Executive summary

Mott MacDonald has been commissioned by NHS South West London Collaborative Commissioning (SWLCC) on behalf of the six south west London CCGs to undertake an initial equalities analysis of the ideas outlined within its Issues Paper Help us build a new NHS in south west London.

This report sets out the findings of the equalities analysis, first identifying those protected characteristic groups who may have a disproportionate need for the services. It then explores the potential positive and negative impacts which may arise should changes to services be suggested in the future. A set of suggested mitigating actions are then outlined for further work and consideration.

The ‘scoped in’ protected characteristic groups

Through a combination of evidence review and demographic mapping, Sections 3-4 of the report identify, for each service, the groups that may have a disproportionate need for the services covered within the Issues Paper. At an overarching level these groups include:

- Age (Children and young people)
- Age (Older people)
- Disability
- Pregnancy & maternity
- Race & ethnicity
- Sexual orientation
- Gender reassignment
- Deprived communities
- Social isolation
- Homeless
- (Carers).

In particular, this analysis has identified that there are a number of groups which are likely to be disproportionately impacted under a number of service areas and they include: Age (Children and young people); Age (Older people); Disability; Race & Ethnicity; and Deprived communities.

Impact analysis

The second part of the equalities analysis explores the potential positive and negative impacts which may arise as a result of the proposed ideas indicated within the Issues Paper, although it is recognised that these are currently at a high level.

These impacts have been identified through a programme of initial strategic engagement which involved telephone interviews with the Equality Leads representing the six CCGs and with a small sample of representatives from scoped in protected characteristic groups. It has also been informed by the findings of the deliberative events held by SWLCC in September 2015 and has been supplemented with relevant evidence.

Sections 5-6 of the report consider the potential impacts likely to be experienced by protected characteristic groups with each service area in turn.

As part of this assessment, it is recognised that there are a number of protected characteristic groups who are likely to experience the potential positive and negative impacts identified in this analysis to a disproportionate extent. This includes people with physical or learning disabilities or certain mental health conditions, the socially isolated, those from deprived communities, the homeless, as well as people from certain BAME groups or migrant communities.

At a summarised level, impacts which are likely to be experienced by these protected characteristic groups include:

Potential positive impacts:

- Services which are designed to empower patients with increased emphasis on prevention, early identification and the self-management of conditions.
- The potential to improve outcomes and quality of life for patients and service users.
- The potential to improve access to services.

Potential negative impacts:

- Through the development of services, increased patient choice.
- Through the integration of patient pathways, the opportunity to provide joined up care for patients.
- Removing the existing fragmentation, variation and duplication in the local health economy.
- An opportunity to provide services in facilities which are fit for purpose, are cognisant of patient dignity and well-being.

Suggested mitigating actions

Section 7 of this equalities analysis identifies suggested mitigating actions to maximise positive impacts or mitigate potential negative impacts for these protected characteristic groups as the programme progresses. These are structured around a number of key themes:

- Equalities analysis
- Service development
- Service area specific mitigations
- Workforce
- Implementation.
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1. Introduction and methodology

Mott MacDonald has been commissioned by NHS South West London Collaborative Commissioning (SWLCC) on behalf of the six south west London CCGs to undertake an initial equalities analysis of the challenges and ideas outlined within the Issues Paper Help us build a new NHS in south west London.

This report sets out the findings of the equalities analysis, first identifying those protected characteristic groups who may have a disproportionate need for the services. It then explores the potential positive and negative impacts which may arise as a result of these ideas. A set of suggested mitigating actions are then outlined for further work and consideration.

Methodology

1.1 Identifying the protected characteristic groups who may have a disproportionate need for these services

The first part of this report (sections 2 to 4) considers each protected characteristic group in turn, reporting available evidence and demographic profiling.

This has been informed through:

1. demographic analysis which sets out the characteristics of the south west London population, and particularly the distribution of residents from different equality groups; and
2. an evidence review of available literature which identifies population groups who may have a disproportionate need for services.

This information has been used to ‘scope in’ groups who may have a particular need for the services covered within the Issues Paper. This is not to say that other groups will not need these services, rather it is to suggest that there does not presently exist a body of strong clinical evidence indicating a disproportionate need. This scoping opinion has also been supplemented with evidence that has been gathered through the strategic stakeholder interviews.

Latest available census data has been used to complete the demographic analysis. For population numbers this relates to 2013 and socio-demographic variables are based on 2011 data.

An example of the demographic mapping has been included below. The study area spans the six CCGs which form SWLCC; Croydon, Kingston Merton, Richmond, Sutton and Wandsworth CCGs. To provide context, this map marks hospital and mental health provider locations, although it should be noted that some of these services may also be provided from community locations. For example, across Croydon, mental health services provided by South London and Maudsley NHS Foundation Trust are delivered in community locations as well as from Croydon University Hospital. Existing providers of primary and community care have also not been mapped.
1. Introduction and methodology

1.2 Identifying the potential impacts:

The second stage of the equalities analysis has been to explore the potential positive and negative impacts which may arise should some of the ideas outlined in the Issues Paper be implemented in the future.

It is important to recognise however, that at this stage, these ideas are still high level and further work will be needed to assess these impacts as further detail is derived.

This equalities analysis also identifies suggested mitigating actions to maximise positive impacts or mitigate potential negative impacts, as well as future considerations for future equalities impact analysis as the programme progresses.

This stage of the equalities analysis has been informed through:

a) A programme of initial strategic engagement which involved telephone interviews with the equality leads representing the six CCGs. The majority of CCG equality leads were also asked to share a 'call for equalities evidence' with their local networks. This asked for local representatives from equality and community groups to share any particular information or evidence which could inform this initial equalities analysis. This however was not possible for all leads due to the timing of the interviews. This could be an approach which is extended as the equalities analysis is revisited by the programme.

b) A small programme of engagement with representatives from protected characteristic groups from across south west London. Twenty nine stakeholder groups were targeted based on the findings of stage one which identified those protected characteristic groups likely to be disproportionately impacted should future changes to services take place. Twelve telephone interviews were subsequently undertaken. A topic guide has been used to guide these interviews to ensure consistency of approach.

c) Utilising available evidence as to the potential positive and negative impacts. This has included both evidence from the programme itself as well as wider evidence gathered through other publically available sources.

d) Evidence from the six deliberative events held by SWLCC in September 2015 has also been incorporated into this assessment. These events were attended by 309 stakeholders. (OPM (2015) Public and local stakeholder deliberative engagement events: report for NHS SWLCCC).

These have informed the impact analysis.

Impact Analysis

The second part of this report (section 5-6) considers the impacts associated with each service area. It describes the potential positive and negative impacts, as well as those considered specific to the 'scoped in' protected characteristic groups. The service areas under consideration are as follows:

- Primary care
- Out of hospital care
- Urgent and emergency care
- Children and young people's services
- Maternity
- Planned care
- Mental health
- Cancer.

Finally, in section 7, a set of suggested mitigating actions are outlined for consideration by SWLCC.

Supplementing this report is a data pack appendix which details the demographic mapping and analysis in further detail and at a larger scale.
2. South West London population profile

The overall population and the density of population provide a baseline from which to break down the key socio-demographic trends in the study area.

Total population

The table below shows the total population of each of the six CCGs, as well as wider area comparators.

<table>
<thead>
<tr>
<th>Area</th>
<th>All usual residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>372,752</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>166,793</td>
</tr>
<tr>
<td>Merton</td>
<td>203,223</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>191,365</td>
</tr>
<tr>
<td>Sutton</td>
<td>195,914</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>310,516</td>
</tr>
<tr>
<td>Study area</td>
<td>1,440,563</td>
</tr>
<tr>
<td>London</td>
<td>8,416,535</td>
</tr>
</tbody>
</table>

Source: Census 2013

The table indicates that the largest numbers of people live in the Boroughs of Croydon (with nearly 373,000 people) and Wandsworth (with 310,500), whilst the least populated is Kingston (with nearly 167,000 people). The total population of the study area is just over 1.4 million.

It should also be noted that the population of south west London is predicted to increase by 13.8% between 2016 and 2041 to 1.666 million (GLA Intelligence (2013) GLA 2012 Round Population Projections).

Population density

The map above illustrates the overall population density for the study area. It shows that the highest densities of people live predominantly in the north and east of the area, in the London Boroughs of Wandsworth, Croydon and Merton. Other parts of the study also have localised high population densities, including Canbury, St Mark’s and Surbiton Hill (in Kingston upon Thames), Mortlake, Richmond and Twickenham (in Richmond upon Thames) and St Helier, Sutton and Beddington South (in Sutton).

The large areas of parkland within the SWL area (including Richmond Park and several parklands and semi-rural on the outskirts of London) mean that certain areas have very low population densities.

Source: Census 2013
This section of the report considers each of the nine ‘protected characteristic’ groups in turn, as well considering other disadvantaged groups as recognised in the refresh of the NHS Equality Delivery System. These groups include:

- Age and specifically children, young people and older people
- Disability
- Pregnancy and maternity
- Race and ethnicity
- Sexual orientation
- Gender reassignment
- Religion and belief
- Marriage and civil partnership
- Deprived communities
- Social isolation
- Carers

For each group, it is noted whether there is evidence of disproportionate need for the services considered within the Issues Paper and a summary of this evidence is provided. Socio-demographic maps are used to demonstrate where the density and distribution of these population groups are across south west London. Larger versions of these maps and the supporting data tables are available in Appendix A.

A summary of the in-scope groups is then provided alongside a commentary as to the profile of these population groups across south west London.
### 3.1 Age (Children and young people)

<table>
<thead>
<tr>
<th>Service area</th>
<th>Evidence of disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>☒</td>
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<tr>
<td>Out of hospital care</td>
<td>☒</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>☒</td>
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<tr>
<td>Children and young people</td>
<td>☒</td>
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<tr>
<td>Maternity</td>
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<tr>
<td>Planned care</td>
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<tr>
<td>Mental health</td>
<td>☒</td>
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<tr>
<td>Cancer</td>
<td></td>
</tr>
</tbody>
</table>

#### Population density of residents aged under 16 years

Source: Census 2011

#### Population density of residents aged 16-25 years

Source: Census 2011
### 3.1 Age (Children and young people)

#### Examples of evidence to demonstrate disproportionate need

<table>
<thead>
<tr>
<th>Service area</th>
<th>Evidence Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care and out of hospital care</td>
<td>Parents’ preference for initial advice is their General Practitioner (GP) and children account for around a quarter of a typical GP’s workload (when making up nearly one-fifth of the population) (RCPCH (2015) Facing the Future: Together for child health). Additionally, it is estimated that, on average, children under 5 will see a GP 6 times a year – around twice as much as older children (Health and Social Care Information Centre (2009), Trends in Consultation Rates in General Practice - 1995-2009). Nationally, many children and young people with long-term conditions have not benefited from the improved health outcomes experienced by adults with long-term conditions. As an example, fewer of those under 25 years old with Type 1 diabetes in England and Wales have good diabetes control compared to their peers in other countries (Department of Health (2013) Annual Report of the Chief Medical Officer 2012: Our Children Deserve Better: Prevention Pays). Locally, in five of the six south west London Boroughs, levels of obesity in children aged 10-11 are above the average level nationally (Public Health England (2014) Child Health Profiles). Obesity is a known risk factor for ill health.</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>Children and young people comprise over 25% of attendances at A&amp;E or emergency departments (RCGP (2011). Guidance for commissioning integrated urgent and emergency care). This is also reflective of local evidence that 25% of all A&amp;E attendances at south west London hospitals are by those aged under 15 (South West London Urgent Care Project (2013)). Estimations of the proportion of these emergency department attendances which are unnecessary and potentially avoidable vary from 15% to 40%. Within these estimates the largest subgroup is children presenting with symptoms of minor illness (RCPH (2015) Facing the Future: Together for child health). There is evidence that young children make up a disproportionate number of A&amp;E attendances with 9.8% of A&amp;E attendances for children aged 4 and under (HSCIC (2015) Hospital Episode Statistics. Accident and Emergency Attendances in England - 2013-14). This is higher than the percentage of 0-4 year olds as a proportion of the whole population (6.3%) (ONS (2014) Annual Mid-year Population Estimates, 2013). In five of the six Boroughs in south west London the number of children presenting at A&amp;E aged under four is higher than the national average (Public Health England (2014) Child Health Profiles).</td>
</tr>
<tr>
<td>Children and young people</td>
<td>Children aged 0-16 years will have a disproportionate need for these services by their nature.</td>
</tr>
<tr>
<td>Mental health</td>
<td>One in ten children between the ages of 5 and 16 had a clinically diagnosed mental health disorder (Office for National Statistics (2004) Mental health of children and young people in Great Britain, 2004). It is widely acknowledged that children and adolescents with poor mental health have relatively worse prospects throughout their adult life (Mental Health Network NHS Confederation (2014) Key facts and trends in mental health). However, this still represents a relatively small proportion in contrast to the finding that 1 in 4 adults in the UK will experience a mental health problem each year (MIND (accessed 2015) Mental health facts and statistics). Therefore, for children aged between 5 and 16, there might not be a disproportionate need for mental health services. It can conversely be argued however that young people aged 16-25 have a disproportionate need for mental health services. Despite the lack of firm prevalence data to reflect this in the UK, several studies have discussed the issue. One study conferred that the profile of incident cases for mental health and substance use problems directly mirrors the profile of chronic physical disorders, with the former predominantly affecting the young (up to age 25) and the latter predominantly affecting the elderly (McGorry et al, (2011)). The authors note that mental health problems are the major contributor to disease prevalence in young people with a contrasting decline in prevalence of physical health illnesses for the same age group. As an example of a specific disorder, one UK study identified three distributions and three means for the age of onset of bipolar disorder, which demonstrated one mean age of onset of 18.7 years old (Hamshere et al, )2009)). Challenges in accessing services have also been highlighted by stakeholders for children or young people who are carers, facing homelessness, refugees without adult or family support, or university students (Local engagement programme).</td>
</tr>
</tbody>
</table>
## 3.2 Age (Children and young people) – continued

<table>
<thead>
<tr>
<th>Service area</th>
<th>Examples of evidence to demonstrate disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health (cont.)</td>
<td>In terms of current mental health service provision, a new report has demonstrated that one in five children have been turned away from mental health services, with the NSPCC Chief Executive commenting that the NHS faces a “time bomb” of serious mental health conditions in children and young people <em>(Young Minds, accessed October 2015)</em>. Moreover, there is an issue of transition from CAMHS to adult mental health services, with NHS England describing the transition as a “cliff edge” that does not provide adequate mental health care for young people <em>(House of Commons Health Committee, third report of session, 2014-2015)</em>.</td>
</tr>
<tr>
<td>Maternity</td>
<td>Research indicates that teenage pregnancy has a higher risk of preterm delivery <em>(BMC Pregnancy and Childbirth (2010) Preterm Birth and reduced birth weight in first and second teenage pregnancies: a register based cohort study)</em> and experience a higher rate of stillbirths, perinatal death and neonatal death <em>(NHS (2011) Improving maternity care in London)</em>. The level of underage pregnancies has fallen across London in the last decade. Almost all boroughs saw a fall, and the fall in London has been greater than the fall nationwide <em>(London’s Poverty Profile (2014) Underage pregnancy by borough)</em>. London has one of the highest rates of teenagers having unwanted pregnancies in the UK <em>(General Practice Transformation Programme (2013) Transforming Primary Care in London)</em>. Whilst the number of teenage pregnancies is decreasing, in 2013 there were 24,306 conceptions to women aged 18 and under in the UK, with just over half of these conceptions leading to an abortion (51%) <em>(ONS (2013) Conceptions in England and Wales)</em>. There is also evidence that almost 40% of girls who give birth between the ages of 14 -16 years will give birth again aged 17-19 <em>(Department of education(2013) Reducing risky behaviour through the provision of information research report)</em>. Teenagers are less likely to access maternity care early on in their pregnancy compared to older people and are more prone to missing appointments, due to a number of reasons such as a chaotic lifestyle and limited access to transport <em>(DH (nd) Getting maternity services right for pregnant teenagers and young fathers)</em>.</td>
</tr>
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</table>
# 3.2 Age (Older adults 65-84 years)

<table>
<thead>
<tr>
<th>Service area</th>
<th>Evidence of disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>☑</td>
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<tr>
<td>Out of hospital care</td>
<td>☑</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>☑</td>
</tr>
<tr>
<td>Children and young people</td>
<td>☑</td>
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<tr>
<td>Maternity</td>
<td>☑</td>
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<tr>
<td>Planned care</td>
<td>☑</td>
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<tr>
<td>Mental health</td>
<td>☑</td>
</tr>
<tr>
<td>Cancer</td>
<td>☑</td>
</tr>
</tbody>
</table>

**Population density of residents aged 65-84 years**

Source: Census 2011

### Examples of evidence to demonstrate disproportionate need

The prevalence of long-term conditions (LTCs - e.g. hypertension, depression, asthma, diabetes, coronary heart disease), rises with age, affecting about 50 per cent of people aged 50, and 80 per cent of those aged 65 ([The Kings Fund (2013) Delivering better services for people with long term conditions](#)). Those experiencing LTCs tend to have a greater need to use health care services.

There is also evidence to show that the prevalence of people living with multiple LTCs increases with age. For those over 65 years, most people have one LTC and for those over 75 years, most people have two or more ([Oliver, D. et al. (2014) Making our health and care system fit for an ageing population, King’s Fund](#)). As the population ages, more people are living with one or more LTC, complex needs and dementia. ([The Kings Fund (2010) Avoiding hospital admissions](#)).

A study of trends in primary care consultations spanning a thirteen year period identified that consultation rates varied markedly by age and the highest rates were found in older people. ([Research and The Health and Social Care Information Centre (2009) Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the Research database](#)).
### 3.2 Age (Older adults aged 65-84 years) - Continued

<table>
<thead>
<tr>
<th>Service area</th>
<th>Examples of evidence to demonstrate disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency care</td>
<td>Nearly two thirds (65%) of people admitted to hospital are over 65 years old (<a href="https://www.kingsfund.org.uk">Cornwell J et al (2012) Continuity of care for older hospital patients: a call for action. King’s Fund</a>). In 2012, people over 65 accounted for 70% of occupied bed days and a 65% increase in secondary care episodes for those over 75 had been seen over the past decade, compared with 31% for those aged 15–59 (<a href="https://www.rcplondon.ac.uk/">RCP (2012) Hospitals on the edge? The time for action</a>). Falls are a significant cause of admission to hospital and are the leading cause of ambulance call-outs to the homes of people over 65 (<a href="https://www.gov.uk/government/publications/prevention-package-for-over-65s">DH (2009) Prevention package for older people resources</a>).</td>
</tr>
<tr>
<td>Planned care</td>
<td>Many conditions that require surgical intervention become more common with age. Life expectancies and older people’s fitness are improving each year; however, comorbidities and complex clinical conditions often increase alongside a person’s advancing biological age, with 65% of people admitted to hospital being over 65 years old (<a href="https://www.kingsfund.org.uk">Cornwell J et al (2012) Continuity of Care for Older Hospital Patients: A Call for Action. London: King’s Fund</a>). Planned surgery and procedures are therefore undergone by a greater number of older people, than the population in general. Ageing can also be a major contributory factor to the weakening of bones. This is because bone density and mass significantly reduces with age through the loss of calcium and other minerals which can cause bones to become brittle and break easily or compress. Therefore older people (particularly over the age of 75) are particularly susceptible to sustaining fractures and/or broken bones or indeed requiring joint replacements (<a href="https://www.ncbi.nlm.nih.gov">Boskey, A and Coleman, R (2010): ‘Aging and Bone’</a>).</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental disorders are highly prevalent among older people, with depressive disorders being among the most prevalent. (<a href="https://www.ncbi.nlm.nih.gov">Forsman A et al (2011) Psychosocial interventions for the promotion of mental health and the prevention of depression among older adults</a>). Evidence from the Institute for Public Policy Research suggests that many older people are dissatisfied, lonely and depressed, and many are living with low levels of life satisfaction and wellbeing (<a href="https://www.nice.org.uk/">NICE quality standard (2013) ‘Mental wellbeing of older people in care homes’</a>). The link between older people and LTCs has been established above. Studies show that people with LTCs are two to three times more likely to experience depression than the general population, and co-morbidities are also common in dementia, cognitive decline and some other conditions. As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly. In addition, the costs of providing care to this group of people are increased as a result of less effective self-care and other complicating factors related to poor mental health (<a href="https://www.kingsfund.org.uk/">The King’s Fund (2012) ‘Long-term conditions and mental health: The cost of co-morbidities’</a>). Dementia disproportionately impacts older people, it affects one in every 79 (1.3%) of the entire UK population and one in every 14 (7.1%) of the population aged 65 years and over (<a href="https://www.alzheimers.org.uk/">Alzheimer’s Society (Accessed 2013) Demography’</a>). This is one of the main causes of disability in later life and has a disproportionate impact on capacity for independent living (<a href="https://www.dh.gov.uk">DH (2013) Dementia: The state of the nation report on dementia care and support in England</a>).</td>
</tr>
<tr>
<td>Cancer</td>
<td>Cancer is primarily a disease of older people, with incidence rates increasing with age for most cancers. More than a third (36% in the UK in 2009-2011) of cancers are diagnosed in people aged 75 and over (<a href="https://www.cancerresearchuk.org/">Cancer Research UK (2014) Cancer incidence by age</a>). Cancer Research UK has reported bowel cancer as one of the most common forms of cancer which is strongly linked to age. In the UK between 2008 and 2010, on average 73% of bowel cancer cases were diagnosed in people over the age of 65 and age-specific incidence rates for this cancer increase sharply from around age 50 (<a href="https://www.cancerresearchuk.org/">Cancer Research UK (2014): Bowel cancer incidence statistics</a>).</td>
</tr>
</tbody>
</table>
3.3 Age (Older adults aged 85 years+)

<table>
<thead>
<tr>
<th>Service area</th>
<th>Evidence of disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>✓</td>
</tr>
<tr>
<td>Out of hospital care</td>
<td>✓</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>✓</td>
</tr>
<tr>
<td>Children and young people</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
</tr>
<tr>
<td>Planned care</td>
<td>✓</td>
</tr>
<tr>
<td>Mental health</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Population density of residents aged 85 years and over**

*Source: Census 2011*

Evidence discussed on the previous slide with regards to older people aged 65-84 years is also relevant for this group.

**Examples of evidence to demonstrate disproportionate need**

A study of trends in primary care consultations spanning a thirteen year period, identified that the highest overall consultation rates occurred in the age band 85 to 89 years for both sexes (both around 13 consultations per person-year). *(QResearch and The Health and Social Care Information Centre (2009) Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch database).*

One of the challenges highlighted in *Improving general practice: a call to action* is the ageing population with growing co-morbidities, resulting in large increase in consultations, especially for older patients. It highlights a 95% growth in the consultation rate for people aged 85-89 in ten years up to 2008/09 *(NHS England (2013) Improving General Practice – a call to action).*


In 2012, people over 85 years old accounted for 25% of bed days, an increase from 22% over the past 10 years. This equates to more than five bed days per annum, compared to only one fifth of a bed day each year for those under 65. People over 85 tend to spend around eight days longer in hospital than those under 65 *(RCP (2012) Hospitals on the edge? The time for action).*

*Please see slide above.*

Dementia disproportionately impacts older people. One in six people aged 80 and over have dementia *(Alzheimer's Society (Accessed 2015) Statistics)*

Over a third (36%) of all cancers are diagnosed in older people. However, incidence rates peak in those aged 85 and above, primarily because there are fewer people of this age in the population compared with other age groups. For example, the highest incidence of bowel cancer can be seen in the 85+ age group *(Cancer Research UK (2014): Bowel cancer incidence statistics).*
### 3.4 Disability

#### Service Area

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Evidence of disproportionate need</th>
</tr>
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<tbody>
<tr>
<td>Primary care</td>
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<td>Out of hospital care</td>
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<td>Mental health</td>
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<td>Cancer</td>
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#### Population density of residents with a long term disability

Source: Census 2011

**Examples of evidence to demonstrate disproportionate need**

People with learning disabilities (PLD) experience higher rates of ill health and have more complex health needs compared to the general population, including epilepsy, dental problems, behavioural and nutritional disorders. In addition to this, PLD can have problems accessing primary care due to difficulties in communication, barriers between health professionals and overcoming practical issues such as long wait times. As a consequence, PLD may have undiagnosed health conditions (SCIR Research briefing (nd) Access to primary care services for people with learning disabilities).

It is recognised that PLD are more likely to be obese or underweight, and less likely to exercise than the general population. Hence, they are more likely to suffer from chronic and long term illnesses. Although fewer adults with severe learning disabilities smoke tobacco compared to the general population, rates of smoking among people with mild learning disabilities are higher than among their peers (Emerson et al. (2011). Health Inequalities and People with Learning Disabilities 2011. Improving Health and Lives Learning Disabilities Observatory).

The proportion of admissions to general hospitals which happen as emergencies is substantially larger for PLD than for those without (50 per cent versus 31 per cent) (Learning Disabilities Observatory (2012) People with Learning Disabilities in England). In addition, many of the conditions identified as ambulatory care sensitive conditions (ACSCs), for example convulsions and epilepsy, and respiratory diseases, are more common among people with learning disabilities which can put this group at risk of requiring emergency care (Royal College of Nursing (2011) Learning from the past – setting out the future: developing learning disability nursing in the United Kingdom).

People with Down’s syndrome have a predisposition to lung abnormalities, a poor immune system and a tendency to breathe through their mouth. (Royal College of Nursing (2011) Learning from the past – setting out the future: developing learning disability nursing in the United Kingdom) The association between these diseases means they are often in greater need of emergency care and surgery than other members of the general population.
### 3.4 Disability - Continued

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<th>Service area</th>
<th>Examples of evidence to demonstrate disproportionate need</th>
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<td>Urgent and emergency care continued</td>
<td>Dementia is an underlying factor in 42 per cent of emergency admissions for patients over 70 years old and these patients often find the pace and noise in A&amp;E departments difficult to cope with (NHS England (2013) Transforming urgent and emergency care services in England: Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review). A 2013 study into the effect of mental health conditions on unplanned admissions found that patients with a mental health disorder were more likely than patients with no mental health disorder to have unplanned (10.8% v. 4.5%) or potentially preventable unplanned admissions (2.1% v. 0.8%) (Payne R et al. (2013) The effect of physical multi-morbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study, CMAJ,185 (5)). Having a long term mental health disability like Alzheimer’s can also result in higher levels of emergency admission and can lead to falls and other accidents. In 2012/13, 73% of hospital admissions for Alzheimer’s sufferers were emergency admissions (HES (2013) Admitted Patient Care, England 2012-13).</td>
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<tr>
<td>Children’s services</td>
<td>Disabled children are likely to require support in a number of areas, particularly around: eating; speech and communication; movement and coordination; learning; dental care; toilet training and continence; behaviour and sleep. As specific examples, Children with neuromuscular conditions can find it difficult to chew and swallow food. Children with learning disability or autism spectrum disorders (ASDs) can have difficulties that may relate to overeating, under eating or being very selective about what they will eat. Some behavioural difficulties are more likely in children with particular medical conditions or disabilities for example, attention deficit hyperactivity disorder (ADHD) and ASD. Children with learning, sensory or physical disabilities may have delayed or no speech and need alternative ways to communicate. Children with certain genetic conditions may be more prone to obsessive thoughts, anxiety, overeating, poor sleep or self-injurious behaviour (Contact a Family (2015) Health services for disabled children and young people Information for health professionals).</td>
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<tr>
<td>Planned care</td>
<td>It is commonly acknowledged that disabled people have poorer health, not just in relation to their primary impairment or long-term health condition but because of reduced access to health services and generally higher levels of social deprivation. This puts them at a higher risk of illness and means they are likely to have a greater need for planned care and procedures (NCEPOD (2008) Elective and emergency surgery in the elderly: study protocol).</td>
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<tr>
<td>Mental health</td>
<td>People with mental health conditions are considered within the disability group of the Equality Act. Therefore, by their nature, they are likely to have a disproportionate need for services.</td>
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### 3.5 Pregnancy and maternity

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In 2013/14, Kingston Hospital NHS FT had the greatest number of deliveries at nearly 5,600. This was followed by St. George's Healthcare Trust at 5,150, Epsom and St Helier University Hospitals NHS Trust at 4,850 and Croydon Health Services NHS Trust at nearly 2,600 (HES (2013/14) Place of delivery).

#### Service area

- Maternity
- Mental health

#### Examples of evidence to demonstrate disproportionate need

By the nature of maternity services, this group of women have a disproportionate need for these services.

Recent fertility trends have highlighted that more women are giving birth later with conception rates increasing for women aged 35 and over (ONS (2013) Conceptions in England and Wales). Rising maternal age leads to an increased risk of early labour, obstetric and neonatal complications. Additionally, pregnant women over the age of 35 have a more likelihood of experiencing stillbirths, miscarriage or ectopic pregnancy (Royal College of Obstetricians and Gynaecologists (2011) Scientific Impact paper No.24. Reproductive Ageing).

Four of the six Boroughs of SWL (Croydon, Sutton, Kingston upon Thames and Wandsworth) have a higher proportion of low birth weight of term babies than the London average (Public Health England (2012/13) PHOF). Two of six Boroughs of SWL (Croydon and Sutton) also have higher rates of mothers smoking at the time of delivery than the London average (Public Health England (2013/14) PHOF). Three of six Boroughs of SWL (Wandsworth, Kingston and Croydon) have a neonatal mortality rate (per 1,000 live births) which exceeds the London average of 2.6 and is equal to or exceeds the England average of 2.7 (ONS (2013) Deaths by area of usual residence).

Between 8-15% of new mothers develop postnatal depression (Mental Health Foundation (Accessed 2015) Post-natal depression PND). Depression and anxiety are the most common mental health problems in pregnancy and they affect 10-15 in every 100 women (Royal College of Psychiatrists (2014) Postnatal Depression). Whilst this an important consideration, this group is not considered to have a disproportionate need for mental health services.
3.6 Race and ethnicity

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### Examples of evidence to demonstrate disproportionate need

There is a higher prevalence of chronic and long term illness such as diabetes and cardiovascular conditions in some BAME population groups which can require ongoing support from primary care or community care services. For example, national evidence has shown that people from South Asian, Black African, or African Caribbean groups are at higher risk of developing type 2 diabetes (Diabetes UK (Accessed 2015) Diabetes Risk Factors) and international studies and studies in the UK have shown that people from South Asian ethnic backgrounds are up to six times more likely to develop Type 2 diabetes than people from white backgrounds (Diabetes.co.uk (Accessed 2015) Diabetes and Ethnicity). Those from Bangladeshi, Indian, Pakistani and African Caribbean heritage are at an increased risk of coronary heart disease (British Heart Foundation (2014) Risk factors).

There is also evidence that the outcomes associated with these conditions may be less favourable for those from BAME groups. For example, the National Diabetes Audit highlights that non-white ethnicity is related to a reduced risk of short term mortality (The Healthcare Quality Improvement Partnership, National Diabetes Audit 2011–2012 Report 2: Complications and Mortality) and there are higher rates of poor health outcomes among Bangladeshi and Pakistani women (Joseph Rowntree (2011) Poverty and ethnicity: a review of evidence).

Obesity has been identified as risk factor in a wide range of diseases and illness including coronary heart disease, stroke, type 2 diabetes, hypertension, metabolic syndrome and cancer, and obesity prevalence varies between ethnic groups. Black African women have the highest obesity prevalence based on weight circumference as a measure and Bangladeshi women when using waist-to-hip ratio. It is also reported that Indian and Pakistani women are over five times more likely to develop obesity (National Obesity Observatory(2011) Obesity and ethnicity).

There is evidence that refugees and people seeking asylum often experience multiple barriers in accessing primary care services which can lead to increased A&E admissions, delayed treatment and lead to higher costs for the healthcare system (North West Regional Asylum Activism (2014) Issues Affecting the Health of Refugees and People Seeking Asylum). Indicative work from the North West found that specific challenges including difficulties registering for a GP, booking appointments, having appropriate support through an interpreter for example, or not having the confidence to discuss mental distress with GPs (asylum seekers experience high levels of mental health problems) (United for Change Health Group (2013) Access to GP Services for Refugees and People Seeking Asylum in Salford).
3.6 Race and ethnicity - Continued

Examples of evidence to demonstrate disproportionate need

Being from a minority ethnic group is associated with a higher risk of emergency admissions and Asian and black groups within the population are generally associated with the highest number of emergency admissions (The Kings Fund (2010) Avoiding Hospital Admissions). As described above, coronary heart disease, strokes and diabetes are particularly prevalent conditions for specific ethnic groups and exacerbations or escalations of these conditions can result in a need emergency care.

The percentage of live births in England and Wales to mothers born outside the UK has increased every year since 1990 (when it was 11.6%) reaching 27% in 2014. This trend in the proportion of births to women born outside the UK has been higher than those born in the UK is thought to be because fertility levels are generally higher among foreign-born women and, the foreign-born and UK-born female populations of reproductive age have different age structures (ONS (2015) Live births to mothers born outside the UK). Other research suggests that certain sections of the UK’s South Asian population – most notably Pakistani and Bangladeshi communities – are more likely to have large families, and therefore high fertility and birth rates are common. Numerous population studies have revealed this trend (See, for example, Coleman D et al (2010) The fertility of ethnic minorities in the UK, 1960s-2006 in Population Studies).

In the UK, 8% (4,715) of all deliveries for Asian and Asian British mothers were low birth weight compared to 6% (1,831) of black and black British mothers and 5.0% (21,530) of white mothers (Health and Social Care Information Centre (2013): Hospital Episode Statistics: NHS Maternity Statistics 2012-13). Previous confidential enquiries have identified that maternal and infant outcomes remain poor for many BAME groups, particularly among women who have recently migrated to the UK (Lewis, G. (ed.) (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH)). Again, now somewhat dated, national surveys also indicate that, as a whole, women from BAME groups are more likely to ‘book late’, are less likely to receive antenatal care regularly and therefore also tend to receive fewer antenatal check-ups. (Race Equality Foundation (2008) Addressing Ethnic inequalities in maternity service experiences and outcomes: responding to women’s needs and preferences). For example, African and Bangladeshi women received their first antenatal check-up beyond the recommended 12 week mark and were less likely to have a scan at 20 weeks compared to white British women. It was also found that women from BAME groups were more likely to experience complications such as needing a hospital stay during pregnancy, having a longer stay in hospital after birth and having their baby cared for in a neonatal unit (Healthcare Commission (2008) Towards better births. A review of maternity services in England).

People from BAME groups living in the UK are: more likely to be diagnosed with mental health problems; more likely to be diagnosed and admitted to hospital; more likely to experience a poor outcome from treatment; more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health (Mental Health Foundation (Accessed 2015) ‘Black and Minority Ethnic Communities). In particular, South Asian women living in the UK, particularly of Pakistani family origin, have a higher prevalence of depression, suicide and self-harm than white women. Research indicates that British Pakistani women with depression lack social support and experience marked difficulties, particularly in marital and close relationships (Gater R et al (2010) ‘Social intervention for British Pakistani women with depression: randomised controlled trial). Lack of knowledge and understanding of cultural beliefs has an influence on how service users and their families perceive mental health illness and treatment (Croydon BME Forum (nd) Mind the Gap).

A local survey of Asian women in Wandsworth identified that, over 50% of respondents indicated that they were experiencing depression (Wandsworth Asian Women’s Association (2014) Seldom Heard Groups Report).

The number of people with dementia from BAME groups is expected to rise significantly as the BAME population ages (DH (2013) Dementia: The state of the nation report on dementia care and support in England). This is in part because the risk factors for developing dementia e.g. high blood pressure & diabetes more prevalent amongst BAME groups (Alzheimer’s Society, (nd) Connecting Communities Project).

The mental health of resettled refugees is poorer than that of the general population. Resettlement to a new country and culture can present social challenges, such as building new social support networks and gaining suitable employment (Campbell M (2012) Social determinants of mental health in new refugees in the UK: cross-sectional and longitudinal analyses). These challenges can impact on the mental health of refugees living in the UK.

Qualitative discussions with CCG equality leads highlight that there may also be barriers in BAME groups seeking support from mental health services due to a feeling of fear or shame (Evidence gathered through interview programme). This is also evidenced through local research which highlighted the following barriers to access:

- Cultural competency and sensitivity within services, a lack of understanding towards cultural requirements, ranging from the provision of food to language barriers.
- The stigma of mental health illness amongst BAME communities creates a barrier to accessing and receiving support.
- Refugees and asylum seekers approach mental health services with complex needs, however not all services are well equipped to respond effectively.
- There are challenges in delivering talking services to BME service users which need to be addressed and access to talking therapies needs to be offered as part of integrated, ongoing support. (Croydon BME Forum (nd) Mind the Gap and Croydon (2015) Croydon Integrated Mental Health Strategy for Adults 2014-2019).

Cancer is more common in white and black males than in Asian males and more common in white females than in Black or Asian females (Cancer Research UK (2014) Cancer incidence by ethnicity). For this reason, this group has not been determined to have a disproportionate need for cancer services. It should be noted however that for some cancers, such as breast cancer, Black and Asian groups do have lower survival overall than the White ethnic group (Cancer Research UK (2014) Cancer incidence by major ethnic group) and there is also some local evidence that the BME community may receive a poorer patient experience (Croydon (2014) Cancer Strategy 2014-19).
3.6 Race and ethnicity - Continued

The following maps illustrate the density of two largest BAME groups across south west London.

Population density of residents from Black ethnic groups
(This includes Black, Black African, Black Caribbean and Black British groups).

Population density of residents from Asian ethnic groups
(This includes Asian and Asian British groups).

There are high densities of people from Black and Asian groups living within Croydon, as well as parts of Wandsworth and Merton. There are also relatively high densities of people from Asian groups living within Kingston and some parts of Sutton.
3.6 Race and ethnicity - Continued

Engagement with local CCG equality leads and review of relevant public health information suggests that as well as more established BAME communities and the disproportionate need they may have for services, there are other growing communities for which there is a less established evidence base. Qualitative evidence suggests that these groups include:

- Polish communities and people from other EU Succession countries;
- Tamil populations;
- Korean populations; and
- Refugee, asylum seekers and migrant communities (anecdotally reported to be from Afghanistan, Libya and Syria).

It has been identified that for some of these emerging communities, there are challenges in accessing and understanding how to use health and social care services and this is likely to require further consideration locally. For example, several stakeholders have noted that there is an over representation of emerging or new communities in accessing emergency care. This is thought to be because of:

- A lack of familiarity and understanding of the local system meaning that people may end up in the ‘wrong place’;
- A preference for hospital care;
- Experience of seeking medical support in their home nation. For example, anecdotal evidence from local engagement with some Eastern European communities has suggested that these communities may go A&E directly as they believe that they have to pay to access GP services as they do in their home nation; and
- For refugee and asylum communities (as well as homeless communities more widely), there are challenges in registering for primary care as they may not have a place of residence. As a result of this, access to other health and care services may also be limited.

Where information is available, the following maps illustrate the density of these emerging ethnic groups across south west London. As can be seen, the profile of each of these groups does differ across the south west London area.

Population density of residents from Polish ethnic groups

There are relatively high densities of people from Polish communities living within Merton and Wandsworth.

Source: Census 2011
3.6 Race and ethnicity - Continued

There are high densities of people from Tamil groups living within Merton, as well as within small parts of Croydon and Kingston. There are high densities of people from Korean groups living within Kingston, as well as within Merton and small parts of Sutton.

For further detail on these groups, please see Appendix A.
Whilst both genders have a need for the following services, due to a disproportionate need for certain conditions, they are not screened in as separate groups because they do not have a disproportionate need for the entire service (i.e. men do not have more of a need for it then women and vice versa). For example:

- **Urgent and emergency care:** Evidence suggests that men and women have a higher propensity to suffer from different types of conditions, but both of which may require emergency care. Research shows that, compared to women, incidence of heart failure is 60% higher in men compared with women (Heart Research Institute UK (Accessed 2015) UK Heart Facts) and men are also six times more likely to have an abdominal aortic aneurysm than women (NHS Choices (accessed 2015) Abdominal aortic aneurysm). In contrast, hip fractures are reported to be four times more common in women, as is one of the likely risk factors osteoporosis (NHS Evidence (2012) Hip fractures introduction and Arthritis Research UK (Accessed 2015) Who gets it?). The National Diabetes Audit report highlights the serious impact of diabetes on advanced kidney disease, amputations and the ‘vascular diseases’ stroke, myocardial infarction and heart failure. Many complications of diabetes are more common in males, although females are associated with reduced odds of short term mortality (The Healthcare Quality Improvement Partnership, National Diabetes Audit 2011–2012 Report 2: Complications and Mortality).

- **Cancer:** The risk of developing cancer up to the age of 50 years is higher in women (1 in 20) than for men (1 in 35) (Cancer Research UK (2015) All cancers combined). However, figures show that the numbers of cases of cancer in men is significantly higher than in women once they reach 60 (Age UK (2015) Health of older men slipping through the net). Prostate cancer, lung cancer and bowel cancer are the most common cancers in men (Cancer Research UK (2014) Cancer incidence and mortality in the UK). Breast cancer, lung cancer, bowel cancer, cancer of the uterus and ovarian cancer are the most common in females (Cancer Research UK (2014) Ten most common cancers in females).

- **Mental health:** Gender differences occur in the rates of common mental disorders - depression, anxiety and somatic complaints. As examples, depression is not only the most common women's mental health problem but may be more persistent in women than men although more research is needed. The lifetime prevalence rate for alcohol dependence, another common disorder, is more than twice as high in men than women. Men are also more than three times more likely to be diagnosed with antisocial personality disorder than women. There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect less than 2% of the population (WHO (nd) Gender disparities and mental health). ONS data indicates that the male suicide rate is more than three times higher than the female rate (ONS statistical bulletin (2015) Suicides in the United Kingdom, 2013 Registrations). Women are more likely to have been treated for a mental health problem than men (29% compared to 17%) (Mental Health Foundation (Accessed 2015) Mental Health Statistics: Men & Women). It is also estimated that 61% of people with dementia are women; this is likely to reflect the fact that women live longer than men and age is the biggest known risk factor for the condition (Alzheimer’s Research UK (2015) Women and dementia: A marginalised majority).

It should be noted however that for some services, gender may provide a barrier to access. For example, in primary care, research has found that on average, men are less likely to consult with their GP than women between the ages of 16 – 60 years which can lead to men presenting with a serious disease at a later (and less treatable) stage (Wang Y et al (2013) Do men consult less than women? An analysis of routinely collected UK general practice data).
3.8 Sexual orientation

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### Examples of evidence to demonstrate disproportionate need

- **Mental health**
  - There is evidence that non-heterosexual people including gay women, gay men, and bisexual people have poorer mental health than heterosexuals (Colledge L et al (2015) Poorer mental health in UK bisexual women than lesbians: evidence from the UK 2007 Stonewall Women’s Health Survey). A 2011 study into the mental health of the non-heterosexual population in England found that self-reported identification as non-heterosexual was associated with unhappiness, neurotic disorders overall, depressive episodes, generalised anxiety disorder, obsessive–compulsive disorder, phobic disorder, probable psychosis, suicidal thoughts and acts, self-harm and alcohol and drug dependence. Non-heterosexuals were also more likely to have reported mental health-related general practitioner consultations and community care service use over the previous year (Chakraborty, A. & McManus, S. et al. (2011) Mental health of the non-heterosexual population of England).
  
  Recent research indicates that bisexual orientation in particular is associated with worse mental health than heterosexual orientation on a range of measures of psychological distress, with the homosexual group falling between the two. Bisexual women are more likely to report poor mental health or psychological distress than lesbians, this may be due to the ‘double discrimination’ of homophobia and biphobia (Colledge L et al (2015) Poorer mental health in UK bisexual women than lesbians: evidence from the UK 2007 Stonewall Women’s Health Survey).

  Gay men and bisexual men are more likely to experience depression than their heterosexual counterparts with bisexual men most likely to experience moderate to severe levels of depression. These trends are also reflected in the rates of attempted suicide; a 2012 survey of gay and bisexual men found that in the previous year three per cent of gay men and five per cent of bisexual men had attempted to take their own life, in the same period, 0.4 per cent of all men attempted to take their own life. Rates of self-harm were also higher in gay men (7%) and bisexual men (11%) than in the male population as a whole (3%) (Stonewall (2012) Mental health briefing).

- **Cancer**
  - Evidence has suggested that gay women are less likely to access routine breast and cervical screening than heterosexual women, which may increase their risk of some cancers. (Powers, D. & Bowen, D. et al. (2001) The Influence of Sexual Orientation on Health Behaviours in Women)

Census information on the geographical distribution of people on the basis of their sexual orientation is not available.

Information from the local Joint Strategic Needs Assessments (JSNAs) indicates that between 5% to 7% of the population are lesbian, gay or bi-sexual (for example Richmond Upon Thames (2014) Knowing our communities. Borough demographics: January 2014 Equality analysis and Sutton Equality and Diversity Data Card 2014-15).

This equates to between 72,000 and 101,000 people across south west London.

A recent Healthwatch consultation with lesbian, gay, bisexual, and transgender (LGBT) groups in Merton identified current challenges in service provision. As well as identifying gaps in service provision (Hepatitis A, B and C testing and vaccination for example), LGBT awareness was considered to be poor. Specific issues also raised included clarity about next of kin and nearest relative, as for many health conditions many LGBT community members would prefer the contact not to be their nearest relative. It was acknowledged this was better for planned admissions but still a contentious issue (Merton Healthwatch (2015) Merton lesbian, gay, bi-sexual and transgender (LGBT): Community engagement workshop).
## 3.9 Gender reassignment

### Evidence of disproportionate need

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Examples of evidence to demonstrate disproportionate need

The UK’s largest survey of trans people found that 34 per cent (more than one in three) of adult trans people have attempted suicide. The same survey found that 65% of trans people had experienced negative interactions/discrimination when accessing health services. This suggests that trans health and awareness training may be needed for staff to ensure that trans people do not experience barriers when accessing urgent and emergency care (National Mental Health Development Unit (2013) Transgender).

The findings of a Scottish large scale survey on ‘trans’ mental health identified that trans people experienced high rates of mental health issues and were likely to report difficulties when accessing mental health services. This included:

- 10% of the participants had been an inpatient in a mental health unit at least once.
- Rates of current and previously diagnosed mental ill health were high, with many participants additionally feeling that they may have experienced particular issues which remain undiagnosed.
- Depression was the most prevalent issue with 88% feeling that they either currently or previously experienced it.
- 53% of the participants had self-harmed at some point, with 11% currently self-harming.
- The majority of participants, (84%) had thought about ending their lives at some point. 35% of participants overall had attempted suicide at least once and 25% had attempted suicide more than once.

The same survey found that some trans people avoided mental health services altogether because they did not want to discuss their trans identity or history. This may be due to the high percentage (63%) of trans people experiencing negative interactions when accessing general mental health services. This suggests that as trans people have a disproportionate need for mental health services, trans health and awareness training may be needed for staff to ensure that trans people have the same access to healthcare as other people (McNeil J et al (2012) Trans Mental Health Study).

Census information on the geographical distribution of the trans community is not available.

At present, there is no official estimate of the trans population. The Gender Identify Research and Identity Society (GIRES) in their Home Office funded study in 2009, estimated that the number of trans people in the UK to be between 300,000 - 500,000 (Reed, B., Rhodes, S., Schofield, P. and Wylie, K (2009) Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution Gender Identity Research in Education Society). Most recent estimates are that in the UK, around 650,000 people, 1% of the population, are estimated to experience some degree of gender non-conformity (GIRES).

In south west London, this equates to approximately 14,400 people.

A recent Healthwatch consultation with LGBT groups in Merton highlighted that the focus on gender identity services can often lead to the person’s wider physical health being neglected and overlooked, reporting that it was felt that many transgender members of the community going under the radar and their health and well-being neglected. The report also highlighted that the support groups for transgender members of London’s communities are reporting increasing numbers of suicide and, at present, there appears to be a lack of coordinated regional action to address this issue. (Merton Healthwatch (2015) Merton lesbian, gay, bi-sexual and transgender (LGBT): Community engagement workshop).
3.10 Other groups: Deprivation

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Examples of evidence to demonstrate disproportionate need

People with long-term conditions account for more than 50 per cent of all general practice appointments (Nigel M et al (2011) Care Planning: Improving the lives of people with long term conditions. Royal College of General Practitioners) and evidence suggests that long-term conditions are more prevalent in deprived population groups; those in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease (Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition).

Socio-economic factors are known to be powerful determinants of health. People from deprived communities are more likely to smoke and have substance abuse issues and are less likely to exercise regularly and eat fresh fruit and vegetables on a regular basis (Communities and Local Government (2010): ‘Improving health outcomes in deprived communities: Evidence from the New Deal for Communities Programme’).

Those living within deprived areas are therefore more likely to have lifestyle risk factors which can result in high blood pressure (Blood Pressure UK (Accessed 2015) FAQs) or develop into type 2 diabetes (Diabetes UK (2015) Diabetes Risk Factors). The National Diabetes Audit shows that there is a gradient of risk related to socio-economic deprivation with lower odds of short term mortality found in less deprived areas (The Healthcare Quality Improvement Partnership, Diabetes Audit 2011–2012 Report 2: Complications and Mortality).

People living in deprived areas also tend to make lower use of screening and immunisations as well as other preventative services, placing them at greater risk of requiring care to remedy poor health conditions (Marmot M (2010) Fair Society, Healthy Lives).

Analyses of A&E attendances and levels of multiple deprivation statistics show that patients living in areas with high levels of deprivation are more likely to use A&E services (NHS England (2013) Transforming urgent and emergency care services in England: Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review). There is evidence from the UK, North America and Europe that people who live in areas of socio-economic deprivation have higher rates of emergency admissions, after adjusting for other risk factors (King's Fund (2011) Reconfiguring hospital services).

A 2013 study into the effect of socioeconomic deprivation on unplanned admissions found that people in the most socioeconomically deprived quintile were more likely than those in the least deprived quintile to have unplanned (8.2% v.4.1%) or potentially preventable unplanned (1.7%v. 0.6%) admissions to hospital. (Payne R et al. (2013) The effect of physical multi-morbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study, CMAJ,185 (5)).
3.10 Other groups: Deprivation continued

**Service area**

**Children services**

**Examples of evidence to demonstrate disproportionate need**

There is evidence to suggest that poverty and low income is a factor in driving ill health in children (HM Government (2014) An evidence review of the driver of child poverty for families in poverty now and for poor children growing up to be poor adults). Taking the risk factor of obesity, deprivation remains closely linked to childhood obesity, with prevalence almost twice as high among children from the 10% most deprived local authorities in England (National Obesity Observatory (2011) National Child Measurement Programme).

Children from socially deprived backgrounds are also more likely to live in substandard housing conditions. Children living in bad housing are more likely to suffer from poorer general health, respiratory health problems and asthma – with children living in private rented housing more likely to have poorer general health and wheezing problems. (Shelter (nd) The impact of bad housing).

It has been found that pregnant women from poor socio-economic backgrounds are more likely to give birth to low birth babies, particularly women from Pakistani and Bangladeshi origin. (End Child Poverty (2008) Health consequences of child poverty).

There is also a strong correlation between teenage pregnancy and social deprivation. The rate of teenage pregnancy in girls under the age of 18 is almost five times higher than in the most deprived areas compared to the least deprived (ONS (2014) Teenage pregnancies at a record low: how does your area compare?).

There is evidence of a correlation between maternal obesity and socioeconomic deprivation. Women with the highest clinical risk are those facing the highest level of inequality (Heslehurst N et al (2010) A nationally representative study of maternal obesity in England). Maternal obesity has significant implications for the health of women and their babies, including but not limited to: maternal death; severe morbidity; cardiac disease; miscarriage; preeclampsia; gestational diabetes and; infections.

Those with low incomes are more likely to suffer from poor mental health and poverty effectively causing or contributing to poor mental health. Observationally, both individual and neighbourhood deprivation increase the risk of poor general and mental health. The rates of admission for acute psychiatric care tend to be higher in deprived areas (Patient Plus (2011) Poverty and Mental Health).

There is evidence that the relationship between multiple long-term conditions and experiencing psychological distress is exacerbated by socio-economic deprivation. This is thought to be because a greater proportion of people in deprived areas have multiple long-term conditions, but also because the effect of this multi-morbidity on mental health is stronger when deprivation is also present. For example, among those with three or more long-term conditions living in highly deprived areas, more than half had signs of significant psychological distress (The King’s Fund (2012) ‘Long-term conditions and mental health: The cost of co-morbidities).

Evidence from Scotland suggests a link between deprivation and mental health with more deprived areas having higher rates of psychiatric inpatient discharges. In 2013/14, the rate in the most deprived fifth of the population was over three times that of the least deprived (NHS Scotland (2015) Mental Health Hospital Inpatient Care: Trends up to 31 March 2014).

Overall cancer incidence shows a positive association with socio-economic deprivation. Age standardised rates for cancer in the most deprived quintile is 432.1 (per 100,000), significantly higher than rates from people in the least deprived quintile (366.3 per 100,000) (Cancer Research UK (2014) Cancer incidence by socio-economic group).

Qualitatively, transport costs in accessing health and care services more generally are a barrier to access (local engagement programme).
### 3.11 Other groups: Social isolation

<table>
<thead>
<tr>
<th>Service area</th>
<th>Evidence of disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>☑</td>
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<tr>
<td>Out of hospital care</td>
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<td>Urgent and emergency care</td>
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<tr>
<td>Children and young people</td>
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<tr>
<td>Maternity</td>
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<tr>
<td>Planned care</td>
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<tr>
<td>Mental health</td>
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<tr>
<td>Cancer</td>
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</tbody>
</table>

#### Examples of evidence to demonstrate disproportionate need

Research has identified that social isolation can have a severe impact on the health and wellbeing of older people and may even lead to increased mortality (Pitkala K et al (2009) Effects of Psychosocial Group Rehabilitation on Health, Use of Health Care Services, and Mortality of Older Persons Suffering from Loneliness: A randomised Controlled Trail).

Social isolation and exclusion is likely to lead to higher health and social care use and higher admissions into residential and nursing care (Windle K et al (nd) Preventing loneliness and social isolation: interventions and outcomes, Research briefing 39. Social Care Institute for Excellence).

Many older people experience ‘minor’ ailments that can significantly affect their independence, wellbeing and social engagement if not dealt with, for example, mobility; foot health, chronic pain, visual and hearing impairment (The Kings Fund (2014) Making out health systems fit for an aging population).

Research suggests a two-way link between social isolation and poor mental health, with 42% of people saying that they have felt depressed because they felt alone (Mental Health Foundation (2010) The Lonely Society).

In 2013/14, Kingston upon Thames and Croydon had lower proportions of their population reporting that they had as much social contact as they would like (37.8% and 38.4% respectively, compared to the London average (40.7%) (HSCIC (2013/14, Adult Social Care Framework)).
### 3.12 Other groups: Homeless

<table>
<thead>
<tr>
<th>Service area</th>
<th>Evidence of disproportionate need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
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<tr>
<td>Out of hospital care</td>
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<td>Urgent and emergency care</td>
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<td>Children and young people</td>
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<td>Maternity</td>
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<td>Planned care</td>
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<tr>
<td>Mental health</td>
<td>☑</td>
</tr>
<tr>
<td>Cancer</td>
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</tbody>
</table>

**Examples of evidence to demonstrate disproportionate need**

Homeless people make up a disproportionate proportion of A&E attendances. A 2014 report into the health of homeless people found that 35% of homeless people had attended A&E in the past six months with A&E visits per homeless person four times higher than for the general public. On average, homeless people reported 1.66 A&E attendances per year compared with 0.38 per year for the general public. Some had multiple visits per month. The most common reasons for attending A&E were due to violent incidents or assaults. A high number also attended because of alcohol use or a mental health need or crisis (Homeless Link (2014) ‘The unhealthy state of homelessness: Health audit results 2014’).

Mental ill health is correlated with homelessness as both a cause and consequence of the loss of accommodation. The prevalence of common mental health problems is estimated to be over twice as high and of psychosis 4-15 times as high amongst the homeless population compared to the general population (Crisis (2009) Mental Ill Health in the Adult Single Homeless Population: A review of the literature).

In 2014, a large scale survey of homeless people, Homeless Link, found that 80% of homeless people reported some sort of mental health issue and 45% had been diagnosed with a mental health issue (compared with 25% of the general population). Homeless people are more likely to be heavy users of mental health services. In particular, the incidence of depression amongst homeless people is substantially higher than incidence rates for the general population at 36% compared to 3% for the general population (Homeless Link (2014) ‘The unhealthy state of homelessness: Health audit results 2014’).

Public Health Outcomes Framework data indicates that two of the six south west London Boroughs have a greater rate of homeless acceptances per 100,000 population compared to the London average (Wandsworth at 5.4 and Croydon at 5.1, compared to the London average of 5.0) (Public Health England (2013/14) PHOF).
3.13 Other protected characteristic and vulnerable groups

There are three protected characteristic groups for who there is limited evidence on their propensity to use the services under review. As a result, it is considered that they do not have a disproportionate need for any of the services under review. This includes:

- **Age** (beyond young people up until 64 years);
- **Religion and belief**; and
- **Marriage and civil partnership**. (Marriage and civil partnership is covered by the Equality Act 2010 only on the grounds of preventing unlawful discrimination. People who are married or in a civil partnership must be treated the same as people who are not and, similarly, people who civil partners must be treated the same as married couples on a wide range of legal matters).

As with gender, it is recognised that some of these such as **religion and belief** may provide barriers to service accessibility. For example:

- Women from ethnic minorities have reported a lack of understanding amongst care staff about their religious beliefs, which can have an adverse impact on their experience of maternity care. For example, some Muslim women felt uncomfortable with the presence of men (including medical practitioners and other pregnant women’s partners) during childbirth and whilst on the wards. Women also felt that the quality and choice of appropriate food (e.g. halal meat) was poor (*The Maternity Alliance* (2004). *Experience of Maternity Services: Muslim women’s perspectives*).
- Some women from ethnic minority groups and refugees or asylum seekers found it difficult to discuss health issues and/or be examined by male health professionals due to cultural and religious reasons (*Hallowell, J et al* (2012) *Increasing the early initiation of antenatal care by Black and Minority Ethnic women in the United Kingdom: a systematic review and mixed methods synthesis of women’s views and the literature on interventions effectiveness*).
- An international study of care for Muslim women found that a majority (93.8%) of responding patients reported that their healthcare provider did not understand their religious or cultural needs. Providers and patients outlined similar barriers/challenges including: lack of providers’ understanding of patients’ religious and cultural beliefs; language-related patient-provider communication barriers; patients’ modesty needs; patients’ lack of understanding of disease processes and the healthcare system; patients’ lack of trust and suspicion about the healthcare system, including providers; and system-related barriers (*Hasnain M et al* (2011) *Patient centred care for Muslim women: Provider and patient perspectives*).

Whilst **carers** themselves may not have a disproportionate need for these services, they are likely to be supporting people who do. As a result, the potential impacts on this group have been considered within this analysis. In considering this group in south west London:

- Qualitative feedback from local stakeholders suggests that carers may prioritise the care of those they care for, meaning that are less likely to access services such as primary care for their own needs. Challenges in finding someone to replace their caring responsibilities whilst they receive care may also reduce access to services such as planned care. It is also suggested that carers may also be more likely to experience mental health conditions due to the anxiety and stress carers commonly suffer. Access to Child and Adolescent Mental Health services (CAMHS) is thought to be a particular challenge for young carers (*local engagement programme*).
- The areas with the greatest density of residents providing between 1 and 20 hours unpaid care a week are in Croydon and Wandsworth, as well as more localised areas across the other Boroughs (*for further detail, please see Appendix A*).
- The areas with the greatest density of residents providing over 20 hours unpaid care a week are in Wandsworth, north Croydon, west Merton and St Helier (Sutton).
- In the most recent biennial survey, in 2012/13, Sutton had a lower reported carer quality of life measure (7.4) than other Boroughs of south west London and the London average (7.7). Croydon and Wandsworth had rates equal to the London average (*HSCIC (2013/14, Adult Social Care Framework)*).
## 4. Summary of ‘scoped in’ groups

Outlined below is a summary of the groups who have been scoped in as having a disproportionate need for the services covered within the Issues Paper.

<table>
<thead>
<tr>
<th>Protected characteristic groups by service area</th>
<th>Primary care</th>
<th>Out of hospital care</th>
<th>Urgent and emergency care</th>
<th>Children and young people</th>
<th>Maternity</th>
<th>Planned care</th>
<th>Mental health</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Children and young people)</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Age (Older people)</td>
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<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Disability</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Pregnancy &amp; maternity</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Race &amp; ethnicity</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Sexual orientation</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Gender reassignment</td>
<td>✓</td>
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<td>✓</td>
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<td>Religion &amp; belief</td>
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<td>Marriage &amp; civil partnership</td>
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<tr>
<td>Deprived communities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Social isolation</td>
<td>✓</td>
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<tr>
<td>Homeless</td>
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<td>✓</td>
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</tbody>
</table>

So far, a desk top evidence review has highlighted that the above protected characteristic groups have a disproportionate need to use these health services; however, this is of course not to say that other groups will not need these services in the future. Presently, there is no strong body of evidence to suggest otherwise but as ideas come forward, further research and engagement with protected characteristic groups may be beneficial to ensure that this is the case.
4. Summary of ‘scoped in’ groups

The following geographical areas have been identified as having high densities of scoped in protected characteristic groups. In addition to this we have also looked at proportional representation of groups to understand where groups are particularly prevalent in a certain area (compared with the overall population composition in that area); where this represents a different trend to population density we have made a comment on this.

For further detail demographic detail, please see Appendix A.

<table>
<thead>
<tr>
<th>Scoped in groups</th>
<th>Geographical areas in south west London with a high proportion or density of these population groups, compared to the overall population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Children and young people)</td>
<td><strong>Density trends</strong>: The areas with greatest density of children and young people are in Croydon and Wandsworth. <strong>Proportion trends</strong>: Croydon also has the highest proportion of children at 22% (compared with 20% for the total study area and London), Wandsworth has the smallest proportion of all six CCG areas at 17%. Kingston has the highest proportion of young people at 15% (compared with 12% for the whole study area).</td>
</tr>
<tr>
<td>Age (Older people)</td>
<td><strong>Density trends</strong>: The areas with the greatest density of older people aged 65 to 84 years can be seen in Croydon, Sutton and Wandsworth. The areas with the greatest density of older people aged 85 years and over are Croydon, Richmond and Sutton. <strong>Proportion trends</strong>: The greatest proportions of older people are found in Sutton and Richmond.</td>
</tr>
<tr>
<td>Disability</td>
<td><strong>Density trends</strong>: The areas with greatest density of people with a long term disability or health problem are in Croydon and Wandsworth, as well as smaller pockets of this group in Croydon and Merton. <strong>Proportion trends</strong>: As a proportion of the population, greater proportions of disabled people are found across Croydon and Sutton.</td>
</tr>
<tr>
<td>Pregnancy &amp; maternity</td>
<td><strong>Density trends</strong>: The areas with greatest density of women aged 18 to 45 years are in Wandsworth and Croydon. Of hospitals in south west London, Kingston Hospital has the highest number of deliveries. <strong>Proportion trends</strong>: As a proportion of the population, the greatest proportion of the population can be seen in Wandsworth. In contrast, the proportion in Croydon is below that of the total study area.</td>
</tr>
<tr>
<td>Race &amp; ethnicity</td>
<td><strong>Density trends</strong>: The greatest density and proportion of those people from BAME groups can be seen in Croydon and Wandsworth. <strong>Proportion trends</strong>: In addition to Croydon and Wandsworth, a high proportion of the population of Merton are from a BAME group.</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>No data available.</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>No data available.</td>
</tr>
<tr>
<td>Deprived communities</td>
<td><strong>Trends</strong>: Areas of greatest deprivation are in Croydon, Wandsworth and Merton.</td>
</tr>
<tr>
<td>Social isolation</td>
<td><strong>Trends</strong>: Areas with greatest barriers to housing and services (as part of the measure of deprivation) are Merton, as well as parts Sutton and Richmond.</td>
</tr>
<tr>
<td>Homeless</td>
<td>There are greater rates of homelessness acceptances in Wandsworth and Croydon (PHOF).</td>
</tr>
<tr>
<td>Carers</td>
<td><strong>Density trends</strong>: The areas with the greatest density of unpaid carers are in Croydon and Wandsworth. <strong>Proportion trends</strong>: No significant differences across south west London.</td>
</tr>
</tbody>
</table>
5.1 Impact Analysis: Primary care

Ideas outlined in the *Issues Paper* to transform primary care:

- Local practice networks that take a collective responsibility for the health of their population.
- GPs, primary care teams, community services, social care, mental health and specialist services to work jointly, to provide coordinated care for patients with long term conditions or complex needs.
- A review of primary care premises/estates, to ensure that primary care is delivered in appropriate settings and is located alongside other appropriate services.
- Increase the use of technology to create more capacity and support the preferences of patients who do not need face-to-face care.
- GPs and their practices taking a more proactive approach to wellbeing, public health and self-management.
- Creating new roles such as care navigators or enhancing the role played by pharmacists and nurses in delivering care. Working with provider trusts and the London Ambulance Service to make care more joined up.

Scoped in groups include: Age (children, older people), disability, ethnicity, deprived communities and social isolation.

Potential impacts identified through engagement and evidence review:

**Potential positive impacts:**

- Whilst there is currently a lack of good quality evidence on the interventions considered to have most impact in enhancing GP access (*University of York (2015) Enhancing access in primary care settings*), proposals to increase access in primary care through technological developments or the creation of local practice networks are considered to be positive by stakeholders. They are particularly felt to be of benefit to those may face challenges in accessing primary care such as working age adults, young families, parents with young children. The local deliberative events also highlighted this potential benefit for visually impaired people and deaf people.

- In achieving more accessible care, people may have increased confidence that their general practice can offer greater continuity of care (and GP for example) which can support them to receive high quality care. This is likely to disproportionately provide benefits for groups who value this continuity including for example older people, those with complex needs (including disabled people) and some BAME groups (*Wandsworth Asian Women’s Association (2014) Seldom Heard Groups Report*).

- Enhanced access provides an opportunity to deliver longer appointments, allocating the right amount of time, attention and skill to all patients to those of most need. This is likely to disproportionately provide benefits for groups who may have complex needs or multiple long term conditions, including for example older people, disabled people, people from BAME groups and those from deprived communities. Feedback from the local deliberative events also highlighted benefits for older people in being able to access other professionals in primary care who might be better placed to reassure the patient and signpost them on to other support.

- Proposed ideas around the development of local practice networks will support the delivery of more coordinated care. Care co-ordination, case management, risk stratification, multidisciplinary working, care navigators and the use of shared care record has the potential to deliver joined up care for people with long term conditions, complex needs including a support to increase their social welfare, as well as those identified to be at the end of life. This is likely to disproportionately provide benefits for older people, disabled people, people from BAME groups, those from deprived communities and people who are socially isolated. Nationally, it is recognised that existing variation in the quality of care might be significantly improved if a more proactive approach to multidisciplinary care management were adopted (*Goodwin N et al (2010) Managing people with long-term conditions: Research Paper. The Kings Fund*); primary care has a key role within this.

- There is the potential for an increased focus on prevention which may in turn create impacts such as an increased uptake in immunisation and health screening. By offering increased health promotion and signposting, patients may be encouraged to choose healthy behaviours and this is felt to be particularly important for deprived communities who are known to experience greater lifestyle risk factors, or some BAME groups who may face barriers to access.
5.1 Impact analysis: Primary care

Scoped in groups include: Age (children, older people), disability, ethnicity, deprived communities and social isolation.

Potential positive impacts continued:

- **Patients will be better supported in the self-management of conditions.** Patients with ongoing or complex conditions will be supported by a personalised self-management plan which has the potential to impact on long-term quality of life. As above, this is likely to disproportionately provide benefits for older people, people from BAME groups and those from deprived communities.

- The development of local practice networks which have a collective responsibility for the health of the local population may provide an opportunity to **remove the barriers of access to primary care** for groups such as refugees, asylum seekers, the homeless and university students and will support the safeguarding of vulnerable people. This is particularly important, given the role of the GP in referring patients to other services such as mental health services.

- Enhanced access to GP services **may reduce use of other services such as A&E attendances and avoidable hospital admissions, allowing these resources to be used most effectively.** This may be because groups such as working age adults, or parents with young children are now able to access services. It may also be because those with chronic or complex conditions (including older people, disabled people, people from BAME groups and those from deprived communities) are being better supported through active disease management, preventing potential exacerbations of their conditions.

- The ideas outlined in the issue paper have the potential to support the delivery of frontline care from premises which are safe, suitable and facilitate multidisciplinary working and the use of enhanced roles such as extended pharmacists. This has the potential to ensure that a patients' privacy is maintained and that wide primary care services are accessible. This may particularly impact disabled people and those with mobility challenges, as well as those who feel less confident in accessing services such as those from some BAME groups or some migrant communities.

- In ensuring that primary care facilities are fit for purpose and are provided in a physical space in the community associated with health and wellbeing, this has the potential to **improve the range of services that patients have access to locally.** Some stakeholders have highlighted the benefits of co-located services as a way of increasing access to wider support services, particularly when some stakeholders may have reservations about accessing an unfamiliar location for care. This may have particular benefits for those who are socially isolated, people from deprived communities as well as some BAME groups.

Potential negative impacts:

- **Whilst increasing the use of technology is likely to deliver positive benefits for some cohorts of the population, for others it may create an additional barrier to access.** This may impact those who do not have frequent access to computer or do not have computer literacy skills. This may include older people and particularly those aged 85 years and over, people with learning difficulties, migrant communities and those from deprived communities. Similarly telephone booking systems or appointments present barriers for the deaf and those who may have language challenges such as some BAME groups. Learning the lessons from the roll out of the universal credit system, some voluntary organisations have been required to provide increased support to their users; the increased use of technology in health and care developments could exacerbate this further. The groups affected by these barriers could be argued to be those most likely to need these services and as a result, any such challenges must be considered to ensure that increased access is delivered equitably.

- There are concerns regarding the **availability of GP resources** to be able to deliver the aspirations for primary care. If proposals are not delivered in full, this could lead to confusion or gaps in services for patients. This could increase the existing barriers to access for groups such as BAME groups and the homeless and could mean that those with ongoing or complex conditions are not able to receive the support they require; particularly impacting older people, disabled people, people from BAME groups and those from deprived communities.
5.2 Impact Analysis: Out of hospital care

Ideas outlined in the Issues Paper to transform out of hospital care:

- Training and development programmes and addressing gaps in the workforce (e.g. district nurses and midwives) to deliver more care outside of hospital.
- Community, primary care, social care and community-based specialists need to be more joined up.
- Encourage and promote healthier lifestyles. Harness the energy in communities, so that people are better able to support one another and that all the resources available to people who are unwell or vulnerable are working together.
- Better support for people living with long term conditions and their carers, allowing them to manage their condition on a day-to-day basis and to seek help when needed. Support should be available in the community, at home and should include better rapid response and urgent care treatment in the community.
- Support older people, particularly those who are frail or living with a long term illness, to stay well, maintain their independence and to be treated closer to home where possible, avoiding unnecessary hospital admissions.
- Improve hospital discharge planning, post discharge support and rehabilitation.
- Provide better support for patients known to be nearing the end of their lives.

Scoped in groups include: Age (children, older people), disability, ethnicity, deprived communities and social isolation.

Potential positive impacts:

- Out of hospital developments place increased emphasis on prevention, health promotion as well as the self management of care and these are considered to be important potential positive impacts by stakeholders, empowering people to stay healthy, remain independent and avoid exacerbations of their condition. This is supported by a growing body of evidence on the importance of effective self-management of long-term conditions (Coulter A, et al (2013) Delivering better services for people with long-term conditions: Building the house of care), as well as evidence which highlights that better integration between primary health care, secondary health care and social care are key to reducing the number of avoidable conditions (The Kings Fund (2014) Making best use of the Better Care Fund). This is likely to disproportionately provide benefits for older people, disabled people, people from BAME groups and those from deprived communities.

- Nationally, the potential positive impacts associated with increased integration are well established; integrating primary and social care has been shown to reduce admissions, and integration of primary and secondary care for disease management of patients with certain conditions has been shown to reduce unplanned admissions (Ham C, Curry N (2010) Clinical and service integration: The route to improved outcomes). Better access to urgent care treatment in the community will also support this. This is also likely to disproportionately provide benefits for those with ongoing and complex conditions including older people, disabled people, people from BAME groups and those from deprived communities.

- Many people who are living with a chronic or long term condition may experience fragmented or duplicated care as a result of the different agencies involved. This can delay treatment and can lead to conditions deteriorating, leading to poor outcomes and experiences for patients. It is considered that this can be particularly true for the older people, children and adults with disabilities, and those with multiple chronic and mental health illnesses. Stakeholders have therefore highlighted the potential benefits in creating a more joined up and coordinated approach and removing this variation for these groups. It is also considered that this joined up approach may avoid confusion and instead facilitate more timely access to services such as mental health or social care and this may be particularly beneficial for groups such as BAME groups and refugee communities.

- For some stakeholders, being able to access the support of these services in a community location or in people’s homes may be more convenient. This may be of particular benefit to older people or those who do not have access to private transport such as those from deprived communities.
5.2 Impact analysis: Out of hospital care

Scoped in groups include: Age (children, older people), disability, ethnicity, deprived communities and social isolation.

Potential positive impacts continued:

- There are local examples as to how outreach services, working with community partners, are already delivering benefits in increasing access to support for protected characteristic groups such as migrant or homeless communities within the local population. They also support the education and upskilling of staff and volunteers within these services. Proposals place focus on enhancing this good practice further, harnessing communities so that people are better supported in a joined up way. This can provide a more holistic package of support to patients, carers and their families; including for example access to housing support, financial advice, home adoptions or befriending services which may create anxiety or delay recovery if support is not provided. Again this is likely to be of most impact to vulnerable communities such as those from deprived communities, the socially isolated, refugees and asylum seekers and the homeless. Feedback from the local deliberative events identified that this may also particularly benefit vulnerable people at risk of neglect because traditionally there is no one to speak up for them.

- The benefits of improved discharge arrangements and reablement support provided by an integrated out of hospital team including social care has been highlighted by local stakeholders as being particularly important for older people, the socially isolated, and those who rely on the support of carers. As well as improving patient experience and supporting the maintenance of their independence, this may also reduce readmission rates.

- Whilst there is little detail at present, patient experience will be enhanced for those people who are at the end of the life and are supported to die in their preferred place. This disproportionately benefit older people as well as those from deprived communities who may have an increased prevalence for conditions such as cancer.

Potential negative impacts:

- Stakeholders have commented that the quality of peoples’ place of residence is essential to receiving good care in an out of a hospital setting. Where there are issues in the quality of this accommodation (for example people in temporary accommodation) this could reduce the quality of care received. This could particularly impact on young families, vulnerable adults, people with mental illness, addiction and those with previous convictions.

- There may be challenges in implementing the aspirations of the out of hospital care programme which mean that quality of care could be negatively impacted. For example, this includes affordability, ensuring that records can be appropriately shared and updated and overcoming organisational boundaries and culture. If proposals are not delivered in a joined up way, this could lead to gaps or disruption to services for patients. This could increase the existing barriers to access for groups such as BAME groups and the homeless and could mean that those with ongoing or complex conditions are not able to receive the support they require; particularly impacting older people, disabled people, people from BAME groups and those from deprived communities.

- There is a concern that the increased demands on out of hospital care services could further constrain their capacity. Relationships are important in enabling older people to be confident in living independently or in developing the trust of communities such as those people who are socially isolated and time is needed to develop these. The development of these relationships could be negatively impacted through increased pressure on resources.

- Whilst services may be available in out of hospital settings, there may still be a requirement to travel to these which can be challenging for some people and particularly those who do not have access to private transport or require the support of a carer. The cost of making these journey may particularly impact those on low incomes or socio-economically deprived communities. The implications of making a different journey may also impact disabled people and those with mobility challenges, as well as those with learning disabilities or those for who English is not their first language.
5.3 Impact Analysis: Urgent and emergency care

Ideas outlined in the Issues Paper to transform urgent and emergency care:

- Specialist hospital care when needed from senior doctors seven days a week, meeting the London Quality Standards (LQS) at all acute hospitals.
- Better information for patients about services and how to access them.
- Ensure that hospital and community services adjust their service levels in response to changes in demand from patients.
- A&E departments should follow best practice for handling patients with major illnesses or injuries, including early review by a senior clinician.
- Make sure that hospitals and local authority social services and housing departments are better coordinated, to avoid delayed discharges and reduce length of hospital stay where appropriate. Better, earlier support for people in the community to help them to avoid ending up in hospital.

Scoped in groups include: Age (children, older people), disability, ethnicity, gender reassignment, deprived communities, social isolation and the homeless.

Potential impacts identified through engagement and evidence review:

Potential positive impacts:

- Changes to urgent and emergency care have the potential to ensure that resources are used effectively. Stakeholders have commented for example that developments such as a ‘navigator role’ will direct patients to the right service, first time. This may be particularly important for groups who currently face barriers to access such as refugees, asylum seekers and some BAME groups.

- Increased access to urgent care services based out of hospital are considered to provide better support to patients with ongoing or complex needs. This will provide rapid access to more appropriate support, enabling people to confidently manage their own conditions. This has the potential to create positive patient experiences as a result of a well-connected urgent and emergency whole system. This is likely to disproportionately provide benefits for older people, disabled people, people from BAME groups and those from deprived communities.

- In achieving the London Quality Standards, there are likely to be positive impacts associated with improved outcomes and quality of care for all patients. This may include greater parity of care across a seven day week; high level of clinical competence ensuring rapid and appropriate decision making; improved safety, fewer errors; improved outcomes for patients which follow from timely diagnosis and clinically skilled interventions; skilled judgement and performance leading to the most effective working and more efficient use of resources; GP access to the opinion of a fully trained doctor; patient expectation of access to appropriate and skilled clinicians and information; and training opportunities for the benefit of junior doctors (Academy of Medical Royal Colleges (2012) The Benefits of Consultant–Delivered Care, Academy of Medical Royal Colleges (2012) Seven Day Consultant Present Care). Whilst this will benefit all patients, there is likely to be a particular impact on all of those groups identified as having a disproportionate need for emergency care.

- In delivering hospital based emergency care in line with good practice standards and team working practices, there is also evidence this can have a significant impact on the length of time patients wait between arrival in the department and admission to hospital or discharge. Where this is not being effectively managed, patient safety, privacy and dignity can be compromised and evidence shows that overcrowding in A&E departments can lead to a 30 per cent increase in ten day mortality rates (Collis (2010) Adverse effects of overcrowding on patient experience and care; Emergency Nurse; Volume 18, no 8, pp34-39). This may have a disproportionate impact on those with specific cultural needs such as some BAME communities, or those people with learning disabilities or mental health conditions (such as dementia or autism) which may cause them to experience anxiety in this situation.
Potential negative impacts:

- Stakeholders have raised concerns that some people may be confused about changes to urgent and emergency care, and particularly as to how to access services. This may result in people delaying access to services or living with conditions which would benefit from early intervention and treatment; resulting in them seeking emergency support as their condition exacerbates. This confusion may disproportionately impact those who face language barriers such as some BAME groups, as well as those with learning disabilities or mental health conditions such as dementia.

- Feedback from the local deliberative events highlighted the potential delay in patients accessing emergency care if they had to travel further to access these services (by ambulance or other modes of transport). This is likely to have a particular impact on all of those groups identified above as having a disproportionate need for emergency care.

- For some groups of the population, potentially accessing urgent or emergency care in a different or unfamiliar location and environment could cause anxiety. It is considered that this could particularly affect the following groups: people with mental health conditions such as dementia or autism, people with learning or sensory disabilities, older people, people who face communication barriers, as well as migrant communities.

- For visitors of patients receiving emergency care, there may be challenges in accessing services at a different site. This may be in terms of barriers to travel but also in terms of physical access on site including for example ramps for wheelchair users. This may particularly impact disabled people.

- Feedback from the local deliberative events highlighted that, if changes to join up discharge planning for patients who had required emergency care were not successfully implemented, older people would be the most vulnerable to experiencing the negative effects of this fragmentation. This is considered to be because older people can be less able to understand the services available to them and how to coordinate access to these.

5.3 Impact Analysis: Urgent and emergency care

Scoped in groups include: Age (children, older people), disability, ethnicity, gender reassignment, deprived communities, social isolation and the homeless.
5.4 Impact Analysis: Services for children and young people

Ideas outlined in the Issues Paper to transform care for children and young people:

- Develop more resilient community services and closer work between the NHS and local authorities to develop integrated services that keep children well, happy and out of hospital unless they need to be there.
- Children and young people should get specialist hospital care when they need it, from senior doctors and specialist nurses, seven days a week, meeting the London Quality Standards at all hospitals that keep children in overnight.
- A south west London-wide review of children’s services, to assess the differential health indicators of children across south west London and how well existing services support them, to include an analysis of changes to the population and their impact.
- A new Children’s Network was established in December 2014. This network is developing shared clinical guidelines and pathways across south west London. Networked services across south west London, will bring together local expertise and service leaders to advise CCGs on priorities and working together to improve children's health services.

Scoped in groups include: Age (children), disability and deprived communities.

Potential impacts identified through engagement and evidence review:

Potential positive impacts:

- Through closer work between NHS and local authorities to develop integrated services, there is the potential to increase awareness of public health issues such as childhood obesity and the uptake of vaccinations. This is known to be one of the public health interventions which can have the greatest impact on health (World Health Organisation). This may have a disproportionate impact on children from deprived communities and groups which may face barriers to access these health promotion services such as those from some BAME groups and migrant communities.

- Through greater coordination and integration and developments such as increased health visitor support, there is the potential for the earlier identification of physical or mental health illness. This early intervention can allow for support to be put in place before a condition deteriorates and can potentially support the child or young person in leading a full and active life. This may have a disproportionate impact on children from deprived communities, BAME groups and migrant communities who may currently face barriers in access.

- Existing services for children and young people can be disconnected and the focus on developing integrated services has the potential to remove this fragmentation. This will allow children and their families to feel supported and better communicated with, potentially increasing their experience of care and enabling them to be better able to navigate services. This will impact all children who require care. This may also improve the transition from children's to adult services which is felt to be particularly important for children and young people with complex needs, learning disabilities or mental health needs. Nationally, this is recognised as a key outcome indicator of the quality of care.

- Proposals may deliver better access to care. This may be in the form of access to appropriate services on a seven day basis, which has been highlighted to be beneficial for school age children, young people and families as this fits around work and study commitments. Improved access is also likely to be experienced as a result of the enhanced services developed out of hospital and closer to home. This may make these services more accessible and convenient for children and their families, particularly for parents who are employed, have other dependent children, are potentially single parent families or are on low incomes. This is underpinned by national evidence that, whenever possible, taking care of children locally in less intrusive settings, close to their home, is in their best interests. Feedback from the local deliberative events also identified that participants value access to affordable or free services which support parents, and this may be particularly important for those on low incomes or from deprived communities. Separate programmes such as the closure of children’s centres have reduced this access, and these ideas could provide an opportunity to enhance this further, supporting the promotion of healthy lifestyles.
5.4 Impact Analysis: Children and young people

Scoped in groups include: Age (children), disability and deprived communities.

Potential positive impacts continued:

- For specialist or inpatient services for children, there is a body of evidence which supports the principles of consolidating services to provide the necessary critical mass of facilities and expertise for doctors to maintain their paediatric skills and knowledge. Networks of care such as the local Children’s Network are considered to be effective ways of ensuring equity of access (Children and Young people’s Health Outcomes Forum (2012) Children and Young People’s Health Outcomes Strategy). This is supported by evidence which indicates that children with high risk conditions have better outcomes when treated in specialist centres by doctors who specialise in children’s medicine, and improved outcomes are achieved when patients are treated by specialised doctors who perform a high volume of clinical work (Department of Health (2007) Making the Clinical Case for Reconfiguration – Evidence Based Review). This is likely to have a disproportionate impact on children who have a need for specialist care.

- The implementation of the London Quality Standards will ensure that children who do require specialist services will have access to high quality consultant delivered care, being seen by medical trainees with appropriate training or children’s nurses with the right skills set and knowledge. Evidence suggests that a consultant-delivered service will reduce unnecessary admissions in emergency care and improve safety and training and supervision (Royal College of Paediatrics and Child Health (2011) Facing the Future: A Review of Paediatric Services). This is likely to have a disproportionate impact on children who have a need for specialist care.

- In increasing the treatment which is available from an appropriate children’s facility, there is the potential to improve the quality of care for these children and young people. This may particularly impact those children and young people with ongoing or complex conditions, including those with disabilities.

Potential negative impacts:

- With any change to specialist or inpatient services, it is recognised that there are likely to be transitional difficulties in implementing change and these will need to be managed appropriately to ensure that negative impacts are not experienced by children and their families. This is likely to have a disproportionate impact on children who have a need for specialist care and may also particularly impact those with children and young people with disabilities who may require ongoing care.

- If the number of paediatric inpatient services were to reduce or if families are required to travel to different facilities, there may be likely negative impacts around travel and access for families. This may be particularly challenging for parents who do not have access to private transport and who have other dependent children, at a potentially distressing time for the family. The cost of making these journeys may particularly impact those on low incomes or socio-economically deprived communities. The implications of making a different journey may also impact children and parents with disabilities or those for who English is not their first language.
5.5 Impact Analysis: Maternity

Ideas outlined in the Issues Paper to transform maternity care:

- 24/7 care in hospital obstetric units, led by senior consultants in line with the London Quality Standards, to improve outcomes in hospital births.
- Easier access to high quality obstetric care for women with complex needs and easier access to midwife-led care for low risk women.
- Increased availability of midwife-led care and home births for those women who want these options. More continuity of midwife-led care.
- A more holistic approach to caring for both mother and baby, supporting women and their families throughout their pregnancy and after giving birth.
- Better services outside hospital to support antenatal and postnatal care and improve the access, consistency and range of these services.
- Improve the quality of referrals to maternity services, so that women with chronic medical conditions can be assessed by ten weeks and seen by the appropriate specialist team early in their pregnancy.
- A new South West London Maternity Network, launched in July 2013, is working with women across the six boroughs in south west London to better understand their experience of maternity services. The feedback should be used to drive improvements in maternity care.

Scoped in groups include: Pregnancy and maternity, ethnicity and deprived communities.

Potential impacts identified through engagement and evidence review:

Potential positive impacts:

- The early identification of potential pregnancy and birth complications through the enhancement of access to antenatal services. This provides the opportunity to prevent these complications becoming more serious and may be particularly beneficial for women who are known to have more complex pregnancies, including for example women with chronic health conditions and older mothers, as well women from BAME groups who are more likely to ‘book late’ and are less likely to receive antenatal care regularly and therefore also tend to receive fewer antenatal check-ups (Race Equality Foundation (2008): ‘Addressing Ethnic inequalities in maternity service experiences and outcomes: responding to women’s needs and preferences’).

- An improved range of accessible information on maternity care can support women to feel better supported in making decisions about their own care; having a better experience of care. This may particularly impact those communities who currently face barriers to accessing this information such as those for who English is not their first language, including women from certain BAME groups and migrant communities. It may also provide the opportunity for increased health promotion advice for teenage mothers or those from deprived communities who are known to experience risk factors associated with low birth weight babies for example.

- Increased choice has been highlighted as an important factor for those women with specific needs. For example, for BAME communities, this includes allowing women’s cultural needs to be met by having choice as to the gender of staff treating them. As part of the enhanced antenatal care, any cultural needs can be identified early, allowing relevant support to be put in place. This could include for example, a request for interpretation support or access to FGM (female genital mutilation) support. For women with mental health conditions or physical disabilities, this includes providing them with access to the support their require to manage their own health and wellbeing through pregnancy, birth and beyond.

- Greater continuity in midwifery led care has been highlighted as an important potential benefit for women, providing comfort and support at this important time. This is considered to disproportionately impact the pregnancy and maternity protected characteristic group by its very nature, as well as those groups who experience increased anxiety where this continuity is not maintained; for women with specific needs related to their culture or disability for example. Feedback from the local deliberative events also highlighted the importance of supporting ongoing and personalised care for women with complex needs or chronic medical conditions; this may include women with disabilities for example.

- Ensuring that midwifery led or consultant led facilities are fit for purpose has also been highlighted as an important benefit by stakeholders, creating a soothing and safe environment and supporting a high quality experience of care. This is considered to disproportionately impact the pregnancy and maternity protected characteristic group, as well as those groups who may experience increased anxiety when accessing healthcare services such as those women from BAME groups with specific cultural requirements.
5.5 Impact Analysis: Maternity

Scoped in groups include: Pregnancy and maternity, ethnicity and deprived communities.

Potential positive impacts continued:

• The increased availability of midwifery led care and home births was viewed positively by stakeholders as this is felt to offer increased choice for women, as well as being “more comforting”. This is supported by evidence that, for low risk women, alternative setting such as midwifery units and home births are safe for the baby and offer benefits for the mother. For example, a woman’s choice of place of birth (home, birth centre, alongside midwifery-led unit, team care labour ward/obstetric unit) makes no difference in the likelihood of adverse outcome for lowest risk pregnant women and their babies, except for first time mothers who have an increased likelihood of adverse outcome if they plan a birth at home. Added to this, women who planned birth in a midwifery unit had significantly fewer interventions, including substantially fewer caesarean sections, and more ‘normal births’ than women who planned birth in an obstetric unit (Birthplace in England Research Programme (2011) The Birthplace national prospective cohort study). This is considered to disproportionately impact the pregnancy and maternity protected characteristic group by its very nature, as well as some BAME groups who are known to utilise maternity services to a greater extent as a result of multiple births.

• In achieving the London Quality Standards, there is evidence of the clinical benefits arising from increased consultant presence in delivery facilities, with studies identifying links to falling caesarean section rates, a reduction in complication rates from vaginal operative deliveries and a reduction in fetal distress leading to neonatal mortality and severe disability (Royal College of Obstetricians and Gynaecologists (2005) The future role of the consultant). As well as the pregnancy and maternity protected characteristic group, this is considered to disproportionately impact those mothers who may be at greater risk of complications during birth or with baby. This includes for example, teenage mothers, older mothers as well as those from deprived communities.

• Increased access to postnatal care out of hospital is also considered to be beneficial for new mothers. This allows more convenient access to services at a time when they may be recovering from the birth and experiencing the emotional impacts of being a parent. This may also support the early identification of complications such as postnatal depression. This is considered to disproportionately impact the pregnancy and maternity protected characteristic group, as well as those groups who may require additional support beyond birth including for example teenage mothers, those from deprived communities, or those who are socially isolated.

Potential negative impacts:

• It has been commented that NHS maternity services are not joined up with wider community based resources. If these links are not considered as part of the proposals, then the opportunities to provide holistic care such as increasing the uptake of new born screening, which meets the needs of mothers and babies, may not be achieved. This is considered to particularly impact BAME groups who are known to face inequalities in accessing antenatal support, as well as groups who may require additional support including for example teenage mothers, those from deprived communities, or those who are socially isolated.

• Should changes to services be suggested in the future, then the SWLCC need to consider that if complications in low risk women arose during home births or a midwifery led birthing centre, which was not co-located with an obstetric services, patients would need to be transferred to the nearest consultant-led service. These emergency transfers could negatively impact the outcomes and experience of care for patients, as well as resulting in capacity implications for ambulance resources. This could disproportionately impact those mothers who may be at greater risk of complications during birth or with baby. This includes for example, teenage mothers, older mothers as well as those from deprived communities.
5.6 Impact Analysis: Planned care

Ideas outlined in the Issues Paper to transform planned care:

- Within five years, no planned surgery in south west London should be cancelled due to emergencies elsewhere in a hospital.
- Develop centres of excellence in different surgical specialties, based on the South West London Elective Orthopaedic Centre (SWLEOC) at Epsom Hospital, which is jointly managed by the four local hospital trusts. Urology services could be a potential ‘pilot’ as there is strong clinical support for change among urologists.
- Develop a more efficient system, separating planned operations from emergency care.

 Scoped in groups include: Age (older people) and disability.

Potential positive impacts:

- The separation of emergency and planned surgery is in line with national guidance which indicates that this can result in fewer cancelled operations due to emergency patients from disrupting planned activity and vice versa thus minimising patient inconvenience and maximising productivity for the Trust. It is also considered to reduce infection rates, and the presence of senior surgeons for both elective and emergency work can enhance patient safety and the quality of care, and ensure that training opportunities are maximised (The Royal College Of Surgeons Of England (2007) Separating Emergency And Elective Surgical Care). This is considered to particularly impact those groups identified as having a disproportionate need for planned care services; older people and disabled people.

- Stakeholders have highlighted the benefit of reduced cancellations for patients noting that they can be particularly distressing for older people. Cancellations are also considered to have implications on the capacity of support services such as voluntary transport services, for older people, disabled people and those who are socially isolated may be reliant on. Findings from the local deliberative events also highlighted the benefits of reduced cancellations to those who are employed and have to agree time off work with their employer.

- Stakeholders have also highlighted the opportunity to improve and join up discharge arrangements for patients who have received planned surgery. Through the planning of care and shared decision making which forms part of this, patients and services will have clear expectations as to when they may be discharged and the support they may require to continue their recovery at home. This is felt to be particularly important for older people, disabled people, the socially isolated and those reliant on carers.

- Building on the success of SWLEOC, the establishment of an inpatient elective centre will allow specialist resources (surgeons and equipment for example) to be brought together. Evidence suggests that hospitals and surgeons who undertake a critical mass of surgery cases are able to demonstrate better clinical outcomes. Whilst recognising that there is some debate as to the evidence which links volume and outcomes, numerous studies have demonstrated better outcomes at high-volume hospitals with cancer surgery, and other high-risk procedures. There is also a robust evidence base that risk-adjusted peri-operative mortality and long term conditional survival worsen as hospital surgical volume decreases (Numerous sources including Bilimoria K et al (2008) Directing Surgical Quality Improvement Initiatives: Comparison of Perioperative Mortality and Long-Term Survival for Cancer Surgery, J Clin Oncol 26:4626-4633 and Halm EA et al (2002) Is volume related to outcome in health care? A systematic review and methodological critique of the literature. Ann Intern Med 137:511-520). The consolidation of caseloads to dedicated centres also enables specialisation by both individual doctors and the overall units, which has been shown to improve outcomes (Paterson-Brown S (2014) Core Topics in General & Emergency Surgery: Companion to Specialist Surgical Practice. Fifth edition). This is considered to particularly impact those groups identified as having a disproportionate need for planned care services; older people and disabled people. Some stakeholders have commented that people are supportive of the potential to improve outcomes though the consolidation of other specialist services, having seen the impact of this already being implemented in clinical areas such as stroke and trauma.
5.6 Impact Analysis: Planned care

Potential negative impacts:

• If services are provided from different or fewer sites, there are likely to be negative implications for travel and access both in terms of patients and their visitors. This may be in terms of:
  - Gaining information as to how to get to other unfamiliar sites;
  - Finding the resources needed to make the journey (for example financial or carer support, or finding a friend or relative to provide transport);
  - The implications of having to make longer journeys (when there are other dependents or caring responsibilities for example);
  - Physical access on site including for example ramps for wheelchair users; and
  - For patients, the physical impact of being uncomfortable in making these longer of different journeys.

It is therefore considered that this may disproportionately impact people who face communication barriers (such as the deaf or BAME groups for who English is not their primary language), those who may feel anxious with change (for example older people, those who are socially isolated, those with mental health conditions such as dementia), those who may struggle physically to make different journeys such as older people or those with poor mobility, as well as people with learning or physical disabilities, those reliant on a carer, as well as those on low incomes or from socio-economically deprived communities. This may also create additional pressure on the capacity of voluntary transportation services; for who some of these groups are reliant. Some of these travel impacts were also highlighted within the local deliberative events.

• Findings from the local deliberative events identified that, if services are provided from different or fewer sites, a patients’ experience may be negatively impacted if their family are not able to visit them due to the travel implications described above. This may have a particular impact for older people or those who are reliant on the support of a carer.

• Accessing an unfamiliar environment can cause anxiety for some groups of the population, negatively impacting their wellbeing and experience of care. It is considered that this could particularly affect people with mental health conditions such as dementia, people with learning disabilities or older people. This negative impact may also be enhanced for BAME communities if services are not able to accommodate different cultural needs (provision of hospital food for example).

• Telephone booking systems for planned care appointments present barriers for the deaf, for those who English is not their first language, for older people as well as those with dementia.

• For some planned care procedures or diagnostic tests, it is challenging to see how waiting times will be reduced without significant investment in services. If waiting times deteriorate, this can delay access to treatment which can result in the deterioration of a patients condition. This can in turn impact on their likely recovery and potential to lead an independent life. This is considered to particularly impact access for those groups identified as having a disproportionate need for planned care services; older people and disabled people.

Scoped in groups include: Age (older people) and disability.
5.7 Impact Analysis: Mental health

Ideas outlined in the Issues Paper to transform mental health:

• Services across physical healthcare, social care and the voluntary sector should be more joined up, working together to develop care plans for service users that treat them as a ‘whole person’.
• Service users should be able to expect much better quality of and access to mental health services in the community, helping people to stay well and out of hospital where possible.
• Service users should have better access to crisis care in an emergency.
• People heading towards a mental health crisis should have access to appropriate and timely support, with a plan in place ahead of any crisis developing.
• Systems should be put in place to measure the quality of life for people with mental health problems, to make sure that the most effective services achieving the best outcomes for people are protected and funded.
• Increase patient choice and the personalisation of services.

Scoped in groups include: Age (children and young people, older people), disability, ethnicity, sexual orientation, gender reassignment, deprived communities, social isolation and homeless.

Potential positive impacts:

• Joined up and integrated services have the potential to support the prevention and early identification of mental health conditions. This will allow service users to access support which may prevent their condition from deteriorating, potentially supporting improved outcomes and a better quality of life. This may also support improved diagnoses, with dual diagnosis through integrated mental health and substance misuse services for example. This is considered to impact for those groups identified as having a disproportionate need for mental health services, including disabled people. This may also be particularly beneficial for groups who may face barriers in accessing services including for example the homeless or socially isolated. Findings from the local deliberative events also highlighted that providing targeted mental health promotion information to men, job seekers and the retired has the further potential to reduce some of the existing barriers to access which exist.

• In integrating pathways, there is the potential to improve a service users well-being and quality of care by ensuring services are able to respond to both physical and mental health needs. This is particularly important given the evidence that quality of life for those with some co-morbid mental and physical health problems is considerably worse compared with the quality of life for people with two or more physical health problems (The King’s Fund (2012) ‘Long-term conditions and mental health: The cost of co-morbidities’). Given the link between long term conditions, mental health and deprivation, this may be particularly beneficial for people from deprived communities, as well as older people and those from BAME communities.

• Stakeholders, supplemented by local evidence, have highlighted the existing inequalities in access to coordinated mental health services (Croydon BME Forum (nd) Mind the Gap: A Report on BME Mental Health Service Provision in Croydon). A consistent approach implemented across south west London has the potential to enhance equity of access and remove the variation which currently exists for these BAME groups and migrant communities.

• The suggested ideas have the potential to improve access to services, particularly in terms of:
  – Access to appropriate services (talking therapies for example)
  – Timely access (to crisis support)
  – Access to services in a community location.

Increased access to services should better support people to live a full and active life. When a crisis does occur, however, service users are better able to access safe support, avoiding unnecessary and inappropriate admissions to A&E as they are able to access services which better meet their needs. This may particularly impact for groups who may face barriers in accessing services including, for example, people from BAME groups, disabled people, the homeless or socially isolated.
5.7 Impact Analysis: Mental health

Scoped in groups include: Age (children and young people, older people), disability, ethnicity, sexual orientation, gender reassignment, deprived communities, social isolation and homeless.

Potential positive impacts continued:

- Findings from the local deliberative events identified that increased services available closer to home can reduce the “emotional stress” that some patients currently experience when they are discharged to support facilities in areas which are geographically unfamiliar to them. This is thought to particularly impact the most vulnerable groups using mental health services.

- The development of care plans which treat service users as a ‘whole person’ and join up relevant services will enable people to only tell their story once. Stakeholders also commented that they consider this will increase the responsibility of the service user by mental health services and their partners. This is considered to particularly impact for those groups identified as having a disproportionate need for mental health services. It may also be beneficial for those with complex needs or multiple mental and physical health conditions, including for example, older people and disabled people.

- It is currently considered that not all current facilities are fit for purpose for the delivery of psychological support services and to meet the needs of people using them; young people or those from BAME communities for example. Enhanced community access has the potential to ensure that these services can be accessed in an environment which supports the dignity and privacy of the service user. Findings from the local deliberative events also reflected this suggesting that if services are considered to be more approachable, this may support groups such as young people to seek help.

Potential negative impacts:

- It has been commented that the gap between the current provision of services and the aspirations set out in the Issues Paper, raises a concern as to feasibility. Building on this, if the vision for these services is to be achievable, increased resources and capacity will be required and if this not appropriately supported there is a risk of greater fragmentation and variation in services. This may impact on ongoing care for those people identified as having a disproportionate need for mental health services, as well as potentially increasing the barriers some groups face in terms of access; impacting people from BAME groups, the homeless or socially isolated.

- Learning the lessons from a separate local consultation around potential ideas to inpatient mental health services, there is a concern that potential negative impacts could emerge as a result of disruption to services, unless new community services are first established. This may impact on ongoing care for those people identified as having a disproportionate need for mental health services and may have a particular impact on those with multiple or complex needs such as older people and disabled people.

- Travel and access were also identified as potential concerns depending on the location of services and were thought to have the potential to disproportionately impact those who may have to travel out of borough for services due to their place of residence, those with complex needs, people with disabilities, people who live alone, those who are reliant on carers, as well as those on low incomes or from economically deprived communities.
5.8 Impact Analysis: Cancer

Ideas outlined in the Issues Paper to transform cancer services:

- Greater focus on prevention of disease, early diagnosis and patient experience, with an emphasis on patient choice and care provision in the community during active treatment, recovery, and, where necessary, improved support during the end of life phase.
- A focus on getting better at making sure every patient is treated as an individual and offered the full support of the healthcare professionals involved.

Scoped in groups include: Age (older people) and deprived communities.

Potential impacts identified through engagement and evidence review:

Potential positive impacts:

- The opportunity to increase the focus on primary prevention and improve early diagnosis through the promotion of patient awareness campaigns and the uptake of screening services. Nationally it is recognised that diagnosing substantially more cancers earlier could be transformative in terms of improving survival reducing mortality and improving quality of life (Independent Cancer Taskforce (2015) Achieving World-class Cancer Outcomes). This is considered to particularly impact those groups identified as having a disproportionate need for cancer services; older people and those from deprived communities. Enhanced screening opportunities for ‘high risk groups’ (such as older people and those from deprived communities), and subsequent early diagnosis, was also highlighted as a potential benefit in the local deliberative events.

- The focus on care provision in the community is considered to potentially improve access for patients as some services will be available in more convenient settings. This may be particularly beneficial for patients who are receiving intensive treatment such as chemotherapy and who require support from carers in accessing these appointments. It is recognised that this may particularly impact people who are socially isolated, people with disabilities, older people and those on low incomes or from deprived communities.

- An increased focus on patient choice can support cancer patients in feeling better informed, and more involved and empowered in decisions around their care. These are recognised as important outcomes for cancer patients (Independent Cancer Taskforce (2015) Achieving World-class Cancer Outcomes). This is considered to particularly impact for those groups identified as having a disproportionate need for cancer services. This may also be beneficial for patients with particular needs; people with disabilities or from BAME groups for example.

- Ensuring that every patient is treated as an individual and supported by relevant professionals is considered to be a positive impact, no matter the stage of treatment. This is felt to be particularly beneficial at key transition points, ensuring that the patient does not have to repeat their story. As well as older people and those from deprived communities, this may particularly be beneficial for people with complex needs. This approach will also provide support for the patients family and/ or carer.

- Stakeholders commented that increased access to support for patients living with and beyond cancer is also an important potential benefit. This is particularly important given that many cancer patients suffer long-term consequences from their cancer or their treatment and are at higher risk of cancer recurrence. Many will suffer psychological or financial hardship and most will have another long-term condition in addition to their cancer. (Independent Cancer Taskforce (2015) Achieving World-class Cancer Outcomes). This is considered to particularly impact those groups identified as having a disproportionate need for cancer services, as well as those with mental health conditions or those who may be socially isolated.

Potential negative impacts:

- Cancer services are being developed at both a regional and local level and there is a need to ensure that good practice is replicated across the whole health economy. If this does not happen in an coordinated way, there is a risk that additional variation in the quality and accessibility of services may be created. This has the potential to impact those groups which traditionally face barriers in accessing services, including for example some BAME groups and migrant communities.
5.9 Impact Analysis: Wider impacts

Whilst the analysis has focused on equalities impacts, through this review, a number of other potential wider impacts have been highlighted. Examples of this evidence are summarised below and it is recommended that this is further explored by SWLCC as further detail is developed on the proposed service ideas outlined in the issue paper. This could be undertaken as part of a wider health impact assessment (HIA) which looks at impacts and outcomes on the whole patient population as well as system and delivery impacts.

Potential health or service related impacts:

Positive impacts

- The integration and joining up of care has the potential to result in the more effective use of resources through the development of new roles and reduction of duplication.
- Rapid decision making is also considered to have a wider impact on patient flow and aspects such as ambulance delays (NHS England (2013) Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report: Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review).

Negative impacts

- Although the future configuration of local hospital based emergency services is still being developed, some stakeholders have expressed a concern that access to these services would be reduced if services are rationalised. This may have implications for ambulance resources if patients have to be taken to a hospital which is further away and could potentially delay access to specialist care. It is understood that this will be considered in the development of more detailed proposals.
- A national review identified that whilst centralisation may encourage greater paediatric specialisation and concentration of expertise, there is a concern that this could result in the deskilling of surgeons in other hospitals which may limit their ability to manage critically ill children who present at their hospital. Clinically managed networks for children’s surgical and anaesthetic care are therefore an essential solution (NCEPOD (2011) Are We There Yet? A review of organisational and clinical aspects of children’s surgery).

Potential workforce related impacts:

Positive impacts

- The development of new roles, increased collaborative working and networking opportunities between services and professionals may have a positive impact on staff satisfaction. This may in turn improve staff retention, as well as supporting staff recruitment.
- As a result of the implementation of the new models of care, staff performance and engagement may increase if they feel valued and satisfied at work. Anecdotally it has been suggested that this may in turn support the delivery of a high quality service.
- The potential consolidation of specialist services such as urological elective care will create more sustainable rota and working arrangements and which will allow scarce resources to be utilised in a more effective way. In turn, it is considered that this would contribute to increased morale in that these rota are appropriately resourced.
- A focus on joined up care, supported by multi-disciplinary teams has the potential to support staff to share learning and good practice.

Negative impacts

- Should changes to service be suggested in the future then the SWLCC need to consider that this may result in some staff having to travel further to their place of work. This could result in inconvenience associated with different journeys, as well as potentially increasing the personal costs of travel to their place of employment.
- Increased pressures on roles such as GPs may impact on their job satisfaction, retention and may have a negative impact on the future recruitment of these professionals.
- Some staff may experience changes to their role, team or working arrangements (rotas for example). As a result of this, some staff, may consider that they are not able or willing to accept these changes and as a result may choose to leave the local service.
- Stakeholders have raised concerns about the availability of staff resources (GPs for example). It is recognised that national challenges around the retirement profile of staff, combined with defined numbers of training posts may exacerbate this further.
6. Summary

It is recognised that at this stage of the analysis, there are challenges in identifying detailed positive and negative impacts on protected characteristic groups which may arise should future service changes be made. Nonetheless, several common themes have emerged and, at a high level, these are briefly summarised below:

Positive impacts:

- Services which are designed to **empower patients** with increased emphasis on **prevention, early identification and the self-management** of conditions.
- The potential to improve **outcomes for patients and service users** through the concentration of skills and expertise and the achievement of the London Quality Standards.
- The potential to improve **access to services**, in terms of both timely access but also through the increased provision of services out of hospital and the development of new roles and integrated teams.
- Through the development of services, **increased patient choice**. This may be with regards to time of access, the range of services available or the location of services.
- Through the integration of patient pathways, the opportunity to provide **joined up care for patients**, ensuring that they do not have to repeat their story and supporting them and their carers to better navigate the care that is available, including urgent access.
- **Removing the existing fragmentation, variation and duplication** in the local health economy. This supports the effective use of resources and ensures that high quality care is available for all.
- An opportunity to provide services in **facilities which are fit for purpose** and are cognisant of a patient’s dignity and well-being.

Negative impacts:

- Where services may be consolidated or provided from a different location, **travel and access** are common concerns. This is in terms of a patient’s ability to travel to different location as well as the inconvenience of longer journeys and the support that may be required as part of this.
- Accessing an **unfamiliar environment can cause anxiety for some groups** of the population, negatively impacting their wellbeing and experience of care.
- Should future service change takes place, there are concerns that **access to services may be disrupted** unless new services are established before hospital based services are consolidated.
- Similarly, should future service change take place, there is a possibility that people may be confused about the changes and particularly how to access services. This could potentially deter people for accessing services which could potentially lead to a deterioration in their condition.
- There are some concerns regarding the **feasibility of implementing some of the ideas for potential change**. This may be because of the scale of change required (in mental health services for example), due to capacity and resources (in areas such as primary care) or because of potential barriers such as IM&T challenges around an integrated patient record. This may have implications for patients within these groups if ongoing care is disrupted.

This analysis has identified the protected characteristic groups who are considered to have a disproportionate need for the service areas covered within the Issues Paper. There are a number of groups which are likely to be **disproportionately impacted under a number of service areas** and they include:

- Age (Children and young people)
- Age (Older people)
- Disability
- Race & Ethnicity
- Deprived communities

There are also a number of protected characteristic groups who are **likely to experience the potential positive and negative impacts described above to a disproportionate extent**. This includes people with physical or learning disabilities or certain mental health conditions, the socially isolated, those from deprived communities, the homeless, as well as people from certain BAME groups or migrant communities.

As further detail becomes available on the ideas proposed in the Issues paper, it is recommended that these impacts be explored in more detail and are used to inform the ongoing development of proposals.
7. Suggested mitigating actions and opportunities

A number of mitigating actions and opportunities are suggested for consideration by SWLCC. It is recommended that these actions be reviewed and updated once further detail emerges on the proposed ideas.

**Equalities analysis:**

- Building on the enthusiasm of stakeholders engaged with as part of this initial analysis, as proposals become more developed, further engagement is needed to understand the potential positive and negative impacts in greater detail. It will be particularly important to target those groups which have been identified as likely to experience any adverse impacts. This further engagement could take the form of:
  - Small workshops or drop in sessions where local representatives from protected characteristic groups are invited to come and share their views.
  - Direct engagement with local patient and involvement reference groups as well as local organisation such as Healthwatch.
  - Focus on engaging with often hard to reach groups such as the homeless, socially isolated, people from certain BAME groups or those with mental health conditions. Community development workers, the local CCG and voluntary sector organisations may be able to support this access.
  - Engagement with CCG leads of providers as they may have greater insight into the practical signposting or access barriers which may impact their patients.
  - Engagement with staff from across the service areas and providers involved.

- Building on this initial equalities analysis, further analysis and engagement should consider protected characteristic groups as well as other vulnerable groups such as carers, those from deprived communities, the homeless and socially isolated.

- Depending on the detail of proposals, this analysis could also look to quantify potential travel impacts, mapping these against the protected characteristic groups identified as having a disproportionate need for services.

- A more detailed assessment of the impacts can then be undertaken, considering each impact against the following criteria:
  - *Scale of impact:* This relates to the likely number of people who will experience impacts.
  - *Likelihood:* This is defined as how likely it is that the impact will be realised and existing mitigations actions can be considered as part of this.
  - *Duration:* This looks at whether the impact will be permanent (long term) or temporary (short term).

- A detailed action plan of agreed mitigating actions should be developed, with owners and timescales attached.

- Outputs from engagement with equality groups should continue to be shared to demonstrate how views have been incorporated and used.

**Service development:**

- SWLCC should consider undertaking a wider HIA alongside future equalities analysis to support the assessment of wider impacts on the whole patient population and system impacts which may arise from should future changes be made.

- In developing the detail of proposed service changes, it will be important to map and establish links to voluntary and community sector organisations (VCSOs); creating a network which provides holistic care. There is an opportunity for these services to complement health and social care services but pathways and communication will be essential for this to work in practice. Education and training may also be needed to support the establishment of these links.

- At a programme level, the potential inter-dependencies between service area workstreams, and across patient pathways, must be considered as further detail is developed. For example, this may include the interdependency between physical and mental health services, or, more practically, developing consistent approaches to protocols or components of care such as carers assessments.

- In planning service developments, clear points of access to services must be developed which are relevant for all patients and service users.

- Access to support which enables people to access and feel confident in using services should be expanded. This includes access to interpretation or signing support, as well as patient advocates.

- Services must be able to accommodate the different cultural needs of their local communities and recommendations from local work such as *Mind the Gap* must be considered as part of this.

- At a programme level, there will be a need to consider the consistency of developments across south west London boroughs so as to maximise equality of accessibility and outcomes.
7. Suggested mitigating actions and opportunities

Workforce:

- In further stages of analysis, a programme of engagement is needed with providers and staff to understand further the potential impacts which may be experienced by staff and particularly by protected characteristic groups within the workforce such as BAME communities or women. The implications on protected characteristic groups within the local workforce should also be assessed, in line with the NHS Workforce Race Equality Standard.

- Once these potential impacts and issues have been identified, appropriate support arrangements can be developed. This could potentially be led through a workforce sub-group. This could include for example, training and education and access to career advice.

- From an equalities perspective and in line with the Public Sector Equality Duty, local providers have already embedded, and are reporting regularly on aspects such as career progression, diversity and dignity at work. This is supplemented through developments such as equality and diversity awareness training, unconscious bias training, mediation services, or research on the issues raised. This also supports staff awareness of local population issues which may in turn improve the patient experience. Enhanced training on LGBT issues, understanding the cultural needs of BAME groups and supporting vulnerable young people have been highlighted by stakeholders as requiring further work.

- It has been qualitatively suggested that staff from BAME communities may face inequalities in terms of recruitment, career progression (board representation for example), and bullying and harassment. As part of the developed actions to support staff, the NHS Workforce Race Equality Standard should be considered to ensure that if any changes are implemented, they do not disproportionately impact staff from BAME communities.

Implementation:

- If any of the ideas outlined in the Issues paper are implemented, clearly communicating these changes and key messages to the public will be essential. In addition, ensuring that people understand the services available to them and how to access these will be vital. This should include the sharing of good news stories to support the public in building trust in these service developments and should enable people to see “what the developments mean for them”. In communicating these changes, the needs of different protected characteristic groups need to be considered, for example how to appropriately communicate these changes to people who do not speak English, or those who live alone or who may be isolated. Guidance such as the NHS Accessible Information Standard could be adopted as part of this.

- As part of ongoing monitoring, it is essential that providers improve the quality of data that is collected locally of the demographic indicators of patients, including known gaps such as data on sexual orientation. This includes primary care, community care, hospital and mental health providers.
Primary care:
• Should changes to services be suggested in the future, it is recognised that in order to gain the most benefits in primary care, targeted communication and information will be important. This is needed in order to begin to influence the behaviour of some community groups in how they use services, encouraging the appropriate use of services such as A&E and out-of-hours services, which for some groups there is less awareness about.
• Clear information must also be provided on the options for accessing primary care, ensuring that groups such as older people do not become marginalised through the increased use of technology.
• Primary care staff must be able to share consistent information about the eligibility criteria for people to register with a GP practice, removing barriers to this foundation of healthcare.
• GPs and patients should have access to support services to ensure patients feel confident in using primary care. This could include access to interpretation services or support for people with learning disabilities.

Out of hospital services:
• In designing out of hospital services, links to voluntary sector organisations must be optimised as they are already providing support to hard to reach populations and have an important role to play in the wider holistic care of patients.

Emergency and urgent care:
• Signposting within locations should be reviewed to try and optimise access for people with sensory impairments and people who face communication challenges.
• SWLCC have themselves identified an increase in the use of the London Ambulance Service and emergency care in 20-30 year olds and note that this will be examined in more detail to ensure that their needs are responded too.
• Within the local deliberative events, it was highlighted that a new initiative of patient passports is being developed across SWL. Within these passports, ‘need to know’ information about the patient is summarised and shared. These patient passports can support more personalised care and can prevent the patient from having to repeat information to different professionals. Opportunities to roll out this good practice should be considered and professionals should look to utilise this resource when caring for patients; particularly those with multiple or complex needs.

Services for children and young people:
• Locally, in areas such as Richmond, work is being undertaken to ensure that GPs are confident in treating children and targeted same day appointments are also considered to support access. Good practice should be rolled out across south west London to reduce variation in outcomes.
• Within the local deliberative events, it was suggested that a steering group of children and young people be formed as part of the local network; to ensure the voices of children and young people are heard.

Maternity:
• Consideration of the potentially different needs of young women, older women, women of certain faith groups and women in same sex relationships is required.
• As part of the development of proposals, work with local community and voluntary providers to develop a joined up offer for women.

Planned care:
• In developing the detail of proposals, there is an opportunity to ‘join up’ services with the voluntary sector. For example, in one area, the local branch of Age UK provide a ‘Nightingale’ service which supports patients in their own homes on discharge. As well as supporting a patient’s recovery, this has the potential to reduce avoidable readmissions to hospital.

Mental health:
• Mental health services must be designed to be culturally sensitive and able to accommodate the cultural needs of BAME groups including for example the provision of food and overcoming language barriers. The language used around mental health also needs to be considered as for some BAME communities, words such as ‘dementia’ or ‘depression’ carry stigma and can isolate these communities from accessing services. It will therefore be important to consider the recommendations of local work such as Mind the Gap in the design of services, as well as involving and testing any proposed changes with representatives from these communities.
• Increased education and training around mental health is needed across the spectrum of services which support people; from health services to education for example, as well as ensuring that mental health assessments are undertaken consistently. Providing training to teachers in schools for example will allow conditions to be identified early and may prevent conditions from deteriorating.
• Examples of good practice should be rolled out across south west London. For example, to improve understanding of the links between mental health, diabetes support and medication, some local providers have undertaken health promotion activities on fasting and diabetes.