Older people transformation of mental health inpatient services

Equality Impact Assessment (EIA)

Date and author

SWYPFT branding

Contents

Version control

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1. Our approach to equality and addressing health inequalities

Identifying and reducing health inequalities in access, experience and outcomes is essential to the delivery of high quality, mental health care. The aim of the Equality Impact Assessment (EIA) resource is 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. We know that there is no quality without equality.

Our approach to transformation is to ensure we meet the diverse needs of our communities. The pandemic has further exposed the gross inequalities in our society. Inequalities in health, housing, income, barriers to accessing services and discrimination remain. We know these inequalities put people at greater risk of ill health, mental ill health or distress. We also know that people who are mentally ill, those with a learning disability and those who live in poverty face wider health consequences as a result. Systemic racism and prejudice also affect our Black, Asian and minority ethnic communities.

We must continuously improve and develop our services through effective communication, involvement and engagement. By working with people, to co-design and develop services that are person centred, culturally appropriate and better than they were before ensuring they are accessible to everyone and reflect the populations.

To ensure we deliver on our approach we must comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty (PSED), Health and Social Care Act and NHS Constitution. We must also ensure we deliver on Trust wide policies that are in place to address inequalities such as Translation and Interpretation, Disability and Accessible Information Standard policies.

For our workforce we need to ensure that we meet the high impact actions in the NHS Equality, Diversity, and Inclusion Improvement Plan, the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap. National and local priorities to address health inequalities and consideration of equality, co-production, and involvement at each stage of service design, delivery, and implementation forms part of any decision-making process on future services.

2. Our partnership

NHS South West Yorkshire Partnership Foundation Trust are working in partnership with West Yorkshire Integrated Care Board (ICB) and place leads to transform older people mental health services. The areas of transformation will directly impact the population of Calderdale, Kirklees, and Wakefield. Whilst we deliver services to

Barnsley, South Yorkshire ICB have already identified they will not be directly impacted by any change and will be included as a stakeholder.

As a Trust we are committed to improving the population health of our population by advancing equality and reducing health inequalities in line with the requirements of the NHS Long Term Plan. To ensure the obligations of equality and inequalities legislation are met we have Equality Impact Assessments (EIAs) that have been used to inform our decision making. These tools are an integral part of, and central to, our transformative approach.

3. Background to the transformation

From 2015 onwards, a programme has been taken forward between South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and partners to considering how to improve the provider Trust mental health services for older adults. Whilst the programme of work has led to changes and improvements across community pathways, there have yet to be any changes to the inpatient model, which we know does not align to best practice models of inpatient care.

Therefore, a partnership programme approach between SWYPFT and CCGs (now ICB) partners was established to focus on improving services for inpatients. This phase of work is now underway after being delayed by the global coronavirus pandemic.

3.2 Current model:

The need for access to acute mental health hospital beds for two groups of older adults is still required and these are for:

- people with needs such as dementia (sometimes referred to as organic needs), and
- people with other mental health needs such as depression, anxiety, and psychosis (sometimes referred to as functional needs).

The Trust inpatient ward offer remains mostly mixed and comprises of the following:

- 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, Priestley unit** 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 bedded, mixed gender, mixed needs, 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.

- **In Barnsley, Willow ward** on the Kendray site is the only exclusively functional ward on the trust footprint and is a 10 bed, mixed gender ward. As this operates as a functional only ward there are no plans to change this part of the model.

Features of the current model 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.

Although the older people inpatient wards are in place, they operate as part of a shared system, meaning that people can be and often are admitted outside of their 'home' locality depending on demand. The table below sets out the admissions which have taken place outside of local area between the dates 2018-2021:

	Barnsley Wards	Calderdale Wards	Kirklees Wards	Wakefield Wards	Total
Calderdale	12		126	33	171
Kirklees	14	18		26	58
Wakefield	7	4	61		72
Total	33	22	187	59	301

From the information provided 171 people from Calderdale are admitted out of their local area each year, 72 from Wakefield and 58 from Kirklees. Overall, about 30% of all admissions in the time were outside of locality, with Calderdale having the highest proportion. More information is in the context and current model section of the business case.

3.1 Why change - Vision for clinical model

There is a strong evidence base to support the case to change and improve the current operating model to deliver specialist needs based care. The evidence includes best practice guidance, learning from what others have done, and listening to what people tell us that we should deliver.

NHSE 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 restrictive setting possible (October 2022) identify the following 7 key principles:

- Care is personalised.
- Admissions are timely and purposeful.
- Hospital stays are therapeutic.
- Discharge is timely and effective.
- Services actively identify and address inequalities.
- Services grow and develop the acute inpatient workforce in line with national workforce profile.

The West Yorkshire ICB strategy refresh Five Year Plan - Our vision (wypartnership.co.uk) 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.

Having separate in-patient beds for the two functional and dementia (organic) groups has been consistently regarded as good practice. They allow the older people who need an inpatient stay to have the right care and support, whether they have dementia, depression, psychosis or any other need.

Many of the standards for delivering separate specialist care were agreed several years ago. The joint commissioning panel (May 2013) for mental health guide advocates:

- Where possible, separate ward space for functional and dementia (organic) disorders
- Gender separation guidance for inpatient services being properly applied

In Scotland, the Mental Welfare Commission has undertaken several research studies into the ward environments, including their 2020 report (Older people's functional mental health wards in hospitals - new report | Mental Welfare Commission for Scotland (mwcscot.org.uk)).

They found that:

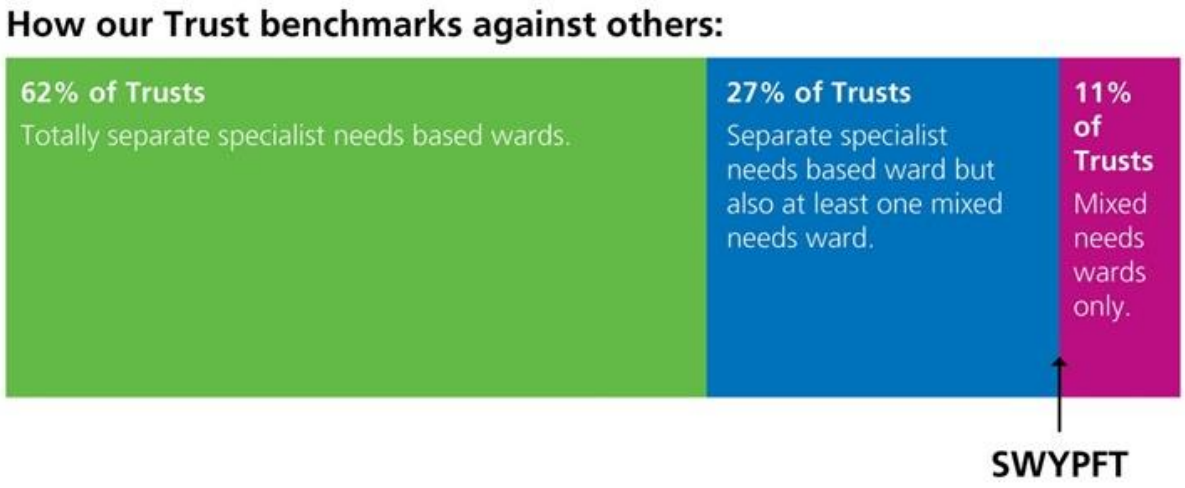
> *"While it is appropriate that these wards can and do treat some patients who have both functional mental illness and dementia, the Commission is clear that mixing patients who are solely diagnosed with dementia with those who*

do not have that diagnosis is challenging, and does not meet the needs of either group".

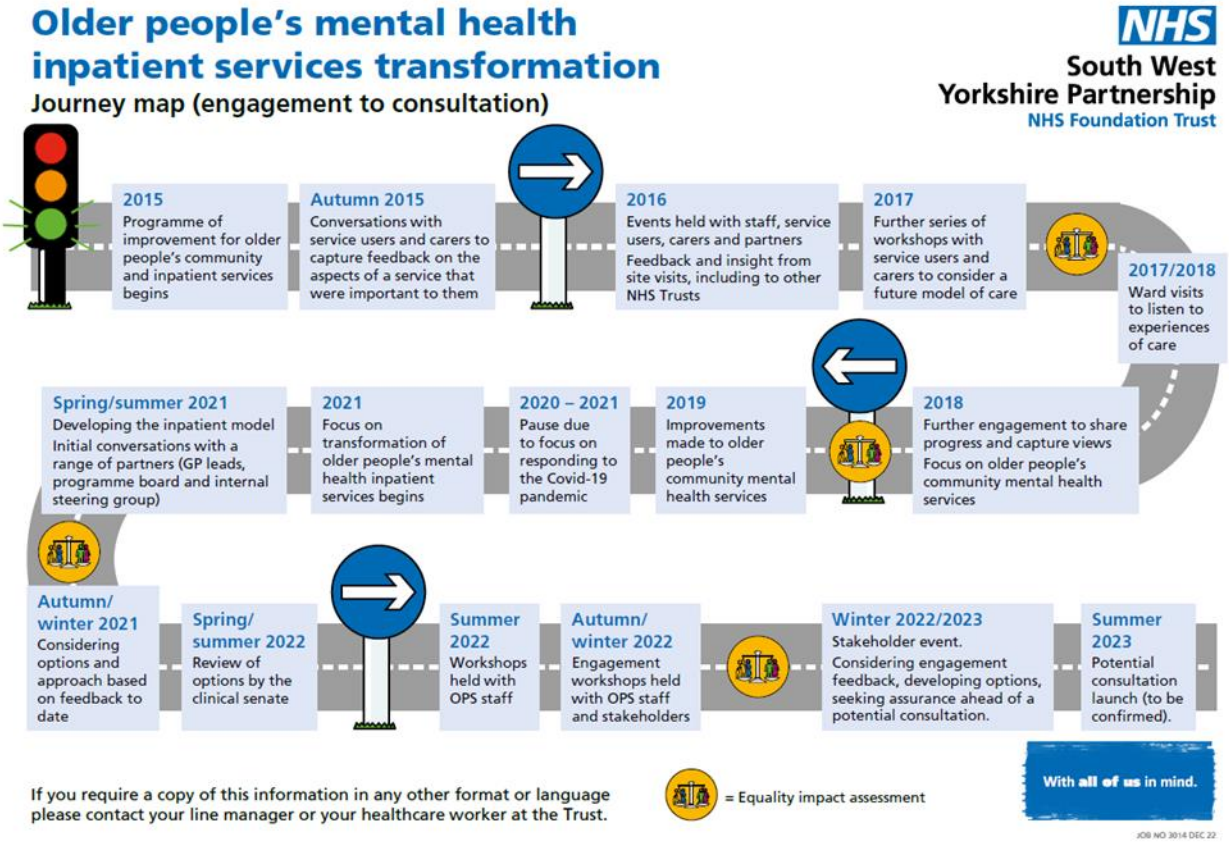
The type of supervision and clinical intervention and workforce skills needed for the two groups may be quite different (Audit Commission, 2000 and 2002). This was reiterated in the document 'Everybody's Business' (Care Services Improvement Partnership, 2005b). The Health Education England (2017) Older People's Mental Health Competency Framework highlighted the need for skills and specialism based on patient group. On mixed needs wards, providing activities that would be stimulating and meet the needs of each person is cited as challenging.

In terms of needs, training and skills, patients with severe dementia and distressed behaviours in secondary care have specific care needs (feeding, dressing, tailored care approaches, etc.) that require staff with specific dementia training, expertise, mentoring, and time to deliver care. The Royal College of Psychiatrists (2019) Standards for Older Adult Mental Health Services, sets minimum standards for dementia specific education and skills.

From a desktop review of the national picture, we found that 62% of Trusts nationally have a fully specialist needs based model, with a further 27% having separate specialist needs based wards, but also at least one mixed needs ward. 11% of Trusts only have mixed needs provision.



Engagement has taken place throughout the programme and a timeline of activity is set out below:



Our engagement with inpatients, family and carers also identified challenges across the current ward configuration. Direct feedback of challenges that were highlighted included:

- It was very upsetting and worrying for me coming in to contact with someone with dementia for the first time. I was worried all night hoping the person could not get into my room.
- I think the 'time element' of support currently is more geared to service users with dementia. We all need support.
- Dementia patients are more awkward and need extra care. Having specialist ward helps to aid recovery with patients with the same illness.
- Everybody in a similar position so can be catered to the person's needs. Sometimes helps to talk to and share with others who suffer similar things.
- Some patient behaviour can be challenging and upsetting.
- Be easier for staff if functional only. The ward would be calmer and better especially for dementia patients, who required more care and looking after.
- Seriously unwell patients need to be segregated from other patients for the benefit of both staff and other patients.

More evidence on the benefits of a specialist needs based model, the ward environment, the staffing required, pathways, interfaces etc can be found in the **Vision for the clinical model** section of the business case.

4. Scope

The scope of this EIA is to describe the potential impact of the options that will be put forward for public consultation. The options have been developed using equality data and insight. Impact will be felt by:

- Patients (with both dementia and mental health service needs)
- Staff at all units
- Carers and other patient loved ones.
- Voluntary and other support organisations / community groups that signpost to and support patients around the service.
- Partner organisations in the health and care system, particularly West Yorkshire Integrated Care Board (ICB) and to a lesser extent South Yorkshire ICB

The approach to develop the options is set out below:

Options Development	
Options Review Workshops 2022	A range of clinical and operational staff members from both provider and partner side met in April and November 2022 to review and appraise the options. In addition, The OPS SWYPFT steering group reviewed the scoring for the 'Deliverability and sustainability' criteria domains for all the options and fed into the following programme board.
Northern England Clinical Senate - from March 2022 to August 2022	The Northern England Clinical Senate review of proposals to change the existing configuration of the older adult inpatient wards to deliver specialist care for people with dementia and for those with functional mental health needs. The Senate formed an independent expert clinical panel from the North of England, Yorkshire and Humber and North West Clinical Senate Councils as well as some additional experts in older people's social work, occupational therapy and mental health nursing. The remit of the senate was to provide a review of the options and to comment on: 1. the viability, sustainability and appropriateness of the proposed models of care, and support those that are suitable for implementation 2. the extent to which the proposed models are likely to: a) Deliver improvements in the quality of care b) Impact on access to services c) Be sustainable for a period of 5-10 years

	d) Be in line with the drivers for change 3. the alignment of other interdependent services required to make the models effective and safe 4. the robustness of the quality and equality impact analysis associated with the proposed models and the appropriateness of any mitigations identified 5. whether they are any other options that might be workable and to provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made
Workshop / Events late 2022	These workshops were used to test the options and process to establish the options with a range of key stakeholders. Further detail included above.
Options Finalisation review workshop 9th May 2023	A wide group of stakeholders reviewed the previous scores against the agreed set of domains and tested whether they were still valid, using a range of data and supporting information.
Options work strand – alignment with strategies Jan – Jun 23	A group including ICB and SWYPFT considered the impact of the strategies criteria against each of the options and proposed scores into the subsequent programme board. Information was then reviewed and updated in May-June 2023.
Options subgroup: Value for Money May – Jun 23	A partnership subgroup established to assess value for money of the different options, included finance leads from both SWYPFT and ICB

The options appraisal found **3 options that are potentially viable**. These are summarised below:

4.1 Option 1: A dedicated central specialised dementia unit developed on Ward 19 Priestley Unit, Dewsbury, Kirklees. There are two ways that this could be done:

- **Option 1a -** A Specialist Dementia Unit at the Ward 19 Priestley unit in Kirklees comprised of two single sex 15 bed wards at Dewsbury District Hospital.
  Crofton ward, at Fieldhead Hospital Wakefield would become a specialist functional unit with **10 extra beds**. Making 2 single sex 13 bed wards.
  Beechdale, at Calderdale Royal Hospital would become a specialist functional ward. The Poplars ward would be closed.
  There would be 72 beds in this option.

- **Option 1b** – A Specialist Dementia Unit at the Ward 19 Priestley unit in Kirklees comprised of two single sex 15 bed wards at Dewsbury District Hospital.
  Crofton ward, at Fieldhead Hospital Wakefield would become a specialist functional unit with **6 extra beds**. This means that Crofton Ward would operate a single 22 bedded mixed gender functional needs only ward. Beechdale, at Calderdale Royal Hospital would become a specialist functional ward. The Poplars ward would be closed.
  There would be 68 beds in this option.

Features of these options:

- Ward 19, Priestley Unit, on the site of Dewsbury and District Hospital, would become a 30 bedded dementia specialist ward, staffed, and modelled as 2 x single sex 15 bed wards.
- For **option a** there would be **10 additional beds** at Crofton, Fieldhead which would mean a specialist functional only ward comprising of two single sex wards with 16 and 10 beds, with could flex to 12 and 14, or **option b** where there would be **6 additional beds** at Crofton Fieldhead which would mean a functional only ward comprising of one mixed gender ward of 22 beds.
- Beechdale, Calderdale would become a specialist functional ward.
- The Poplars would remain a dementia ward, in the short-term, whilst a planned transition to the new model took place. This would enable time to consider when and how the Poplars could be repurposed to support the Wakefield system.
- **Option a** could increase the offer of single sex accommodation in Wakefield as 2 separate wards are created.
- **Option b** would mean that all functional wards remain mixed gender.
- Admissions from patients who are deemed younger adults will receive the support in the most suitable location. This may mean admission to one of these inpatient wards or a suitable working aged adult ward depending on the individuals' clinical needs.

4.2 Option 2: A Specialist Dementia Unit in Crofton ward, at Fieldhead Hospital Wakefield of 2 single sex 13 bed wards. Ward 19, Priestley in Kirklees would become a functional unit of 2 single sex 15 bed wards at Dewsbury District Hospital. Beechdale, at Calderdale Royal Hospital would become a functional ward. The Poplars ward would be closed. **There would be 72 beds in this option.**

Features of this option:

- In Wakefield, Crofton ward based at the Fieldhead site would be the specialist dementia ward with 26 beds, managed as 2 separate dementia wards.
- Ward 19, on the site of Dewsbury and District Hospital, would become a 30 bedded specialist functional ward, though it would still be staffed and modelled as 2 x 15 beds.
- Beechdale, would be a specialist functional only ward.

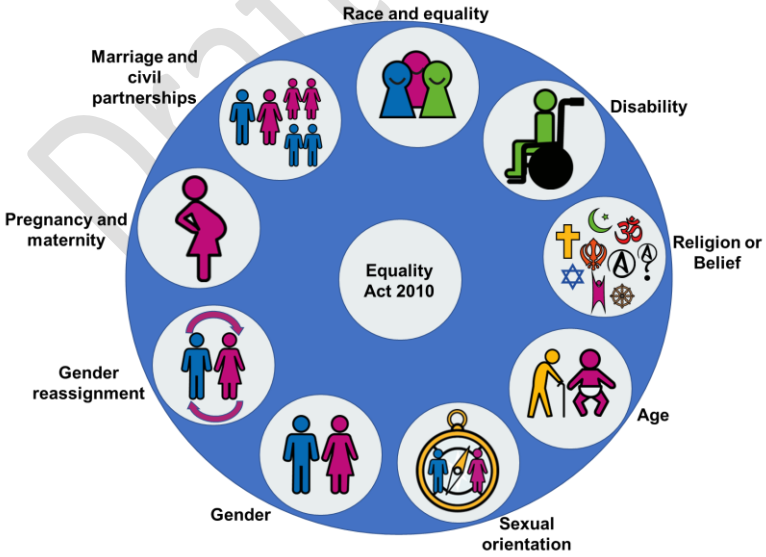
- In the short-term, the Poplars would remain a dementia ward whilst a planned transition to the new model took place. This would enable time to consider whether and how the Poplars could be repurposed to support the Wakefield system.
- This option could increase the offer of single sex accommodation in Wakefield as 2 separate wards are created.
- Admissions from patients who are deemed younger adults will receive the support in the most suitable location. This may mean admission to one of these inpatient wards or a suitable working aged adult ward depending on the individuals' clinical needs.

Barnsley is outside the scope of the programme as the system in Barnsley does not commission acute inpatient dementia beds and there would be no proposed change to the operation of the existing Willow ward. Which will remain as meeting the needs of functional only patients.

5. Groups protected under the Equality Act

When considering the protected characteristics, we are referring to the groups set out below:

- Race and equality
- Disability
- Religion or Belief
- Age
- Sexual orientation
- Gender
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnerships



Carers are not one of the protected characteristics. However, 'carers and representatives' of individuals who use health services were specifically included in the legal duty to involve (s13Q of NHS Act 2006) as part of the 2022 Health and Social Care Act. The Trust recognise this as an additional consideration and therefore the impact for carers is part of equality impact assessment.

5.1 Mental health and protected groups

5.1.1 Dementia

As a system we need to be mindful that an individual's risk of developing dementia can be significantly determined by several factors. Some of these factors are ethnicity, learning disability, gender and others are caused by social or geographical factors. Addressing health inequalities should feed into the development of initiatives. Dementia is a significant and growing problem. Over the last 20 years deaths from dementia have nearly doubled. A review in 2015 examined how common dementia is and how much it varies between groups with the following characteristics: socio-economic position, race or ethnic group, religion, gender, sexual orientation and disability. The findings for this study can be found on the Public Health England website under Prevalence of dementia in population groups by protected characteristics (2015).

The likelihood of having good physical and mental health in later life in England is not evenly distributed across the population and there is a social class gradient in life expectancy, and disability free life expectancy. This report focuses on inequalities in the experience and prevalence of poor mental health, cognitive impairment and dementia. The report can be found on the Institute of Health Equity under Inequalities in mental health, cognitive impairment and dementia among older people.

A more recent study breaks down the considerations by protected group and highlights some of the key considerations. The full findings can be found on the UK Health Security Agency website under https://ukhsa.blog.gov.uk/2016/03/22/ health-matters-health-inequalities-and-dementia/ each section is listed below with additional content added from other sources including considerations for delivering equality, diversity and inclusion in mental health practice.

https://qualifications.pearson.com/content/dam/pdf/NVQ-and-competence-based qualifications/care/2017/specification/Unit65_Equality_Diversity_and_Inclusion_in_Dementia_Care_Practice.pdf which describes how individual experiences of dementia are unique and so the care or support needs to encompass an individual's heritage, culture, history and personal experiences described as:

- Recognition of personhood.
- Provision of care and support that meets the needs of the individual.
- Empowerment of individuals.
- Promotion of positive self-esteem.
- Promotion of individual identity.
- Holistic approach to care.

Age

Dementia is not an inevitable part of ageing, but we know that the risk of developing dementia increases with age. This increased risk may be due to factors associated with ageing, such as higher blood pressure in midlife, an increased incidence of some diseases, and a weakening of the body's natural repair systems.

There are at least 40,000 people under 65 in the UK who have dementia. This group of people may face increased stigma and difficulties particularly if they are carers for young children and are in employment.

In the UK, the Equality Act 2010 obliges employers to provide reasonable work adjustments for disabled people living with dementia. It's not known how employers have handled these requirements for employees with dementia, how challenges are dealt with once diagnosis is made and how capability and fitness for work is assessed. There are guides in place to support this.

Reducing the stigma attached to dementia is an important step in enabling individuals to acknowledge and discuss any problems that they might be having at work because of their dementia. Difference in experience between older and younger individuals are highlighted below:

Younger individuals:

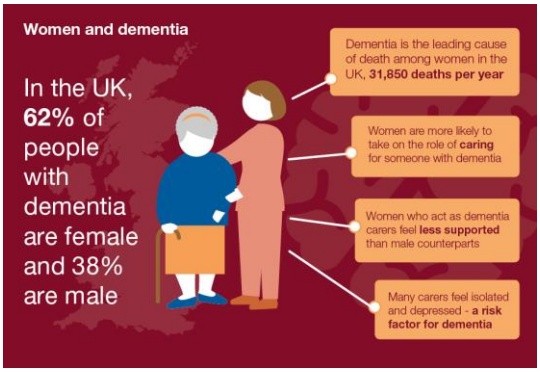
- disruption of career
- reduction of working hours
- reduction of ability to earn income.
- loss of income; negative effects on social circle, relationships
- lack of appropriate health and social care provision for younger adults
- symptoms at referral may be more subtle than those of older individuals.
- perceived loss of future
- loss of independence.

Older individuals:

- confusion of symptoms with other conditions
- assumption that symptoms are associated with older age.
- effects of coexisting conditions associated with older age.
- memory loss, effects of ageing process on short-term memory
- discrimination and oppression due to age-related prejudice
- loss of partners and friends in older age
- physical frailty
- loss of independence
- marginalisation, isolation and loneliness
- misdiagnosis by health professionals
- awareness of loss of skills in early stages
- loss of dignity due to inappropriate care, deterioration of physical functions
- abuse by family, carers
- emotional distress
- compounding of discomfort by age-related sight loss, age-related hearing loss.

Gender

In the UK in 2022, 62% of people with dementia are female and 38% are male. This is likely to be down to the fact that women live longer than men and age is the biggest known risk factor for the condition. While some studies have suggested that other factors may affect the number of men and women with dementia, there is no firm evidence that women are more likely than men to develop dementia at any given age. Women are more likely to be dementia carers than men and this often leave them feeling isolated and depressed – a risk factor for dementia.



Ethnicity

There is a greater prevalence, up to 4 times greater, of dementia in Black and South Asian ethnic groups. In 2011, there were 25,000 people with dementia from Black, South Asian groups in England and Wales. This number is expected to double to 50,000 by 2026 and rise to over 172,000 by 2051.

People in these groups are more prone to risk factors such as cardiovascular disease, hypertension, and diabetes, which increase the risk of dementia and contributes to increased prevalence. People from ethnic minority groups are less likely to receive diagnosis of dementia for several reasons such as:

- difficulties in accessing health services.
- poorer understanding and awareness of dementia
- stigma may be greater in some communities.

The Race Equality Foundation found that about two thirds of those living with Dementia in the UK are living with Alzheimer's disease with roughly a further 20% living with vascular dementia. It has been estimated that there are over 25,000 people from Black, Asian and minority ethnic communities living with Dementia in the UK. However, this estimate assumes that the prevalence of dementia in these communities is the same as that for the White UK indigenous population. There is increasing evidence that the African and Caribbean population in the UK is at higher risk of vascular dementia than the indigenous White population. There is also evidence that the early onset vascular type of dementia is more prevalent in African-Caribbean population. Further reading can be found on the Race Equality Foundation website under Dementia and BAME Communities.

A research study which can be read on the National Library of Medicine website under the reference PMC6087031 also concluded that people from the Black ethnic group had a higher incidence of dementia diagnosis and those from the Asian ethnic group had lower incidence compared with the white ethnic group. We estimated that black men developing dementia were less likely than white men to have a diagnosis of dementia, indicating that the increased risk of dementia diagnosis reported in the black ethnic group might underestimate the higher risk of dementia in this group. It is unclear whether the lower incidence of dementia diagnosis in the Asian ethnic group reflects lower community incidence or underdiagnosis.

A study led by UCL stated dementia rates are 22% higher among black people in the UK compared to white people, while black and South Asian dementia patients die younger, and sooner, the research can be found on the UCL website by searching Dementia rates over 20% higher among black adults than UK average. The research states that people in ethnic minority communities may be less likely to seek treatment for memory problems, perhaps due to stigma around dementia, or other barriers to accessing timely and effective care.

Disability

The prevalence of dementia is four times greater among people with a learning disability. Dementia is much more common in people with Down's syndrome, and onset often begins earlier. People with other pre-existing health conditions such as diabetes, heart disease or depression are at greater risk of developing dementia. Loneliness and social isolation are risk factors for dementia. The main CVD risk factors that are known to increase a person's risk of getting dementia are high blood pressure, increasingly stiff and blocked arteries (known as 'atherosclerosis') high blood cholesterol levels, being overweight and physically unfit as well as type 2 diabetes. Risk factors for dementia - Alzheimer's Society

LGBT+

This is an area that is only beginning to be addressed in dementia research, but studies have shown that 41% of older lesbian, gay and bisexual people live alone compared to 28% of heterosexual people. Loneliness and social isolation are risk factors for dementia. Little is known about the risk of dementia among the transgender community.

A recent study by SCIE states that lesbian, gay, bisexual, and transgender (LGBT+) people, living with dementia can be additionally stressful. Not only are LGBT+ people less likely to have family members and children who can support them as they deal with the disability, they are also more likely to live on their own and be single than heterosexual people. Even with a 'family of choice', LGBT+ people often have an increased need to use social care services for support and help as their disease progresses. Many fear that mainstream care services will not be willing or are not able to understand how to meet their needs. The full report can be found on the Social Care Institute for Excellence under LGBT+ communities and dementia.

The dementia action alliance study found that it can be a challenge to identify people affected by dementia who are from the LGBT+ community. This can be for several reasons. Firstly, people generally do not get asked their sexuality when they receive a diagnosis, enter a care home, or get admitted to hospital. Another important

consideration is that stigma is unfortunately still present in relation to homosexuality, especially amongst people over 654 . This means that should someone be asked about their sexuality; they may not state that they are LGBT+ and therefore will not receive appropriate and person-centred support (if they are lucky enough to receive care from an LGBT+ friendly provider). The full report can be found on the Dementia Action website by searching Dementia and the Lesbian, Gay, Bisexual and Transgender (LGBT+) Community.

Religion or belief
Some culturally specific conceptualisations of dementia as a normal part of ageing or of having a spiritual, psychological or social cause have prevented many groups from seeking support. Faith - https://www.alzheimers.org.uk/sites/default/files/2018-05/Faith%2C%20culture%20and%20dementia%20conference%20write%20up.pdf

Further insight tells us that there are additional factors that need to be considered if we are to address health inequalities. These are:

Carers

Impact on carers can be:

- Depression/depressive symptoms.
- Emotional stress, increased levels of stress.
- Physical tiredness.
- Reduction in ability to earn income, loss of employment.
- Reduction in social circle, loss of social activities.
- Experience of prejudice, stigma by association.
- Marginalisation, isolation and loneliness.
- Confusion due to lack of information from professionals.
- Negative effects on relationships.
- Reduced immunity to illness due to the effects on the allostatic load

5.1.2 Functional mental health

Age
Figures from the Office for National Statistics (ONS) (2016) show that older people are expected to make up a growing proportion of the UK's population over the next 30 years. While the population overall is projected to grow by 12.7% from 2016 to 2046, the population aged 65 or over is forecast to grow by 55.1% and those aged 75 or over by 101.9%. In other words, the number of people aged 75 or over is expected to double in the next 30 years.

Older people are no less prone to mental health problems than younger adults, although such difficulties often manifest differently in older age. The Department of Health has estimated that 40% of older people in GP clinics have a mental health problem, rising to 50% of older people in general hospitals and 60% of those in care homes (Social Care Institute for Excellence, 2006). Depression is the most common mental health problem in this age group. It is estimated that it affects 22% of men

and 28% of women aged 65 or over and 40% of older people in care homes (Age UK, 2016). Anxiety disorders affect 1 in 20 older people (Bryant et al, 2008). Less commonly, patients present to services with psychosis due to bipolar disorder or a psychotic disorder. Their psychotic illness may have been long-standing, but it may also present for the first time in later life.

A report from the King's Fund (McCrone et al, 2008) suggests that by 2026 ageing will be the sole driver for increasing the numbers of people with any form of mental disorder. The prevalence of depression alone is projected to increase by 43%, severe depression by 49% and dementia by 70% between 2017 and 2035, according to figures compiled by Projecting Older People Population Information (POPPI; www.poppi.org). Source: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2

Conservative estimates from the Department of Health suggest that, in the UK, mental health problems are present in 40% of older people who attend their GP, in 50% of older adult inpatients in general hospitals, and in 60% of residents in care homes. Just over a quarter of admissions to mental health inpatient services involve people over the age of 65. In the next 10 years, the number of people aged over 65 will increase by 15%, and the number aged over 85 by 27%. Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from a long-term illness. As a result of the ageing population, the number of people with dementia in the UK is set to increase significantly. At present, there are approximately 700,000 people with dementia, and it is estimated that there will be over a million people with dementia by 2025. The financial cost of dementia to the UK each year is over £17 billion and is set to increase. Preliminary research commissioned by the Department of Health estimated that eliminating age discrimination in adult mental health services in England could require an additional £2 billion, against a current spend of £8.4 billion (a 24% increase in funding).

Older adults with mental health needs have not benefited from some of the developments in services experienced by younger adults and any developments in services for older people do not always fully meet their mental health needs.
In 2003, a report from the Commission for Health Improvement on the abuse of older people with mental health problems noted a lack of priority for mental health services for older people generally within the health community, and "confused and ineffective" implementation and monitoring of the relevant national service frameworks.7 The Commission for Health Improvement also noted that "the focus of policy, local priorities and the national performance indicators remain centred around adult mental health services" as opposed to older people's services. In the same year, the Social Services Inspectorate found that services for older people with mental health difficulties needed urgent attention.
Source:https://www.cqc.org.uk/sites/default/files/documents/equality_in_later_life.pdf

According to a study conducted by the Department of Health, Inequality disproportionately affects certain groups during childhood and adolescence, these include looked after children (5 fold increased risk of any childhood mental health problems), young offenders (3 fold increased risk of mental health problems),

children of prisoners (3 fold increased risk of antisocial behaviour) and homeless young people. Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

In addition, Adults whose antisocial behaviour began in childhood as opposed to adolescence have higher levels of mental illness, substance dependence, financial problems, work problems, and drug-related and violent crime, including violence against women and children. Nearly half of children with early onset conduct problems go on to have persistent, serious life-course problems including crime, violence, drug misuse and unemployment. However, if conduct disorder is limited to childhood, there is no increased risk of poor adult outcomes and conduct disorder beginning in adolescence rarely continues beyond adolescence.

Early identification and intervention for children and young people who are developing problems is critical as half of lifetime of mental health problems arise by the age of 14 and three fourths by the mid-twenties. Timely intervention is critical to both improve outcomes across a range of areas but also prevent progression into adulthood since it has been estimated that 25-50% of mental illness during adulthood could be prevented with effective intervention during childhood and adolescence.

However, very few children are able to identify their own mental health needs or to self-refer, and most rely on their needs being identified and met by nonprofessional such as parents or teachers. Furthermore, there is lack of screening and low levels of treatment: In 2004, it was estimated that around three in four of 5-15 years-olds with mental health problems are not in contact with child and adolescent mental health services (CAMHS). Source: Social Exclusion Unit (2004), Mental Health and Social Exclusion, ODPM, cited in the Department of Health report No health without mental health.

Ethnicity

Mental ill-health particularly affects BME groups. Government statistics show that Black, African, Caribbean, Black British people have higher rates of mental illness and are therefore more likely to encounter mental health services.

The 2017 Race Disparity Audit found that Black women are the group most likely to have experienced a common mental disorder such as anxiety or depression and that Black men are the group most likely to have experienced a psychotic disorder.

Statistics show that Black men are ten times more likely than white men to experience such a disorder. A special issue of Race & Class, published in January 2021 points to the ways in which the mental health of BME people, migrants and refugees are affected by state policies.

The Mental Health Foundation suggest that immigrants and asylum seekers are also more likely to experience poor mental health than the local population. One 2018 study, for example, found that non-European immigrant women, including young South Asian women, were a particularly high-risk group for suicide attempts.

Government statistics published in March 2019 showed that Black people were more than four times as likely as white people to be detained under the Mental Health Act. Black Caribbean people had the highest rate of detention out of all ethnic groups. A January 2018 Care Quality Commission (CQC) report also showed that people from the 'any other Black' background are detained at over 10 times the rate of the white population group. Within this, NHS statistics reveal that Black, black British and 'mixed race' people are arrested under section 136 (forcibly removed from a public place to a 'place of safety') twice as often as white people and are put on Compulsory Treatment Orders eight times more frequently than white people. Source: https://irr.org.uk/research/statistics/health/

The lack of socially oriented and holistic frameworks of knowledge and understanding in medical training and services is experienced as epistemic injustice, particularly among those who attribute their mental illness to experiences of migration, systemic racism, and complex trauma. Fear of harm, concerns about treatment suitability, and negative experiences with health providers such as racist care and medical neglect/injury contribute to avoidance of, and disengagement from, mainstream healthcare. The lack of progress in tackling ethnic inequalities is attributed to failures in coproduction and insufficient adoption of existing recommendations within services.
Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9746991/

Men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk and are more likely to be diagnosed with schizophrenia. Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

Black adults are the least likely ethnic group to report being in receipt of medication for mental health, or counselling, or therapy. Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

Black people in the UK are less likely to have the involvement of GPs leading up to a first episode of psychosis than white patients. They are far more likely to experience police involvement in their first contact with mental health services. They are also eight times more likely than White British people to be given a community treatment order after being treated in hospital under the Mental Health Act. Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

Faith, religion and belief

The value of spiritual belief in supporting people with mental illness towards recovery is well-attested; a review of 101 studies found that 65% reported a significant positive relationship between a measure of religious involvement and lower rates of depression or depressive symptoms, anxiety, and hopelessness. (Koenig HG, McCullough ME, Larson DB, editors (2001). A meta-analysis of 147 studies involving almost 100,000 subjects found that religious involvement was also associated with reduced depression particularly for stressed populations. (Smith J, Richardson J,

Hoffman C, Pilkington K (2005). However, certain kinds of spiritual beliefs can also contribute to triggering episodes of mental illness or to worsening existing conditions. Staff awareness of a patient's religion and/or spirituality as well as their interpretations of mental events is a key component for effective treatment. Diagnosis, treatment and recovery prognosis are all likely to be adversely affected if health professionals and other service providers ignored the beliefs of patients.
Source:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

Sexual orientation
The aims of the review below were to synthesize the best available evidence on the experiences and perceptions of older people who identify as LGBTQ+ regarding their mental health needs, and to establish factors that may support or inhibit access to appropriate mental health interventions and supports.
https://pureadmin.qub.ac.uk/ws/portalfiles/portal/201074594/2019JAN_LGBTQ_Older_People_final.pdf

A study investigating mental disorder, suicide and self- harm in the UK discovered that LGB participants were 1.5 times higher risk for depression, anxiety disorders and alcohol dependence than the general population. Lifetime prevalence of suicidality was significantly higher in gay and bisexual men (King et al., 2008)
In the USA, one study documented a 10 per cent prevalence of mental illness in LGB adults living in the community (Meyer, 2003). In the transgender population, mental health issues including depression, anxiety, suicidality, interpersonal trauma, and substance use are significantly elevated among transgender and gender non-conforming adults (McNeil et al. 2012; Valentine & Shipherd, 2018). In a study on suicide risk among transgender people (n=153), 41 per cent of trans men and 20 percent of trans women reported suicide attempts. The main contributory factors identified included female sex assigned at birth, psychiatric hospitalisation, and violent attacks (Maguen & Shipherd, 2010).

To help maintain their sexual identity and community links, nurses working in aged care facilities need to identify ways of facilitating access to community resources and facilities and support networks, including those specific to LGBTQ+ people (Smith et al. 2019; Villar et al. 2019). This is important in relation to nursing practice as evidence highlights that facilitating access to social support networks has a positive effect on mental and physical health, with a need for individualised, tailored interventions and supports (Fredriksen-Goldsen et al., 2012).
Source:
https://pureadmin.qub.ac.uk/ws/portalfiles/portal/201074594/2019JAN_LGBTQ_Older_People_final.pdf

According to a study conducted in the USA, compared with matched heterosexual men, older gay and bisexual men had more chronic general medical conditions and mental health issues; they also had fewer inpatient stays related to substance use disorders. Older lesbian and bisexual women had higher rates of tobacco use, alcohol use, and substance use disorders than heterosexual women; moreover, they reported more inpatient stays and emergency department visits related to substance

use disorders. SOURCE: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000940 (USA)

People who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people, and the gap is greater for older adults (over 55 years) and those under 35 than during middle age. Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

The National LGBT Survey (2018) found that 24% of respondents had accessed mental health services in the last year, but a further 8% had tried to get help and failed. The majority of those who sought help found it difficult, with long waiting lists and unsupportive responses from GPs cited as reasons for this. Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

Disability

Disability covers a very broad spectrum of physical or sensory impairment, each of which can affect people's mental health as well as their ability to access services. Children, young people, and adults with learning disability have higher rates of mental health problems. Children with learning disability have psychiatric disorder prevalence rates of 36% compared with 8% in children without learning disability. They comprise 14% of all British children with a diagnosable psychiatric disorder. Children with learning disability are 6.5 times more likely to have a psychiatric disorder, 3.6 times more likely to have an emotional disorder 3.9 times more likely to have an anxiety disorder and 8.9 times more likely to have ADHD or a conduct disorder compared to those without learning disability. Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

Deaf people are twice as likely to experience mental health difficulties. 70% of children with autism and 80% of adults with autism have at least one mental health condition. Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

Marriage and Civil Partnership

A major international study across 15 countries and 34,493 people published recently found that getting married is associated with better mental health of both men and women, resulting in reduced risks of most mental disorder. By contrast, ending marriage through separation, divorce or being widowed, is associated with substantially increased risk of mental disorder in both genders in particular substance abuse for women and depression for men.
Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

Pregnancy and Maternity

During pregnancy, 12.7% of mothers experience depression. Subsequent rates are 5.7% between birth and 2 months post-natal, 6.5% at 6 months and 21.9% at 12

months. Income, marital status, occupational position, and number of children are significant predictors of postnatal depression. Risk is increased for low-income urban mothers more than half of whom experienced depression in the 3 months following birth. Maternal depression increases the risk of mental illness in children to the extent that they are five times more likely to have a mental health problem , more than three times more likely to have an emotional problem that persists for at least three years and almost seven times more likely to have conduct problems that persist for at least three years.
Source:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

Transgender
According to the World Health Organisation, Trans and gender diverse people are more likely to experience mental ill health because of their experiences of transphobia, discrimination, and violence. (2002)
A survey from Stonewall reported almost half (48 per cent) of TGD people in Britain have attempted suicide at least once; 84 per cent have thought about it and more than half (55 per cent) have been diagnosed with depression at some point.
https://www.london.gov.uk/sites/default/files/health_committee_-_report_-_trans_health_matters.pdf

Transgender/transsexual people seeking access to interventions such as hormone treatments or gender reassignment surgery are required to obtain a diagnosis of gender dysphoria from a consultant psychiatrist as part of current clinical practice. Almost all transgender people who have undergone transition report that the change was a life-enhancing move. 149 Transgender people report that general psychiatrists often lack understanding and knowledge about gender dysphoria; this can result in inappropriate treatment and delays in access to assessment and treatment by experienced gender specialists. A survey of 872 adult transgender people found that 34% had attempted suicide (NMHDU)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

5.1.3 Socio economic – all mental health

Dementia
There are several dementia risk factors related to socio-economic position such as a lack of physical activity and early year's education.

There is a strong link between cigarette smoking and socio-economic group. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK.

Smoking is one of the biggest risk factors for dementia and studies suggest that it can double the risk of developing the condition.

Cost of living – all mental health

A report on cost of living and depression in adults in Great Britain provided the following information. The study relates to the period 29 September to 23 October 2022, based on adults in Great Britain. The full report can be found here: https://commonslibrary.parliament.uk/research-briefings/sn06988/

- Around 1 in 6 (16%) adults experienced moderate to severe depressive symptoms; this is similar to rates found in summer 2021 (17%), however higher than pre-pandemic levels (10%).
- When comparing within population groups, prevalence of moderate to severe depressive symptoms was higher among adults who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), adults in the most deprived areas of England (25%), young adults aged 16 to 29 years (28%) and women (19%).
- Around 1 in 4 (24%) of those who reported difficulty paying their energy bills experienced moderate to severe depressive symptoms, which is nearly three times higher than those who found it easy to pay their energy bills (9%).
- Around 1 in 4 (27%) adults who reported difficulty in affording their rent or mortgage payments had moderate to severe depressive symptoms; this is around two times higher compared with those who reported that it was easy (15%)
- Nearly a third (32%) of those experiencing moderate to severe depressive symptoms reported that they had to borrow more money or use more credit than usual in the last month compared with a year ago; this is higher compared with around 1 in 6 (18%) of those with no or mild depressive symptoms.

Areas of deprivation

Data published by the Office for National Statistics has shown that in England, the gap in life expectancy between the least and most deprived areas was 9.4 years for males and 7.4 years for females. These differences in health outcomes are related to the overlapping, interrelated effects of long-term inequality and poverty.

BME groups are disproportionately affected by these health inequalities. Census data has shown, for example, that people from ethnic minority groups are far more likely than white British people to live in the most deprived 10% of neighbourhoods in England. Pakistani and Bangladeshi people, for example, are over three times more likely than white British people to live in these deprived neighbourhoods, and Black African and Caribbean people were more than twice as likely to live in these areas.

The follow-up to The Marmot Review, published in 2020, underlined, amongst other things, the way that poor health outcomes are pronounced for BME people.

Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%. Children and young people with a learning disability are three times more likely than average to have a mental health problem.

Source: https://www.centreformentalhealth.org.uk/publications/mental-health-inequalities-factsheet

5.1.4 Addressing health inequalities.

Health inequalities are avoidable and unfair differences in health status and determinants of health. They can be seen as differences between groups of people when measuring demographic, socioeconomic, geographical, and other factors. Source: https://fingertips.phe.org.uk/profile/severe-mental-illness/supporting-information/inequality

Addressing health inequalities has been a priority in mental health for years, as highlighted in the Five Year Forward View for Mental Health and the NHS Long Term Plan. In light of the COVID-19 pandemic, it has become more important than ever. The virus and its social and economic impacts are disproportionately impacting specific groups, including black, Asian and minority ethnic (BAME) communities. https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

Reducing Inequalities in mental illness experienced by people living with mental health problems, will only be evident by achieving improved health outcomes and life expectancy.

Physical Health

People with SMI are at a greater risk of poor physical health and have a higher premature mortality than the general population. People with SMI in England:

- die on average 15 to 20 years earlier than the general population.
- have 3.7 times higher death rate for ages under 75 than the general population.
- experience a widening gap in death rates over time.
- It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented.
- Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension.

Compared to the general population, people aged under-75 in contact with mental health services in England have death rates that are:

- 5 times higher for liver disease
- 4.7 times higher for respiratory disease
- 3.3 times higher for cardiovascular disease
- 2 times higher for cancer

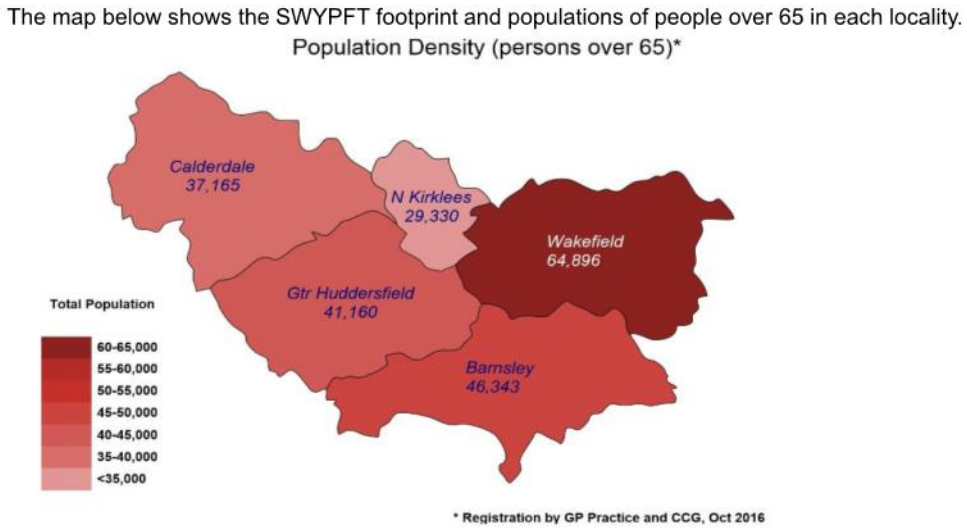
At the same time, the difference between the death rate in people under 75 years of age in contact with mental health services and the general population is:

- 84 more deaths per 100,000 population in adults with SMI for liver disease
- 147 more deaths per 100,000 population in adults with SMI for respiratory disease
- 198 more deaths per 100,000 population in adults with SMI for cardiovascular disease
- 142 more deaths per 100,000 population in adults with SMI for cancer

Reducing the difference in the premature death rate from each of the conditions will address health inequality experienced by the population with SMI. For more information go to: https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#smi-prevalence

5.2 About the local population

The proposals will directly impact older people those aged 65 or over although the proposals may impact those younger than 65. The map below shows the over 65 population of Barnsley, Calderdale, Kirklees and Wakefield.



Based on the **2011 census** key considerations suggest that Kirklees, when considered as a whole (North Kirklees and Greater Huddersfield), has the highest over 65 population - 70,490. Kirklees has approximately 10% more older people than Wakefield, 50% more than Barnsley and nearly double the Calderdale population.

Older people are disproportionately high users of health and care services and mental health. Dementia affects 5% of people over 65 years and over 20% in those over 80 years. The highest prevalence of depression in the population is found in those over 75 years (https://www.kingsfund.org.uk/publications/paying-price**)**

Most of the morbidity in older people is not Dementia, but functional illness such as depression and psychosis. Suicide data also suggests that a suicide attempt in an older person is more likely to be successful and that men aged 75 years and above had the highest suicide rates (http://bjp.rcpsych.org/content/200/5/399).

In the coming years, the number of older people in the UK population will increase significantly. By 2036 it is expected that 23.9% of the population will be over 65 (ons.gov.uk) and over 5% of the population will be over 85 years of age. Mental Health issues and especially depression and dementia are becoming more commonly diagnosed amongst older people.

The 2021 Census data

According to the latest census data 2021 The Trust serve 1.237 million people living across South and West Yorkshire, this is an increase of 17,000 people since 2011. This is broken down by the local authorities of Barnsley which is 244,572 (an increase by 5272 since 2011), Calderdale 206,631 (decrease by 3169 since 2011) , Kirklees 433,213 (decrease by 6787 since 2011) and Wakefield 353,370 (an increase of 21,370. The Trust also have services and staff in North Leeds, Sheffield, Doncaster, and Rotherham.

Most of the care we provide is delivered in local communities. This means we work in all the villages, towns, and cities, from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east and to Hoyland and the Dearne Valley to the south of Barnsley – and all points in between. Our population lives in a mix of rural and urban areas. In all communities the 2021 census tells us:

- Overall, the population total average of male and female reflects the England average. The England average is male 49.2% and female 50.8%, with female reporting higher across all local areas.
- Across all ages Kirklees now has the highest 0-17 population at 22.6% with Calderdale second highest at 19.6%. Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 25.8%, an increase of 2% from 2011.
- Christianity (highest in Barnsley at 68.5%) and Islam (which is highest in Kirklees at 14.5%) respectively are both the highest reported religion and belief.
- We know that white British people make up 86% of our region's local authority population (a slight decrease of 1% from 2011) but higher than the England average of 81%.
- Of the other main minority groups Black or Black British people comprised 2% (an increase of 1% since 2011) which is less than the England average which is now 4%.
- Asian or Asian British people comprised 9% (increase by 1%), the same as the England average. The local authorities with the largest proportions of Asian people are Kirklees 19% (an increase of 3% since 2011) and Calderdale 10% (an increase of 2% since 2011).
- The percentage population of people who reported having a disability was highest in Barnsley at 22% and Wakefield 20.1% with Calderdale and Kirklees in line with the England average of 17.3%.
- Gender identity being the same as when registered at birth in England is 1% lower than in Barnsley, Calderdale, and Wakefield. Gender identity different from sex registered at birth in our region ranges from 0.1 -0.3%
- Marriage and civil partnership figures are again comparable to the England average with 44.7% of people married or in a civil partnership.

- The number of individuals who reported they provided more than 50 hours of unpaid care were highest in Kirklees (10079 people) and Wakefield (10861 people).

As the proposals will impact the population of Calderdale, Kirklees and Wakefield the current activity for each local area is set out below. The table below shows the average number of admissions per year from these local areas:

2018-2022 average	**Functional**	**Organic (Dementia)**	**Total**
Calderdale	47	24	71
Kirklees	75	27	102
Wakefield	50	33	83
Total	172	84	256

Analysis also shows that overall, approximately 30% of people are admitted outside of their locality. In this time Calderdale had more than half of the population admitted outside the area. In addition, it is worth noting that 45% of people with dementia will have more than one ward stay and whilst population analysis shows an increasing number of older people, data shows a reducing number of dementia admissions over the most recent 10-year period.

5.3 Local activity – current inpatient figures

The table below shows the average numbers of per year (taken as the mean average over the period 2018/19 to 2021/22) in the analysis. The number of spells shows how many unique inpatient spells there were, whilst ward stays consider the total number of wards stays across these spells. The travel analysis is based on the discharge ward and measures number of complete spells (discharges), which differs slightly from the numbers of admissions, used in the table above:

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 demonstrates that activity in Calderdale of the 37,165 over 65 (206,600 population total) is highest based on the population size with Wakefield over 65 population at 64,896 (350,00 population total) experiencing a similar number of inpatient stays.

If the data is broken down by postcode for the number of spells and wards stays per year of the people from the 20% most deprived areas in each locality, the figures are higher for Calderdale, North Kirklees and Wakefield:

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

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 Black, Asian, minority ethnic background.

5.4 SWYPT Workforce

At the time of writing the EIA The Trust currently employs 4,594 staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services. The data from our most recent workforce audit report can be found here: Audit to assess the level of staff awareness of (southwestyorkshire.nhs.uk) The electronic staff record data shows that:

- 8.4% of our staff consider themselves to have a disability, which is an increase from the previous year's figure of 6.4%. The total number of disabled staff who have disclosed they have a disability currently stands at 384, this is an increase of 92 since last year but may not fully reflect the current workforce due to under reporting.
- The Trusts staff profile has a comparable White British representation to the demographics of the people that it serves collectively at just under 89%. Staff from Mixed or Multiple ethnic groups are under-represented by 0.05%, Black staff are over-represented by 2.40% and South Asian/Asian British staff are under-represented by 2.67%. However, the Trust's local demographic has large variation in Black Asian and Minority Ethnic representation and there is a significant under representation of South Asian staff in Kirklees and Calderdale (exact percentage not available due non geographical teams)
- There continues to be improvements in the number of staff reporting their religion and sexual orientation. Currently 82% of staff have provided data regarding their religion and 86.4% of staff have provided data indicating their sexual orientation.
- Gender – stable at 21% male 79% female
- The data shows that 38.9% of Trust staff are aged 50 or over.

6. Equality data by ward – patients and staff

All wards have an up-to-date equality impact assessment (EIA) in place. The assessments are updated annually and ensure we continue to understand the impact on protected groups. The service EIAs have been used to ensure the options continue to consider the impact on our local population. Findings from the EIAs for each service are set out below. All affected wards EIAs are attached for reference.

EIA Poplars 2022.docx

Ward 19 EIA NEW TEMPLATE.docx

Beechdale EIA new template August 2022

EIA Crofton May 2022 V2.docx

A review was undertaken on people who use services and staff. Data was analysed on disability, gender, age, sexual orientation, religion and belief and the impact on carers.

6.1 Protected characteristic – disability

	Calderdale	Kirklees	Wakefield	Total	%
All Residents	206,629	433216	353370	993,215	
Does not apply	0	0	0	0	0%
Disabled under the Equality Act: Day-to-day activities limited a lot	16421	33163	32529	82,113	8.27%
Disabled under the Equality Act: Day-to-day activities limited a little	21439	42428	38677	102,544	10.32%
Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited	14917	28277	24272	67,466	6.79%
Not disabled under the Equality Act: No long term physical or mental health conditions	153852	329348	257892	741,092	74.62%

According to the ONS 2011 census data, approximately 10 million people in England and Wales are limited in daily activity because of a health problem or disability. National statistics show that 4.5% of the national population have a disability.

The local figures of the data are that Wakefield has 22% of people identify as having a long-term disability or health problem. In Barnsley this figure is 23.9%. Both areas are slightly higher than the national average (17.6%). In both Calderdale and Kirklees, the figure is 18% which is comparable with the general population.

Disability, measured as Limitations on Activities of Daily Living (LADL) affects 40% of older people aged 60, and 75% of those aged 80 and above. The disability is severe for 20% of older people aged 60 and 50% of those aged 80 and above.

Dementia is a disability, according to domestic law and international convention. In the general population dementia is a disease largely associated with old age, one in every 14 people over 65 from the general population have dementia, rising to 1 in 6 of the over 80s[2].

6.1.1 Crofton ward

Crofton Ward is a 16 bed Acute Assessment Inpatient Ward for people aged over 65 who have Mental Health problems and have been assessed as requiring inpatient care. The ward is mixed sex but has single sex ensuite accommodation on male and female corridors.

Crofton accepts admissions of service users with both functional and organic presentations and a significant number of service users over the past year have been admitted with either a working or confirmed diagnosis of dementia. Given the increase in dementia presentations there is a need for specific dementia training for the team.

Patient disability – Crofton

Disability	Total	%
Disability	6	4%
Disability status not given - patient refused	7	5%
Not disabled	107	75%
Not recorded	7	5%
Registered Disabled	16	11%
Total Patients	163	100%

Crofton serves people aged over 65 and disability would be expected to be high amongst this ward population. To address this and assess and meet the needs of the service users there is a dedicated ward-based therapy team of occupational therapists, physiotherapists, and activity facilitator. The nursing team also proactively care plan and support the individualised needs of service users.

Crofton do have access to audiology and specialist equipment to support people with their communication. We do not have signage in Braille or immediate access to e-books or pictorial literature, however, should any service user require these services we would be able to source them. The team use British Sign Language interpreters for service users who are hearing impaired. Care plans will be in situ outlining

support needs and support required. Service users with learning disabilities/difficulties will not be excluded.

The ward is a single storey purpose-built unit which makes access for wheelchairs and walking aids easy. The ward has one specially designed accessible ensuite bedroom and an accessible bathroom.

A range of moving and handling equipment is located on the ward to support service users with mobility needs, including a hoist and Elk cushion. Equipment is also available for the management of falls including chair and bed alarms, bedroom nurse call buttons and nurse call wrist bands. The therapy team (occupational therapists and physios) based on the ward and are very accessible to the service users and nursing team.

We also have an Advanced Clinical Practitioner on Crofton who can focus on the physical health care of the service users and we have close access to the local Acute hospital.

Staff disability – Crofton

Data table suppressed due to small numbers.

6.1.2 Poplars ward

The Poplars is a 12-bed inpatient unit for people usually aged over 65 with a diagnosis of Dementia. People on the unit can exhibit challenging behaviour and have been assessed as requiring inpatient care for assessment and treatment. The ward provides single sex sleeping accommodation with male and female corridors.

We are age sensitive and aim to provide safe transition for people leaving working age adult services and entering Older People Services. Some patients are under the age of 65 but will have a diagnosis of Dementia or Alzheimer's.

Individuals eligible to receive our service are predominantly residents in the Wakefield area and the catchment area of South West Yorkshire Partnership NHS Foundation Trust.

Patient disability – Poplars ward

Data table suppressed due to small numbers.

Poplars do have access to audiology and specialist equipment should this be needed to support people with their communication. We do not have signage in Braille or immediate access to e-books or pictorial literature, however, should any service user require these services we would be able to source them. The team use British Sign Language interpreters for service users who are hearing impaired. Care plans will be in situ outlining support needs and support required. Service users with learning disabilities/difficulties are also catered for.

The service operates from a single storey purpose-built unit. There are no barriers to anyone with physical problems within or outside the unit. We work continually to address all needs; however, we recognise that there are times when we need to secure other or outside specialist services to meet these needs.

The unit has 12 bedrooms all on one floor. The ward has disabled bathing and shower facilities. Access to specialist equipment through physiotherapy and occupational therapy can be accessed as and when required and these therapists are based at Poplars as part of the ward team.

All areas have wheelchair access being located on one level, including the entrance to the ward. The ward has several wheelchairs and a small stock of walking aids including sticks and frames for use if required. A range of moving and handling equipment is located on the ward including hoist and 12 profiling beds. The ward also has its own Elk cushion to aid with management of falls.

Staff disability – Poplars ward

Data table suppressed due to small numbers.

The percentage of Poplars staff who have a disability is in keeping with the population.

6.1.3 Ward 19 Dewsbury

The service provision is an acute inpatient ward for older people living with mental health issues, Kirklees. Ward 19 comprises 2 x 15 bedded wards, one male and one female, for the assessment and treatment of service users aged 65 years and over from predominantly the Kirklees area and the catchment area of Southwest Yorkshire Partnership NHS Trust. The ward has 2 self-contained inpatient areas as well as communal areas used predominantly for the provision of therapeutic activities, visiting areas and clinical meetings.

The ward caters for those service users who, through assessment of risk and mental health presentation, require 24-hour care and treatment. Ward 19 provides assessment, treatment, and therapeutic intervention with the emphasis on safety and individualised care.

Patient disability – Ward 19 Dewsbury

Patient- Disability data set 2022/23

Disability	Number	%
Not disabled	107	75.89%
Registered disabled	12	8.51%
Not recorded	11	7.80%
Disability NOS	6	4.26%
Status not given- patient refused	5	3.55%
TOTAL	141	100%

One bedroom on each ward is provided with a bariatric bed and commode. Access to specialist equipment through Physiotherapy and Occupational therapy i.e. wheelchair or toilet provision is also available.

There is a pack of audio books in the ward activity room for people with sight impairment, but the ward does not have information or signage in Braille and no access to eBooks, pictorial literature or facilities for the deaf such as a listening loop. Communication tools provided by the Speech and Language Therapists (from Mid-

Yorkshire Acute Hospitals Trust) enhanced communication with a service user who was unable to speak.

Physical health needs of all patients which may require hospital care e.g. A&E, can be accessed via the local acute service trust. We work closely with the acute trust on an individual basis to provide care and treatment in the most appropriate setting for service users who have both a physical illness and mental health needs.

On the ward, the nutritional requirements of service users will be addressed and adjusted for age, gender, activity, medical condition, disability and cultural needs. Those service users who have specific therapeutic, cultural or ethical dietary requirements (e.g., gluten-free, halal or vegan) will be provided for. Nutritional screening is routinely undertaken on admission to the ward and dietetic input is provided as required.

The service user's food likes/dislikes and specific dietary requirements will be checked on admission and recorded in the appropriate section of the service user's record by the ward staff.

Staff disability – Ward 19 Dewsbury

Staff- Disability data set 2022/23 (Male ward)

Data table suppressed due to small numbers.

Staff- Disability data set 2022/23 (Female ward)

Data table suppressed due to small numbers.

6.1.4 Beechdale ward

The service provision is an acute inpatient ward for older people living with mental health issues, based at the Dales Calderdale Royal Hospital Beechdale ward is a 16 bedded, mixed sex ward for the assessment and treatment of service users aged 65 years and over from predominantly the Calderdale area and the catchment area of South West Yorkshire Partnership NHS Trust.

The ward caters for those service users who through assessment of risk and mental health presentation require 24-hour care and treatment. Beechdale provides assessment, treatment, and therapeutic intervention with the emphasis on safety and individualised care.

Patient disability – Beechdale ward

Disability	Total	%
No	20	100%
Total Patients	20	100%

Access to specialist equipment through Physiotherapy and Occupational therapy i.e. wheelchair or toilet provision is also available.

Communication tools provided by the Speech and Language Therapists enhanced communication with a service user who was unable to speak.

Physical health needs of all patients which may require hospital care e.g. A&E, can be accessed via the local acute service trust. We work closely with the acute trust on an individual basis to provide care and treatment in the most appropriate setting for service users who have both a physical illness and mental health needs.

On the ward, the nutritional requirements of service users will be addressed and adjusted for age, gender, activity, medical condition, disability, and cultural needs. Those service users who have specific therapeutic, cultural, or ethical dietary requirements (e.g., gluten-free, halal or vegan) will be provided for. Nutritional screening is routinely undertaken on admission to the ward and dietetic input is provided as required.

The service user's food likes/dislikes and specific dietary requirements will be checked on admission and recorded in the appropriate section of the service user's record by the ward staff.

Staff disability – Beechdale ward

Data table suppressed due to small numbers.

Staff Disability Network is available for staff. Staff are encouraged to attend Occupational health appointments to be signposted to support groups to manage health conditions and disabilities.

6.2 Protected characteristic – gender

	Calderdale	Kirklees	Wakefield	Total	%
All Residents	206,631	433216	353370	993,217	
Male	100,730	212346	173831	486,907	49%
Female	105,901	220870	179539	506,310	51%

The population breakdown between females and males shows a mostly even split with slightly more women. There were 50.9% females and 49.1% males' resident in Barnsley, Calderdale (51.1% females and 48.9% males), Kirklees (50.6% females and 49.4% males) and Wakefield (50.9% females and 49.1% males). These figures do not reflect those who identity as non-binary or transgender which is also collected. At least half of women who are using mental health services have experienced some form of violence or abuse.[3] Staff are mindful of this when working with female service users and can access specialist advisor input from teams such as safeguarding, RRPI, and trauma informed care to inform care planning and patient centred interventions.

The table below shows the overall gender mix across all wards in the year 2022/2023:

	Female	Male
Functional	59%	41%
Organic	46%	54%
Grand Total	55%	45%

Considering data across the years more females than males required access to functional beds, ranging from 67 / 33% in Female / Male mix in 2017 to 49 / 51% in 2020. The dementia gender mix is more even, with slightly more males and a range from 42 / 58% in 2019 and 2022 through to 50 / 50% in 2015 and 2016.

6.2.1 Crofton ward

Patient gender- Crofton

Gender	Total	%
Male	69	48%
Female	74	52%
Total Patients	143	100%

The data for Crofton shows for 2021-2022 a balanced number of both male and females were admitted to the ward, which reflects the population.

Crofton provides mixed sex inpatient care with 8 designated male beds and 8 female beds on male and female corridors to offer privacy and dignity for both. There is also a designated female only lounge on the ward.

Staff Gender – Crofton

There are 24 staff members working on Crofton Ward 5 of these staff are male, 19 are female. To ensure patient gender needs are met, when needed staff resource from neighbouring wards will be utilised.

Gender	Total	%
Male	5	21%
Female	19	79%
Total	24	100%

6.2.2 Poplars ward

Patient gender – Poplars ward

Gender	Total	%
Male	21	55%
Female	17	45%
Total	38	100%

The data for Poplars shows a balanced number of both male and females were admitted to the ward, and this is similar figures to the population areas served by the ward.

Poplars provides mixed sex inpatient care with 6 designated male beds and 6 female beds, there is flexibility to adjust this depending on demand. The ward is divided into different areas so that a female and male corridor can offer privacy and dignity to service users of both genders. There is also a designated female only lounge on the ward as per the trusts Delivering same sex accommodation policy.

Staff gender – Poplars ward

There are 34 staff at Poplars, 3 of these staff are male, the rest are female. The number of female staff working on Poplars is significantly higher than the locality averages and is not representative of the patient gender profile. To ensure patient gender needs are met, staff resource from within other Wakefield inpatient wards at Unity Centre are utilised. There is also the ability to use both Trust Bank and external Agency staff to address resource needs, and male staff can be specifically requested through these sources.

6.2.3 Ward 19 Dewsbury

Patient gender – Ward 19 Dewsbury

Patient- Gender data set 2022/23

Gender	Total	%
Male	70	49.65%
Female	71	50.35%
Total	141	100%

Both wards have 15 bedrooms – none has en-suite facilities but there are a showers, bath and assisted bath on each ward, each with a toilet, as well as separate toilet facilities on each ward. Each ward has its own lounge and dining facilities.

There is a large central area which is used for therapeutic activities, such as movement and dance groups and a further 2 shared activity rooms which are used for individual and mixed groups. An individualised risk management and observation care plan is in place to continually assess for vulnerability or risk(s).

The off duty reflects a mix of male and female staff when available. However, the opportunity to provide same gender staff to service users is compromised due to the current establishment of male/female workers (1 male nurse on the male ward versus 12 female nurses and 6 males versus 8 female health care assistants).

Staff gender – Ward 19 Dewsbury

The current staff comprise of 7 males and 20 female staff who are either nurses or health care assistants. All occupational therapy staff are female as are the housekeeping, domestic and administrative staff. One male physiotherapist spends

some time each week on the ward and is available at that time to undertake assessments with individuals.

6.2.4 Beechdale ward

Patient gender – Beechdale ward Patient- Gender data set 2022/23

Gender	Total	%
Male	42	38.89%
Female	66	61.11%
Total	108	100%

The ward has 16 bedrooms – two with en-suite toilet and sink. All bedrooms are situated within three pods (one male, one female) a further pod is either male or female depending on service demand in accordance with CQC and MHA Code of Practice.

A shower room and two bathrooms sited on the main ward corridor are available but are now gender specific. Two gender specific lounges are available at the end of corresponding pods supplemented by two mixed gender communal lounges sited on the main ward corridor. An individualised risk management and observation care plan is in place to continually assess for vulnerability or risk(s).

The off duty reflects a mix of male and female staff with same sex staff being available to accompany service users for physical examination, intimate search, and observation.

Service users have the option of same sex carer staff e.g., nurses, health care assistants but is compromised as the number of male staff is less than the number of female staff. Overall, the ability to provide same gender staff to service users is compromised due to the current establishment of male/female workers.

Staff gender – Beechdale ward

Gender	Total	%
Male	5	21.70%
Female	18	78.30%
Total	23	100%

6.3 Protected characteristic – Age

Population ages of Barnsley, Calderdale, Kirklees, Wakefield:

	Calderdale	Kirklees	Wakefield	Total	%
All Residents	206627	433222	353375	993224	
Aged 4 years and under	11317	25,144	20,074	56535	5.69%
Aged 5 to 9 years	12803	27,647	20,994	61444	6.19%
Aged 10 to 15 years	15877	34,153	24,764	74794	7.53%
Aged 16 to 19 years	9038	21,328	13,933	44299	4.46%
Aged 20 to 24 years	10125	25,844	18,001	53970	5.43%

Aged 25 to 34 years	24920	54,869	48,974	128763	12.97%
Aged 35 to 49 years	39471	83,410	67,143	190024	19.13%
Aged 50 to 64 years	43769	84,012	72,882	200663	20.20%
Aged 65 to 74 years	21958	42,461	36,927	101346	10.20%
Aged 75 to 84 years	12688	25,146	22,110	59944	6.04%
Aged 85 years and over	4661	9,208	7,573	21442	2.16%

6.3.1 Crofton Ward

Patient age Crofton

Data table suppressed due to small numbers.

There were a small number of service users admitted who are younger than 65 years and this is either due to their clinical needs being best met on an older people's ward or because of bed unavailability within services. Where it is the latter, the service user is transferred to an adult ward bed as soon as possible.

Activities and facilities on the unit are age appropriate. Activities on the ward and patient satisfaction are routinely discussed during community meetings, which occur weekly with the input of the ward manager.

Staff age Crofton:

Data table suppressed due to small numbers.

The workforce has 2 staff members older than 65 years, however exact ages have not been disclosed.

6.3.2 Poplars ward

Patient age – Poplars ward

Data table suppressed due to small numbers.

Based on local admission data, service users admitted to Poplars are on average older than the average population ages of the district area. This would be expected given Poplars is an OPS ward for people aged 65 and over with a diagnosis of dementia. There has been a small number of service users admitted who are younger than 65 years and this is due to their clinical needs being best met on Poplars due to their diagnosis and presentation. Activities and facilities on the unit are age appropriate and dementia appropriate (e.g., reminiscence work, singing groups)

Staff age – Poplars ward

Data table suppressed due to small numbers.

The workforce is largely of working age, with 4 staff members older than 60 years, however exact ages have not been disclosed. The Trust is mindful that staff are choosing to work longer, and an older workforce may require consideration from a health and wellbeing perspective regarding initiatives and support to maintain them in employment.

6.3.3 Ward19 Dewsbury

Patient age – Ward 19 Dewsbury

Data table suppressed due to small numbers.

Staff- Age data set 2022/23 (Male side)

Data table suppressed due to small numbers.

Staff age – Ward 19 Dewsbury

Staff- Age data set 2022/23 (Female side)

Data table suppressed due to small numbers.

6.3.4 Beechdale ward

Patient age – Beechdale ward

Data table suppressed due to small numbers.

Staff age – Beechdale ward

Data table suppressed due to small numbers.

6.4 Protected characteristic - Sexual Orientation:

	Calderdale	Kirklees	Wakefield	Total	Percentage
All Residents	166632	346278	287538	800448	
Does not apply	0	0	0	0	0
Straight or Heterosexual	149815	311501	261615	722931	90.32
Gay or Lesbian	2811	4340	4321	11472	1.43
Bisexual	1968	3697	2968	8633	1.08
Pansexual	395	732	504	1631	0.2
Asexual	71	147	126	344	0.04
Queer	62	58	29	149	0.02
All other sexual orientations	22	61	30	113	0.01
Not answered	11488	25742	17945	55175	6.9

A 2020 Office for National Statistics report shows that 3.1% of the population identify as lesbian, gay or bisexual (LGBT). People aged 16 to 24 are more likely to identify as lesbian, gay or bisexual than any other age group (8%) and only 1.2% of the population aged 65 and over identify as lesbian, gay or bisexual. Source: Sexual orientation, UK – Office for National Statistics (ons.gov.uk) The Trust has a gold Rainbow tick- awarded in 2014 and has a LGBT+ staff network.

6.4.1 Crofton ward

Patient sexual orientation - Crofton **

Data table suppressed due to small numbers.

Staff sexual orientation - Crofton

Data table suppressed due to small numbers.

6.4.2 Poplars ward

Patient sexual orientation – Poplars ward

Data table suppressed due to small numbers.

Staff sexual orientation – Poplars ward

Data table suppressed due to small numbers.

6.4.3 Ward19 Dewsbury

Patient sexual orientation – Ward 19 Dewsbury

Patients- Sexual orientation data set 2022/23

Data table suppressed due to small numbers.

Staff sexual orientation – Ward 19 Dewsbury

Staff- Sexual orientation data set 2022/23 (Female side)

Data table suppressed due to small numbers.

Staff- Sexual orientation data set 2022/23 (Male side)

Data table suppressed due to small numbers.

6.4.4 Beechdale ward

Patient sexual orientation – Beechdale ward

Data table suppressed due to small numbers.

Due to the ward being a mixed ward staff make sure patients are safeguarded and made to feel safe whilst on Beechdale, Individualised risk assessments are completed on admission.

Staff sexual orientation – Beechdale ward

The ward has 40% of people not recorded for or sexual orientation unknown and 55% Heterosexual, staff.

6.5 Protected characteristic – faith and religion:

	Calderdale	Kirklees	Wakefield	Total	%
All Residents	206631	433216	353367	993214	
No religion	86,787	150599	145,949	383335	38.6
Christian	85,677	170577	173070	429324	43.23
Buddhist	630	996	797	2423	0.24
Hindu	1,173	1723	1270	4166	0.42
Jewish	153	187	127	467	0.05
Muslim	19,650	80046	11279	110975	11.17
Sikh	387	3476	501	4364	0.44
Other religion	1,045	1663	1402	4110	0.41
Not answered	11,129	23949	18972	54050	5.44

The 2011 Census saw an increase in the following faiths: Buddhist, Hindu, Muslim and Sikh, the largest increase was for Muslims which rose by 2% in 2001 to 7.3% in 2011. Like the national picture, Muslims continue to form the second largest practising faith in Barnsley, Calderdale, Kirklees and Wakefield.

Christians remain the largest faith in all 4 localities. Individuals declaring no religion ranges between 24% (Barnsley, Kirklees and Wakefield) to 28% (Calderdale). All service users have access to Pastoral and Spiritual Support through SWYPFT networks and this service is based on site at Fieldhead. Staff members will be encouraged to access spirituality awareness training and could access spirit in mind workshops.

6.5.1 Crofton ward

Patient religion and faith - Crofton

Data table suppressed due to small numbers.

Staff religion and faith - Crofton

Data table suppressed due to small numbers.

The presence of religious faith can often be associated with greater hope, increased sense of meaning in life, higher self-esteem, optimism, and life satisfaction.

To support the religious faith of service users and staff, there is access to a multi faith room located within the Unity Centre.

There is a weekly service held every Sunday and Crofton supports services users to attend if they wish. For those service users who do not have leave away from the ward, religious leaders can be arranged to visit the ward in person. A variety of information is displayed on the ward relating to spiritual needs, access to pastoral

care, and dietary needs. A Bible and Quran are both available on the ward, as well as prayer mats.

Mixed wards may also cause stress to female Muslims, but this is also disturbing to women patients of any faith. Where a service user had a strong preference for a female only ward, transfer to Ward 19 Female ward would be considered. The ward manager supports staff during religious holidays and celebration festivals (for example Eid) and is considerate of rota requests or temporary flexible agreements.

6.5.2 Poplars ward

Data to add

6.5.3 Ward19 Dewsbury

Data to add

6.5.4 Beechdale ward

Data to add

6.6 Protected characteristic – Race and ethnicity

	Calderdale	Kirklees	Wakefield	Total	%
All Residents	206,631	433213	353370	993,214	
Asian, Asian British or Asian Welsh	21,726	84202	12633	118,561	11.94
Black, Black British, Black Welsh, Caribbean or African	1,439	9948	4516	15,903	1.6
Mixed or Multiple ethnic groups	4,027	13588	4938	22,553	2.27
White	177,836	318969	328742	825,547	83.12
Other ethnic group	1,603	6506	2541	10,650	1.07

Barnsley, Calderdale, Kirklees, and Wakefield the populations have become more diverse since the 2001 Census. The white population has fallen slightly 96% (Barnsley), 89.6% (Calderdale), 79.1% (Kirklees) and 95.2% (Wakefield). In 3 geographical areas (Calderdale, Kirklees, Wakefield) Asian/Asian British: Pakistani is the largest non-white minority group. In Barnsley it is Black/African/Caribbean/Black British: African The growth seen in the White Other grouping is likely to reflect increased international migration, in part from the EU accession states in Central and Eastern Europe, the majority being from Poland and the Czech Republic.

Incidence of mental health issues in BME groups is complex according to a national report by the Alzheimer's association. It found that some Black groups have admission rates around three times higher than average. African-Caribbean people are particularly likely to be subject to compulsory treatment under the Mental Health Act. South-East Asian women are less likely to receive timely, appropriate mental health services, even for severe mental health conditions. There is little difference between white, Black and South Asian men in the rates of common mental health

issues. Rates of all common mental health issues are higher among South Asian women.

In 2011, there were 25,000 people with dementia from Black, Asian and minority ethnic (BAME) groups in England and Wales (Alzheimer's Society, 2012). This number is expected to double to 50,000 by 2026 and rise to over 172,000 by 2051.This is a nearly a seven-fold increase in 40 years, compared to just over a two-fold increase in the numbers of people with dementia across the whole UK population in the same period.

Despite this, the All-Party Parliamentary Group on Dementia has found that people from Black, Asian and minority ethnic backgrounds are less likely to receive a diagnosis or support. The number of people with dementia in England and in the areas SWYPT covers can be expected to rise in the upcoming decades, with the largest increase being in the prevalence of severe dementia. Kirklees is predicted to have the largest population with dementia compared to other SWYPT areas (7,543 by 2030)**.** Calderdale is projected to have the largest increase in the number of people diagnosed with dementia. Data sources: Projections of older people with dementia and costs of dementia care in the United Kingdom, 2019–2040 https://www.alzheimers.org.uk/sites/default/files/201940/cpec_report_november_2019.pdf

Gypsies and Travellers are nearly three times more likely to experience anxiety than average and just over twice as likely to be depressed. Women in these communities are twice as likely to experience mental health issues as men. This group is extremely vulnerable due to social exclusion, poor literacy levels, low life expectancy. They are also a high risk group in terms of self-harm and suicide (No health without mental health: a cross-government mental health outcomes strategy for people of all ages).

6.6.1 Patient ethnicity – Crofton

Patient ethnicity – Crofton ward

Data table suppressed due to small numbers.

Analysis of the last years equality dashboard data (2021/22) has identified that 95% of all admissions have been from White British backgrounds. This is an over-representation when compared to the most recent census for the Barnsley, Calderdale, Kirklees and Wakefield districts (2011)

Staff ethnicity – Crofton

Ethnicity	Total	%
White - British	26	100%
Total	26	100%

6.6.2 Poplars ward

Patient ethnicity – Poplars ward

Ethnicity	Total	%
White British	38	100%
Total Patients	38	100%

Analysis of the last years equality dashboard data (2021/22) has identified that 100% of all admissions have been White British. This is an over-representation when compared to the most recent census for the Barnsley, Calderdale, Kirklees and Wakefield districts (2011).

Staff ethnicity – Poplars ward

Staff data is comparable to local census data. The Trust's Staff wellbeing survey results showed that, staff from black, Asian, minority ethnic backgrounds were subject to high levels of racial abuse from service users/carers and from colleagues.

The Ward Manager is proactive in supporting staff who are subject to racial abuse, including checking on their well-being post incident, linking with Equity Guardians and supporting staff to report incidents of hate crime to the police.

6.6.3 Ward19 Dewsbury

Patient ethnicity – Ward 19 Dewsbury

Data table suppressed due to small numbers.

Several members of the nursing team speak community languages and they have acted as an interpreter on a number of occasions. Interpreting services are used as required to facilitate assessments and clinical meetings.

Staff ethnicity – Ward 19 Dewsbury

Staff- Ethnic origin data set 2022/23 (Male side)

Data table suppressed due to small numbers.

Staff- Ethnic origin data set 2022/23 (Female side)

Data table suppressed due to small numbers.

6.6.4 Beechdale ward

Patient ethnicity – Beechdale ward

Data table suppressed due to small numbers.

Staff ethnicity – Beechdale ward

Data table suppressed due to small numbers.

6.7 Carers

	Calderdale	Kirklees	Wakefield	Total	%
All Residents	206,631	433216	353370	993,217	
Does not apply	11317	25144	20074	56,535	5.7
Provides no unpaid care	177337	371038	301565	849,940	85.57
Provides 9 hours or less unpaid care a week	6740	13352	9731	29,823	3
Provides 10 to 19 hours unpaid care a week	2453	5165	4137	11,755	1.18
Provides 20 to 34 hours unpaid care a week	1730	3588	3085	8,403	0.85
Provides 35 to 49 hours unpaid care a week	2070	4220	3917	10,207	1.03
Provides 50 or more hours unpaid care a week	4984	10709	10861	26,554	2.67

Carers have the right to a Carer's needs assessment under the Carer's (Recognition and Services) Act 1995, and the Carers and Disabled Children Act 2000. There are over 260,000 carers in the West Yorkshire STP area, more than the number of staff employed in Health and Social Care system. It is estimated they save the health and social care budget around £6 billion a year. 1 in 8 adults are currently providing unpaid care and over 2 million people each year take on a caring role for a loved one or friend.

Just over a quarter (26%) of people who have no experience of caring think it is likely that they will take on the role of a career in the future. Of those who are not currently carers there is a marked difference between male and female expectations with 24% of men thinking it is likely they will become a carer compared with 32% of women. (*Taken from Carers Trust UK report)*

Some staff may have additional caring responsibilities outside of work and which can be reflected in (for example) flexible working patterns and by allowing agreed time to attend meetings or care reviews, in line with the Trust Policy for Granting Special Leave.

The staff carers' passport provides a framework for staff to have a meaningful conversation with their manager about caring responsibilities and is promoted by Ward Managers to enable discussions around support and flexibility, balancing the

staff carer needs with the needs of the service. The Trust has also recently launched a Carer contact form on System One to promote and capture carer engagement and needs. As this is a new form, it will require promotion within the staff team to increase awareness and usage.

7. Summary of identified impacts for all protected groups that have been used to inform the options

We know that there is clinical evidence to support changes in models of care for having separate in-patient beds for patients with functional and organic (dementia) groups, based on clinical best practice, advice from the Joint Commissioning Panel, feedback from staff and wider engagement.

We also know there are real opportunities in enhancing both wards to create spaces that are more dementia friendly and better provide for the cultural and pastoral needs of all patients, carers and patient's loved ones in line with service improvements.

The Clinical Senate also commended the way in which options have been developed and acknowledged this will significantly improve the care of older adults with both organic and functional mental health needs.

To fully understand the impact on protected groups and to demonstrate our public sector equality duty, the information for each strand has been both iterative and emergent. Initially the understanding for each service area came from the existing Equality Impact Assessments. These impacts identified by each service for the protected groups identified created a baseline of intelligence. An EIA has been developed at each stage of the programme to inform the next steps. This includes findings from the engagement process and a literature review. The Clinical Senate also identified impacts in an independent report. This is available as an appendix of the pre consultation business case for the inpatient transformation.

From all this information the known impacts are documented below. These impacts have already been considered as part of the options development in the outline business case, these are:

7.1 Disability:

- Physical access to estates and built environments:
    - Parking bays
    - Access to public transport
    - Ease of access into buildings
    - Visitor areas
    - Accessible toilets
    - Adult changing toilets
- Considering hidden disabilities such as promote the sunflower scheme.
- Different types of seating and access:
    - Designated wheelchair seating areas

    - Wider doorways and fewer heavy doors
    - Automatic doors with ramps rather than stairs
- Accessible lifts, signs and reception areas at visible heights
- Sensory impairment such as people who are deaf, hard of hearing, blind or partially sighted.

7.2 Gender
- Access to single sex wards
- Access to same sex clinician/staff,
- Tailored activities
- Considerations for people who identify as non-binary.

7.3 Age
- Impact on people aged 65 and over. Some consideration of impact on those under the age of 65 who require care, consideration of activities / environment.
- A diverse range of age-appropriate communications in alternative formats
- Digital should not be the sole means of information / communication / contact for families and carers.
- Estates and environment design enable independence and safe and easy access for older people / frailty.
- Consideration for sensory impairment – sight and hearing using adaptions to environment / signage / loop system / large print information.

7.4 Sexual orientation considerations include:
- Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe.
- Visible symbols (such as the NHS Rainbow Badge, and/or use of badges and lanyards)

7.5 Faith, religion or belief considerations include:
- Access to faith and prayer rooms (including staff)
- Ensuring parity of pastoral support for all faiths on inpatient wards

7.6 Race and ethnicity considerations include:
- Addressing barriers of access – culturally appropriate environments, food and activities.
- Faith and religious needs considered in built environments and through décor.
- Reflective workforce, who are culturally and spiritually competent.
- Access to an interpreter and translation materials.
- Appropriate toilet facilities and consideration of bathing preferences.

7.7 Carer considerations include:
- Travel, particularly for older carers and those with other caring responsibilities – including functional patients accessing care.
- Staff at all units who can identify and support carers.
- Voluntary and other support organisations / community groups that signpost to and support patients around the service.
- Visiting times and contact arrangements

- Estates and facilities – canteen, waiting/communal areas.

7.8 Gender reassignment considerations include:
- Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors.
- Considering environments such as ward allocation, privacy, gender neutral facilities in line with trust policy and additional support through advocacy.
- Considering how, for transgender people, how issues surrounding gendered wards can lead to poor experiences of care.

7.9 Maternity and pregnancy considerations include:
- Managing additional caring responsibilities
- Ensuring flexibility for visiting times.
- Facilities are accommodating to visitors (for example parent access to changing facilities).

7.10 Marriage and civil partnership considerations include:
- Travel for partners to visit.
- Visiting times and contact arrangements
- Estates and facilities – canteen, waiting/communal areas.

8. Travel, transport, and parking

We know that one of the main impacts of any changes to the model will relate to travel, transport, and parking. As the Trust is based across the geography of Barnsley, Calderdale, Kirklees, and Wakefield the impact on staff, family and carers will need to be considered fully through formal consultation.

We have internally done some travel analysis using data from 2018/19 to 2021/22. The results are in appendix 8 of the pre consultation business case, the detail below describes what we found and how it has the potential to impact on inpatients, carers, families, friends and visitors. The data was based on individual patient postcodes and used the postcode of the patient prior to admission, the postcode of the ward they stayed in and compared this to the ward they were likely to stay in in each option. More information on the methodology is also in the travel and transport appendix.

We know from the data that for some people there could be a positive impact. This is because already approximately 30% of admissions to older people's beds are outside of the home locality and people, for example, with functional needs in Calderdale would be very likely to be admitted to their local ward in a new model.

	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 2014 to 2022):

CKW	**1**	**2+**	**Total**
functional	**1394**	**324**	**1718**
2013/2014	206	36	242
2014/2015	170	50	220
2015/2016	168	36	204
2016/2017	147	28	175
2017/2018	134	31	165
2018/2019	118	38	156
2019/2020	146	37	183
2020/2021	160	31	191
2021/2022	145	37	182
Dementia (organic)	**628**	**410**	**1038**
2013/2014	125	34	159
2014/2015	110	57	167
2015/2016	80	57	137
2016/2017	69	52	121
2017/2018	55	47	102
2018/2019	50	41	91
2019/2020	41	48	89
2020/2021	43	32	75
2021/2022	55	42	97
Grand Total	**2022**	**734**	**2756**

There is provision of parking at all wards, and all have different levels of access by public transport. Most of the parking available will cost visitors, except for Crofton ward at Fieldhead and the Poplars. There is accessible parking at each site, but this is limited.

Both sites are based out of a town centre location and are not in walking distance from local transport hubs. There are bus networks operating to both sites, but frequency and times will need to be considered as part of visiting hours to ensure access.

The Trust recognises the importance in providing accessible services for families and carers to care and support older people in hospital of being able to be visited regularly by their family and carers. To determine the support, we could provide and would consider:

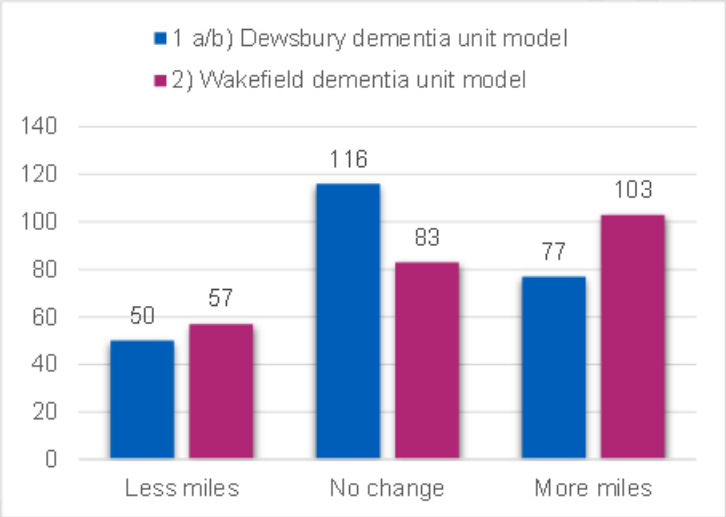
- Mobility issues.
- Journey time.

- Number of transport changes needed to complete the journey.
- Physical, sensory, or mental health problems that make travelling by public transport difficult.
- Personal safety considerations, including travelling after dark.

Currently in situations where a journey is agreed as significantly more complex, **a total journey time of 45 minutes or more the** care co- coordinator will determine with the carer how the Trust might support the individual to maintain their visiting arrangements. This might include the provision of taxis, payment towards parking costs or provision of hospital transport. The transport arrangements will be reviewed regularly by the ward team and the carer throughout the patients stay.

8.1 Driving distance

Mean change per year: Inpatient activity (discharge ward):



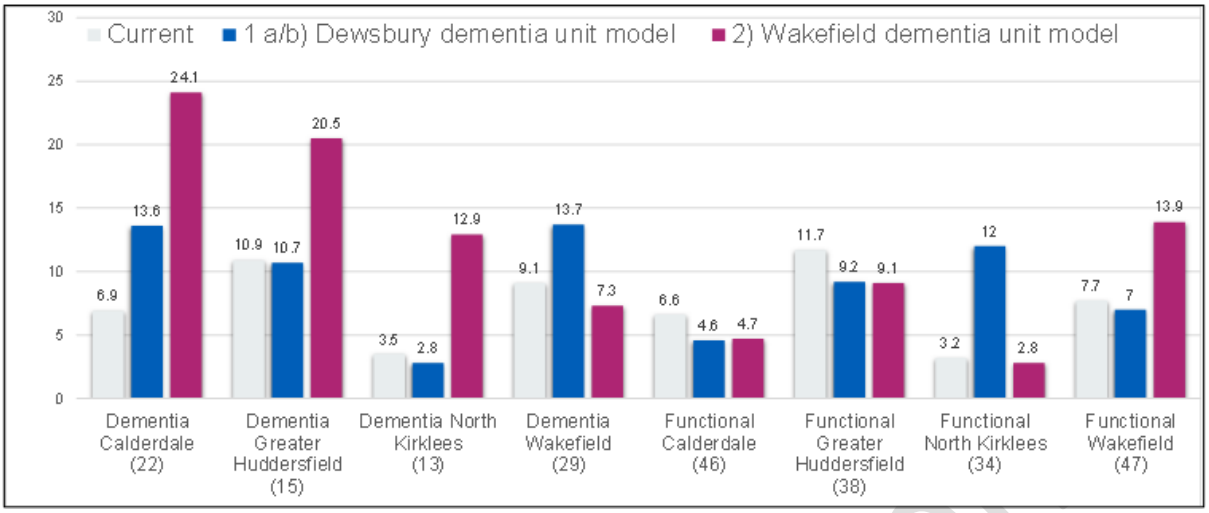
Considering individual stays and based on the discharge ward, in a model where the dementia unit was based in Dewsbury District Hospital as outlined in the **proposed Option 1 (see section 4.1)** it would mean:

- 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 Fieldhead Hospital Wakefield as outlined in **proposed Option 2 (see section 4.2)** it would mean:

- 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.

The following chart shows the average driving distance based on inpatient activity (discharge ward):



If the proposed dementia unit were Option 1: 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 proposed dementia unit were Option 2: Wakefield:

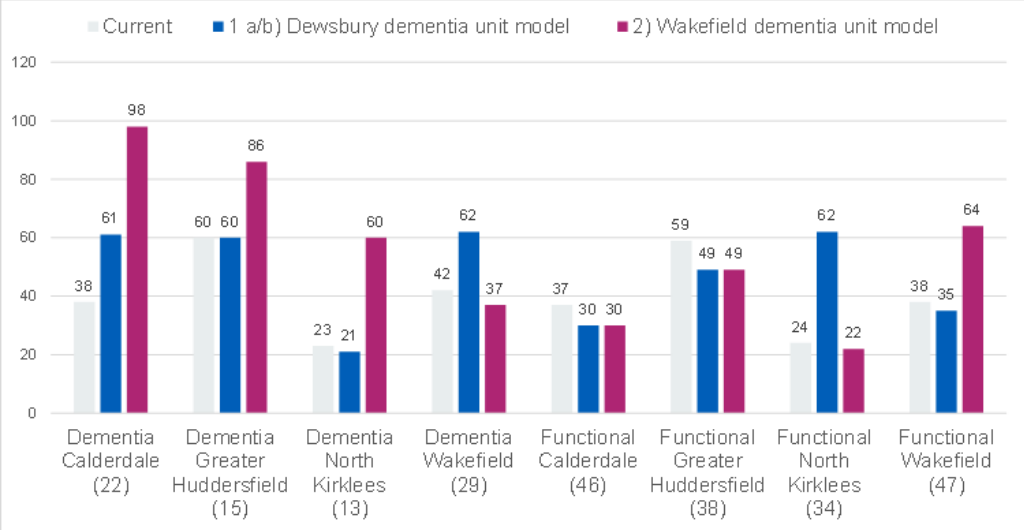
- The longest average travel distances would be people with dementia from Calderdale (22 people per year) and Greater Huddersfield (25 people) with 24- and 21-mile average journeys respectively.
- 46 Functional admissions from Wakefield would have an average 14-mile journey from their home and 13 dementia admissions from North Kirklees would average 13 miles.

In both models some people would have less distance to travel though this is likely to happen because 30% of people are currently admitted outside of their local area – patient and public insight.

8.2 Public Transport

We know that for many people the impact of increased journey times may be further complicated by public transport. Not all public transport will offer a direct route to a service with some populations having to travel further and make numerous changes. In addition, we know that all wards are not close to central terminals for public transport, but most have frequent bus services.

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

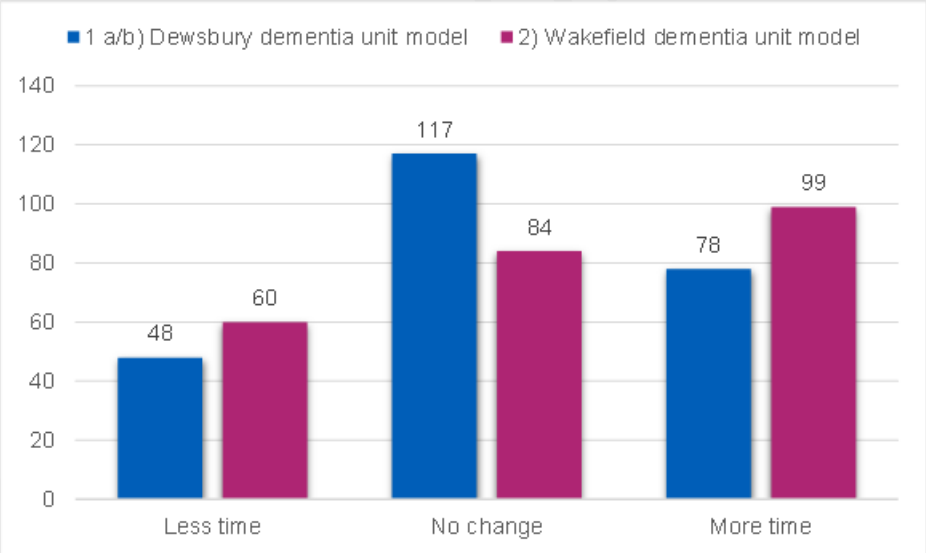
The following gives more of an indication of what some of the journey may be like (taken from WY Metro website journey planner 2022 to arrive at destination at 1630):

	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

	Day of travel	Dewsbury Hospital	Pinderfields Hospital (sited near Fieldhead)	Calderdale Royal
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
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

	Day of travel	Dewsbury Hospital	Pinderfields Hospital (sited near Fieldhead)	Calderdale Royal
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	37minutes via 1 bus	136 minutes via 2 trains & 2 buses

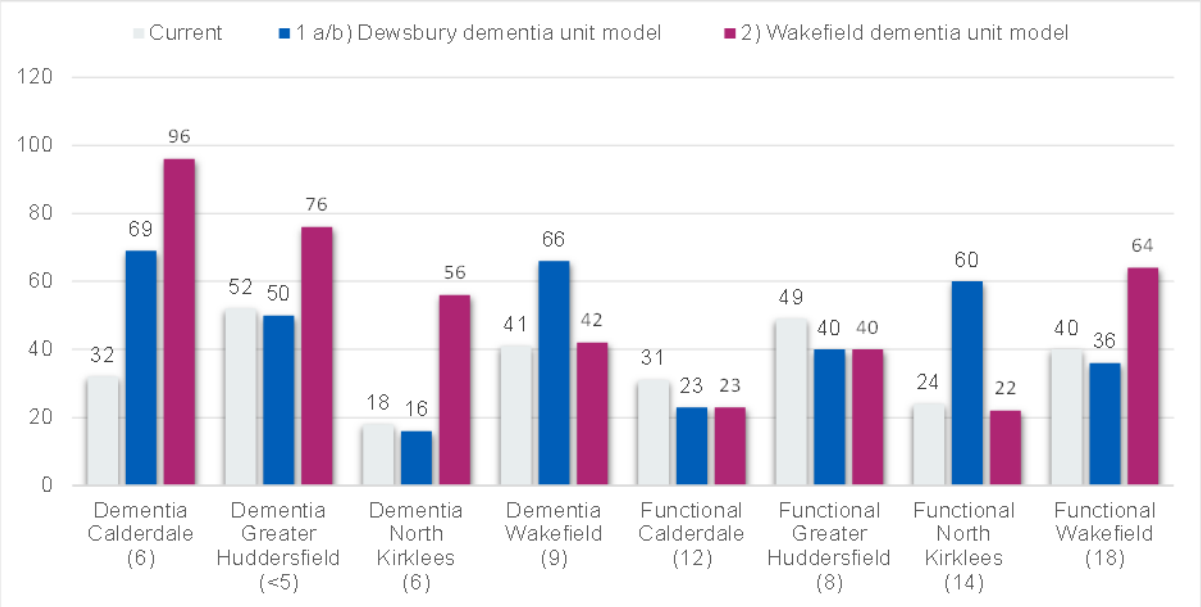
Set out below is the summary of numbers of people that would have shorter or longer public transport journeys based on the proposed options:



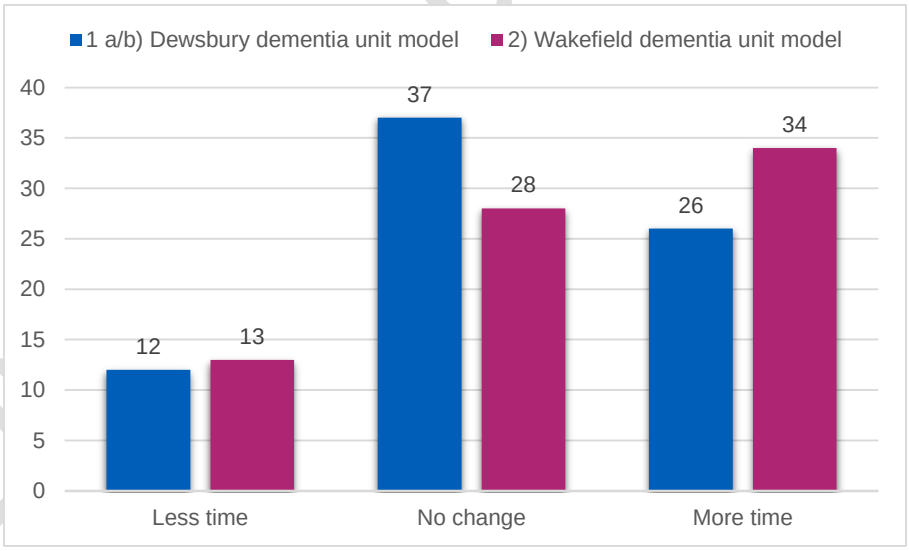
Overall, there would be an average of around **80 people per year that would have a longer journey with a dementia unit being in Dewsbury whilst around 100 people per year would have a longer journey to Wakefield.**

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

Analysis of impact on the 20% most deprived areas will be an important factor in ensuring we do not create an inequality. The following diagram 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.



Public transport – numbers of people that are positively or negatively impacted per year:



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 would be:

- **Proposed option 1 (see 4.1)** - Whilst not as high travel times there are still several significant typical (one hour plus) journeys for people travelling to a model with a proposed dementia unit in Dewsbury, including people from

Calderdale, Great Huddersfield and Wakefield, plus functional admissions from North Kirklees.

- **Proposed option 2 (see 4.2) -** 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.

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.

There are 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.

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.

8.3 Parking charges

The table below summarises the parking charges of each site (as of December 2022). The information clearly shows that whilst charges apply to site in Calderdale and Kirklees, that Wakefield sites offer free parking.

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

8.4 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, overall, more people would have to travel further than if the dementia unit were in Dewsbury.

In the Dewsbury (W19) dementia model option, 1a and 1b) there are on average 80 people a year who must travel further than now. In the Wakefield dementia model, option 2, there would be around 100 people per year with further travel. 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. Calderdale residents travelling under proposed Option 2 Crofton at Fieldhead would have much longer journeys, particularly those who would rely on public transport. They would have on average around 60 minutes travel to Dewsbury and 100 minutes to Wakefield.

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

When considering the 20% most deprived areas, findings highlight:

- Around 25-35 people per year would have further to travel because of the proposed 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 for 'Option 2'- proposed Dementia unit at Fieldhead Hospital, Wakefield, but the gap is more limited because 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 'Option 1' proposed dementia unit at Dewsbury District hospital 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, overall, would not face exceptionally long journeys.

8.5 Travel and transport considerations

The table below summarises the themes and potential solutions that were raised in relation to travel impact across the model:

Themes:	**Possible solutions for travel and transport:**
• The impact of travel for both patients and their carers. • Car parking at Dewsbury and how much consultation has been carried out on patient/carers transport times.	• Reimbursement of travel costs. • Community transport solutions • Door to door transport solutions • Guidance and help for people finding their way to a new unit. • Buddy systems • Taxi support

• Age of people that need to travel. • Long and complex public transport journeys from parts of the Trust footprint. • Unreliability of public transport. • Needs of differing ethnic groups including language and cultural needs. • Impact on services required to support changes across new boundaries (LA, pharmacy). • Implications for people that still need to access the service from Barnsley. • Choice and potential access to beds in another Trust if that is closer. • Supporting people back home when they're admitted outside of their local area.	• Using technology for some virtual contact • Shuttle busses • Integrated discharge from hospital • Using local transport systems in the most appropriate way • Admitting to a neighbouring Trust if closer / more accessible.

8.6 Travel, transport, and parking conclusion

More family and carers will have further to travel and greater travel times if a new proposed model is implemented. The negative impact is greater in the options where the dementia unit is in Option 2: Wakefield compared to Option 1: Dewsbury, however consideration should be made to the fact that the Wakefield option does offer free parking.

9. Impact by geographical location

9.1 Impact by geographical location of 'Option 1': proposed specialist dementia unit at Dewsbury District Hospital

The table below summarises the overall expected impact of option 1 for functional patients per year, both in terms of numbers of people and the overall population impacted.

	Functional Closer	Functional Same	Functional Further	GP practice population total 65+ (2016)	Functional Closer (% of pop'n)	Functional Same (% of pop'n)	Functional Further (% of pop'n)
Calderdale	9	148	0	37,165	0.02%	0.40%	0.00%
Greater Huddersfield	27	2	8	41,160	0.07%	0.00%	0.02%

North Kirklees	0	1	33	29,330	0.00%	0.00%	0.11%
Wakefield	3	44	0	64,896	0.00%	0.07%	0.00%
Total	39	195	41	172,551	0.02%	0.11%	0.02%

The table below summarises the overall expected impact of option 1 for dementia patients per year, both in terms of numbers of people and the overall population impacted.

	Dementia Closer	Dementia Same	Dementia Further	GP practice population total 65+ (2016)	Dementia Closer (% of pop'n)	Dementia Same (% of pop'n)	Dementia Further (% of pop'n)
Calderdale	0	5	16	37,165	0.00%	0.01%	0.04%
Greater Huddersfield	1	13	0	41,160	0.00%	0.03%	0.00%
North Kirklees	1	12	0	29,330	0.00%	0.04%	0.00%
Wakefield	9	1	19	64,896	0.01%	0.00%	0.03%
Total	11	31	35	172,551	0.01%	0.02%	0.02%

Using the most recent inpatient spell data and GP practice population totals for those people aged 65+, a dedicated specialist dementia ward in Dewsbury would negatively impact on inpatient spells from **Calderdale and Wakefield ,with 0.04% of the Calderdale population and 0.03% Wakefield population having to travel further** to receive a specialist dementia service. In addition, **0.11% of North Kirklees and 0.02 of Greater Huddersfield spells for functional care would be negatively impacted.**

9.2 Impact by geographical location of 'Option 2': proposed specialist dementia unit at Fieldhead Hospital, Wakefield

The table below summarises the overall expected impact of option 2 for functional patients per year, both in terms of numbers of people and the overall population impacted.

	Functional Closer	Functional Same	Functional Further	GP practice population total 65+ (2016)	Functional Closer (% of pop'n)	Functional Same (% of pop'n)	Functional Further (% of pop'n)
Calderdale	25	38	0	37,165	0.07%	0.10%	0.00%
Greater Huddersfield	32	3	10	41,160	0.08%	0.01%	0.02%
North Kirklees	4	36		29,330	0.01%	0.12%	0.00%
Wakefield	7	9	46	64,896	0.01%	0.01%	0.07%
Total	68	86	56	172,551	0.04%	0.05%	0.03%

The table below summarises the overall expected impact of option 2 for dementia patients per year, both in terms of numbers of people and the overall population impacted.

	Dementia Closer	Dementia Same	Dementia Further	GP practice population total 65+ (2016)	Dementia Closer (% of pop'n)	Dementia Same (% of pop'n)	Dementia Further (% of pop'n)
Calderdale	0	3	30	37,165	0.00%	0.01%	0.08%
Greater Huddersfield	0	1	15	41,160	0.00%	0.00%	0.04%
North Kirklees	1	1	14	29,330	0.00%	0.00%	0.05%
Wakefield	18	27	8	64,896	0.03%	0.04%	0.01%
Total	19	32	67	172,551	0.01%	0.02%	0.04%

Using the most recent inpatient spell data and GP practice population totals for those people aged 65+, a dedicated specialist dementia ward in Wakefield would negatively impact admissions from **Calderdale and Kirklees with 0.08% of the Calderdale population, 0.04% of Greater Huddersfield and 0.05% of the North Kirklees population having to travel further** to receive a specialist dementia service. In addition, **0.07% of Wakefield admissions for functional would be negatively impacted.**

10. Workforce impact

The main expected **impact for staff on these proposals will be for those working in Poplars**. A proposed change would result in staff having to travel to the nearest ward. The travel impact for these staff has been calculated and whilst the numbers remain small some staff will be impacted by longer travel times, whilst others may be closer to Fieldhead sit in Wakefield. **There will be limited impact of the proposals on the remainder of the workforce** as the proposal will retain and maintain at least current workforce levels, with staff able to remain in designated local wards. Opportunities will be explored through consultation for staff to move wards if they wish to work in a specific specialism.

11. Impacts for all protected groups

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
Age • Impact on those under the age of 65 who require care, consideration of activities/environment.	**Option 1a**	Functional patients will have access to ensuite facilities in Wakefield.	No ensuite toilet and bathroom for dementia patients,	Currently the service supports all age admissions for both dementia and functional patients.

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
• A diverse range of age-appropriate communications in alternative formats • Digital should not the sole means of information /communication/contact • Estates and environment design enable independence and safe and easy access for older people/frailty. • Consideration for sensory impairment – sight and hearing using adaptions to environment/ signage/loop system/large print information	**Option 1b**	Functional patients will have access to ensuite facilities in Wakefield.	No ensuite toilet and bathroom for dementia patients,	Currently the service supports all age admissions for both dementia and functional patients.
	Option 2	Dementia patients will have access to ensuite facilities in Wakefield.	Only 2 en suite bedrooms across the 46 functional beds in this model.	Currently the service supports all age admissions for both dementia and functional patients.
	All options	All ward environments are set up to support the needs of frail and elderly patients, hand rails, colour contrast and flooring. Separating dementia and functional patients may have a positive impact on patients of all ages as the environments are set up to support clinical need.	Older visitors may find it harder to visit/ have contact with dementia and functional patients who are placed out of the local area.	Activities for both functional and dementia patients are targeted and there are opportunities to offer age-appropriate offers.
Gender • Access to same sex clinician/staff, • Tailored activities • Considerations for people who identify as non-binary	**Option 1a**	Gender specific wards in Kirklees for dementia patients Gender specific functional ward in Wakefield	Calderdale residents would have to travel to Wakefield rather than Kirklees (or Wakefield) if they preferred a gender specific ward for functional patients.	Mixed gender ward would remain in Calderdale.
	Option 1b	Gender specific wards in Kirklees for dementia patients	There would be no offer of a Gender specific functional ward in Wakefield	Mixed gender ward would remain in Calderdale.
	Option 2	Gender specific dementia ward in Wakefield Gender specific functional ward in Kirklees.		Mixed gender ward would remain in Calderdale. Calderdale residents would have to travel to Kirklees if they preferred a gender specific ward for functional patients.
	All options	A range of activities and Occupational health interventions cater for gender.		Workforce is currently a mix of male/ female/ non binary staff. Single sex accommodation guidance would be fully met in options where wards are mixed gender.

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
Carer • Travel, particularly for older carers and those with other caring responsibilities. • Staff at all units identify and support carers. • Voluntary and other support organisations / community groups that signpost to and support patients around the service. • Visiting times and contact arrangements • Estates facilities for carers	**Option 1a**	Carers who live in North Kirklees will always have relatives with dementia admitted in the local area. Some patients with functional needs in Wakefield and Calderdale are currently admitted outside of locality. They are much more likely to be admitted locally in the new model. Data shows that around 48 carers per year would have a shorter travel time in this model than they currently have Carers from Wakefield visiting dementia patients in Dewsbury can use the hospital shuttle bus to support visiting.	Carers who live in Calderdale and Wakefield who have relatives with dementia needs will have to travel out of area. Carers in North Kirklees will have to travel out of area for patients with a functional need. Wakefield carers will now have to pay for parking to visit patients with dementia.	Calderdale carers will continue to pay for parking to visit a patient.
	Option 1b	Carers who live in North Kirklees will always have relatives with dementia admitted in the local area. Some patients with functional needs in Wakefield and Calderdale are currently admitted outside of locality. They are much more likely to be admitted locally in the new model. Data shows that around 48 carers per year would have a shorter travel time in this model than they currently have Carers from Wakefield visiting dementia patients in Dewsbury can use the hospital shuttle bus to support visiting.	Carers who live in Calderdale and Wakefield who have relatives with dementia needs will have to travel out of area. Carers in North Kirklees will have to travel out of area for patients with a functional need. Wakefield carers will now have to pay for parking to visit patients with dementia.	Calderdale carers will continue to pay for parking to visit a patient.
	Option 2	Carers of people with dementia in Wakefield will have relatives with dementia admitted in the local area. Some patients with functional needs in Kirklees and Calderdale are currently admitted outside of locality. They are much more likely	Carers who live in Calderdale and Kirklees who have relatives with dementia needs will have to travel out of area. Carers in Wakefield will have to travel out of area for	Calderdale carers will continue to pay for parking to visit a patient.

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
		to be admitted locally in the new model. Data shows that around 60 carers per year would have a shorter travel time in this model than they currently have. Carers from Wakefield visiting functional patients in Dewsbury can use the hospital shuttle bus to support visiting.	patients with a functional need. Wakefield carers will now have to pay for parking to visit patients with functional needs.	
	All options	Dedicated space for visitors – gardens and grounds in all locations – Calderdale, Kirklees, and Wakefield. All locations have a restaurant or canteen – offering food and refreshments.	Carers in all local areas will have some sort of travel impact. At the present time services are available in local areas for both dementia and functional patients.	Identification of carers is embedded as a Trust approach and a carer's passport offered.
Race and ethnicity • Addressing barriers of access – culturally appropriate environments, food and activities. • Faith and religious needs considered in built environments and through décor. • Reflective workforce, who are culturally and spiritually competent. • Access to an interpreter and translation materials. • Appropriate toilet facilities and consideration of bathing preferences.	**Option 1a**	Dementia patients in Kirklees will have male and female only spaces – supporting cultural considerations. Functional patients in Wakefield will have male and female only spaces supporting cultural considerations.	Dementia patients in Kirklees will have to share toilet and bathing facilities which may make it harder to support cultural practices.	Catering arrangements for Kirklees and Wakefield are provided by the Trust catering team. The team have worked closely with our nutrition team to provide culturally appropriate foods – including foods that celebrate the faith calendar.
	Option 1b	Dementia patients in Kirklees will have male and female only spaces – supporting cultural considerations.	Dementia patients in Kirklees will have to share toilet and bathing facilities which may make it harder to support cultural practices.	Functional patients in Wakefield will remain mixed with some male and female spaces such as lounges. Catering arrangements for Kirklees and Wakefield are provided by the Trust catering team. The team have worked closely with our nutrition team to provide culturally appropriate foods – including foods that celebrate the faith calendar.
	Option 2	Dementia patients in Wakefield will have male and female only spaces – supporting cultural considerations.	Functional patients in Kirklees will have to share toilet and bathing facilities which may make it harder to support cultural practices.	Catering arrangements for Kirklees and Wakefield are provided by the Trust catering team. The team have worked closely with our nutrition team to provide culturally

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
		Functional patients in Kirklees will have male and female only spaces – supporting cultural considerations.		appropriate foods – including foods that celebrate the faith calendar.
	All options	The Trust have a translation and interpretation service. All wards have neutral décor and patients have their own large room which can accommodate personal possessions.	Calderdale catering arrangements are part of Calderdale Royal Hospital which means the Trust have less influence on the catering arrangements.	Functional wards in Calderdale will remain the same. Functional patients in Calderdale will continue to share toilet and bathing facilities which makes it harder to support cultural practices.
Gender reassignment • Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors. • Considering environments such as ward allocation, privacy, gender neutral facilities in line with trust policy and additional support through advocacy. • Considering how, for transgender people, how issues surrounding gendered wards can lead to poor experiences of care.	**Option 1a**	Mixed gender functional ward in Calderdale will mean a mixed gender environment. Wakefield has en-suite facilities ensuring privacy and dignity.	Separation of male and female wards in Kirklees and Wakefield could result in a patient being incorrectly placed. Kirklees dementia services will only be able to offer gender specific environments. Kirklees dementia patients will have to share bathrooms and toilet facilities – dignity and privacy compromised.	
	Option 1b	Mixed gender functional ward in Calderdale will mean a mixed gender environment. Mixed gender functional ward in Wakefield will mean a mixed gender environment. Wakefield has ensuite facilities ensuring privacy and dignity.	Separation of male and female wards in Kirklees and Wakefield could result in a patient being incorrectly placed. Kirklees dementia services will only be able to offer gender specific environments, Kirklees dementia patients will have to share bathrooms and toilet facilities – dignity and privacy compromised.	
	Option 2	Mixed gender functional ward in Calderdale will mean a mixed gender environment. Wakefield dementia patients ensuite facilities ensure privacy and dignity.	Separation of male and female wards in Kirklees and Wakefield could result in a patient being placed in a gender specific environment. Wakefield dementia services will only be able to offer gender specific environments. Kirklees functional services will only be able to offer	No change for functional patients in Calderdale.

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
			gender specific environments. Only 2 ensuite bedrooms in functional model would mean careful management required to ensure privacy and dignity.	
	All options	The Trust has a transgender policy for both staff and people who use services.		
Sexual orientation • Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe • Visible symbols (such as the NHS Rainbow Badge, and/or use of badges and lanyards)	**Option 1a**	Wakefield has many visible symbols – a flag, crossing and hut painted in the rainbow flag.	There are no visible estate symbols in Dewsbury and Calderdale.	
	Option 1b	Wakefield has many visible symbols – a flag, crossing and hut painted in the rainbow flag.	There are no visible estate symbols in Dewsbury and Calderdale.	
	Option 2	Wakefield has many visible symbols – a flag, crossing and hut painted in the rainbow flag.	There are no visible estate symbols in Dewsbury and Calderdale.	
	All options	All staff can wear visible symbols such as rainbow lanyards and badges.		
Religion or belief • Access to faith and prayer rooms (including staff) • Ensuring parity of pastoral support for all faiths on inpatient wards	**Option 1a**		The prayer room for dementia patients in Kirklees is not located on the ward. There is no dedicated space for a prayer room for functional patients in Wakefield.	The prayer room for functional patients in Calderdale is accessible on request. And for Wakefield there is no designated space.
	Option 1b		The prayer room for dementia patients in Kirklees is not located on the ward. There is no dedicated space for a prayer room for functional patients in Wakefield.	The prayer room for functional patients in Calderdale is accessible on request. And for Wakefield there is no designated space.
	Option 2		The prayer room for functional patients in Kirklees is not located on the ward. There is no dedicated space for a prayer room for dementia patients in Wakefield.	The prayer room for functional patients in Calderdale and Kirklees is accessible on request.

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
	All options	Faith calendar in place supports celebrations – visual symbols.	Not all wards have dedicated or accessible prayer room.	
Maternity and pregnancy • Managing additional caring responsibilities • Ensuring flexibility for visiting times. • Facilities are accommodating to visitors (for example parent access to changing facilities).	**Option 1a**	Parents/ expectant parents who live in North Kirklees will definitely have relatives with dementia admitted in the local area. Some patients with functional needs in Kirklees and Calderdale are currently admitted outside of locality. They are much more likely to be admitted locally in the new model meaning any parents/ expectant parent are more likely to have local travel.	Parents/ expectant parents who live in Calderdale and Wakefield who have relatives with dementia needs will have to travel out of area. Parents/ expectant parents in North Kirklees will have to travel out of area for patients with a functional need. Wakefield parents/ expectant parents will now have to pay for parking to visit patients with dementia.	Parents/ expectant parents from Calderdale will continue to pay for parking to visit a patient. Parents/ expectant parents from Wakefield visiting dementia patients in Dewsbury may not be able to use the hospital shuttle bus to support visiting. Parents/ expectant parents of functional patients in Wakefield wards will receive free parking.
	Option 1b	Parents/ expectant parents who live in North Kirklees will definitely have relatives with dementia admitted in the local area. Some patients with functional needs in Kirklees and Calderdale are currently admitted outside of locality. They are much more likely to be admitted locally in the new model meaning any parents/ expectant parent are more likely to have local travel.	Parents/ expectant parents who live in Calderdale and Wakefield who have relatives with dementia needs will have to travel out of area. Parents/ expectant parents in North Kirklees will have to travel out of area for patients with a functional need. Wakefield parents/ expectant parents will now have to pay for parking to visit patients with dementia.	Parents/ expectant parents from Calderdale will continue to pay for parking to visit a patient. Parents/ expectant parents from Wakefield visiting dementia patients in Dewsbury may not be able to use the hospital shuttle bus to support visiting. Parents/ expectant parents of functional patients in Wakefield wards will receive free parking.
	Option 2	Parents / expectant parents from Wakefield will definitely have relatives with dementia admitted in the local area. Some patients with functional needs in Kirklees and Calderdale are currently admitted outside of locality. They are much more likely to be admitted locally in the new model. Parents / expectant parents will benefit from this.	Parents/ expectant parents who live in Calderdale and Kirklees who have relatives with dementia needs will have to travel out of area. Parents/ expectant parents in Wakefield will have to travel out of area for patients with a functional need. Wakefield Parents/ expectant parents will now have to pay for parking to visit patients with functional needs.	Calderdale carers will continue to pay for parking to visit a patient.

Protected Group impact	Option	Positive impact	Negative impact	Neutral impact
	All options	Dedicated space for visitors – gardens and grounds in all locations – Calderdale, Kirklees, and Wakefield. All locations have a restaurant or canteen – offering food and refreshments.	Parents/ expectant parents in all local areas will have some sort of travel impact. At the present time services are available in local areas for both dementia and functional patients.	

Disability
• Physical access to estates and built environments:
  • Parking bays
  • Access to public transport
  • Ease of access into buildings
  • Visitor areas
  • Accessible toilets
  • Adult changing toilets
• Considering hidden disabilities
• Different types of seating and access:
  • Designated wheelchair seating areas
  • Wider doorways and fewer heavy doors
  • Automatic doors with ramps rather than stairs
• Accessible lifts, signs and reception areas at visible heights
	Option 1a	A specialist dementia ward in Dewsbury means a space specific to meet the needs of dementia patients that can be adapted to meet those needs.
		
		Wakefield functional ward will have fully accessible ensuite facilities.
			A specialist dementia ward in Dewsbury means shared bathing and toileting facilities – assisted bathing may need to be planned.	

	Option 1b	A specialist dementia ward in Dewsbury means a space specific to meet the needs of dementia patients that can be adapted to meet those needs. Wakefield functional ward will have fully accessible ensuite facilities.	A specialist dementia ward in Dewsbury means shared bathing and toileting facilities – assisted bathing may need to be planned.	
	Option 2	A specialist dementia ward in Wakefield means a purpose-built space specific to meet the needs of dementia patients.	A functional ward in Dewsbury means shared bathing and toileting facilities – assisted bathing must be planned,	
	All options	Dedicated support and environment for people with dementia. Dedicated support and environment for those with functional needs		Calderdale functional ward will continue to have shared bathing and toileting facilities. All estates are currently DDA compliant. Car parking, including bays for people with a disability located vary but are available on all sites. All estates have accessible toilets.

12. Consideration of all impacts against each option

Below is a summary of the impacts identified from all the above impacts against each of the options.

12.1 all impacts

Options	Impact
Option 1a: A dedicated central specialised dementia unit in North Kirklees developed on Ward 19 with additional functional bed capacity adjoined to the existing Wakefield 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. The Wakefield Poplars site would not be in this model.	• Higher capacity for people with dementia who need inpatient support • No ensuite facilities for dementia patients – shared bathing and toilets only • Longer stays for dementia patients may mean visitors paying for parking. • The specialist dementia unit would be geographically central to Calderdale and Wakefield • Single sex ward standards met. • Dewsbury dementia ward and Wakefield functional wards would be single gender, Beechdale in Calderdale would remain mixed gender. • Functional patients' visitors will have to pay for parking in Calderdale. • Proximity to acute general hospital care for functional patients would be co-terminus in Calderdale and via the nearby Pinderfields hospital in Wakefield. • Proximity to acute general hospital care for dementia patients would be co-terminus at the Dewsbury District Hospital site, which would benefit carers, families, loved ones. • Dementia and functional services are currently under represented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food, and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer.
Option 1b:	• Higher capacity for people with dementia who need inpatient support • No ensuite facilities for dementia patients – shared bathing facilities and toilets only • Longer stays for dementia patients may mean visitors paying for parking. • The specialist dementia unit would be geographically central to Calderdale and Wakefield • Single sex ward standards met. • Dewsbury dementia ward would be single gender, Beechdale in Calderdale and Wakefield would remain mixed gender. • Functional patients' visitors will have to pay for parking in Calderdale.

Options	Impact
	• Proximity to acute general hospital care for functional patients would be co-terminus in Calderdale and via the nearby Pinderfields hospital in Wakefield. • Proximity to acute general hospital care for dementia patients would be co-terminus at the Dewsbury District Hospital site, which would benefit carers, families, loved ones. • Dementia and functional services are currently under represented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food, and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer.
Option 2: Option 2: Crofton ward in Wakefield, as the dedicated central specialised dementia unit. This would operate as 2 wards with 26 beds in total. Ward 19 in North Kirklees and Beechdale ward in Calderdale would be functional only wards. The Poplars site would not be in this model.	• Higher capacity for people who use services with functional needs, lower dementia capacity. • No en-suite facilities for functional patients on ward 19 – shared bathing and toilets only. Only 2 functional e/s in the whole system at Beechdale. • The specialist dementia unit would be on the east side of the Trust footprint. • Dementia patients would have a single sex ward. • Functional ward would be mixed sex in Calderdale. • Functional patients' visitors will have to pay for parking in Calderdale and Kirklees. • Proximity to acute care for functional patients would be co-terminus. • Proximity to acute care for dementia patients could be either Mid York's which would benefit carers, families, loved ones. • Dementia and functional services are currently underrepresented for patients from a BAME background. This would need to be addressed – look at staff who were reflective of the population and environments, food and cultural activities (cooking) and faith rooms. We need the voice and views of this population to help shape the offer. • Greater impact on travel, transport and parking for all localities including 20% most deprived populations.

12.2 Impact mitigations by protected group

Protected Group	Option	Mitigations and further insight required
Age	**Option 1a**	• Determine if the options to have no ensuite option for dementia patients has an age implication through consultation.

• Impact on those under the age of 65 who require care, consideration of activities/environment. • A diverse range of age-appropriate communications in alternative formats • Digital should not the sole means of information /communication/contact • Estates and environment design enable independence and safe and easy access for older people/frailty. • Consideration for sensory impairment – sight and hearing using adaptions to environment/ signage/loop system/large print information	**Option 1b**	• Determine if the options to have no ensuite option for dementia patients has an age implication through consultation.
	Option 2	
	All options	• Identify through consultation any specific age impacts of both options. • Identify visiting times that support working age adults and young people of school age/ students. • There may be opportunity to add several ensuites to Ward 19 in Dewsbury, Kirklees via minor capital works, which would benefit both options.
Gender • Access to same sex clinician/staff, • Tailored activities • Considerations for people who identify as non-binary	**Option 1a**	• Consider how gender specific environments could be supported for functional care for Calderdale residents who may request this option.
	Option 1b	• Consider how gender specific environments could be supported for functional care for Calderdale and Wakefield residents who may request this option.
	Option 2	• Consider how gender specific environments could be supported for functional care for Calderdale residents who may request this option.
	All options	• Attract and ensure a gender mix of staff
Carer • Travel, particularly for older carers and those with other caring responsibilities. • Staff at all units identify and support carers. • Voluntary and other support organisations / community groups that signpost to and support patients around the service. • Visiting times and contact arrangements • Estates facilities for carers	**Option 1a**	• Calderdale carers are the most impacted by parking charges – having to pay to see both dementia and functional patients – identify options to mitigate costs in line with carers coming from Kirklees and Wakefield. • Identify the option to use the Pinderfields/ Pontefract Mid Yorkshire shuttle bus for Wakefield Carers visiting relatives in a functional ward in Dewsbury.
	Option 1b	• Calderdale carers are the most impacted by parking charges – having to pay to see both dementia and functional patients – identify options to mitigate costs in line with carers coming from Kirklees and Wakefield. • Identify the option to use the Pinderfields/ Pontefract Mid Yorkshire shuttle bus for Wakefield Carers visiting relatives in a functional ward in Dewsbury.
	Option 2	• Calderdale carers will have to travel the furthest to visit a patient with dementia – ensure a plan is in place to support the carer with flexible visiting times and access to refreshments and lounge/ waiting areas.
	All options	• Identify visiting times that support carers to visit. • Promote the use of the 'Chatpad' to support contact for carers using a digital device. • Ensure every carer is identified and receives a carers passport. This will help ensure the specific needs of carers are supported.

Race and ethnicity • Addressing barriers of access – culturally appropriate environments, food and activities. • Faith and religious needs considered in built environments and through décor. • Reflective workforce, who are culturally and spiritually competent. • Access to an interpreter and translation materials. • Appropriate toilet facilities and consideration of bathing preferences.	**Option 1a**	• Calderdale patients who for cultural reasons may request a male or female only ward should have their needs considered but will have to travel further for both functional and dementia care. • Having Kirklees as the dementia specialist ward may mean that more considerations to cultural bathing and toileting considerations are needed.
	Option 1b	• All functional patients who for cultural reasons may request a male or female ward will have to be considered on an individual basis as all wards are mixed gender. Wakefield may be able to cohort patients. This means Calderdale patients will have further to travel. • Having Kirklees as the dementia specialist ward may mean that more considerations to cultural bathing and toileting considerations are needed.
	Option 2	• Having Kirklees as a functional ward may mean that more considerations to cultural bathing and toileting considerations are needed. • Calderdale patients who for cultural reasons may request a male or female only ward should have their needs considered, but will have to travel further for both functional and dementia care
	All options	• To maintain and improve the diversity of the workforce in all care settings. • Ensure that the environments reflect the diversity of the 'Trust wide' population rather than the 'place' population.
Gender reassignment • Workforce who are competent in providing care to transgender and gender non-conforming patients and accommodating visitors. • Considering environments such as ward allocation, privacy, gender neutral facilities in line with trust policy and additional support through advocacy. • Considering how, for transgender people, how issues surrounding gendered wards can lead to poor experiences of care.	**Option 1a**	• Option to cohort patient needs to be considered in Kirklees for dementia patients and Wakefield for functional patients.
	Option 1b	• Option to cohort patient needs to be considered in Kirklees for dementia patients and Wakefield for functional patients.
	Option 2	• Option to cohort patient needs to be considered in Kirklees for functional patients and Wakefield for dementia patients.
	All options	• Advocacy for transgender patients' needs to be identified. • Need to ensure that the policy for transgender patients forms part of the proposals for service redesign. • Ward allocation would need to consider transgender patients.
Sexual orientation • Workforce receiving appropriate training and awareness so they can provide care which considers individuals and environments, ensuring people feel safe • Visible symbols (such as the NHS Rainbow Badge, and/or use of badges and lanyards)	**Option 1a**	
	Option 1b	
	Option 2	
	All options	• Maintain Trust wide visibility, staff development and person-centred care planning. • Improve visible symbols of support across all locations
Religion or belief • Access to faith and prayer rooms (including staff) • Ensuring parity of pastoral support for all faiths on inpatient wards	**Option 1a**	
	Option 1b	
	Option 2	
	All options	• Ensure all estates have adequate access and availability of prayer rooms and appropriate pastoral and spiritual support.

Maternity and pregnancy • Managing additional caring responsibilities • Ensuring flexibility for visiting times. • Facilities are accommodating to visitors (for example parent access to changing facilities).	**Option 1a**	
	Option 1b	
	Option 2	
	All options	• Need to understand through consultation the impact of travel and transport/ visiting for parents/ expectant parents. • Ensure all sites have the provision for baby changing and feeding. • Identify options for parking which include parent and child spaces. • Identify visiting times that support parenting responsibilities. • Ensure visiting environments are suitable and can cater for parents/children and expectant parents.

Disability
• Physical access to estates and built environments:
  • Parking bays
  • Access to public transport
  • Ease of access into buildings
  • Visitor areas
  • Accessible toilets
  • Adult changing toilets
• Considering hidden disabilities
• Different types of seating and access:
  • Designated wheelchair seating areas
  • Wider doorways and fewer heavy doors
  • Automatic doors with ramps rather than stairs
• Accessible lifts, signs and reception areas at visible heights
	Option 1a	• Consider the impact of no ensuite facilities for dementia patients in Kirklees as part of the consultation

	Option 1b	• Consider the impact of no ensuite facilities for dementia patients in Kirklees as part of the consultation
	Option 2	• Consider the impact of no ensuite facilities for functional patients in Kirklees as part of the consultation .
	Both options	• Estates and environment can be improved to meet specific needs of patients. • Use the consultation as an opportunity to look at access to accessible car parking. • Consideration for additional travel and access to suitable transport/ location of public transport.

The formal consultation will further inform the public consultation process and reach into any specific communities who we need to hear from. This includes missing information on specific groups that we need to know more about. The questions will be designed to pick up this information and all analysis of responses will be broken down by protected groups, and carers. The EIA will be further updated following the consultation.

The equality impact assessments and the EIA will continue to be updated as feedback and insight are gathered during the process. The final version of the EIA will inform a decision on the proposed options and a full business case.

14. Recommendations and next steps

The following recommendations and next steps have been identified:

14.1 Ensure the consultation reaches the identified audience impacted and can evidence the sample group is reflective of each protected group.

14.2 Ensure the consultation responses are analysed by each protected group and any differential impact is highlighted, considered, and conscientiously considered with impacts mitigated and/or addressed.

14.3 That the questions that are asked in consultation can ensure that responses inform the mitigations.

14.4 That single sex accommodation is considered in future estates planning for both dementia and functional patients. This highlights the benefits of designing gender flex into the system, particularly for functional needs.

14.5 That solutions for travel, transport and parking address the geographical impacts for populations, particularly those from the 20% most deprived postcodes.

15. Key legislation

The EIA demonstrates the legislation has been applied and that options development up to this point have shown a due regard and considered the impact on those groups protected under the equality act with iterative EIAs that have been developed at each stage. This EIA continues to demonstrate compliance with the following:

15.1. Duties under the Equality Act 2010

Within the Equality Act, the NHS as a public authority has a legal requirement to promote equality and set out how we plan to meet the "general" and "specific" duties. specified in Section 149 (1) of the Public Sector Equality Duty. As a public authority we are required to pay "due regard" to the three aims of the general equality duty to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- Having "due regard" for advancing equality involves:
    - Removing or minimising disadvantages people encounter due to their protected characteristics
    - Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
    - Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

As part of the transformation of services we are legally bound to demonstrate that we are taking action to promote equality in service developments and employment. Within the Act, we also have a legal duty to show that we have given due regard to

carers (determined by our own governance) and the nine protected characteristics below:

- Sex
- Ethnicity
- Gender
- Disability
- Religion / belief
- Sexual orientation
- Gender reassignment
- Marriage or civil partnership
- Pregnancy / maternity
- Age.

14.4 to ensure that any future developments in the estate or built environment consider access and are culturally and spiritually appropriate.

15.2. The Human Rights Act

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. The Act sets human rights in a series of 'Articles' and each Article deals with a different right. There are 16 Articles; details of which are at: www.equalityhumanrights.com/en/human-rights/human-rights-act

This EIA draws particular attention to Article 14: Right to freedom from discrimination (which in effect means protection from discrimination for any other reason that is not one of the protected characteristics e.g., socio economic status) amongst all the other articles.

15.3. The Health and Social Care Act 2012 – Health Inequalities

The Health and Social Care Act 2012, states that we must, in the exercise of its functions, have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services.
- Reduce inequalities between patients with respect to the outcomes achieved for them

We have incorporated health inequalities considerations into the assessment template to ensure these requirements are considered.

15.4. The Brown Principles

Case law known as the Brown Principles sets out a broad indication of what public sector organisations need to do to in respect of the aims set out in the general equality duties and they provide useful insight into how courts interpret the duties although they are not additional legal requirements. In summary, the Brown principles say:

- Decision-makers must be made aware of their duty to have “due regard” to the
  three aims of the general equality duty
- Due regard is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under development and consideration, as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind. A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken as this is unlawful. Attempts to justify a decision as being consistent with the exercise of the duty, when it was not considered before the decision, are not enough to discharge the duty.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty has to be integrated within the discharge of the public functions of the body subject to the duty. It is not a question of “ticking boxes”.
- The duty cannot be delegated and will always remain on the body subject to it is good practice for those exercising public functions to keep an accurate record showing that they had considered the general equality duty and pondered relevant questions. If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by the equality duties.

The use of an EIA in this instance can help provide a record required and the application of the above principles.

15.5. Judicial Review

EIAs are legal documents that can be used by a court to determine whether we have undertaken activity in line with the requirements of the Equality Act.
If we do not undertake equality impact analysis through our EIA process or do not carry out this function in a robust and transparent manner, we may fail to comply with the Equality Act 2010 s.149 duty.

This failure to successfully apply the s.149 duty can be challenged by means of an application for judicial review to the High Court. Judicial review (JR) is the process of challenging the lawfulness of decisions of public authorities; usually local or central government. JR can be brought by anyone with a “sufficient interest” in the case. In most cases, the applicant to the court will be an individual who is directly affected by a public authority decision or other measure.

However, in other cases, a decision or other measure may not have an impact on an individual but still has implications for the wider public. In that circumstance, “pressure” groups, “representational” groups, or “public interest” groups may bring an application for
judicial review.