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| **Equality Impact and Engagement Assessment Form** | | | | | | | | | | | |
| **Complete this section**  **Please retain one copy, and pass one copy to both the Equalities and Engagement leads** | | | | | | | | | | | |
| **Section one – Project or plan details** | | | | | | | | | | | |
| 1.1 | **Project Title:** | | | | | | | | | | |
| **Amparo Service Specification** | | | | | | | | | | |
| 1.2 | **Project Lead:** | | | | | | **Contact Details:** | | | | |
| Beki McAlister | | | | | | Rebecca.mcalister@nhs.net | | | | |
| 1.3 | **This activity /project is:** | | | | | | | | | | |
| **Project** | | | | | | | | | | |
| 1.4 | **Describe the activity/project** | | | | | | | | | | |
| The South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) has identified Mental health is a key priority - suicide prevention is one strand within the priority. The SY&BL ICS recognises that the impact of suicide is complex and the effects profound, not only on the family and friends of the person who has died, but also on the wider community. It also recognises the importance of those who are bereaved from, affected by or exposed to suicide receiving the support they need, with partners across the health and social care system working together to develop consistent, evidence-based approaches.  As part of the suicide postvention pathway development across SYB a decision has been taken to work together to pilot the joint commissioning of a bereavement support service to ensure that all people who are bereaved from suicide across SYB have timely access to a support service. An SYB ICS bereavement support task and finish group has been established to support this area of work and monitor the effectiveness of the pilot of SYB wide bereavement support in the coming months. At the time of writing commitment has been secured from Rotherham, Doncaster, Barnsley and Sheffield to jointly commission this Service.  This EIA is to support the decision-making around the contract with Amparo to provide a consistent and accessible support service to those who are exposed to, affected by or bereaved by suicide – across Sheffield, Barnsley, Rotherham and Doncaster. This Service will provide postvention support for people who have been exposed, affected or bereaved suicide, to support their recovery and to prevent adverse outcomes, reduce their distress and to prevent adverse outcomes. Effective postvention support is viewed across the ICS as contributing toward suicide prevention among those people who are bereaved by suicide. | | | | | | | | | | |
| 1.5 | **Timescales** | | | | | | | | | | |
| 01 January 2020 to 01 January 2021 | | | | | | | | | | |
| 2 | **Equality Impact Assessment** | | | | | | | | | | |
| 2.1 | **Gathering of Information:** This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.  Please add any general information here. | | | | | | | | | | |
| It is widely acknowledged that Service provision has been patchy to date across the ICS footprint. The change in commissioning arrangements will extend the Service to other LA/CCG areas where the Service hasn’t been available previously and ensure a consistent pathway across a wider geographical footprint.  It will also widen access to the Service to explicitly include anyone of the age of 18 years old who has been exposed to, affected by or bereaved by suicide. This broader access criteria allows for people who work in Barnsley, Rotherham, Sheffield and Doncaster to access the service even though they may not be a “resident” or have a GP in one of the above listed areas.  The following local outcomes have been identified by the SYB ICS bereavement support task and finish group in relation to this Service:   * A reduction in suicide rates among people exposed to, affected or bereaved by suicide * An Increased Service uptake * A Consistently offer of high quality support available in all local places * An increase for individual well-being and community resilience * A reduction in the distress of people bereaved by suicide   As set out above the overarching aim of the Service is to reduce suicide rates among people exposed to, affected or bereaved by suicide. See section 3.3 for further information. | | | | | | | | | | |
| 2.2 | **Screening** | | | | | | | | | | |
| **Please complete each area)** | | | **What key impact have you identified?** | | | | | | **Information Source** | |
|  | | | **Positive Impact** - will actively promote or improve equality of opportunity. | **Neutral Impact -** where there are no notable consequences for any group. | | | **Negative Impact** negative or adverse impact causes disadvantage or exclusion. **If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures.** | | What action, if any, is needed to address these issues and what difference will this make? For example:  *At this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess.* | |
| Human Rights | | | **N** | **Y** | | | **N** | |  | |
| Age | | | **Y** | **N** | | | **N** | | The Service is for people aged 18 or over. Children and Young People will be signposted to appropriate local services for support. | |
| Carers | | | **N** | **Y** | | | **N** | |  | |
| Disability | | | **Y** | **N** | | | **N** | | The Service will provide information NHS England's Accessible Information Standard.  The Service will provide access to an interpreter (including British Sign Language) or advocate if needed. | |
| Sex | | | **N** | **Y** | | | **N** | |  | |
| Race | | | **Y** | **Y** | | | **N** | | The Service will be accessible to people who do not speak or read English | |
| Religion or belief | | | **Y** | **N** | | | **N** | | The Service will be culturally appropriate. | |
| Sexual Orientation | | | **N** | **Y** | | | **N** | |  | |
| Gender reassignment | | | **N** | **Y** | | | **N** | |  | |
| Pregnancy and maternity | | | **N** | **Y** | | | **N** | |  | |
| Marriage/civil partnership (only eliminating discrimination) | | | **N** | **Y** | | | **N** | |  | |
| Other relevant groups | | | **N** | **Y** | | | **N** | |  | |
|  |  | | |  |  | | |  | |  | |
| **3** | **Engagement Assessment** | | | | | | | | | | |
| 3.1 | **What is the level of service change**? – see diagram 3 above  **If your project is classed as a ‘significant variation’ (level 3) or ‘major change’ (level 4)** please contact [england.yhclinicalstrategy@nhs.net](mailto:england.yhclinicalstrategy@nhs.net) for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process.  The assurance process generally looks at the ‘case for change’ The key players in the process include overview and scrutiny teams, and the clinical senates. You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes) <http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-hempsons_stp.pdf> DH 2013 | | | | | | | | | | |
| **Circle or highlight the appropriate level of service change**  Level 2 | | | | | | | | | | |
| **Add additional information and rationale for this scoring below** | | | | | | | | | | |
| Within the NHSE criteria as set out above, the level of engagement required is level 2 **Minor Change**  This is because engaging an additional provider will require engagement with patients to offer choice and also engagement with the current service provider (RDaSH) to integrate the offer within the existing pathway. It will also require engagement with voluntary sector organisations who represent the voice of families and advocate on behalf of children and young people to be informed and aware so that they can support communication with families. | | | | | | | | | | |
| 3.2 | **Who are your stakeholders?**  Consider using a mapping tool to identify stakeholders - who is the change going to affect and how?  Complete below or attach or link to a mapping document | | | | | | | | | | |
| The organisations that will help develop and steer the pilot are:   * The current Listening Service delivered by Amparo * Public Health Departments of RMBC, DMBC, BMBC and SMBC. * South Yorkshire Police (real time surveillance and local work) * Rotherham CCG as the lead commissioner   In addition there are a wide range of front-line organisations that might refer, sign-post or engage with/to the service. These include:   * General Practices/Primary Care Networks * South Yorkshire Police * Housing Providers * Adult Social Care * Local employers | | | | | | | | | | |
| 3.3 | **What do we already know?**  What do you already know about peoples’ access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements. | | | | | | | | | | |
| **Place Profiles**  Rotherham  The latest data from the Fingertips Profiles Updates (PHOF and Suicide Prevention Profiles) shows that after a small decrease between 2013-15 and 2014-16, the 3-year age-standardised rate for Rotherham increased from 13.9 to 15.9 deaths per 100,000 population between 2014-16 and 2015-17. The latest update to 2016-18 shows a decrease to 13.1 deaths per 100,000 reducing the gap with England which remained at 9.6 per 100,000. Rotherham is significantly higher than England (Red RAG-status) and ranks as 2nd highest compared to 15 CIPFA nearest neighbour local authorities.  The number of registered deaths reduced from 107 for 2015-17 to 87 for 2016-18 largely due to the loss of 2015 data from the period with its high number of deaths. Rotherham is now statistically similar to all nearest neighbours (was significantly higher than 7 of 15 nearest neighbours for 2015-17 data)  Males account for around three-quarters of suicide deaths with the trend in death rates matching the total trend. After reaching its highest in 2015-17 (in the period since 2001-03) the rate decreased in 2016-18 from 24.0 to 20.3 deaths per 100,000 population. However, Rotherham is still significantly higher than England and ranks 2nd highest of nearest neighbour authorities.  After increasing every period since 2010-12 the female rate decreased from 8.4 to 6.4 deaths per 100,000 population between 2015-17 and 2016-18 and is now statistically similar to England again (was significantly higher/worse in 2015-17). Rotherham’s female rate ranks as highest among CIPFA nearest neighbours.  By age (5-year combined data) – **Data not yet updated to include 2018**  The age 10-34 rate has risen consistently between 2011-15 and 2013-17 and is significantly higher than England (20.7 compared to 10.5 deaths per 100,000 population). The rates for the 35-64 and 65+ age groups were stable between 2011-15 and 2012-16 but both increased for 2013-17. The rates for ages 35-64 and 65+ are higher than England but still statistically similar.  Rotherham rates rank 2nd highest among CIPFA nearest neighbour authorities for deaths in ages 10-34, average for ages 35-64 and 3rd highest for ages 65 and over  Doncaster  The suicide rate in Doncaster (12.3 per 100,000) is higher than both regional and national average. The most reason suicide audit from April 2015 to present showed:   * 44 recorded suicides * 7 open verdicts * No coroner’s verdict reached yet for 15 cases- 12/2017-present * 21/44 – 30-60 year olds * 32/44 were men * 12/44- were women * 28/44 hanging was the method used.   Furthermore, emergency admissions for intentional self-harm in Doncaster is higher than the Yorkshire and Humber average.  Barnsley  Barnsley’s 2016/18 suicide rate per 100,000 population (9.2) is similar to the England rate of 9.6 per 100,000. Compared to similar authorities, Barnsley’s rates is the third lowest. Rates have fluctuated over recent years, with the lowest rate being 6.6 per 100,000 in 2006-08 and the highest being 12.0 in 2003-05.  The current rate equates to approximately 20 deaths per year in Barnsley from suicide. 59 people dying by suicide from 2016-2018. Barnsley’s male suicide rate is several times higher than the female rate (15.6 per 100,000 compared to 3.1 per 100,000) – this is also the case nationally. With this in mind, Barnsley’s current real time surveillance saw a surge in female suicides in 2018.  In terms of related risk factors for suicide, Barnsley has higher rates than England for:   * Recorded depression * Estimated users of opiates and/or crack cocaine * Long-term health problems or disability * Children in the youth justice system * Marital breakups * People living alone (including older people) * Long term claimants of Jobseeker’s Allowance * Hospital admissions for alcohol-related conditions * Emergency hospital admissions for intentional self-harm     With the above risk factors in mind, Barnsley’s real-time surveillance data from January 2018 onwards suggests that a large number of people who have taken their own life did have a number of protective factors such as being in employment and having young children.    Sheffield  For men and women in Sheffield, the suicide rate fell slightly in the period (2014-16 combined) compared with a steady rise between 2010-12 and 2013-15. A peak in 2013-15 saw the Sheffield rate rise above the national average for the first time since 2006-08 although the difference was not statistically significant. The rate fell up to 2014-16 but the most recent data from 2015-2018 shows an increase, though still below the below the England average and the lowest rate in the whole of Yorkshire and Humber  Men are more at risk of suicide than women. In the most recent period (2015-18) the rate of suicides for men was 12.2 per 100,000 population compared with 4.2 per 100,000 for women. Men were 3.5 times more likely to die by suicide than were women. This figure (subject to some variation) has remained consistent since 2001-03. | | | | | | | | | | |
| **Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?**  How will the insight available to you help to inform your decision? | | | | | | | | | | |
| A significant level of engagement has taken place to support the development of the pilot so far:  In June 2019 Support After Suicide Survey was conducted across the SY&B. The Survey ran for about 3 weeks and the response was from 104 people across the area. The Survey sought to identify from a service user point of view - when and what were the most challenging times, what helped and what could have been done differently*.*It is worth highlighting that many times people mentioned talking and listening and addressing the stigma.   * A timely response following a suicide * More support and people who can listen (more talking and listening) * Knowing what is out there to support people. * Awareness raising about the long nature of this type of bereavement   In August 2019 the SY&B Suicide Prevention Group began discussions through a workshop, to share ideas on developing consistent regional suicide bereavement services, informed by the perspectives of people with lived experience. The shared aim across the ICS it to establish a systematic and consistent way to approach/respond to those bereaved by suicide.  The SY&B ICS workshop in August 2019 was attended by over 100 organisations. It identified the following groups and needs:  a) First responders   * Training and supervision in suicide prevention, intervention and postvention * Ideally a professional First Responder service * Opportunity to emotionally debrief about the event; acknowledge distress of experience * Community of practice (e.g. peer supervisors, paired working, mentoring/modelling of skills)   b) Witnesses   * Permission to talk; acknowledge distress of experience (Acknowledge, Ask, Act) and normality of reactions * Religious and or spiritual support if required * Key person to liaise/link with on what happens next * Linking with GP; signposting to other support * Ongoing support (challenging when demand strong and capacity weak) * Whole community approach (e.g. recognition of the needs of witnesses, written information) * Access to Good Neighbour groups   c) Colleagues   * Mental health/suicide bereavement awareness training for managers * Acknowledge distress/loss (Acknowledge, Ask, Act) and normality of reactions * De-stigmatise talking/listening and allow feelings of grief in the workplace * Postvention training/awareness (learning from incident, move away from culture of blame and shift language) * Linking with occupational health/staff wellbeing support; pastoral support * Making information and signposting available; memorial activities   d) Neighbours   * Acknowledgement of distress; encourage talking * Receive appropriate information and leaflets for late use (e.g. local help Is At Hand link) * Peer group support; access to community support worker * Community outreach interventions in schools, pubs, gyms etc. * Cultural sensitivity for different groups affected * Encourage sensitive media reporting   e) Children and young people   * Specialist critical incident help; community response plan - all agencies (early and proactive) * Open and honest communication (Acknowledge, Ask, Act); de-stigmatising the process of help * Reassurance of confidentiality; access to talking with a trusted adult * Creative approaches focused on child/young person being involved in/in control of activities * Ongoing support (including access to bereavement counselling) if needed * Support to parents of child/YP * Parents and schools working together to support child/YP and other children/YPs indirectly affected * Positive social media use and how to respond safely to risky material on social media * Talk more about suicide; engagement with positive role models * Support during school holidays   f) Other groups   * Training in suicide prevention, intervention and postvention for police, fire, ambulance staff, funeral directors   The findings from this workshop have been written up in a workshop report and the findings have been used to develop the Service Specification. | | | | | | | | | | |
| **Briefly describe how the existing or proposed engagement will be ‘fair and proportionate’**, in relation to the activity? | | | | | | | | | | |
| An engagement and communication plan will be developed by March 202 to promote and raise awareness of the service. This plan should identify all key stakeholders, key messages and method of communication. Specific work will also be undertaken to engage with the coroners’ offices and funeral directors.  The Service specification requires the Provider to ensure the Services is available and accessible for the people who are entitled to receive the support, in line with the Equality Act 2010 and with regard to the duty to reduce health inequalities under the Health and Social Care Act 2012. The Provider will need to take into account the different and diverse communities across the SYB ICS areas when developing the service response.  Contract monitoring arrangements will require the Service Provider to include case studies for each area to highlight individual’s journeys and demonstrate areas where the Service is making a difference as well as any challenges. | | | | | | | | | | |
| 3.4 | **Reaching out to overlooked communities**  Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that ‘seldom-heard’ groups, those with ‘protected characteristics’ under the Equality Act, and those experiencing health inequalities are involved   * Seldom-heard groups Yes/No * Nine Protected Characteristics Yes/No * Health inequalities Yes/No   If yes, please provide a brief outline of your approach and objectives for any additional patient participation targeted at these groups | | | | | | | | | | |
| No additional engagement is planned at this stage | | | | | | | | | | |
| Do you need to make any of your resources accessible (i.e. for people with learning disabilities, sight impairments, or alternative languages?) | | | | | | | | | | |
| N/A | | | | | | | | | | |
| 3.5 | **What resources do you need for this?**  Consider the sections above   * The timescales * The need to reach overlooked communities * Accessible materials * Gaps in knowledge | | | | | | | | | | |
| No additional resources have been identified as being needed at this stage. | | | | | | | | | | |
| 4 | **Feedback and Evaluation** | | | | | | | | | | |
| 4.1 | How will you use the feedback – who does it need to be shared with? | | | | | | | | | | |
| N/A | | | | | | | | | | |
| 4.2 | Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity. | | | | | | | | | | |
| N/A | | | | | | | | | | |
| 4.3 | How will the outcomes of participation be reported back to those involved? | | | | | | | | | | |
| N/A | | | | | | | | | | |
| 4.4 | How will you assess the ongoing impact of the change on patients and the public after it has been completed? | | | | | | | | | | |
| Through appropriate contract KPIS. Take up of the service offer will be closely monitored to help understand the accessibility of the model. | | | | | | | | | | |
| 5 | 1. **Engagement and Equality Impact Plan** | | | | | | | | | | |
|  | **Action** | | **Approx.**  **Timescale** | | | **Lead** | | | **Deadline** | | **Comments/**  **progress** |
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| 6 | Form details | | | | | | | | | | |
|  | Completed by: | Rebecca McAlister | | | | | | | | | |
|  | Job title: | Senior Contract Manager | | | | | | | | | |
|  | Date | 05.12.19 | | | | | | | | | |
|  | Reported to |  | | | | | | | | | |