South London and Maudsley NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT
PART 1 – INITIAL SCREENING

SLaM wants to ensure that we provide accessible and equitable services that meet the needs of our diverse community and to meet the first principle of the NHS constitution – to provide comprehensive services available to all, paying particular attention to marginalised groups who are not keeping pace with the rest of society.

Under the Equality Act 2010 we are all protected from less favourable treatment or discrimination based on age; disability; pregnancy and maternity; gender reassignment; race; religion / belief; sex; sexual orientation; marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]. As an organisation we are legally obliged to consciously think about equality as part of the decision making process in the design, delivery and evaluation of our services and policy development/review. This is why we ask you to begin / conduct the EIA at the planning stage and in a group, using the screening tool as a prompt to the necessary conversations about the impact of your work on equality. *(See guidance for further information)*

1. Name of the policy / function / service development being assessed?

The re configuration of psychological therapies in Southwark

2. Name of Lead person responsible for carrying out the assessment? (where there is a service change, this should be the individual with responsibility for implementing the change)

SLaM Staff:
Simon Rayner – Head of Pathways (lead person)
Steve Davidson – Service Director
Jonathan Bindman – Clinical Director
Alice Glover – Public and Patient Lead
Kay Harwood – Head of Planning and Equality

Others:
Gwen Kennedy – Deputy Director of Client Group Commissioning
Jo Holmes – Joint Mental Health Commissioner

3. Describe the main aim, objective and intended outcomes of the policy / function / service change/ development?

Aim:
- To create borough based psychological therapy services that are well integrated with other borough mental health services and pathways. In particular with the Improving Access to Psychological Therapies [IAPT] services.
- To improve the efficiency of the service by moving delivery of treatment from several teams to one key team and through the creation of a single point of referral and assessment.

- Provision of a comprehensive assessment addressing the full range of client needs resulting in provision of client centred, support and recovery care plan - that addresses all service user needs – psychological, social and medical.
- To enable delivery of Trust cost efficiencies and commissioner Quality Innovation Productivity and Prevention targets.

Objectives:
The reconfiguration of psychological therapy provision in Southwark, [also in Lewisham and Lambeth] has been developed in collaboration with our commissioner and will allow improvements to be made to psychological therapy provision and provide a clearer care pathway and reduce inefficiency.

Outcomes:
We intend that people requiring psychological therapy will continue to receive high quality evidenced based services. Provision of a central point of access and assessment will reduce the need for additional or duplicate assessments. A single assessment will allow the patient to access the correct service rather than on occasions needing to be transferred between teams. The single assessment will provide the service user with a tailored care plan that will address all their needs; medical, psychological and social.

The outcomes of the reconfiguration will be closely monitored to ensure that these outcomes are met and that access to the service remains as intended. Service user experience will be closely monitored.

The service configuration and capacity will be regularly reviewed with commissioners and adjustments made as required.

Proposed Service change

Review of the existing service and care pathway development

Psychological therapy provision in Southwark is complex and fragmented and does not offer clear referral pathways to GPs or other referrers. A number of services operate from different locations, having developed independently over time, as a product of history, rather than clinical best practice. The current arrangements often result in services being offered to people on the basis of where they live in the borough rather than for good clinical reasons.

While the fragmentation of services may not be apparent to patients who are referred directly from primary care to psychotherapy, they often become aware of the difficulties when assessed by one service and not accepted but another service is suggested. We have received complaints from service users about having to move between services which has lengthened the time before starting therapy. Rather than having their needs meet within a clear care pathway within an integrated service/team of professionals.

Service users who work closely with the management team have highlighted the importance of reducing multiple or duplicate assessments as well as inconsistency in access to services.

The reconfiguration will lead to the creation of a single psychological therapy team within Southwark. The team will bring together therapy provision previously delivered in the separate services. They will work alongside our existing community mental health teams (CMHTs) and will provide patients and GP referrers with a single point of access to a range of psychological therapies, according to assessed clinical need.

High level care pathways for anxiety, depression and personality disorder have been developed by clinical experts, in their field, service users (details in section 5), and other staff within the Mood Anxiety and Personality [MAP] Clinical Academic Group [CAG]. Clinical protocols for diagnostic groups (Maps of

Medicine[1]) have also been developed by clinical experts in their field, service users and other staff in the MAP CAG. These have been signed off by the MAP CAG Executive. The next step in the process is to confirm how the interventions recommended by the pathways are accessed within each borough. Development of the integrated services will support this process.

The CAG commitment to clarity of pathway and outcomes is shared by commissioners who require clarity as to:

- which clients are served by each pathway
- what is provided
- what outcomes can be expected
- how it is accessed

The current arrangement has the potential for duplication of services, whether by condition (for example services for trauma being provided by Centre for Anxiety Disorders and Trauma - CADAT and Traumatic Stress Service - TSS or by modality (for example CBT for various conditions being provided by CMHT psychologists, at St. Thomas's Psychotherapy Service (SPS) and at Maudsley Psychotherapy Service (MPS). As a result, the pathways whereby people assessed as requiring particular treatments access those treatments is not transparent, to service users, carers, referrers or commissioners

Proposed service model

An integrated psychological therapies team (IPTT) will be developed in each Borough. (The use of the term team rather than service will minimise confusion with the existing Intensive Psychological Therapy Service (IPTS) at Guy's Hospital). As above, integrated in this context, means that all treatments for psychological therapies are provided by a single multi-modality team with a single point of access.

The borough IPTT will provide all specialist psychotherapies required by NICE[2] guidelines for people with anxiety, depression, personality disorder, and post-traumatic stress disorder (PTSD), as represented in the CAG condition specific pathways. These are listed in table 1. In addition, other modalities of therapy may be provided as part of clinical studies, on the basis of evidence other than that already included in NICE guidelines, or for other specific purposes, where agreed by the managers of the service and by commissioners.

The following therapies will be provided within the new service.

<u>Individual Treatments</u>

Cognitive Analytic Therapy (CAT)
Psychodynamic therapy
Cognitive Behavioural Therapy (CBT)
Trauma specific CBT
Eye movement desensitisation and reprocessing (EMDR)

<u>Group Treatments</u>

Group psychodynamic therapy
Family and couple therapy

[1] The Maps of Medicine enables efficient and effective development of care pathways based on best practice and the needs of local communities.

[2] *National Institute for Health and Clinical Excellence (NICE) guidance sets the standards for high quality healthcare and encourages healthy living.*

Referral routes and criteria
Referrals routes in the new service will be much clearer than in the current model. In future we propose that referrals to the IPTT may come from GPs, IAPT, and MAP Assessment and Treatment (A&T) Teams, and will go through a single point of access in each borough. The point of access will allow for allocation to an appropriate therapy where indicated, or (if referred by a source external to SLaM and not already assessed by A&T) will allow for diversion to the Engagement, Assessment and Stabilisation (EAS) pathway within A&T or to IAPT. The principles of stepped care, as set out in NICE Guidance for depression (and the principle extended to other conditions where feasible) will be followed, with service users allocated to short term primary care psychological treatment or other alternatives outside SLaM where possible, and to more intensive treatments as appropriate in a stepped fashion.

It is proposed that, as the model of service will be highly transparent to referrers and commissioners, and allocation to treatment will be by a clear process and on the basis of clear pathways linking need to interventions required, the current (interim) system of agreeing some psychotherapy referrals via the Southwark specialist outpatient panel will not longer be necessary.

The criteria for acceptance for psychological therapy will be that the person meets the diagnostic criteria set out in the MAP CAG condition specific pathways, and meets threshold criteria for severity which will be agreed by the allocation process.

Allocation to IPTT may be direct where sufficient evidence of the criteria for treatment is available. In other cases it may follow assessment by A&T or a joint assessment between A&T and IPTT. Wherever possible, patients should not receive numerous or duplicate assessments. MAP CMHT assessment services will work to a standardised assessment, and IPTT services will develop a generic assessment process which will support all staff within secondary care to assess sufficiently to allow efficient allocation to the correct pathway.

The integration of psychological therapies into mental health care in Southwark
Consideration was given in the development process to the possibility that the provision of psychological therapies could be fully embedded within A&T teams. This was rejected on the grounds that this would provide insufficient critical mass for the necessary processes of leadership, supervision and support of honorary staff, and that it was not feasible given the current size and location of MAP A&T teams. The IPTT is therefore proposed as a separate team in each borough.

However, the new IPTTs will work more closely with the MAP A&T teams than in the current model. Closer working between A&T and the IPTT than is currently possible between A&T and existing psychotherapy services will be facilitated by the common allocation process, by the borough focus of the new IPTT, and by the smaller numbers of A&T teams than previously (in Lambeth and Southwark). Other methods of developing closer working will also be encouraged, such as the provision of case discussions, supervision and training to A&T staff by IPTT staff. Co-location would of course also facilitate communication and liaison but may not be feasible and will be the subject of a separate review of accommodation for the new IPTT services.

The psychologists who are currently working within the CMHTs will become part of the new IPTT. As such they will be able to provide support to front line practitioners in delivering psychological informed care as well as providing a clear link between the delivery of psychological therapy and the broader range of care that some people may require.

4 (a). What evidence do you have and how has this been collected?

4.1 Race

The following data, shows the ethnic breakdown of people currently using psychological therapies, CMHTs and the ONS projected population for Southwark for 2009. Although not directly comparable to the census data, indicates that people from BME groups are more likely to access community mental health teams than psychological therapy services.

Ethnicity	Service Users Psychological Therapies		Service Users Southwark CMHTs	Ethnic group cumulative	Psychological Therapies		Southwark CMHTs	ONS projected Pop - 2009
	CPTS	Cross borough services			CPTS	Cross borough services		
African	0.8%	4.9%	9.0%	Black or Black British	10.5%	11.9%	16.5%	17.4%
Caribbean	1.7%	2.2%	2.9%					
Any other black background	7.9%	4.8%	4.6%					
Bangladeshi	0.8%	0.0%	1.0%	Asian or Asian British	1.7%	2.6%	2.4%	8.4%
Indian	0.0%	0.4%	0.4%					
Pakistani	0.4%	0.1%	0.2%					
Any other Asian background	0.4%	2.2%	0.9%					
Chinese	0.8%	0.4%	0.5%	Other ethnic groups	20.9%	22.2%	24.3%	4.5%
Any other ethnic group	20.1%	21.8%	23.8%					
White and Asian	0.0%	0.5%	0.0%	Mixed	1.7%	4.3%	1.4%	3.8%
White and Black African	0.4%	0.8%	0.3%					
White and Black Caribbean	1.3%	2.4%	0.5%					
Any other mixed background	0.0%	0.6%	0.5%					
White British	44.4%	37.1%	37.2%	White	64.0%	57.9%	54.7%	65.9%
White Irish	4.6%	2.2%	3.9%					
Any other white background	15.1%	18.7%	13.6%					
Not known	1.3%	1.1%	0.6%	Not known or stated	1.3%	1.1%	0.6%	-
Information not yet obtained	-	-	-					

CPTS – refers to the Coordinated Psychological Therapy Service, a Southwark specific service.
Cross borough services – refers to Maudsley Psychotherapy Service and Traumatic Stress Service. These figures are indicative of the Southwark component (these services cover Lambeth, Southwark and Lewisham).
CMHT – Community Mental Health Team

Improving access to psychological therapy for people from BME groups.

The group of service users accessing community mental health teams is more representative of the local population than those accessing secondary psychological therapy.

Community mental health teams sit within community networks that support and target improved access to services for people from BME groups. All teams have developed excellent links with local organisations who support and advocate for people from BME communities.

The data shows that 'other ethnic groups' accessing psychological therapies are very over represented compared to the local population. We do not wish to make any assumptions about why this group is reporting as so much higher than would be expected, and we will monitor this closely over the next six months to establish the cause and then establish an action plan to address any issues that are identified.

We anticipate that the new model of care will enable our services to be more accessible and acceptable to people who have not traditionally been referred to psychological therapy. This is particularly relevant for people from BME groups.

In particular, the single point of access for psychological therapies being within the community mental health team setting will facilitate this improvement.

A peer support / group coordinator will be established in each team to develop a range of groups and peer support systems that may be accessed as an alternative to formal treatment or used whilst an individual is waiting to see a therapist. The peer support system will involve service users who have had experience of using psychological therapy services. Access to the new support services will be planned with our local commissioners, 3rd sector and services provided by the local authority/social services. The service will have a particular focus on improving accessibility to underrepresented groups. We intend to develop groups and peer work within community settings – linking in with established community groups, faith groups and BME groups.

4.2 Gender

The following data, shows the gender breakdown of people currently using psychological therapies, CMHTs and the ONS projected population for Southwark for 2009 is shown below.

	Psychological Therapies		Southwark CMHTs	ONS projected pop - Southwark 2009
	CPTS	Cross borough services		
Males	33.1%	32.1%	39.0%	51.3%
Females	66.9%	67.9%	61.0%	48.7%

CPTS – refers to the Coordinated Psychological Therapy Service, a Southwark specific service.
Cross borough services – refers to Maudsley Psychotherapy Service and Traumatic Stress Service. These figures are indicative of the Southwark component (these services cover Lambeth, Southwark and Lewisham).
CMHT – Community Mental Health Team

The higher number of women than men using the services is consistent with the national picture of demand for these types of services. We do not believe that the proposed change will have any significant impact on the gender of people accessing psychological therapy. We will monitor service activity against this baseline.

4.3 Age

The following data shows the age breakdown of people currently using psychological therapies, CMHTs and the ONS projected population for Southwark for 2009 is shown below.

	Psychological Therapies		Southwark CMHTs		Psychological Therapies		Southwark CMHTs	ONS projected pop - 2009
	CPTS	Cross borough services			CPTS	Cross borough services		
0-15 years	N/A	N/A	N/A	**0-15 years**	N/A	N/A	N/A	17%
16-18	0.8%	0.1%	1.4%	**16-64 years**	100%	98.3%	98.9%	74%
19-35	31.8%	34.7%	35.9%					
36-65	67.4%	63.5%	61.6%					
65+	0.0%	1.5%	1.1%	**65+**	0.0%	1.5%	1.1%	9%
Not recorded	0.0%	0.1%	0.0%	**Not recorded**	0.0%	0.1%	0.0%	N/A

CPTS – refers to the Coordinated Psychological Therapy Service, a Southwark specific service.
Cross borough services – refers to Maudsley Psychotherapy Service and Traumatic Stress Service. These figures are indicative of the Southwark component (these services cover Lambeth, Southwark and Lewisham).
CMHT – Community Mental Health Team

The service provides for people over the age of 18.

People under the age of 18 are usually seen within our Child and Adolescent mental health services, with a very small number who start in adult services at the age of 18.

We do not believe that the proposed change will have any significant impact on the age range of people accessing psychological therapy. We will monitor service activity against this baseline.

4.4 Sexual orientation

We do not currently collect data concerning the sexual orientation of people using our services; however the new model will enable us to more easily link psychological therapy to LGBT organisations. We will also seek to develop links between these services and our service user LGBT group 'four in ten'.

The Government is using the figure of 5-7% of the population which Stonewall feels is a reasonable estimate. However, there is no hard data on the number of lesbians, gay men and bisexuals in the UK as no national census has ever asked people to define their sexuality. Various sociological/commercial surveys have produced a wide range of estimates, but there is no definitive figure available.

Southwark Council does not currently collect data on sexual orientation.

4.5 Religion/Belief

We collect data on the religion/ beliefs of people using our services however in common with sexual orientation this is information that many service users are reluctant to share with us. The supervision of all therapists provides a focus for the delivery of therapy that is sensitive to religious beliefs. Clients are able to access the Trust multi-faith spiritual and pastoral care service.

We are aware that staff do record the details of religion and belief within clinical case records and we are developing plans to ensure this data is entered into our data set to enable monitoring.

The 2010 ONS annual population survey reports that 79% of the Southwark population identify themselves as belonging to a religious group. This compares to 82% nationally (2001 Census data).

4.6 Disability

We are aware that most service users accessing our services have long term mental health conditions and therefore meet the definition of disabled. We believe that the number of service users with additional identified disabilities is higher than recorded, and that many people do not disclose or recognise that their other conditions are a disability.

However, in relation to mobility, all the buildings will have full physical disability access. Where disabilities are disclosed the service will work to put in place reasonable adjustments to enable it to be accessible.

The decision as to who receives therapy from the service is principally based on the severity and complexity of the mental health condition, which could be a depressive illness, an anxiety disorder, or a personality disorder, or indeed other mental disorder such as bi-polar affective disorder, but diagnosis per se is not a criterion for acceptance or exclusion from services.

4.7 Gender re-assignment / transgender
We do not currently collect this data. Psychological therapy would be appropriate and available to this group of people should they require it. We do not believe there is any disproportionate impact.

In recognition that staff attitudes and organisational culture need to support transgender people, the Trust regularly runs a training day on 'gender concerns in mental health and anti-discriminatory practice'. This programme is co-presented by the Trust's Equality and Diversity trainer and a transgender member of staff.

4.8 Pregnancy and maternity
The Trust delivers specific services for women pre and post-natal with mental health problems. We do not believe there is any disproportionate impact.

4.9 Marriage and civil partnerships
Psychological therapies are available to all people irrespective of their marital or civil status. We do not believe there is any disproportionate impact.

4 (b). Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

NO

Which equality groups may be disadvantaged / experience negative impact? *[please base your answers on available evidence which can include for example key themes from the general feedback you receive via patient experience data (such as patient surveys; PEDIC); carer experience; complaints; PALS; comments; audits; specialist information - your personal knowledge and experience]*

Age NO
There is no disproportionate impact anticipated as a result of someone's age

Disability NO
There is a low disclosure of service users with disabilities.

Gender NO
The higher number of women than men using the services is consistent with the national picture of demand for these types of services

Gender re-assignment / Transgender NO
We do not currently collect this data. There is no disproportionate impact anticipated for this group

Race NO
We believe the new structure will have a positive impact on the accessibility of the service for BME service users

Religion / Belief NO
There is no disproportionate impact anticipated

Sexual orientation NO
There is no disproportionate impact anticipated for this group

Marriage and Civil partnership NO
There is no disproportionate impact anticipated for this group

5. Have you explained your policy / function / service development to people who might be affected by it?

Yes

Involvement Opportunities for Service users and carers from Southwark:

The Mood, Anxiety and Personality Clinical Academic Group (CAG) management team who have developed this proposal, work closely with service users who either have an experience of, or interest in the delivery of care to people with mood, anxiety or personality problems. The CAG have a service user advisory group who meet regularly with CAG management to advise and consult on the development of CAG services.

As preparation for these service changes, the CAG held several care pathway development events which were attended by service users. These workshops were held 28th February, 28th March and 23rd May 2011. Within these workshops service users fed back to staff about components of care that were important to them. Repeated assessments were identified as a concern which has been specifically addressed in the proposed model.

In April 2011 members of service user advisory group identified equal access to services and quality of services as two of their key priorities.

In preparation for the service re design, data was collated from PEDIC; the Trust patient experience collation system and from a service quality session run with service users in July 2011. Within this event service users were asked to identify priority areas of need to inform the psychological therapy review work. They requested that the focus of care be more holistic in approach and identified the need for support when not formally engaged in treatment. The proposed model will have very close working relationships with community mental health teams and primary mental health services in order to be able to provide a more holistic approach to people's needs.

The service user advisory group received updates on the development of reconfiguration plans on 30th September, 28th October and 25th November 2011. The advisory group discussed the final proposal in detail

at the November meeting which was also attended by the CAG Clinical Director, Deputy Service Director and Head of Pathway.

The draft proposal was presented to service users at an event entitled 'Service users and carers - Find out / talk about changes to community Psychological Therapy Services' 21st November 2011.

The aim of the session was for;

- Participants to be more informed about the proposed changes to community psychological therapies services across Lewisham, Lambeth & Southwark
- Participants to have an opportunity to ask questions and give their views about the proposed changes.

In addition to the stakeholders meeting people were invited to find out more individually through contacting the MAP CAG PPI lead. Publicity was sent to:

- Managers of all affected services, including St. Thomas', Maudsley Psychotherapy , Traumatic Stress Service
- Posters were circulated through the advisory group
- The service user blog: twigops - currently 80 subscribers
- All the trust Patient & Public Involvement Leads

Publicity about the stakeholders meeting was taken in person to the Southwark Mind User Council meeting in November.

Further planning involvement

In partnership with Southwark LINks we arranged a meeting for service users and members of the public on the 8th March 2012. In addition we have issued an information leaflet for service users which has been widely distributed through service user networks. Therapists in all affected services have been asked to give this to service users in treatment, where it is safe and appropriate to do so. A jargon free document explaining the changes has been distributed via the LINk. The leaflet also gives contact details for members of the management team and invites service users to make contact to express views and request further information. The dates of the public meetings are listed on this leaflet.

6. If the policy / function / service development positively promotes equality please explain how?

The current fragmentation of services results in residents of different boroughs or areas with a borough receiving a different service with different waiting times (though it is not possible to say that one part has been consistently disadvantaged over time).

The proposed change will ensure that residents of each borough have clear access to the same therapy and assessment.

We believe that this proposal will improve the access of people from BME communities to psychological therapy. This improvement will be realised through the closer connection of psychological therapies to Community Mental Health Teams whose service users more closely reflect the local BME population.

Community mental health teams sit within community networks that support and target improved access to services for people from BME groups. All teams have developed excellent links with local organisations who support and advocate for people from BME communities.

In particular, the single point of access for psychological therapies being within the community mental health team setting will facilitate this improvement.

A peer support / group coordinator will be established to develop a range of groups and peer support systems that may be accessed as an alternative to formal treatment or used whilst an individual is waiting to see a therapist. The peer support system will involve service users who have had experience of using psychological therapy services. Access to the new support services will be planned with our local commissioners, 3rd sector and services provided by the local authority/social services. The service will have a particular focus on improving accessibility to underrepresented groups. We intend to develop groups and peer work within community settings – linking in with established community groups, faith groups and BME groups.

Developing a peer - support approach within psychological therapies teams will allow the involvement of service users in service provision and will enable promotion of their autonomy.

The network of peer led services, and related groups, will provide valuable support to people who require 'stabilisation' in mental health crises, or other short term interventions. These groups will help self management and enable service users to be less socially isolated. These groups can also be offered to service users waiting for other therapeutic treatments. This approach compliments existing partnership networks within boroughs.

We are aware of the potential impact on residents in each borough of the current economic down turn which may lead to a greater need for mental health support. We do not expect this to increase demand for the psychological therapies delivered by these teams to a significant degree as most people treated in these services have long standing difficulties with mood and relationships, commonly related to early traumatic experiences, rather than triggered by recent or short term social stressors. Demand for treatments related to short term anxiety and depression in response to stressors is provided largely by the Increased Access to Psychological Therapy teams (IAPT), which are well developed in Lambeth, Southwark and Lewisham.

The published Adult Psychiatric Morbidity Survey (APMS) 2009 makes the following comments about risk factors; 'Although poverty and unemployment tend to increase the duration of episodes of common mental disorders (CMD), it is not clear whether or not they cause the onset of an episode. Debt and financial strain are certainly associated with depression and anxiety, but the nature and direction of the association remains unclear. There are a wide range of other known associations, including: being female, work stress, social isolation, poor housing, negative life events, poor physical health, a family history of depression, poor interpersonal and family relationships, a partner in poor health, and problems with alcohol.'

The clear linkage between psychological therapy services and community mental health teams presents a framework where medical, psychological and social needs can be addressed in an integrated approach. This will enable us to respond flexibly to a broader range of issues should they be presented.

7. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive: Medium

Negative: Low

Neutral: High (highly likely)

Reason for your decision:
The proposals will have a positive impact on access to psychological therapy services for people from black and minority ethnic groups.

The proposal will have a positive impact on service user empowerment and involvement through the implementation of peer support models.

We assess that the proposal will have a neutral impact on other equality groups.

The impact of the change will be subject to regular review. Activity data for referrals and treatment against ethnic group, age and gender will be carefully monitored against current baseline. User experience data will be scrutinised to elicit further impact of change. The service user advisory group will remain central to the ongoing management and monitoring of the psychological therapy services.

8. Risks and mitigations

Clinical risks arising from transition

Transition to new services may give rise to clinical risks. These relate to the need to contain staff distress and anxiety at the change in order that safe and effective therapy can be maintained, and also the risk of disruption to the therapeutic contract as a result of the change in staff roles.

We are committed to supporting staff throughout the process. All staff have received an individual meeting with management and HR and team discussions have been held at different stages through the process. These will continue.

Staff affected by the change will be subject to the Trust redeployment procedures. Within this we will provide support and coaching and will work closely to assist people where possible in identifying suitable alternatives.

Patients of the current services have been offered periods of treatment which extend beyond the period of the restructure, raising the question of how therapy can be continued at a time when therapists may be at risk of displacement, redeployment or redundancy. Given that the new services will be delivering approximately 90% of the activity levels of the current services, it is unnecessary to suspend allocation for the period of transition, particularly as this would give rise to additional clinical and financial risks. Where staff are moved to new service structures or redeployed within the organisation, it should be possible to release individuals from their new roles over a transitional period to maintain the commitment to individuals in therapy that their therapy will be completed as planned. In the event that staff do not remain within the organisation, the impact will need to be considered on a case-by-case basis, with options including continuation of therapy by the staff member retaining an honorary contract, shortening the period of therapy by agreement, or the offer of an alternative therapy or therapist. Allocation of a care co-ordinator from a CMHT may maintain continuity and mitigate risk for some individuals.

There will be no premature ending of any of the therapy that we currently offer. In addition we will have in place contingency plans to ensure that specialist supervision, group work and individual work will continue by having a group of staff who can continue this work.

Date completed: 7th March 2012

Signed …… Print name …Simon Rayner

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment