NHS

South East
Commissioning Support Unit

Lewisham CCG Partnership Commissioning Intentions for Adults 2017/18 and 2018/19:

Strategic Equality Analysis

EXECUTIVE SUMMARY

31 March 2017

SOUTH EAST/CSU

Executive Summary

Overview

The aspirations of the Partnership Commissioning Intentions are broad and ambitious aspirations strategically aligned with national and local strategic priorities, seeking to transform the local health economy. In order to fully realise these ambitions and implement these proposals, commissioners should be mindful of the equality risks identified and take into account the following recommendations and to support the mitigating actions.

The Equality Analysis (EA) seeks to understand which areas should be given particular attention in the planning and delivery of the Lewisham partners' commissioning activities to ensure the duties under the Equality Act 2010 and the duty to tackle health inequalities in the Health and Social Care Act 2012 are met.

This Equality Analysist (EA) of Lewisham Partnership's Commissioning Intentions covers the five core intentions outlined, namely: Community based care, Neighbourhood Care Networks, Prevention and early action, Planned care, and Urgent and Emergency care.

Approach

Primarily, the EIA was a desk-top based literature review of strategic plans and population data. A robust methodology was developed to ensure that a range of data sources were considered and ensure triangulation of evidence, including demographic data, health inequalities, previous Equality Analysis and service-level commissioning strategies before coming to conclusions regarding impacts and developing recommendations.

Evidence gaps

Depending on the specific area of commissioning intention being reviewed, evidence gaps could appear for any protected characteristic. However, across this assessment, some areas consistently presented as having a lack of 'hard' quantitative data. These were: Sexual orientation and Religion and belief.

General Recommendations:

The following are a series of cross-cutting recommendations which span the whole range of commissioning intentions and should be actioned across the board:

1. **Protected Characteristics**

Based on the findings of this analysis, we conclude that while the Partnership Commissioning Intentions are largely positive, particular attention should be paid to the following protected characteristics/groups in the next stages of implementation:

- Age – specifically people over 65
- Ethnicity – specifically Black and Asian communities, noting that the Asian population in Lewisham which represents about 8% of the population has similar prevalence to cardio

vascular disease, diabetes and obesity as Black African/Black Caribbean/Black Other communities*
- Disability – specifically mental health
- Sexual orientation – lesbian, gay and bisexual
- Gender reassignment – transgender
- Social deprivation**
- Carers

** Please refer to pages 83-84 of the full report for a breakdown of ethnicities in Lewisham in 2013.*

We have concluded that the most significant impacts and highest level of equality-related risk across all the commissioning intentions are linked to these groups, some of which have been singled out in the Partnership Commissioning Intentions to explore further. This could practically mean higher levels of involvement in planning and decision-making or further research undertaken to understand local service usage or prevalence of risk factors in specific groups as implementation plans are developed.

** Social deprivation is the reduction or prevention of culturally normal interaction between an individual and the rest of society. This social deprivation is included in a broad network of correlated factors that contribute to social exclusion; these factors include **mental illness, poverty, poor education, and low socio-economic status.**

The primary focus of the Partnership Commissioning Intentions implementation phases should be to focus on those areas of greatest equalities risk, which are concluded to be the following protected characteristics:

- **Ethnicity**
- **Age - people over 65**
- **Social deprivation**

2. **Further Equality Analysis**

   As a high level analysis, this assessment points to relevant research and data and makes conclusions about areas where commissioners should pay most attention in planning, buying and monitoring local services. In the development of implementation plans, further analyses should be carried out to understand the impacts of proposals, so these can be developed with a more granular level of knowledge and understanding of the needs of people with protected characteristics.

3. **Engagement**

   Although engagement data was not widely available for this exercise, it should be reinforced that the ongoing engagement and involvement of Lewisham's diverse population will be paramount to commissioning local services that meet people's needs, shape the design and delivery of services, and make the best use of resources.

4. **Intersectionality**

   Mainly the impact by protected characteristic has been analysed, but it is important to address multiple needs arising from various aspects of service users' identities i.e. people possess more than one protected characteristic. Meeting health needs will mean responsive and effective models of care must be developed that address these complexities.

5. **Data collection**

   There was a general lack of data collected at service level disaggregated by protected characteristic. Services appear to not be routinely collecting or monitoring data for patients. A more nuanced understanding of service usage will support commissioners to better able to understand levels of need, demand for services and how this should be supplied. It should be noted, national findings highlight the lack of data on LGBT service users. To address this, a new sexual orientation monitoring standard (SOMS) is being introduced by NHS England from April 2017, which should begin to yield information the CCG can utilise.

6. **Technology**

   A number of the commissioning intentions and interventions outlined depend on technological solutions as a key enabler to service delivery. 'Inclusive design' must be paramount in the development of all digital products as 'every design decision has the potential to exclude someone' (Public Health Matters, 2016 – https://publichealthmatters.blog.gov.uk/2016/07/22/%EF%BB%BFthe-a-z-of-digital-public-health/)

7. **Cultural attitudes**

   Cultural perceptions regarding access and decision-making may influence how different groups and communities view and use health services. In order to understand this further engagement should be undertaken.

Specific recommendations

1. Community-Based Care

Communication – ensure that promotion of new services is managed sensitively and responsively, according to the communication requirements of individuals and different community groups. Tailored patient information in different formats should be developed which helps support better patient self-management, particularly of long term conditions (LTCs).

Culture – affects the attitudes and behaviours of those who use services, and this should be further understood and applied by health professionals in their practise.

Technology – ensuring that use of technology genuinely enables patients, and where access may become an issue, that alternative solutions are found.

Workforce – support the workforce to respond appropriately and flexibly to the diverse needs and characteristics of people and communities in Lewisham

Targeted interventions – in the development of initiatives particular focus and attention be given to BME communities and older adults, who are most at risk of developing LTCs.

Neighbourhood Care Hubs - The Hubs could be an opportunity to help tackle social isolation for some people and to tackle Obesity by offering fitness/activity sessions perhaps as part of wellbeing services.

2. Neighbourhood Care Networks

Evidence gaps have been identified under gender reassignment, marriage and civil partnership, pregnancy and maternity, and religion and belief where perhaps the granularity of data at a local level is not available or requires further analysis which is out of scope for this exercise.

Development of Neighbourhood Care Networks. The protected characteristics of ethnicity and age should be given a significant focus with high numbers of residents in north Lewisham (Neighbourhood 1) born outside the UK for example, and as one of the most deprived parts of the borough. People over the age of 65 towards the south of the borough are also more disadvantaged with an increased prevalence of long term conditions. This may influence the types and levels of service that need to be commissioned.

Location. Try to ensure locations of Neighbourhood Care Hubs are equidistant in relation to boundaries of Neighbourhoods to enable access to services without the need for extended travel or costs, particularly in the most deprived parts of the borough.

Allocation of resources. Relative levels of deprivation and affluence in neighbourhood areas should be taken into account when allocating resources between the neighbourhoods e.g. south east Lewisham compared to central Lewisham.

3. Prevention and Early Action

Evidence gaps are noted for gender reassignment and LGBT groups, where there is a lack of national data, and disability. This could be addressed at a local level by carrying out further local engagement.

NHS health checks. Continue to address any under representation in the community groups identified, and outreach for other protected characteristics such as transgender people.

Smoking. Initiatives should be targeted to people with mental health conditions, those in areas of higher deprivation and LGBT groups to improve take up to the smoking cessation service. Good practice should continue to be rolled out, such as stop smoking during Ramadan sessions.

Cancer. Screening programmes, where specific groups are affected by certain cancers, should take a targeted approach to improve take-up and detection rates. General promotion of cancer risks for people with learning disabilities should be carried out.

Blood pressure and stroke. Ensure that health checks are being taken up by ‘at risk’ groups: different ethnicities, men, people over 65, carers and those who are LGBT.

Mental health. The Primary Care Mental Health Service pilot is a real opportunity to improve the access, experience and outcomes for a range of protected characteristics, and these should be considered in design and delivery of the service.

Obesity and inactivity. Awareness-raising regarding the higher levels of risk and range of health promotion initiatives for those who may experience disproportionate and differential health needs and lower levels of physical activity.

Alcohol. Health promotion should be targeted at those groups demonstrated at most risk including, for example, White British and other ethnic groups less represented in treatment data. Other groups could be further engaged with where local data is not available.

Health Advocacy. A number of health promotion and awareness-raising activities could be carried out by bi-lingual community 'health advocates' who could improve reach into 'at risk' populations.

4. Planned Care

Evidence gaps have emerged for religion and belief in this area which should be addressed through local patient engagement where relevant.

Data collection. In line with the general recommendation, it was noted that the Referral Support Service did not appear to collect patient data broken down by protected characteristic. Additional data could inform service design, models of care and support patient information and education.

Access to services. National research highlights barriers to access to services for LGBT patients. These should be considered in the next stages of planning, review or engagement of planned care services to ensure all communities feel welcome when using health services, and could result in a range of actions including staff training.

Service improvement. A range of actions can be taken to improve existing services: staff training on LGB awareness; promoting screening; and awareness raising.

Knowledge sharing. The disproportionate and differential needs between the protected characteristics should be shared among practitioners to improve clinical practise and support reduction of health inequalities.

5. Urgent and Emergency Care

Evidence gaps include how the following protected characteristics and 'Inclusion Health' groups use Urgent Care: Gender Reassignment, Disability, Marriage/Civil Partnership, Pregnancy and Maternity, Religion and Belief, Sexual Orientation and other socially deprived groups.

Data collection. In line with the general recommendation, it was noted that although a review of A&E attendances has been carried out, no information was available on how different groups use the service, which could provide further insights into whether care is being appropriately managed and in the right setting. Providers have a contractual obligation to routinely collect this data and to ensure that patient records are accurate and up-to-date.

Improving community-based care could have a positive impact on reducing emergency admissions, particularly for those over the age of 65 and ethnic minority groups where there is a higher risk of emergency admission. Other interventions could include community health advocates to support navigation of health services.

Technology. In line with the general recommendation, the impact of increased use of non-face to face consultations should be assessed and alternatives sought where these might disadvantage those with learning disability or hearing impairment.

Mental Health: Improving the mental health interface with the A&E Department has been highlighted as part of the CCGs Commissioning Intentions, which could include the improvement of psychiatry liaison services.