Equality Impact Assessment

EIA title:	Adult mental health Public Value Review

EIA author:	Liz Tracey Project Assistant

2. Approval

	Name	Date approved
Approved by[1]	Adult Social Care, Directorate Equalities Group	12/09/2012

3. Quality control

Version number	1	**EIA completed**	Yes
Date saved	31/08/2012	**EIA published**	**Oct 2012**

4. EIA team

Name	Job title (if applicable)	Organisation	Role
Liz Tracey	Project Assistant	Surrey County Council	EIA officer – coordinating the EIA process
Jane Bremner	Assistant Senior Manager Commissioning Mental Health	Surrey County Council	Mental health commissioning input
Perry Clifton	n/a	Service user	Contributing perspective of people who use services
Evelyn Mitchell	n/a	Service user member of LINk	Contributing perspective of people who use services
Richard Barritt	Chief Executive	Solent Mind	External challenge and voluntary sector perspective

[1] Refer to earlier guidance for details on getting approval for your EIA.

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5. Explaining the matter being assessed

What policy, function or service is being introduced or reviewed?	1. On 14 July 2009 as part of its consideration of the paper Leading the Way: changing the way we do business, the Cabinet agreed to undertake a three year programme of Public Value Reviews (PVRs) with the aim to look at all services/functions provided by the Council. The outcomes are expected to be services that place the Council in the top quartile of local authorities for performance and the lowest quartile for unit costs thus providing improved outcomes and value for money for the residents of Surrey. 2. Public Value reviews follow a standard methodology: · challenging why, how and by whom a function/service is provided; · comparing performance with others in the quest to be world class; · consulting widely including with residents and specifically vulnerable groups and communities and with staff; · collaborating with partners and/or contractors; and · testing the market to see if the function/service could be delivered more efficiently, effectively or economically. 3. Mental health is everyone's business: lifestyle factors, the communities in which we live, the local economy and the environment all impact on an individual's mental health. In Surrey, it is projected that 111,169 people (16.1% of Surrey adult population) of 18-64 year olds have a common mental health problem, such as anxiety or depression; 57,765 people (8.4%) have a psychotic disorder, personality disorder or 2 or more mental health needs. **Objectives:** The Public Value Review of adult mental health services will culminate with the production of commissioning recommendations for mental health services. The review has examined the following areas: • Full costs of services provided or commissioned for adult mental health services in Surrey. This will be used to inform subsequent analysis and become the determinant of value for money. Service costs will be compared with another local authority of comparable size and population as Surrey • The introduction of personalisation in mental health and substance misuse services • The accommodation pathways for people with mental health needs and the shift from residential to supported living options in the community • The population needs of people with mental health problems

	and the gaps in services in the 11 Districts/Boroughs
	• The pathways between Child and Adolescent Mental Health Services (CAMHS), adult mental health services, and older adult mental health and dementia services
	• The relationship between primary care mental health services (Improving Access to Psychological Therapies (IAPT) services) and secondary care mental health recovery services
	• Partnership working with Safeguarding and Quality Assurance Team within Adult Social Care to
	  ○ Assess the adequacy of related quality assurance system(s) and where appropriate make recommendations for improvement.
	  ○ Design and implement an outcome framework to support the effective commissioning of services for adult mental health
	• The role of public health in terms of health promotion and tackling stigma for people with mental health needs.
	
	Service summary:
	
	The services adults with mental health needs receive directly or indirectly from Surrey County Council and its strategic partners are:
	• Residential and nursing home placements delivered by housing associations or independent providers
	• Supported living services delivered by housing associations or independent providers
	• Care co-ordinator and social care support delivered through Surrey & Borders Partnership NHS Foundation Trust by County Council staff.
	• Carer liaison services delivered through Surrey & Borders Partnership NHS Foundation Trust by Surrey County Council staff
	• Range of third sector community connections services commissioned by Surrey County Council.
	• Employment advisor service commissioned by NHS Surrey
	• Advocacy services commissioned jointly by Surrey County Council and NHS Surrey
	• Housing support services commissioned by Surrey County Council
	• Support Time Recovery (STR) delivered by Surrey & Borders Partnership NHS Foundation Trust by County Council employees
	• Approved mental health professional services delivered by Surrey & Borders Partnership Trust by County Council employees
	• Primary care mental health delivered through personal care and support (only social care services)

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<table>
<tr><td></td><td>
Primary care mental health services delivered through IAPT services commissioned by NHS Surrey.
Frontline services are provided in the main through Surrey & Borders Partnership NHS Foundation Trust which is a secondary mental health service. Surrey County Council's Personal Care and Support service provides primary mental health social care services and Improving Access to Psychological Therapies (IAPTs) provide primary mental health services commissioned by NHS Surrey.
Surrey County Council employs 208.34 social care staff who work in partnership with Surrey & Borders Partnership NHS Foundation Trust delivering an integrated health and social care service. Services include:
Community Mental Health Recovery Services (CMHRSs)
Assertive Outreach Teams
Early Intervention in Psychosis Teams
Home Treatments Teams
Forensic Services
The 11 Community Mental Health Recovery Services (CMHRSs) are modelled on the 11 Districts and Boroughs. There are 2 Home Treatment Teams and 2 Assertive Outreach Teams covering the county; one of each in the East and one of each in the West. The Forensic Team is countywide.
Although the PVR has focused on services for people aged between 18 and 64 years, it has also responded to the need to understand and improve transitions between CAMHS, adult mental health services, and older adult and dementia services.
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<tr><td>What proposals are you assessing?</td><td>
Following extensive engagement with a wide range of stakeholders, the PVR has produced the following recommendations:
<table>
<tr><td>Recommendation 1: Establish a clear commissioning framework for mental health services
'(We need) services that demonstrate outcomes'.</td></tr>
<tr><td>
Develop clear and measurable outcomes and expectations for adult mental health services commissioned and provided by Surrey County Council
Put in place a clear commissioning arrangement with Surrey and Borders NHS Partnership Trust
Put in place clear commissioning arrangements with voluntary sector providers of services
Develop outcomes monitoring tools to ensure track progress of commissioned services
Establish local groups to monitor performance of providers
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	Recommendation 2: Strategic shift to early intervention and prevention: keeping people well *'Need to prevent people using secondary care services, as this is stigmatising'.*
	• Further investment in voluntary sector, supporting the focus on keeping people well, social inclusion and a whole family approach • Revise the way we fund services so that it is based more on local need. Work in partnership to specify the desired outcomes and outputs for services. Offer 3 year grant agreements to services that can deliver these outcomes and outputs • Normalise mental health by supporting people to access resources in the community and use community resources in support of good mental health e.g. by having community mental health champions, increasing provision of local community connections services that are accessible to all people who may need mental health support • Work in partnership with local districts and boroughs, adult and children's health and social care providers and commissioners, the voluntary, community, faith and independent sectors to focus on prevention and early intervention, including earlier information on mental health conditions so people can recognise the signs and carers are supported earlier • Working with suicide prevention group to implement action to prevent suicide • Joint working with children, schools and family services on strategic shift to early intervention and prevention, for example by exploring technologies to engage with young people about mental health, non-stigmatising emotional literacy support for children and young people and support to prevent post-natal depression in 'at risk' groups
	Recommendation 3: Embedding personalisation *'Creating independence, not dependence'*
	• Extend the personalisation model to primary care and the voluntary sector • Work in partnership to implement all 4 quadrants of personalisation: early intervention and prevention; promoting social capital; access to universal services and enabling choice and control • Continue roll-out of personalisation training for staff on planned schedule and implement and measure impact of self-directed support (SDS) • Simplify the SDS process and utilise advocacy and brokerage services to enable people to have more choice and control • Develop clear pathways and processes for personalisation in Enabling Independence Service, integrated mental health teams (18-64yrs), substance misuse and prison services.

Review all individuals and carers currently in receipt of social care funding or support by March 2013

- Ensure potential of personalisation to improve support for carers is fully realised through the carers pathway
- Explore resource allocation system and supported self-assessment suitability for people with mental health problems

Recommendation 4: A focus on improving the mental health and well-being of Surrey County Council's workforce.

- Focus on workforce mental health, 'A mindful employer', valuing diversity in the workforce
- Work with Unison and GMB unions to roll out health checks in Surrey County Council

Recommendation 5: Improving knowledge and awareness of mental health, and addressing stigma and discrimination
'(I am) concerned about people being labelled and then being stuck with that label'

- Work in partnership with public health and link with existing campaigns to improve public understanding of mental health, including needs of whole family by developing public interactive campaigns
- Work with service providers and people with mental health needs to deliver mental health awareness training for GPs ,primary care and the wider public sector, including risk factors for mental health such as autism, learning disability, physical and sensory impairments, domestic abuse and substance misuse
- Mental health services to be delivered, wherever possible, in the community to mainstream and de-stigmatise mental health
- Make sure mental health is on the agenda of key groups such as the Health and Well-being Board and Healthwatch, to ensure there's 'no health without mental health'
- Work with partners to have continued commitment to enabling people with mental health problems to maintain or gain voluntary or paid employment
- Link in with existing anti-stigma campaigns locally and nationally
- Promote use of existing resources, such as Mind mental health activity pack and First Steps website
- Engaging with other agencies such as police, prison and ambulance services to increase awareness of mental health
- Enabling the voluntary, community and faith sector to access public health expertise, to develop strategic thinking based on population needs assessment and contribute to service development

Recommendation 6: Ensuring high quality services
'We need an established way to involve service users and carers;

	nothing about us without us'
	• Monitor services provided or commissioned using a robust framework which focuses on outcomes and outputs that people have told us are important to them, such as agencies working in partnership, dealing with the 'whole person' and are accessible to all those with mental health needs • Mandate person-centred, self-defined outcomes approach to recovery planning and well-being for each person • Develop the mental health workforce on a district and borough basis • Develop joint adult social care and health 'dashboard' to monitor whole systems working, standards and outcomes • Continue to support and develop appropriate and meaningful ways to involve people in delivering and developing services • Joint planning and aligning commissioning of services across different sectors • Implement local and Surrey-wide governance arrangements for mental health • Equality of access to services (see recommendation 13)
	Recommendation 7: Think family *'Keeping parents well in the community equals keeping children and young people well in the community'*
	• Implement family support programme of work ('troubled families') and develop mental health indicators to measure impact of work on the mental health and resilience of families • Work in partnership across agencies to have a whole family approach to keeping people well and supporting families and networks of carers • Work across the health and social care boundaries of provision for children, young people, adults and older adults to develop joint projects to promote 'think family'. • Link in with existing good practice and projects to support the think family agenda
	Recommendation 8: Support for carers *'Carers' liaison workers are currently only in secondary care. When a user doesn't get a service, where does this leave the carer? They are still doing the same job, if not more'*
	• Carers' liaison workers currently operate within integrated secondary mental health teams; this means that carers who care for someone who does not meet the threshold for these services may find it harder to access carers assessments and support. Further exploration required and response to be developed • Promoting personalisation for carers and use of carers pathway to develop a holistic approach to support the emotional health and well-being of carers • Improve identification and response to young carers • Continue to commission specialist mental health carers

	support and ensure appropriate links with generic carers support services, including those for young carers • Ensure mental health specific carers services are embedded in carers care pathway and improve interface between different carers support organisations to make best use of different qualities to maximise services • Promote use of 'Partners in recovery' guidance to enable providers of support to interact appropriately with carers • Supporting carers' mental health by including carers in early intervention and prevention approaches, by partnership working with Carers' commissioning group
	Recommendation 9: Improving the pathway through mental health services *'We need a whole system for mentally healthy communities'*
	• In partnership, develop and implement joined up care pathway, from early intervention and prevention through to services for people with severe and enduring mental health problems and ensure clear linkages to other relevant pathways e.g. physical health and long term conditions, young people and older people's services, learning disability/autism, substance misuse, domestic violence ; recovery at heart of all services • Inform, support and utilise the carers pathway • Develop ,draw a picture of, and implement a joined up, 'whole systems' approach to adult mental health: voluntary/community sector; primary care; districts and boroughs, local social care teams; secondary mental health services and acute care; children, schools and families service and older adult mental health services • Statutory agencies and voluntary sector to be held accountable for whole systems working through local mental health multi-agency groups • Make available a range of referral routes to services: self-referral, from voluntary sector and GP referral • Empower people to have more control over their care and support pathway e.g. by embedding the recovery star tool in mental health service delivery, by enabling self-referral to universal services, access to medical records, peer support and self-management courses • Promote local communication, knowledge and relationships by: supporting existing mental health stakeholder groups; facilitating local social inclusion groups; and, promoting face-to-face networking opportunities to share information across all sectors • Work with partners to ensure more effective sharing of information between the person, carer and different providers to enable proper handover and suitable onward referral e.g. with the person, develop a staying well plan that they own and take with them • Statutory services, including public health, to address the

	physical health needs of people with mental health problems, for example by implementing physical health checks and monitoring progress • Work with local voluntary sector groups to scope demand for therapeutic and well-being groups (a perceived gap) • Work in partnership to address how people access support in a crisis • Address existing geographical gaps in services and work with partners to ensure people can access services that are close to home, even if this is in a different local authority area.
	Recommendation 10: Meeting social care outcomes *'Clear guidance as to role (of social care) and a strengthening rather than dilution of skills that social care workers bring to teams would benefit staff and users alike'*
	• Explore options to strengthen the role of social care for people with mental health problems and their carers/families (currently delivered within integrated secondary mental health services such as community mental health recovery services) and deliver social care outcomes in a more effective way. Assess impact of any proposed changes and conduct options appraisal on the following future options: 1. Continue to deliver social care through integrated teams with Surrey and Borders Partnership Mental Health Foundation Trust, with defined social care partnership arrangements and clear social care outcomes monitoring 2. New partnership and integration options with GP practices 3. Deliver mental health social care within generic adult social care locality teams 4. Mixed model: Adult Social Care ownership of mental health social care agenda and deploy staff flexibly in different settings: voluntary sector, primary care (with GP practices), local social care teams, secondary care settings (with Surrey and Borders) 5. Develop a social enterprise model to deliver mental health social care The outcome from this recommendation will be considered alongside current development of integrated working in Older People's mental health teams. • The timescales and how this project will be developed is in implementation plan.
	Recommendation 11: Support for people with mental health and other needs *'Need staff to be multi-skilled to support people with dual diagnosis'*
	• Substance misuse: Scope services and work with partners to address any gaps for people with a mental health need and substance misuse problem • Military and veteran mental health: Ensure mental health on

	military health agenda through existing forums • People with learning disabilities and/or autism: work in partnership to deliver universal offer for people with autism; mainstream mental health services are accessible to people with a learning disability: LD services provide support to enable a PLD to access MH services • Domestic abuse: Link in with domestic abuse county wide work to get mental health on the agenda • People with long term health conditions: link pathways of care • People in prison: personalisation and raising mental health awareness • Joined up approach to carers' mental health through carers pathway
	Recommendation 12: Housing and support *'The ability to maintain housing may be compromised due to the person's mental health condition'*
	• In partnership with districts and boroughs, identify different levels of supported housing (low need through to high/complex need such as people with a history of arson or ex-offenders) and commissioning of services to meet local need, to address current inequity in provision across Surrey • Support people to maintain housing, through interventions such as budgeting skills and daily living skills • Explore new ways of supporting people e.g. a buddy system of volunteers who provide peer support in the accommodation setting, utilising existing money advice services in the voluntary sector Further develop Shared Lives scheme • Proactive review of residential and nursing placements, including out of area placements, with the aim of reducing these and aligning with Health commissioning • Develop a 'real time' online directory of potential housing resources which describes the services, vacancies, referral procedures and cost • In partnership with districts and boroughs, develop special needs housing panels in all districts and boroughs and hold regular local networking sessions to facilitate good working relationships • Involvement of housing departments and housing providers in care plans and hospital discharge so that adequate planning can be made to ensure the person is properly supported during what can be a destabilising and difficult time • Enable people to use personalised budgets to enhance the range of accommodation with support options
	Recommendation 13: Young people and transition *'Transition can be problematic'*
	• Develop more affordable accommodation with support

	options to meet local need for young people with emotional and behavioural difficulties • Adult Social Care to be a stakeholder in re-commissioning of children's emotional well-being services, to ensure shared vision towards early intervention, prevention and 'think family', including consideration of carers' needs • Work across departments to scope 'vulnerable adults' services • Use evidence from young people's rapid improvement event to shape future services
	Recommendation 14: Information, inclusion and reducing inequalities *'Practitioners to work holistically and make mental health services information more accessible'*
	• Link in with mainstream information and welfare benefits advice commissioning to address impact of welfare reforms, user led hubs, carers commissioning and transport planning to make sure people with mental health needs and their families are on the agenda • Continue to widely promote Surrey Information Point as a single trusted source of information and encourage providers to upload their details • Raise awareness of advocacy support that is available • Clear signposting so people with different communication needs not excluded from services • Reach out to those who may not engage with services, such as gypsies and travellers, through outreach workers, support brokers and community connections services • Information and explanations about services to be accessible in different formats and people able to find out about and access services by appropriate means e.g. by telephone, text message, email • Monitor services on equalities outcomes to make sure there is equality of access to services • Mental health services to make reasonable adjustments to ensure equality of access for people with different communication needs e.g. staff awareness of autism, honest and accurate information about services, seeing the same staff wherever possible, information in different formats, ways to enable people with communication needs to engage with services • Clear communications about new community connections services • Work with health commissioners to advance the goal of parity of mental health and physical health services • Rights of people with mental health problems: advancing knowledge

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Who is affected by the proposals outlined above?	The above recommendations relate to a wide range of stakeholders and could thus affect the following groups: **The general public** are likely to be affected by those recommendations which relate to promoting mental health, raising awareness, and reducing stigma associated with mental illness across various settings. **People who use services** are likely to be affected directly or indirectly by all of the above recommendations. This reflects the PVR's aim of delivering improved outcomes for Surrey residents. **Families** are likely to be affected by a number of the recommendations, particularly recommendation 5 'Think family' and those that relate to supporting young people. **Carers** are likely to be affected directly or indirectly by many of the recommendations, particularly recommendation 6 'Support for carers'. **Voluntary, community and private sectors** are likely to be affected by a number of the above recommendations, including increased investment and strengthening of the voluntary sector, changes to service funding and monitoring arrangements, and the focus on a joined-up 'whole systems' approach. **Statutory agencies** are likely to be affected by the strategic shift to prevention and early intervention, the focus on a joined-up 'whole systems' approach to commissioning and delivering mental health services, and changes to funding and monitoring arrangements. **Surrey County Council staff** are likely to be affected by any changes to the delivery of mental health social care and any recommendations which relate to joined-up 'whole systems' working. They will also be affected by the introduction of health checks for Surrey staff.

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6. Sources of information

Engagement carried out
In line with the engagement plan provided in the PVR terms of reference document, engagement with a range of stakeholders has taken place throughout the PVR: • A range of representatives from Surrey County Council, Surrey and Borders Partnership NHS Foundation Trust, NHS Surrey, and groups that represent people who use services and carers, formed a Project Group with monthly meetings to discuss progress, forward plan, raise issues and obtain feedback on key documents • 4 social inclusion co-design workshops in different parts of Surrey, open for any interested parties to attend • Questionnaire to find out what keeps people well, widely distributed • 1:1 interviews and group discussions with health and social care mental health services managers, enabling independence teams, reintegration services, other mental health and social care practitioners, substance misuse professionals and criminal justice services • 1:1 phone interviews with people who have used mental health services and carers • Individual and group discussions with people who use services and carers • Discussions with stakeholder forums • Discussions with district and borough housing departments, housing providers and people with mental health needs using supported housing services • Individual and group discussions with voluntary sector service providers • Briefings for key individuals and groups. • Email feedback from individuals at all stages of the PVR, with key findings and recommendations being circulated for feedback • A conference attended by 155 people from statutory, private, voluntary and community sectors, people who use services and carers. Participants took part in workshops to explore opportunities for mental health in Surrey • An online survey for those who attended the conference and those who were unable to attend. The findings from this and the conference workshops were analysed and informed the PVR recommendations • A stakeholder workshop for 40 people from a range of sectors, to gather feedback on the initial recommendations.
Data used
Staff from the Surrey County Council Adult Social Care Business Intelligence Team and the Adult Social Care Finance team collected and analysed numerical data from a wide range of sources to generate a data pack. This data pack includes data on demography, measures of the incidence of mental health needs and associated factors, service activity, contracts and grants, expenditure, staffing, and stigma and discrimination. Data sources included: • Office for National Statistics, via Surrey-i • Census data • Survey of carers in households in England 2009/10 • Department for Communities and Local Government, via Surrey-i

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- Joint Strategic Needs Assessment
- Primary research studies published in academic journals
- NHS Information Centre
- Service monitoring data from RIO and AIS databases (RAP reports), Surrey County Council social care and Supporting People teams, NHS Surrey, and SABP.
- Surrey Independent Living Council
- Research reports from charities, think tanks and the Department of Health
- IPF PSSEX1 Benchmarking Club data 2010/11.

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7. Impact of the new/amended policy, service or function

7a. Impact of the proposals on residents and service users with protected characteristics

Protected characteristic[2]	Potential positive impacts	Potential negative impacts	Evidence
Age	An increased range of accommodation and support options for young people meaning they will have greater choice of appropriate accommodation. Increased identification of young carers meaning more young carers will receive support. Partnership working between adult and child/ adolescent health and social care providers and commissioners meaning young people will experience a better transition into adult services. Partnership working with commissioners and providers of older adult		What people told us: • Improve identification and response to young carers. • Work across the boundaries of provision for children, young people, adults and older adults to develop joint projects to promote 'think family' • Develop more flexible/ joined up interfaces between services for different age groups. • Work with schools and youth groups to raise awareness of mental health, e.g. link in with the school curriculum. • Develop more affordable accommodation for adolescents with emotional and behavioural difficulties reaching 18 and greater support to help them find this. • People should be able to access community connections services in all Districts and Boroughs. Community connections services are local services that provide a supported bridge into social and leisure activities, education and training and practical advice on dealing with mental health issues from people who are trusted. Local research: Young people (under age 25) are under-represented in community connections services in Surrey (TriNova, 2010). National research: The ages 16–18 are a particularly vulnerable time when the young person is both more susceptible to mental illness, is going through a period of physiological change, and is making important transitions in

[2] More information on the definitions of these groups can be found here.

	services meaning people will experience better transition into services for older adults. An increase in the number and range of accessible community connections services, plus targeted work with schools, should lead to improved access to support for young people.		their education (Joint Commissioning Panel for Mental Health, 2012). Research in 2001 found that half of young people's advice agencies could get virtually no help for 16-18s from CAMHS or adult services (Wilson, C., 2001). Young people (aged 16-24) are less likely to seek help from their GP for a common mental health problem than other age groups (Oliver, M. I., Pearson, N., Coe, N. And Gunnell, D., 2005). National policy: Schools and colleges should promote good mental health for all children and young people, alongside targeted support for those at risk of mental health problems (Department of Health, 2012). There is a need to commission for effective transitions between child/ adolescent, working age adult, and older peoples services (Department of Health, 2012).
Disability	**For people with a mental health need:** A joined up care pathway will be developed and clearly communicated meaning that people with a mental health need will experience smoother transitions between services. Services will be monitored using a framework of outcomes that people have told us are important to them – meaning people with a	**For people with a mental health need:** Potential negative impact of re-distributing resources to commission services according to population size. Impact will depend on level of funding secured.	**People with a mental health need** What people have told us: • There is no clear pathway of care and support for people with a mental health need and people experience difficulties transitioning between services. • Services need to be person-centred and deliver outcomes that matter to the individual. • There is not enough variety of accommodation to meet the diverse requirements of people with mental health needs. Local data: Estimated prevalence amongst people aged 18 – 64 in Surrey (2012) Common Mental Disorder = 111 169 Two or more psychiatric disorders = 49 505 Borderline personality disorder = 3110 Anti-social personality disorder = 2389 Psychotic disorder = 2761 (Source: PVR datapack)

mental health need experience person-centred support that delivers outcomes that matter to them.

Commissioning of accommodation services to meet local need meaning that people with a mental health need have greater choice and access to suitable accommodation.

Commissioning services in relation to population size will result in an equitable distribution of services across the county – meaning people with a mental health need have access to local services.

People with a mental health need and other disability:

An increase in the number and range of accessible community connections services leading to improved access to support for people with a learning

Funding of services for people with a mental health need, by Borough or District

Borough	Working age population (16 – 59/64)	Proportion of the working age population of Surrey	Current community service funding allocation	Proportion of overall Surrey community service spending
Elmbridge	79,400	11.6	46678	5.9
Epsom & Ewell	45,100	6.6	0	0.0
Guildford	87,900	12.9	52171	6.5
Mole Valley	48,500	7.1	111688	14.0
Reigate & Banstead	84,900	12.4	20000	2.5
Runnymede	55,700	8.1	144144	18.1
Spelthorne	57,000	8.3	5770	0.7
Surrey Heath	50,900	7.4	2266	0.3
Tandridge	48,100	7.0	0	0.0
Waverley	68,300	10.0	309176	38.8
Woking	57,800	8.5	104782	13.2
TOTAL	683,600	100	796,675	100

(Source: PVR datapack)

People with a mental health need and other disability

What people have told us:

- There is not enough support for people with a learning disability to access services.
- GP's and other primary care staff need to be made more aware of the risk factors for mental illness, including autism and learning disability.
- Mental health services need to make reasonable adjustments to ensure equality of access for people with different communication needs e.g. staff awareness of autism, honest and accurate information about services, seeing the same staff wherever possible.
- Information about services and signposting needs to be accessible

	disability. Improved awareness within primary care of the link between autism/ learning disability and mental health - meaning more people with a learning disability and mental illness receive timely support. Development of signposting and information suitable for people with learning disability and autism improving access to services and ensuring that these people are not excluded. Development of a care and support pathway with links to other relevant pathways meaning that people with a functional/physical or learning disability receive a joined up service that addresses both mental health and other needs. Continuing implementation of		to people with learning disability. • The care and support pathway for mental health should link to other pathways including physical health/ long term conditions, and learning disability pathways. Local data: In 2010 in Surrey, the number of people aged 18-64 with: A moderate/ severe learning disability = 3827 Baseline learning disability = 16 751 Autistic spectrum disorder = 6907 (PANSI, 2009) Surrey projections for 2012 indicate that the total number of people with a moderate or severe physical disability will be 76 069 people, or 11% of the 18 – 64 population. National research: People with a learning disability have a higher rate of mental illness than the general population[i] and can experience the full range of mental health problems. However, it may be more difficult to identify a mental illness due to masking of the clinical presentation. (Royal College of Psychiatrists, 2003). These individuals also face more barriers to accessing services. These may take the form of physical and communication barriers, or a lack of time and knowledge amongst GP's and specialist mental health practitioners which may lead to under detection of mental health needs (NHS, 2009). Those with a long-term condition are two to three times more likely to have a mental health need, particularly depression or anxiety, than the general population (Naylor et al., 2012).

	personalisation in mental health meaning people with a learning/ physical disability and mental health need can access services that are more acceptable/ sensitive to their needs. Services monitored on equality outcomes ensuring accessibility and acceptability for people with a physical or learning disability.		
Gender reassignment	Continuing implementation of personalisation in mental health meaning people who have undergone/ are undergoing gender reassignment can access services that are more acceptable/ sensitive to their needs. Enabling self-referral to universal services, peer support and self-management courses - meaning people who have undergone/ are undergoing gender reassignment can have more control over what support they access and		Local data: there is no data on the number of people living in Surrey who have/ are undergoing gender reassignment. National research: It is estimated that 20 in 100 000 people aged 15 and over in the UK have undergone gender reassignment (Reed et al., 2009). 'Trans' is a term used to capture experiences of being gender variant in behaviour and preference, as well as social and legal gender change (National Mental Health Development Unit, no date). The UK's largest survey of trans people showed that 34% (over 1 in 3) of adults had attempted suicide. Trans people are at a greater risk of depression, self-harm and suicide (NHS, no date). Young trans people report insecure housing, economic hardship, stigma, difficulty accessing appropriate healthcare, limited family support and high rates of substance abuse (National Mental Health Development Unit, no date). People who have a mental illness and have/ are undergoing gender reassignment may experience a double stigma and considerable

	how. Public awareness campaigns to reduce stigma could lead to less discrimination and earlier access to services.		discrimination (National Alliance on Mental Illness, 2007).
Pregnancy and maternity	A family focused, early intervention approach to keeping people well, meaning those experiencing pregnancy and maternity receive support that is sensitive to their needs and the needs of their children. The other recommendations will not impact this protected group (either positively or negatively) more or less than the general population.		What people have told us: • Support needs to focus on the whole family. National research: Mental ill-health following childbirth may have an adverse effect on the woman herself, on her marriage/ partnership, her family and the infant (Oates, M., 2000). Home-based interventions for pregnant women and new mothers have been shown to result in improved mental health and social outcomes for both mother and baby (Jane-Llopis et al., 2005). National policy: As part of early intervention, children and parents should receive evidence based mental health promotion from birth (Department of Health, 2012).
Race	Further development of community connections and outreach services that are accessible to all people with a mental health need could increase the number of BME people accessing		What people have told us: • We need to raise awareness of mental health across diverse communities and work with faith groups to achieve this. • Mental health services need to ensure equality of access for people with different communication needs. Local data:

	mental health services and support in their local community. Public awareness campaigns and targeted work with faith groups could reduce the stigma and fear surrounding mental health in some ethnic minority groups, leading to earlier access to services. Continuing implementation of personalisation in mental health will support people from BME groups to access services that are more acceptable/ sensitive to their needs. Enabling self-referral to universal services, peer support and self-management courses, meaning services are more accessible for people from BME communities who may fear or distrust traditional services.		The Audit Commission define Black and Minority Ethnic (BME) people as including White Irish, White other (including White asylum seekers and refugees and Gypsies and Travellers), mixed (White & Black Caribbean, White & Black African, White & Asian, any other mixed background), Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background), Black or Black British (Caribbean, African or anyother black background), Chinese, and any other ethnic group. Using this definition 16.99% of Surreys population are from BME groups. This is compared to 17.21% across England and 14.28% in the South East. Epsom & Ewell and Woking have the highest percentage of non-White residents while Waverley has the lowest. The largest ethnic minority group in Surrey is Indian (2.3% of the population) (Surreyi, 2009). National policy: To translate the vision of the No Health Without Mental Health strategy into a reality, services must be accessible, acceptable and culturally sensitive to all (Department of Health, 2012). National research: Minority groups, relative to the white majority, report significantly higher scores of psychological distress, poor self assessed general health, and a severe lack of social support. (Erens et al, 2001). The prevalence of psychosis has been found to be significantly higher in the African Caribbean and Black African population, compared to the White British population in the UK. The rate was also slightly higher for Asian groups (Fearon, 2006). National data has identified the highest rates of GP consultation for schizophrenia amongst African Caribbean people. This group also had the highest consultation rates for personality disorder (Shah et al., 2001). National data also indicates higher rates of admission to hospital and detention under the mental health act for some Black and Minority Ethnic (BME) groups, particularly Black Caribbean and Black African

			(Commission for Healthcare Audit and Inspection, 2005). However, data from the Office for National Statistics shows that GP consultation rates for all psychiatric conditions combined were highest in Whites (20% and 94% higher than African Caribbean and Asian people respectively) (Shah et al., 2001). A contributing factor to these lower consultation rates may be that stigma, fear and distrust of mental health services in ethnic minority communities stops people from seeking help from their GP at an early stage or even at all (The Sainsbury Centre for Mental Health, 2002). Research also shows that few people from ethnic minority groups with mental health problems are accessing direct payments, despite their potential for facilitating culturally sensitive support (Spandler, H. and Vick, N., 2004). National policy: Services could make good use of technology to deliver self-help and peer support in an accessible and stigma free environment (Department of Health, 2012).
Religion and belief	Public awareness campaigns and targeted work with faith groups could reduce the stigma and fear surrounding mental health and lead to earlier access to services. Continuing implementation of personalisation in mental health should enable people from different faith groups to		Local data: The 2001 census revealed that 74.6% of the Surrey population were Christian; 1.3% Muslim; 0.3% Buddhist; 0.7% Hindu; 0.3% Jewish; 0.2% Sikh; 0.3% Other; and, 15.2% had no religion. National research: For some people there is a strong association between their religion or spiritual belief and their mental health. Spirituality may: help people cope better; help people to feel more in control; and, provide social support. These factors can contribute to positive mental health (Mental Health Foundation, 2007). A research report by the Mental Health Foundation recommends that mental health services develop partnerships with 'local spirituality-orientated organisations that will support users positively.' (Mental Health

	access services that are more acceptable/ sensitive to their needs. Monitoring of services on equality outcomes leading to services that are accessible and acceptable to all (depending on target group). Enabling self-referral to universal services, peer support and self-management courses - meaning people from different faiths have more control over the services and support they access.		Foundation, 2007, p.6). It also recommends that religious and spiritual leaders should increase their own awareness of mental health so that they can fully support their community members and address stigma and discrimination (Mental Health Foundation, 2007) National policy: To translate the vision of the No Health Without Mental Health strategy into a reality, services must be accessible, acceptable and culturally sensitive to all (Department of Health, 2012).
Sex	Increase in the number of accessible community connections services leading to improved access to local support for women. Increased emphasis on universal services - meaning women with a low to moderate need (i.e. those not eligible for secondary services) can access a range of		Local data: Women are under-represented in community connections services in Surrey (TriNova, 2010). National research: **Rates of Common Mental Disorders are higher in women than men.** The 2007 Adult Psychiatric Morbidity Survey showed that men were less likely to have experienced neurotic symptoms (depressive episode, mild anxiety or depressive disorder, Generalised Anxiety Disorder, phobias, Obsessive Compulsive Disorder, and panic disorder) in the week prior to the survey than women (11.6% and 18.4% respectively). This pattern was true across all age groups (The NHS Information centre for health and social care, 2007).

<table>
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<td></td>
<td>low level support.

A strategic shift to early intervention plus increased opportunities for self-referral to universal services, peer support and self-management courses - meaning more men may access support earlier.</td>
<td></td>
<td>Suicide rates are higher in men than women. Age-standardised suicide rates for the UK population between 2006 and 2010 show that males of all ages have higher suicide rates than females. For the age group 15-44 males have a suicide rate over 4 times that of females in the same age group (Office for National Statistics, 2012).

Men are less likely to consult their GP about a mental health problem. Data from the Fourth National Morbidity Survey in General Practice shows that between 1991-1992 women had 84% higher consultation rates for mental health problems than men (Shah et al., 2001).</td>
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<tr>
<td>Sexual orientation</td>
<td>Further investment in the voluntary sector may result in services which are more acceptable to Lesbian, Gay or Bisexual (LGB) people.

Stigma campaigns and encouraging access to community based services and support will help to normalise mental health.

Continuing implementation of personalisation in mental health should enable LGB people to access services that are more acceptable/ sensitive to their needs.

Monitoring of services</td>
<td></td>
<td>Local data:
The 2001 census showed that there was a smaller percentage of people living in a same sex couple in Surrey than in England and the South East.

Although there is no definitive data, if we take the national estimate of 5-6% then approx. 55 000 - 66 000 people in Surrey would identify as lesbian, gay or bisexual (Surrey Joint Strategic Needs Assessment, 2011).

National research:
Many LGB people experience bullying, discrimination and isolation which have been linked to poorer mental health (NHS, 2012).

Lesbian, gay and bisexual (LGB) people are at a higher risk of mental health problems and drug and alcohol abuse than the general population (NHS, 2012). However, the real picture is uncertain because of reluctance of some people to disclose their sexuality and some healthcare staff feeling uncomfortable asking the question (Ash and Mackereth, 2010; NHS, 2012).

Estimated rates of Common Mental Disorders
<table>
<tr><td></td><td>LGB population</td><td>General population</td></tr>
<tr><td>Depression</td><td>28 – 40%</td><td>6%</td></tr>
<tr><td>Anxiety</td><td>18%</td><td>5%</td></tr>
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	on equality outcomes, leading to services that are accessible and acceptable to all (depending on target group). Increased opportunities for self-referral to universal services, peer support and self-management courses may result in improved access to and experience of services for LGB people.		<table><tr><td>Self harm</td><td>20 – 25%</td><td>2.4%</td></tr><tr><td>Suicide attempts</td><td>20 – 40%</td><td>4.4%</td></tr></table> LGB people use mental health services more frequently than their heterosexual counterparts. However, they report mixed experiences of services ranging from lack of empathy about sexual orientation to homophobia. One-third of gay men, a quarter of bisexual men and over 40% of lesbians reported negative or mixed reactions from mental health professionals when they disclosed their sexual orientation. One in five lesbians and gay men and a third of bisexual men stated that a mental health professional made a causal link between their sexual orientation and their mental health problem (King and McKeown, 2003). Voluntary sector organisations may be better suited to working with LGB people, because of their flexibility (Ash and Mackereth, 2010).
Marriage and civil partnerships	The recommendations will not impact this protected group (either positively or negatively) more or less than the general population.		Local data: Compared to England as a whole and the South East, Surrey has high rates of marriage (47.2% for Surrey compared with 43.5% for England and 44.7% for South East). Surrey rates of separated or divorced individuals are also low compared to England and the South East (Surrey County Council, no date).

7b. Impact of the proposals on staff with protected characteristics

Protected characteristic	Potential positive impacts	Potential negative impacts	Evidence
Age	Any workforce changes resulting from the recommendations may have positive and negative impacts. These changes will be subject to their own		

EQUALITY IMPACT ASSESSMENT TEMPLATE

	Equality Impact Assessment.		
Disability	Surrey County Council staff will benefit from a focus on workforce mental health including the roll out of health checks across the Council.		What people have told us: We need to work with employers to improve the mental health of staff and make sure employees have access to information about mental health and services. National research: Satisfying work can play a vital role in maintaining positive wellbeing. However, work related stress can have a significant impact on mental wellbeing, absenteeism, performance, motivation and relationships at work (World Health Organization, 2000). Interventions such as screening for anxiety and depression in the workplace, followed by Cognitive Behavioural Therapy, have been found to be effective and cost-effective (McDaid et al., 2011).
Gender reassignment	Any workforce changes resulting from the recommendations may have positive and negative impacts. These changes will be subject to their own Equality Impact Assessment.		
Pregnancy and maternity	As above		
Race	As above		
Religion and belief	As above		
Sex	As above		

EQUALITY IMPACT ASSESSMENT TEMPLATE

Sexual orientation	As above	
Marriage and civil partnerships	As above	

EQUALITY IMPACT ASSESSMENT TEMPLATE

8. Amendments to the proposals

Change	Reason for change
No changes have been made to the recommendations as a result of the Equality Impact Assessment.	

9. Action plan

Potential impact (positive or negative)	Action needed to maximise positive impact or mitigate negative impact	By when	Owner
All positive impacts detailed above for LGB people/ BME communities / people from diverse faiths.	Invite representatives of LGB, BME (including Gypsy and traveller), and faith sector groups to take part in a stakeholder workshop to ensure their views are captured and incorporated into the PVR recommendations.	6 September 2012	Stuart Deacon
	Grant bidding document for community connections services will require bidders to describe how they will meet local need, engage with 'hard to reach' people, and ensure that services do not discriminate directly or indirectly against people with protected characteristics.	Document completion end September Provider event mid October	Jane Bremner
Potential negative impact of re-distributing resources to commission services according to population size. Impact will depend on level of funding secured for services.	Develop business case for increased funding. Engagement with NHS Surrey and Clinical Commissioning Groups to secure funding to have jointly commissioned local universal services.	End of October	Donal Hegarty

EQUALITY IMPACT ASSESSMENT TEMPLATE

	Grant bidding document for community connections services will state the need for a 3 month handover period for individuals and groups to the new provider and bidders will be prompted to consider how they will manage this transition.	Document completion end September Provider event mid October	Jane Bremner
	Conduct separate Equality Impact Assessment for changes to community connections services.	Prior to implementing the changes	Jane Bremner
Any potential positive or negative impacts of Surrey County Council workforce changes.	Conduct separate Equality Impact Assessment for Surrey County Council workforce changes.	Prior to implementing the changes	Jane Bremner

10. Potential negative impacts that cannot be mitigated

Potential negative impact	Protected characteristic(s) that could be affected

11. Summary of key impacts and actions

Information and engagement underpinning equalities analysis	In line with the engagement plan provided in the PVR terms of reference document, engagement has taken place throughout the PVR with a range of stakeholders. This has included one-to-one and group discussions with commissioners, providers (statutory, voluntary and private sector), carers and people who use services; surveys; and, consultation on key documents. Other data sources have included national and local survey and census data; data from RIO and AIS databases; data from other Surrey County Council, NHS Surrey, and Surrey and Borders Partnership NHS Foundation Trust reports and records; academic research; and, reports from charities, think tanks and government.

EQUALITY IMPACT ASSESSMENT TEMPLATE

Key impacts (positive and/or negative) on people with protected characteristics	The recommendations are likely to have a range of positive impacts for people with protected characteristics. - Continuing implementation of personalisation in mental health should enable people with protected characteristics to access services that are considered acceptable/ sensitive to their needs. - Increasing the number of accessible community connections services should mean that people with protected characteristics can access services that are considered acceptable/ sensitive to their needs, within their local area. - Enabling self-referral to universal services, peer support and self-management courses should mean that people with protected characteristics have more control over what support they access and how. - A strategic shift to prevention and early intervention (including awareness raising and stigma reducing campaigns) should mean that people with protected characteristics experience better mental health. - Partnership and whole systems working should mean that people with protected characteristics (particularly disabled people, young people and older adults) experience a joined up care and support pathway and smooth transitions between services. Potential negative impact - Redistribution of funding to commission community connections services according to population size could result in negative impact for people who currently use community connections services in some areas.
Changes you have made to the proposal as a result of the EIA	No changes have been made to the recommendations as a result of the EIA
Key mitigating actions planned to address any outstanding negative impacts	The potential negative impact described above will depend on the level of funding secured to commission these services. Several key actions will be taken to mitigate any potential negative impact: • Develop business case for increased funding. • Engagement with NHS Surrey and Clinical Commissioning Groups to secure funding to have jointly commissioned local universal services. • The grant bidding document for community connections services will state the need for a 3 month handover period for individuals and groups to the new provider and bidders will be prompted to consider how they will manage this transition.

	• A separate Equality Impact Assessment will be undertaken for changes to community connections services.
Potential negative impacts that cannot be mitigated	N/A

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