South London and Maudsley NHS
NHS Foundation Trust

Equality Impact Assessment Guidance

What is an Equality Impact Assessment?
An equality impact assessment (EIA) is a systematic way of analysing a policy, function or proposed service change / development to check its potential or actual impact on equality of treatment or outcomes. The EIA process is in two parts; an initial screening and a full assessment. The screening should start as soon as planning is under way, as this will inform and strengthen your planning.

Why carry out Equality Impact Assessments?
EIAs are a method for individuals and teams to use to think about the likely impact of their work and to make sure that, as far as possible, any negative outcomes for disadvantaged groups are eliminated or minimised and that opportunities for promoting equality are maximised. It is a process that will help to identify groups who may be receiving differential treatment or outcomes that are discriminatory or unfair.

The Equality Act 2010 requires public authorities such as SLaM to have due regard [which means an adequate evidence base for decision making] to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

These three aims apply to the following 'protected characteristics:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion / belief
- Sex
- Sexual orientation
- Marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]

SLaM is legally required to conduct analysis of the effects on equality of new or revised policies or service changes/developments. To conduct this analysis policy reviewers/authors and leads for service change/developments should conduct an Equality Impact Assessments to show this has been taken into consideration in all decisions, policies and practices. 'Policies and practices' covers all proposed and current activities which the authority carries out.

An initial screening is carried out to decide if any part of the policy or service change/development is likely to have an impact on equality for any group or groups; that is to identify where differential treatment or outcomes that are discriminatory or unfair may exist. Where it is likely that the proposed policy or service change/development may have a

negative impact it is important to remove or minimise as far as possible any disadvantages suffered by people due to their protected characteristics and to take steps to meet the needs of people from protected groups (often referred to as protected characteristics) where these are different to the needs of other people.

Where required to implement a decision over which the Trust has no control an equality impact assessment should still be conducted, and where there is a likely impact to consider mitigating measures or alternative ways of doing things to minimise the impact and to meet our legal requirements as outlined in the public sector duty.

What equality groups need to be considered?
The EIA process should cover the following areas:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion / belief
- Sex
- Sexual orientation
- Marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]

THE PROCESS:
When should an EIA be carried out?
The process of conducting an equality impact assessment should not be an after-thought, but part of the 'day to day' work, and the initial screening used as early as possible in:

- the development of new policies and procedures
- the review of current policies
- the development of a business case
- the planning stage of all new services changes/developments/projects

The full EIA assessment should be conducted for:

- All policies, functions and service developments where an adverse or negative impact on equality group(s) has been identified during the initial screening process.

Who should conduct the EIA?
It is important that the process is conducted by those working and planning the policy, function or service change/development. They will have expertise in that particular area as well as a thorough understanding of the main aim, objectives and intended outcomes.

Part 1 – the initial screening

The initial screening prompts, through a series of questions, an assessment of negative impact or gaps in knowledge about likely impact. It should be a relatively short process which uses a range of information, such as:

- personal knowledge and experience
- relevant research and reports
- previous consultation results
- analysis of complaints, comments, surveys or audits
- demographic data and other statistics including census results
- Trust equality monitoring data
- specialist advice (internal and external)

The information collected during the initial screening should be analysed to decide whether the policy, function or service change/development could potentially affect different groups of people/protected characteristics, and whether any of these differences are likely to result in a negative impact. As well as a negative impact, the screening process may highlight a neutral impact, a positive impact or a differential impact (where the impact on one or more protected characteristic may be greater than for another).

Neutral impact
There may well be some policies that are assessed as having no specific impact or relevance to equalities. This will become evident during the initial screening process and, where there is a neutral impact, the full assessment is not required although it is important to always set out the evidence for this decision.

Positive impact
The assessment may show a positive impact for one or more protected characteristics, or an improvement in relationships between people who share protected characteristics. This impact may be differential, where the impact on one group is greater than for another group.

Negative impact
A negative impact is where the way the policy, function or service change/development is implemented or provided may, often unintentionally, result in inequalities or discrimination being experienced. This disadvantage may also be *differential*, where the negative impact on one protected characteristic is likely to be greater than for another.

The process and findings of a screening need to be recorded, even when it highlights that a positive or neutral impact is likely.

Part 2 – the full impact assessment

If the initial screening shows that a negative impact seems likely a full assessment should be conducted to establish the extent of the impact and to make recommendations aimed at minimising any negative differential in outcomes.

As with the screening stage it is important to be clear of the aims, objectives and specific outcomes you hope to achieve from the proposed policy, function or service development.

Using the evidence

Which of the protected characteristics is likely to be affected? Consider the evidence, what does the data show? Is quantitative and qualitative information available in-house and externally from relevant community groups or networks? Is there strong evidence, some evidence with considerable gaps or is it anecdotal? Does the information need to be supplemented through new consultation exercises to fill the gaps?

Consultation and involvement

Internal and external consultation is an important and on-going part of the process. Identify and consult people from relevant groups who are likely to be affected, tailoring the methods used to best reach the various groups, e.g. using existing networks, consultation meetings, focus groups, reference groups and survey questionnaires. Local SLaM diversity groups will also be a helpful resource (CAG Equality Leads[1] will be able to provide details on these groups and also on local service user networks). Externally, identify relevant stakeholders who are interested in promoting equality from individuals to community groups.

[1] Each clinical academic group has at least one Service Equality Lead. If you are not sure who this person is, contact kay.harwood@slam.nhs.uk or phone 020 3228 2157 for guidance.

Remember to circulate results of any consultation and feed them back into your planning and decision making processes.

Assessing the evidence
This involves making a reasonable judgment on the evidence you have drawn together as to whether there is likely to be a negative impact on some protected characteristics. It may be that the evidence indicates both positive and negative impact is likely for some, and if this is the case you will need to balance these when making a decision about the likely overall effect of implementing the policy, function or service development.

The following questions may be useful when assessing the likely impact:

- Do you need to make changes in response to concerns raised by interested groups and relevant stakeholders, or issues raised during any consultation that has been conducted for the assessment process?

- Is there is potential for the policy, function or service change/development to be directly or indirectly discriminatory? If there is, you should find another way to meet the aims. If it is indirectly discriminatory and there is no alternative way can you justify the decision to proceed as it is?

- If the policy, function or service change/development is not directly or indirectly discriminatory is there still potential for some groups to experience a negative impact on equality of opportunity or good community relations? If a negative impact is likely can it be justified because of the overall objectives of the policy, function or service change/development, or can it be adapted so that it compensates for any adverse effects?

- Could other measures be taken to reduce or remove the negative impact without affecting the overall aim of the policy, function or service change/development?

- Will any changes to the policy, function or service development be significant and will you need to consult about them?

What should be published?
Results of all EIAs should be published. Even if the screening process shows that there is no negative impact, this should be published so that groups and individuals can see how this conclusion was reached and enable them to respond if they feel it is inaccurate. This is another reason why it is important to support your decisions with appropriate evidence. In order that is clear why a particular service development or policy has been assessed as having a neutral; positive or negative impact. Decisions on any changes made as a result of the assessment should also be noted.

Remember to feed back results to everyone who has contributed to the assessment and ensure that the information is available to all interested parties.

Where the full assessment is very detailed a summary of the assessment may be published, however, the complete documentation should be made available to anyone who requests it. Your CAG Equality Lead or Kay Harwood will provide advice on this, and they will also arrange for the assessments to be placed on the Trust website.

External verification

Once completed, EIA's relating to service developments may require external verification. Your CAG Equality Lead in consultation with the CAG Service Director/CAG Executive will advise if the process you have used is sufficient, or if external scrutiny of the assessment should take place, via a relevant group or groups, such as a local Partnership Board or Overview and Scrutiny Committee. If external scrutiny is required the CAG Service Director/Equality Lead will make the necessary arrangements.

Further advice

If you have any questions when working through the assessment contact your CAG Equality Lead or Kay Harwood by emailing: kay.harwood@slam.nhs.uk or phone: 020 3228 2157

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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?

Establishment of a Home Treatment Team as part of the Mental Health for Older Adults and Dementia (MHOAD.

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)
[The EIA should, wherever possible, be completed and considered in a group]

Lead: David Norman/Cha Power

Others involved:
e.g. staff, service users / service user consultants / carers / carers consultants:

This EIA draws on the views of staff, service users, carers and those who work with older people in Lambeth and Southwark.3. Describe the main aim, objective and intended outcomes of the service change?

Aim
SLAM is seeking to *redesign* services in order to avoid unnecessary admissions to hospital based services. The primary motivation in doing so is the need to provide more appropriate, effective, efficient and patient centred 'crisis' care.
There is significant evidence (see elsewhere in this assessment) to suggest that
1) the majority of patients would prefer to be supported and 'treated' in their own home;
2) prolonged periods spent in hospital can have a detrimental impact on an individual's ability to recover from a 'crisis'.

Objective –
These proposals will enable the MHOAD to better meet the needs of those who experience 'crisis' incidents, provide quicker, more effective interventions within the home. It is important to underline that reference to 'home' include all relevant types of residence, including an individual's house or flat, or sheltered accommodation.

The basic proposal is for MHOAD develop a new Home Treatment Team (HTT) to provide early interventions for people experiencing or at risk of 'crisis' in their own homes. As a result of reduced admissions over time there may be a reduction in bed numbers.

The Lambeth and Southwark Older Adults Home Treatment Team will provide comprehensive and accessible crisis resolution and home-based care and treatment to people in the acute phase of mental illness which, in the absence of the team, would result in admission to hospital. It will be a multidisciplinary service offering crisis assessment , home treatment and onward referral for the residents of Lambeth and Southwark

The team will:

- Gatekeep all Lambeth and Southwark admissions to the MHOA&D CAG inpatient beds.
- Oversee the allocation of the MHOA&D CAG inpatient beds.
- Offer an assessment service for residents of Lambeth and Southwark who, immediately prior to the team's involvement; have been assessed as requiring admission to hospital.
- Provide intensive home-based treatment to patients in the acute phase of mental illness, thus diminishing the need for hospital admission.
- Facilitate early discharge from hospital
- Secure appropriate follow-up care for the patient once the alleviation of the acute phase of mental illness has occurred.
- Be fully integrated into the Lambeth and Southwark mental health systems and the community as a whole.

Principles of the Service

The team will:

- Provide a safe and effective home based alternative to hospital admission for residents of the area defined as Lambeth and Southwark.
- Provide rapid assessment and intensive planned care 7 days a week.
- Oversee the allocation of inpatient beds for the MHOA&D CAG. All patients living in Lambeth and Southwark who are deemed to require more intensive input will be assessed by the HTT prior to any allocation of an inpatient bed. All patients living in Lewisham and Croydon will not be assessed by the HTT.
- Act as gatekeeper to all Lambeth and Southwark MHOA & D beds by ensuring that each patient referred for inpatient care receives a

comprehensive assessment before a final decision is reached as to eventual treatment location.

- Facilitate early discharge for inpatients and providing high intensity support in the community.

- Work co-operatively and collaboratively with patients, their families and carers, primarily in their place of residence, and encourage them to take an active part in the decision-making process regarding the care they receive.

- Recognise the pivotal role of family and carers and aim to provide them with or signpost them to the relevant support.

- Acknowledge the importance of a patient's current and potential support system which can include the community as a whole as well as voluntary and statutory agencies. The team will engage and work within the patient's support system when conducting assessments, providing ongoing care and when planning a patient's discharge and aftercare from the service.

- Recognise that Lambeth and Southwark have a richly diverse population. The Team's aim will be to provide care that is constantly sensitive and appropriate to the patients' circumstances, gender, ethnicity, language and culture. Patients will be assisted in accessing specific services relevant to themselves and their individual needs.

- Remain relevant to both patients of the service and the Lambeth and Southwark mental health system for older adults as a whole. For this reason, the team will encourage ongoing dialogue and feedback with individuals and organisations which will assist in shaping the team's operation and activity.

4 (a). What evidence do you have and how has this been collected? *[Please list the main sources of data, research and other sources of evidence reviewed to determine the impact on the equality groups, sometimes referred to as protected characteristics. Your data can include demographic data, access data, national research, surveys, reports; focus groups; information from your service?]*

Evidence suggests that SLAM currently provides a greater number of hospital beds per head of the local population(s) as compared with the national average and has higher admission rates than other similar urban areas, including other London boroughs (see main assessment). There is also emerging internal evidence which suggests that patients experience longer stays on existing SLAM wards that those in other similar units. The proposed service development of Home Treatment Team as part of the wider Mental Health of Older Adults and Dementia Clinical Academic Group, (MHOAD) is an attempt to redress a historical over reliance upon in-hospital services. This will achieved by developing and delivering improved home based interventions, including during periods outside current service hours.

We have used data relating to local population, service use and service evaluations from both the Trust and other MH units. This data covers a number of the equality protected

grounds, however there are gaps in terms of current data collection (for example in relation to disability) and these are addressed in the action plan which accompanies this EIA.

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

YES

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	YES
Disability	YES
Gender reassignment	YES
Pregnancy and maternity	NO
Race	YES
Religion / Belief	NO
Sex (?)	YES
Sexual orientation	YES
Marriage and civil partnership	YES

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)
Group NO

5. Have you explained your policy / function / service development to people who might be affected by it? *(Please let us know who you have spoken to and the results of these conversations and what actions/ developments/ changes have come out of them)*

Yes

If 'yes' please give details of who you involved and what happened as a result.

- Staff consultation - Staff consultations were held in February 2012. Staff were given the opportunity to be seconded into the Home Treatment Team for the duration of the pilot.
- User consultation – The "Being Involved" Group – which is effectively our current Service user and Carer Advisory Group in MHOAD CAG, received three presentations on the proposals to develop the Home Treatment Service – they gave constructive and useful

feedback which shaped the development of the service. This group is made up of service users, carers and ex-carers. Many ex-carers expressed the view that they would have welcomed the existence of a HTT when they were caring for their loved ones.
The start of the pilot in June 2012 will see managers increasingly consulting with local agencies, discussing ways in which the service can be delivered and improved. A Service user and carer participation group has been established which will also guide the development of the pilot in the coming months.

- Carers consultation - Carers groups supported by the Alzheimers Society were consulted on the development of the Home Treatment Service. The proposal received a positive response. The CAG has Advisory Groups in each of the four boroughs it serves. Notification of the development of the Home Treatment Team was brought to both Southwark and Lambeth meetings. Both have asked to be kept informed. Feedback from these meetings informed the development of the pilot.

6. If the policy / function / service development positively promotes equality please explain how?
The proposals will lead to the provision of enhanced 'out of hours' services, which will effectively ensure that older people can access the same levels of service currently available to working age adults.
Community Mental Health Teams currently operate Monday to Friday (office hours). The new service would represent a significant extension of provision, with the Home Treatment Team (HTT) operating seven day a week, 365 days a year between the hours of 9am and 8pm. This means that the proportion of the week during which the HTT can provide 'crisis' care will be significantly increased. The following EIA includes proposed measures to enable MHOAD to cover the remaining periods (outside HTT's operating hours).

Disability – Our service users include people with dementia, learning disability, physical disability/health issues. Our service will support them by treating them in their own home, thus preventing hospital admission, unless the crisis cannot be treated at home. The emphasis in the work of the HTT will be to keep people in their lives, and in their communities as far as possible.
Age – this change brings services for older people into line with those for people in other age ranges.
Ethnicity – opportunity to ensure services are culturally appropriate and responsive to the needs of services users from different ethnic groups. The HTT will liaise with local BME groups to ensure they know about their service and can receive referrals – links will also be established with the BME volunteer programme in SLAM to seek support from BME volunteers to support people – such as accompanying people to lunch clubs, or church.

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:	High (highly likely to promote equality of opportunity and good relations)	Medium (moderately likely to promote equality of opportunity and good relations)	Low (unlikely to promote equality of opportunity and good relations)
Negative:	High (highly likely to have a	Medium (moderately likely to have a	Low (probably will not

negative impact) negative impact) have a negative impact)

Neutral: High (highly likely)

Reason for your decision: The nature of the services which are provided means that this development is clearly relevant to the equality duty. It is important therefore to ensure that the service development does not lead to any unintended consequences for particular groups and communities and that these service changes are properly assessed so that we can identify any potential problems at the earliest possible stage and put in place measures to remove any potential discriminatory or inequality of access and outcome.

Date completed: ……..

Signed ……. Print name ……..

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

Given that there is the potential for this policy to affect different groups differentially, it has been decided that the policy would benefit from a full equality impact assessment. This will enable us to identify gaps in current approach/systems and identify additional support for particular groups and communities. This will ultimately strengthen the policy overall.

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

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

Establishment of a Home Treatment Team as part of the Mental Health Older Adults and Dementia (MHOAD).

2. From the initial screening process, which groups may experience negative impact?

Age	YES
Disability	YES
Gender reassignment	YES
Pregnancy and maternity	NO
Race	YES
Religion / Belief	NO
Sex	NO
Sexual orientation	YES
Marriage and Civil partnership	YES

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)

Group:…… NO

It is important to underscore that as we are dealing with mental health services (which clearly fall within the definition of disability for the purposes of the Equality Act 2010, thus all significant changes to these services are deemed relevant to the duty.

Introduction

This proposal is in line with significant policy and academic thinking regarding the most effective interventions for older people with mental health issues.

This now substantial literature underscores the importance of
1) early, community and home based interventions which avoid unnecessary admissions,
2) early, appropriate and non-delayed discharge.

The literature is explored in greater detail below. This literature includes JRF, 2011, Older People and High Support http://www.jrf.org.uk/sites/files/jrf/older-people-and-high-support-needs-full.pdf), McGlynn, P (ed) (2006) **Crisis Resolution and Home Treatment: A practical guide, The Sainsbury Centre for Mental Health 2006** http://www.centreformentalhealth.org.uk/pdfs/Crisis_resolution_and_home_treatment_guide.pdf and http://www.centreformentalhealth.org.uk/pdfs/crisis_resolution_mh_topics.pdf and Pinner, G et al (2011), In-patient care for older people within mental health services, Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists. The latter notes that:

'Significant numbers of mental health beds have been reportedly occupied by people whose discharge has been delayed: 13.3% of functional mental illness beds and 28.6% of organic assessment beds in a national survey by the Faculty of Psychiatry of Old Age (Barker & Bullock, 2005). More recent findings by the Mental Welfare Commission for Scotland (2010) show very similar results, reporting that on average 2.5 patients on dementia assessment wards and 0.75 patients on functional assessment wards are there because of delayed discharges at any one time, the main delay being patients waiting to move into a care home.'

It concludes:

'Community services must be developed to allow proper alternatives to in-patient care to avoid unnecessary admission. Services such as crisis intervention and home treatment are all too often exclusive to adult mental health services, but arrangements should be made within trusts to provide equally relevant services for older people. This is an area which is clearly age discriminating and contravenes the Age Discrimination Act that will be enforceable by 2012.'

The proposed service change will enhance access and therefore improve service provision for groups across the broad equality agenda. Key improvements will include:

(i) Extending service provision
(ii) Equalising services for all age groups
(iii) Greater opportunities to develop and deliver integrated care packages.
(iv) More bespoke support for individual service users, their families and carers.
(v) Reducing disruption for individuals, their families and carers.

Current provision
MHOAD currently provides 81 acute beds across the trust. This is significantly higher than for other comparable parts of London. The pilot will demonstrate if there is a possibility of reducing bed numbers in order to reconfigure services to be more bespoke and cost effective.

Bed numbers in Neighbouring Trusts

TRUST	BED NUMBERS	AGE GROUP	HOME SERVICE	FUNCTIONAL/ORGANIC SPLIT
Oxleas	73	65	No	Yes
South West and St Georges	41	75	Yes	No
CNWL	31	65	Yes	No
East London and City	70	65	No but specialist Dementia Teams	Yes
West London NHS Trust	48	65	No	No

3) What evidence do you have? Please give details.

a) Strong evidence

There is a strong national and local evidence base for the proposed changes. This draws on local service level data, service reviews and audit, DH/NICE guidance and advice and independent research by think tanks and academics. This has been supplemented with findings from recent consultation exercises with MHOAD patients, carers and staff (2010 and 2011/2012

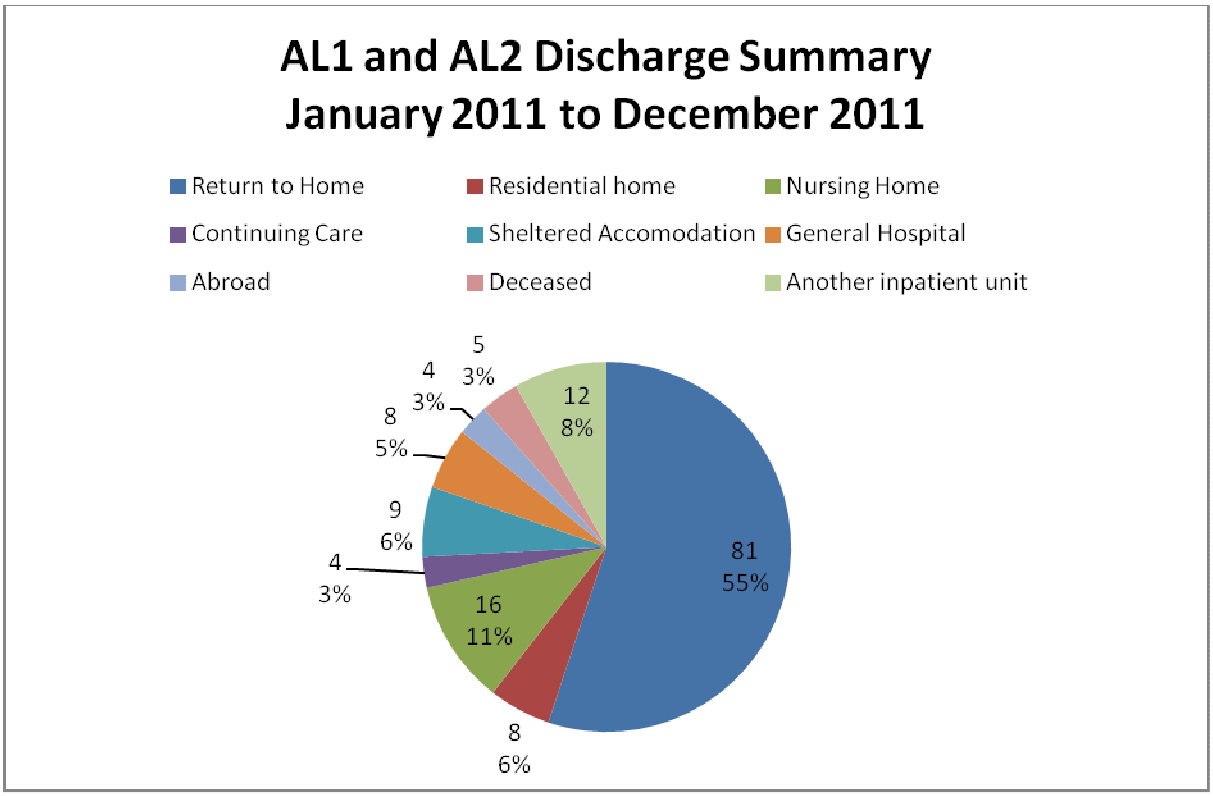
In addition, the Home Treatment pilot will be evaluated through a Programme Board consisting of representatives from NHS and Social Services commissioners, Social Services managers, clinicians from the MHOA service, and representatives from Kings and St Thomas's hospitals and the voluntary sector.
There will be a separate service user and carers reference group which will provide input into the development of the pilot and any subsequent recommendations. The draft terms of reference for these groups are attached. This group will support further engagement exercises between August 2012 – March 2013.

Action: A draft version of this EIA and/or a summary version will be circulated to both stakeholder groups.

MHOAD in-Patient activity
(i) Historic and current over provision of in-hospital services within SLAM
There is evidence to suggest that SLAM has historically retained and used a greater number of beds (per head of the population) than other comparable (location, social mix and population size) areas/boroughs. Internal records show the following:

	MAY 2011	JUN 2011	JUL 2011	AUG 2011	SEP 2011	OCT 2011	NOV 2011	DEC 2011	JAN 2012	FEB 2012	MAR 2012	APR 2012
AL1	33	28	24	40	49	34	51	47	45	39	46	0
AL2	45	46	33	60	27	65	39	23	35	35	34	28
Chelsham	66	40	51	35	33	49	32	45	42	29	32	20
Hayworth	45	43	27	59	46	21	43	45	44	34	73	62

(ii) A substantial proportion of those leaving AL1 and AL2 'go home'
Table two shows that 81% of those discharged (or leaving AL1 & AL2) during 2011 returned 'home' (using the broad definition outlined above of home being a person's residence). Just 8% went directly to another inpatient mental health service, with a further 5% entering into general hospital care.



This data underlines the importance of continuity of care and importance of the 'home' environment in the provision of on-going long-term care. It also prompts the question of whether it would be more appropriate to try and keep people in their own homes and provide on-going interventions in these and other community based settings.

Academic and policy evidence to support a move towards home based care
There is now a considerable body of evidence to support a shift away from traditional hospital based care for older people with mental health diagnosis. This literature which dates back to 2001 and beyond, argues that more effective outcomes can be achieved by a combination of early, home based interventions and a focus on

ensuring timely, non-delayed discharge from hospital settings (in appropriate cases). This literature includes academic, think tank and service provider evidence.

Commission for Social Care Inspection (2006) stated that service users who have made the transition to older people's service noted the inequality of provision

Kings Fund and Centre for Mental Health (2010) : to meet current financial challenges strengthen home treatment and crisis especially in older adults where provision is "patchy"

"Mental Health and the Productivity Challenge: Improving quality and value for money" (Naylor, C. & Bell, A (2010), Mental health and the productivity challenge Improving quality and value for money, Kings Fund, London http://www.kingsfund.org.uk/publications/mental_health_and.html) which says that improving value for money can often be achieved by also improving the quality of services.

The report's three key messages about the way that older people's mental health services can contribute to improving productivity are that:

- *Delivering services to care homes can reduce the use of primary and secondary health services, and can also reduce unnecessary prescribing of antipsychotic drugs, which are currently estimated to be overprescribed to the value of £14 million per year*
- *Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates*

Perhaps most importantly in the context of this assessment, the Kings Fund report quotes Anderson et al (2009) which suggests that:

Provision of specialist older people's CRHT services can reduce hospital admission rates by up to 31 per cent, as well as reducing length of stay and admission to care homes (Anderson et al 2009).

This forms a major part of the rationale for the current service proposal. It is not simply that more effective home based interventions can reduce hospital stays and readmissions, but rather it can wholly avoid unnecessary admissions in the first place by facilitating earlier interventions, which prevent individuals entering full blown crisis.

The most exhaustive analysis of the evidence base for home based interventions has been provided by Dr Sara Turner (2011). The following section provides an overview of this analysis.

The notion of introducing models of crisis intervention which is built around home treatment teams is not a new one. The NHS National Service Framework for Mental Health (published in 1999) proposed that such arrangements should be at the heart of future mental health provision.

However, take up and implementation during the intervening period has been somewhat patchy, although by 2005, 243 CRHTTs had been established (Turner, S, Reviewing models of crisis and home treatment teams to aid planning a better community service). In relation to provision for older people the picture was much starker – just 9% of areas had introduced specialist services for older people, and in many of these the services were available for shorter periods than comparable services for the wider population (Turner & Healthcare Commission). An earlier Healthcare Commission review of older people's services found that:

The out-of-hours services for psychiatric advice and crisis management for older people were much less developed, and older people who had made the transition between these services when they reached age 65 said there were noticeable differences such as poorer quality, fewer services and less support. (Healthcare Commission)

Action: It is clearly important that the service provision offered by HTT matches that of comparable services for other age groups, in order to ensure equality of service and provision under the Equality Act 2010.

Hospital stays can have a longer term detrimental impact on an individual's longer term health prospects. As Turner underlines:

The main reasons that people with functional problems are admitted to hospital are because of risk of suicide or self-harm (may be psychotic or non-psychotic) or because of an acute psychotic episode. The unintended consequence of admission to hospital is that there is a loss of independence and there can be difficulties for both the person and the support system in re-establishing the previous level of acceptable/adaptive functioning. The loss of confidence from an admission can often make it difficult to achieve discharge without substantial packages of support. The philosophy behind crisis and home treatment teams has been to put short term intensive treatment and support into the community setting to maintain all of the links that the person has. When admission is unavoidable, such a team can also provide intensive input to promote earlier discharge and rebuild confidence.

As Turner shows a number of localities have already adopted the home based care model and there are further examples which underline the growing importance of this approach for the care of older people with mental health diagnoses. The proposed approach has already been explored and adopted in other London boroughs. Islington is pursuing this approach having identified that ineffective community based interventions have historically led to an over reliance on hospital based services. It noted:

'weaknesses in community based services can lead to avoidable admissions to acute hospital care, while over reliance on residential care diverts money away from community services, reducing their capacity.' (Islington, Joint Commissioning Strategy - http://www.ncl.nhs.uk/media/43939/120511-joint-commissioning-strategy.pdf)

The current proposal will allow SLAM to redress this imbalance.

A further example is provided by West Sussex NHS which recently commissioned a review of its acute bed provision for older people which recommended a move toward home based care (NHS West Sussex, (http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media//publications/consultations/improving-mental-health-services/Sussex_Older_Peoples_Mental_Health_Services_Review_of_Acute_Bed_Provision.pdf)

The proposals for the establishment of a HTT is clearly in line with the wider national agenda of a move away from traditional hospital based treatment to more responsive, individualised and effective home based care services.

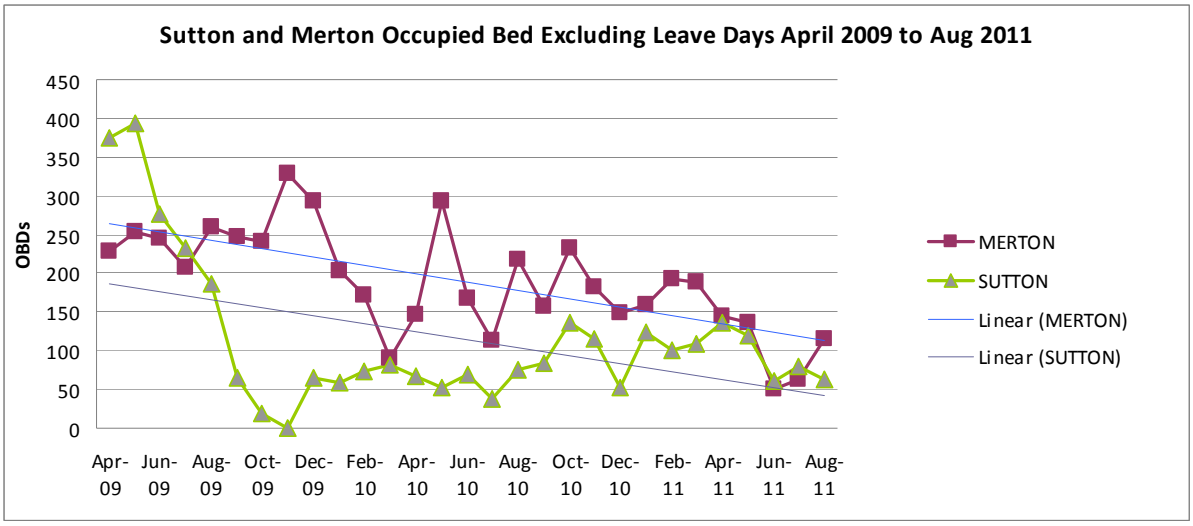
Evidence of more effective interventions

Turner's review of a range of older people's HTTs found that their development led to improved outcomes for service users and a reduced reliance on in-hospital services. A review of a HTT in Sheffield found *'no re-admissions within 28 days and a reduced rate of re-admissions over a period up to a year'* (Turner, 2011). Turner notes that there are *'clear suggestions that the establishment of Specialist Older People's Teams has had an effect on admissions and discharges however the evaluations have again not been robust so results also have to be treated with caution'* (Turner, 2011).

Turner concludes:

'The evidence presented so far in this report supports the view that older people can frequently be maintained in their own homes if timely, intensive input is offered to them. Those services which previously reported pressure on beds no longer report this and those which have reduced bed numbers have reported success. The evidence is not hard research evidence from controlled research trials but it is consistent. The reports of service users, carers and professionals have been almost universally positive with any concerns about having several people involved in the care of an individual not being borne out in practice' (Turner, 2011)

A review of Sutton's Intensive Home Treatment Team (pilot) which was established in 2009 found that a significant decrease in the number of hospital beds used (comparison with neighbouring Merton) following the establishment of the IHTT.



Sutton OPMH services have seen fewer inpatient admissions over this period than the other Borough Services:
As a result, Sutton had far lower hospital admissions compared to its neighbouring boroughs –

In developing the pilot the following questions were considered.

Do we have the correct hours of service?
The establishment of the HTT would see some service users move from 24/7 to home based services. This raises the question of whether the HTT should operate 24/7. Evidence from other similar HTTs suggests that 24/7 is not the norm. Turner's review found that no existing service provides an around the clock service and just one providing telephone support at night. Most services appear to operate extended hours, usually 7am – 10-11pm (Turner, 2011).

One review paper wrote of night time admissions found:

"Overnight presentations requiring immediate admission are rare in the over-65 age group. The Generic Home Treatment Team was the only service we visited that was fully operational on a 24/7 basis and saw an average of just two older people presenting at night per month. Our own local audit of acute psychiatric admissions found that fewer than 8% of older adults admitted over a one-year period had presented in crisis overnight (between 8pm and 8am), and three quarters of these night time admissions were under the Mental Health Act, suggesting that home treatment was probably inappropriate at that point in time."

It is important that we think about this gap and consider the options on the basis that HTT will provide a core between 9am and 8pm.

As outlined above, the Home Treatment pilot will be evaluated through a Programme Board consisting of representatives from NHS and Social Services commissioners, Social Services managers, clinicians from the MHOA service, and representatives from Kings and St Thomas's hospitals and the voluntary sector. In addition, there will be a separate service user and carers reference group which will provide input into the development of the pilot

and any subsequent recommendations. They will support the managers to consider gaps throughout 2012/13.

Service user, relative and carer feedback will be obtained.

Complete and reliable information and outcome measures will be obtained from
HoNOS65+/MHCT: at assessment and discharge
Zarit Burden Interview: at assessment and discharge

Staff and team well-being will be assessed.

It is hoped that the development of the HTT will inform the evidence base for home treatment for older people.

Role of the HTT

It is proposed that the HTT will provide a range of services and interventions:

- Handle staged discharge of those leaving hospital and establish care packages to help avoid readmissions
- Provide home visits
- Work with relevant providers to identify service users at risk of crisis
- Be the first point of contact for services experiencing or on the verge of a crisis.
- Act as 'gatekeepers' to relevant key services
- Work with hospital based colleagues to ensure continuity of treatment and wider provision
- Facilitate access to psychological services.
- Ensure continuity of provision between services.
- Signpost service users and carers to other relevant services

Currently the team is co-located on the MHOAD CAG Aubrey Lewis 2 Ward. The team operates from 9am-9pm Monday- Friday and 10.am-6pm at weekends and will be available 365 days a year. Current staffing is provided by existing ward and community staff with one new appointee (HTT Manager) on secondment. This is in order to see if the HTT model is effective, efficient and provides good value for money.

It is important to note that the establishment of HTT does not mean that those service users who use the HTT will not be able to access in-hospital services if they are required. HTT members will be able to fast-track those service users who need in-hospital treatment and will have the skills and capacity required to handle the most complex cases.

Continued availability of hospital provision for those who need it
It is also important to underline that in-hospital and other residential alternatives will still be available to those for require, including those for whom their home circumstances are at the root of their mental ill health.

Action: Set out protocols for admission to in-hospital services.

Action: Training for HTT members on hospital referrals. This is already being implemented as in the current pilot the team is located on the ward, working directly with ward staff on admissions and discharge. This is being explored as a model for future work.

Analysis of equality data

(1) Ethnicity breakdown of crisis patients

Detailed data is provided in the following table.

	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	Z	Not Recorded	Total
Croydon	1062	60	180	4		2	5	61	18	1	32	86	15	14		15		20	1575
Lambeth	286	76	234	4			1	22	7	1	25	185	42	13	3	27	1	19	946
Lewisham	477	38	137	3	2			6	1		13	140	26	7	2	9	1	9	871
Other Borough	6		2								2								10
Southwark	296	50	120	4	1	1	3	4	1	1	7	84	24	10	4	19	2	3	634
Total	2127	224	673	15	3	3	9	93	27	3	79	495	107	44	9	70	4	51	4036

A	White British
B	White Irish
C	White Other
D	White & Black Caribbean
E	White & Black African
F	White & Asian
G	Mixed Other
H	Indian/British Indian
J	Pakistani/British Pakistani
K	Bangladeshi/British Bangladeshi
L	Asian Other
M	Black Caribbean
N	Black African
P	Black Other
R	Chinese
S	Other Ethnic Groups
Z	Not Stated

This data shows a significant difference in the proportions of white British and other Black and ethnic minority communities across the different boroughs, with higher numbers of BME service users in Lambeth and Southwark. It will be important that as the policy is developed, the resulting services deliver improved outcomes for different communities. The previously mentioned review by NHS Islington argued that a greater emphasis on community based interventions can help improve services and outcomes for particular groups and communities:

'With poor experiences and outcomes obtained in psychiatric hospitals, alternative services for the black and ethnic minority population present a new and innovative way of providing acute mental health care. Such services have taken due consideration of cultural needs and the problems experienced by these communities. Our indications are that such considerations are welcome but that the problems of working with marginalised communities may lie not singularly in providing culturally specific services but in working with staff to enhance cultural understanding and further consideration of patient-centred care provision.' (Islington, Joint Commissioning Strategy - http://www.ncl.nhs.uk/media/43939/120511-joint-commissioning-strategy.pdf)

Action: Map all relevant service use by ethnicity.
Action: Review service user records to determine whether any service users require language support or other additional needs.
Action: Ensure that all HTT members receive comprehensive equalities training.
Action: HTT to make contact and build working relationships with local community organisations which work in particular
Action: HTT management should consider diversity profile

2) 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 as the disability will be detailed in the case notes narrative.

In relation to mobility, all the buildings 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 our service is principally based on the severity and complexity of the mental health condition, which could be a depressive illness, an anxiety disorder, a personality disorder, dementia, or any other mental disorder such as bi-polar affective disorder, but diagnosis per se is not a criterion for acceptance or exclusion from services.

All of those using wards AL1 and AL2 are for the purposes of this EIA covered by the Equality Duty by virtue of their disability mental health. It is clearly important that this is considered in the development of the HTT. It is also important to consider the wider disability needs of service users.

However, MHOAD currently only collects disability data as part of the narrative recording of the 'patient journey', it does not routinely collect wider disability monitoring data.
This is a significant gap which we will develop address as outlined in the action plan

Action: Introduce routine data collection of disability related data. Consult local disability organisations in order to ensure the most appropriate approach to collection.
Action: Undertake an assessment of the disability needs of existing service users.
Action: Once meaningful data has been collected, undertake detailed analysis of the wider disability impact and implement appropriate remedial measures and service adaptations.
Action: Ensure that all communication (verbal and written) is delivered in appropriate formats. Identify appropriate sources of communication support.

3) Gender
The following table shows current service use by gender and borough for the last twelve months

	Female	Male	Total
Croydon	1007	568	1575
Lambeth	573	373	946
Lewisham	548	323	871
Other Borough	6	4	10
Southwark	399	235	634

As the above table demonstrates there is significantly greater service use by women. This is in line with the national picture which demonstrates that there is a clear gender dimension to mental ill health in the UK (NHS Confederation (2011) Key facts and trends in mental health, London - http://www.nhsconfed.org/Publications/Documents/Key_facts_mental_health_080911.pdf)
Such patterns mean that the majority of those affected by the proposed changes are likely to be women. It is therefore important that as the policy is developed that those responsible are aware of the needs of both men and women.

Action: Consultation and discussions with service users and carers should seek to determine whether female and male users have different service needs.

4) Sexual Orientation/ Gender re-assignment/transgender
We do not currently collect this data. It is not clear that it would be appropriate to collect systematic data relating to sexual orientation. MHOAD will seek advice from local LGBT organisations and/or Stonewall as there may be steps which MHOAD can take to make sure that the service is inclusive and accessible – for example, ensuring recognition of same sex partners. The service is available to this group 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 Marriage and civil partnerships
Mental Health Older Adults services are available to all people irrespective of their marital or civil status. We do not believe there is any disproportionate impact.

Action: Consider whether to introduce data and record rationale for decision (either way).
Action: Undertake a quick review of key systems (information recording – civil partnerships, next of kin policies et al) to ensure that they are inclusive and appropriate.
Action: Ensure that staff equality training includes a sexual orientation and age component.

5) Age
The following table shows the age profile of service users by borough.

	0-15	16-18	19-35	36-65	65+	Not Specified	Total
Croydon			3	112	1460		1575
Lambeth			3	35	908		946
Lewisham			2	70	793	6	871
Other Borough					10		10
Southwark				22	612		634

6) Religion and belief
We collect information 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. Supervision of staff provides a focus for the delivery of a service 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 record the details of religion and belief within clinical case records. Part of the action plan we are developing will ensure this data is entered into our data set to enable monitoring.

We will review to review to identify potential impacts and barriers

Good relations
Need to consider how the service development will be perceived by wider communities. Need to ensure that the changes are communicated clearly in order to avoid any misconceptions (as in earlier media coverage of 'Care in the Community' in the 1980s).

Action: We are developing a communications plan with the team implementing the pilot, explaining rationale and evidence for changes and we are ensuring transparency about plans. We have informed local stakeholders about the development. MHOAD is developing a new website that will hold information on the pilot and our findings.

4.. Please outline steps taken during the EIA process to raise awareness and consult/involve interested parties and those who may be affected by the policy / function / service development

Staff consultation- Staff consultations were held in February 2012. Staff were given the opportunity to be seconded into the Home Treatment Team for the duration of the pilot.
User consultation – The "Being Involved" Group – which is effectively our current Service user and Carer Advisory Group in MHOAD CAG, received three presentations on the proposals to develop the Home Treatment Service – they gave constructive and useful feedback which shaped the development of the service. This group is made up of service users, carers and ex-carers. Many ex-carers expressed the view that they would have welcomed the existence of a HTT when they were caring for their loved ones.
The start of the pilot in June 2012 will see managers increasingly consulting with local agencies, discussing ways in which the service can be delivered and improved. A Service user and carer participation group has been established which will also guide the development of the pilot in the coming months.
Carers consultation - Carers groups supported by the Alzheimers Society were consulted in the development of the Home Treatment Service. The proposal received a positive response. The CAG has Advisory Groups in each of the four boroughs it serves. Notification of the development of the Home Treatment Team was brought to both Southwark and Lambeth meetings. Both have asked to be kept informed. Feedback from these meetings informed the development of the pilot.

5. What does available evidence / results of consultation show?
The results of the engagement exercises to date indicate that local communities are interested in the development of the HTT and wish to remain informed and involved. This is why a Programme Board for the pilot as well as the user and carer Reference Group have been established. As outlined above the pilot is an important contribution to national knowledge on the effectiveness or otherwise of a Home Treatment Service for older adults.

6. If you have not been able to conduct consultation how do you intend to test out your findings and recommended actions?
This is a pilot. Consultation and engagement has commenced and will continue throughout the period of the pilot.

7. What changes or practical measures would reduce the negative impact on particular groups? (Think what a successful outcome would look like and what can be done to bring about this outcome)

See attached action plan.

If changes are required please complete the action plan template overleaf

8. What are the main conclusions of the assessment?
The main conclusions of the assessment are that it is correct to have a pilot phase of the Home Treatment Service in order to be sure that it meets the requirements of our local communities.
It is necessary and important to seek the support and partnership of our local stakeholders in this programme of work.

9. Has a monitoring process been established to measure/review the effects of the policy, function or service development? (This may include statistical analysis of monitoring data, satisfaction surveys or use of networks)

A senior psychologist is leading on measuring the effects of the pilot.

Yes (if yes, please include details in the action plan overleaf)

Date completed: ……..

Signed ……. Print name ……..

Please send an electronic copy of the completed assessment, action plan (if required), any relevant monitoring reports used and a summary of replies received from people you have consulted, to:

1. Kay.harwood@slam.nhs.uk
2. Your CAG Equality Lead

ACTION PLANNING

Agree actions and insert into action plan

The following action plan should summarise the proposed actions, setting out the timescale, lead individual and include details of any monitoring needed in the future to check that desired outcomes are reached.

Issue / Adverse impact identified	Proposed actions	Responsible/ lead person	Timescale	Progress
Important to ensure service users and stakeholders are aware of considerations and thinking in terms of the development of the HTT.	A draft version of this EIA and/or a summary version will be circulated to stakeholders as part of this process.	Nuala Conlan	June 2012- June 2013	Draft EIA being developed.
Important that the service provision offered by HTT matches that of comparable services for other age groups, in order to ensure equality of service and provision under the Equality Act 2010).	Establishment of the HTT will help ensure that the Trust ensure equality of service delivery for people of all age groups.	Cha Power	June 2012	Pilot to begin
How do we know that the HTT service hours are the rights ones?	Review service hours.	Cha Power	October 2012	
How will we cover those periods outside HTT operating hours?	Produce clear communication resources explaining out of hours arrangements.	Cha Power	July 2012	Operational policy developed
How can we be sure that the service will improve outcomes for service users?	Put in place data collection systems to monitor outcomes for HTT service users and monitor admissions.	Cha Power Alice Mills	July 2012	Currently in discussion
Will the HTT have strong enough relationships with local organisations which provide residential care for service users?	Continue to develop links and contacts with residential care providers, housing associations specialising in supported housing and mainstream health and social care providers.	Nuala Conlan Cha Power		Ongoing
Some service users, carers and other stakeholders may be concerned that service users will not be referred to in-hospital services, when and where	Set out protocols for admission to in-hospital services and provide reassurances regarding access to appropriate services.	Cha Power	July 2012	Operational Policy

appropriate. This is particularly important for service users for whom their home environment is a contributory factor in their condition.				
Will staff know when services should be referred for in-hospital treatment?	Training for HTT members on hospital referrals.	Cha Power	July 2012	Training programme
Ensure current ethnic monitoring categories are comparable with the Census 2011 categories.	Review ethnic monitoring categories to ensure comparability with Census 2011.	Cha Power Nuala Conlan	March 2013	
Do we have a complete picture of the ethnic profile of all service users?	Map all relevant service use by ethnicity.	Cha Power	December 2012	To be discussed with business managers
Do individual service users have particular language support needs?	Review service user records to determine whether any service users require language support or other additional needs.	Cha Power	July 2012	Part of the operational policy
Will staff have the knowledge and skills needed to deliver services to a range of communities?	Ensure that all HTT members receive comprehensive equalities training.	Cha Power	July 2012	
How can the HTT ensure that it provides appropriate services, interventions and solutions for different communities – including signposting to wider services?	HTT to make contact and build working relationships with local community organisations which work in particular	Nuala Conlan	Sept - 2012	Discussions happening on how to do this.
How will the HTT ensure that it can provides services which are appropriate to different communities and groups?	HTT management should consider diversity profile of the team and ensure that all staff are properly trained to deal with different communities and groups.	Cha Power	Recruitment policy Training programme	
It is not yet clear whether female and male services have different expectations and needs.	Consultation and discussions with service users and carers should seek to determine	Nuala Conlan	During the pilot	

	whether female and male users have different service needs.			
There is currently insufficient disability data.	Introduce routine collection of disability related data. Consult local disability organisations in order to agree suitable categories and ensure the most appropriate approach to collection.	Cha Power Nuala Conlan	During the pilot	
We do not currently possess a clear picture of the wider disability profile and needs of service users.	Undertake an immediate, swift assessment of the disability needs of existing service users.	Nuala Conlan	By December 2012	
Ensure that all disability data that is collected is regularly analysed to plot the disability impact of the service.	Once meaningful data has been collected, undertake detailed analysis of the wider disability impact and implement appropriate remedial measures and service adaptations.	Cha Power	By December 2012	
Is information available and delivered in different formats (disability)?	Ensure that all communication (verbal and written) is available and delivered in appropriate formats. Identify appropriate sources of communication support. Ensure consistency across all related services.	Cha Power Laura Broadley	Ongoing	
Should the HTT service collect and analyse data relating to the sexual orientation of service users?	Consider whether to introduce data and record rationale for decision (either way).	Nuala Conlan		Discussions planned with LGBT groups
Are all relevant, current policies and practices appropriate in terms of sexual orientation?	Undertake a quick review of key systems (information recording – civil partnerships, next of kin policies et al) to ensure that they are inclusive and appropriate.	Nuala Conlan Cha Power	Ongoing	
Do staff and managers have the knowledge and skills to deal with service	Ensure that staff equality training includes a sexual orientation and age	Cha Power		Training to be arranged

users on issues relating to sexual orientation?	component.			
Need to consider how the service development will be perceived by wider communities. Need to ensure that the changes are communicated clearly in order to avoid any misconceptions.	Develop communications strategy explaining rationale and evidence for changes and ensure transparency about plans.	Nuala Conlan Team Leader	Ongoing	
How will we ensure that the projected impacts are correct and that the policy does not have any unintended consequences?	In addition to on-going monitoring and appropriate remedial action, there will be further review of all equality data and assessment of impact of the work of the HTT after twelve months.	Cha Power	Autumn 2013	

Please send an electronic copy of your completed assessment to:

1. Kay.harwood@slam.nhs.uk

2. Your Service Equality Lead

The national annual admission rate thus derived is 343/100,000 people aged 65+. The admission rate for Sussex overall 2008/09
FYE based upon Q1-Q3 admissions) was calculated to be 426/100,000 based on the ONS population .

http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1304-075_V01.pdf