition, such as step-down facilities.
- **Theme 4: Consider the impact on staff** of the potential changes and ensure that staff are fully engaged in the process and are consulted on the changes. It is important that staff feel involved in the process and can deliver the proposed approach solving any current staffing pressures.
- **Theme 5: Consider the additional option to centralise specialist services in Wakefield** - Following feedback from clinical senate and discussions which took place at the workshop it is evident that the Trust need to option appraise centralising specialist

services on the Wakefield site.

- **Theme 6: Describe what the Trust mean by re-purposing Poplars** in the proposed options so that we can articulate this clearly to key stakeholders and the public.
- **Theme 7: The length of time since engagement** should be considered and the Trust need to make sure that any gaps in information or target audience is picked up in consultation.

7.2 December 2022 Stakeholder event

A stakeholder event was held in December 2022 with further wider stakeholders from Barnsley, Calderdale, Kirklees, and Wakefield. In total 67 attendees attended the event. The key themes for the event are summarised as:

Theme 1: Clinical Model - General agreement across several group discussions that a change is needed. Separating the services out and having a specialist dementia ward and the staffing was seen as positive dependent on the correct staff numbers with the right training and skill being in place. The change would provide better outcomes for patients and doing nothing was not seen as an option.

Theme 2: Use of estates – Several groups discussed the inpatient estate and there was a general view that Ward 19 would work better as a dementia ward in the model than Crofton. Overall, the ward environment of Ward 19 lends itself more to being a site for dementia due to design, layout, and use of space. More work would be required on the site to further improve the environment, though some improvement activity is already taking place. Need to consider spaces for families particularly for patients nearing end of life.

Theme 3: Bed numbers and ward sizes - The number of beds and ward sizes within the proposed model and how capacity will be managed. Ensuring the model is still fit for purpose in 10 years, given the predicted population increase.

Theme 4: The Poplars – Most people felt Poplars should not be part of the proposed acute model but could be used in other ways to support people. The future use of the Poplars site needed to be clearly articulated as there are several identified potential uses.

Theme 5: Barnsley patients – how Barnsley patients would be accommodated in the model, given that some patients are currently admitted to West Yorkshire, needs to be described. Also, to clearly articulate why there is no impact for Barnsley public in the consultation.

Theme 6: Alignment with other services – Need to ensure that the proposed options align with the wider systems including both SWYPFT teams and partner organisations that will need to work in new ways and across boundaries to support a different model.

Theme 7: Workforce – Need to consider the workforce implications for all proposed options including staffing to the right levels, roles, staff specialist skills for each group but not losing overall old age specialism. The workforce model needs to be clearly articulated for each

option to ensure that the workforce implications can be considered fully.

Theme 8: Travel, transport, and parking - The impact of travel, transport and parking for both patients, carers, families, loved ones and staff should be considered. This includes transport times and aligning with visiting, the age of people travelling (including access) and the frequency and reliability of transport networks. Transport during discharge should also be considered if the patient is out of their local area.

Going forward the consultation will need to specifically identify any positive or negative impacts of the options on each of the protected groups to ensure that the option considered provide an opportunity to demonstrate due regard, reduce health inequalities and advance equality of opportunity.

8 Principles of consultation

To ensure we meet our statutory obligations we must satisfy the principles set out in Gunning. The 'Gunning Principles' are applied if a decision is taken to judicial review. The Gunning Principles are:

- Consultation must take place when the proposal is still at a formative stage.
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response.
- The product of consultation must be conscientiously taken into account.

It is worth noting that it is not the decision that is tested but the process that has been followed to come to that decision. In addition, a shared set of principles have been developed which set out a partnership approach to consulting people including our commitment to equality of opportunity.

The principles are set out below:

- We will use what we already know as a starting point.
- The consultation will be supported by **clear information** and opportunities for **communication**, so people feel informed and able to participate.
- We will ensure that we consult the right people at the right time in the **development and design** of services.
- We will ensure we are fully **inclusive** in our consultation approach.
- We will be **honest and transparent in our approach** which will include being honest about what people can and can't influence and the reasons why.
- For the things people can influence we will provide **a genuine opportunity for consultation**. This will include providing the right conditions for people to get involved.
- The views gathered will be properly **documented** so people can see the information they have provided and feel confident that it is gathered in such a way that it can inform a decision on future services.
- We will thank people for their contribution and **provide feedback** on our next steps.

- That we keep people **informed and in the loop** by providing a communication platform which everyone can access.

9 Approach to Consultation

The purpose of the consultation is to deliver the agreed mandate which is described and set out in section 5 gathering feedback from the key stakeholders set out in section 6. The Trust will do a mid-point review at week 6 to ensure that we are gathering a representative population sample based on our local census data 2021. Targeted approaches to capture the views of those underrepresented will take place using community contacts, and the Trust equality and involvement team.

The consultation approach to support delivery is set out below:

9.1 Survey online and hard copy – in easy read, other formats, and translation.

A survey will be used to provide feedback on the consultation proposals. These questions will ensure that we can fully understand and capture the impact of the proposed approach. Surveys will be provided online and in paper format. All responses will be collated centrally.

9.2 Face to face and/or digital meetings

Face to face and/or digital meetings will take place, these will be aimed at staff, stakeholders, and public audiences. These meetings will be supported by a presentation of the proposals. Clinicians and subject matter leads will be available to support responses to any questions. Questions will be submitted in advance where possible. Meetings will ensure people can gain the information they need, provide an opportunity to have clarity on any proposals. The aim of the meeting is to support a clear understanding allowing for an informed consultation response.

9.3 Advocacy

We know that the involvement of older people with dementia and functional mental health requires specialist input and that our independent advocacy teams work closely with our inpatients to provide much needed independent support. As service reconfiguration may have an impact on our workforce we will be inviting staff to respond to the consultation. This means that we need to maintain a level of independent support for those inpatients so they can respond without relying on Trust staff.

Advocacy services will support inpatients to respond to the consultation by providing information and/ or communicating in a way that meets the needs of that inpatient. Ensuring that all inpatients have been approached and included, and capacity to be involved assessed. Families, carers, loved ones and relatives will be contacted directly on day one of the consultation. A letter will be sent to the home address or email of an identified person for each inpatient, sign posting them to information and resources so that they can also provide a response.

9.4 Asset based approaches.

Each locality has a wealth of assets and contacts that can be harnessed to support a consultation approach. Funding will be available to support asset-based initiatives to capturing feedback from communities. This will provide an opportunity for people who do not feel involved to have a say at a very local grass roots level those who cannot access digital meetings or online surveys.

9.5 Capturing views creatively.

For those who cannot respond using the proposed methods there will be an opportunity for creative methods of feedback. Prompts will be used but people can respond using other media for example:

- A short film
- By providing a story
- Through the creation of an image/art
- Pictures and images

10 Communications

10.1 Aim

The aim of our communications approach is to provide clear and timely information to our wide range of stakeholders, helping to build awareness, understanding, and encourage engagement at every stage of the consultation process.

10.2 Objectives

- To be respectful, honest, open, and transparent.
- Work with our partners and stakeholders to ensure a broad and relevant reach across our geographical locations, particularly amongst those groups who are typically under-represented.
- Produce clear, concise, and accessible information available in a range of formats.
- Proactively inform, involve, and engage our stakeholders at each stage.
- To inform, engage and support our staff through each stage, and encourage them to give feedback.
- Make appropriate connection to other transformation work which may be happening in other health and social care organisations.
- Make it easy for people to give their views.
- To keep people informed and up to date, in a timely manner, on the progress and outcome of the consultation.

10.3 Outputs

The Trust will develop the following communication outputs to support the delivery of the consultation, with the main aim of ensuring that the information provided is accessible and inclusive to all audiences including those who do not English as a first language, people requiring reasonable adjustments and accessible materials and formats. We will be testing in consultation the quality of the information we provide and whether it was accessible. We

will ensure we adjust our offer accordingly in line with feedback. The following media will be used (note that this is not an exhaustive list and further outputs may be created):

- Consultation document – electronic and hard copy, full version and summary version, Easy Read, text only webpage, audio only option
- Posters – including a general poster, and posters tailored for each consultation event/local place – electronic and hard copy.
- Q&A materials
- PowerPoint slide for use on digital screens
- Display boards for key locations across every place
- Social media graphics and content
- Direct mail to carers and families of current inpatients
- Website page(s) – to act as one source of information.
- Internal communications – including copy for use in newsletters, staff event(s), frequently asked questions (FAQs)
- Consultation events – face to face, virtual
- Digital assets – including use of video and graphics.
- Media release – consultation launch, and localised media releases tailored to each local place, aligned to consultation events.
- Toolkit for partners/stakeholders to facilitate promotion – including printable posters, social media planner, website content, shared narrative, and briefing packs, and content for onward cascade.

10.4 Insight and involvement

The Trust will involve our staff and stakeholders in the development of our communications to ensure that they are clear, cohesive, and accessible to our stakeholders.

Insight and involvement will be sought from:

- A dedicated communications and engagement reference group, consisting of communications, involvement, and equality professionals from our partners, and representing the broad scope of our geographical locations.
- Communications and involvement professionals with expertise in producing accessible information.
- Staff, including those working in older people's mental health inpatient services and staff networks.
- Appropriate stakeholders – such as voluntary and community sector organisations who work with older people, their families, and carers.

10.5 Feedback channels

We want to make it as easy as possible for people to give their feedback. To do this we will use a variety of channels, including (but not limited to):

- Online form/survey
- Face to face conversations including advocacy and peer to peer approaches

- Dedicated email address
- Freepost address for return of paper-based consultation questionnaires
- An identified telephone number.

Our approach to run face to face and virtual events throughout the consultation period will enable a two-way dialogue with our stakeholders and encourage people to ask any questions they may have. These will continue to form part of a Q&A which will be published and shared with those who are supporting the consultation.

As stated Information will be produced in a variety of formats, this will include a word version of all publications on our website. For those who, for accessibility reasons, require information in an alternative format, a point of contact will be given to be able to request this and a timely alternative will be provided using our Trust Translation and interpretation service who will receive a full and summary word version of all materials to support quick and easy alternatives. All documents, including the survey will be in plain English summary and easy read.

10.6 Communication channels

The Trust will utilise the following communication channels to ensure messages are cascaded to stakeholders (note that this is not an exhaustive list and further channels may be added):

- **Internal channels:**
 - o Regular staff newsletters and briefings
 - o Events – face to face and virtual
 - o Staff networks
 - o Intranet
 - o Direct email
 - o Posters and leaflets
 - o Cascade via leadership teams
- **External channels:**
 - o Trust website
 - o Trust social media accounts
 - o Stakeholder websites and social media accounts
 - o Local media
 - o Direct email / mail
 - o Public events – face to face and virtual
 - o Public newsletters
 - o Cascade via partner and stakeholder networks / channels – including key stakeholder organisations working in the voluntary and community sector.

We will work with colleagues and named leads within our partner organisations to ensure delivery to our key target audiences. Some key target audiences and delivery methods are outlined below:

Target audience	Delivery method
People who have had direct experience of health and care services –all older people currently using our older people’s mental health services (inpatient and community), families, relatives, and carers	Raise awareness of the consultation through: • Direct mail to carers and families of current inpatients • Third sector networks and assets • Patient groups • Carers groups • Via staff working on wards • Display boards located on site/in wards. • Consultation events • Posters and leaflets • Direct with our communities via community representatives • At relevant appointments with service users/patients (e.g., our Trust, GPs) • Social media – organic and paid (if budget) • Websites and newsletters • Local media • Video • Public newsletters
Voluntary and community sector organisations who support, represent or advocate for older people, carers, and their families	• Direct briefings to organisations • Toolkit for onward cascade and to support promotion. • Consultation events • Via relevant meetings • Local media • Websites and newsletters • Social media • Posters and leaflets • Video • Public newsletters
Staff working in older people’s mental health services (inpatient and community)	• Direct briefings • Internal staff bulletins • Staff intranets • Cascade via leadership team and managers • Posters and leaflets • Direct email • On site display boards

Key NHS partners and stakeholders with a stake/interest in older people's mental health services	• Direct mail out to all Trust members • Direct briefings to organisations • Toolkit for onward cascade and to support promotion. • Consultation events • Via relevant meetings • Local media • Websites and newsletters • Social media • Posters and leaflets • Video • Public newsletters
People identified as future service users	• Third sector networks and assets – the reach of these groups can be found in the place-based delivery plans in the appendix. • Patient groups • Carers groups • Consultation events • Posters and leaflets • Direct with our communities via community representatives • At relevant appointments with service users/patients (e.g., SWYPFT, GPs) • Social media – organic and paid (budget dependant) • Websites and newsletters • Local media • Video • Public newsletters
Under-represented groups / those who are seldom heard	• Third sector networks and assets • Patient groups • Carers groups • Consultation events • Local media – including specialist media outlets. • Communications assets (e.g., posters and leaflets) – adapted to meet accessibility needs
Other patients and the public	• Patient groups • Carers groups • Consultation events • Posters and leaflets • Social media – organic and paid (if budget) • Websites and newsletters • Local media • Video • Public newsletters

10.7 Media protocol

Proactive media planning will cover the public announcement of the consultation, consultation launch, social media, and ongoing media relations.

Reactive media will be managed by the marketing and communications team at our Trust, working with partners in the NHS West and South Yorkshire ICBs, local HCPs, and appropriate stakeholders as required.

Media protocol will include:

- An approvals process for proactive and reactive media. This will include arrangements for handling media enquiries out of hours if required.
- Identified communications leads within our Trust and partner organisations.
- Identified senior management and clinical spokespeople.
- Media briefings planned for appropriate milestones in the consultation timeline.
- Frequently asked questions which will be published on our website, and regularly reviewed as the consultation progresses.
- Media monitoring, including social media.

10.8 Evaluation

The effectiveness of communication and engagement activity will be monitored using the following measures (not an exhaustive list):

- Website data
- Social media data
- Media coverage
- Consultation response rates
- Consultation event attendance rates
- Anecdotal feedback

We will regularly review each of these measures throughout the consultation so we can adapt our communications and involvement approach as required. Where possible, this data will capture equality data and geographic information. This will enable us to target further communications more effectively to the areas and communities we may not have reached.

11 Equality

An Equality Impact Assessment (EIA) has been developed on all the options and this has informed the consultation approach. The consultation will ensure that any gaps in our understanding from previous involvement work are addressed. We will make sure we reach the groups that have been identified in the EIA as being potentially more affected, through their underrepresentation in our services, the factors that influence the experience of mental ill health (?) and dementia and by the other impacts service change may bring.

We understand from the data and insight that support the EIA that there is more likely to be potential impacts on the following groups:

- Black, Asian and minority ethnic communities
- Carers
- Trans people
- Lesbian, Gay and Bisexual people

- Faith groups – particularly Muslim and Sikh people
- Working age adults with dementia
- People with a disability – sensory, physical and learning disability

The consultation activity will specifically target these groups to ensure representative views are collected. Progress on this will be monitored and where there are gaps activity will be designed to address.

The approach to capturing feedback has been designed to be appropriate and accessible, but there are also ways for people to access additional support where there are unaddressed needs.

All respondents to the consultation will be asked to provide equality monitoring data to assess the representativeness of the views gathered during the process. This will include a mid-point review. The mid-point review will highlight any risks in under or over representation and the consultation approach will be refocussed where necessary to ensure feedback is reflective of the groups identified by the EIA as potentially more likely to be impacted.

Following the consultation process the data and insight will be analysed and used to update the EIA.

The EIA will provide an understanding of the potential impact of the options on different groups. The EIA will form part of the process for decision making and its conclusions will influence the outcomes.

12 Resources

There will be a resource and budget implication for the delivery of the consultation, and some may be sought using in house contributions. The overarching list of resources required to deliver this work are set out below:

- Developing a survey – online and paper version – printing
- Consultation materials, including document, summary version, posters and displays – printing.
- Discussion group hosts – cost implications
- Circulation of materials to a range of audiences – partners commitment and time of staff to do this.
- FREEPOST host and costs
- Communication plan – dedicated time to create materials for circulation.
- Analysis of findings and report writing
- Report publication

13 Analysis of data and presentation of findings

Following the consultation all the feedback generated including equality monitoring will be analysed and a report of findings will be developed. The report will be shared initially with the NHS West Yorkshire ICB committees and Overview and Scrutiny Committees (OSC) in Calderdale, Kirklees, and Wakefield. In parallel the report will be used to facilitate a workshop style event where the findings, including equality data will be considered against

each of the proposed options. As part of this approach the EIA will be further updated with any additional considerations and impacts that were raised during the consultation.

In addition, using the consultation plan and report of findings the local NHS West Yorkshire ICB committees will review the consultation process. As the duty to consult sits with the commissioner each local NHS West Yorkshire ICB committee will want to be assured that the approach and process were robust, that the feedback reflects and represents adequately the views of those agreed in the mandate and that there are no gaps in representation that require further work to capture.

Feedback from the local NHS West Yorkshire ICB committees and OSCs will be triangulated with internal conversations and our Trust will use all the feedback to make recommendations to inform a decision on the future of older people's mental health inpatient services.

14 High level timeline for delivery

Process	Action for Equality, Involvement, and communication	Timeline
Prepare for formal consultation process	Preparation and planning for Consultation including a review of engagement and EIA documents and stakeholder mapping	
	Develop a draft consultation plan, including consultation mandate, document and survey which articulates the proposals to be formally consulted on	
	Share draft consultation plan and collateral with the NHS West Yorkshire ICB and NHSE for comment and assurance	
	Following NHS West Yorkshire ICB/NHSE approval share the consultation plan and collateral with the Overview and Scrutiny Committee for any final comments and considerations	
Preparing for launch	Develop collateral required to deliver formal consultation	
Consultation Launch and delivery	Website updated with consultation materials, consultation in the public domain	Considering school holidays and religious festivals – launch (tbc)
	Consultation (12 weeks) – will include clinical support to front conversations with resources to support/ social media and media publicity maintained throughout	12 weeks delivery

Consultation assurance	Mid-point review of reach – approach adjusted if required	6 weeks in consultation
Post consultation	Report of findings on consultation including equality section. EIA updated	4 weeks post consultation
	Report of findings and EIA shared with NHS West Yorkshire ICB and OSC for comment and assurance	6 weeks post consultation
Deliberation	Internal deliberation of the findings from consultation and EIA – including feedback from NHS West Yorkshire ICB and OSC	10 weeks post consultation
Decision	Business case updated for decision.	14 weeks post consultation

The midpoint review took place on Monday 12 February 2024. See appendix 6 for summary of key points and agreed plan.

15 Appendix 1: Overarching delivery plan

Audience	Activity	Pre Consultation		Consultation (mid point review)											
		2 WEEKS BEFORE	1 WEEK BEFORE	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
Briefing for all place Leads	facilitator packs, Q&A and script	MS teams meeting													
Consultation documents: locations in each place plan	distribution of requested documents to each ICB place		documents sent direct to ICB place	Documents distributed											
website	SWYPFT website goes live - link on all ICB and place websites		send link and website narrative for upload to ICB comms leads	Day 1 - website goes live											
Healthwatch	send link and website narrative for upload to ICB comms leads			week 1											
Briefing of community assets Calderdale (7) Kirklees (12) and Wakefield (7)	Presentation, materials distributed and sign post to consultation information			week 1											
Community assets deliver - 19 + Wakefield	A range of activities taking place														
Staff directly impacted	letter, consultation document and survey			Day 1											
All SWYPFT Staff	Information on the intranet/ promoted via Headlines, The														
Staff side	Presentation and sign post to consultation information														
staff networks	Presentation and sign post to consultation information														
People currently in older people MH services	Letter, consultation document and survey -			Day 1											
Families, carers and loved ones of people currently in	Letter, consultation document and survey			Day 1											
Governors	Presentation and sign post to consultation information														
Members council – all members on database	Letter/ email and sign post to website				Week 2										
Local Councillors and MPS	Letter and sign post to information			week 1											
Health and social care leaders	Letter and sign post to information			week 1											
Digital meetings															
Public Meetings x 6 (ideally week 2-3 or could be week 3-4)	panel, presentation, Q&A		Briefing		3 x meetings	3 x meetings	3 x meetings	3 x meetings							
Information stands	roller banner stands in all SWYPFT hospital entrances,			Day 1											
Road shows Calderdale (4) Kirklees (7) and Wakefield (7) town centre and supermarkets	stands in various public locations	schedule in place	facilitator Briefing												
Stakeholder meetings (24) - Calderdale (11) Kirklees (7) and Wakefield (8)	Presentation and sign post to consultation information	schedule in place	facilitator Briefing												
News article	article in local newspapers to promote consultation and public meetings, sign post			week 1	week 2										
local radio					week 2								week 10		

16 Appendix 2: SWYPFT delivery plan

Audience	Activity	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
Staff directly impacted	Direct mail One to one	DAY 1											
Staff	Consultation document Online tools	DAY 1	PROMOTE WEEKLY IN HEADLINES AND THE VIEW										
Staff side	Presentation												
People in our services	Consultation documents and survey – all formats	DAY 1					PUSH						
	Healthcare comms – tablets												
	Chatpad												
	Creative activities												
Families, carers and loved ones	Letter to named contact. Consultation documents and survey – all formats Focus group?	DAY 1											
Governors	Presentation												
Members council – all members on database	Via Website												
BAME staff network	Presentation Intranet												
Disability staff network	Presentation Intranet												
LGBTQ+ staff network	Presentation Intranet												
Carers staff network	Presentation Intranet												
Volunteers	Volunteer newsletter Website												
Befriending service	Volunteer newsletter Website												
Spirit in mind	Pastoral newsletter Website												
Creative Minds	Artwork submission												
Wakefield mental health Alliance and partners Healthwatch Wakefield Nova Wakefield VCS organisations Wakefield PCN's Local councillors	Email details of the consultation and promote response options												
Kirklees mental health partnership board Healthwatch Kirklees Third sector leaders VCS organisations Kirklees PCN's Local councillors	Email details of the consultation and promote response options												
Calderdale mental health partnership board Healthwatch Calderdale VAC VCS organisations Calderdale PCN's Local councillors	Email details of the consultation and promote response options												
South Yorkshire ICS ICS Barnsley Barnsley Local Authority Barnsley PCN	Letter to chair/CEO with opportunity to provide a written response												
MPs – Calderdale, Kirklees, and Wakefield	Letter to MP with details of the consultation and an opportunity to provide a written response												

17 Appendix 3: Place based delivery plan

	Calderdale Key contacts: ICB – wyicb-cal.comms@nhs.net CIEEC partners – ICB Jill Dufton (jill.dufton1@nhs.net) Healthwatch - Karen Huntley (karen.huntley@healthwatchcalderdale.co.uk) Calderdale Council - TBC VCSI / VAC – Emma Worsley (emma.worsley@cvac.org.uk) VAC ECs – Tamsin Woodhead (Tamsin.Woodhead@cvac.org.uk) Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)	Kirklees Key contacts: ICB Comms – wyicb-kirk.comms@nhs.net ICB engagement – wyicb-kirk.engagement@nhs.net LA – Ambreen Mirza – ambreen.mirza@kirklees.gov.uk Healthwatch – helen.barlow@healthwatchkirklees.co.uk Third Sector Leaders – comms@tslkirklees.org.uk VAC - Tamsin Woodhead - Tamsin.Woodhead@cvac.org.uk Community Pharmacy WY (Alison Hemsworth – alison@cpwy.org)	Wakefield Key contacts: ICB – wyicb-wak.communications@nhs.net CIE partners – ICB Dáša Farmer / Claire Vodden (dasa.farmer1@nhs.net / clairevodden@nhs.net) Healthwatch – Gary Jevon (gary.jevon@healthwatchwakefield.co.uk) Wakefield Council – Charlotte Parker charlotteparker@wakefield.gov.uk; Emma Samardzija – esamardzija@wakefield.gov.uk Ebony Ellis ebonyellis@wakefield.gov.uk NOVA – Scott Copeland Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)
Activity	Action	Action	Action
Commissioning of community outreach and briefing assets. Assets will be briefed no later than day 3 and will use peer to peer approaches to help communities respond to the consultation.	- Calderdale Forum 50plus - Age UK Calderdale and Kirklees - ACE (Advancement of Community Empowerment CIC) - Healthy Minds - Mums on a Mission - Stainland & District Parish Council - Our Place & Girlguiding Elland	- Simba's Friends - Kumon Y'all - Thornton Lodge Action Group - IMWS / MEDO / Al-Ehsan trust - Jamaica National Council Huddersfield - Ravensthorpe Community Centre - Ready Steady Active - Shaping Care in Kirklees CIC - Moldgreen United Reform Church - ACE (Advancement of Community Empowerment CIC) - JJ Heartisan (One Good Turn) - Locorum Care	TBC from the following: All Saints Community TA - The Well Castleford Heritage Trust Eastmoor Community Project Limited/ St Swithun Ferrybridge Community centre Association Five Towns Christian Fellowship Havercroft and Ryhill Community Learning NEXT Generation Red Roof Centre Rycroft Leisure St Catherines Church centre St Georges' Lupset St Mary's Chequerfield Community Project Bless Community Services Memory Action Group Carers Wakefield Wrenthorpe Assist 5 Towns Veterans Support Hub CIC (Alan) Gasped Friends of Featherstone Community Age UK
Distribution of consultation documents/ summary, full and posters	Place based distribution to: - Calderdale Councillors – briefing to all councillors so they can have conversations with residents in their wards. - GP practices (21 practices) each to receive 2 posters and 5 summary documents or 10 leaflets depending on what the comms pack contains. GP practices to receive a briefing document on what is expected, how to contact for more copies and/or support – this to be shared with all venues / distribution channels. - Community anchors - PCNs - Engagement Champions – summary documents, easy read, other formats sent to VAC. - Community centres - posters and summary documents - Westgate House – local authority - Libraries – via Council	Place based distribution to: - LA including communities' team/Social Prescribing - CVS - Third Sector Leaders - PRG Network - HCP C&E Network - Your health, your say - Kirklees Councillors – briefing to all councillors so they can have conversations with residents in their wards. - GP practices including Health centres – Batley, Dewsbury, Heckmondwike, and Liversedge – (64 practices) each to receive 2 posters and 5 summary documents or 10 leaflets depending on what the comms pack contains. GP practices to receive a briefing document on what is expected, how to involve their PRGs, who to	Place based distribution to: - PPG Network - HCP CIE group - ICB engagement database - Peer Leaders, Social Care Citizen Panel, Covid Community Champions - People Panel - Wakefield Councillors – briefing to all councillors so they can have conversations with residents in their wards. - GP practices (36 practices) each to receive 2 posters and 5 summary documents or 10 leaflets depending on what the comms pack contains. GP practices to receive a briefing document on what is expected, how to involve their PRGs, who to contact for more copies and/or support – this to be shared with all venues / distribution channels.

	Pharmacies – via Community Pharmacy WY (Alison Hemsworth – alison@cpwy.org)	contact for more copies and/or support. 9 PCNs - Community anchors linked to PCNs. - Community Voices – summary documents, easy read, other formats sent to VAC. - Community centres - posters and summary documents - Norwich Union House	- Connecting Care Hubs - Organisations signed up to outreach activity via NOVA. - Community centres - posters and summary documents - Alzheimer's UK - Age UK
Stakeholder meetings	Presentations to: - Involving People Network (Jill Dufton (jill.dufton1@nhs.net) - Calderdale Collaborative Community Programme Board (3CPB) (Shabana Kausar (shabana.kausar5@nhs.net) - MHLNDND delivery group - Calderdale Health and Wellbeing Board - Ageing Well Board / Sub Group (contact TBC) - Acute and community Geriatricians and older people specialist teams including safeguarding. - PCN clinical directors and GPs and other primary care/community HCPs with special interest in geriatric medicine/links with care homes - Social care colleagues and managers with responsibilities for older people's services (Contact TBC) - VCSE assembly - Chief Officers - Volunteer managers	Presentations to: - PRG Network - Kirklees Mental Health Alliance - Ageing Well Board - Kirklees Health and Well-being Board - Acute and community Geriatricians and older people specialist teams including safeguarding. - PCN clinical directors and GPs and other primary care/community HCPs with special interest in geriatric medicine/links with care homes - Social care colleagues and managers with responsibilities for older people's services	Presentations to: - PPG Network - Wakefield Mental Health Alliance including - Stakeholder Forum - Dementia Steering Group - Wakefield Health and Wellbeing Board - Acute and community Geriatricians and older people specialist teams including safeguarding. - PCN clinical directors and GPs and other primary care/community HCPs with special interest in geriatric medicine/links with care homes. - Social care colleagues and managers with responsibilities for older people's services.
	Roadshow stands (suggested locations) tbc - Supermarkets (Asda – Thurn Hall, Morrisons - Cousin Lane) - Shopping centres (Woolshops, outside M&S) - Maurice Jagger Centre	Roadshow stands (suggested locations) tbc - Supermarkets - Shopping centres	Roadshow stands (suggested locations) tbc - Supermarkets - Shopping centres – The Ridings, especially linked to organised events e.g. AgeUK WD and Silver Sunday
Public meetings	There will be 2 public meetings in Calderdale: - Halifax town Centre - Hebden Bridge	There will be 2 public meetings in Kirklees: - Huddersfield town centre - Dewsbury/Batley	There will be 2 public meetings in Wakefield: - Wakefield town centre - Hemsworth

18 Appendix 4: public meeting plan

Older People Transformation consultation – Public meeting plan

The working assumption is that prior to this event a briefing has taken place in the form of a meeting and event pack with all staff in attendance which includes executive leads, clinical leads, and key stakeholders. The briefing pack will consist of:

- Consultation document and survey
- Script of key messages
- Q&A document
- Data capture form – to capture any questions and feedback.
- Public meeting plan.
- Layout of the venue and who is in the room.
- Customer service information leaflet
- Membership information – if people express a desire to become involved with the Trust

1. Purpose of the plan

The purpose of the plan is to provide information on the public meeting format for the older people transformation, including:

- The purpose of the public meeting
- Set up and pack up.
- The layout of the building – planned use of spaces.
- List of programme leads and facilitators required.
- Presentation and consultation material.

2. Purpose of the public meeting

The purpose of the public meeting is to provide an opportunity **for people, including staff, members of the public and key stakeholders to drop in and get information** on the proposed options so they can respond. The purpose of the meeting is as follows:

- To have a visible presence in our communities to discuss the proposals supported by a range of clinical staff and system leads.
- Provide a local space for people to get information on the options.
- To support people to respond to the consultation.
- To listen to any concerns or queries and log them or sign post as needed to customer services.
- To capture any questions, not necessarily respond to all but to update the Q&A
- To respond to any questions in line with the business case, which will be supported by a core script.

The focus of the public meeting is to support our gunning and brown principles by ensuring people get the information they need in the required format so they can provide an informed response to the consultation.

The meeting will be central to our local communities and will run as a drop in. This means people can come at any time during the public meeting. Discussions with key members of the workforce will be crucial to ensure that people can get clarity on the proposals and ask questions. The **suggested timings of public meetings will be 2-7pm** – but time either side will be required to help set up and pack up. The venues have been suggested by our place leads and all will be fully accessible, risk assessed and have the space required to fulfil the venue plan (see section 5). The suggested venues are 2 in each location, and they are:

2.1 Calderdale central – one meeting in either:

Halifax Town Hall (preference)

Shay stadium.

To note, the following venues are not available on our date options:

Elim church, Halifax

Kings Centre, Halifax

Maurice jagger centre, Halifax

Hopwood Lane community centre

2.2 Calderdale upper valley – one meeting in either:

Hebden Bridge Town Hall (preference)
Todmorden town hall

2.3 Kirklees (Greater Huddersfield)– one meeting in:

Brian Jackson House

To note, the following venues are not available on our date options:

Hudawi centre

Huddersfield Town Hall

2.4 Kirklees (North Kirklees) one meeting in either:

Dewsbury Town Hall (preference)

Batley Town Hall

Al-Hikmah Centre-Batley

2.5 Wakefield – one meeting in either:

Wakefield Town Hall (preference)

Brook house working men's club.

St Swithuns centre

2.6 Wakefield – one meeting in:

Hemsworth community centre

Provisional dates and venues (table below shows booking times to include set up and packing up:

No	Date	Venue	Locality
Week 2			
1	Tuesday 16 January 2024 12:00 -20:00	Wakefield Town Hall	Wakefield Central

2	Wednesday 17 January 2024 12:00 - 20:00	Halifax Town Hall (Calderdale)	Calderdale Central
3	Thursday 18 January 2024 12:00 - 20:00	Brian Jackson House	Kirklees (Greater Huddersfield)

Week 3			
1	Tuesday 23 January 2024 12:00 -20:00	Hemsworth community centre (Wakefield)	Wakefield wide
2	Wednesday 24 January 2024 12:00 - 20:00	Dewsbury Town Hall	North Kirklees
3	Thursday 25 January 2024 12:00 - 20:00	Hebden Bridge Hall	Calderdale upper valley

2.7 Promoting public meetings.

Public meetings will be promoted through the following channels:

- o Internal communication channels for workforce and people who use services.
- o Trust website
- o Trust social media accounts
- o Stakeholder websites and social media accounts
- o Local media
- o Direct email / mail

- o Public events – face to face and virtual
- o Public newsletters
- o Cascade via partner and stakeholder networks / channels – including key stakeholder organisations working in the voluntary and community sector.

We will work with colleagues and named leads within our partner organisations to ensure delivery to our key target audiences. Some key target audiences and delivery methods are outlined below:

3. Communication and information required to deliver a public meeting.

The communications collateral required for public meetings is set out below these materials will be managed centrally by SWYPFT to ensure the event is accessible and inclusive for all. Staff attending will already have been briefed and will receive a facilitator pack. The Q&A part of this pack will be updated following each public meeting and this will be refreshed in facilitator packs periodically. The information and communication materials required on the day will be:

3.1 To deliver the event:

- Facilitator pack (spare packs) – updated Q&A.
- Signing in sheet – log of attendance.
- Evaluation – emoji sign in and out approach.
- Display boards on – case for change, our estates finances and workforce, clinical model, travel, transport, parking, and sustainability.
- The case for change film and equipment – projector, speakers, and screen.
- A range of seating – high and low.
- A feedback board – post it notes available.

- Light refreshments – tea, coffee, soft drinks, biscuits etc... (no single use plastic please).
- Box to collect completed surveys.
- Portable loop system.
- Extension cables and hazard tape
- Staff name badges/ names displayed on tables.
- Who is in the room welcome board.

3.2 For public attending the event:

- Tablet to complete surveys x 2
- QR codes around the room – links to survey via android phone.
- Full consultation document.
- Summary consultation document.
- Easy read documents
- Range of word version full and summary - large print, black on yellow and black on pink, braille.
- Paper surveys – including easy read, large print, black on yellow and black on pink, braille.
- Other resources: customer services, membership, being a volunteer and connecting people leaflets.
- Pens and pencils.
- Interpreters on request.

4. Facilitators, support staff and roles

4.1 Resourcing each meeting.

Organisation	Senior leadership	CEE leads	Support

SWYPFT	TBC but likely to include 1 to 2 SWYPFT EMT members and/or NED's	Dawn Pearson Zahida Mallard Heather McKnight Kamal Wrathall	A mix of programme team support, operational and clinical support and other key programme board members.
Calderdale	TBC – at least one senior leader from NHS West Yorkshire ICB	Jill Dufton Amiee Haggas	Healthwatch - Karen Huntley (karen.huntley@healthwatchcalderdale.co.uk) Calderdale Council - TBC VCSI / VAC – Emma Worsley (emma.worsley@cvac.org.uk) VAC ECs – Tamsin Woodhead (Tamsin.Woodhead@cvac.org.uk) Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)
Kirklees	TBC – at least one senior leader from NHS West Yorkshire ICB	Kirsty Wayman Zubair Mayet Siobhan Jones	LA – Ambreen Mirza – ambreen.mirza@kirklees.gov.uk Healthwatch – helen.barlow@healthwatchkirklees.co.uk Third Sector Leaders – comms@tslkirklees.org.uk VAC - Tamsin Woodhead - Tamsin.Woodhead@cvac.org.uk Community Pharmacy WY (Alison Hemsworth – alison@cpwy.org)
Wakefield	TBC – at least one senior leader from NHS West Yorkshire ICB	Dasa Farmer Claire Vodden Helen Haythorne	Healthwatch – Gary Jevon (gary.jevon@healthwatchwakefield.co.uk) Wakefield Council – Charlotte Parker charlotteparker@wakefield.gov.uk; Emma

			Samardzija – esamardzija@wakefield.gov.uk Ebony Ellis ebonyellis@wakefield.gov.uk NOVA – TBC following meeting with SWYPFT Community Pharmacy WY - Alison Hemsworth (alison@cpwy.org)
Other		Karen Coleman Colin Hurst	

4.2 Welcome and support staff

Welcome and support staff will be responsible for ensuring the following:

- People are signed in and navigated to each part of the meeting.
- People are aware of fire/ evacuation procedure.
- People get the information they require.
- People have support to complete the survey – using the available resources.

4.3 Facilitators

Facilitators will host a table or display and they will talk to people about the area they are presenting. The facilitator will also navigate to colleagues in the room and note down any helpful information to support Q&As.

4.4 Specialist support

Specialist staff will include:

- Digital or IMT support

- Communication – management of press enquiries

5. Venue plan and layout:

Key requirements:

- fully accessible,
- risk assessed
- have the space required to fulfil requirements

See generic venue plan and layout below which will be adapted for each event based on site specific layout.

Draft Generic Floor plan (depending on windows and doors layout)

OPS public consultation meetings for 16, 17, 18, 23, 24 and 25 January

Tables/networking space

1. Clinical
2. Executive Directors / Non-Executive Directors
3. Programme team
4. Staff side
5. Estates
6. Facilitator
7. Special support
8. Marshall
9. Support Staff – IT

Plus:

The OPS team will be showing a video presentation on the consultation.

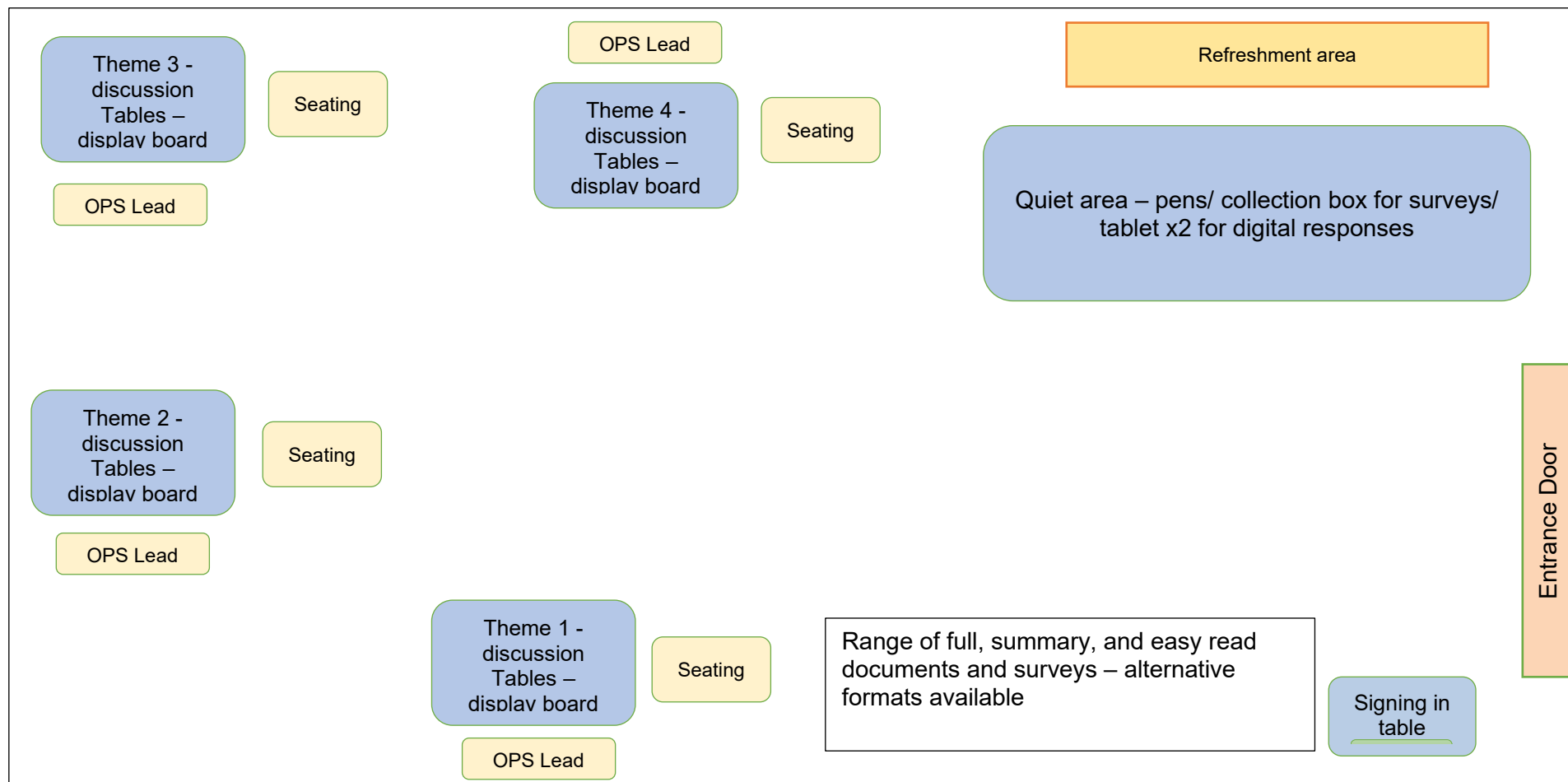
Schedule

1200 noon	Room set up
1300	Facilitator briefing
1345 – 1400	Facilitators needed
1400 -1900	Public access
1400-1900	Refreshment available
1900- 2000	Close down and leave venue

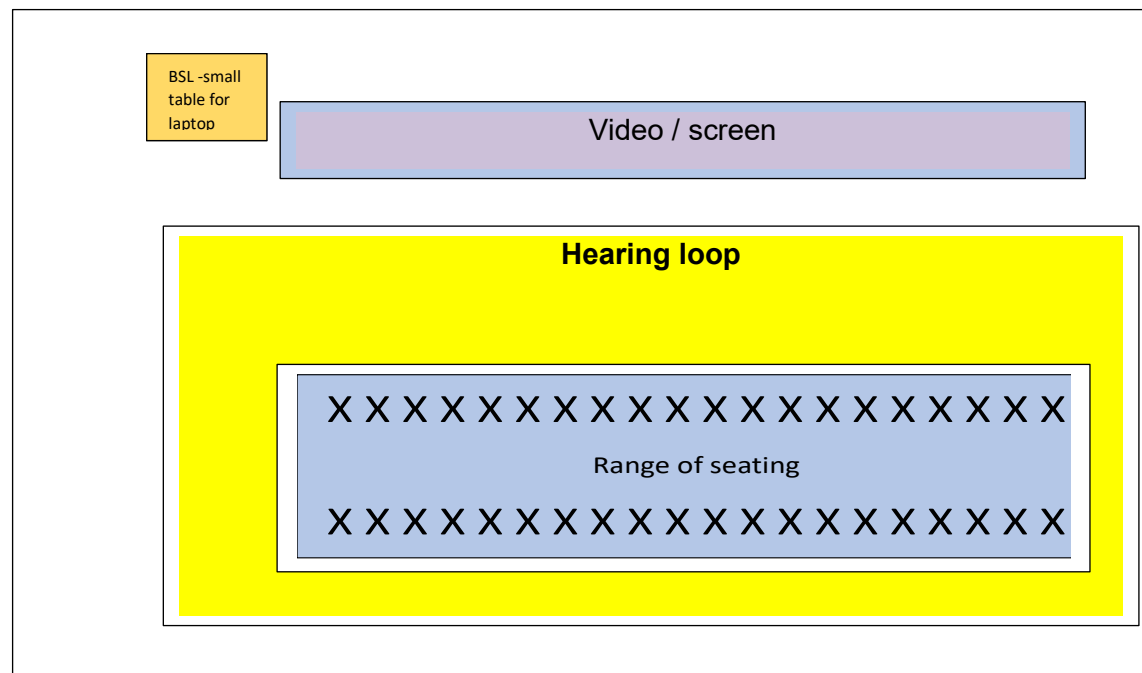
The video and presentation will be set up by the venue.

A portable hearing loop will be in the video room and we will also have two BSL interpreters in the at each meeting (subject to availability).

Room layout example



Video room



19 Appendix 5: Advocacy plan

Proposal to utilise advocacy service skills to support the involvement of inpatients in the Older People Services inpatient consultation.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

1. Purpose of the proposal

To identify if the Trust can utilise advocacy services to support inpatient involvement in a formal consultation. The proposal sets out:

- The background to the consultation
- The scope of the work
- Indicative timescales

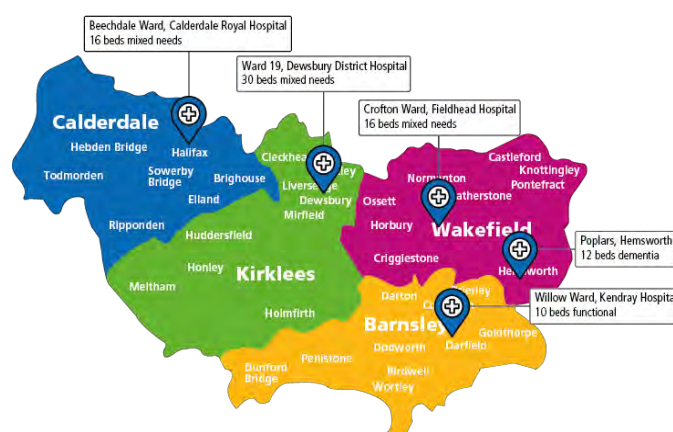
The proposal aim is to engage advocacy services in the approach and identify if they can support this work and identify any additional costs that may be associated with delivery.

2. Background

South West Yorkshire Partnership NHS Foundation Trust and the Calderdale, Kirklees and Wakefield Health and Care Partnerships have been working together to review how we improve mental health care for older people in our inpatient wards. There is a need to better support the small proportion of people who are acutely unwell, who present with complex needs and co-morbidities, and therefore require admission to an inpatient ward. The Trust has five older people's mental health wards. These are:

- Halifax at Calderdale Royal Hospital (mixed functional and dementia patients, 16 beds)
- Priestley Unit in Dewsbury, located in Dewsbury and District Hospital (mixed functional and dementia patients, 30 beds; 15 male beds and 15 female beds)
- Two wards in the Wakefield district – one on the Fieldhead Hospital site (mixed functional and dementia patients, 16 beds) and one at The Poplars in Hemsworth (dementia patients, 12 beds).

In South Yorkshire, the Trust has a ward for people with functional mental health needs (10 beds) at Kendray Hospital in Barnsley. This ward will not be in scope. A map of where all our services are located is set out below (please note that mixed functional and dementia wards are referred to as 'mixed needs'):



Map of locations of older people's mental health inpatient services within the South West Yorkshire Partnership NHS Foundation Trust footprint

3. Scope

We know that the involvement of older people with dementia and functional mental health requires specialist input and that our independent advocacy teams work closely with our inpatients to provide much needed independent support.

As service reconfiguration may have an impact on our workforce we will be inviting staff to respond to the consultation. This means that we need to maintain a level of independent support for those inpatients so they can respond without relying on Trust staff.

Families, carers, loved ones and relatives will be contacted directly on day one of the consultation. A letter will be sent to the home address or email of an identified person for each inpatient, sign posting them to information and resources so that they can also provide a response.

The scope of the project would be:

- To **act as an independent** who could ensure that the Trust has demonstrated a desire to capture the views of inpatients in a way that is appropriate, accessible, and inclusive as part of formal consultation.
- To **support inpatients to respond to the consultation** by providing information and/ or communicating in a way that meets the needs of that inpatient. Ensuring that all inpatients have been approached and included, and capacity to be involved assessed.
- To **capture the voice and views of those inpatients using the consultation survey or an alternative structure** that simplifies the consultation questions. For example:
 - Asking if a person understood the information.
 - Asking if they had any views.
 - Asking if they had any concerns.
- **For anyone that can't complete a survey please document their response anonymously** in the form of a report – one report per ward and if possible split by views relating to gender or other diverse characteristic that would help us understand the impact for different protected groups.
- **Provide an independent and written response to the consultation** on behalf of the inpatients and using professional judgement to help the Trust understand any impacts or feedback that would help inform a decision.

4. Project timeline

The time scale for delivering formal consultation is not yet agreed but we anticipate that it could be as early as December 2023 or as late as early to mid-January 2024. We will have more information early November. The **consultation will be 12 weeks** from this start date. The timescales to note would be:

- The timeline for delivering consultation conversations will be within this 12-week window.
- A report would have to be with us on the last day of consultation to be included as a response.
- We will produce a report of findings from consultation no more than 4 weeks following the end date and the report from advocacy will be analysed along with other responses, and the report will be added in the main body of the report or as an appendix. This report will be published so all findings will be publicly available at least 3 months after formal consultation.

- Feedback on the outcome of consultation could be up to 6 months after and we will ensure that advocacy services receive a briefing that they can share back with inpatients.

5. Next steps

For advocacy services to consider the proposal and provide any feedback on the approach by Friday 20th October. Could you advise on the following:

- If you can support the approach – if yes we will set up a briefing at least one week before consultation.
- If there any additional costs associated with delivering the approach.
- Any additional resources you may require to support you.

Your help to involve our patients would be crucial to ensure their voice is heard, we very much hope you can support us, thank you.

20 Appendix 6: Summary of key points and plan following midpoint review

Key points:

- Feedback on limited communication/publicity, information available on the consultation process and the survey/questionnaire.
- Effectiveness of delivery of information – Joint Committee to discuss further. Assurance needed that materials are disseminated appropriately.
- Definition of 'skipped' on the survey. Clarified.
- Metric/value for responses not set – more an emphasis on good quality responses reflective of the community.
- Transport and travel is a major consideration. Task and finish group to be established and use lobby groups.
- More evidence of meeting people where they 'are at' and deliver a simple presentation.
- What is the feedback looking like so far? Noted feedback from people working in the Trust, less so Council and community responses. Work is underway targeting community groups and also target work with social care workforce.
- Good engagement at events – positive feedback on how the events held and opportunity to provide clarity.
- Targeted work underway to engage with different faiths
- Student nurse feedback – information on the consultation came from tutors at university
- Carers (predominantly dementia) – cornerstone of work done and valuable feedback given.
- Paper surveys available at events and advocacy to support completing the surveys.
- Number of beds available – assurance given at events and in discussion.
- Everyone to complete the online survey and share with others.

Summary from the Chair:

- Huge amount of work already done and mostly on track
- Assurance on effective communications required
- Further consideration of accessibility and range of communications needed
- Transport and location of services needs a focus
- Broaden scope of consultation – who else to target, look at areas of under representation.
- Closer liaison with councillors to facilitate communication and roll out

Agreed actions:

Action	Owner
Check where leaflets have been distributed – are they visible? Is the consultation visible to the population and how we can increase it?	Programme Board
Briefing to Joint Committee to include effectiveness of delivery of information and that information circulated is being displayed – assurance needed.	Comms, Engagement and Equality Leads
Develop a detailed plan that will update the existing consultation plan which will be available on the website.	Programme Team
Targeted communications with local authority and other key stakeholders such as Healthwatch / VCSE to ensure visibility and reach.	Comms, Engagement and Equality Leads
Establish a travel and transport working group.	Programme Team
Support the visibility of the consultation, identify places with gaps / groups we can talk to.	All

Actions to address gaps in responses:

Group	Activity in place	Recommendation	Any Further Actions
Someone living with dementia	Advocacy teams on each of our wards	Advocacy - approximately 30 contacts. Dementia groups and care homes in community.	Message to community teams to promote supporting approach for people in community mental health teams.

Social care workers	Promotion of consultation through partners	Pro-active comms	Partner digital meeting, Kirklees SWYPFT/LA meeting.
Voluntary and community sector	Engagement champions and community voices, VAC, Nova and Third Sector leaders briefed and supporting the consultation	Not viewed as a risk – confident of at least 700 responses	Kirklees focus required limited number of organisations have signed up. To review reach in Calderdale and Wakefield too.
People who identify as single	No specific activity	Monitor – expected to achieve	

Group	Activity in place	Recommendation	Any Further Actions
Males	No specific activity	Target men's mental health groups	For example, contact Andy's Man Club and Men's Sheds.
Age – 80+	Age Concern and Age UK	Care homes, day centres	Make contact with partners in LAs that oversee care homes.
Asian/ Asian British and mixed ethnicity	Engagement champions and community voices – voluntary and community sector (VCS) groups targeting these communities	Monitor – expected to achieve	
Disability – learning disability and sight loss		Targeted work to reach people with a learning disability and Blind and partially sighted groups	

Group	Activity in place	Recommendation	Any Further Actions
Calderdale	Engagement champions and community voices – VCS groups targeting these communities	Monitor – expected to achieve	
Heterosexual	No specific activity	Monitor – expected to achieve	
Faith	Engagement champions and community voices – VCS groups targeting these communities	Target places of faith	Huddersfield Sikh temple – 3 Mar VCSE targeting faith groups – to monitor.

Further Events and online meetings:

Roadshows planned for:

- Tuesday 27 February, Halifax Borough Market. 10.00 – 13.00
- Wednesday 28 February, Cleckheaton Market, 10.00 – 13.00
- Friday 1 March, Pontefract Hospital, 10.00- 12.30
- Monday 4 March, Huddersfield Royal Infirmary, 9.00 – 11.30
- Tuesday 5 March, Normanton Market, 10.00 – 13.00
- Wednesday 6 March, Calderdale Royal Hospital, 13.00 – 15.30
- Thursday 7 March, Todmorden Market, 10.00 – 13.00
- Tuesday 12 March, Pinderfields Hospital, 10.00 – 12.30
- Wednesday 13 March, Pontefract Market, 10.00 – 13.00
- Tuesday 19 March, Dewsbury and District Hospital, 10.00 – 12.30

Further online meeting:

Monday 11 March, 14.00 – 15.00

Calderdale, Kirklees and Wakefield Joint Health Overview and Scrutiny Committee

Feedback into stakeholder workshop 23 August 2024

Feedback on the older people's mental health inpatient services consultation report and the equality impact assessment.

Following a meeting of the JHOSC held on the 15 August 2024, the Committee was asked to provide feedback from their deliberations on the consultation report and EIA.

Set out below is the Committee's initial comments.

The Committee was asked to provide feedback on the following areas:

Considering the findings of the report and the equality impact assessment, are the committee assured that:

- Due regard to equality and diversity has been paid through the delivery of consultation activity, and in the independent report of findings.
- Adequate time has been given for you to consider the responses contained in the independent report and findings.
- The product of consultation has conscientiously taken into account all the key themes that need to be considered.

The Committee felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.

Members of the JHOSC were provided with the consultation report and the EIA on the 17 July 2024, and although these documents ran to nearly 500 pages, sufficient time was allowed prior to the formal meeting of the JHOSC on the 15 August 2024. The presentation at Committee was helpful in segmenting key points whilst maintaining a necessary overview to allow meaningful discussion, questions and comment.

The key themes are adequately reflected, and the report demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation.

The Committee would make the additional following observations:

Transport, Travel and Parking

The Committee welcomes the emphasis placed on transport, travel and parking and notes the commitment to consider the implications on those people impacted by the proposed options. However, there is no indication in the consultation report as to how much weight the decision-maker will place on transport considerations, as opposed to

clinical quality, for example. The Committee understands there will be conflicting views as the decision-maker seeks to balance 'trade offs' between local access and the provision of centralised specialist services.

Mixed Wards

The consultation shows that the public are not in favour of mixed wards. However, it was indicated at the JHOSC that there may have been some misunderstanding as to the nature of mixed wards on mental health inpatient wards. The Committee felt this should have been better explained in the consultation and will need further explanation in any feedback.

Lived experience

The Committee believes it is important that patient experience commands the same level of importance as other dimensions of quality of care, and this is largely reflected in the consultation report and findings.

However, one area perhaps worthy of further examination is lived experience. Did the consultation fully capture the opinions of previous service users, for example:

Did the consultation adequately seek the views of those with lived experienced of dementia and functional mental health needs - carers and family members, whose loved ones have sadly passed away and who have had the time to reflect on their experience, rather than being in the moment, so to speak. Is the Trust assured they have captured all relevant constituent stakeholder views on this point?

In all public consultation, the response cannot be seen as representative of the whole population but is representative of interested parties who were made aware of the consultation and who were motivated to respond. In light of this, is the Trust assured that the consultation process accurately captured the views of the wider population rather than just those who are self-motivated to respond?

Other points and questions

A number of other points were raised at the JHOSC and answers were given including:

- Cost of the consultation compared to volume of people who have contributed – is this good value for money?
- Staffing – will re-training be required for pre-existing staff currently working at sites that will be re-purposed?
- Community based healthcare – involvement in the consultation?
- Does the diversity captured within the survey respondents reflect the diversity of the communities/Local Authorities that will be impacted by this proposed change?
- Current financial figures are likely to go up – subject to inflation and pay awards.
- Voluntary sector – how are they reflecting the views of the people they represent?

Conclusion

It was suggested that the consultation themes will be used as part of the decision-making process. The JHOSC was informed that the aim of the programme board is to develop a set of recommendations that will be taken back through appropriate governance, and this will include a further JHOSC meeting to share the proposed recommendations.

At this further JHOSC meeting, members will be asked to make an assessment of how the Trust has taken into account the consultation findings, what weight has been given to consultation outcome, how public opinion has influenced their decision, and what, if anything has been discounted and why.

Andy Wood
Overview and Scrutiny Officer
Wakefield Council
Tel: 01924 305133
awood@wakefield.gov.uk

On behalf of Calderdale, Kirklees and Wakefield JHOSC

21 August 2024.

Older people's mental health inpatient services consultation

**Report of findings from the older people's mental health
inpatient services consultation stakeholder workshop
23 August 2024**

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust and
NHS West Yorkshire Integrated Care Board

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Version control			
Version	Name and title	Date	Status
V0.1	Csilla Fabian	September 2024	Initial draft
V0.2	Csilla Fabian	September 2024	Second draft
V0.3	Ryan Hunter	11 September 2024	Third Draft

1. Purpose of the report

The purpose of the report is to present the report of findings from older people's mental health inpatient services consultation stakeholder workshop held on 23 August 2024.

2. Summary of findings

Themes

This section provides a high-level summary of the key themes and considerations raised in the event. In this section eight of the full findings from the stakeholder event are included and providing more detail of the discussions. The key themes from the breakout room and jam board are set out below:

Theme 1	Support of the consultation
Theme 2	Travel, transport and visiting
Theme 3	Pathways and partnership working, including creative solutions
Theme 4	Sustainability and access
Theme 5	Ward environment
Theme 6	Response rates
Theme 7	Support for staff

Theme 1: Support of the consultation.

That findings of the consultation were comprehensive, thorough, focussed on the correct themes including travel and transport, and were supported by attendees.

Theme 2: Travel, transport and visiting.

Distance from home, travel from deprived areas, tracking any emerging issues, and ensuring people weren't isolated were raised as themes. Opportunities for support included public transport, shuttle busses, changing routes, financial support, guidance, using VCSE and flexible visiting including long/overnight visits.

Delivering care close to home ranked highest in the consultation feedback but all of the options will include some people that will be cared further away from their home.

Feedback that there are benefits despite the travel impact.

Theme 3: Pathways and partnership working, including creative solutions.

VCSE collaboration / joint working with other partners to support discharge, volunteer support, and creative solutions, continuity of care where people are admitted outside of their home place.

Theme 4: Sustainability and access.

Ensuring there are enough beds, being future proofed and access for minority groups.

Theme 5: Ward environment.

Focus on ward environment such as soft furnishings, music, colours; creative solutions; single sex wards; a working group to support activity

Theme 6: Response rates.

Some places had lower response rates, particularly the east side of the Wakefield district.

Theme 7: Support for staff

Consider staff wellbeing and staff support through the transformation process.

Feedback from key stakeholders

To support the workshop, feedback was captured from key stakeholders as follows:

Joint Health Overview and Scrutiny

The Committee felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.

Members of the JHOSC were provided with the consultation report and the EIA on the 17 July 2024, and although these documents ran to nearly 500 pages, sufficient time was allowed prior to the formal meeting of the JHOSC on the 15 August 2024. The presentation at Committee was helpful in segmenting key points whilst maintaining a necessary overview to allow meaningful discussion, questions and comment.

The key themes are adequately reflected, and the report demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation.

NHS West Yorkshire Integrated Care Board

The Integrated Care Board confirmed that they are assured of the following:

- Due regard to equality and diversity has been paid through the delivery of consultation activity, and in the independent report of findings.
- Adequate time has been given for you to consider the responses contained in the independent report of findings.
- The product of consultation has conscientiously taken into account all of the key themes that need to be considered.

The Committee felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.

Members were provided with the consultation report and the EIA in advance of the formal meeting, as per the joint sub-committees agreed terms of reference and governance timelines, allowing sufficient time prior to the meeting. The presentation at the joint Sub-Committee was very helpful in focusing on the process and key points. The format of the meeting supported the delivery of the overview of the process and independent findings, to allow meaningful discussion, questions and comments.

The independent report demonstrates a full and comprehensive consultation was undertaken. The key themes, identified and considered in the report, fully reflect those areas the joint sub-committee expected to be included based on the consultation scope and plan.

The Joint Sub-Committee noted the comprehensive consultation process and the mid point review process, which allowed for additional sessions to be included to extend the reach, where gaps were identified.

3. Background to Older people's mental health inpatient services consultation.

The consultation sought views on proposals to create specialist inpatient wards for people living with dementia and dedicated inpatient wards for other older people's mental health needs in Calderdale, Kirklees and Wakefield.

Currently, older people with dementia who need to be admitted as an inpatient are cared for on the same ward as those with functional mental health needs. These are known as mixed needs wards.

Separate specialist wards for people with dementia, and dedicated wards for people with functional mental health needs, is good practice and can improve both the care and experience for people, their families, carers and loved ones.

Where wards are now:



The options agreed to take into consultation were:

1. A dedicated central specialised dementia unit developed on Ward 19 in Dewsbury with dedicated specialist functional units in Calderdale and Wakefield.

There are two ways that this could be done:

- a. with additional functional bed capacity at the Crofton Ward (10 beds relocated at Crofton) and an overall inpatient bed number of 72. The site at Crofton Ward would operate as 2 wards across the 26 beds.

- b. with additional functional bed capacity of 6 beds being relocated to Crofton Ward. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward.

And:

2. A dedicated central specialised dementia unit developed on Crofton Ward in Wakefield with dedicated specialist functional units in Calderdale and Kirklees. This would be a 26-bed dementia unit operating as 2 wards, with 10 beds being relocated from Poplars. Ward 19 and Beech Dale would be functional wards.

The consultation ran from Friday 5 January 2024 to Friday 29 March 2024.

4. Purpose and objectives of workshop

The purpose of the event provided a final opportunity for key stakeholders and partners to **deliberate on the findings from the consultation**. And the final part of the public consultation process before the insight is considered in the decision-making stage which follows.

The event was an essential part of post consultation deliberation to finalise and firm up the key considerations and impacts to ensure that we have fully considered the outcome of the consultation and given due regard to all groups protected under the equality act, including carers.

The event objectives were:

- To provide the space to receive and discuss the consultation findings.
- To provide the space to receive and discuss the equality considerations and impacts.
- To receive a view on the deliberation of the consultation findings from key stakeholders.
- To sense check the information presented and give stakeholders an opportunity to comment further
- To explain the next steps.
- To use the output of the event to help inform the final recommendations.

The event objectives also included a focus of testing the findings of the consultation, considering the key tests for consultation and equality, the Brown and Gunning principles, with specific focus on the following questions in feedback from key stakeholders:

- o Due regard to equality and diversity has been paid through the delivery of consultation activity, and in the independent report of findings.

- o Adequate time has been given for you to consider the responses contained in the independent report of findings.
- o The product of consultation has conscientiously taken into account all of the key themes that need to be considered.

The outputs gave assurance that the right themes have been identified to take into deliberations over which option to take forward.

The Brown Principles for equality state an organisation must be aware of their duty set out below:

- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigor and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.

The 'Gunning Principles' state that:

- Consultation must take place when the proposal is still at a formative stage (i.e., no decision until the process has concluded)
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response (clearly describe the model, criteria used to determine the model and reasons)
- Adequate time must be given for consideration and response (the length of the consultation is important to ensure it allows for this)
- The product of consultation must be conscientiously taken into account (demonstrate clearly how the product of consultation has been considered).

5. Stakeholder event findings

The stakeholder event was **attended by 58 people**. There were 4 breakout discussions and people were divided four rooms. Each group had a facilitator and scribe. The table below shows the number of people per group per discussion:

Group	N° of people
1	14
2	11
3	12
4	11

In addition to the people in the breakout rooms above there were 10 people providing supporting roles including facilitators, senior / clinical leadership and scribes.

The discussion gave people the opportunity to tell us:

- 1. Any thoughts on what you have heard?**
- 2. Do you agree that these are the right themes?**
- 3. Is there anything missing?**

This is what people told us:

Breakout room notes:

Any thoughts on what you have heard?

Group 1

- The most important theme was 'care close to home' – but process means it can only be near to some.
- Are we confident we are future proofing dementia services – Confident we have built in enough flex for at least 10 years plus based on modelling and demographics.
- Eastern side of Wakefield responses feels low – are people aware of the Poplars changes. – a lot of work to capture views (local events) – postcodes not available for all respondents. Any implementation phase will mean we continue keeping people involved.
- Public transport – link was difficult to access – will this be kept up to date? Needs to include things like the shuttle bus and weekend differences. Bus company have also changed the routes which may cause additional journeys in Wakefield. – noted that this is linked to Mid Yorks and we want to explore this but not be dependant in it. – We want to make solutions that are person centred and an intent to put a timescale on commissioning, but it will have to go through future scrutiny.
- Transport group –and thinking about the East of Wakefield and higher levels of deprivation – need to think specifically about this locality so we can support

access. Also, supporting travel arrangements may need to be considered in future commissioning arrangements.

- ICB feedback – Wakefield – value for money assessment and comments – consultation document had costings and FAQ was updated – the real difference in cost was explained to people i.e. building cost and where it was coming from – not asking for more. Also, what we already spend was explained – the difference and increase is not much different. Using what we have better. Increase in staff will be an additional cost.
- Creative health system – nothing included in the proposals on patient/staff wellbeing – how do we collaborate between the statutory and voluntary sector – not asked about this and hope it will form part of the proposals going forward. A working group looking at environments and out of ward work will be picked up through implementation phase. The joint working came across strongly in the feedback from consultation – people want to see this happen.
- Creativity – CQC – reported there needed to be a better offer – these have been fully referenced in the business cases and will be taken forward.
- Memory action group – supported consultation. Carers want to be more involved in the care and have more volunteers to support person centred care i.e. hydration/ feeding – we will be looking at visiting/ opening hours etc... we know the value of carers and the Trust are part of Triangle of Care (TOC).

Group 2

- The first proposal makes sense. A mixed sex bed/ward adds resilience and more contingency when support needed but appreciate separate wards.
- Travel and transport – won't know until things start. Need to recognise emerging issues. As a system we're open to taking improvements. There is never an end to this work.
- Comprehensive document and gone wide in engagement. Mental health not recognised in South Asian communities – seen as a taboo, but engagement was wide.
- Reassuring that scrutiny committees are engaged.
- All seems very considered (process) and clearly put together.
- Question asked how the options were created in the first place? Response: started with community transformation then looked at inpatient. Workshops

were held and had over a dozen options to start with, then looked at demand and capacity modelling. NHSE Clinical Senate visited sites based on options appraisal to distil the options. An additional option was also added based on NHSE Clinical Senate feedback.

- Interesting to see the proposals and why splitting across places.
- People being isolated in inpatient settings has huge impact when families/friends can't visit.
- Question asked if inpatient and has Alzheimers can families stay longer / overnight etc? Response: At this point in time we don't have the facilities to accommodate families staying over. We look at flexible visiting times and flexible MDT meetings. Also ability to spend longer periods of time with patient (not overnight). Looking at visitors support pack.
- Families staying longer/overnight shouldn't be a capacity issue – families can support with feeding, bathroom etc when nurses don't have the time. From a personal experience perspective, a lot of time and attention is needed supporting a person with dementia.
- Having a specialist dementia unit will have a targeted population for more dementia friendly things which is more difficult when mixed ie dementia and functional.
- Question asked if it was more of a home than hospital setting eg soft furnishings, music playing? Response: they are wards on a hospital site however meetings are planned with various stakeholders as part of implementation to prepare for a dementia friendly environment eg, colours, textures, furnishings etc.

Group 3

- Very thorough consideration given to this piece of work- all participants agreed.
- Great to see consideration given to the transport element of the work which has been identified as a barrier in the past.
- Comment about the lower number of Wakefield respondents compared to other areas. Feedback in part due to the larger VCSE networks in other areas who were able to go out into the community for responses. There is an aspiration to strengthen this in the future.
- Positive feedback re: public consultations and how these have been received. Very thorough.

- A lot of information has come back and professionals have noted how comprehensive this has been. Looking forward to getting the work moving.
- Impressed at the outcomes which have been achieved. Views have been sought from varied sectors and considered as a whole in a transparent manner. We've gone 'the extra mile' involving as many partners as possible to ensure we haven't missed anything.
- Some of the impact on staff may have been missed but hopeful this will come later (a staff consultation is planned for the next phase).

Group 4

- Correct themes focused on- quality of care important. Same sex wards will improve care. Good focus on transport helping people to visit family.
- Agreement - good focus of the consultation and the themes explored
- Good consultation on a difficult topic- handled well. Highlighted again transport being important to make visiting accessible.
- Pleasantly Surprised by how little pushback to the proposals. Lots of explaining done in the explaining of the approach and benefits. Now responsibility as a programme board we respond proactively around issues with transport- practical solutions/ potential support for people to afford the public transport.
- Looking at solutions for transport such as financial support to travel, guidance with travel planning and helping people understand the journeys available.
- People understand the shared bed base and spread across the CKW area so more accepting of the move. Need more beds not fewer – wouldn't want fewer beds.
- Look at how VCSE have solved transport issues which may help find solutions. J

Do you agree that these are the right themes?

Group 1

- Agreed – all in the room agreed.

Additional comments:

- Beechdale ward manager – there has been lots to think about – the set up of the ward does struggle to manage both types of patients – this will improve.
- Reinforce the role of creativity on all wards.

Group 2

- General responses noted above.

Group 3

- Agreement that the right themes have been identified and explored.
- Question re: cost of consultation. A lot of this was used to supply printed material needed to ensure consultation was open to everyone including people that don't find IT as accessible, and the use of independent analysis. There was also a cost associated with VCSE partner organisations.
- comment in the chat that perhaps any underspend from the consultation could be used to support staff through the transition.
- The cost of the model is the overall Older Adults inpatient provision across the Trust.

Is there anything missing?

Group 1

- Calderdale dementia – supporting people to get involved – found there was a difference between those who had or had not used services. People who have used the Dales did state the current environment did not offer the right environment for dementia. Recognised that there are benefits despite the travel impact for carers, families, visitors. For those who had not used the service a focus seemed to be much more on local services. – all units had advocacy support to engage in the consultation to have a voice. Younger voice reflected in the feedback.
- VCS and creativity missing – need to improve this offer
- More volunteers on wards to support people with care
- Involvement of carers - TOC
- Capital cost – are we confident this will still be available?
- Continuity of care following an out of local area admission – need to maintain relationships, support and links locally.
- Funding partnerships with VCSE – thinking about how we support bids and revenue.

Group 2:

- Nothing identified by the group as being missed. Agreed summary of the key points raised: learning, continuous service improvement, travel and transport, service user experience, design/development of wards (dementia friendly)

Group 3:

- How do we link in with the voluntary sector from a discharge perspective? Consideration to be given to this in future discussions. Aging well provide provision for patients who are discharged (Age UK) for equipment, shopping, home support etc. Funding is available for Pinderfields for example but not Fieldhead so would be good to identify the gaps.
- Links with the voluntary sector generally speaking and how these links could avoid future relapse and re-admission.
- More detailed work needed on staff that will be impacted in next phase.
- Trade Union involvement is key in implementation
- Would have been nice to see a side-by-side summary slide of the options which shows the trade-off.
- Ensure we capture learning from the consultation, have a 'what have we learned/what would be do differently' document from this piece of work

Jam Board Notes:

Q1. Are there any thoughts about what you have heard?

To add your response - click on the left hand tool bar and select 'sticky note' - type in your response and press save

Looks like a thorough piece of work, with lots of public input. Good.

comprehensive process that was undertaken, good reach across our populations

Some concern re the reach of the consultation to Eastern Wakefield, specifically in relation to the Poplars

Implementation Phase will be key for some VCSE partners (such as hoot creative arts and others from Working Together Better) to support patients & staff retention/wellbeing

Good to see the thorough summary of responses. Was there any degree of error built in as a couple of options seemed quite close in response %s

Interesting to see transport being a key factor and I agree with this. Very good presentation.

Transport - is the working group considering the changes that MYTT to their shuttle bus

Yes

Q2. Do you agree that these are the right themes?

YES - add a sticky note and write 'yes'

NO - add a sticky note and tell us why

yes

Yes

Yes

Yes

Yes

YES

missing: Creative Care planning and creative activities (to support patients experience and staff retention/wellbeing) included in the themes. No question prompts no responses

Q3. Is there anything missing?

Has the underpinning data looked at those areas where demand is lower for services, potential unmet need?

the real strengths of the VCSE in service delivery - both for staff & individual welfare - we need to ensure that this is fully explored & exploited within implementation

Previously mentioned: Creative Care Planning / Creative Activities In-Reach and Out-reach linking to community provision from VCSEs

need to be conscious of continuity of care with services in places if we move to centralised services

Useful Ref re staff wellbeing and partnership working VCSE/Stathttps://www.wkingfund.org.uk/in-sight-and-analysis/reports/integrated-care-systems-workforce

Planning for staff support during any transition

Acting on reports such ashttps://baringfoundation.org.uk/blog-post/covid-19-arts-and-creative-resources-for-older-people-and-anyone-else-in-isolation/

https://baringfoundation.org.uk/blog-post/getting-creative-with-dementia/

6. Evaluation and equality analysis

See Appendix 5: Equality monitoring and event evaluation

7. Next steps

The following have been agreed as next steps following the workshop:

- We will review the report, along with the revised equality impact assessment (EIA), alongside the final set of considerations that we have heard today.
- We will take this forward into our deliberations.
- Following deliberations a recommended option will be taken through a governance process in Autumn 2024.
- We will keep people informed through our communication channels.

Appendix 1: Legislation

The Trust has a strategy which describes how we will involve people. The Equality, involvement, communication, and membership strategy can be found here: [Equality-Involvement-Communication-and-Membership-Strategy.pdf \(southwestyorkshire.nhs.uk\)](https://southwestyorkshire.nhs.uk/equality-involvement-communication-and-membership-strategy.pdf) .

The strategy clearly sets out how people can expect to be involved and the approach and principles we will follow. The Trust also need to follow legislation to ensure that our legal obligations and that of our commissioners are met.

Health and Social Care Act 2022

In its responsibilities for public involvement and consultation under section 13Q of the National Health Service Act 2006, NHS England, and Integrated Care Boards (ICB) has a duty to consult individuals to whom services are being or may be provided, in the planning and development of commissioning arrangements for those services. The Act extends this to include “carers and representatives” of people receiving a service or who may do so. The extension of this duty is replicated in an equivalent duty on integrated care boards.

NHS Constitution (Refreshed March 2013)

The NHS Constitution produced by the Department of Health establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve. A copy of the refreshed NHS Constitution and supporting handbook can be accessed via the following link; <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>. Seven key principles guide the NHS in all it does. They are underpinned by core NHS values designed with staff, patients, and the public. Principle Four is about patient engagement and involvement.

Principle Four

The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families, and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients, and staff, welcome it and use it to improve its services

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of patient rights which a legal entitlement are protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. All public authorities have this duty so partners will need to be assured that "due regard" has been paid through the delivery of engagement activity and in the review as a whole.

Appendix 2. Event Plan

1. Attendees

Targeted invitations will be sent to organisations and networks who attended the pre-consultation stakeholder event in December 2022 and any other key stakeholders engaged at this stage. This list of those attendees is set out below:

- Staff from SWYPFT – including Clinical leads.
- Governors of SWYPFT
- Barnsley, Calderdale, Kirklees, and Wakefield (BCKW) NHS ICB place
- Primary care representation from across (BCKW)
- Any identified service user and carer representatives
- Third sector organisations and groups representing older people services, carers, and representation.
- Healthwatch
- Local authority colleagues from (BCKW)
- MPs and local councillors
- Any other local health providers who have an interest in this service – Acute hospitals, Locala
- Care Homes sector.
- Domiciliary home care and extra care facilities
- Ambulance service
- Clinical network NHSE/I
- Clinical Senate
- NHSE
- Education providers – college, university
- Police
- Fire service.
- Pharmacy services

The stakeholder event is not:

- An event for the wider public
- An event for us to review our consultation process, this will have already been evaluated by the ICB as the statutory lead.
- To persuade people of our thinking; It is a listening exercise and is part of post consultation activity to ensure we deliberate.

2. Presenters, facilitators, and venue

Presenters: Programme SRO will chair the event and presenters will be identified by SWYPFT and supported by the Communication, Involvement, Equality, and Inclusion Lead to develop appropriate presentation material. The following items for presentations have been identified:

Slide set in order:

- Slide – event title – welcome and housekeeping – Chair.
- About today - Chair
- The change proposals and why they are important – Subha
- Consultation findings, including travel and transport plus sustainability - Ryan
- Equality Impact Assessment – Dawn
- Stakeholder Reflections
- Discussion topic slide – breakout room instructions
- Next steps slide name – Chair
- Close and thanks – Chair

Facilitators: To facilitate the event, we will require several staff to facilitate and scribe/ capture discussions. We will require the following:

- Four to five people willing to facilitate and manage discussion.
- Four to five scribes who can support capturing data.

Depending on numbers attending this should ensure we have four to five breakout sessions. Each facilitator and scribe will receive a facilitator pack and be offered the opportunity to have a briefing beforehand. Scribes will be asked to record the discussion on a capture form and submit to SWYPFT for the report.

Event Chair: The day will be chaired by xxxx who will manage the agenda, housekeeping, introduce each presenter, facilitate activities, and provide a close and thanks.

Digital platform management: SWYPFT will book the meeting, manage registration via Eventbrite, and put in place arrangements to ensure the event and resources are in place including any associated costs. SWYPFT will manage the presentation and IT requirements for the event and provide support on the day.

3. Proposed agenda

event agenda Friday 23 August 2024			
Time	Item	lead	key purpose/ messages
10.00	Event starts (5 minutes to allow people to join)	Chair	Ensure the presentation is open on the welcome page so people know they are in the right meeting
10.05	Welcome and housekeeping.	Chair	Too many people to welcome so ask if people can use the chat box to introduce themselves and introduce key people and speakers only

10:10	About today	Chair	Share the agenda on screen and emphasise this is post-consultation deliberation. This is the final part of the formal consultation process. We want people to remain included and involved in our deliberations so that we can move to consideration of findings in the recommendation phase. This is a chance to have a final influence on what we collectively believe the output of consultation is telling us.
10:15	Independent report of findings – including, travel and transport, equality and sustainability considerations.	Ryan Hunter – Change & innovation partner SWYPFT/ Dawn Pearson – Associate Director of CEII SWYPFT	A summary of the report of findings including equality and sustainability considerations.
10:45	Stakeholder reflections – 10 mins each • JOSC • Healthwatch • ICB • NHSE	TBC	Managed conversations – 10 minutes
11:15	Introduction to the discussion – Thinking about each option:	Chair	Introduce break-out sessions x 5/4 – links put in the chat box – participants split alphabetically by surname.

	- Any thoughts on what you have heard? Do you agree these are the right themes? - Is there anything missing?		Discussion topics shared on screen and use of jam board. Groups take place after the comfort break.
11:20 Comfort break – 10 minutes			
11:30	Introduction to the discussion – Thinking about each option: - Any thoughts on what you have heard? Do you agree these are the right themes? - Is there anything missing?	4/ 5 facilitators - tbc 4/5 scribes - tbc	Discussion and sense check using a jam board, chat box and discussion in break out groups
12:10	Pop up feedback	Nominated person from each breakout group	Feedback on discussion – 2 minutes allocated to each group. – highlight if the group agreed with the deliberation feedback or not – highlight the key additions or considerations.
12:20	Next steps	SRO/Chair	SRO to outline next steps for the programme and timeline. Evaluation to be shared in chat box – short survey monkey with equality monitoring.
12:25	Final reflections, close and thanks	Chair	Opportunity to thank people and for any final words and close

Appendix 3: Workshop invitation

Older people's mental health inpatient services consultation update

Invitation to attend a stakeholder workshop, 23 August 2024

South West Yorkshire Partnership NHS Foundation Trust and NHS West Yorkshire Integrated Care Board (ICB) have now received the independent report of findings from the older people's mental health inpatient services consultation.

Following the publication of the report, we would like to invite you a **workshop on Friday 23 August (10am – 12.30pm) which will be held on MS Teams**. This workshop will be attended by a wide range of our key stakeholders and will be used to consider the findings from the consultation and the updated equality impact assessment (EIA).

We will deliver a summary presentation of the impact and what people told us, followed by a discussion. This is with a view to having a final set of considerations that we will take forward into our deliberations.

[Please register for the workshop using this Eventbrite link](#). If you are unable to come, please do forward this information on to a colleague who can attend on your behalf.

We want to make sure that we have suitable representation from across our key stakeholders. You are also welcome to forward on this information to other partners who you feel may wish to join. Please do let us know if you have forwarded this invitation so we can keep track of attendance.

About the report of findings

The report pulls together a summary of all the feedback we heard during the consultation which closed on 29 March 2024.

It outlines the feedback into a few categories:

- what people thought was most important when thinking about older people's mental health inpatient services,
- what people told us about each of the proposed options,
- travel, transport and parking,
- equality data,
- sustainability,
- any additional considerations.

The report has been independently written by NHS Arden and Greater East Midlands Commissioning Support Unit (CSU) and NHS Midlands and Lancashire CSU.

Further information

You can read the [report of findings](#) and the [updated EIA](#) on our [website](#).

If you would like a reminder of the proposed changes to our older people's mental health inpatient services, you can still read all the information and watch our videos on the consultation website – www.southwestyorkshire.nhs.uk/opsconsultation

We would like to thank you for your support throughout the consultation, and for helping to share information within your organisation and local communities.

If you have any questions, please contact us at opsconsultation@swyt.nhs.uk

We hope to see you at the workshop.

Appendix 4: Workshop presentation slides



Older people's mental health inpatient services consultation Stakeholder workshop 23 August 2024, 10am – 12.30pm

In partnership with:
South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board



Introductions

NHS West Yorkshire Integrated Care Board

- **Vicky Dutchburn (chair)** – director of operational delivery and performance, senior responsible officer, older people's mental health inpatient transformation for Kirklees Health and Care Partnership (on behalf of NHS West Yorkshire Integrated Care Board)

South West Yorkshire Partnership NHS Foundation Trust

- **Professor Subha Thiyagesh** – chief medical officer, consultant in psychiatry for older people and clinical lead for older people's transformation
- **Dawn Pearson** – associate director, communication, involvement, equality and inclusion
- **Ryan Hunter** – change and innovation partner

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Welcome and housekeeping

- Thank you for joining our stakeholder workshop
- Please mute your mic unless you are speaking.
- Please introduce yourselves using the chat box
- You are welcome to put your cameras on for the introduction and breakout discussion if you are comfortable doing so.
- You can raise questions using the chat function or ask them during the breakout discussion.

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NHS West Yorkshire Integrated Care Board



Aims of the workshop

- To present consultation findings and the updated equality impact assessment
- Hear views on the consultation findings from our key stakeholders as we draw the consultation to a close.
- To explain the next steps.

In partnership with:
South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

Agenda

Time	Item	Presenter
10:05	Welcome and housekeeping	Vicky Dutchburn
10:10	About today	Vicky Dutchburn
10:15	Background to the consultation and options	Professor Subha Thiyagesh and Ryan Hunter
10:25	Independent report of findings	Ryan Hunter and Dawn Pearson
11:00	Reflections from our stakeholders (5 minutes each)	Healthwatch Joint health overview and scrutiny committee NHS West Yorkshire ICB
11:15	Introduction to discussion sessions	Vicky Dutchburn
11:20	Comfort break	
11:30	Discussion sessions	Facilitators
12:10	Feedback from each discussion session	Facilitators
12:20	Next steps	Ryan Hunter
12:25	Final reflections and close	Vicky Dutchburn

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NHS West Yorkshire Integrated Care Board

Background – about the consultation

- The consultation sought views on proposals to create specialist inpatient wards for people living with dementia and dedicated inpatient wards for other older people's mental health needs in Calderdale, Kirklees and Wakefield.
- Currently, older people with dementia who need to be admitted as an inpatient are cared for on the same ward as those with functional mental health needs. These are known as mixed needs wards.
- Separate specialist wards for people with dementia, and dedicated wards for people with functional mental health needs, is good practice and can improve both the care and experience for people, their families, carers and loved ones.
- The consultation ran from Friday 5 January 2024 to Friday 29 March 2024.

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NHS West Yorkshire Integrated Care Board



You can read the consultation information on our website:
www.southwestyorkshire.nhs.uk/opsconsultation

Where wards are now



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NHS West Yorkshire Integrated Care Board

We need to make changes

Mixed needs wards do not help us provide the best possible care or support the wellbeing of our patients, because:

- the clinical and personal needs of patients can be very different
- activities are not stimulating and appropriate for all patients
- the ward environment does not help patients be independent
- there is more chance of incidents
- the space could be used better to support therapies, safety and wellbeing for all our patients.

Specialist inpatient wards for people living with dementia and dedicated wards for people with functional mental health needs can improve care, wellbeing, and give a better experience for our inpatients, carers, families and staff. It also follows best practice guidelines and is common in other older people's mental health inpatient wards in the NHS.

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NHS West Yorkshire Integrated Care Board

Mixed sex wards

- Service Users have their own individual bedroom on all of our wards.
- On our mixed sex wards, the areas for male and female bedrooms are separate from each other and the wards have mixed communal areas.
- This meets required standards and would be implemented in any of the options.
- However, it is best practice to have fully separate single sex wards.
- The mix on high acuity mental health wards can, at times, create challenges that are difficult to manage.

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NHS West Yorkshire Integrated Care Board

The proposed options Option 1a

- **Dementia Service:**
 - Ward 19, Dewsbury and District Hospital. Two separate male and female wards. 30 beds.
 - **Functional Service:**
 - On Crofton Ward (Wakefield), two separate male and female wards, 26 beds, and,
 - On Beechdale Ward (Calderdale), one mixed gender ward, 16 beds.
 - 42 beds.
- 72 beds in total.
- Cost to setup- £8.2m
Cost to run each year- £9.1m

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NHS West Yorkshire Integrated Care Board



The proposed options Option 1b

- **Dementia Service:**
 - Ward 19, Dewsbury and District Hospital. Two separate male and female wards. 30 beds.
 - **Functional Service:**
 - On Crofton Ward (Wakefield), one mixed gender ward, 22 beds, and,
 - On Beechdale Ward (Calderdale), one mixed gender ward, 16 beds.
 - 38 beds, 4 less than option 1a, all mixed gender wards.
- 68 beds in total.
- Cost to setup- £5.5m
Cost to run each year- £8.2m

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NHS West Yorkshire Integrated Care Board



The proposed options Option 2

- **Dementia service:**
 - Crofton Ward, Fieldhead Hospital, Wakefield
 - Two separate male and female wards. 26 beds.
 - **Functional service:**
 - Ward 19, Dewsbury and District Hospital, with two separate male and female wards, 30 beds, and,
 - On Beechdale Ward, Calderdale Royal Hospital, with a mixed gender ward, 16 beds.
 - 46 beds.
- 72 beds in total
- Cost to setup- £8.2m
Cost to run each year- £9.3m

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NHS West Yorkshire Integrated Care Board





Independent report of findings

This section will cover:

- Feedback on the most important elements when thinking about older people's mental health inpatient services
- Feedback on each of the proposed options
- Sustainability and environmental considerations
- Travel, transport and parking considerations
- Equality considerations



The independent report of findings and the next presentation have been written by NHS Arden and Greater East Midlands Commissioning Support Unit (CSU) and NHS Midlands and Lancashire CSU. You can read the full report on our consultation website:
www.southwestyorkshire.nhs.uk/opsconsultation

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NHS Yorkshire and the Humber Integrated Care System



Travel and transport

- A travel and transport group is looking at people who could be impacted by the proposed options and helping us develop mitigations.
- Group membership has a range of people and includes carer representation from across the Trust footprint.
- The group has been exploring the establishment of a visitor support pathway that will help improve access via flexible visiting to wards, support with planning travel and use of technology, as well as ensuring failsafe's for people that are still unable to visit.
- Staff who may need to move from their current base will be given help using our internal HR processes.

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NHS Yorkshire and the Humber Integrated Care System



Independent report of findings

In the breakout session we'll be asking for consideration of the following based on these findings:

Thinking about each option:

- Are there any thoughts about what you have heard?
- Do you agree that these are the right themes?
- Is there anything missing?



The independent report of findings and the next presentation have been written by NHS Arden and Greater East Midlands Commissioning Support Unit (CSU) and NHS Midlands and Lancashire CSU. You can read the full report on our consultation website:
www.southwestyorkshire.nhs.uk/opsconsultation

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Equality considerations

This section will cover:

- How we met pre-consultation EIA recommendations
- Analysis of options by protected groups and inequalities
- Equality impacts and mitigations



You can read our updated equality impact assessment on our consultation website:
<https://www.southwestyorkshire.nhs.uk/wp-content/uploads/2024/07/Older-Peoples-Mental-Health-Inpatient-Transformation-EIA-v8.0.pdf>

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NHS Yorkshire and the Humber Integrated Care System

How we met pre-consultation EIA recommendations

EIA recommendation	What we did
Ensure the consultation reaches the identified audience impacted and can evidence the sample group is reflective of each protected group.	We reached a reflective sample of the combined population of Calderdale, Kirklees and Wakefield in line with the census data. From the data received we know that we achieved this.
Ensure responses are analysed by each protected group and any differential impact is highlighted, conscientiously considered with impacts mitigated and/or addressed.	Analysed every response by all protected groups to identify differential impact. The final report of findings contains this information.
Questions that are asked can ensure that responses inform the mitigations.	All questions equality monitored. The biggest identified impact was travel, transport and parking. We asked for anyone to highlight any additional impacts after each question and at the end. The questionnaire met this requirement.
That single sex accommodation is considered in future estates planning for both dementia and functional patients.	A wide-ranging approach to include various subject matter experts formed part of the Quality Impact Assessment to ensure we met the required standards. All options meet minimum standards though option 1b requires mitigations.
Solutions for travel, transport and parking address the geographical impacts for populations, particularly those from the 20% most deprived postcodes.	Sought feedback which can be traced back to the first 3 digits of postcode and used deprivation questions. Able to identify areas of deprivation at a macro level. A working group is considering this.

Analysis of options by protected groups

Carers  Option 1a scored the highest with variations for option 2 with option 1b scoring the lowest.	Religion  Option 1a and option 2 (variations across faith groups) scored the highest with option 1b scoring the lowest.	Ethnicity  Option 1a and option 2 (variations across groups) scored the highest with option 1b scoring the lowest.	Disability  Option 1a scored the highest with variations for option 2 with option 1b scoring the lowest.
Age  Option 1a highest on all questions with some age variations. Under the age of 18 - option 2 was viewed as the best option to improve dementia care and best value for money. Over the age of 80 - option 2 would provide the best functional care.	Sexual orientation  Option 1a scored the highest.	Gender  Option 1a scored the highest on all questions relating to options.	Transgender  Option 1a scored the highest but option 1b scored joint highest on improving care for dementia and functional patients.

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Analysis of options – addressing inequalities

Cost of living

Option 1a scored the highest with option 2 scoring joint highest for improving the care of people living with dementia for people who are really struggling.



Deprivation

Option 1a scored highest for all questions in the areas with most deprivations.
Option 1b scored lowest for all questions.



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NHS West Yorkshire Integrated Care Board

Equality impacts and mitigations

- The consultation findings have been analysed in detail and used to update the impacts and mitigations required for all proposed options.
- This has ensured that any gaps in our understanding from previous involvement work continue to be highlighted and the actions required to address these impacts are understood.
- The impacts and mitigations can be found in the updated EIA.
- The EIA has now been concluded on all the proposed options and this information will now be used to inform deliberation to identify a recommended option.
- As soon as a preferred option is identified a detailed equality action plan will accompany this option.



You can read our updated equality impact assessment on our consultation website: <https://www.southwestyorkshire.nhs.uk/wp-content/uploads/2024/07/Older-Peoples-Mental-Health-Inpatient-Transformation-EIA-v8.0.pdf>

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Reflections from our stakeholders

We asked each of our stakeholders to reflect on the following:

Considering the findings of the report and the equality impact assessment, are you assured that:

	Yes	No	Not sure
Due regard to equality and diversity has been paid through the delivery of consultation activity, and in the independent report of findings.			
Adequate time has been given for you to consider the responses contained in the independent report of findings.			
The product of consultation has conscientiously taken into account all of the key themes that need to be considered.			

We also provided opportunity for additional comments around each of these areas.

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NHS West Yorkshire Integrated Care Board



Reflections from our stakeholders

NHS West Yorkshire Integrated Care Board (ICB)

Considering the findings of the report and the equality impact assessment, are you assured that:

	Yes	No	Not sure
Due regard to equality and diversity has been paid through the delivery of consultation activity, and in the independent report of findings.	X		
Adequate time has been given for you to consider the responses contained in the independent report of findings.	X		
The product of consultation has conscientiously taken into account all of the key themes that need to be considered.	X		

Additional comments on the following slide: -.

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South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board



Reflections from our stakeholders

Joint health overview and scrutiny committee

The Committee felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings.

Members of the JHOSC were provided with the consultation report and the EIA on the 17 July 2024, and although these documents ran to nearly 500 pages, sufficient time was allowed prior to the formal meeting of the JHOSC on the 15 August 2024. The presentation at Committee was helpful in segmenting key points whilst maintaining a necessary overview to allow meaningful discussion, questions and comment.

The key themes are adequately reflected, and the report demonstrates diligent and careful consideration of those areas the committee would expect to be included in the process and product of consultation.

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Breakout discussion

- You have been allocated a breakout room.
- Following a comfort break, you will have 30 minutes to have a discussion about the following:

Thinking about each option:

- Are there any thoughts about what you have heard?
- Do you agree that these are the right themes?
- Is there anything missing?

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Comfort break – 10 minutes

Please join your allocated breakout discussion group at 11.30am.

MS Teams links for each group will be posted in the chat box and have been allocated alphabetically by surname.

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Breakout discussion – feedback

Thinking about each option:

- Are there any thoughts about what you have heard?
- Do you agree that these are the right themes?
- Is there anything missing?

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Breakout discussion – 30 minutes

Thinking about each option:

- Are there any thoughts about what you have heard?
- Do you agree that these are the right themes?
- Is there anything missing?

- Please rejoin the main meeting at 12.10pm
- We will then hear a two -minute summary of the key considerations from each group.

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Next steps and final reflections

- We will review the report, along with the revised equality impact assessment (EIA), alongside the final set of considerations that we have heard today.
- We will take this forward into our deliberations.
- Following deliberations a recommended option will be taken through a governance process in Autumn 2024.
- We will keep people informed through our communication channels.

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Feedback

- Please can people provide feedback via the following online survey:

<https://www.surveymonkey.com/r/NGJB6SG>

- If you are unable to complete the survey online please stay on the call at the end and we'll make arrangements to assist you to complete the survey.

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Close

**Thank you for joining the stakeholder workshop,
your feedback, and the time you have taken to
contribute to this work.**

We will keep you updated on our progress.

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NHS West Yorkshire Integrated Care Board



	0800 587 2108
	opsconsultation@swyt.nhs.uk
	www.southwestyorkshire.nhs.uk/opsconsultation

Appendix 5: Equality monitoring and event evaluation

Workshop evaluation survey link: <https://www.surveymonkey.com/r/NGJB6SG>

16

Total Responses

Date Created: Monday, August 19, 2024

Complete Responses: 16

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Q1: How would you rate the workshop agenda?

Answered: 16 Skipped: 0



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Q1: How would you rate the workshop agenda?

Answered: 16 Skipped: 0

	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
	0.00% 0	6.25% 1	0.00% 0	31.25% 5	62.50% 10	16	4.5

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Q2: Was the information provided clear, and easy to understand?

Answered: 16 Skipped: 0



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Q2: Was the information provided clear, and easy to understand?

Answered: 16 Skipped: 0

	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
	6.25% 1	0.00% 0	0.00% 0	43.75% 7	50.00% 8	16	4.31

Powered by  SurveyMonkey

Q3: Were you able to provide your feedback during the session?

Answered: 16 Skipped: 0



Powered by  SurveyMonkey

Q3: Were you able to provide your feedback during the session?

Answered: 16 Skipped: 0

	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
	0.00% 0	0.00% 0	12.50% 2	18.75% 3	68.75% 11	16	4.56

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Q4: Overall how would you rate the workshop?

Answered: 16 Skipped: 0



Powered by  SurveyMonkey

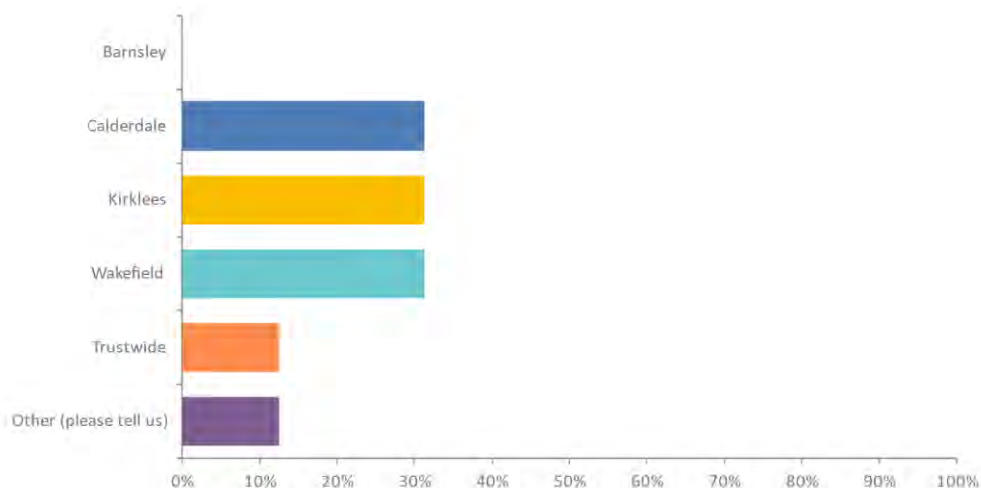
Q4: Overall how would you rate the workshop?

Answered: 16 Skipped: 0

	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
★	0.00% 0	0.00% 0	0.00% 0	50.00% 8	50.00% 8	16	4.5

Q6: Tell us about you - which locality do you work in? Tick all that apply

Answered: 16 Skipped: 0



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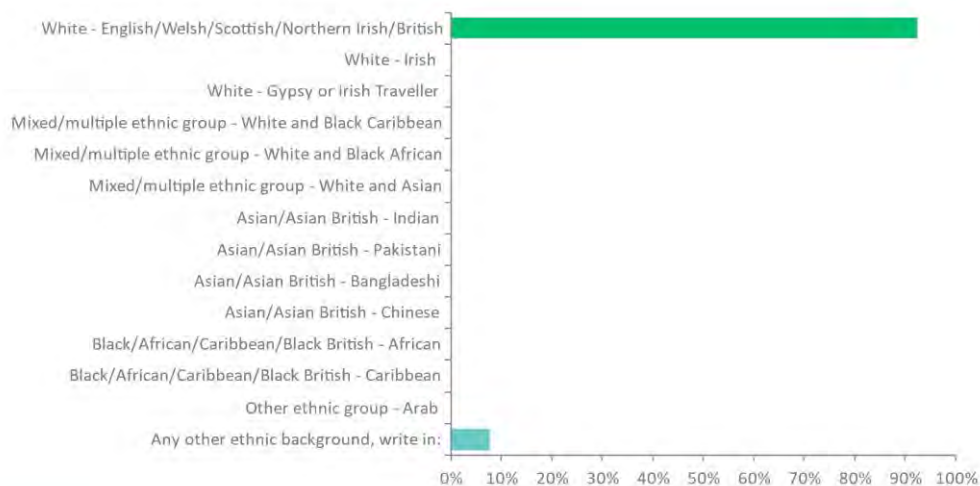
Q6: Tell us about you - which locality do you work in? Tick all that apply

Answered: 16 Skipped: 0

ANSWER CHOICES	RESPONSES	
Barnsley	0.00%	0
Calderdale	31.25%	5
Kirklees	31.25%	5
Wakefield	31.25%	5
Trustwide	12.50%	2
Other (please tell us)	12.50%	2
TOTAL		19

Q9: Race (please select from the list)

Answered: 13 Skipped: 3



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Q9: Race (please select from the list)

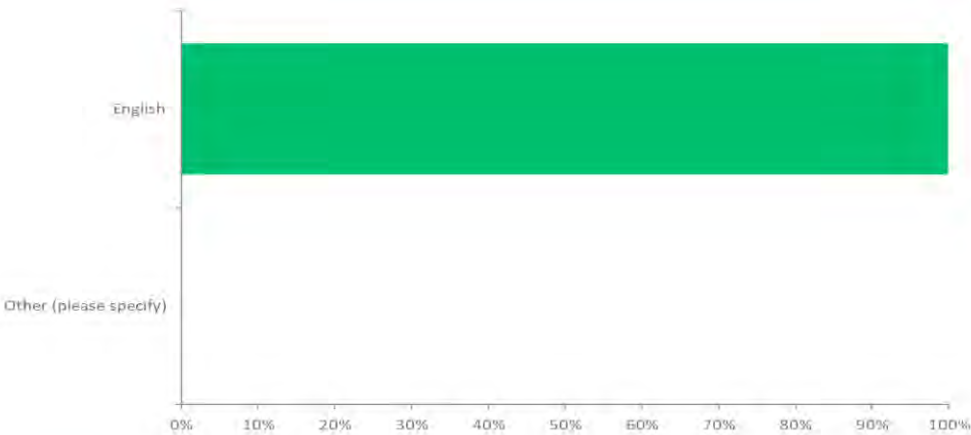
Answered: 13 Skipped: 3

ANSWER CHOICES	RESPONSES	
White- English/Welsh/Scottish/Northern Irish/British	92.31%	12
White- Irish	0.00%	0
White- Gypsy or Irish Traveller	0.00%	0
Mixed/multiple ethnic group- White and Black Caribbean	0.00%	0
Mixed/multiple ethnic group- White and Black African	0.00%	0
Mixed/multiple ethnic group- White and Asian	0.00%	0
Asian/Asian British- Indian	0.00%	0
Asian/Asian British- Pakistani	0.00%	0

Powered by  SurveyMonkey

Q10: What is your language?

Answered: 13 Skipped: 3



Powered by  SurveyMonkey

Q10: What is your language?

Answered: 13 Skipped: 3

ANSWER CHOICES	RESPONSES	
English	100.00%	13
Other (please specify)	0.00%	0
TOTAL		13

Q11: How well can you speak English?

Answered: 13 Skipped: 3



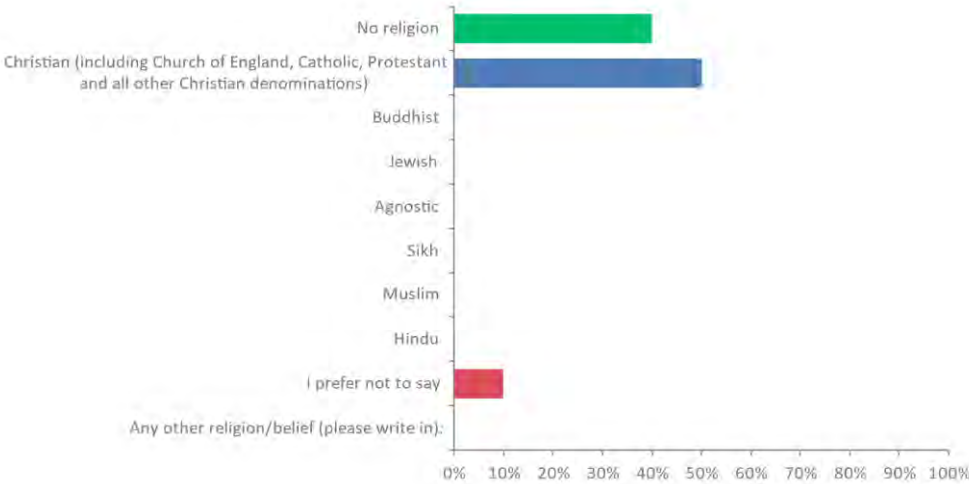
Q11: How well can you speak English?

Answered: 13 Skipped: 3

	1	2	3	4	TOTAL	WEIGHTED AVERAGE
★	0.00%	0.00%	0.00%	100.00%	13	4
	0	0	0	13		

Q12: Religion/belief (please select from the list)

Answered: 10 Skipped: 6



Q12: Religion/belief (please select from the list)

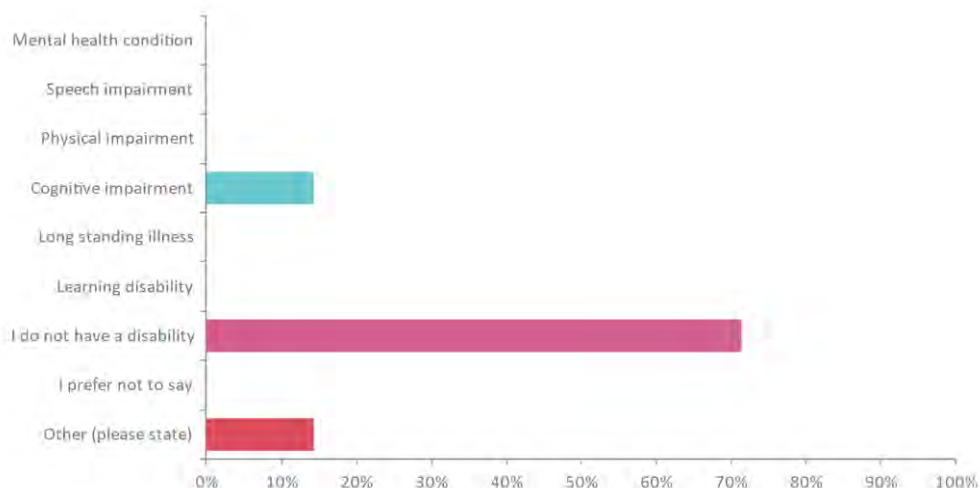
Answered: 10 Skipped: 6

ANSWER CHOICES	RESPONSES	
No religion	40.00%	4
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	50.00%	5
Buddhist	0.00%	0
Jewish	0.00%	0
Agnostic	0.00%	0
Sikh	0.00%	0
Muslim	0.00%	0
Hindu	0.00%	0
I prefer not to say	10.00%	1

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Q13: Do you consider yourself to have any of the following? (Please tick all that apply)

Answered: 7 Skipped: 9



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Q13: Do you consider yourself to have any of the following? (Please tick all that apply)

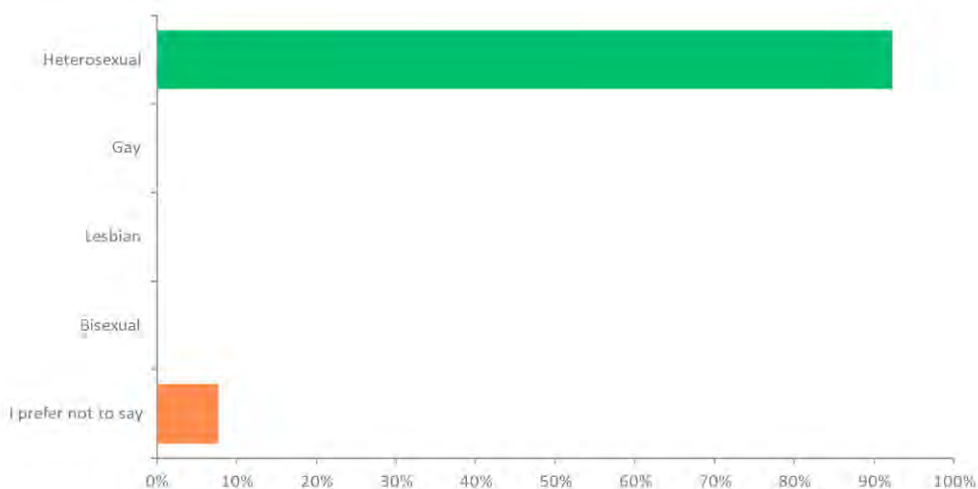
Answered: 7 Skipped: 9

ANSWER CHOICES	RESPONSES	
Mental health condition	0.00%	0
Speech impairment	0.00%	0
Physical impairment	0.00%	0
Cognitive impairment	14.29%	1
Long standing illness	0.00%	0
Learning disability	0.00%	0
I do not have a disability	71.43%	5
I prefer not to say	0.00%	0
Other (please state)	14.29%	1

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Q14: What is your sexual orientation?

Answered: 13 Skipped: 3



Powered by 

Q14: What is your sexual orientation?

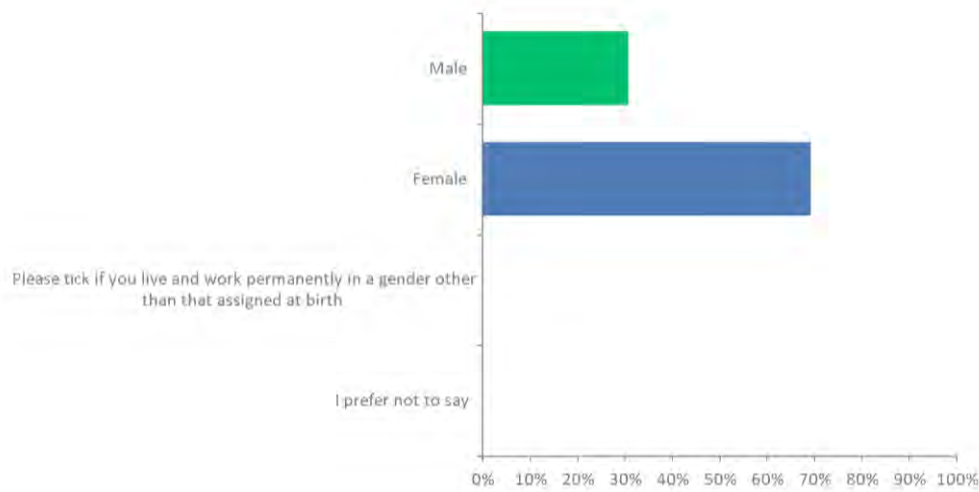
Answered: 13 Skipped: 3

ANSWER CHOICES	RESPONSES	
Heterosexual	92.31%	12
Gay	0.00%	0
Lesbian	0.00%	0
Bisexual	0.00%	0
I prefer not to say	7.69%	1
TOTAL		13

Powered by 

Q15: What is your sex?

Answered: 13 Skipped: 3



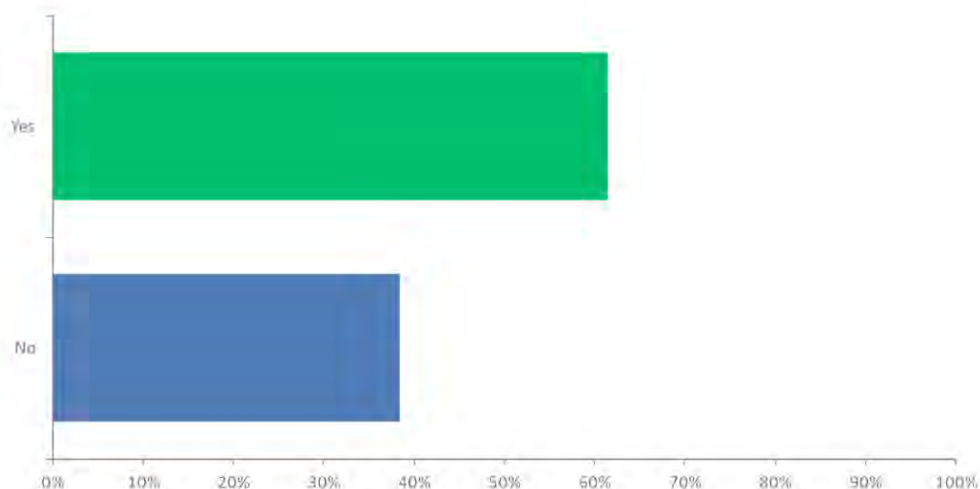
Q15: What is your sex?

Answered: 13 Skipped: 3

ANSWER CHOICES	RESPONSES	
Male	30.77%	4
Female	69.23%	9
Please tick if you live and work permanently in a gender other than that assigned at birth	0.00%	0
I prefer not to say	0.00%	0
TOTAL		13

Q16: Do you currently look after a relative, neighbour or friend who is ill, disabled, frail or in need of emotional support?

Answered: 13 Skipped: 3



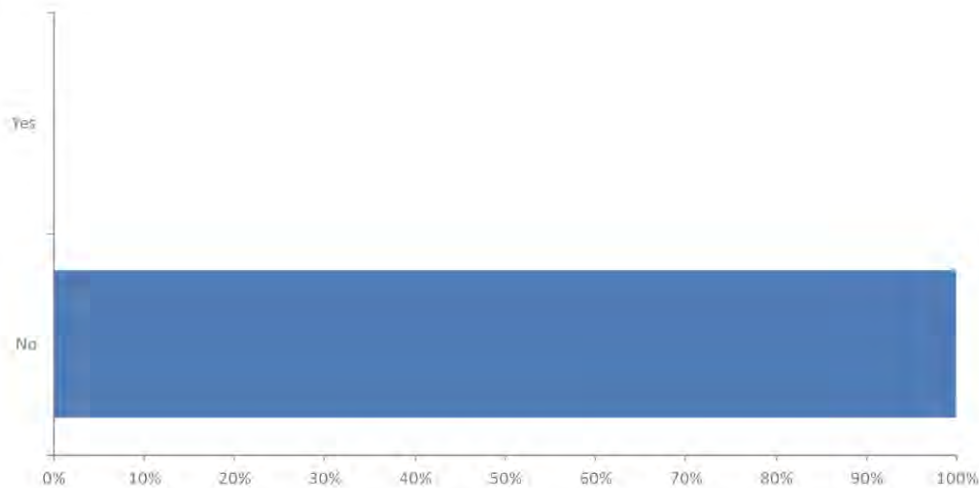
Q16: Do you currently look after a relative, neighbour or friend who is ill, disabled, frail or in need of emotional support?

Answered: 13 Skipped: 3

ANSWER CHOICES	RESPONSES	
Yes	61.54%	8
No	38.46%	5
TOTAL		13

Q17: Are you pregnant?

Answered: 12 Skipped: 4



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Q17: Are you pregnant?

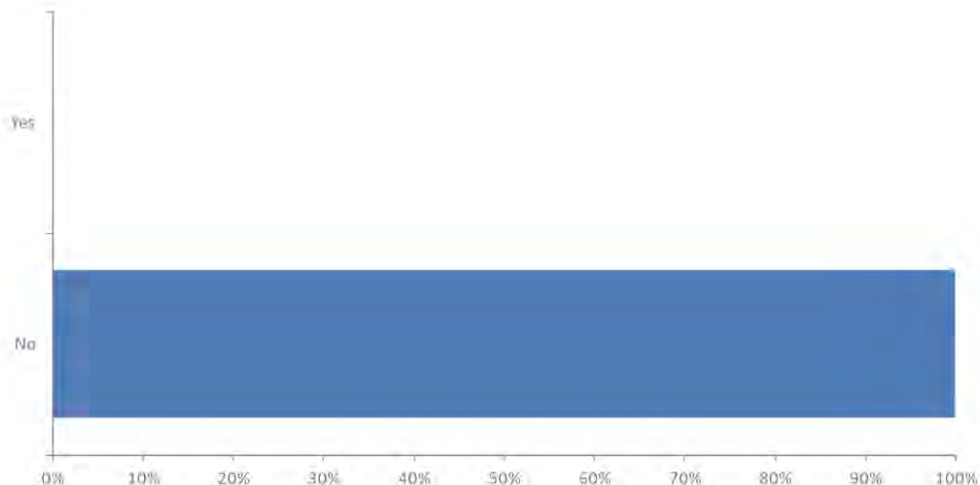
Answered: 12 Skipped: 4

ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	100.00%	12
TOTAL		12

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Q18: Have you had a baby in the last 12 months?

Answered: 12 Skipped: 4



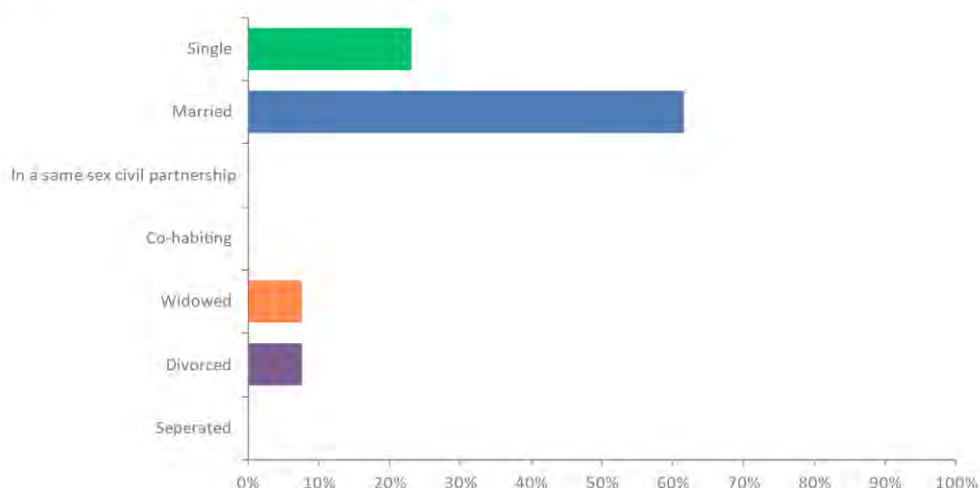
Q18: Have you had a baby in the last 12 months?

Answered: 12 Skipped: 4

ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	100.00%	12
TOTAL		12

Q19: Marriage and Civil Partnership (please tick one box)

Answered: 13 Skipped: 3



Q19: Marriage and Civil Partnership (please tick one box)

Answered: 13 Skipped: 3

ANSWER CHOICES	RESPONSES	
Single	23.08%	3
Married	61.54%	8
In a same sex civil partnership	0.00%	0
Co-habiting	0.00%	0
Widowed	7.69%	1
Divorced	7.69%	1
Seperated	0.00%	0
TOTAL		13

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Older people's mental health inpatient services consultation

Recommendations

3 September 2024

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust

NHS West Yorkshire Integrated Care Board

Introduction

The purpose of the extraordinary programme board meeting on 03 September is to review the findings from the consultation and agree recommendation of the preferred option.

Consultation exercise and deliberations

Public consultation: 12 weeks through Jan – Mar 2024

Analysis of findings was commissioned independently of the programme.

Feedback that we delivered robust findings – report and EIA:

ICBJC and JHOSC both felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings and that the key themes, identified and considered in the report.

These were tested with a range of stakeholders and in a workshop in August 2024

Assured that it's given us the correct themes need to be considered for the decision phase.

All of these findings have been taken into the decision-making process to support reach a recommendation of preferred option.

No other options were identified during formal consultation.

Initial scoring matrix

The table below summarises the overall scoring across the domains when weighted (for example, 8 out of 10 for quality would be weighted to 24 (out of 30)). This is based on the work done through to May 2023 to inform which options should be taken into public consultation.

		Quality Domains				Total quality score	Value for Money	Total
	Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	70	30	100
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21	14	6	8	49	19.2	68.2
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15	8	4	5	32	21.6	53.6
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	44	19.2	63.2

Information used for review

Original options appraisal and rationale were reviewed . The review to reach a recommended option used the same criteria to rescore.

Updated information used:

Quality Impact Assessment – revised 2024

Travel Impact Assessment – revised 2024

Sustainability Impact Assessment

Strategic Alignment Assessment – revised 2024

VfM assessment

Equality Impact Assessment – updated post consultation

Consultation findings, including independent report, feedback from key stakeholder and workshop outputs.

Quality Domain

Option 1a is the strongest option from an equality perspective. 1a Gives the best option for more people over a greater span of time. **1a – increase from 7 to 8.**

Option 1b received negative feedback in relation to the lack of single sex wards for functional needs.

- No single sex option for functional needs if a patient wants or requires this.
- Inequality of access – this maintains a barrier of access, but 1a and 2 offer options to address the barrier as they include a single sex functional ward.
- Score for option **1b reduced from 5 to 4 in quality** as it means that there is more than one key area that can’t be met: though mitigations could be put in place to manage, this is sub optimal.

Option 2 – no change.

People with functional needs more likely to benefit from en-suite but no / very limited access to this in option 2. Option 1a has no/very limited en-suites for dementia, but patients with dementia more likely to need bathroom/bathing support.

Option / Weight	30
1A	21 rescored to 24
1B	15 rescored to 12
2	18 no change

Access Domain

- Calderdale most impacted by the options and there is a greater impact with option 2. Extra travel for option 2 raised as key specific negative themes by people in Calderdale:
 - This option will create difficulties around transport for patients, carers and families (14 / 19%)
 - Locations are hard for patients, families and carers to reach (9 / 12%)
- The updated Travel Impact Assessment identified that whilst all options created extra travel, the overall impact of option 2 is greater (more people impacted and a bigger impact for those that are).
- Consultation theme in relation to access: the lower number of dementia beds in option 2 and whether there is capacity to meet demand.
- Consideration was given as to whether the access score for option 2 should be reduced but these issues were identified in 2023 options assessment and scored accordingly then.
- For criteria of access for **1a, 1b, and 2 options scores remain the same.** No additional considerations.

Option / Weight	20
1A	14
1B	8
2	12

Other domains – no change to scores

Sustainability

- The focus of the sustainability criteria was primarily on whether each solution could be sustained for a period of up to 10 years – see domain.
- Nothing to indicate a change to scores based on these criteria
- Contribution to wider sustainability plans could be factored in but based on existing criteria no change.

Strategic Alignment

- No significant changes but this will be validated the next WY MHLDA PB, where there is an update on priorities for Older people's work programme.
- Both option 1a and 2 scored well from strategic point of new, no new information to date that changes that.

VfM

- Agreed the previous assessment does not change.
- Noted though that Option 1b was not recognised as offering the same value for money in the consultation feedback compared to other options, even though it is lower cost.
- Score remains because it does not change the scoring assessment.

Though some scores to the options appraisal weren't changed as a result of consultation, the findings supported the previous analysis and options appraisal that has taken place.

Revised scores following review of findings:

		Quality Domains				Total quality score	Value for Money	Total
	Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	70	30	100
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21 rescored to 24	14	6	8	49	19.2	72.2
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15 rescored to 12	8	4	5	32	21.6	50.6
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18 no change	12	6	8	44	19.2	63.2

Based on the updated findings of the consultation and impact assessments, the overall ranking hasn't changed but some scores have.

Summary

Equality considerations have been woven through each of the domains.
JHOSC asked how travel factored in – part of access scoring above and considered.

Feedback from the consultation has reinforced what we knew but some feedback from consultation has changed scores resulting **in a clear recommendation for option 1a**

We have captured and considered the mitigations required and will factor these into the implementation plan.

Supporting Statement for Calderdale, Kirklees and Wakefield Older People's Mental Health Inpatient Transformation Business Case

This business case for the development of specialist inpatient mental health services for older people is fully aligned with the strategic objectives of the **West Yorkshire Integrated Care Board (ICB)** and the priorities of the **Mental Health, Learning Disabilities, and Autism (MHLDA) Programme**. It supports the ICB's overarching goals of improving outcomes, reducing inequalities, and enhancing the quality, accessibility and experience of mental health services for older adults, while also promoting sustainability and environmental responsibility.

The proposed specialist inpatient services will specifically benefit the populations and communities across the **Kirklees, Calderdale, and Wakefield** places, addressing the identified clinical and quality gaps in specialist mental health provision for older adults in these places. However, this provision will also contribute to the **overall enhancement of services across West Yorkshire**, strengthening the region's ability to deliver high-quality, equitable care for older people with complex mental health needs.

The services outlined in this business case are designed to support older adults with both organic mental health conditions, such as dementia, and functional conditions, including depression, anxiety, and psychosis. By establishing specialist, dedicated inpatient units, this proposal will help older people in these communities receive the comprehensive, tailored care they require, in a setting that promotes recovery, dignity, and well-being.

A robust and inclusive consultation process has been at the heart of the business case development. We are assured that the consultation has been comprehensive, involving input from a broad range of stakeholders, including patients, carers, clinicians, and community representatives. Importantly, **independent findings** from the consultation have been fully considered and incorporated, ensuring that the final proposal is both evidence-based and reflective of the needs and priorities of the communities we serve.

Patient and carer engagement has been a central pillar of this business case. Extensive efforts were made to capture the voices and experiences of older people and their families through surveys, focus groups, and one-on-one interviews. This ensures that the design and delivery of services are aligned with the lived experiences and expectations of those who will benefit from these enhancements, creating a service that is truly responsive to patient needs.

Sustainability is also a key component of this business case, aligning with West Yorkshire ICB's commitment to environmentally responsible healthcare delivery. The proposed inpatient services will incorporate energy-efficient infrastructure to reduce waste and promote sustainable practices in daily operations. This ensures that the new provision not only meets the immediate and long-term mental health needs of the population but also contributes positively to the region's environmental objectives.

In addition to directly benefiting the populations of Kirklees, Calderdale, and Wakefield, this new provision will play a vital role in strengthening mental health services across the entire West Yorkshire system. By improving access to specialist inpatient care, the new services will help reduce pressures on existing facilities and ensure more equitable access to high-quality care for older people across the region. This aligns directly with the strategic objectives of the MHLDA Programme Board and contributes to our collective vision of providing seamless, accessible, and effective mental health care for all.

This work represents a significant step forward in delivering specialist, sustainable, and patient-centred care for older adults across Kirklees, Calderdale, Wakefield, and the wider West Yorkshire region, while also addressing the ICB's priorities of health equity, patient experience, and long-term sustainability.

A handwritten signature in blue ink, appearing to read 'Keir Shillaker', is positioned above the printed name.

Keir Shillaker

Programme Director: West Yorkshire Mental Health, Learning Disability & Autism

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A handwritten signature in blue ink, appearing to read 'Keir Shillaker', is positioned above the printed name.

Keir Shillaker

Programme Director: West Yorkshire Mental Health, Learning Disability & Autism

OPS Workstreams Post Decision October 2024

The information below sets out the initial list of post consultation workstreams – this will be developed further over in late 2024 as the programme moves into the operational planning and delivery phase.

These are informed by the drivers for change identified in each impact assessment – see table below.

Estates

Crofton Development work
Improvements on ward 19
Poplars site

Workforce and operational delivery

Staff consultation
Staffing up / recruitment
Transition to new model

Training and Skills

Training programme for dementia staff
Training programme for functional staff

Pathways and new ways of working

Social care and other partners ways of working
SWYPFT Teams alignment with new ward structure and ways of working

Clinical pathways on the wards

Clinical pathways and ways of working on the dementia ward
Clinical pathways and ways of working on the functional ward
Review of pathways / process when people from our wards admitted to general hospital

Travel and Transport

Implementing visitor support pathway
Systems to track usage and impact
Aligning with combined authority over system travel improvements

Outcomes and Benefits

Review and update benefits framework
Tracking delivery of benefits (could form part of each work strand).
Review and update of impact assessments (EIA, QIA, SIA, TIA)

Alignment with Trust Strategy:

Across these workstreams we will evidence alignment with the Trust strategy including the following key drivers:

- Providing the best quality services
- Being the best place to work and learn
- Being the best partner
- Providing the best value

Drivers for change:

Workstream	Strands	Equality Drivers	Quality Impact Assessment Drivers	Other impact drivers
Estates	Crofton Development work	Ensure estate facilities for carers are planned in to any developments – this includes seating areas, access to food and refreshments. Wudu; decor, food. Transgender policy and engagement in design; gender neutral facilities; faith spaces, child baby friendly waiting areas; disability needs	QIA – A model with the best specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation. e.g., dedicated socialisation for people with similar needs. Separate wards for functional / dementia: functional design principles Single sex accommodation.	SIA: estates strategy is to improve the energy efficiency of buildings and equipment as part of relocation and ensuring that all new buildings and refurbishments meet sustainability standards. Waste management improvements.
	Improvements on ward 19	Lack of e/s at W19 Ensure estate facilities for carers are planned in to any developments – this includes seating areas, access to food and refreshments. Wudu; decor, food. Transgender policy and engagement in design; gender neutral facilities; faith spaces, child baby friendly waiting areas; disability needs	QIA – A model with the best specialist ward environments to support people with design of the environment for appropriate therapies and to support socialisation. e.g., dedicated socialisation for people with similar needs. Lack of e/s on W19 and dementia design principles. Gender flex	
	Poplars site	Staff travel impact across different demographic groups.	Challenges identified with safely managing the isolated site.	SIA bringing the Poplars service into the Fieldhead site would support some streamlined pharmacy processes. There are regular journeys to the site to deliver medicine and pharmacy staff visits. There is also an expanded medicines stock list required and held on site due to the Poplars isolation. Reducing IT infrastructure.
Workforce and	Staff consultation		Staffing to appropriate levels, in line with clinical need to support safety.	

Workstream	Strands	Equality Drivers	Quality Impact Assessment Drivers	Other impact drivers
operational delivery	Staffing up / recruitment	Ensure staff reflect the population – proactive recruitment from the community.	Staffing to appropriate levels, in line with clinical need to support safety.	
	Transition to new model	Sexual orientation: Staff rainbow lanyards, flags, posters.	Staffing to appropriate levels, in line with clinical need to support safety	
Training and Skills	Training programme for dementia staff		Staff skilled and delivering specialist support to each group based on evidence based best practice and tailored therapeutic care. QIA Identifies benefits in separating the services out and having a specialist dementia ward and the staffing of it, you can get the correct staff training/skills in place.	
	Training programme for functional staff		As above.	
Pathways and new ways of working	Social care and other partners ways of working	Identify advocacy support that specialises in the support of trans people.	Accessible services for partner organisations such as acute general hospitals, social care and advocacy. Aim to improve pathways to reduce length of stay.	
	SWYPFT Teams alignment with new ward structure and ways of working		Clinical and non-clinical support staff teams and services, across pathways to work together to deliver safe, effective care.	
Clinical pathways on the wards	Clinical pathways and ways of working on the dementia ward	Think about images in pictures, activities/ music and entertainment that considers diversity. Ensure the Trust transgender policy is considered in the design and development of services.	Will deliver positive outcomes of care and allow for implementation of evidence-based practice. That we have the right capacity in the system to meet the demand required, factoring in projected population increases.	

Workstream	Strands	Equality Drivers	Quality Impact Assessment Drivers	Other impact drivers
			Aim to improve pathways to reduce length of stay.	
	Clinical pathways and ways of working on the functional ward	Identify the offer under this option to respond to requests for patients with functional needs from Calderdale being admitted to a single sex ward. Ensure the Trust transgender policy is considered in the design and development of services.	Will deliver positive outcomes of care and allow for implementation of evidence-based practice. That we have the right capacity in the system to meet the demand required, factoring in projected population increases. Aim to improve pathways to reduce length of stay.	
	General Hospital interface		Accessible services for partner organisations such as acute general hospitals, social care and advocacy.	
Travel and Transport	Implementing visitor support pathway	Review visiting times to meet the need of all age visitors. Ensure the carers passport is rolled out and supported. Promote the use of the 'Chatpad' to support contact for carers using a digital device. Identify a SOP to support travel for carers and monitor feedback so the approach is evaluated.	The service users, family and carers are able to access the service as needed.	SIA: use of chat pads to reduce travel; Active travel plan and green travel. TIA: Implementation of the visitor support pathway including: - Provide guidance on travel by the wards. - Ensure flexible visiting is adopted. - Offer digital solutions. - Factor in needs of carers - Ensure there is a failsafe / contingency in place for essential visitors such as carers / next of kin
	Systems to track usage and impact	Identify a SOP to support travel for carers and monitor feedback so the approach is evaluated.		
	Aligning with combined authority over system travel improvements		The service users, family and carers are able to access the service as needed.	- Ongoing engagement with combined authority to support wider system improvements.

Workstream	Strands	Equality Drivers	Quality Impact Assessment Drivers	Other impact drivers
Outcomes and Benefits	Review and update benefits framework	To consider all equality drivers and impacts identified and reflect in framework	To consider all quality drivers and impacts identified and reflect in framework	To consider all other drivers and impacts identified and reflect in framework
	Tracking delivery of benefits	Continue to ensure benefits are aligned to impact assessments.	Continue to ensure benefits are aligned to impact assessments.	Continue to ensure benefits are aligned to impact assessments.
	Review and update of impact assessments (EIA, QIA, SIA, TIA)	Continue to keep impact assessments relevant to drive change	Continue to keep impact assessments relevant to drive change	Continue to keep impact assessments relevant to drive change



Older people's mental health inpatient services

Summary of recommendations

6 November 2024

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust

NHS West Yorkshire Integrated Care Board

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Introduction and Consultation Outputs

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

Introduction

The purpose of these slides is to summarise the recent activity of the decision-making process and the recommendation of which option to implement in the business case.

It will describe what the benefits of this option are also what measures we will need to put in place to support successful implementation and to ensure that it has a positive impact for people from every place.

Consultation exercise and deliberations

- Public consultation: 12 weeks through Jan – Mar 2024
- Analysis of findings was commissioned independently of the programme.
- Feedback received that findings of the report and EIA were robust
- ICB Joint Committee and JHOSC both felt that the Equality Impact Assessment Report is robust and demonstrates that equality and diversity has been considered both in the consultation delivery and in the independent report of findings and that the key themes, identified and considered in the report.
- Findings tested with a range of stakeholders and in a workshop in August 2024.
- Workshop outputs supported that it has identified the correct themes need to be considered for the decision phase.
- All of these findings have been taken into the decision-making process to support reach a recommendation of preferred option.



Reaching a Recommendation

In partnership with:

South West Yorkshire Partnership NHS Foundation Trust
NHS West Yorkshire Integrated Care Board

Feedback from consultation

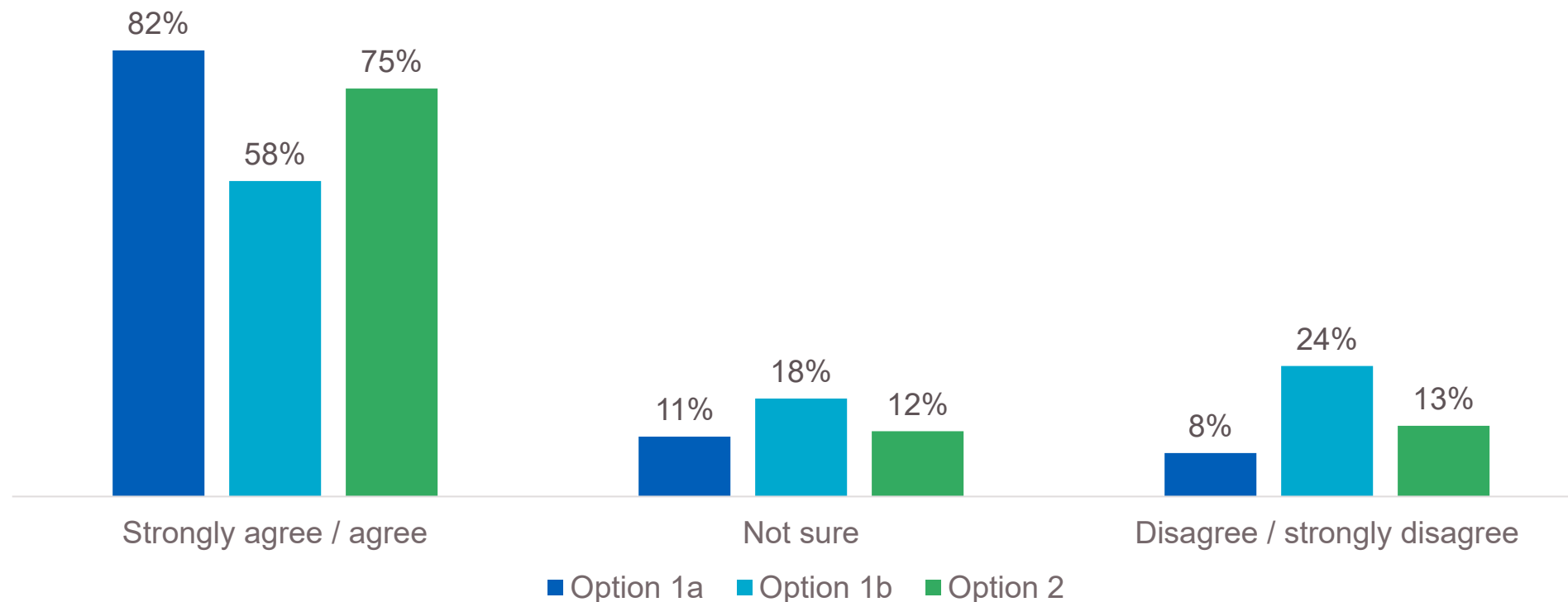
A brief reminder of what the consultation told us

The following 5 slides are excerpts from the CSU report

Comparing the options

The options will improve care for people living with dementia

Most consultation survey respondents agreed option 1a will improve care for people living with dementia (946 / 82%). Agreement towards this statement was lowest for option 1b (661 / 58%).

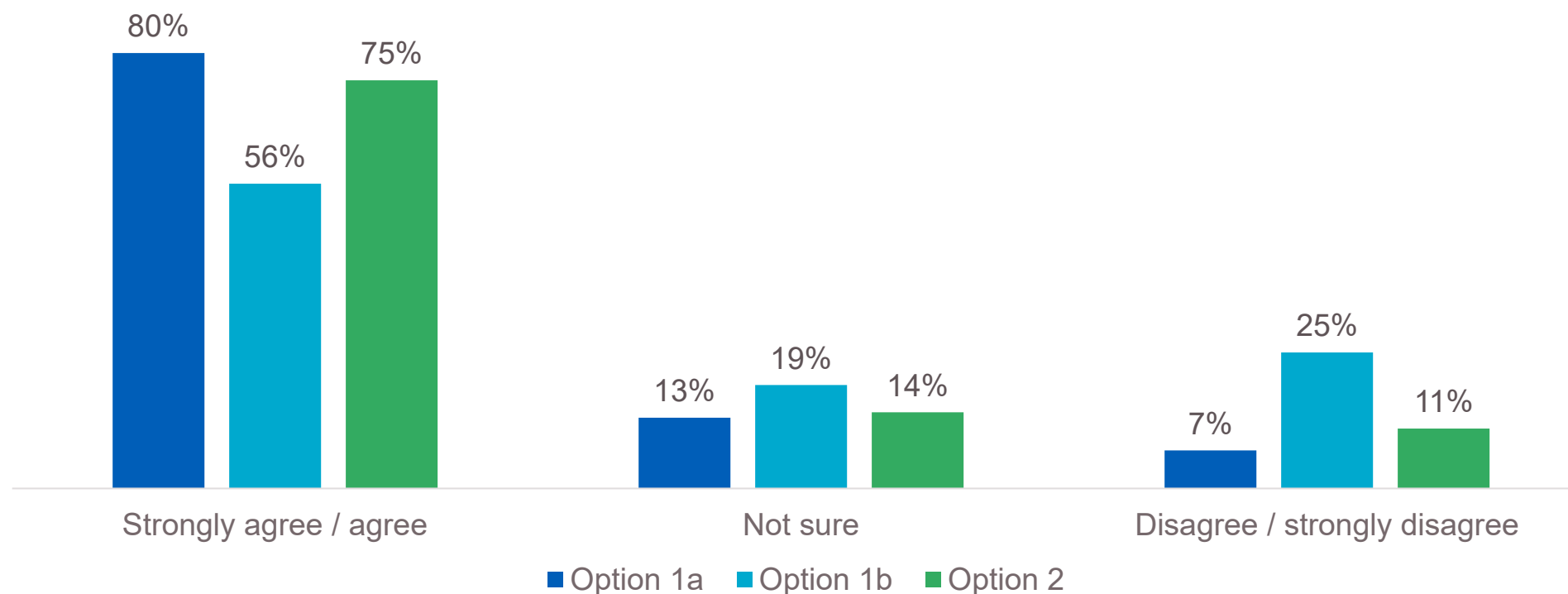


Thinking about option [1a / 1b / 2], how much do you agree with the following statements?: Option [1a / 1b / 2] will improve care for people living with dementia Base: 1,138 – 1,160

Comparing the options

The options will improve care for people living with a functional mental health need

Most consultation survey respondents agreed option 1a will improve care for people living with functional mental health needs (929 / 80%). Agreement towards this statement was lowest for option 1b (645 / 56%).

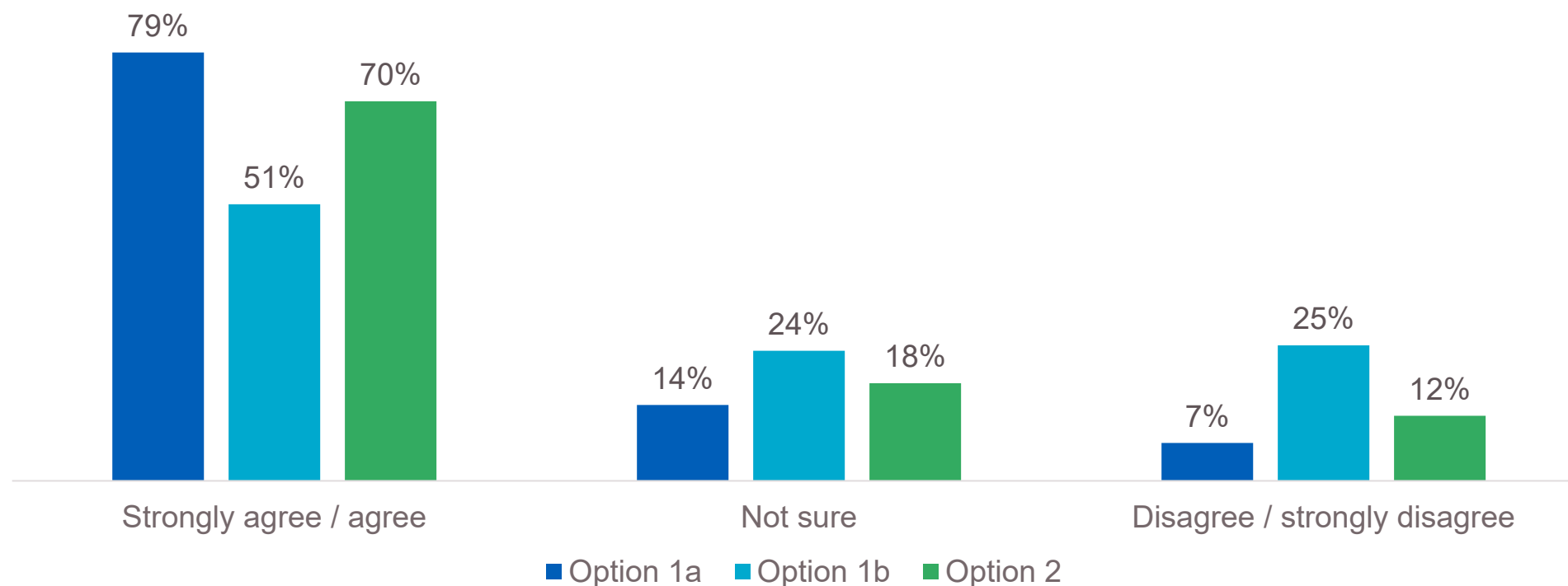


Thinking about option [1a / 1b / 2], how much do you agree with the following statements?: Option [1a / 1b / 2] will improve care for people living with a functional mental health need Base: 1,136 – 1,158

Comparing the options

The options will offer the right care for patients with mental health needs

Most consultation survey respondents agreed option 1a will offer the right care for patients with mental health needs (909 / 79%). Agreement towards this statement was lowest for option 1b (588 / 51%).

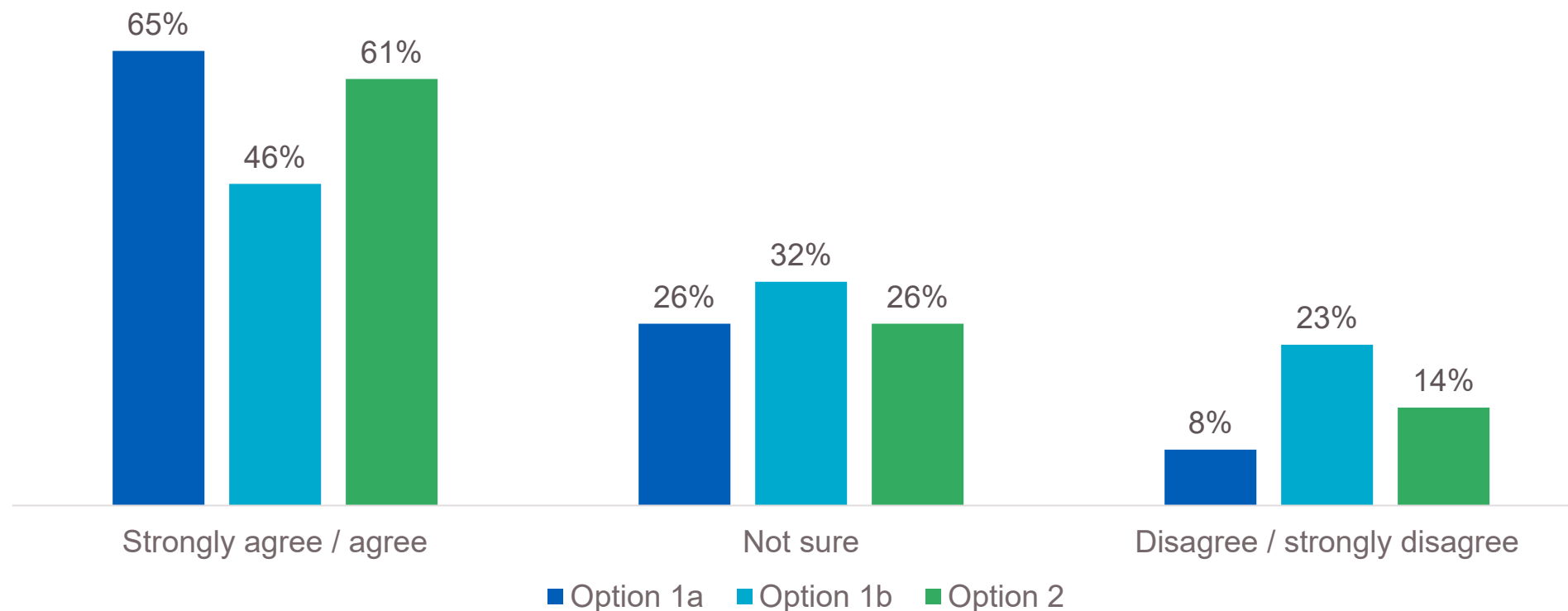


Thinking about option [1a / 1b / 2], how much do you agree with the following statements?: Option [1a / 1b / 2] will offer the right care for patients with mental health needs. Base: 1,138 – 1,156

Comparing the options

The services offer value for money

Most consultation survey respondents agreed option 1a will offer value for money (755 / 65%). Agreement towards this statement was lowest for option 1b (520 / 46%).



Thinking about option [1a / 1b / 2], how much do you agree with the following statements?: Services offer value for money. Base: 1,133 – 1,153

Comparing the options

Top themes

Option 1a	Option 1b	Option 2
Neutral – Quality of care Wards should be single-gender / disagreement with mixed-gender wards (98 / 27%)	Negative – Quality of care Wards should be single-gender / disagreement with mixed-gender wards (203 / 47%)	Neutral – Quality of care Wards should be single-gender / disagreement with mixed-gender wards (56 / 18%)
Positive – Access Option 1a is a good option (46 / 13%)	Negative – Access Option 1b is not a good option (36 / 8%)	Positive – General Option 2 is a good option (38 / 12%)
Positive – Quality of care Separating dementia and functional mental health needs services would be beneficial (39 / 11%)	Negative – Quality of care Concern over the reduction of beds (33 / 8%)	Negative – Finance This is not a cost-effective option (28 / 9%)
Negative – Finance This is not a cost-effective option (23 / 6%)	Negative – Finance Cost saving negatively affects service provision (30 / 7%)	Negative – Transport This option will create difficulties around transport for patients, carers and families (22 / 7%)
Negative – Transport This option will create difficulties around transport for carers and families (20 / 6%)	Neutral – Quality of care Consider the needs of individuals to give the best care (28 / 7%)	Negative – Quality of care Reducing the number of dementia beds may have a negative impact now and in the future (20 / 6%)

Initial scoring matrix



The table below summarises the overall scoring across the domains when weighted (for example, 8 out of 10 for quality would be weighted to 24 (out of 30)). This is based on the work done through to May 2023, in partnership with a range of stakeholders, to inform which options should be taken into public consultation.

		Quality Domains				Total quality score	Value for Money	Total
	Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	70	30	100
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21	14	6	8	49	19.2	68.2
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15	8	4	5	32	21.6	53.6
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18	12	6	8	44	19.2	63.2

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Options Review – further considerations

No other options were identified during formal consultation.

Equality considerations have been woven through each of the domains.

Travel and transport impact of each option was considered as part of the access domain.

Some scores changed as a result of consultation and the feedback received.

Many scores remained the same because the findings supported and aligned to the previous scoring process.

Scoring matrix (for reference)

The table summarises the scoring criteria used:

Score	Description
10	meets fully and exceeds
9	meets fully
8	meets the vast majority of requirements
7	meets the vast majority of requirements with additional work required
6	meets most with more work required
5	meets most but a key area not met
4	meets some parts not others with key areas not met
3	limited criteria met with several key areas not met or one significant risk
2	meets very few criteria well with many key areas not met / significant risks
1	does not meet criteria

Information used for review

The original options appraisal took place in 2023 in a partnership approach. The assessment / rationale from then were reviewed post consultation, using the same criteria as in 2023 to review and rescore using the following updated information:

- Consultation findings, including independent report, feedback from key stakeholder and workshop outputs.
- Equality Impact Assessment
- Quality Impact Assessment
- Travel Impact Assessment
- Sustainability Impact Assessment
- Strategic Alignment Assessment
- VfM assessment

Quality Domain

Option 1a is the strongest option from an equality perspective. 1a Gives the best option for more people over a greater span of time. **1a – score increase from 7 to 8 (from 21 to 24 out of 30).**

Option 1b received negative feedback in relation to the lack of single sex wards for functional needs.

- No single sex option for functional needs if a patient wants or requires this.
- Inequality of access – this maintains a barrier of access, but 1a and 2 offer options to address the barrier as they include a single sex functional ward.
- Score for option **1b reduced from 5 to 4 in quality (12 out of 30)** as it means that there is more than one key area that can’t be met: though mitigations could be put in place to manage, this is sub optimal.

Option 2 – no change.

People with functional needs more likely to benefit from en-suite but no / very limited access to this in option 2. Option 1a has no/very limited en-suites for dementia, but patients with dementia more likely to need bathroom/bathing support.

Option / Weight	30
1A	21 rescored to 24
1B	15 rescored to 12
2	18 no change

Access Domain

- Calderdale is the most impacted by the options and there is a greater impact with option 2. Extra travel for option 2 was raised as key specific negative themes by people in Calderdale:
 - This option will create difficulties around transport for patients, carers and families (14 / 19%)
 - Locations are hard for patients, families and carers to reach (9 / 12%)
- The updated Travel Impact Assessment identified that whilst all options created extra travel, the overall impact of option 2 is greater (more people impacted and a bigger impact for those that are).
- The following consultation theme also raised in relation to access: the lower number of dementia beds in option 2 and whether there is capacity to meet demand.
- Consideration was given as to whether the access score for option 2 should be reduced but these issues were identified in 2023 options assessment and scored accordingly then.
- For criteria of access for **1a, 1b, and 2 options scores remain the same.** No additional considerations.

Option / Weight	20
1A	14
1B	8
2	12

Other domains – no change to scores

Sustainability

- The focus of the sustainability criteria was primarily on whether each solution could be sustained for a period of up to 10 years – see domain.
- Nothing to indicate a change to scores based on these criteria.

Strategic Alignment

- No significant changes
- Both option 1a and 2 scored well from strategic point of view, no new information changes that.

VfM

- Agreed the previous assessment does not change.
- Noted though that Option 1b was not recognised as offering the same value for money in the consultation feedback compared to other options, even though it is lower cost.
- Score remains because it does not change the scoring assessment.

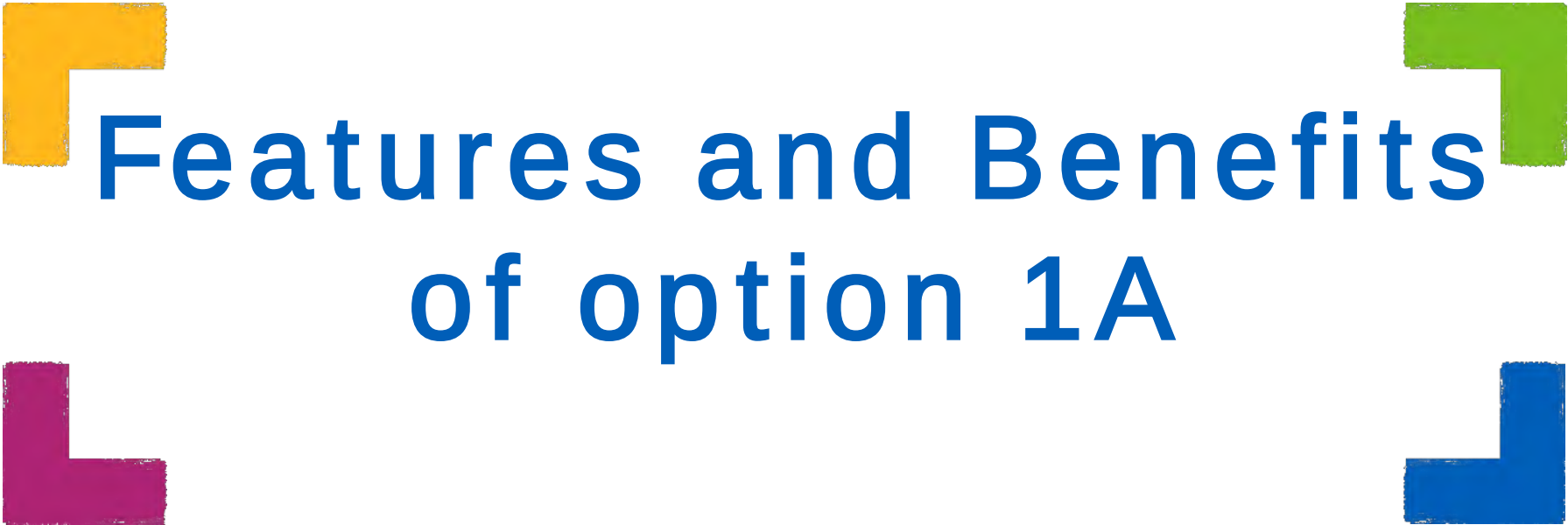
Revised scores following review of findings:

		Quality Domains				Total quality score	Value for Money	Total
	Option	Quality (clinical)	Access	Deliverability / Sustainability	Strategy alignment			
Weight		30	20	10	10	70	30	100
1A	W19 dementia unit, 10 extra beds at Crofton (managed as 2 wards), Poplars not in this model	21 rescored to 24	14	6	8	49	19.2	72.2
1B	W19 dementia unit, 6 extra beds at Crofton, Poplars not in this model	15 rescored to 12	8	4	5	32	21.6	50.6
2	Crofton being a 26-bed dementia unit (2 separate wards), all other wards functional	18 no change	12	6	8	44	19.2	63.2

Based on the updated findings of the consultation and impact assessments, the overall ranking hasn't changed but some scores have.

Summary

Feedback from the consultation has reinforced what we knew, resulting
in a clear recommendation for option 1a

Four L-shaped corner graphics in orange, green, purple, and blue are positioned around the central text.

Features and Benefits of option 1A

Features of option 1a

	Option 1a
The dementia service	• A dementia service on Ward 19, Dewsbury and District Hospital • 2 separate male and female wards • 30 beds
The functional mental health needs service	• On Crofton Ward, Fieldhead Hospital, Wakefield, 2 separate male and female wards, 26 beds, and, • On Beechdale Ward, Calderdale Royal Hospital, 1 mixed-gender ward, 16 beds • There would be 42 beds for a functional mental health needs service in total.
Total beds	72
Cost to set up	£8.2 million
Cost to run each year	£9.1 million

The positive benefits of the model and option 1A



Implementing option 1A means that all people will receive the right specialist care, on the right ward environment, with:

- Best practice model – in line with national guidance and predominantly implemented across England.
- Separate wards based on diagnosis - functional and organic, delivering the specialism to meet needs.
- Improved specialist environments and resourcing to meet the needs of each group, supporting reduction of incidents and addressing risks associated with mixed wards.
- Mitigated clinical risks attached to the isolation of the Poplars, with the building of a new ward based at the Fieldhead hospital site.
- Reduced risk with the environment of the Beechdale ward which will benefit from only having people with functional needs.
- Improved consistency and pathway of care, removing the need to transfer most people across wards, and supporting reduced lengths of stays, particularly for people with dementia.
- Robust workforce model and enhanced staff skills to support improved clinical interventions and tailored therapeutic care.

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The benefits of option 1A over other options



Option 1A will deliver single sex accommodation on 4 of the 5 wards and there will be a single sex ward for anyone with dementia and functional needs. This is an improvement from the current model, where only 2 wards are mixed sex, and option 1B, which didn't have any single sex wards for people with functional needs.

Option 1A delivers all wards at optimum ward sizes whilst option 1B includes a ward that has more bedrooms than best practice guidance.

Option 1A has more beds overall than option 1B. It has the same overall beds as option 2 but a greater number of dementia beds, 30 in total, whilst option 2 has 26 dementia beds, which is the lowest amount feasible based on the modelling.

While all options have some travel impact, option 1A will have a lower travel impact than option 2 as the dementia ward is more central. For example, average public transport time for people from Calderdale to Wakefield (option 2) is **approximately to 100 minutes** compared to 60 minutes for option 1A.

The ward environments suit option 1A better. The environment of Ward 19 in Dewsbury is more appropriate for people with dementia whilst Crofton in Fieldhead Hospital, Wakefield, works well for people with functional needs.

Four L-shaped corner graphics, each with a textured, slightly distressed appearance. They are positioned at the corners of the central text area: orange at top-left, green at top-right, purple at bottom-left, and blue at bottom-right.

Effective implementation of the model

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Effective Implementation

As with any transformation, actions will need to take place to enable the new model of care and recommended option to be implemented effectively. Activity required has been identified through a series of impact assessments and includes:

- Support for people to travel who are impacted as a result of the changes (see slides below);
 - Improvements to ward environments that factor in the needs of differing protected groups, with working groups to ensure inclusive approaches are taken;
 - Partnership working to facilitate new pathways of care across places;
 - Staff support;
 - Implementing creative solutions;
 - Green travel solutions and energy efficient building works in line with the green plan.
-
- More information on these can be found in the business case, the impact assessments and the implementation workstreams document.

Travel and Transport: how many people impacted for option 1A



People impacted by the change	Admissions (ave per year)	Carers with access to cars (approx. based on consultation feedback)	Average car journey time in new model	Ave public transport time in new model
Calderdale Dementia	20	85%	34 mins	61 mins
Kirklees Functional	35	85%	23 mins	62 mins
Wakefield Dementia	30	85%	27 mins	62 mins

- We don't know how many people will have challenges travelling to visit yet.
- Data shows average journey times and some people's journeys will be longer than this,
- It is hoped that there will only be a small number of people that struggle to travel to visit.

We will find a way to support people that struggle to access the wards (see following slides).

Travel and Transport



A working group with a mix of carers, governors, SWYPFT and ICB staff was tasked with making recommendations to support family, carers and loved ones that have difficulty travelling due to transformation, considering feedback from the public consultation.

The group has recommended the implementation based and personalised approach via a visitor support pathway for people impacted which includes:

- Provide guidance on travel by the wards.
- Ensure flexible visiting is adopted.
- Offer digital solutions.
- Factor in needs of carers, for example the triangle of care principles, carers' passports and carers' assessments.
- Ensure there is a failsafe / contingency in place for essential visitors such as carers / next of kin that are unable to visit as a result of changes made which factor in the needs of the service user and the ability of next of kin to visit. This could include volunteer drivers, VCSE support or paid taxis.

Work will also continue with partners including the Combined Authority to influence improvements public transport solutions that better link hospitals and improve ease of public transport journeys.

Travel and Transport criteria for further support



If the measures above do not provide enough support to enable an essential carer to visit the ward, a range of circumstances will be considered including:

- Needs of service user – how beneficial visiting is, how frequently they would benefit from visits.
- Visitor circumstances:
 - If it requires a complex and long journey, for example, more than 1 change of public transport, or the journey takes over 1 hour.
 - If the visitor has disabilities or a condition, including frailty, that makes the journey difficult.
 - High cost of travel makes the journey unaffordable.

In these situations, where an essential visitor is unable to travel, it is proposed that the provider Trust will work with the next of kin to capture the evidence of need and will **find a way to support the visitor to access the ward** as is most appropriate for the service user needs.

It is proposed that the visitor support pathway is supported for an initial 5-year time period and then evaluated.



Wider support and summary



System and Finance Support

In September 2024, the programme team received a letter from Keir Shillaker, the Integrated Care Board Programme Director for West Yorkshire Mental Health, Learning Disability & Autism that confirms:

- That the business case for the development of specialist inpatient mental health services for older people is fully aligned with the strategic objectives of the West Yorkshire Integrated Care Board (ICB) and the priorities of the Mental Health, Learning Disabilities, and Autism (MHLDA) Programme.

Jonathan Webb, the West Yorkshire ICB Finance Director has confirmed support for the programme from a finance perspective, both capital and revenue perspective to enable the building work at Wakefield to take place and the specialist staffing to be established for the dementia ward.

Summary:

The new clinical model will have strong benefits for our patients in every place and remove many of the existing challenges.

Option 1A is evidenced to be the best of the 3 options consulted on overall and across a range of considerations.

We have used the impact assessments to support the planning of an effective implementation.

Whilst there is travel impact for some people visiting, we hope the numbers that will struggle to visit as a result of these changes will be low. We will put measures in place to make sure that people can get to the ward to visit their loved ones.

Commitment remains for the financial investment into the models.