Equality Impact Assessment – Leeds Partnerships NHS Foundation Trust and Adult Social Care Mental Health Partnership Project

1. Introduction

This paper outlines the actions undertaken to identify and assess the potential impact of the proposed changes to partnership arrangements between Leeds Partnerships NHS Foundation Trust (LPFT) and the specialist mental health assessment and care management function in Leeds City Council Adult Social Care (ASC). The lead people for this equality impact assessment were John Lennon for Leeds City Council and Michele Moran for LPFT. Members of the assessment team were: Caroline Bamford, Richard Graham, James Hoult, Kim Adams, Iola Shaw and Julie Bootle.

The process included engagement with a range of stakeholders - service users, carers, health and social care staff, council members, voluntary sector organisations, health partners. This information has then informed the mitigating actions included in this assessment.

2. Overview

This is a joint Equality, Diversity, Cohesion and Integration Impact Assessment between Leeds City Council and Leeds Partnerships NHS Foundation Trust.

All local authorities and NHS Trusts need to ensure that all their strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration. In all appropriate instances we will need to carry out an equality, diversity, cohesion and integration impact assessment.

The scope of this project is to develop joint adult mental health services for the population of the City of Leeds, through the provision of services which are service user focused and exemplary in their delivery.

In determining the future model of partnership working there are elements that must be included for the partnership to be a success:

- Clean and clear lines of responsibility for statutory functions including monitoring arrangements and accountability.
- A single management team hosted by one organisation to avoid duplication.
- Streamlined processes and clear pathways.

The project is being linked to wider work that LPFT is undertaking to redesign services around pathways that allow service users to access the support they need quickly without need for repeated assessments. Combining both pieces of work means that the new pathways can be developed holistically with consideration given to individuals' health and social care needs.

3. Scope

This assessment seeks to analyse the impact of the proposed changes on any specific group. The assessment utilises factual data collected by the Leeds City Council Adult Social Care, NHS Leeds, Leeds Partnerships NHS Foundation Trust (specialist mental health trust) and voluntary sector organisations.

The assessment also takes into account comments, opinions and views from a range of stakeholders including service users, staff and management. This information has been analysed by the assessment team to provide an evidence based assessment of potential impacts and identifies actions that may be taken to mitigate these impact should the decision be made to integrate provision.

4. Fact Finding – What do we already know?

4.1 Demographics

4.1.1 Leeds. Leeds is the second largest metropolitan district in England with an estimated population in excess of 750,000 people. Whilst the Leeds economy as a whole, has been a success story, Leeds has a significant amount of deprivation. Five wards in the city have more than half their super output areas (subdivisions of wards) in the 10 per cent most deprived in England. These five wards tend to have the highest levels of deprivation, proportion of people on unemployment benefits and proportion of households in receipt of council benefits.

Like many other cities in the UK, Leeds is now facing unprecedented change and uncertainty. The University of Leeds predicts that by 2026 the total number of people living in the Leeds local authority area will be 830,000. This will include larger numbers of people from ethnic minorities and higher numbers of younger people as well as an increase in people aged 75 and over. In general people are living longer and there are as many people over 60 as under 16. Although the rate of increase in the proportion of older citizens in Leeds is not likely to be as great as in some neighbouring authorities, it is predicted that the number of people in Leeds aged 65 and over will rise by almost 40 per cent to 153,600 in 2031, around 20 per cent of the population.

In particular:

- Leeds has a significantly higher proportion of 15 to 29 year olds (26 per cent compared to the national average approaching 20 per cent);

- there is a significant student population of over 60,000 studying in the two universities in the city;

- Stonewall estimates that a large city such as Leeds with an established gay scene may be made up of at least 10% lesbian, gay and bisexual people;

- Leeds population broken down by religion or belief is 69.9% Christians, 3% Muslims, 1.1% Sikh. 1.2% Jewish, 0.6% Hindu, 0.2% Buddhist and 24.9% no religion or not stated;

- Leeds is now home to over 130 different nationalities;

- in 2006 the Office for National Statistics (ONS) estimated that 15.1% of the total resident population comprised people from black and minority ethnic communities (including Irish and other white populations), a rise of 5 per cent from the 2001 census; and

- by 2030 the black and minority ethnic population in Leeds is estimated to increase by 55 per cent.

4.1.2. Mental Health Needs. Mental health problems are common. Around one in six adults suffer from a common mental health problem such as anxiety or depression. Nationally 29% of women and 17% of men will suffer some form of mental health problem during their lives; 1 in 4 women and 1 in 10 men will experience an episode of a depressive illness; self harm prevalence stands at 400 per 100,000 population. One in ten mothers suffer from post natal depression. Mental ill health occupies approximately one third of GP time. Ninety per cent of people with common mental health problems are managed entirely within primary care.

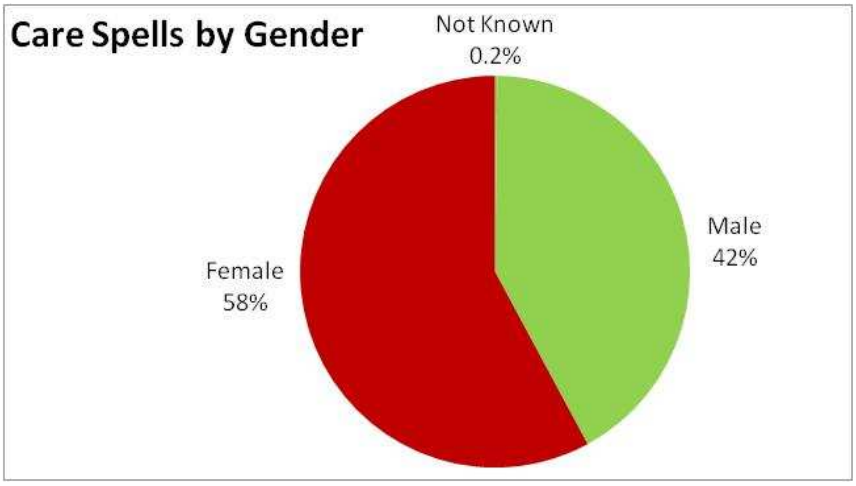
Incidence of mental health problems is more prevalent in the Lesbian, Gay and Bisexual communities. In 2006 research was undertaken with this community within Leeds (Noret, Rivers and Richards, 2006) and found that: over one third of LGB people encountered mental health challenges, with more than half reporting having had suicidal thoughts at some point in their lives. One third of participants also reported self-harming. Of those who reported self-harming, 24% had not accessed a mental health service. Similarly, 33% of those who reported having suicidal thoughts had not accessed a mental health service.

Data for Secondary Mental Health Services in Leeds
LPFT provide detailed information on patient demographics to the NHS Information Centre as part of the mental health minimum dataset (MHMD)[1]. Data from 2009/10 indicates that LPFT provided 19,576 spells of specialist mental health care to 18,331 service users[2]. This represents an access rate of approx 24 care spells per 1000 population.

[1] The MHMDS is derived from all the activity data collected in the Trust on the Patient Record Administration System (PARIS), aggregated into care spells.

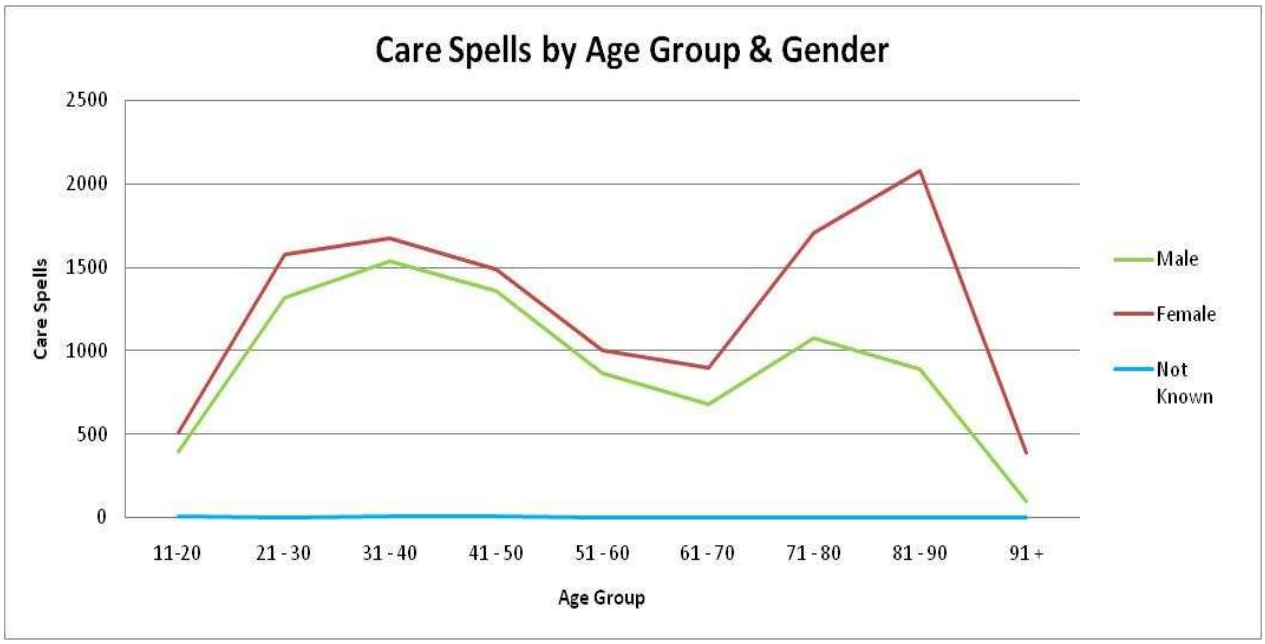
[2] A care spell in the MHMDS is taken as 'a period of specialist mental healthcare in the Trust during which the service user may receive different types of care, including inpatient, crisis resolution and from a community mental health team.' It commences with referral and terminates with discharge. The MHMDS is only as accurate and representative of the data as inputted into PARIS by Trust staff.

Gender. In the reporting period women comprised 58% of the total care spells, roughly the same proportion as the previous year.



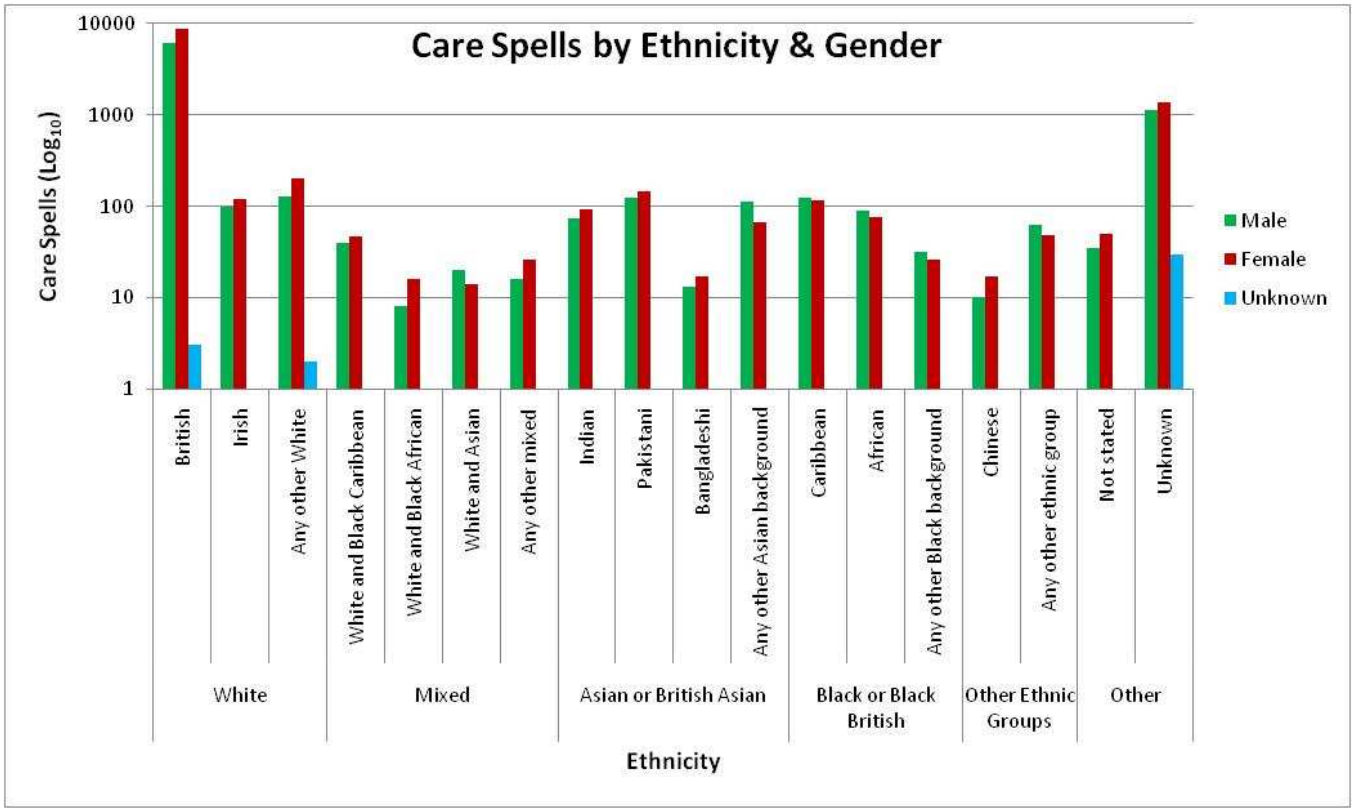
There was significant male under-representation in access to Occupational Therapists and Consultant Psychotherapists (almost 10% less than expected). It may be that male service users are unable to access these services or feel discouraged from doing so.

Age. There are more female than male care spells across all age groups. Both male and female care spells show an initial peak at 31-40 years. This may reflect the higher frequency onset of mental health problems in young adulthood. For males, a second peak occurs at 71-80 years, yet this is lower than the first peak and decreases rapidly towards later age groups, possibly reflecting lower male life expectancy. For females, the second peak at 81-90 years is the highest care spell level; care spells at age 65 and over account for 43% of total female care spells. This may reflect the increasing prevalence of age related dementia for older people as life expectancies increase.

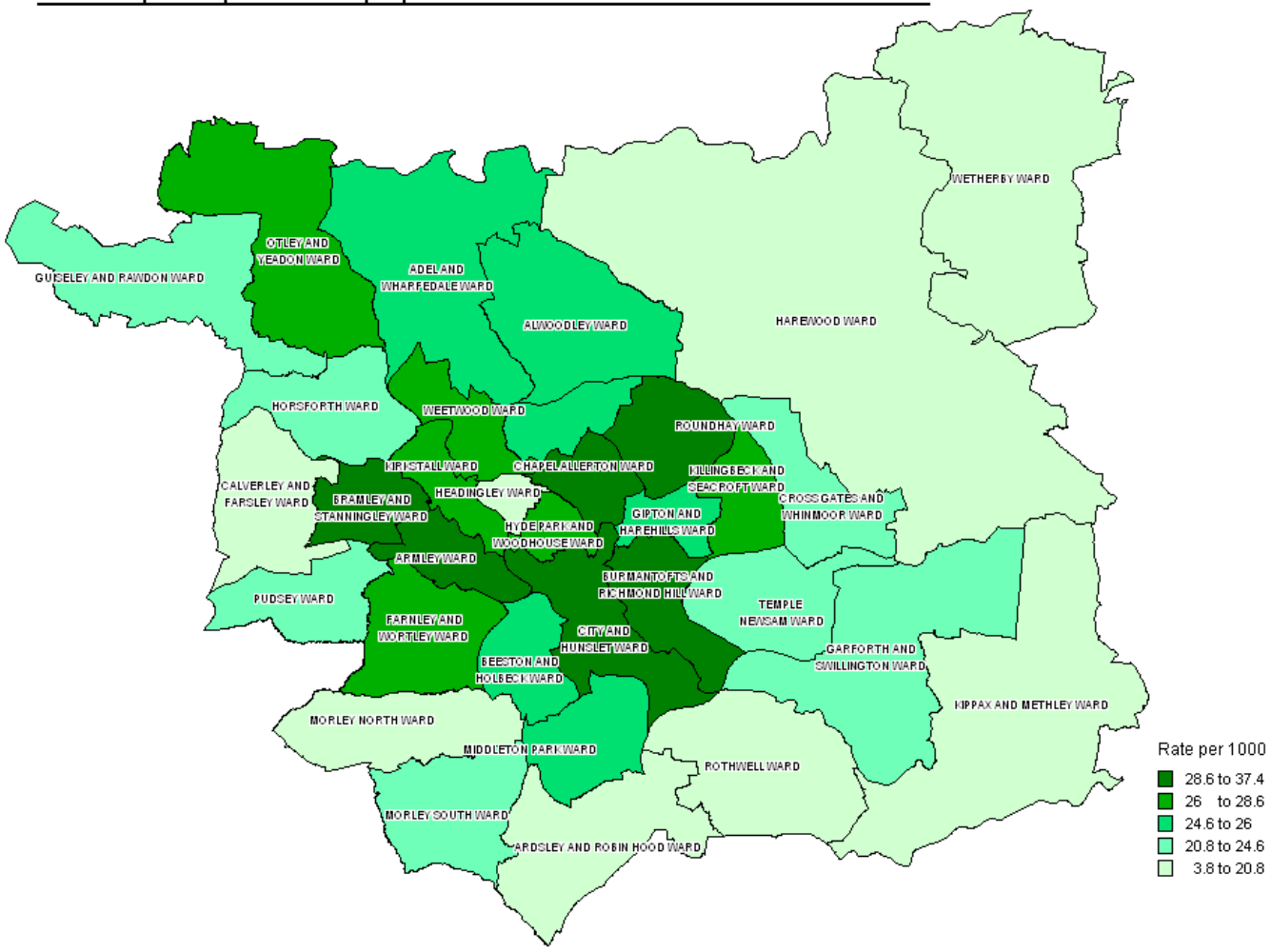


Ethnic Profile. BME groups accounted for 9.8% of Trust care spells. However, BME groups accounted for 17.2% of inpatient care spells, suggesting a BME over representation in inpatient Care.

There was variation in contact rate and the distribution of contacts among different ethnicities. For example, Mixed Ethnicity care spells averaged at 1 contact in 15 days, whereas Asian or Asian British averaged at 1 contact in 22 days. BME care spells are more likely to be on CPA.



Care Spells per 1000 population in the 2009 / 2010 MHMDS



This map of Leeds shows the care spells per 1,000 population across the electoral wards of Leeds.[3] (NB: Electoral ward population comes from ONS estimates of mid- 2007 population for 2009 wards.)

[3] Electoral Ward Population Source: Mid-2007 Quinary Estimates for 2009 wards (experimental) http:/www.statistics.gov.uk/statbase/Product.asp?vlnk=13893

The highest rate was Armley, with 44 spells per 1,000 people. The lowest rate was in Wetherby with 6 spells per 1,000 people. However, care spells per population does not necessarily correlate with socioeconomics, as shown by the high rate in the Roundhay ward (33 spells per 1,000 people) possibly due to its older population (mean service user age: 61.5 years).

Geographic proximity may be having an impact on service user numbers, for example with Wetherby GPs choosing to refer to North Yorkshire and York PCT mental health services in Harrogate.

4.2 Current Provision

4.2.1 Service Provision – Current Partnership Model

Leeds Partnerships NHS Foundation Trust (LPFT) provides specialist mental health services to adults within the Leeds metropolitan boundary.

For a number of years specialist mental health social workers have been co-located with LPFT teams. The majority of mental health service users referred for adult social care services come to the attention of Social Care staff via multi-disciplinary team meetings within LPFT. The service users are individuals from the age of 16 upwards who have complex mental health needs, requiring a multi-agency and multi-professional approach under the Care Programme Approach (CPA) framework.

Service users with complex needs who use a range of services have a Care Co-ordinator within CPA. It is the Care Coordinator's job to ensure that a service user's needs are met in a timely and appropriate way, and to maintain contact with service providers across sectors. Care Coordination is about making sure the right services are responding to the individual's needs in ways that have been agreed with the individual. For most people their Care Co-ordinator will be a member of the CMHT – a nurse, social worker or OT. In Leeds we also work in partnership with some voluntary sector organisations which provide specialist services and perform the Care Coordinator role for their clients.

4.2.2 Access to Social Care Services

There have been inconsistencies identified in the way in which people currently access social care services. Social workers are deployed differently in adult and older people's services. In adult services social workers are typically integrated within the multi-disciplinary teams and share a caseload with health staff. This means that some of the people that social workers are supporting would not have FACS eligible social care needs and some of the people nurses and OTs work with will have eligible needs but will not necessarily see a social worker. In Older People's services social workers operate as a distinct team within the team and only work with people with an identified social care need.

4.2.3 Self Directed Support.

One of the advantages of social workers operating as part of the multi disciplinary team is that service users can access a range of health and social care services without needing to undergo additional assessment. Health professionals have been able to access social care services on behalf of individuals without the need for additional processes and involvement of additional professionals. However, in the last 18 months self directed support (SDS) has been rolled out in social care across Leeds. This gives FACS eligible service users the option of opting for a personal budget in preference to pre commissioned services to shape and personalise the support they feel will best meet their needs.

In older people's services all eligible service users have an assessment for SDS and can make this choice. In adult services only the social workers are trained in SDS and different professionals have differing knowledge base of the opportunities from SDS. This has led to marked differences between over 65s and working age adults

with working age adults access to a personal budget being dependant on their Care Co-ordinator recognising that the individual may benefit from SDS.

The figures for self directed support are detailed in appendix one and indicate that the numbers for mental health are low (these figures refer to under 65s as the over 65s are included in older people's services). The target for mental health service users based on total number of people with mental health support needs accessing social care services is 300.

4.2.4 Partnership Models in Other Areas.

A Benchmarking exercise has been undertaken to look at models of joint working in comparative services (Sheffield, Barnsley, East Riding, Bradford, Lincoln and Nottingham) to consider good practice and lessons learnt in other parts of the country within their health and social care partnerships.

4.2.5 LPFT Transformation Project.

LPFT are concurrently running a project known as the Transformation project. The aims of the Transformation Project is to ensure a sustainable, innovative and service user responsive Care Services Directorate it is essential to transform our clinical services into a new, accessible, care pathways orientated model of care delivery. In particular the proposed model will move the services from the current directorates into 3 integrated care pathways orientated directorates;

- Acute Care Pathways,
- Community Care Pathways
- Regional/In reach Care Pathways

The pathways will be supported by a Clinical Support Unit, aimed at reducing bureaucracy and improving interfaces with corporate services. Learning Disabilities will be reviewed at a later phase in the transition.

The transition will improve access for service users and referrers, improve the delivery of health and social care services, protect posts in the current difficult financial climate and achieve savings of £8.7m by March 2013.

The transformation programme of work will be complex and involve numerous stakeholders to achieve a successful outcome by March 2013. Staff and service users will be central to the redesign work.

4.3 What do people think - Consultation?

In considering making changes to the partnership arrangements between LPFT and LCC we have consulted with a wide range of stake holders.

The consultation activities undertaken include:

- A workshop for service users

- Building Your Trust Event
- A series of workshops for health and social care staff
- Meetings with commissioners
- Discussion at the Joint Strategic commissioning group for mental health
- A questionnaire emailed to all affected staff
- Monthly drop ins and a regular newsletter for staff to update on progress
- Project sponsors send a letter to all directly affected staff after each board meeting to update them on progress.
- Project staff have visited staff teams and used these opportunities and the workshops to build a picture of what a health and social care partnership might look like.
- There are a number of work streams in place to progress the project and all have health and social care membership.
- An external facilitator has been commissioned by the Project Sponsors to undertake work with staff in both health and social care to identify areas of cultural difference and concerns for future joint working.

In addition the Project team have attended further meetings to ensure wider coverage of the project scope and aims are achieved; these have included:

- LPFT Board of Governors.
- LPFT Staff side committee
- Disabled Peoples/Older Peoples Board
- Health Scrutiny
- Adult Social Care Mental Health Managers meeting

4.3.1 Service Users.

Service users were invited to participate in a workshop in July to capture their experiences of health and social care services and to share what is important to them when accessing services. Posters were used to advertise the workshop across LPFT, ASC and the voluntary sector and staff were asked to promote the workshop. A summary of the comments are included at appendix 2. There were about 12 service users who attended the day.

The feedback from the event has helped shape the discussions with the staff teams on how the model of service delivery should look. Whilst the number of service users attending this event was low the feedback they gave reinforced feedback from other stakeholder engagement that had been undertaken for different projects and proposals. Broadly service users have told us that receiving appropriate help when they need it is more important to them than who provides that support and that they are being assessed too many times.

A mix of service users and staff took part in a Building Your Trust event which was held in December.

4.3.2 Staff.

There have been a number of methods used to consult with staff over the course of the project. At the beginning of the project all staff directly affected by the proposals were emailed a questionnaire to give feedback on how effective they felt joint working was under the current partnership arrangements. A summary of this is available. Staff indicated that they thought things could be more joined up – particularly in terms of a shared vision and shared objectives and clear management lines.

Staff have been kept informed of progress and invited to give comment and feedback through update letters, drop in sessions and regular newsletters. They have had the opportunity to give their views on what works and doesn't work within the partnership and on what good joint working should look like through a series of workshops in September and October. Some management team members from both health and social care have been invited to be part of the workstreams progressing the project.

Early in the project the team were concerned that health staff were less involved and engaged than social care staff. The culture change work gathered opinions from both groups and one of the areas of feedback was that there was confusion around the fit of this work with wider transformation work that had just commenced within LPFT. The project team had already identified crossovers and the two projects have more recently been joined so that the development of care pathways can be developed holistically, involving health and social care pathways.

4.3.3 NHS and Adult Social Care Commissioners. In considering the options around partnership working the providers have sought to involve health and social care commissioners. Regular meetings have been established with senior health and social care commissioners and the Programme Manager reports updates to the Mental Health Joint Strategic group whose membership includes commissioners and providers from across health, social care and voluntary sector.

4.3.4 Referrers, Partner Organisations and Other Interested Parties. Many of these organisations are represented through the MH Joint Strategic Group. The Programme Manager also updates a citywide mental health provider partnership group which brings together the voluntary sector umbrella organisations for older people, learning disability and mental health providers with LPFT and Adult Social Care.

4.3.5 The proposal to explore a new model of partnership has been discussed at Policy Cabinet, as part of a scrutiny inquiry into support for working age adults with severe and enduring mental health problems and at Health Scrutiny.

4.4 Workforce Profile

To be supplied by HR departments

5 Overview of Fact Finding and Consultation

From the evidence considered

1) The evidence seen indicates that there is a difference in the way that older people and working age adults access social care services. This can result in fewer working age adults being offered self directed support.

2) Initially health staff were less involved in the project than social care staff and had a perception that the changes would only affect social care staff. There was additional confusion around the fit with Transformation work taking place within LPFT clinical services.

3) Within the lifetime of the project LPFT took a decision to review the delivery of clinical services and to redevelop these around pathways to streamline access to support services. As both projects were looking at care pathways a decision was taken to join the projects.

The potential impacts identified from redesigning the partnership are:

Potential Impacts identified.

There will be a positive impact for all stakeholder groups, both ASC and LPFT services provide equality of services and the integrated project will benefit all stakeholder groups.

The redesigned service will impact positively on service users as the pathway through services will be more streamlined with less duplication of assessment. Service users should have equal access to services they are entitled to and be clearly signposted through the pathway to appropriate support.

Staff will be supported to work in a holistic way considering the individual's health and social care needs in terms of recovery, social inclusion and personalisation. Clear recording systems will be in place.

In looking at single point of access the service needs to consider that not all social care work presents through secondary mental health services and those presenting through area offices need an equally prompt and smooth service.

Consultation has identified that there is the potential for negative impact if a joint information and communication strategy across LPFT and ASC is not implemented. If service users are to experience a holistic, streamlined service clear pathways need to be in place to ensure peoples health and social care needs can be met by the service.

Currently LPFT and ASC have two separate electronic patient data recording systems; it is proposed that an integrated information governance structure will be implemented; the introduction for this will be within the parameters of the project as a whole.

Action plan to ensure mitigation is in place

Engagement with stakeholders needs to continue as pathways are determined to ensure that no equality group is disadvantaged.

Appendix One

Self Directed Support

User Group	As as 30/11/10				As as 31/12/10				As as 31/01/11			
	DP	PB	SDS	SDAQ	DP	PB	SDS	SDAQ	DP	PB	SDS	SDAQ
Older People	729	43	1837	143	732	50	1859	172	737	67	1883	220
Learning Disability	114	28	117	9	113	31	123	8	113	32	125	9
Physical Disability	316	53	155	18	316	56	155	23	316	66	157	31
Sensory Impairment	27	3	7	0	27	3	7	0	27	3	7	0
Mental Health	51	7	27	3	51	10	27	3	51	12	27	5
Other	20	2	2	2	20	3	3	1	20	4	3	1
Equipment (Phys Dis)	4	0	0	0	5	0	0	0	5	0	0	0
Carers(inc Citywide)	404	0	0	0	404	0	0	0	404	0	0	0
Unknown	1	1	0	0	1	1	0	0	1	1	0	0