Equality & Health Inequalities Analysis
Full EHIA Template

Introduction

This Screening Tool has been developed to help you to think through the implications of your work on equality and on addressing health inequalities. It aims to help you take the right steps to make sure that the policy, commissioning / decommissioning, service changes and/or procedure you are developing has the best chance of reducing health inequalities and advancing equality of opportunity, whilst capturing the evidence that you have done so. Essentially it will help you decide whether or not you need to undertake a full Equality and Health Inequalities Analysis (EHIA) for your project or piece of work.

It is your responsibility as the project lead/policy owner to take this decision having worked through the Tool.

Once completed, please contact the ICS Equality Lead who will agree with you the next stage to sign off the Tool i.e. to either undertake an full EHIA or not to undertake a full EHIA.

Legal Duties

The NHS and other public Sector Organisations have two separate duties on Equality and on Health Inequalities. Whilst the purpose of both duties is to ensure that informed and conscious consideration is given by decision makers to assess needs in respect of the equality and inequality duties, it is important to appreciate that they are two distinct duties. This document is therefore divided into two parts; Section A contains the Equality Analysis and Section B the Public Sector Equality Duty.

Full EHIA process

1. Project lead/ Policy owner completes the EHIA screening tool.
2. S/he should liaise with their engagement and quality lead to provide advice on its completion. The Project lead / Policy owner should alert the Quality Lead at the very beginning in the development of the project and or policy.
3. The completed EHIA should be submitted to the AD for Quality in the first instance for review and feedback on whether to carry out a full EHIA.
4. If required, the updated EHIA should be re submitted once all further information addressed
5. The NWL Equality Lead will either feedback in writing or convene an EHIA panel to review the form for sign off.
6. The NWL Equality lead will feedback to the lead/ owner formally that the EHIA has been signed off
7. The lead / owner should include the signed document as part of the papers for

decision.
8. The PPE committee or equivalent should oversee the engagement required and full EHIA report.
9. The Equality committee or sub-committee with respnsibity for Equality should sign off the full EHIA before submission to the Board and publication on the relevant website

Equality Analysis

When completing the template, we suggest you consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

Protected Characteristic	Description
Age	A person belonging to a particular age (e.g. 32 year olds) or a range of ages (e.g, 18-30 year olds)
Sex	A man or a woman
Ethnicity	A group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins
Disability	A person has a disability if he/she has a physical, hearing, visual or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.
Religion or belief	A group of people defined by their religious and philosophical beliefs including lack of belief (e.g. atheism). Generally a belief should affect an individual's life choices or the way in which they live.
Sexual Orientation	Whether a person feels generally attracted to people of the same gender, people of a different gender, or to more than one gender (whether someone is heterosexual, lesbian, gay or bisexual).

Gender re-assignment	Where a person has proposed, started or completed a process to change his or her sex. Gender Identity describes the gender that a person sees themselves as. It is not outlined explicitly as one of the protected characteristics in the Equality Act. However, should also be considered to ensure people are not disadvantaged by their gender identity, which could include (but is not limited to), gender-queer, non-binary, or a gender.
Marriage and Civil Partnership	A person who is married or in a civil partnership.
Pregnancy and Maternity	A woman protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. Also, it is unlawful to discriminate against women breastfeeding in a public place.

NHS England has agreed an additional definition which relates to inclusion health and people with lived experience. Inclusion health has been used to define a number of groups of people who are not usually provided for by healthcare services and covers people who are homeless, rough sleepers, vulnerable migrants, sex workers Gypsies or Travellers and other multiply excluded people. The definition also covers Female Genital Mutilation (FGM), human trafficking and people in recovery. Please consider these groups too in your analysis.

Public Sector Equality Duty

The public sector equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Health Inequalities Duties

The Health and Social Care Act 2012 established the first specific legal duties on Health and Care organstions to have regard to the need to reduce inequalities between patients and service users in **access** to, and **outcomes** from, health and care services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.

The duties require that Health and Care organisations properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

What is meant by "…have regard to…" in the duties?

- Lawyers advise that "having regard to the need to reduce" means health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors.
- Part of having due regard includes accurate record keeping of how the need to reduce health inequalities have been taken into account.

Which Groups are covered by the legal duties on health inequalities?
The Act does not define a list of groups impact by the duties. Any group experiencing health inequalities is covered. This means that Health and Care organisations much consider the whole population for which they are responsible and identify inequalities within that population. Examples of groups that come under this category include homeless groups, carers, communities defined by a particular geographical area.

This Template

Neither the Public Sector Equality Duty nor the Health Inequalities duties specify how health and Care organisations should analyse the effect of their existing and new policies and practices on equality or on health inequalities. These templates are designed to help the North West London Health and Care Partnership staff members to assess the impact of policy and decision-making on equality and on addressing health inequalities and to keep records of doing so. There are and will be overlaps between the two sections and the evidence gathered for each.

The process of using this process and working through the questions is as important as the outcome. The process is an opportunity to evaluate your evidence base for each question

and involve stakeholders in this discussion. If the evidence is not readily available or gaps are found, a proactive approach may be needed. Finally, record keeping should take place as a matter of course.

Title of procedural document:	Acute mental health consultation in Westminster and Kensington and Chelsea
What are the intended outcomes of this work? Include outline of objectives and function aims	Following the temporary closure of 3 adult acute mental health inpatient wards at the Gordon Hospital in 2020, the ICB and CNWL have carried out a public consultation to review and agree the configuration of community and inpatient mental health services in Kensington and Chelsea and Westminster. This EHIA is to support the Decision Making Business Case that outlines the proposal as a result of that consultation. The proposal of the service model is - To maintain increased community based mental health services that have been put in place since 2020 - To keep the reduced number of adult acute inpatient mental health beds in the higher quality site of St Charles. This would mean not reopening mental health beds at The Gordon, a site that does not meet the standards recommended for inpatient MH care - In order to meet the needs of more people when they are having a mental health crisis, expand the number of spaces at the Mental Health Crisis Assessment Service from 8 to 12.
Baseline assessment Has a baseline assessment been undertaken in order to inform what needs to be improved / help assure that deficiencies are not repeated?	The decision making business case and pre consultation business case (PCBC) both review data from before and after the temporary change to understand the impact. This will also go alongside an Integrated Impact Assessment that carried out quantitative analysis of the impacts of the changes on different populations. This document also builds on a draft EHIA that was developed as part of the PCBC with a group of local stakeholders.
Who will be affected? e.g. patients, staff, service users etc.	Staff, Service users and carers, system partners

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Part A EQUALITY ANALYSIS

Evidence
What evidence have you considered? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. Please ensure throughout the compilation of this document that you confirm HOW you reached any conclusions and WHO you involved in building evidence. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.
Data that has been considered in this document and the accompanying IIA includes • CNWL NHS Foundation Trust's data on access to services over the past five years • ONS data on the population • Local JSNA from Westminster and Kensington and Chelsea Information from the consultation and the integrated impact assessment was shared with a workshop of over 70 local stakeholders. This group helped determine groups where the data appears to show a disproportionate impact or groups where it is not evident from the data that there has been an impact but the view of stakeholders is that there should be more work to ensure there is no negative impact. The workshop discussed these agreed groups and proposed mitigations to counteract any potential unintended consequences.
1. Age Consider and detail (including the source of any evidence) across age ranges of older and younger people. This can include safeguarding, consent and child welfare
The services included in the consultation are for working age adults so there is not an impact on older people or children. The IIA looks specifically at data of younger adults (18-25 years old) and there is not shown to be a disproportionate impact on this age group of the changes that have been made. See also comments in respect of families and children visiting inpatients.

2. Disability Consider and detail (include the source of any evidence) on attitudinal, physical and social barriers.
(NB. Mental ill-health is regarded as a disability within the terms of the Equality Act, however, in this section consideration is limited to potential impacts on people with additional disabilities.) The services set out in the consultation are offered to people regardless of disability so there is no evidence in general that there has been a disproportionate impact on anyone based on disability. The IIA has looked specifically at the access to services for people who have a learning disability or autism. The data available on this is limited and numbers are too small to be able to draw conclusions on whether there has been a significant impact but there is no reason to believe that the service change has had a disproportionate impact on people with a learning disability or autism. During consultation, the ICB sought to engage voluntary organisations with interests in both a range of disabilities and neurodiversity. While there was strong support for encouraging participation, the ICB received little feedback which would suggest disproportionate impact or practical mitigations from these groups. However, the ICB has been encouraged (including by the JHOSC) to consider the impact on people with neuro-diverse conditions and/or learning disabilities, and for that reason these groups have been scoped in and summary mitigations are proposed in this document.
3. Gender reassignment Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment
While data collected by the trust on gender reassignment makes it difficult to understand service use for this group, all services offered regardless of gender reassignment meaning this group is not disproportionately impacted. In fact the inpatient wards at the Gordon made it challenging to allow privacy for this group, so delivering inpatient care at a more appropriate site will enable improved care for this population.
4. Marriage and Civil Partnership
All mental health services are delivered the same to people regardless of marital status so there is no disproportionate impact of the changes on anyone in this protected characteristic.

5. Pregnancy and maternity Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities
The Integrated Impact assessment pulls out data of the impact of the model on women of child bearing age. Admissions for this population have decreased, but this has been countered with an increase in referrals to community mental health services. Suggesting this population are getting access to more care than they were before the changes. Alongside carers and wider families, it is noted that the children of parents (especially mothers) who are admitted should also benefit from the ability to visit when appropriate, including travel arrangements, which are referenced in the mitigations listed in this document.
6. Race Consider and detail (including the source of any evidence) on different ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers
It is well known that people from black backgrounds are over represented in the mental health system, particularly in admission under the mental health act, and in more restrictive settings. Indeed, development of the preferred consultation option was informed by the Trust's EDI report which was clear that service users from Black African and Caribbean backgrounds (in particular) often found this experience traumatising. This suggests a beneficial impact for users from these communities of a move to a more community-orientated model where possible. The IIA looked in detail at service access for people who are from a Black background. There is no evidence from the data that there has been a disproportionate impact on this group. There does appear that in the last couple of years there has been an increase in people attending A&E in a mental health crisis by people of black ethnicity, and when this was looked into further, this is primarily from black women. It should be noted that the numbers of individuals were small, so we should be cautious in drawing wider conclusions from these data. Therefore, while this is important to know and should be considered for further service development, there is no evidence that this is as a result of the service change as there has not been a change in admissions or access to community MH services for this group.
7. Religion or belief Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief
All mental health services are offered to people regardless of their religion so there will be no disproportionate impact for people of different religions. There is faith based support offered on all our inpatient sites, and work with all local communities to enable people to access support to practice their faith when admitted

8. Sex Consider and details (including the source of any evidence) on men and women (potential link to carers below)
The IIA reviewed CNWL data on access to services split by gender and there has been a similar reduction in admissions and increase in access to community services for both men and women. Therefore it does not seem that there has been a disproportionate impact on service use for either gender. Due to the environment on the wards there is more privacy for people of all genders who are admitted to St Charles where there is access to ensuite bathrooms and improved ability to separate the wards for people of different genders, so admissions to St Charles provide a better experience.
9. Sexual orientation Consider and detail (including the source of any evidence)on heterosexual people, as well as lesbian, gay and bi-sexual people
Access to mental health services is the same for people of all sexual orientation. There is no evidence that there has been a disproportionate impact on people of any sexual orientation as a result of the changes.
11. Health Inequality groups NHS England has agreed an additional definition which relates to inclusion health and people with lived experience. Inclusion health has been used to define a number of groups of people who are not usually provided for by healthcare services and covers (although not exclusively) people who are: • Looked after and accommodated children and young people. • Carers: paid/unpaid, family members. • Homeless people or those who experience homelessness: people on the street; those staying temporarily with friends/family; those in hostels/B&Bs. • Those involved in the criminal justice system: offenders in prison/on probation, ex-offenders. People with addictions and substance misuse problems. • People who have low incomes. • Communities Disproportionately affective by COVID • People who do not have access to digital tools • People who have poor literacy. • People living in deprived areas • People in other groups who face health inequalities. Please consider these groups too in your analysis:

During Pre-Consultation an initial Equality Impact Assessment was conducted, informed by a dedicated workshop as part of the Options Appraisal process. This included representatives from statutory partners, other providers, front-line staff and people with lived experience, and identified 19 equality groups and deprived communities which were scoped-in to the consultation engagement plan (see Evaluation Report, 11.3 Appendix – Equalities Groups and deprived communities).

Following consultation, the groups that have been considered as priorities for further consideration and the mitigations set out in the document are:

1. Carers
   While the service change means that more people are being cared for in the community than in restrictive impatient environments, for carers where the person they care for needs an admission there could be an increased travel time to visit as they may need to go to St Charles rather than the Gordon. The IIA shows that for those who are admitted there is a maximum average increase travel time of 9 minutes by public transport and 19 minutes by car. While these times are short, it is important to ensure there are mitigations for this increased travel time, particularly for families or carers who will need to visit their loved ones while they are in inpatient care.

2. Homeless people
   Westminster has the highest number of rough sleepers in the country and high numbers of people who are assessed as homeless. It is well known that there are links between homelessness and mental health and the places that people are living can impact their ability to have the same impact from community based services than inpatient care. As such there has been significant work to design mitigations to ensure we are meeting the needs of people who are homeless or rough sleeping and not reducing the service offer for this group.

3. Two areas have been identified as having a particular relevance to the service change proposed (see also below). These are: People living in south Westminster
4. People living in North Kensington

And, in addition:
5. People with learning disabilities or autism
6. People who are homeless or rough sleeping.

There is no evidence of disproportionate impact for other groups.

12. Consider and detail (including the source of any evidence) on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access
Areas of deprivation across the two boroughs. Deprivation and mental health are often co-occurring so it is important to consider the impact of mental health service changes on areas of deprivation. People living in south Westminster There are areas of deprivation that surround the Gordon Hospital where the inpatient wards have been temporarily closed. There has been a higher reduction in admissions for people from this area than other areas, and while there is no evidence that this would be as a result of the changes, this group has been considered for mitigations to the impact of the service change. People living in North Kensington There are particular considerations needed for this population that includes the bereaved and survivors from the Grenfell disaster. The ICB and CNWL have worked closely with this population to ensure there is a service offer that works for those from the Grenfell community and there is no evidence of an increased need for inpatient beds over community-based services, this population has been included to consider mitigations to ensure the service offer is sufficient.

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Summary of analysis

Considering the evidence please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact; if so, state whether adverse or positive and for which groups. How will you mitigate any negative impacts? How will you include certain protected groups in services or expand their participation in public life?
There is limited evidence of disproportionate impact on any particular group based on protected characteristic. The areas agreed with a group of over 70 local stakeholders for further discussion around mitigations of any impact are - Carers - People from black ethnic backgrounds - People from South Pimlico (south Westminster) - People from North Kensington - People with learning disabilities or autism - People who are homeless or rough sleeping. These are detailed further in the Appendix: Mitigating Actions

Part B The Public Sector Equality Duty

B	The Public Sector Equality Duty
B1	*Could the initiative help to eliminate unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?*
	Based on the analysis in the IIA where we have seen a reduction in admissions and increase in access to community based services for people from black backgrounds, it can be considered that this change may support a reduction the over representation of black males under the mental health act.
B2	*Could the initiative undermine steps to eliminate unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?*
	There is no evidence that the initiative will undermine steps to eliminate unlawful discrimination.
B3	*Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?*
	There has been increased access to MH service users through access to community services which support people from all protected characteristics to access the care they need. Wider equalities programmes across the Trust are working to ensure all services are culturally competent.
B4	*Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?*
	There is no evidence that the initiative will undermine the advancement of equality of opportunity.
B5	*Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?*
	There is an increased access to support in the community which enables groups from all protected characteristics to remain in their communities to receive care. There has also been specific VCSE offers implemented for people from BAME backgrounds, older adults and Arabic communities, that were not available before this service change.

B6	*Is there a potential that a group/s could feel they are being treated less favourably than another group/s in order to comply with the Act and cause resentment and ill-feeling. How is this communicated and managed? Eg. involvement and participation of disabled people in public life. The provision of diabetes services targeting the 'Asian'*
	The services in scope of the consultation are not targeted at any particular group or protected characteristic, therefore it is believed that this will not appear to any group that they are being unfairly treated based on protected characteristic. The consultation proposes removing inpatient facilities from the south of Westminster which may appear as a service loss for the population in this part of the borough. In order to ensure this population is aware of the change and the service loss has been mitigated for the following steps have been taken - This group was targeted to be involved in the consultation process and to provide feedback and views on the service change proposed - The building has been maintained and there will be work to ensure that there are services delivered from there that mean this population has access to mental health support when they need it - Further work will be carried out to consider how the Gordon Hospital can be used as an access point for other services to provide crisis or inpatient support in other parts of Kensington and Chelsea or Westminster.

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Part C The duty to reduce health inequalities

<table>
<tr><th>C</th><th>The duty to have regard to reduce health inequalities</th></tr>
<tr><td>C1</td><td>Will the initiative contribute to the duties to reduce health inequalities?</td></tr>
<tr><td></td><td>By increasing access to community based MH services, there is more chance that people from all groups will be able to access MH support earlier and reduce the need for sectioning and admission. There is also significantly increased capacity in community based services to care for more people across both K&C and Westminster.</td></tr>
<tr><td>C2</td><td>Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?</td></tr>
<tr><td></td><td>Service users from Black African and Caribbean (BAC) backgrounds

Rationale:
There is evidence that community services are more readily accessed by people from BAC backgrounds which has been shown in the Integrated Impact Assessment
The Trust has developed and is now implementing service enhancements specifically to reduce impact for this group (see Mitigations plan – Open Dialogue; Hope in the Community)
Communities in North Kensington which experienced the Grenfell fire and aftermath

Rationale:
During consultation we heard about ongoing trauma for these communities and potential impact on mental health, we know from engagement with this community that they want to be able to access support from easily accessible community services
The preferred option, updated to include retention of the piloted MHCAS service at the St Charles Hospital is geared around seeing people for more rapid assessment and earlier during a crisis and beginning treatment earlier</td></tr>
</table>

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	– thereby preventing unnecessary admissions for people with lower levels of acuity • Keeping this at St Charles will maintain easy access for this population as it is based in North Kensington.

Part D Action Planning for Improvement

Action planning for improvement
Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes needs to be summarised (An action plan is appended for action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.
Five groups have been identified as needing potential mitigating actions to ensure there is not a disproportionate impact from the service change these are - Carers - People from Black backgrounds - People from South Pimlico - People from North Kensington - People who are homeless or rough sleeping. - People with learning disabilities or autism. Clear actions are set out as an appendix to this paper.
Please give an outline of your next steps based on the challenges and opportunities you have identified.
As there is limited evidence of disproportionate impact, it is proposed that the service model of increased community based mental health services and slightly fewer beds is continued as has been the case since 2020. For those groups where there may have been an impact or we have had feedback that there should be further consideration, the mitigations set out in the appendix will be included in the action plan for implementation of the model. Further work will be done over the next year to really understand any potential impact on people who are homeless or rough sleeping, and a proposal will be put forward to the ICB to improve the service offer for this group if there is shown to have been an impact.

Part E

Name and job title of person/s who carried out this analysis	Sally Milne, Associate Director of Strategy, System Transformation and Partnerships, CNWL NHS Foundation Trust
Date analysis completed	
Date analysis signed	
Name of Executive lead / reviewer	
Date of executive sign off	

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Appendix: Mitigating actions

A. People Living in Deprived Neighbourhoods

Impacts and challenges:	Reference
• The population of South Pimlico due to the further distance this group would need to travel if they were admitted • Increased travel for relatives and carers admitted to St Charles, with associated cost, inconvenience and unfamiliar location	• IIA • Consultation evaluation
• Discharge from St Charles for inpatients living in south Westminster and for residents of north Kensington to Pimlico if the MHCAS is relocated to the Gordon Hospital	
• Higher levels of stress and mental ill health due to intersectional socioeconomic factors, stigma associated with using mental health services and trauma in north Kensington associated with Grenfell Tower fire	• Consultation evaluation

Mitigating actions:
A.1. Explore potential to provide free or subsidised transport for carers / visitors (e.g. patient transport, dial-a-ride, subsidised taxi/taxi credits). NB. Should also include access for children to visit when patients are admitted
A.2. Review discharge arrangements to ensure that patients from south Westminster have the support they need during their journey home after an inpatient stay, testing against best practice and available guidance
A.3. Maintain services for Grenfell population, exploring provision and how the right services are provided to them in the right place
A.4. Improved local bed provision - explore provision of faster access to admissions and of local step-down beds with closer connections to the local South Pimlico community to support easier reintegration of the population
A.5. Improve access to mental health services in community settings in identified postcode areas with bespoke plans developed and delivered by CNWL community teams, including re-connecting with community services on discharge from inpatient stays or assessment in the MHCAS
A.6. Provide targeted education to reduce stigma and encourage self-help and peer support, working with local authorities, schools, and appropriate community partners
A.7. Increase support and collaboration with third sector and community-level organisations in deprived areas working with service users and communities to provide mental health education and support
A.8. Engage local GPs, NHS trusts, community health services and local authorities to review mental health delivery with a view to maximising use of local clinics and other community settings to serve deprived neighbourhoods

B. People experiencing homelessness

<table>
<tr><th>Impacts and challenges:</th><th>Reference</th><th>RAG</th></tr>
<tr><td>Difficulty accessing consistent and continuous mental health care, especially when discharged back to the street</td><td colspan="2">Consultation evaluation</td></tr>
<tr><td>High prevalence of co-occurring mental health and intersectional challenges: social isolation, lack of stable support networks, physical health issues, physical disabilities, neurodiversity issues and/or substance misuse</td><td colspan="2">Consultation evaluation</td></tr>
<tr><td>MHCAS and other models may not be appropriate without adaptation for this group</td><td colspan="2">Consultation evaluation</td></tr>
<tr><td colspan="3">Mitigating actions:</td></tr>
<tr><td colspan="3">B.1. Integrate mental health services with housing providers, homelessness agencies, local authority services and broader support initiatives to ensure that housing support includes access to mental health care</td></tr>
<tr><td colspan="3">B.2. Provide training for mental health service providers on the unique needs of the homeless population – particularly in inpatient care</td></tr>
<tr><td colspan="3">B.3. Ensure specialist service provision, for example:
Develop multidisciplinary outreach / in reach teams to provide on-the-spot mental health assessment and support to access services
Explore shared care plan with other agencies - perhaps written into funding and commissioning arrangements
Improve signposting to Dual Diagnosis Bi-borough Team to support people with mental illness and substance use difficulties</td></tr>
<tr><td colspan="3">B.4. Develop refined MHCAS model to address the needs of people experiencing homelessness and monitor access, uptake and outcomes for this group working with appropriate agencies and primary care</td></tr>
<tr><td colspan="3">B.5. Improve discharge pathway for the homeless population - explore an “ideal” model for discharge / exit from the service for rough sleepers and ensure there is a clear understanding of the pathway for this population</td></tr>
<tr><td colspan="3">B.6. Involve 3rd party organisations to support complex needs - explore provision of nutrition and other "intersectional" support, such as physical health checks; use homeless agencies as a channel to keep in touch</td></tr>
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C. People with Neurodiversity, Learning Disabilities, and Autism

Impacts and challenges:	Reference
• Misdiagnosis or underdiagnosis due to lack of specialised knowledge among healthcare providers	
• Higher vulnerability to mental health issues and less likely to receive appropriate care due to lack of access to tailored mental health services	• Pre-consultation engagement The Voice Exchange Report
Mitigating actions:	
C.1. Partner with autism and learning disability charities e.g. the Advocacy Project https://www.advocacyproject.org.uk to co-design services and interventions to make services more accessible	
C.2. Develop tailored mental health programs for individuals with neurodiversity, with enhanced early identification and intervention services	
C.3. Implement specialised training programs for clinicians and staff on neurodiversity	
C.4. Integrate mental health within neurodiversity assessment in primary care, schools and other settings to enable early identification and intervention	

D. People from Black African and Caribbean backgrounds

Impacts and challenges:	Reference
• Over-representation within the mental health system, particularly in secure wards and with negative experiences and poorer outcomes from inpatient care	• Consultation evaluation
• Higher levels of stigma associated with mental health issues, cultural barriers and mistrust towards mental health services	• Consultation evaluation
• Secure settings experienced as traumatising, with consequent preference for community-based models	• The Trust's EDI Final Report (2021)
Mitigating actions:	
D.1. Development of Hope in the Community services at the Gordon Hospital, a culturally appropriate self-referral offer in an approachable and welcoming area with café, workshop space and counselling booths. Associated programmes include: • Partnership space for voluntary groups (>30 provider agreements in place) working on (e.g.) wellbeing, mental health support and equalities • Innovative services below the threshold for clinical care, such as tackling gambling addictions and the Listening Project (a bereavement in partnership with Age UK)	
D.2. Building on the model of Hope in the Community, develop further culturally appropriate community-based services as part of a future service offer for south Westminster beyond the Gordon Hospital	

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D.3.	Open Dialogue – a programme led by the Jameson Medical Director based on a systemic approach and involving family and friends in the wellbeing and care for service users
D.4.	Patient and Carer Race Equality Framework (PCREF) - as part of this national programme, CNWL has established: • A Black Service User Group with a remit to feed into service improvement plans and create a community of interest focused on people with lived experience of acute mental health care • A Co-Produced Group (service users and staff) to explore themes in the EDI report in more depth, and consider the 15 recommendations made in the report around: Policy; Training and education; Research; and Services • Take forward implementation and further work on recommendations in the EDI report with involvement by Westminster BAME Voices for Mental Health (including service users and staff)
D.5.	Explore opportunities along the pathway to avoid unnecessary admissions under section, including: • Work alongside local authority AMHPs to involve them to develop the pathway and build their confidence in community alternatives • Support AMHPs to take share responsibility for prevention through encouraging safe application of the least restrictive approach and improve knowledge and awareness of in-borough alternatives to secure care • More work with inpatient staff to deliver improvements targeted at Black service users
D.6.	Provide appropriate training around (e.g.) cultural competence, unconscious bias to mental health and other clinicians
D.7.	Engagement, signposting and improved admission to community services (which has previously been lower relative to peers) to avoid escalations to the point of admissions; improve communication to signpost people to the community support offer; minimise delays along the assessment / referral process
D.8.	Collaborate on outreach and engagement activities which build understanding, reduce stigma and facilitate links with partners such as community leaders, advocacy groups and service user organisations
D.9.	Review literature and (where there are gaps) conduct further research to better understand the mental health needs of Black African and Caribbean communities and inform service development

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E. Carers

Impacts and challenges:	Reference
• The community model places demands on families/carers to cope, including managing distressed or disturbed/aggressive behaviour and liaising with the Police and other agencies if service users become unmanageable at home while waiting for assessment, diagnosis or for community services to begin	
• Potential to push people, especially young people, out of their home environment if they do not wish to be cared for by family, potentially leading to social isolation and/or homelessness	
• Carers, particularly from South Westminster this is due to recognition of increased travel time when the person they care for is admitted	
Mitigating actions:	
E.1. A support programme will be developed for families and carers on how to cope, which should include access to psychological services for carers if required and social / peer support	
E.2. Mental health and other relevant care staff delivering care in community settings will be supported to identify if carers / families are at risk of crisis and signpost an facilitate access to mental health help and / or alternatives	
E.3. Carer as part of mental health treatment model, e.g. carers inclusion in care and treatment plans	
E.4. Explore provision of transport and financial support for the minority of carers whose travel time and / or costs have increased e.g. meal credits to caregivers / visitors who may have been travelling from further location	
E.5. Explore development of an NWL Carers Strategy	

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