

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 Leads¹ 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

**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)

<p>1. Name of the policy / function / service development being assessed?</p> <p>Establishment of a Home Treatment Team as part of the Mental Health for Older Adults and Dementia (MHOAD CAG)</p>

<p>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]</p> <p>Lead: David Norman/Cha Power</p> <p>Others involved:</p> <p>Staff in the Mental Health of Older Adults Service including nurses, psychiatrists, psychologists and researcher; users and carers; Local Authority representatives from LB Lambeth and Southwark, voluntary sector organisations and NHS Commissioners from Lambeth and Southwark.</p>
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<p>This EIA draws on the views of staff, service users, carers and those who work with older people in Lambeth and Southwark.</p> <p>3. Describe the main aim, objective and intended outcomes of the service change?</p> <p>Aim SLAM is seeking to <i>redesign</i> 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’.</p>

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 than 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 be 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	Yes
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:	<u>High</u>	Medium	Low
	(highly likely to promote equality of opportunity and good relations)	(moderately likely to promote equality of opportunity and good relations)	(unlikely to promote equality of opportunity and good relations)
Negative:	High	<u>Medium</u>	Low

will not (highly likely to have a negative impact) (moderately likely to have a negative impact) (probably 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: 22nd February 2013

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 YES

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

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

June 7th 2012

TRUST	BED NUMBERS	AGE GROUP	HOME SERVICE	FUNCTIONAL/ORGANIC SPLIT
Oxleas	73	65	No	Yes
South West	41	75	Yes	No

and St Georges				
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.

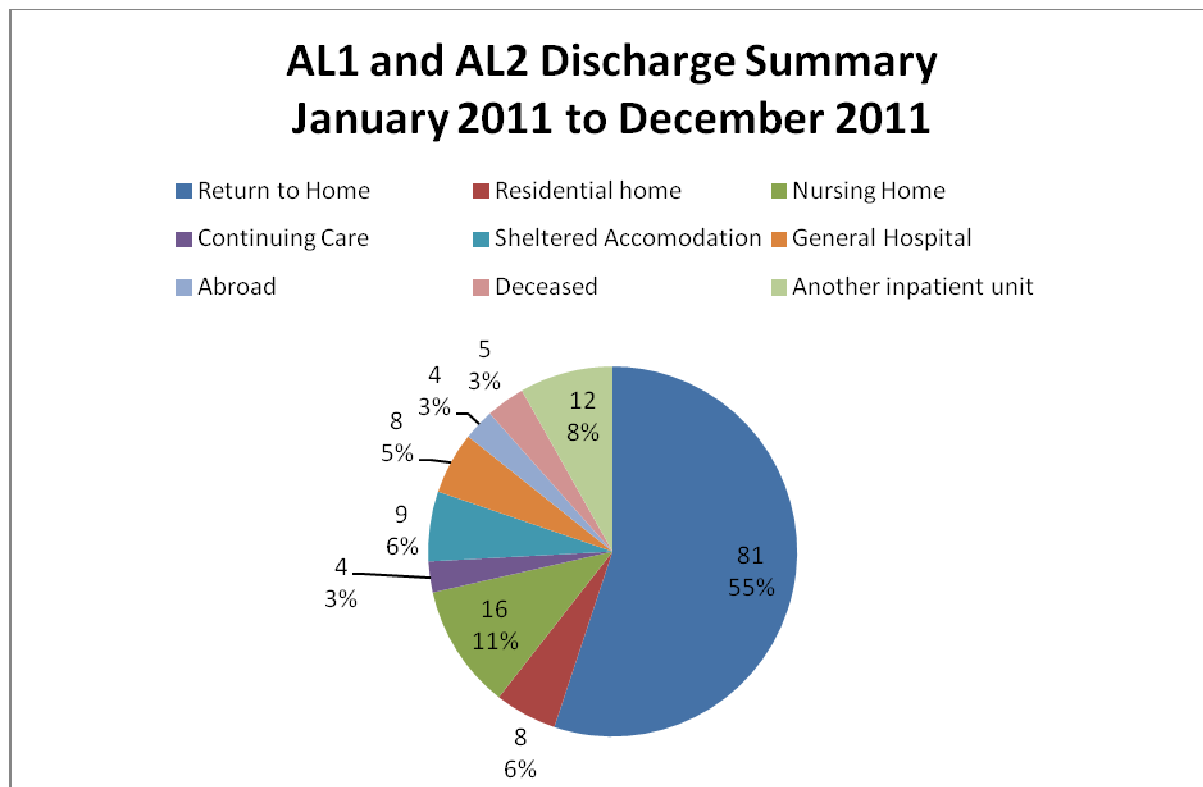
MHOAD in-Patient activity

(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	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	Last 12 Months
	2011	2011	2011	2011	2011	2011	2011	2011	2012	2012	2012	2012	
AL1	33	28	24	40	49	34	51	47	45	39	46	0	40
AL2	45	46	33	60	27	65	39	23	35	35	34	28	39
Chelsham	66	40	51	35	33	49	32	45	42	29	32	20	40
Hayworth	45	43	27	59	46	21	43	45	44	34	73	62	45

(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](http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media//publications/consultations/improving-mental-health-services/Sussex%20Older%20Peoples%20Mental%20Health%20Services%20Review%20of%20Acute%20Bed%20Provision.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).

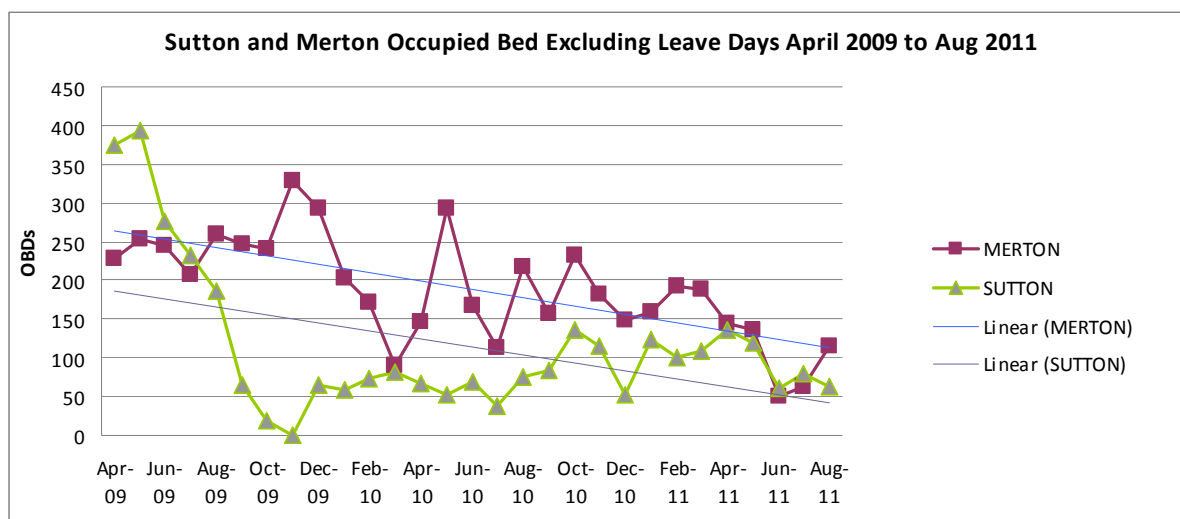
Turner notes that there are *'clear suggestions that the establishment of Specialist Older People's Teams has had an effect on admissions and discharges however the evaluations have again not been robust so results also have to be treated with caution'* (Turner, 2011).

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.

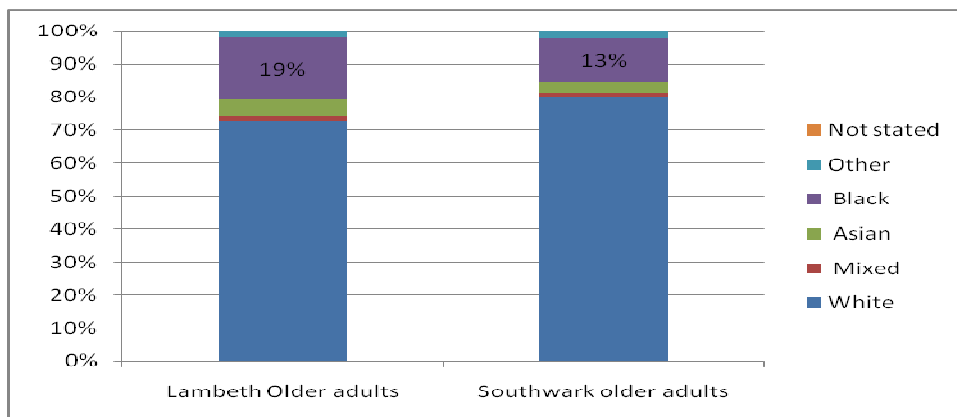
Action: Training for HTT members on hospital referrals. This is already being implemented as in the current pilot the team is located on the ward, working directly with ward staff on admissions and discharge. This is being explored as a model for future work.

Analysis of equality data

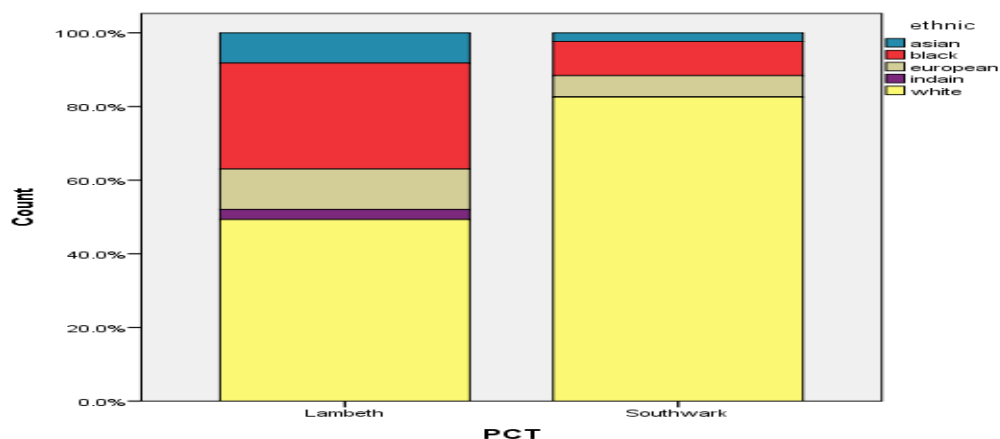
(1) Ethnicity

The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their ethnicity and what the HTT needs to do address these needs. An example of this can be the provision of interpreters. Data on ethnicity is recorded on ePJS.

The chart below shows the ethnicity profile of older adults in Lambeth and Southwark using Office for National Statistics Table PEEGC309: LAD 2009 Single Year of Age by Ethnic Group, mid-2009



The chart below shows the ethnicity profile of referrals to the HTT for Lambeth and Southwark between 1st May and 28th November 2012



This data suggests that there are a disproportionately low number of Black older adults being referred to the HTT in Southwark. It will be important for the HTT in Southwark to address this under-representation by raising awareness among Black older adults in Southwark as well as their families and carers and relevant VCS organisations with the aim of increasing referrals. The HTT will regularly review the ethnicity profile of HTT service users to monitor progress in achieving this aim. 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>)

Therefore addressing any under-representation by BME older adults in the HTT is likely to have a positive impact and this will help SLaM to deliver improved race equality outcomes.

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. 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.

The HTT use the initial assessment undertaken with new service users to identify whether or not they are disabled; whether they have any specific needs of requirements arising from this disability and what the HTT needs to do to put in place reasonable adjustments to enable it to be accessible to the service user. Reasonable adjustments can relate to physical access to SLaM buildings, the provision of information in alternative formats; the provision of BSL interpreter and hearing loops as well as making other reasonable adjustments in way the service is delivered.

Data on disability is recorded as part of the narrative recording of the 'patient journey'.

3) Gender

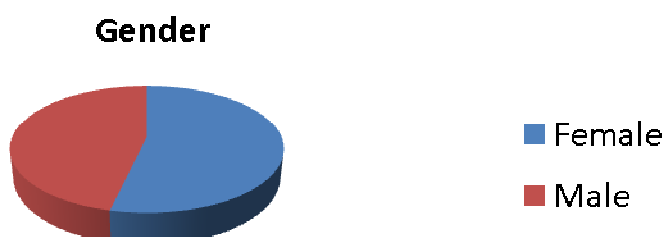
The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their gender and what the HTT needs to do address these needs. Data on gender is recorded on ePJS.

Data from <http://www.poppi.org.uk/> shows the following estimated gender profile of older adults in Lambeth and Southwark in 2012:

	Lambeth	Southwark
Females	55%	56%
Males	45%	43%

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



4) Sexual Orientation/ Gender re-assignment/transgender

The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their sexual orientation and what the HTT needs to do address these needs. Data on sexual orientation is recorded as part of the narrative recording of the 'patient journey'.

Evidence from research and internal discussions has helped us increase our understanding of potential impacts on sexual orientation equality. In particular, we are aware that we need to be mindful of invisibility and assumed heterosexuality as well as exposure to stigma and discrimination. We are also aware that our LGBT Service users may anticipate negative treatment given their possible negative past experiences of services offered. The age group we are offering a service to grew up in a time when homosexuality was perceived as a mental disorder (removed from the Diagnostic and Statistical Manual of Mental Disorders in 1973) so they may not be confident in disclosing their sexual preferences.

In recognition that staff attitudes and organisational culture need to support gay, lesbian, bisexual and transgender people, all HTT staff have undertaken equality training. The Trust also 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.

5) Age

The development of a Home Treatment Team for older people has significant potential to help eliminate age discrimination by creating a service that can deliver better outcomes for older people where no such service existed before.

HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their age and what the HTT needs to do address these needs. Data on age is recorded on ePJS.

6) Religion and belief

The HTT use the initial assessment undertaken with new service users to establish whether they have any specific needs or requirements arising from their religion or belief and what the HTT needs to do address these needs. Data on religion or belief is recorded as part of the narrative recording of the 'patient journey'.

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.

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. We will ensure that we use this engagement and consultation to help address any gaps in our understanding of potential impacts experienced by people with protected characteristics. We have informed local stakeholders about the development.

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 has 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.

In practice during the pilot both of these groups have been successful so they are being merged as they discuss the same issues. Feedback on this approach can be provided at the end of the pilot.

Further in depth consultation is planned with service users in March and April 2013.

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 we will ensure that this includes a focus on equality to help improve our understanding of the potential equality impacts and what HTT do to maximise any

positive impacts and mitigate any negative impacts. Further in depth consultation is planned with service users in March and April 2013

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.

Date completed:25th February 2013.....

SignedCha Power Deputy Manager MHOAD CAG
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.	Durand Darougar – Clinical Services Manager	June 2012- June 2013	Draft EIA being developed. Key agencies locally have been invited to attend the User and Carer Participation Group - this group now merging with the managers reference group.
Important that the service provision offered by HTT matches that of comparable services for other age groups, in order to help eliminate age discrimination in the provision of SLAM services.	Establishment of the HTT for older adults that enables older people to remain in their homes and get the mental health services they need.	Cha Power	June 2012	Pilot has begun alongside ongoing equality impact assessment
How do we know that the HTT service hours are the right ones?	Review service hours.	Cha Power	October 2012	Service hours under review as part of the pilot. No changes following review in October
How will we cover those periods outside HTT operating hours?	Produce clear communication resources explaining out of	Cha Power	July 2012	Operational policy developed

	hours arrangements.			
How can we be sure that the service will improve outcomes for service users?	Put in place data collection systems and monitor admissions and outcomes for HTT service users	Cha Power Alice Mills	July 2012	Data collection in place. Initial analysis undertaken Ongoing review of EIA planned See reports that have been compiled.
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.	Cha Power		Ongoing – HTT WMHD event had service users and carers and a number of agencies in attendance. HTT team had a stall at Copelestone event. HTT refers to local agencies such as Alzheimers Project and Dulwich Helpline.
Some service users, carers and other stakeholders may be concerned that service users will not be referred to in-hospital services, when and where appropriate. This is particularly important for service users for whom their home environment is a contributory factor in their condition.	Set out protocols for admission to in-hospital services and provide reassurances regarding access to appropriate services.	Cha Power	July 2012	Operational Policy
Will staff know	Training for HTT	Cha Power	July 2012	Staff in HTT

when services should be referred for in-hospital treatment?	members on hospital referrals.			are trained mental health practitioners. There is joint working with the wards.
Ensure current ethnic monitoring categories are comparable with the Census 2011 categories.	Review ethnic monitoring categories to ensure comparability with Census 2011.	Cha Power	March 2013	SLAM Ethnic monitoring is in accordance with census 2011
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	The ethnicity of service users is recorded on Electronic Patient Journey (ePJS)
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 – Interpreters are used as required – provided by the Trust.
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	Staff have received Equalities Training
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 with older adults	Cha Power	Sept - 2012	Relations are being established across Lambeth and Southwark. Service users are referred to agencies depending on their needs as identified in care planning. Particular attention will be given to increasing

				referrals from Black older adults in Southwark
How will the HTT ensure that it can provide 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	The team composition reflects the local population
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 whether female and male users have different service needs.	Cha Power	During the pilot	Services are provided on a needs led basis. If a specific service is required based on gender then it is provided.
Ensuring we understand the disability profile of service users and any potential positive and negative impacts in relation to disability	Record disability in ePJS case notes Consider use of PEDIC can help improve understanding of potential impacts of HTT in relation to disability	Cha Power	Ongoing Consider use of PEDIC in the pilot – with proviso that numbers are small	HTT developed prompt to consider disability in initial assessments with service users. Disability recorded in narrative of ePJS case notes
Is information available and delivered in different formats	Ensure that all communication (verbal and written) is available and delivered in appropriate formats. Identify appropriate sources of communication support. Ensure consistency	Cha Power Laura Broadley	Ongoing	All requests for information in different formats are met.

	across all related services.			
Should the HTT service collect and analyse data relating to the sexual orientation; religion and belief of service users?	Record sexual orientation and religion and belief in ePJS case notes Consider where consultation and use of PEDIC can help improve understanding of potential impacts of HTT in relation to sexual orientation and religion and belief	Cha Power	Ongoing	HTT developed prompt to consider sexual orientation and religion and belief in initial assessments with service users. Sexual orientation and religion and belief recorded in ePJS case notes
Are all relevant, current policies and practices appropriate in terms of sexual orientation?	See above	Cha Power	Ongoing	
Do staff and managers have the knowledge and skills to deal with service users on issues relating to sexual orientation?	Ensure that staff equality training includes a sexual orientation and age component.	Cha Power		Staff have received Equalities training
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.	Cha Power	Ongoing	Leaflet has been produced. Staff held a WMHD event. Staff have attended local events they were invited to. HTT has also received positive feedback

				from partner agencies.
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	This is being monitored as the pilot progresses.

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.netsec.ac.uk/hsdr/files/project/SDO_FR_08-1304-075_V01.pdf