Equality Impact Assessment Report	Please enter responses below in the right hand columns
Date	26 January 2015
Sign-off path for EIA (please add/delete as applicable)	Cluster management team (Commissioning) Cabinet
Title of Project, business area, policy/strategy	Integrated Personalised Support Alliance (IPSA)
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London Borough of Lambeth Full Equality Impact Assessment Report	Please enter responses below in the right hand columns.
1.0 Introduction	
1.1 Business activity aims and intentions *In brief explain the aims of your proposal/project/service, why is it needed? Who is it aimed at? What is the intended outcome? What are the links to the political vision, and outcomes?*	The Integrated Personalised Support Alliance (IPSA) is a developmental pilot to test out a new collaborative way of working as a 'proof of concept' initiative. NHS Lambeth CCG and Lambeth Council wish to improve the care and support for people with severe and enduring mental health needs and complex life issues through significantly reducing the current over reliance on in-patient rehabilitation beds and residential care home placements. The funds currently being spent on these services will be combined to provide new accommodation options and personalised care and support packages. The IPSA proposals initially concern approximately 200 people in existing rehabilitation services but will also apply to others who will benefit from the approach in the future. The aim is to move away from the traditional 'service-led' approaches to one that responds to people's hopes and ambitions for their lives and builds on their strengths and assets rather than focusing on their needs and deficits. The approach will also move away from one that is risk-averse to one that actively manages risks as part of an holistic plan for recovery and independence. The IPSA proposals will fulfil the wider 'Big 3' outcomes agreed by the Living Well Collaborative (see details below). To achieve these outcomes the proposals intend to: • Provide integrated personalised support packages for people who are currently rehabilitation ward in-patients or living in residential spot placements

	• Support and, if appropriate, manage the process and funds for care packages and personal budgets for all those who are assessed as eligible The IPSA proposals bring together a range of stakeholders – commissioners, clinicians, providers, voluntary and community organisations, people using services and carers. The proposals will support the creation of a multi-agency community rehabilitation service to provide personalised support to people through person-centred support planning. This team will enable move-on from institutional care settings for around 90 people through the provision of lower support accommodation and via NHS Lambeth CCG and Council commissioned services. The development of the IPSA is a key element of the service transformation programme being led by the Mental Health Integration Programme (MHIP), supported by the Lambeth Living Well Collaborative (LLWC). This proposal will support the ambitions of the MHIP and the LLWC to deliver whole system change through co-production and a focus on the provision of personalised care and support. There are clear links between this development and Lambeth Council's Community Plan 2013-16 objectives, particularly in the following areas: • Vulnerable people get the support and protection they need • Older, disabled, and vulnerable people can live independent lives and have control over the support they need • People are healthier for longer • People have the skills to find work • Lambeth residents have more opportunities for better quality homes

	• All Lambeth communities feel they are valued and are part of their neighbourhoods The provision of integrated personalised support will also enable delivery of the big three Collaborative outcomes identified by people using Lambeth mental health services: i. To recover and stay well • Experiencing improved quality of life, physical and mental health ii. To make their own choices and achieve personal goals • With the skills to do this well iii. To participate on an equal footing in daily life • Including friends and family, a home, work, financial independence and the opportunity to 'give back' The IPSA proposals will be delivered by an alliance of local providers and commissioners through an innovative Alliance Contract arrangement.

2.0 Analysing your equalities evidence

2.1 Evidence

Any proposed business activity, new policy or strategy, service change, or procurement must be informed by carrying out an assessment of the likely impact that it may have. In this section please include both data and analysis which shows that you understand how this decision is likely to affect residents that fall under the protected characteristics enshrined in law and the local characteristics which we consider to be important in Lambeth (language, health and socio-economic factors). ***Please check the council's equality and monitoring policy and your division's self assessment. Each division in 2012 reviewed its equality data and completed a self assessment about what equality data is relevant and available.***

IF YOUR PROPOSAL ALSO IMPACTS ON LAMBETH COUNCIL STAFF YOU NEED TO COMPLETE A STAFFING EIA.

Protected characteristics and local equality characteristics	Impact analysis **For each characteristic please indicate the type of impact (i.e. positive, negative, positive and negative, none, or unknown), and:** *Please explain how you justify your claims around impacts.* *Please include any data and evidence that you have collected including from surveys, performance data or complaints to support your proposed changes.* *Please indicate sources of data and the date it relates to/was produced (e.g. 'Residents Survey, wave 10, April 12' or 'Lambeth Business Survey 2012' etc)*
Race	**Positive and negative** Opportunities exist for **positive impact** in relation to race and ethnicity, as the whole focus of the IPSA proposals is to increase the flexibility of services to support diverse choices and needs. The proposals offer the opportunity to maximise individual control and independence for people currently living in institutionalised settings. There is some evidence of the existing inequalities and challenges in the system in terms of race, and analysis of the breakdown of the ethnicity of people on Lambeth rehabilitation wards indicates an over-representation of people from black and minority ethnic groups relative to the local population - although the breakdown of ethnicities in residential care placements is more balanced. NHS Lambeth CCG commissioned the 'Rehabilitation QIPP Project Group' to undertake a review of SLaM's Adult Mental Health rehabilitation provision. A needs assessment was undertaken in mid-2013 of hospital and private placements which included a breakdown of ethnicity:

White		Asian or Asian British		Black or Black British		Other ethnic groups	
White British	16	Asian/British/ Asian Other	5	Black British	10	Not Stated/Other	*
White Other	4			African/Other African	11		
				Caribbean	7		
				Mixed Black	*		

*indicates small numbers

National research has found a 15-fold difference in severe mental illness between prevalence in black men (3.1%) compared with white men (0.2%) – (*ONS Adult Psychiatry Morbidity Survey in England 2007, published in 2009).* The 'Count Me In' Census in 2011 found that black groups are 40% more likely to access mental health services via a criminal justice gateway (*Black Health and Wellbeing Commission report 2014).* Efforts have been made to improve outcomes for BME people using mental health services, but people from African-Caribbean and African backgrounds still experience greater dissatisfaction with mental health services than white service users (*The Schizophrenia Commission's 2012 report, 'The Abandoned Illness'*).

An overwhelming majority of people from black and minority ethnic (BME) backgrounds in the UK living with mental health problems face regular discrimination because of their illness according to a report from the anti-stigma organisation, Time to Change. In the first survey the organisation has conducted, exclusively of people from BME groups, 93% said they had experienced discrimination in everyday life due to their mental health difficulties. Respondents also reported high levels of racial discrimination (73% had faced it at some point and 28% in the previous 12 months), leading the study's authors to warn about the serious issue of "dual discrimination" blighting people's lives. The research

	surveyed 740 people in 2013 from a mixture of African, Caribbean, Indian, Pakistani and Bangladeshi backgrounds in England with mental health issues. Most alarmingly, it found that almost half (49%) had faced discriminatory behaviour from mental health staff. (*Guardian March 2014*). The IPSA proposals should work to address the imbalances, discrimination and poor outcomes detailed above by providing opportunities for people from different ethnic groups to have greater choice and control over the care and support provided to them, also possibly combined with a personal budget allocation if eligible. Personal budgets are a mechanism which allows people the flexibility and autonomy to acquire the care and support they need according to cultural and other requirements. Extension of this approach could be expected to have a positive impact. Some of the findings from Personal Health Budgets (PHB) have been encouraging for example; an evaluation of the PHB pilot in Northampton between 2010-12 found that PHB holders used fewer in-patient, A&E and GP services than those in the control group by an average of £3050 a year (*PHBs for Mental Health, V. Alakeson, July 2014*). The Alliance should ensure that there is equal access to opportunities which are developed, that people from different groups are included in developing new service offers, that people are placed in less restrictive environments, that there is extensive training for staff around equalities issues and challenging discrimination, and that people are able to choose more personal and relevant service options. In terms of **negative impact** however, there may be some concerns about people from different ethnicities benefiting from personalisation as evidence is not available that this is indeed the case. Unfortunately research about personalisation is very variable in the extent to which it reports on equalities and the outcomes which have been achieved. Information available includes a paper published in July 2014 by the Race Equality Foundation (*Personalisation for Black and Minority Ethnic Groups*). This report states: 'Uptake of personal budgets in mental health services appears to be low across all ethnic groups. Organisations advocating on behalf of black and minority ethnic groups with mental

	health problems argue that their negative experiences of mental health services may act as an additional disincentive to trying personal budgets'. The report considers that the lack of information on the specific experiences of people from black and minority groups makes it difficult to draw firm conclusions on what is working well and where improvements need to be made. The report does however state that the numbers of people receiving personal budgets is increasing and the use of direct payments are becoming more popular amongst this group. This suggests that improvements are being made, as previous research had highlighted poor take-up of direct payments. The Social Care Institute for Excellence identified ten specific barriers to BME service users accessing direct payments (Stuart, O (2006) *Will community-based support services make direct payments a viable option for black and minority ethnic service users and carers?)*, these include difficulties in recruiting personal assistants who are able to meet the cultural, linguistic and religious requirements of individuals. The Race Equality Foundation report also notes that as well as offering greater choice for people using services, personalisation potentially offers greater choice and control for family carers about the ways in which they would like to be supported in their role. However, a study (*Glendinning et al., 2013*) is referenced to argue that opportunities have been missed to achieve greater co-ordination between policies aimed at developing personalisation and policies aimed at achieving better support for carers.
Gender	**Positive** There are currently more males resident in Lambeth rehabilitation wards, but a more or less equal proportion of males and females in residential placements. In considering equalities issues it is useful to consider the differences between genders which affect experience of illness and service use. The Alliance will need to consider how the different roles of men and women may affect positive and negative impact. Gender can determine social position, status and treatment in society and susceptibility and exposure to specific mental health risks.

	There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder between men and women, but men are more than three times more likely to be diagnosed with anti-social personality disorder than women. Gender differences have been reported in age of onset of symptoms, frequency of psychotic symptoms, course of these disorders, social adjustment and long-term outcome. The disability associated with mental illness falls most heavily on those who experience three or more comorbid disorders - where women pre-dominate. Gender differences occur particularly in the rates of common mental disorders - depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 6 people in the community at any one time and constitute a serious public health problem. Unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women. The lifetime prevalence rate for alcohol dependence, another common disorder, is more than twice as high in men than women. In developed countries, approximately 1 in 5 men and 1 in 12 women develop alcohol dependence during their lives. **Gender specific risk factors** Depression, anxiety, somatic symptoms and high rates of comorbidity are significantly related to interconnected and co-occurrent risk factors such as gender based roles, stressors and negative life experiences and events. Gender specific risk factors for common mental disorders that disproportionately affect women include socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and responsibility for the care of others. The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following such violence, renders women the largest single group of people affected by this disorder. The Alliance will need to consider any issues around domestic violence including payment of personal budgets.

	(*Above* i*nformation from the World Health Organisation website*) The IPSA proposals should allow increased personal choice for men and women, allowing them to select support options and packages which better meet individual needs. The Alliance will need to understand and challenge discrimination or stereotyping based on gender roles, and ensure that there is equal access to the opportunities which are being developed.
Gender re-assignment	**Unknown** There is at present little evidence about the particular experiences of transgender people in the areas of social care and mental health services. This may be an area in which the Alliance will wish to carry out further research and which could be considered as part of any future developments. What is known about this group is that transgender people are more likely to experience mental distress due to the social disapproval and discrimination that they encounter. Research in the areas of employment, health provision, social exclusion and hate crime indicates that transgender or trans people (people who don't conform to the traditional division of male and female) experience higher levels of discrimination, harassment and violence. Consequently, trans people are at greater risk of depression, self-harm and suicide. A 2007 survey of 872 trans people found that 34% of respondents had considered suicide. This is considerably higher than the general population. There are some specific health needs identified such as access to treatment (surgery) and issues related to being transgender in mainstream health service such as single sex wards, care of older people, recording of gender on forms and so on. (*Above* i*nformation from the NHS Choices website*)

Disability	**Positive and negative** It has previously been suggested that people with physical disabilities and mental health support needs tend to be overlooked by policy-makers and commissioners of services. Many people with disabilities report having difficulty accessing mental health services because of their physical impairments. Many also have difficulty accessing physical disability services because of the inadequate recognition of mental health needs within disability related services (*Morris, J. (2004b) People with physical impairments and mental health support needs: a critical review of the literature*). There is a lack of information about the prevalence of disability within IPSA's proposed populations, and further research is required in this area. Observations from the Mental Health Funding and Advisory Panel and Social Worker Occupational Therapy (SWOT) team assessments indicate that there are people with disability issues living in Lambeth residential care homes, particularly people with co-morbid learning difficulties (mild to moderate). There are also people with sight and hearing impairments and limited mobility whose needs need to be considered by the Alliance to ensure equal access to personalised care and support options. There could possibly be a lack of suitable accommodation options for people which could prevent move-on from rehabilitation services. Personalisation should offer people with disabilities the opportunity to purchase goods and services which better meet their needs and reduce reliance on services. This could include choosing digital services, assistive technology options or aids and adaptations which may not be otherwise be available. The IBSEN study of individual budget pilots found outcomes were particularly improved for people with mental health problems and other disabilities. (*C Glendinning et al, The national evaluation of the Individual Budgets pilot programme (IBSEN Individual Budgets Evaluation Network); Social Policy Research Unit, University of York, 2008*)

	The national Personal Health Budget Pilot evaluation showed that benefits were more marked where people had higher levels of need and large support packages, where they could exercise more control and individual choice. From the analysis of the structured outcome tools and cost data, the evaluation found that, over a 12-month follow-up period, the use of personal health budgets was associated with significant improvement in patients' care-related quality of life and psychological well-being (*Personal Health Budgets Evaluation*, *PSSRU, University of Kent, November 2012*). This could well be the case for people in rehabilitation services with disabilities, who may require complex care and support packages. Although people with learning disabilities are currently one of the most likely groups to be in receipt of a personal budget, they are one of the groups who may require additional support to enable better take-up. Similarly, people with issues such as autism, hearing or sight impairments or physical health issues may require additional support to access the new options being developed by the IPSA proposals. The Alliance will also need to consider how to work with people who lack capacity to make certain decisions under the Mental Capacity Act, which may involve working closely with a suitable person or the person's carer. The Alliance will therefore need to ensure that they consider all people who have a long-term condition which gives rise to disability or disadvantage, including conditions such as cardio-vascular disease or diabetes, for example. It will be important to give attention to a person's physical health conditions and ensure their diet and medications are appropriate and that they are not excluded from opportunities. Many groups of disabled people will have particular needs in relation to services; for example people with HIV are at risk of discrimination and poor treatment because stigmatising and discriminatory views about the virus persist (*The National Aids Trust*).

Age	**Positive and negative** If the IPSA proposals are brought effectively into practice at a local level, we would expect older and younger people to experience improved outcomes in the same way as other equalities groups. Locally, for example, there has been a good response in take-up of personal budgets for younger people as they leave hospital or residential care, and some people have requested personalised options to improve fitness, community connection or funding for employment or training options. The Alliance will need to consider whether older people require more support in order to get the best outcomes from personalisation and personal budgets, and in being able to exercise more choice and control in their care and support. Some people living in residential care homes may have been resident there for some time and there have been reports from the SWOT team that some people could be quite institutionalised. Personalisation could have a more positive impact with younger adults who have little or no knowledge of services provided by social care and so should be able to choose service options without being influenced by previous services they received. Previous studies have found that older people have been less likely to be offered a personal budget and personalised support planning/self-assessment, as it is sometimes automatically and wrongly assumed that they will find the process too difficult or confusing. (*C Glendinning et al, The national evaluation of the Individual Budgets pilot programme* (*IBSEN Individual Budgets Evaluation Network); Social Policy Research Unit, University of York, 2008).* There is also evidence to suggest that older people face discrimination in using mental health services (*Equality in Later Life Healthcare Commission (2009*)), and that older people with other equality characteristics can face multiple disadvantage. For example, Stonewall highlighted particular equality issues for older lesbian, gay and bisexual people in its report LGB in Later Life (2011). More than two in five LGB people are not confident that

	mental health services would be able to understand and meet their needs. Further research is required in this area to understand the extent of positive and negative impacts for older and younger people arising from the IPSA proposals.
Sexual orientation	**Unknown** There is currently a lack of information to fully assess impact, although there is some previous evidence which suggested that assessment processes for social care do not currently correctly assess the needs for lesbian, gay and bisexual groups. A survey conducted by the former Commission for Social Care Inspection (CSCI) found that only 24% of people felt that their needs as an LGBT person were adequately considered at their last assessment (*Putting people first: equality and diversity matters – providing appropriate services for lesbian, gay and bisexual and transgender people (CSCI, 2008)).* Research shows that LGBT residents are more likely to have seen or experienced hate crime compared to residents overall. Indeed official data from the Metropolitan police shows that in the 12 months to March 2012 there were 142 reported incidences of homophobic crime in the borough up from 103 the year before. In relation to the housing and social care support needs of older LGBT residents there is a high divergence in need and that for some the current housing provision for older people was not always appropriate for older LGBT residents. In 2006 the LGBT Matters study of Lesbians, Gay men, Bisexual and Trans (LGBT) men and women who live, work and socialise in Lambeth similarly found that the needs and experiences of the LGBT population are influenced profoundly by other social factors (ethnicity/race, class, income, gender, age) However as people are supported more holistically and innovatively through the IPSA proposals, there will be increased opportunities to take into account any needs arising specifically as a result of an individual's sexual orientation. People may choose to access LGBT organisations or community groups, or choose a PA who better understands their sexuality. Currently Lambeth support planners do encourage people to identify needs and outcomes in relation to sexual orientation and identity and this has resulted in some very

	personalised options being identified during recovery and support planning sessions. The Alliance will need to consider that there may be some negative impact if there are no changes to the current lack of knowledge about sexual orientation or the continued risk of discrimination and harassment.
Religion and belief	**Positive** It is not expected that the IPSA proposals will have a particularly negative impact related to issues of religion and belief, although more information is required in this area. As services become personalised more people will be supported through the innovative and flexible use of a personal budget. Previous learning from the Lambeth Personal Health Budget Pilot has shown that people may choose to spend their budgets on faith-related activity as a way to reduce isolation and build better community links, or to deal with stress and its effects on mental health and wellbeing. Personal budgets could support people to attend their desired place of worship or to employ a personal assistant from the same faith background if this is important to the individual. It is known that religious affiliation can be protective in some circumstances yet some religious traditions may deny the existence of mental health problems. In Lambeth the SLaM Mental Health Promotion Team have experience of working with some of the different Muslim, Christian and other faith communities on mental health awareness. It is clear from this experience that there is a great range of opinions, knowledge, experiences and willingness to engage even within individual faith traditions. There may also be a risk that the outward and visible forms of religious observance may expose people to discrimination. This may be of particular relevance with the rise of Islamophobia and experience of Muslims in relation their treatment in the media. New service options could consider how to better meet faith needs, such as consideration of the need for a prayer room, diet choice and preparation of food or personal assistants available from different faith groups. Religion and belief may also be very closely

	intertwined with the culture of some communities as well as people's cultural practices and beliefs about health and illness - even if a person identifies as having a particular belief no assumptions can be made about practice thus a wide perspective will be important to maintain.
Pregnancy and maternity	**None** It is not anticipated that the IPSA proposals will have a significant effect on pregnancy and maternity issues as a whole. Support and information would need to be available for women in this situation so they are able to make informed choices.
Marriage and civil partnership	**None** It is not thought to be any impacts on people depending on their marriage / civil partnership status However it will be essential for the service to take account of a person's home situation including their partner and any children. As for the section on sexual orientation there could be a risk of discrimination from staff or from other people using services.
Socio-economic factors	**Positive** Many Lambeth residents are exposed to high levels of socioeconomic deprivation, with poverty and social exclusion posing social challenges in the borough. The latest deprivation data is the 2010 Index of Multiple Deprivation (IMD). IMD 2010 places Lambeth as the 8th most deprived borough in London and 14th most deprived in England, a relative worsening of position since 2008 when Lambeth was ranked 19th most deprived (*Lambeth State of the Borough Report 2014, Lambeth Council*). The risks of mental ill health in relation to income is well known and demonstrated repeatedly in research studies; people living in households with the lowest levels of income are more likely to have common mental illness than those living in the highest

	income households. Psychotic illness is nearly ten times as common in the lowest socio-economic group (0.9%) compared to the highest (0.1%).The rates of admission for acute psychiatric care tend to be higher in deprived areas. People in rehabilitation and residential care homes will typically be unemployed and in receipt of benefits, have a history of homelessness and insecure housing, be socially excluded, lack social support networks and generally experience numerous adverse social determinants. Care may serve to reinforce inequalities and discrimination. Some people using services may face significant barriers to participation, for example they may communicate differently, have learning difficulties, be unable to go out, live in restrictive environments, have physical health issues and need personal assistance. Care and support services may reinforce hierarchies and impose conditions which do not meet the needs and choices of people from different groups, leading to feelings of helplessness and lack of control. The Alliance can seek to change these experiences by encouraging people to express their views about services and what needs to change, recognising strengths and assets, including people in co-producing services and local markets. By improving access to less restrictive services, money management and benefits advice, good quality housing and support, employment and training opportunities, community connection and local voluntary groups the Alliance has the opportunity to improve outcomes for people who have been socially excluded and who have experienced a range of social inequalities. The Alliance will need to ensure that as they develop the market for care and support and increase competition between providers that this does not lead to lower wages and more workers on low income. Service providers will need to ensure that they pay at least the London Living Wage to their employees.
Language	**Unknown**

	We do not know the language requirements of people resident on rehabilitation wards or residential care homes. People may require translation or interpretation services, support because of disabilities or capacity issues, or may not be fluent or confident readers or communicators. The IPSA will need to be flexible to respond to individual communication and language support needs as and when they arise. Lambeth Council has publicised that many residents are thought not to be fluent English speakers and that there are approximately 150 languages spoken in the borough. Assumptions could therefore be made that a proportion of people using rehabilitative services will require support in this area or negative impact will result. This may also extend to people's access to and ability or confidence to use computers and web-based resources. Digital inclusion and reasonable adjustments will need to be considered for some people. People may also need ongoing support to understand personalisation and the new service offer, to be fully involved in assessment and support planning processes and to be able to fully benefit from the opportunities available through the IPSA proposals.
Health	**Unknown** People in Lambeth rehabilitative services will have different incidence and prevalence of health issues and different needs with respect to the way in which services should be provided. There are no available data with which to assess positive or negative impact in this area in connection with the IPSA proposals, although some assumptions can be made based on knowledge of the physical health issues which typically affect people with mental health issues. The Mental Health Foundation website reports that many people with mental health problems are likely to have their physical health needs unrecognised or poorly managed: those who use mental health services are less likely than the general population to be offered blood pressure, cholesterol, urine or weight checks, or to receive opportunistic

	advice on smoking cessation, alcohol, exercise or diet. As a result people with mental health problems are much more likely to smoke, be overweight, eat an unhealthy diet and exercise less than the general population. They are also more likely to have co-existing alcohol problems and may take risks with their sexual health including being at risk of sexual exploitation. These factors mean that people with severe and enduring mental illnesses are at increased risk of physical illness including cardiovascular disease, diabetes, infections including sexually transmitted infections, respiratory disease and greater levels of obesity. For example, the Mental Health Foundation report that schizophrenia is associated with: • Double the risk of death from heart disease • Three times the risk of death from respiratory disease - people with schizophrenia are three times as likely to smoke as other people People living on rehabilitation wards or in residential care homes will typically be unemployed, have a history of homelessness or insecure accommodation, have poor community connection and a lack of contact with family or friends. These factors are also associated with poor health outcomes and an increased likelihood of depression or other common mental illness. The IPSA proposals will need to consider how to ensure services take a much more holistic approach to people's physical and mental health putting physical health and mental health on a par and incorporating a person's physical health risks into recovery and support planning. Proper arrangements should be made to ensure that people within the IPSA proposals have equitable access to appropriate health and other services (such as health improvement) in line with their needs. Physical health may not be as closely monitored in lower support accommodation options, and personal assistants will require knowledge in this area. There will also need to be good arrangements with a person's GP and other community health services - GPs must be part of any support and recovery

	planning.
2.2 Gaps in evidence base *What gaps in information have you identified from your analysis? In your response please identify areas where more information is required and how you intend to fill in the gaps. If you are unable to fill in the gaps please state this clearly with justification.*	A lot of the information gathered for this screening is from published literature rather than from local experience. It has been assumed that this information is relevant to people in Lambeth who maybe of a similar equality group or background. This may or may not be the case and it is not really possible to always say that local experience of services is similar to that reported in research. It is essential to have a local understanding of how different equality and other groups experience services and whether this is changing for the better. Services have not been able to provide evidence of where there have been particular initiatives to improve care and support for one or more equality group. Also equality monitoring information is not available from services for all of the people living in rehabilitation or residential care homes with protected characteristics. Areas where it has been difficult to identify equalities impact or where there are gaps in information have been highlighted throughout this document. The Alliance will need to complete an analysis of information required and consider how to collect this as: • Meeting the requirements of the Equality Act (2010) is in all contracts issued by NHS Lambeth CCG and the Council so basic equality monitoring should already be fundamental to Alliance providers. An update and agreement on a common template for equality monitoring that is integral to the clinical record may be needed. • For all groups but especially where small numbers are expected, more will be needed than quantitative monitoring to demonstrate the Alliance is fulfilling the Equality Duties and promoting equity of services. It will be important to capture personal experience including whether people feel they have been treated fairly and with respect especially for people who are more at risk of discrimination either from staff or from the process of care. Therefore providers will need to

	prioritise which group or groups are most at risk of unequal treatment, identify people and communities with whom they can engage to learn how best to respond to diverse needs, take action and monitor improvements over time.
3.0 Consultation, Involvement and Coproduction	
3.1 Coproduction, involvement and consultation *Who are your key stakeholders and how have you consulted, coproduced or involved them? What difference did this make?*	The Lambeth Living Well Collaborative's work in co-producing mental health service transformation means that there is a strong foundation upon which to develop the IPSA proposals. There have been a range of events, forums, workshops, pilots and service prototypes which have enabled engagement with a wide range of stakeholders including: people using services, carers, statutory support providers, commissioners, councillors, senior managers across health and social care, local voluntary organisations and official bodies such as NHS England. The different co-production elements have all added knowledge and insight into how services should change to become more personalised, recovery-focussed and responsive to individual requirements. Previous engagement events have showcased the work that has been done by the Collaborative and partners and, supported conversations with a large number of attendees about to develop new and improved service offers. The specific details of the IPSA proposals have involved the participation of a range of senior managers from NHS Lambeth CCG, Lambeth Council, the South London and Maudsley Trust and partner provider organisations. The proposals have been developed in conjunction with an alliance contract specialist consultant and were refined following detailed consideration of the practical, legal and financial implications of establishing an innovative contract arrangement.
3.2 Gaps in coproduction, consultation and involvement *What gaps in consultation and involvement and coproduction have you*	The Collaborative has not specifically looked at equality issues arising for different groups. Therefore development of the IPSA proposals will require consideration and specific information on equalities issues and impacts from people directly affected by the

identified (set out any gaps as they relate to specific equality groups)? Please describe where more consultation, involvement and/or coproduction is required and set out how you intend to undertake it. If you do not intend to undertake it, please set out your justification.	proposals. The Alliance will need to consider where there are gaps in knowledge and information about equalities and how these gaps should be addressed. The Alliance will also need to consider how to involve people from diverse backgrounds in developing the IPSA proposals by: • Encouraging involvement in planning groups and decision-making processes and actively supporting and enabling people from diverse backgrounds to participate • Direct conversations with people about how to personalise services especially people from the different equality groups • Involving people in co-producing and delivering new support arrangements including ensuring an active approach and making reasonable adjustments so all have equal opportunity to participate • Looking at gaps in the care and support market and segmenting by equality groups and their specific and diverse needs • Considering how outcomes can be effectively monitored and measured, and services reviewed from an equality and equity perspective both qualitatively and quantitatively • Developing a communications and engagement plan that will work for diverse communities with different levels of literacy and different interpretations and understanding of mental health, and varied experience and knowledge of services • Developing and delivering staff training sessions focusing on capabilities and competence to provide appropriate care to highly diverse populations • Providing appropriate support and supervision of staff to perform their responsibilities equitably and well in all circumstances and with any person and their carers and family
4.0 Conclusions, justification and action	
4.1Conclusions and justification *What are the main conclusions of this EIA? What, if any, disproportionate*	The IPSA proposals aim to improve the experiences of people likely to benefit from an intensive and personalised mental health rehabilitation service. The IPSA developments

negative or positive equality impacts did you identify at 2.1? On what grounds do you justify them and how will they be mitigated?	are also an opportunity to take positive steps to reduce existing inequalities, promote better relations between groups, improve wellbeing and encourage better access to more personal and recovery-focussed care and support. Alliance teams will work co-productively with people, moving away from the traditional 'service-led' approaches in which people are expected to fit in to services which may not properly address their needs or aspirations for the future. Positive impacts will result through the development of services that recognise people's strengths and assets rather than needs and deficits, and work in a less risk-averse way to improve individual outcomes and opportunities for independence. Individuals will be able to determine the outcomes they would like to achieve for the future during assessment and recovery and support planning, which could include where they would like to live and how they would like to spend any eligible personal budget/health budget allocations. Person-centred planning will support people to identify options which may include more individualised, non-mainstream options which better address their cultural or other equalities needs and choices. The development of personalised support options are generally considered to be positive, and previous learning from Lambeth's Social Worker Occupational Therapy (SWOT) Team has shown that people from 24-hour supported environments can successfully step-down to lower support accommodation and live more independently with personalised support. The SWOT Team pilot carried out assessments of people living in residential care homes and identified people who could step-down into lower support accommodation. A number of people moved and are still in their accommodation, achieving much better outcomes whilst also enabling large savings to be achieved. However, there is a risk that there could be some confusion or lack of understanding about personalisation and personal budgets, and about what services and support can be accessed. A lack of accessible information and advocacy, possibly combined with years living in an institutionalised setting, may mean that some people are reluctant to engage with the ‘new ways of working’ that IPSA proposes. There may also be difficulties in ensuring that accommodation services and community support provision really does

	address the needs and aspirations of people from a range of different groups. The Alliance should not consider that personalisation automatically addresses inequality for all of the protected characteristics and people of all backgrounds. In reality, the best way to address inequalities is to understand how they are played out in individual's lives. This means not making any assumptions and active enquiry with each individual about what would work best for them accompanied by a flexible and appropriate response from individual staff and the service as a whole. For each protected characteristic there will need to be factors which are considered in order to develop personalised approaches which fully incorporate individual issues. For all of the groups considered, discrimination and stereotyping are always a potential risk although much of this may be unconscious and not deliberate. The Alliance providers will need to be aware of the risks which may arise as a result of this, and take steps to ensure this is being identified on an individual and systemic level as well as having service improvement plans to promote equity and fairness for all groups where improvement can be demonstrated over time. **Mitigations** There is the opportunity to develop specific activities which will help with the mitigation of impact for people from different backgrounds. As discussed, an assumption that there will be no significant adverse impact is based on the understanding that the focus of the IPSA proposals will be to develop personalised services which better meet the needs of people with a range of complex issues including equalities needs. However this assumption must be demonstrated by the Alliance over time. The Alliance has the opportunity to support greater choice and control to people from all equalities groups. IPSA providers and commissioners have previously been involved in developing innovative initiatives such as lower support accommodation options for people moving on from residential care, the Living Well Network Hub, Lambeth Community Options Team, Personal Health Budget pilot, medication prototype, peer

	support and community connection services. This learning can be used to develop and reconfigure services and markets to better meet individual needs. To mitigate any negative impacts which may emerge as a result of the IPSA proposals the following actions will need to be considered: • An agreed and systematic approach to equality monitoring so that outcomes can be reviewed by equality group over time. • A detailed equalities action plan to be developed by the Alliance with priorities set using the risks identified in this screening and in consultation with people currently receiving rehabilitation or residential care services and their carers • Targeted support to people and groups in accordance with their needs and wishes, ensuring that people have been fully involved in the decision-making process around their care and support options • As part of a person's review and recovery planning identifying with the person any barriers that may hinder their ability to benefit equally from the IPSA 'offer', for example in relation to literacy, English language skills, physical health or disability and previous experience of discrimination. This would include: - Educating people on personalisation and how to make choices, providing support to ensure that they understand the impacts of the new ways of working - Ensuring that the appropriate level of support is provided to help manage change for individuals affected by the IPSA proposals - Ensuring support is available to help people develop recovery and support plans, consider new options and manage their personal budget if required - Information is clear and accessible to all people and services are available to support those who have language and communication needs - Offering a range of care and support options including personal assistants are available to ensure increased choice for people from different groups - Include assessment of the household environment

	• Individuals who lack capacity and are without family or carers who are able to help in making choices on their behalf are appropriately supported and offered advocacy support • Learning and development support for staff along with appropriate induction that where necessary challenges people's assumptions and preconceived ideas • Employing a varied and diverse group of staff and actively providing opportunities for staff to learn from one another and their different backgrounds with the support of management • Links developed with peer supporters and local organisations to support and connect people from different groups A governance structure will be needed to scrutinise the work commissioned in this area, with particular emphasis on the equality impacts of the activities and safeguarding process. Monitoring and performance frameworks will need to include equalities considerations and the need for improved and more extensive data collection.
4.2Equality Action plan *Please list the equality issue/s identified through the evidence and the mitigating action to be taken. Please also detail the date when the action will be taken and the name and job title of the responsible officer.*	
Equality Issue	**Mitigating actions**
Example: That the equality analysis may not have accurately covered all the equality impacts; and the mitigations may not act to reduce disproportionate impact	**Example**: Review the EIA and assess whether the mitigating actions were sufficient. **12/09/12. Joe Bloggs. Head of ABC**
Equalities impacts and mitigations are not fully considered and addressed	An equalities action plan to be developed by the Alliance in order to fully address gaps, understand impacts and plan for the development of the IPSA proposals
Services commissioned do not meet the needs of all	A programme of consultation and engagement with people affected by the proposals and will need to be undertaken by the Alliance to inform service developments ensuring that there is diverse representation
Uncertainty and lack of clarity about the	Development of a communications and engagement plan, with support and advocacy

IPSA proposals which cause anxiety and concern to some people who may have difficulty understanding the implications	available to help people understand the proposals and successfully manage change
Lack of information and data available to properly assess impacts, equalities action planning and review processes	Review information available and identify gaps and how these can be addressed. Develop an extensive equalities performance and monitoring framework and governance arrangements
Lack of understanding of equalities issues and impacts and lack of real change in this area	Develop a workforce development and training plan
5.0 Publishing your results	
The results of your EIA must be published. Once the business activity has been implemented the EIA must be periodically reviewed to ensure your decision/change had the anticipated impact and the actions set out at 4.2 are still appropriate.	
EIA publishing date	
EIA review date	
Assessment sign off (name/job title):	

All completed and signed-off EIAs must be submitted to equalities@lambeth.gov.uk for publication on Lambeth's website. Where possible, please anonymise your EIAs prior to submission (i.e. please remove any references to an officers' name, email and phone number).