

Appendix A

# Equality Analysis Toolkit

Recommissioning Mental Health Services in  
Lancashire

For Decision Making Items

July 2015

[www.lancashire.gov.uk](http://www.lancashire.gov.uk)

## **What is the Purpose of the Equality Decision-Making Analysis?**

The Analysis is designed to be used where a decision is being made at Cabinet Member or Overview and Scrutiny level or if a decision is being made primarily for budget reasons. The Analysis should be referred to on the decision making template (e.g. E6 form).

When fully followed this process will assist in ensuring that the decision-makers meet the requirement of section 149 of the Equality Act 2010 to have due regard to the need: to eliminate discrimination, harassment, victimisation or other unlawful conduct under the Act; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard means analysing, at each step of formulating, deciding upon and implementing policy, what the effect of that policy is or may be upon groups who share these protected characteristics defined by the Equality Act. The protected characteristics are: age, disability, gender reassignment, race, sex, religion or belief, sexual orientation or pregnancy and maternity – and in some circumstances marriage and civil partnership status.

It is important to bear in mind that "due regard" means the level of scrutiny and evaluation that is reasonable and proportionate in the particular context. That means that different proposals, and different stages of policy development, may require more or less intense analysis. Discretion and common sense are required in the use of this tool.

It is also important to remember that what the law requires is that the duty is fulfilled in substance – not that a particular form is completed in a particular way. It is important to use common sense and to pay attention to the context in using and adapting these tools.

This process should be completed with reference to the most recent, updated version of the Equality Analysis Step by Step Guidance (to be distributed ) or EHRC guidance - [EHRC - New public sector equality duty guidance](#)

Document 2 "Equality Analysis and the Equality Duty: Guidance for Public Authorities" may also be used for reference as necessary.

This toolkit is designed to ensure that the section 149 analysis is properly carried out, and that there is a clear record to this effect. The Analysis should be completed in a timely, thorough way and should inform the whole of the decision-making process. It must be considered by the person making the final decision and must be made available with other documents relating to the decision.

The documents should also be retained following any decision as they may be requested as part of enquiries from the Equality and Human Rights Commission or Freedom of Information requests.

Support and training on the Equality Duty and its implications is available from the County Equality and Cohesion Team by contacting

[AskEquality@lancashire.gov.uk](mailto:AskEquality@lancashire.gov.uk)

Specific advice on completing the Equality Analysis is available from your Directorate contact in the Equality and Cohesion Team or from Jeanette Binns

[Jeanette.binns@lancashire.gov.uk](mailto:Jeanette.binns@lancashire.gov.uk)

## **Name/Nature of the Decision**

### **Recommissioning Mental Health Services in Lancashire**

Mental Health services for adults 18 – 65 yrs in Lancashire are delivered through various arrangements, many of which involve partnerships with NHS bodies both at a service level and certainly at a whole system level.

However, most local stakeholders would share a common analysis that the "whole system" of MH services in Lancashire and some of its key components are not working effectively to deliver cost effective and affordable outcomes either for many of the target individuals who use the services or for the mental health commissioners and providers of services. Budget pressures are bringing many of these concerns to a head and certainly for the council there is an imperative to get the budget under control and reduce it alongside other adult social care and public health budgets – the current budget is likely to be unaffordable to sustain over the next few years unless there are further significant transfers from the NHS.

The project to reshape mental health services in Lancashire was included in the savings programme considered by Cabinet in November 2013 and 6<sup>th</sup> November 2014 as part of the new service offers. The Lancashire County Council spend in mental health services net total is £18.9m per annum and has risen year on year. If no action is taken this is likely to continue with the overspend of budgets.

The pressures are undoubtedly increasing further due to the impact of changes in the criminal justice and penal system, the Lancashire Care Foundation Trust (LCFT) hospital inpatient reconfiguration and - at a neighbourhood and individual level - challenges to the resilience of many vulnerable people whose mental health may be at greater risk during these difficult economic times. It's also widely recognised that LCC MH spend is unbalanced with far more spent on nursing / residential care than nationally benchmarked averages, and this reflects a lack of commissioning and procurement capacity devoted to achieving the right balance of services in each area. Since residential and nursing home placements can easily default to "homes for life" for relatively young adults (i.e. the under 50s), it can lead to institutionalisation, over dependence and an indeterminate spending commitment for the Council for an individual extending potentially over decades.

This piece of work follows on from the work to reshape the section 75 MH rehabilitation and supported living services which were transferred to NHS Lancashire Care Foundation Trust in 2013. The project was also included in the ACS Commissioning Business Plan 2013 – 15.

## What in summary is the proposal being considered?

An integrated service provision for adults with mental health problems in Lancashire that is based around rehabilitation and recovery rather than maintenance and dependence. It will be made up of distinct elements that work together. This is based upon the principles and proposed actions of less reliance on residential and nursing home care, greater access to community alternatives either in own home or in supported living settings and improved flow throughout the "system". In addition it uses the review of rehabilitation services carried out recently on behalf of the Clinical Commissioning Groups (CCGs) and three Local Authorities to develop a systematic approach in commissioning effective rehabilitation services and the associated pathway.

There is a need for change across the whole system of provision as spend has increased year on year, is no longer sustainable and with the right actions and changes, savings totalling £5.3m is planned to be achieved.

The report identifies that the disjointed nature of mental health provision leads to insufficient capacity of the right kind leading in turn to a high level of out of area residential placements and increased length of stay in possibly inappropriate care and support settings. In addition the core approaches of providing choice, control and least restrictive option are difficult to pursue.

The current "system" lacks the rigour that modern, properly formed and governed service frameworks and specifications would bring, resulting in unclear expectations for quality, outcomes and cost.

Specific activity within adult mental health social care commissioning will be :

- Develop Framework Agreements for residential and nursing care and domiciliary care;
- Develop a Lancashire wide rehabilitation model;
- Restrain and ultimately reduce expenditure from existing budgets

The Cabinet Member for Adult and Community Services has been recommended to:

- Endorse the proposals for a programme of work to establish new procurement arrangements including new provider frameworks for implementation by September 2016
- Approve the design of the contracts to enable new approaches and innovations in service delivery and payment mechanisms

Is the decision likely to affect people across the county in a similar way or are specific areas likely to be affected – e.g. are a set number of

branches/sites to be affected? If so you will need to consider whether there are equality related issues associated with the locations selected – e.g. greater percentage of BME residents in a particular area where a closure is proposed as opposed to an area where a facility is remaining open.

The decision will affect the residents of Lancashire in similar ways as the frameworks developed will ensure a consistent approach in all geographical areas. All activity including reviews, service development and consultation will be delivered so as to achieve as equitable approach as possible to the population of the county while recognising the specific needs of locations and communities.

**Could the decision have a particular impact on any group of individuals sharing protected characteristics under the Equality Act 2010, namely:**

- Age
- Disability including Deaf people
- Gender reassignment
- Pregnancy and maternity
- Race/ethnicity/nationality
- Religion or belief
- Sex/gender
- Sexual orientation
- Marriage or Civil Partnership Status

In considering this question you should identify and record any particular impact on people in a sub-group of any of the above – e.g. people with a particular disability or from a particular religious or ethnic group.

It is particularly important to consider whether any decision is likely to impact adversely on any group of people sharing protected characteristics to a disproportionate extent. Any such disproportionate impact will need to be objectively justified.

Yes

If you have answered "Yes" to this question in relation to any of the above characteristics, – please go to Question 1.

If you have answered "No" in relation to all the protected characteristics, please briefly document your reasons below and attach this to the decision-making papers. (It goes without saying that if the lack of impact is obvious, it need only be very briefly noted.)

## Question 1 – Background Evidence

What information do you have about the different groups of people who may be affected by this decision – e.g. employees or service users (you could use monitoring data, survey data, etc to compile this). As indicated above, the relevant protected characteristics are:

- Age
- Disability including Deaf people
- Gender reassignment/gender identity
- Pregnancy and maternity
- Race/Ethnicity/Nationality
- Religion or belief
- Sex/gender
- Sexual orientation
- Marriage or Civil Partnership status (in respect of which the s. 149 requires only that due regard be paid to the need to eliminate discrimination, harassment or victimisation or other conduct which is prohibited by the Act).

In considering this question you should again consider whether the decision under consideration could impact upon specific sub-groups e.g. people of a specific religion or people with a particular disability. You should also consider how the decision is likely to affect those who share two or more of the protected characteristics – for example, older women, disabled, elderly people, and so on.



The levels of mental disorder across the population are increasing. It is widely accepted that in any given year, an estimated 1 in 4 individuals will experience a diagnosable mental health condition (Mental Health Foundation). For Lancashire this means approximately 296,000 people will experience such and, as this will also affect their families and carers, it is unlikely that many people will remain untouched by mental health problems.

The Lancashire Mental Health Joint Strategic Needs Assessment provides an overview of mental health in Lancashire. It presents data on prevalence, hospitalisation and mortality and data relating to some important risk factors for mental ill health.

### ***Prevalence***

- In Burnley, Fylde, Hyndburn, Pendle and Preston the prevalence of mental health is significantly higher than England
- In Chorley, South Ribble, West Lancashire and Wyre, the prevalence of mental health is significantly lower than England
- In all Lancashire districts the prevalence of 18+ depression is significantly higher than England
- In 11 out of 12 districts there is a positive correlation between mental health prevalence and practice deprivation; strongest in Chorley, Fylde, Ribble Valley & Wyre district
- In 6 out of 12 districts there is a negative correlation between 18+ depression prevalence and practice deprivation
- In Ribble Valley, Rossendale, South Ribble and Wyre there is a moderate positive correlation between 18+ depression prevalence and practice deprivation

### ***Hospitalisation & Mortality***

- Apart from Ribble Valley & South Ribble, in all other Lancashire districts emergency hospital admissions for intentional self-harm are significantly higher than England
- Apart from Fylde, Hyndburn, Pendle and Ribble Valley in all other Lancashire districts, the rate of emergency hospital admissions from neurosis is significantly higher than England
- In Burnley, Hyndburn, Pendle, Preston and West Lancashire the rate of emergency hospital admissions as a result of schizophrenia is significantly higher than England's rate
- In Preston mortality from suicide and injury undetermined (15-44 year olds) is significantly higher than England

### **Risk factors**

A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease, injury or mental health problem. Some examples of the more important risk factors in mental health are under and overweight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness ([www.nepho.org.uk/cmhp](http://www.nepho.org.uk/cmhp), Lancashire mental health profile).

### **Deprivation**

According to the rank of average Index of Multiple Deprivation (IMD) 2010 score, Burnley, Pendle, Hyndburn, Preston and Rossendale are the five most deprived districts in Lancashire, respectively. According to the rank of employment, Preston is most deprived and Lancaster is second most deprived.

### **Unemployment**

Out of all Lancashire districts, in Burnley, the percentage of 16-64 year olds claiming Job Seekers Allowance (JSA) is considerably higher than England percentage.

Although Burnley has the highest proportion of 16-64 year old JSA claimants, it should be noted that within most Lancashire districts (apart from Ribble Valley) there are wards with higher than England percentage of JSA claimants.

### **Employment and current workforce**

Across England, jobs in adult residential services increased between 2009 and 2012 (by 60,000 or 10%) before decreasing by 2% between 2012 and 2013.

Across Lancashire it is estimated 1578 workers (excluding nurses) provide direct care in adult nursing and residential care settings to adults with mental disorders or infirmities.

Overall, the adult social care workforce remains one where females make up over 80% of the workforce.

Overall, 80% of the adult social care workforce in England has a white ethnic background; 10% of the workforce has a Black / African / Caribbean or Black British background and 7% has an Asian / Asian British background. In the North West 91% are white and 9% from BME background.

Both senior care workers and care workers are paid, on average, less in the north of England, and most in the south. In the North West the mean hourly pay in residential settings for direct care workers is £7.01, rising to £7.88 for senior care workers.

### **Ethnicity**

In Pendle and Preston the percentage of BME populations is significantly higher than the England percentage.

Asian and British Asian populations form a higher proportion of the BME populations. In Burnley, Hyndburn, Pendle and Preston the percentage of Asian/British Asian populations is significantly higher than the England percentage.

### **Long-term health problems**

Apart from Ribble Valley, in all other Lancashire districts the percentage of population stating that day to day activities limited a little or a lot by a long term health problem or disability, is significantly higher than the England percentage.

### **Alcohol related self-harm**

In Burnley, Chorley, Hyndburn, Pendle, Preston, Rossendale, South Ribble and West Lancashire the rate of hospital stays for alcohol related harm is significantly higher (worse) than the England rate. In Ribble Valley and Wyre the rate of hospital stays for alcohol related harm is significantly lower (better) than the England rate.

### **Drug Misuse**

In Burnley, Hyndburn, Lancaster, Pendle and Preston the rate of drug misuse is significantly higher than the England rate. In Chorley, Fylde, Ribble Valley, Rosendale, South Ribble and West Lancashire rate of drug misuse is significantly lower than the England rate.

### **Prevalence Data by group**

Detailed prevalence data is available across the above and age and ethnicity groups based upon geographical locations within the county. This will be used to identify how project activity should be shaped and targeted and also to give baselines of prevalence so that the effect of actions to reduce the impact of inequalities on mental health in communities can be measured and monitored.

Currently across Lancashire as of March 2015 there are 375 commissioned placements; 292 are residential placements and 83 nursing placements. Some of these placements are commissioned as rehabilitation however it is difficult to identify this on our systems.

The table below gives an overall mental health profile for the county.

## Mental Health Profile of Lancashire

Indicator	Reporting Period	England	Lancashire
Directly standardised rate for hospital admissions for mental health	2009/10 to 2011/12	243	243
Directly standardised rate for hospital admissions for unipolar depressive disorders	2009/10 to 2011/12	32.1	42.6
Directly standardised rate for hospital admissions for Alzheimer's and other related dementia,	2009/10 to 2011/12	80	107
Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders	2009/10 to 2011/12	57	73
Allocated average spend for mental health per head,	2011/12	183	192
Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population	2011/12	2.5	2.5
Numbers of people on a Care Programme Approach, rate per 1,000 population	2010/11	6.4	6.3
In-year bed days for mental health, rate per 1,000 population,	2010/11	193	182
People with mental illness and or disability in settled accommodation,	2011/12	66.8	65.5

## Question 2 – Engagement/Consultation

How have you tried to involve people/groups that are potentially affected by your decision? Please describe what engagement has taken place, with whom and when.

(Please ensure that you retain evidence of the consultation in case of any further enquiries. This includes the results of consultation or data gathering at any stage of the process)

A consultation and communication plan was designed and is in implementation following the sanctioning of the approach by cabinet in November 2014.

To date consultation has taken place with the Insight Forum representing service users and a few providers predominantly from the third sector. This was undertaken face to face at the inception of proposal in November 2013 and attended by approximately 25 people.

Consultation has taken place with the 5 Clinical Commissioning Groups within the Lancashire footprint (North, Chorley South Ribble and Greater Preston, West Lancs, Fylde and Wyre and East Lancashire) during November 2014 to January 2015. The case for change document was shared via email, discussed as an agenda item and individual face to face meetings with individual CCGs.

Consultation has taken place with Commissioning Delivery Group consisting of all CCGs including Blackburn with Darwen and the Commissioning Support Unit (CSU), face to face attendance at monthly meetings in April, May and June 2015. Separate meetings have also been held with CSU in July 2015.

Consultation has taken place with existing Mental Health practitioners (social workers, health professionals and stakeholders) January 2015 with the case for change document shared via email and again face to face in June with a presentation (delivered by Head of Safeguarding) and face to face at Interface Meetings (between LCC and Lancashire Care Foundation Trust) during June and July 2015.

Engagement has taken place with current providers represented by Lancashire Care Association at a face to face meeting January 2015. Invitations were sent to 101 adult mental health residential and nursing care home establishments/providers for face to face briefings in July 2015, this was attended by 14 people. The presentation delivered on the day was shared by email to the 101 invitees.

Further consultation and engagement will be undertaken with:

- Citizens, people who experience long term mental illness, carers / families
- Lancashire Care Foundation Trust management and community staff
- CCG commissioners and Commissioning Support Unit
- Lancashire County Council Adult Social Care staff including those working in section 75 services
- Residential, nursing and rehabilitation care home providers

Consultation will be tailored in such a way that individuals are enabled to participate fully.

Until recently engagement with stakeholders has been limited and this will be addressed.

### **Question 3 – Analysing Impact**

Could your proposal potentially disadvantage particular groups sharing any of the protected characteristics and if so which groups and in what way?

It is particularly important in considering this question to get to grips with the actual practical impact on those affected. The decision-makers need to know in clear and specific terms what the impact may be and how serious, or perhaps minor, it may be – will people need to walk a few metres further to catch a bus, or to attend school? Will they be cut off altogether from vital services? The answers to such questions must be fully and frankly documented, for better or for worse, so that they can be properly evaluated when the decision is made.

Could your proposal potentially impact on individuals sharing the protected characteristics in any of the following ways?

- Could it discriminate unlawfully against individuals sharing any of the protected characteristics, whether directly or indirectly; if so, it must be amended. Bear in mind that this may involve taking steps to meet the specific needs of disabled people arising from their disabilities
- Could it advance equality of opportunity for those who share a particular protected characteristic? If not could it be developed or modified in order to do so?
- Does it encourage persons who share a relevant protected characteristic to participate in public life or in any activity in which participation by such persons is disproportionately low? If not could it be developed or modified in order to do so?
- Will the proposal contribute to fostering good relations between those who share a relevant protected characteristic and those who

do not, for example by tackling prejudice and promoting understanding? If not could it be developed or modified in order to do so? Please identify any findings and how they might be addressed.

It is not envisaged that the project will discriminate unlawfully against individuals sharing any of the protected characteristics. It will seek to promote the rights of individuals and groups.

It is expected that this work will enable individuals to play a greater part in community life. For example through moving away from residential care provision to community alternatives individuals will be automatically less isolated and able to participate in and contribute to, with the right level of support, their community.

The stigmatisation of those with mental health problems reinforces negative stereotypes and consequently further isolates those individuals. This work will enable and empower individuals to become greater participants in their communities, become more visible and make communication and understanding across the mental "illness" boundary more achievable. Where services are to be developed in new settings, and perhaps in new communities, work will be undertaken to allay fears and improve understanding.

#### **Question 4 –Combined/Cumulative Effect**

Could the effects of your decision combine with other factors or decisions taken at local or national level to exacerbate the impact on any groups?

For example - if the proposal is to impose charges for adult social care, its impact on disabled people might be increased by other decisions within the County Council (e.g. increases in the fares charged for Community Transport and reductions in respite care) and national proposals (e.g. the availability of some benefits) . Whilst LCC cannot control some of these decisions, they could increase the adverse effect of the proposal. The LCC has a legal duty to consider this aspect, and to evaluate the decision, including mitigation, accordingly.

If Yes – please identify these.

By working through joint commissioning plans both of the County Council (including both social care and public health) and Clinical Commissioning Groups and also with other key partners such as District councils it is expected that

aligning this work will result in overall greater effectiveness through greater coordination and economies of scale. Wherever possible services for people with mental health problems will be mainstream not "specialist" so this requires this project to be part of a whole system approach. Existing residential and nursing care home placement levels will be reduced year on year through a targeted programme of review.

This work does recognise the potential impact upon vulnerable service users of change especially where change is happening in different areas of an individual's life. This can clearly raise anxieties and be detrimental to their overall wellbeing including mental wellbeing unless managed actively and well. All activity will be fully shared with and explain to service users, their carers and families. In the main this will be done at an individual level with more general information being made available for wider consumption.

Those people who may be faced with changes in service will be provided with a full and personalised review by a suitably trained and experienced practitioner. The outcome of this will form the basis for their individual support plans. Experience of assisting individuals to move from institutionalised single service support to Self Directed Support shows that this can be a positive experience and one in which individuals feel in control and empowered.

As a key principle of the work is to enable people to receive services closer to or in their own home through a Self Directed Support arrangement any change in availability of resource in this area could be a challenge. The numbers affected would however be small, especially in the first instance.

### **Question 5 – Identifying Initial Results of Your Analysis**

As a result of your analysis have you changed/amended your original proposal?

Please identify how –

For example:

Adjusted the original proposal – briefly outline the adjustments

Continuing with the Original Proposal – briefly explain why

Stopped the Proposal and Revised it - briefly explain

As a result of this analysis it is intended to continue with the original proposal of a contracting framework which is outcome focussed. This is because the core



elements of the proposal are strong around anticipating and responding to the potential for negative impacts upon groups and individuals including those with relevant protected characteristics.

Specific activity within adult mental health social care commissioning will be:

- Develop Framework Agreements for residential and nursing care and domiciliary care;
- Undertake robust reviews of service users currently resident in residential and nursing homes;
- Develop a Lancashire wide rehabilitation model;
- Develop supported accommodation schemes for people with mental health problems;
- Confirm and implement the process of consultation with a wide range of stakeholders including service users, their carers and families and partner agencies;
- Restrain and ultimately reduce expenditure from existing budgets

Consideration has been given to the original proposal in relation to pathway navigation/gateway following feedback from stakeholders (Adult Social Care, CCGs and Commissioning Support Unit (CSU)). Work will continue to improve people's journey through the system however initial proposals as to how this will be executed are being revised in light of the feedback received.

## **Question 6 - Mitigation**

Please set out any steps you will take to mitigate/reduce any potential adverse effects of your decision on those sharing any particular protected characteristic. It is important here to do a genuine and realistic evaluation of the effectiveness of the mitigation contemplated. Over-optimistic and over-generalised assessments are likely to fall short of the “due regard” requirement.

Also consider if any mitigation might adversely affect any other groups and how this might be managed.

The consultation and communication plan aims to reduce the potential for anxiety and concern through providing a clear and consistent message and the means for feedback. This is designed to cover all who may have any protected characteristic and to highlight where this may not be effective triggering reporting into the project team and management team. In turn this will trigger further action as appropriate.

## **Question 7 – Balancing the Proposal/Countervailing Factors**

At this point you need to weigh up the reasons for the proposal – e.g. need for budget savings; damaging effects of not taking forward the proposal at this time – against the findings of your analysis. Please describe this assessment. It is important here to ensure that the assessment of any negative effects upon those sharing protected characteristics is full and frank. The full extent of actual adverse impacts must be acknowledged and taken into account, or the assessment will be inadequate. What is required is an honest evaluation, and not a marketing exercise. Conversely, while adverse effects should be frankly acknowledged, they need not be overstated or exaggerated. Where effects are not serious, this too should be made clear.

The proposal has at its core a desire to enhance outcomes for individuals while also achieving value for money and savings. While there is some tension in this there is evidence that moving to more community based alternatives that look to recovery and rehabilitation rather than maintaining and accommodating are more cost effective. In addition they result in a much more person centred and empowering approach. There are not seen to be any negative effects for individuals or groups as a result.

## **Question 8 – Final Proposal**

In summary, what is your final proposal and which groups may be affected and how?

It is proposed that the project continues as originally set out with strengthening of the engagement and consultation framework.

The primary group to be affected by this work is adults living in Lancashire who suffer from mental health problems and their families and carers. Of these it will be those who meet eligibility thresholds for services mainly affected, with those with lower level needs mainly unaffected. Despite anticipated overall savings of £5.3m it is anticipated that the reshaping of the overall offer will result in better outcomes for individuals.

## **Question 9 – Review and Monitoring Arrangements**

Describe what arrangements you will put in place to review and monitor the effects of your proposal.

The project has in place a proper project management structure and governance arrangements.

The project board meets monthly and will consider the equality impact as work progresses.

The monitoring of the impact of the project, on all of the nine protected characteristic groups will be included in the project closure report and following handover to business as usual to Adult Social Care.

Equality Analysis Prepared By Julie Dockerty/Giulia Grieco

Position/Role Project Manager/Strategic Improvement Officer

Equality Analysis Endorsed by Line Manager and/or Chief Officer -  
Dawn Butterfield

Decision Signed Off By

Cabinet Member/Chief Officer or SMT Member