Health Inequalities and Equality Impact Assessment of 'Healthcare for London: consulting the capital'

Scientific Annex II
Rapid Evidence Review and Appraisal

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Rapid evidence review and appraisal Scientific Annex 2

Health Inequality and Equality Impact Assessment of Healthcare for London: Consulting the Capital

Report prepared for the London Health Commission

by Ben Cave Associates Ltd

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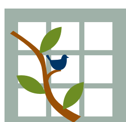

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HEALTH COMMISSION

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Abbreviations and acronyms

A&E .... Accident and Emergency
BAME .... Black, Asian and Minority Ethnic
DH .... Department of Health
EqIA .... Equality Impact Assessment
FGC/M .... Female genital cutting/ mutilation
GLA .... Greater London Authority
GRS .... Gender Reassignment Surgery
HIIA .... Health Inequality Impact Assessment
IMD .... Index of Multiple Deprivation
IMR .... Infant Mortality Rate
LEFM .... Local Economic Forecasting Model
LHO .... London Health Observatory
LTCs .... Long-term conditions
NHS .... National Health Service
NHSD .... NHS Direct
NS-SEC .... National Statistics Socio-Economic Classification
NICE .... National Institute of Health and Clinical Excellence
QOF .... Quality Outcomes Framework
PCT .... Primary Care Trust
RCOG .... Royal College of Obstetricians and Gynaecologists
TIA .... Trans ischaemic attack
WHO .... World Health Organization

1. Executive summary

Background

1.1 On 17th December 2007 Ben Cave Associates (BCA) was commissioned by the London Health Commission (LHC) to undertake a rapid evidence review and appraisal of the health inequalities and equalities impacts of *Healthcare for London: consulting the capital* (1). The work took place between 19th December 2007 and 7th March 2008 when this final report was submitted.

1.2 The rapid evidence review and appraisal is part of a wider Health Inequalities Impact Assessment and Equalities Impact Assessment (HIIA/EqIA) that NHS London and the London Commissioning Group has requested the LHC undertake. The HIIA/EqIA is overseen by a Steering Group made up of key stakeholders.

1.3 The final report builds on responses to the interim report, discussed at the Steering Group meeting on 17th January 2008, and the draft final report, discussed on 8th February 2008.

Aim of the work

1.4 The aim of the integrated health inequalities and equalities impact assessment as laid out in the scoping paper prepared by the Steering Group is "to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process, to maximise health gains, to reduce or remove negative impacts and reduce inequalities".

Scope, structure and methodology

1.5 It is essential the scope, structure and methodology of the rapid evidence review and appraisal are transparent, coherent and robust enough to withstand external scrutiny. They must also meet the requirements of the Steering Group and be realistic given the time available. Therefore, this report describes the proposed approach in some detail.

1.6 As directed by the scoping exercise undertaken by the LHC, this work focuses on the primary care, maternity care and stroke pathway proposals included in the Healthcare for London: consulting the capital' document, with additional information taken from the earlier report "A framework for action".

1.7 The scope of this work is to identify and review evidence that builds understanding of how the proposals contained in *Healthcare for London: Consulting the Capital* (1) may impact on health inequalities and equalities groups in London. It is not within the scope of this work to critique the clinical evidence base used to inform the proposals or to critically re-evaluate the analytical framework that describes current and future health care activity and costings.

1.8 This rapid evidence review and appraisal has drawn on systematic reviews but has not been conducted using the methodology of a systematic review. As there is very little routine data on the health and healthcare experiences of the equalities groups, many non-routine sources of data and evidence have been used, including grey literature, systematic reviews, community intelligence and primary research. The report explains in some detail how evidence has been identified, the benefits and limitations of each type of evidence and how this evidence has been used.

1.9 Public organizations have statutory responsibilities to assess and consult on the likely impact of proposed policies on equalities groups. The rapid evidence review and appraisal has been undertaken in line with GLA (2;3) and Commission for Race Equality (4) best practice. This will assist NHS London to fulfil its statutory duties and it will contribute to the examination of whether NHS London have given proper consideration to the likely impact on equalities groups.

1.10 However, because of the high level nature of proposals at this stage, the rapid evidence review and appraisal has not looked at the impact on equalities groups of specific service reconfigurations or of the implementation of proposals at a local level. HIIA/EqIA should be

considered as an on-going process throughout the development and implementation of the proposals.

1.11 Because the proposals concern healthcare, discussion on health inequalities has focussed on health status and outcomes, including life-expectancy and morbidity, and health services, including access and patient experience. In order to ensure the important role of the social determinants of health in causing health inequalities is not lost, it has been included as indicator of health inequalities in the summary tables.

1.12 For the rapid evidence review and appraisal we have used the definition of equalities used by the Greater London Authority (GLA), as directed by the Steering Group. This definition is based on six equality themes - age, disability, faith, gender, race and sexual orientation. Each of these themes contains one or more equality groups. We have also highlighted particular vulnerable groups where these are not covered by these equalities groups.

1.13 The methodology of the report is based on six key stages: project start-up; scoping; identifying and reviewing of key documents and evidence; undertaking the initial appraisal and preparing the interim report; participating in the stakeholder workshop; and undertaking the final appraisal and preparing the final report.

1.14 After the detailed explanations of structure, scope, and methodology, the report is structured in three sections: primary care, maternity care and stroke pathway. Each of these sections describes the situation now, summarises the proposals, appraises potential impacts on equalities groups and health inequalities and proposes recommendations.

1.15 This report should be read in conjunction with the Health Equity Profile prepared by the London Health Observatory as the baseline for the Health Inequalities Impact Assessment and Equalities Impact Assessment (5).

Key findings and recommendations

Overall findings

1.16 A recurring theme is that the proposals could either increase or reduce health inequalities depending on *how* they are implemented. The changes to models of care proposed are likely to improve health outcomes. However, health inequalities are likely to increase and equalities groups will suffer disproportionately if these improvements primarily benefit those who already have adequate levels of access to quality healthcare and healthy lifestyles.

1.17 In addition, while the implementation of the proposals *in full* is likely to improve health outcomes, their *partial* implementation could further exacerbate health inequalities. For example, a move to earlier discharge after stroke without an improvement in home support could lead to an additional burden on carers, who are themselves a vulnerable group whose health needs are often unmet.

1.18 In order for the proposals to reduce health inequalities the improved models of care need to benefit those who currently have the worst health. Broadly speaking this will involve several major changes to current healthcare models.

- *The inverse care law must be reversed*. More deprived areas and communities must receive resources, including funding, staffing and infrastructure, in line with the higher levels of health need in those areas and by those communities.
- Models for *assessing and meeting unmet health* need should be developed and incorporated into PCT planning and performance management. There is a danger that vulnerable groups who currently cannot access healthcare will be left out of the improvements promised by the proposals, further increasing health inequalities between the most marginalized groups and the population as a whole.
- New models of healthcare must take account of the needs of equalities groups, vulnerable groups and those with the worst health by *addressing the barriers that have historically prevented equalities groups and deprived communities accessing health care* and benefiting from health improvement services. These barriers for different equalities groups include physically inaccessible services, a lack of language support and the cultural insensitivity of services. For deprived communities barriers also include poor access to healthy lifestyle choices, stress, social isolation, low aspirations and the affects

of multiple deprivation such as poor housing, crime and fear of crime, unemployment, and poor access to services.

- New models of healthcare must be *targeted* at equalities groups, vulnerable groups and those with the worst health and provided at sufficient levels to meet their needs. This will necessitate developing ways of incentivising healthcare providers to work with traditionally-under-represented groups.

1.19 The lack of routine data collection and analysis on health outcomes for equalities groups means it is not possible to assess the likely impact of key proposals on some of the equalities groups. The inadequacy of the data will make it impossible to adequately monitor the impact of the proposals on equalities groups. NHS London and PCTs must work together to improve data collection and analysis on health outcomes for equalities groups as a matter of high priority.

1.20 Key groups at risk of experiencing continued health inequalities

- Carers;
- People not currently registered with a GP;
- Refugees, asylum seekers and newly arrived people who may have existing unmet health needs;
- People with physical and sensory disabilities, reflecting the high numbers of inaccessible primary care premises based on most recent information;
- People with mental health problems; and
- People with learning disabilities.

Overall recommendations:

- NHS London and PCTs must ensure the implementation of Healthcare for London needs to reverse the inverse care law. Deprived areas need high quality health services and a level of provision that reflects the higher level of health need their populations' experience. This will require substantial shifts in resources, including funding and staffing, and investment in infrastructure.
- NHS London and PCTs must work together to improve data collection and analysis on health outcomes for equalities groups as a matter of high priority. London PCTs should explore with NHS London the possibility of using the QOF system to negotiate a London-wide incentive system to report equalities data as part of their reporting systems. PCTs and NHS London must prioritise improving routine data collection and analysis on the equalities groups.
- At a local level commissioning must be informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require PCTs to undertake local health equity audits and health inequality impact assessments.
- PCTs need to better understand groups that are not currently accessing healthcare and the extent of this unmet need by undertake local assessments. Resources and services must then be targeted to meet this unmet need.
- NHS London need to ensure that monitoring and addressing unmet need is included in the performance management of healthcare commissioners and providers.
- PCTs need to ensure that mainstream services are be designed to meet the needs of traditionally-under-represented groups by taking account of the low income, stress, social isolation, cultural sensitivities, lack of transport, poor access to exercise facilities.
- NHS London and PCTs need to ensure mainstream services are targeted at deprived areas and communities and vulnerable groups.
- NHS London and PCTs need to ensure extra funding and incentives are made available to ensure healthcare commissioners and providers do target these groups.
- NHS London must ensure that reducing health inequalities is included as an explicit objective in local plans for the implementation. NHS London needs to agree indicators for this objective. The focus of these indicators should be should be on better outcomes for client groups.

- NHS London and PCTs must ensure service infrastructure developments and reconfigurations re-provide existing inadequate and inaccessible premises, rather than incorporating them.
- NHS London and PCTs must ensure planning for accessibility by public transport must be included in an early stage of the development of polyclinics. Transport plans should be developed for each polyclinic and other major healthcare facility. Transport for London and NHS London should work together to provide PCTs with guidance on how to do this.
- When planning the reconfiguration of services Primary Care Trusts must be aware of, and have capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000 (6), Section 3 of the Disability Discrimination Act 2005 (7) and Part 4 of the Equality Act 2006 (8).
- NHS London should ensure that the local reconfiguration of services takes full and proper account of the effects of the proposals on the physical and social environment.

Specific recommendations

Recommendations relating to primary care

- NHS London should clarify the modelling with regard to the location and average distance to polyclinics. NHS London and PCTs should work together to ensure physical proximity and ease of travel by public transport is prioritised in the development of polyclinics. Consideration also needs to be given to the convenience of the location of primary care services, for example proximity to shops and/or other services. This means avoiding an ad-hoc development based solely on the location of existing healthcare infrastructure and ensuring that polyclinics are situated where there are good public transport facilities.
- NHS London and Transport for London should jointly issue guidance to Primary Care Trusts, and transport providers outlining the transport planning issues to be considered in developing polyclinics. Transport accessibility indicators should be developed. Under Local Area Agreements transport services should be planned jointly with public transport providers. Patients should be provided with information about how to get to the polyclinic, for example through personalised travel planning. Each polyclinic should develop a Green Travel Plan to minimise carbon emissions associated with patient and staff travel.
- NHS London and PCTs should work together to ensure that in implementing the proposals, investment patterns reverse the inverse care law. Areas with the highest levels of need must receive funding to meet these needs.
- NHS London and PCTs should ensure a greater investment of mainstream NHS resources in prevention services. This increased investment should be appropriately targeted to deprived areas and communities and provided at a level which reflects their need.
- NHS London and PCTs should work together to ensure ways continuity of care can be protected, for example by including this as an explicit feature of polyclinics.
- NHS London and PCTs should work together to ensure that polyclinics include collocated non-healthcare services such as advice and support on employment, housing and welfare, exercise facilities, adult education and community organisations.
- NHS London and PCTs should work together to put in place services to ensure the recruitment and retention of sufficient staff in the most deprived areas of London.
- NHS London and PCTs should work together to explore models of primary care that specifically target those who have very poor existing access such as homeless people, refugees and asylum seeks or those living in deprived areas that are underserved by existing services. These will need to include models that allow for flexibility of registration or care without registration.
- NHS London and PCTs should commit to ensuring that the polyclinic model will include the development of premises to replace existing physically inaccessible and unsuitable GP surgeries. As a first step NHS London should obtain and make public up to date

information on the accessibility and suitability of GP premises and how they are dispersed across London.

- NHS London and PCTs should work together ensure the availability of adequate and consistent language support services for people who do not speak English as a first language and Deaf and hard of hearing people and British Sign Language (BSL) users. This should include pan London co-ordination on needs-assessment, commissioning, financial management, planning, quality standards and user involvement.
- NHS London and PCTs should work together to build measures to improve the accessibility of all primary care services into the proposals. These should include services which meet the needs of people with learning disabilities and mental health problems. They should also include measures to ensure the sensitivity of services to lesbians and gay men.
- NHS London and PCTs should build in language support for people who do not speak English as a first language and Deaf and hard of hearing people and BSL users as a core part of any new telephone service.
- NHS London and PCTs should ensure that proposed new health improvement services take into account the stress, isolation and disempowerment and lack of access that prevent many vulnerable groups from benefiting from existing services.
- PCTs should commission immunisation services to cover services that were provided by GPs who have since opted out.
- NHS London and PCTs should obtain further data on which equalities groups and vulnerable groups are most affected by being unable to register with a GP. PCTs need to better understand groups that are not currently accessing healthcare and the extent of this unmet need by undertake local assessments. Resources and services must then be targeted to meet this unmet need.
- NHS London need to ensure that monitoring and addressing unmet need is included in the performance management of healthcare commissioners and providers.
- London PCTs should explore with NHS London the possibility of using the QOF system to negotiate a London-wide incentive system to report equalities data as part of their reporting systems. PCTs and NHS London must prioritise improving routine data collection and analysis on the equalities groups (see Table 1 for a list of equalities groups).
- NHS London and PCTs should work together to ensure primary care offers adequate and appropriate support to women experiencing domestic violence. This should include the implementation of recommendations in the DH Domestic Violence Resource Manual, the Mayor of London's minimum standards for all agencies (9). PCTs should also work towards the specific standards for PCTs. This will require working in partnership with other agencies and ensuring adequate funding is available for the support of women identified as experiencing domestic violence so this is not left to inadequately resourced voluntary agencies. It will also require proper training and support for staff.
- PCTs should work with primary care services need to ensure they take active steps to support carers in their caring roles but also to ensure that carers own health needs are meet.
- NHS London and PCTs should ensure that people with learning disabilities and mental health problems receive regular health checks. If necessary greater use could be made of Local Enhanced Services agreements and these checks should be incorporated into the QOF system.
- NHS London and PCTs must ensure that community practitioners have the necessary training and support to provide additional services from primary care settings.

Recommendations relating to maternity care

- In view of the poor performance of London trusts in the Healthcare Commission's recent review of maternity services, NHS London and PCTs should give urgent attention to improving maternity care across the capital. In particular, attention should be focused on how the good practice and outcomes achieved by some Trusts in London can be shared with those that were rated as least well performing.

- NHS London and PCTs should ensure pre-conception advice and support is built into the proposals.
- PCTs should ensure women from disadvantaged groups and deprived communities are targeted for early ante-natal booking. PCTs should undertake health equity audits of women booked for ante-natal care by 12 weeks and >22 weeks as recommended by the DH.
- NHS London and PCTs should ensure the development of maternity services include direct access to community midwives.
- PCTs should ensure interpretation services should be available to support the whole range of maternity services from pre-pregnancy care to post-natal care. Women should not be expected to use children, partners of other family members as interpreters.
- PCTs should ensure maternity services take account of the particular needs of women experiencing domestic violence. In particular, routine enquiry should be implemented in all maternity services, in line with the recommendations in the DH Domestic Violence Resource Manual.
- PCTs should ensure culturally sensitive and appropriate care is available to women living with FGC/M. Women from counties where this is likely to be practiced should be sensitively asked about this during pregnancy and management plans agreed during the antenatal period. Adequate training and support should be available for midwives, obstetricians and other healthcare staff to ensure they can provide this support.
- PCTs must ensure that at a local level commissioning is informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require local health equity audits.

Recommendations relating to stroke pathways

- PCTs should participate in further research to better understand the increased susceptibility of BAME to stroke, including which communities have an increased susceptibility and why, so as to better design prevention, treatment and rehabilitation to meet the needs of these communities.
- PCTs should ensure that stroke prevention services are culturally sensitive to the needs BAME groups and targeted to them in view of the higher incidence of stroke amongst these communities.
- PCTs should ensure that stroke prevention services address the factors that have historically prevented vulnerable groups and deprived communities from benefiting from health improvement measures.
- PCTs should ensure that stroke prevention services actively target vulnerable groups and deprived communities, as well as groups at a higher risk of stroke and that funds are made available to support this targeting.
- PCTs must ensure that at a local level commissioning is informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require local health equity audits.
- PCTs need to work with local authority social services and voluntary groups to ensure that measures are in place to identify and support carers.
- Moves to earlier discharge and increased home based support will require shifts in funding from the NHS to social care agencies. NHS London and PCTs need to work closely with local authority social services to ensure that home based rehabilitation is adequate resourced. It will also be important to ensure that social care is available to those discharged earlier free of charge. If adequate funding for social care is not available, health outcomes for stroke victims and their carers will suffer.

Recommendations on issues outside the scope of this work

1.21 NHS London and the London Commissioning Group need to ensure that the potential impacts on health and health inequalities of the proposals included in *Healthcare for*

London: Consulting the Capital (1) that are outside the scope of this rapid evidence review and appraisal are examined.

1.22 NHS London and the London Commissioning Group need to ensure that proposals relating to child health and development take account of the high rates of child poverty in London and address the health needs of children living in poverty (10).

1.23 NHS London and the London Commissioning Group need to undertake more detailed modelling to explore the net job loss or gains, which areas they are likely to occur in and which equalities groups may be affected.

1.24 PCTs and NHS London need to undertake local impact assessments on proposed changes to individual services or sites to assess the effects on employment and local economies.

1.25 PCTs and NHS London need to ensure that the environmental effects of reconfiguring health services are considered as part of any further impact assessments: transport and biodiversity are key areas of concern.

1.26 NHS London and Primary Care Trusts work with the NHS Sustainable Development Unit to identify how the reconfiguration will enable physical, social and environmental sustainability to be a core part of the NHS business case.

2. Structure of the rapid evidence review and appraisal

2.1 The rapid evidence review and appraisal is made up of this report and its appendices.

- In section 3 this report explains the background of the rapid evidence review and appraisal of the consultation document: *Healthcare for London: Consulting the Capital* (1).
- Section 4 gives the aim and objectives of the rapid evidence review and appraisal.
- Section 5 goes on to describe the scope and methodology of the work.
- Section 6 briefly summarises the national policy context for *Healthcare for London: Consulting the Capital* (1) and describes policy on reducing health inequalities.
- Section 7 gives an overview of health inequalities and equalities groups in London.
- Sections 8, 9 and 10 focus on primary care, maternity services and stroke pathways respectively. Each section begins by looking at the experience of equalities groups and the extent of health inequalities now in relation to the service area being examined. Next it outlines the proposals for change included in *Healthcare for London: Consulting the Capital* (1). Each section then goes on to discuss the evidence and appraise the potential impacts of the proposed changes on equalities groups and general and geographical health inequalities. Finally, recommendations are proposed to enhance possible positive impacts and mitigate negative ones.
- Section 11 discusses issues which are outside the scope of this work, but which have been identified as having potential impacts on health inequalities and equalities groups in London. Recommendations are made on how these issues can be further explored and addressed.
- Section 12 concludes the report by bringing together the key messages emerging from the rapid review of the evidence and appraisal. It also summarises the recommendations in a proposed checklist for action to maximise the positive (and minimise the adverse) impacts of the proposals on health inequalities and equalities groups.

2.2 This report should be read in conjunction with the Health Equity Profile (11) prepared by the London Health Observatory as the baseline for the Health Inequalities Impact Assessment and Equalities Impact Assessment.

3. Background

3.1 On 17th December 2007 Ben Cave Associates (BCA) was commissioned by the London Health Commission (LHC) to undertake a rapid evidence review and appraisal of the health inequalities and equalities impacts of *Healthcare for London: Consulting the Capital* (1).

3.2 The consultation document was published by NHS London and the London Commissioning Group on 30th November 2007. It presents comprehensive proposals for fundamental changes in the way health care is delivered in London. The consultation period finished on 7th March 2008.

3.3 This rapid evidence review and appraisal is part of a wider health inequalities and equalities impact assessment (HIIA/EqIA) that NHS London and the London Commissioning Group requested the LHC undertake.

3.4 The aim of the HIIA/EqIA is

... to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process, to maximise health gains, to reduce or remove negative impacts and reduce inequalities" (see scoping paper attached as appendix 1).

3.5 In addition to this work, the HIIA/EqIA includes a baseline profile of health equity and inequalities in London prepared by the London Health Observatory (LHO) (12) and a stakeholder workshop held in February 2008.

3.6 The HIIA/EqIA was directed on behalf of the LHC and the London Commissioning Group by a Steering Group of key stakeholders which included representatives of the LHC and London Equalities Commission and other key stakeholders including the GLA, LHO, NHS London, Local Authorities, London Development Centre/CSIP.

3.7 The rapid evidence review and appraisal took place between 19th December 2007 and 7th March 2008 when the final report was submitted. This final report builds on an interim report which was submitted on 15th January 2008 and the Steering Group's responses to that interim report. The draft final report was discussed at the Steering Group meeting on 8th February 2008.

4. Objectives of the Health Inequalities Impact Assessment and Equalities Impact Assessment

4.1 The aim of the integrated health inequalities and equalities impact assessment as laid out in the scoping paper is "to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process, to maximise health gains, to reduce or remove negative impacts and reduce inequalities".

4.2 The specification for the rapid evidence review and appraisal also defined the following specific objectives for the a rapid evidence review and appraisal:

- to consider evidence relating to the impact of the principles and selected models of care in the context of a baseline profile of health inequalities in London provided by the London Health Observatory (13);
- to consider the strength of the evidence;
- to pay particular attention to equalities groups;
- to take account of existing evidence used to inform the consultation document, including *Healthcare for London: A Framework for Action* (14) document which was published earlier this year and also HIAs, HIIAs and/or /EqIAs of other relevant healthcare strategies;
- to take account of the results of the public consultation to be undertaken by Mori for the London Commissioning Group, which includes specific questions relating to health inequalities and equalities;
- to take account of the proceedings and recommendations of a LHC led stakeholder workshop;
- to be set out according to the principles and proposals within the consultation document; and
- to identify gaps in current evidence.

5. Methodology

Methodology of the rapid evidence review and appraisal

5.1 The rapid review of evidence and appraisal is made up of six stages. These stages are as follows:

- First stage: project start up
- Second stage: Scoping the issues to be covered
- Third stage: Identifying and reviewing key documents and evidence
- Fourth stage: Preparation of initial report and evidence review in summary
- Fifth stage: Participation in the stakeholder workshop
- Sixth stage: Appraisal and preparation and presentation of final report

5.2 This section briefly explains each of these stages in turn. It then describes how the evidence has been identified and used. Finally, it describes the scope of the rapid review of evidence and appraisal and the definitions used.

First stage: project start up

5.3 This stage consisted of a meeting with the Steering Group on 18th December 2007 to explore the requirements and expectations of the work.

Second stage: Scoping the issues to be covered

5.4 This stage involved a detailed reading of the *Healthcare for London: Consulting the Capital* (1) and the Healthcare for London: A Framework for Action documents together with the HIIA/EqIA scoping paper in order to identify which proposals the rapid evidence review and appraisal needed to focus on. These proposals were then extracted and summarised. It also involved considering the most appropriate indicators of health inequalities for the work.

5.5 Finally, this stage involved an exploration of the scope of equalities issues to be covered by this work. As directed by the Steering Group, the equalities approach was taken from the GLA State of Equalities in London. This was supplemented by the inclusion of additional vulnerable, including people with mental health and well-being problems.

Third stage: Identifying and reviewing of key documents and evidence

5.6 This stage included reading the Health Equity Profile for London (the baseline profile) prepared by the LHO and using this information to describe the current situation in London based on indicators of health inequalities (15). It also included looking at how health inequalities affect the equalities groups and vulnerable groups and geographical manifestations of health inequalities.

5.7 Another key activity as part of this stage has been identifying and reviewing evidence relating to the proposals and how they may impact on health inequalities, the equalities groups and the other dimensions of equalities. We discuss in more detail below how the evidence has been identified and interpreted.

Fourth stage: Preparation of initial report and evidence review in summary

5.8 The interim report was distributed to Steering Group members and discussed at the Steering Group meeting on 17th January 2008.

5.9 Steering Group members were then requested to submit additional comments to the project manager. These comments were discussed with the consultants and have been incorporated into this report, where agreed by the project manager.

5.10 The Steering Group were also asked to suggest additional sources of evidence. Several were received and have been included in this work.

Fifth stage: Participation in the stakeholder workshop

5.11 BCA participated in the stakeholder workshop on the 27th February 2008.

Sixth stage: Appraisal and preparation and presentation of final report

5.12 The appraisal approach is to analyse data provided in the Health Equity Profile (the baseline provided by the LHO) (16) and evidence by asking the following questions:

- What does existing data say about health inequalities and how these inequalities affect equalities groups? What does it say about the geography of health inequalities?
- Where little or no data exists, what does the evidence base, including community intelligence, say about health inequalities and how these inequalities affect equalities groups? What does it say about the geography of health inequalities??
- What does the evidence say about the likely effectiveness of the forms of care and types of intervention proposed in reducing health inequalities?
- What does the evidence say about how the forms of care and types of intervention proposed are likely to affect the equalities groups and other vulnerable groups?
- Does the evidence indicate that the forms of care and types of intervention proposed are more effective amongst some groups than others?
- In the absence of clear evidence, what judgements can we make about the likely impacts of the forms of care and types of intervention proposed on health inequalities and equalities groups and other vulnerable groups?

5.13 Based on this analysis of the data and evidence, possible positive and negative impacts have been identified. Where possible these potential impacts have been quantified. Them recommendations are proposed for maximising positive impacts and minimising negative ones.

How the evidence has been identified

5.14 The evidence used in this rapid evidence review and appraisal has been identified in a number of ways:

- The Steering Group supplied a list of documents considered to provide important evidence.
- The evidence referred to in the *Healthcare for London: A Framework for Action* (14) document and the clinical working groups was examined.
- The existing BCA reference library of documents relating to health inequalities and health care was used.
- Searches for relevant documents were undertaken on key organisations' websites including the Department of Health, NHS London the GLA, the LHO and the LHC.
- Searches were also done for relevant articles in the British Medical Journal and other medical papers, as well as using general internet search engines including Google.
- All sources are cited in full.

5.15 We were instructed by the Steering Group to use evidence that related to London wherever possible so have prioritised this in our searches. Where no evidence for London is available we have sought evidence that relates to similar cities. Where no evidence is available, we have drawn attention to this in the text of this report and, if appropriate, made recommendations for how the gaps in the evidence can be filled.

The types of evidence used

5.16 Because of the range of documents used, a variety of different types of evidence was generated. Broadly speaking, this evidence can be divided into three different types as briefly described below.

5.17 Systematic reviews or peer reviewed research are published in academic or medical journals. A systematic review is an overview of primary research that uses explicit and reproducible methods, often including meta-analysis (17). It will have a clear protocol for identifying and excluding research. Examples include the reviews undertaken as part of the

Cochrane Collaboration. Peer reviewed research includes systematic reviews but can also include primary research. To be accepted for publication articles will generally need to be approved by at least two experts in the field.

5.18 Grey literature refers to printed or electronic material, either published or unpublished, that is issued by a range of organisations including national, regional and local government, research centres, voluntary organisations and industry, where publishing is not the primary activity of the issuing organisation. It includes newsletters, reports, working papers, strategies, white and green papers, fact sheets, conference proceedings and other publications distributed free, available by subscription, or for sale.

5.19 Community intelligence refers to qualitative information provided by individuals, groups or organisations that captures the subtleties of individuals' or groups' experiences. It is generally subjective and narrative. Community intelligence can include advocacy by user groups, written submissions to scrutiny committees, the outcomes or stakeholder workshops and the outcomes of public consultation.

How the evidence has been assessed

5.20 Each different type of evidence has its advantages. Systematic reviews or peer reviewed research is often considered the "gold standard" of evidence because of its perceived objectivity and robustness. The diversity and extent of grey literature encapsulates a wealth of activity and expertise in the field of health inequalities. The benefit of community intelligence is that it can portray the views of normally unheard groups and describe the complexity of individual experience. The Steering Group proposed evidence falling into each if these three groups for analysis in this review and appraisal.

5.21 However, it is important to stress that not all evidence is comparable or of the same quality. We have sought to assess the evidence used by asking the following questions:

- Where does this evidence come from?
- What type of evidence is it (peer reviewed research, grey literature, community intelligence, etc)?
- Is it contested?
- Where are the gaps in the evidence?
- How can these gaps be filled?

5.22 Answers to these questions are included in the discussion of the evidence.

Scope

5.23 The scope of this work was to identify and review evidence that builds understanding of how the proposals contained in *Healthcare for London: Consulting the Capital* (1) may impact on health inequalities and equalities groups in London. This includes using the evidence, in conjunction with data provided by the Health Equity Profile, to identify possible effects on health inequalities and equalities groups and making recommendations to maximise potential positive impacts and minimise potential negative ones.

5.24 It was not within the scope of this work to critique the clinical evidence base used in *Healthcare for London: Consulting the Capital* (1) and its supporting documents. Nor is it within the scope of this work to critically re-evaluate the analytical framework that describes current and future health care activity and costings (18).

5.25 This scope of this work was to undertake a rapid review of the evidence and appraisal as part of a HIIA/EqIA. The work has not included undertaking a systematic review. A systematic review would not be possible given the high level and outcome based nature of the proposals as systematic reviews address very precisely defined questions. In addition, a systematic review would exclude some of the community intelligence the Steering Group proposed as evidence.

5.26 Public organizations have statutory responsibilities to assess and consult on the likely impact of proposed policies on equalities groups. These responsibilities arise from section 71 of the Race Relations (Amendment) Act 2000 (6), Section 3 of the Disability Discrimination Act 2005 (7) and Part 4 of the Equality Act 2006 (8).

5.27 The rapid evidence review and appraisal has been undertaken in line with GLA (2;3) and Commission for Race Equality (4) best practice. This will assist NHS London to fulfil its statutory duties and it will contribute to the examination of whether NHS London have given proper consideration to the likely impact on equalities groups.

5.28 Equalities groups have been considered consistently throughout the rapid evidence review and appraisal. In addition to the likely impacts of the proposals on race, disability and gender equality, as statutorily required, the rapid evidence review and appraisal also assesses the likely impact on age, faith and sexual orientation equality. The overall approach has been ratified by the London Equalities Commission.

5.29 However, because of the high level nature of proposals at this stage, the rapid evidence review and appraisal has not looked at the impact on equalities groups of specific service reconfigurations or of the implementation of proposals at a local level. HIIA/EqIA should be considered as an on-going process throughout the development and implementation of the proposals.

Scope of the proposals covered

5.30 In view of the comprehensiveness and wide ranging nature of the proposals included in *Consulting the Capital* (1), the Steering Group undertook a scoping exercise to look at which areas the HIIA/EqIA should focus on. The scoping paper is attached as Appendix 1. It proposed the scope of the HIIA/EqIA be limited to the following eight areas:

1. examining the proposed models of primary care delivery and their potential impact on health inequalities and, in particular, on the equalities target groups;
2. understanding the impacts of polyclinics, especially with regards to primary care and wider health-related services;
3. understanding the impacts of the proposed changes to maternity care, bearing in mind the very emotive nature of this area of care,
4. considering the impact on health inequalities and equalities groups of a new model of care; taking examples from parts of the stroke pathway, assessing the impacts from prevention, through primary care, to discharge back to community-based care;
5. focusing on the impacts of these 3 proposed changes on the equalities target groups;
6. focusing on the impacts of the proposed changes to primary care and maternity services on people with mental health and well-being problems;
7. focusing on those areas of London which are most deprived and have the greatest inequalities; and
8. considering the likely impacts of these changes over the next 10 years.

5.31 The report addresses each of these eight areas while attempting to minimise repetition, capture linkages and remain user friendly. To this end we have grouped points 1 to 4 of the areas of focus specified in the scoping report into three separate sections in this report as follows:

- Primary care (points 1 and 2);
- Maternity care (point 3);
- Stroke pathway (point 4).

5.32 The report deals with points 5 to 8 of the areas of focus specified in the scoping report as cross cutting themes in the above three sections.

5.33 The summary of proposals being considered is based on the *Healthcare for London: Consulting the Capital* (1) document. In some cases this is supplemented with information taken from the *Healthcare for London: A Framework for Action* (14) document which provides a more comprehensive description of the proposals.

5.34 Proposals relating to primary care are found throughout each sub-chapter of "How we could provide care: the journey through life" chapter of *Consulting the Capital* (1) and the "Improved care from cradle to grave" chapter of *A Framework for Action* (14). They are also contained in the chapter "Where we could provide care" of *Consulting the Capital* (1)

document and the "Future models of healthcare provision" chapter of *A Framework for Action* (14). The summary of proposals on primary care has been taken from each of these sub-chapters and chapters.

5.35 For the maternity care and stroke pathway sections the summary of proposals are taken respectively from the maternity and newborn care and acute care sub-chapters of "How we could provide care: the journey through life" chapter of *Consulting the Capital* (1) and the "Improved care from cradle to grave" chapter of *A Framework for Action* (14).

5.36 In addition to the specific proposals on primary care, maternity care and stroke pathway, the rapid evidence and review also considered the impact of the five principles laid out in *Healthcare for London: A Framework for Action* (14). These principles are:

- Services should be focused on individual needs and choices;
- Services should be localised where possible, or regionalised where that improves the quality of care;
- There should be joined-up care and partnership working, maximising the contribution of the entire workforce;
- Prevention is better than cure;
- There must be a focus on reducing differences in health and healthcare across London.

5.37 This rapid evidence review and appraisal is limited to the eight areas defined by the scoping exercise. However, where issues that have the potential to impact on health inequalities and equalities have been identified outside these eight areas, they have been briefly discussed in the final section of this report "Issues outside the scope of this work". Where appropriate, we have also included recommendations to the Steering Group as to how these issues could be addressed.

Scope of equalities covered

5.38 For the rapid evidence review and appraisal we have used the definition of equalities used by the Greater London Authority (GLA), as directed by the Steering Group. This definition is based on equalities groups. An equality group is defined as "a group of people who share a common characteristic that has led to historical discrimination and disadvantage. This trait can be something they were born with, have developed through their life or have chosen to adopt" (19).

5.39 There are six equality themes - age, disability, faith, gender, race and sexual orientation. Each of these themes contains one or more equality groups as described below.

Table 1: Equality groups

Equality Theme	Equality Group
Age	Children (0 - 12 years) Young people (13 - 17 years) Young adults (18 - 24 years) Older people (60+ years)
Disability	Disabled people
Faith	People of faith
Gender	Women
Gender identity	Trans people
Race	Ethnic minority people - Asian people - Black people - Chinese people - People of dual or multiple ethnic heritage - White ethnic minorities - Other ethnic minority groups
Sexual orientation	Lesbian women Gay men Bisexual people

5.40 In this report we have discussed evidence and impacts as they relate to equality groups. In the accompanying summary tables we have based our discussion on equality themes to keep the tables to a manageable size, highlighting particular issues for specific equalities groups where relevant. The one exception is age. As older people, children, young people and young adults generally have very different experiences of health we have separated out these equalities groups in the summary tables.

5.41 In addition to the equalities groups defined by the GLA, we have introduced discussion of several other dimensions of equality and inequality in this report and the summary tables.

- Firstly, we give an overview of health inequalities in London and discuss evidence and impact at this level. This is because focusing exclusively on health inequalities as experienced by equalities groups may fail to capture the experience of London as a whole, for example as it compares to other cities. In addition, some of the relevant evidence relates to health inequalities in general but does not focus on the experience of different equalities groups.
- Secondly, we have looked at the geographical manifestations of health inequalities and the experience of people that live in deprived areas because of its inclusion as an area of focus in the scoping paper.
- Thirdly, we have introduced discussion of health inequalities experienced by vulnerable groups where this has not already been captured under the equalities groups. The descriptions of vulnerable groups we have used is that of the interim health inequalities appraisal of *Framework for Acton* (14) which is, in turn, modified from the *Rapid Appraisal Tool for Health Impact Assessment* (20).
- Finally, we have paid particular attention to people with mental health and well-being problems.

Scope of health inequalities covered

5.42 The potential scope of exploration and analysis of health inequalities is huge. The GLA Act (21) defines health inequalities as

> *... inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants.*

5.43 Given the range of causes and consequences of health inequalities, there are many possible indicators. These could include indicators of health including life expectancy, morbidity and self assessed health. Indicators could also include health outcome measures, the way health changes in response to an intervention, such as recovery rates, mortality and disease prevention. They could include indicators related to health services such as physical

access, waiting times, service uptake, satisfaction with services and expenditure on services. Lifestyle factors that cause risk to health could also be used, such as smoking and obesity prevalence.

5.44 Any discussion of health inequalities must also acknowledge the important role of the social determinants of health in shaping individual health and well-being. These social determinants include employment, education, housing, transport, community safety and wider community and social influences (22). The Health Equity Profile describes inequalities in the social determinants of health and the experience of equalities groups (2).

5.45 We have sought to select key indicators that are most relevant to this work. As this review is concerned with proposals relating to health services the main focus of this report is necessarily healthcare, itself one of the determinants of health. We have focused discussion of the health experiences of the equalities groups and health inequalities around into health status and outcomes, which includes indicators such as life-expectancy, infant mortality and morbidity, and access and patient experience.

5.46 Access here has been used to cover

- waiting times;
- physical access;
- accessibility for people with physical and sensory disabilities;
- accessibility for speakers of other languages ;and
- travel time.

5.47 Patient experience covers patient satisfaction, cultural sensitivity and reported appropriateness of services. We have also included the social determinants of health in discussion of evidence and impact where the proposals being examined relate to them.

6. Policy context

The healthcare policy context

6.1 The Healthcare for London review and proposals need to be seen in the context of national government policy on health care.

6.2 *Creating a patient-led NHS: delivering the NHS improvement plan* sums up how NHS services will be expected to adapt and improve to provide truly "patient-led" services (23):

"A patient-led service will require new ways of delivering services that are responsive to patients: fast, convenient services, often delivered very locally and shaped around people's needs and preferences and high quality, integrated emergency, urgent and specialist services for patients wherever they are in the country".

6.3 National Government policy such as the Local Government White Paper *Strong and Prosperous Communities* (24) emphasises the need for public services to be more relevant to local people and more responsive to local needs.

6.4 The White Paper *Our health, our care, our say: a new direction for community services* (25), sets out policy to shift focus towards improved prevention and health promotion activities, and to make major shifts in specialist ambulatory care (both outpatient consultations and diagnostics) out of acute hospitals and into community settings. To achieve these aims, it envisages an explicit and progressive shift of resources from acute hospitals to the community (5% of acute resources over a ten year period). The White Paper states:

This means a shift in the centre of gravity of spending. We want our hospitals to excel at the services only they can provide, while more services and support are brought closer to where people need it most.

6.5 Several elements of the reform programme seek to provide powerful incentives to promote competition between hospitals and other acute providers. These are the promotion of patient choice, the switch to tariff- based payment by results, plurality of provision and the promotion of market entry by new NHS and independent sector providers, and practice based commissioning. These reforms offer substantial opportunities and challenges for the NHS in England (26).

6.6 Choice is a further element of NHS policy, though more controversial in terms of evidence of impact on health and indeed the nature of the choice that the public wishes; none the less it is still an important policy driver.

The health inequalities policy context

6.7 In addition to the policy context on health care, the last few years have seen the introduction of several important government services to reduce health inequalities.

6.8 In 2007, the Department of Health reaffirmed the existing health inequalities National Target to "reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth".

6.9 This target is underpinned by two more detailed objectives:

- starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual group and the population as a whole;
- starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole.

6.10 *Tackling Health Inequalities, A Programme for Action* (27) and *What works?* (28) set out action that local NHS commissioners and providers should take to improve the health of the poorest fastest. These policy documents also emphasized the importance of NHS bodies working in partnership with local authorities and others in Local Strategic Partnerships.

6.11 In 2004 the Government introduced the Spearhead Group initiative as part of a Public Service Agreement target to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. The Spearhead Group is made up of 70 Local Authority areas that are in the bottom fifth nationally for 3 or more of the following 5 factors:

- male life expectancy at birth;
- female life expectancy at birth;
- cancer mortality rate in under 75s;
- cardiovascular disease mortality rate in under 75s; and
- Index of Multiple Deprivation 2004 (Local Authority Summary), average score.

6.12 Areas designated Spearhead areas are expected to achieve faster progress compared to the average in meeting the government health inequality targets.

6.13 In 2007, the Secretary of State for Health announced that the Department of Health will publish a comprehensive strategy for reducing health inequalities in 2008 addressing:

- unjustified gaps in health status
- fair access to NHS services for everyone
- good outcomes of care for all.

6.14 In addition to the national policy context, the Greater London Authority Act (21) gave the Mayor of London the responsibility to develop a Health Inequalities Strategy for London. The Act states that

... the Strategy shall contain the Mayor's proposals and policies for promoting the reduction of health inequalities between persons living in Greater London.'

6.15 The focus of the Strategy, which is currently at Assembly draft stage is tackling health inequalities by reducing inequalities in the determinants of health (29). It will apply across all GLA policy areas. It includes actions relating to access to services which are of direct relevance to a *Framework for Acton* (14).

7. Equalities groups and health inequalities in London

7.1 The estimated total population of London is 7.52 million. This is by far the largest population of any city in the UK – more than seven times bigger than Birmingham and more than 10 times bigger than Glasgow (29).

7.2 London has many immigrants, some of whom stay for a short time. It has high numbers of refugees and asylum seekers. It also has a mobile population, with people often moving in when they are younger and looking for work and moving out when they have families. In some parts of London there is a turnover of 20 to 40 per cent of patients a year on GP lists.

7.3 In addition to the mobile resident population, London also receives one million commuters every day and around 30 million tourists every year.

Equalities groups

7.4 The relationship between equality groups and health inequalities is complex and overlapping. Some of the equality groups experience health inequalities because of low socio-economic status, some because of a genetic pre-disposition, some because of life-experience and some because they occupy a marginal position in society. Many of these categories are not mutually exclusive.

Age

7.5 London is home to nearly 1.63 million children and young people under the age of 18, accounting for almost 22 per cent of London's total population (30).

7.6 Almost 16 per cent of London's population - 1.165 million people – are aged 60 or over.

7.7 Compared to England and Wales, the London population has a relatively young age structure, with 62% of residents being 40 years old or younger (53% for England and Wales), and only 8.5% of Londoners being over 70 (compared to 11.6% for England and Wales).

Disability

7.8 Around 578,000, or 19 per cent, of households in London contain at least one person with a limiting long-term illness, health problem or disability, which limits their daily activities or the work they can do (19).

Faith

7.9 Over 140 faiths are practiced in the capital. Nearly 60 per cent of Londoners are Christian, 8.5 per cent Muslim, 4.1 per cent Hindu, 2 per cent Jewish and 1.5 per cent Sikh. London has the largest Jewish community in England and Wales with 58 per cent of all Jews residing in the capital. Only sixteen per cent of Londoners say they do not have a religion (19).

Gender

7.10 In London 50.5 per cent of the population are women or girls.

Gender identity

7.11 There are no figures for London's trans community (19). Whittle *et al* (31) report considerable work on estimating the number of transgender and transsexual people within the UK population. They conclude that there is simply no publicly available statistical data on which to make firm estimates (31). There is no substantive knowledge of how many people in the UK identify as transgender or transvestite, or use any other gender identity descriptor, but estimates vary considerably: Whittle *et al* conducted a quick internet search and suggest the figures may range from about 1 in 100 to as many as 1 in 20 in the male population (31). A Department of Health publication describes gender dysphoria as a

relatively rare condition for which it is difficult to predict the annual number of new cases at a local level (32).

Sexual orientation

7.12 Six per cent of the population are likely to be lesbian, gay or bisexual. This is thought to be an underestimate. In addition, it has been found that gay couples were more likely to live in the London than the rest of the country. Consequently 10 per cent is considered to be a more accurate estimate (19).

Race

7.13 London is the most ethnically diverse region of the UK. Roughly one third of Londoners has their origin in a BAME community and more than 300 languages are spoken. The table below shows the most recent projections of London's ethnic populations. The figures are based on the Office for National Statistics (ONS) mid-year population estimates and calculated by the Greater London Authority Data Management and Analysis Group (DMAG), taking into account particular knowledge about borough-level migration trends in London.

7.14 The "White other" ethnic category is becoming an increasingly important group, with migration from the European Union A8 countries having a significant impact on London (A8, or Accession 8 countries are Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia).

7.15 There are no city wide statistics about the number of refugees and asylum seekers and immigration status is not recorded on any official data set apart from Home Office records of the flow of people through their initial stage of admission to the UK. However, the GLA has made a "guesstimate" of the number of refugees and asylum seekers in London, including their dependents, of 0.5 million people (33).

Table 2: Ethnic population projections for London 2006 (RLP High)

	Total number	Proportion (%)
White	5,108,100	67.46
Black Caribbean	363,400	4.80
Black African	456,800	6.03
Black other	194,200	2.56
Indian	501,000	6.62
Pakistani	172,100	2.27
Bangladeshi	179,200	2.37
Other Asian	233,700	3.09
Chinese	101,300	1.34
Other	262,200	3.46
All BAME	2,463,900	32.54

Source: GLA data management and analysis group (DMAG). © Greater London Authority

Geographical health inequalities

7.16 11 of the 70 national Spearhead areas are in London. They are Barking and Dagenham, Greenwich, Hackney, Hammersmith and Fulham, Haringey, Islington, Lambeth, Newham, Southwark and Tower Hamlets.

7.17 Women and men have different life expectancies on average, with women generally expected to outlive men. Life expectancy at birth varies markedly between London boroughs. For the period 2003- 2005 residents of Kensington and Chelsea have the longest life expectancy at 82.2 years for men and 86.2 years for women. Islington has the lowest male life expectancy, 74.6 years, while Newham has the lowest female life expectancy, 78.8 years.

7.18 Further information on the equalities groups and health inequalities in London can be found in the Health Equity Profile prepared by the LHO (5).

8. Primary care

Where are we now: an overview of the experience of equalities groups and health inequalities relating to primary care

The experience of equalities groups

Access to health care and patient experience

8.1 Members of equality and vulnerable groups face difficulty in accessing appropriate healthcare and information about healthcare. These groups include people with mental health and well-being problems, people with disabilities, including those with learning disabilities, refugees and asylum seekers, homeless people and Lesbian, Gay and Transsexual people.

8.2 A St Mungo report found that fewer than 1 in 3 homeless people who need treatment are receiving it . Shelter estimates that nationally 28% of homeless people are not registered with a GP, whilst the level of non-registration for the rest of the population is 3% (quoted in source 34).

8.3 The scrutiny of primary care in London carried out by the London Assembly and the Mayor in 2003 concluded that closed GP lists were a major barrier to primary care for some of the most vulnerable in the capital, particularly highly mobile populations such as the homeless, refugees and asylum seekers, travellers and young people (34). The scrutiny also reported evidence from a range of community organisations who perceived GPs to be selective about who they will register and liable to remove individual patients from their lists, without having to explain their reasons for doing so, making it even more difficult for people with complex needs to find and keep a GP (34).

8.4 Although up to date information on the physical accessibility and suitability of GP premises in London has not been identified, the most recently produced data indicates the majority of GP premises in London are neither accessible nor suitable. The GP census for 2001 showed that in London 471 (70%) of GP premises were below the Department of Health minimum standard which included having a proper treatment room, disabled access, heating, lighting and safe storage for records etc. Some PCTs reported to the scrutiny of primary care in London carried out by the London Assembly and the Mayor in 2003 that over 50% of surgeries failed to meet the minimum standard for accessibility in the Disability Discrimination Act 1995. As many premises are converted residential houses they are difficult to adapt to enable the provision of a wider range of primary care services (34).

8.5 Access to language support for patients who speak other languages was found to be inadequate (34). Although interpreting services are provided by local suppliers of Language Line, or a combination, they are not always available and where they are available they are of varying quality. In addition, while interpreting may be available for appointments with GPs, it is rarely available for appointments with other primary care staff (34). Staff are reported to often be unwilling to organise interpreters and to place the responsibility to get an interpreter on the service user (35).

8.6 It is estimated that one in four women experience domestic violence (36). The cost of domestic violence to the London Region of the NHS is £195.31 million a year. This includes costs to GPs and hospitals (37).

8.7 There are over 606,000 carers in London. Their contribution has been estimated at an annual value of £8bn to the London economy in terms of saved social and healthcare costs (38). Carers are also a vulnerable group who have been shown to experience barriers in accessing health services (38). These include:

- lack of recognition of the caring role and awareness of the needs and issues involved;
- professional uncertainty about roles and boundaries;

- reactive rather than proactive approaches; prioritizing the care recipient at the expense of the carer;
- professional models, conceptualisations or stereotypes of carers that may not be conducive to meeting their needs;
- GP surgeries not identifying carers and/or 'tagging' carers' records; lack of training in carers' issues;
- 'gatekeeping'; inflexible appointment systems; waiting times; transport and car parking; costs.

8.8 The health care system of the UK is key to many trans people managing to fulfil their lives. Clearly for some the expertise, help and care they receive is very positive (31). The right to treatment for transsexualism was established in England in a North West Lancashire Health Authority court case. PCTs decide on the priority for funding (32).

8.9 A review found that around 21% of trans people start the process by seeking help from a knowledgeable GP to begin the process of obtaining Gender Reassignment Surgery (GRS), or other relevant services (31). However the researchers also found, that another 21% of respondents' GPs either did not want to help, or in 6% of cases actually refused to help. This is described as an improvement of 50% compared with the experience of services over 15 years ago, but it still represents a considerable barrier. In the more general health care sector 17% of respondents had experience with a doctor or nurse who did not approve of gender reassignment, and hence refused services. Some 29% of respondents felt that being trans adversely affected the way they were treated by health care professionals. Trans people continue to face problems receiving funding for treatments from PCTs and waiting times for assessment or treatment have not improved over the last 15 years (31).

Health status and outcomes

8.10 A 2006 study by St Mungo's found that the death rate among rough sleepers in London aged between 45 and 62 was 25 times that of the general population of this age group (39).

8.11 One million Londoners are estimated to have had mental health problems (40). In terms of more severe mental illness, over 26,500 London residents were admitted to hospital for psychiatric treatment in 2003/04. This was significantly higher than the national average. London also has a considerably higher percentage of inpatients with psychotic disorders, at 23 per cent compared to a national average of 14 per cent. Suicide is the most common cause of death for men under 35 years old, and London is not on track to meet its National Suicide Prevention Strategy target of a twenty per cent reduction in suicide rates by 2010 (41).

8.12 People with mental health problems are more likely than the general population to suffer from health risks and problems including obesity, smoking, heart disease, hypertension, respiratory disease, diabetes and stroke. People with serious mental health problems are also more likely than others to get illnesses like strokes and coronary heart disease before 55. Once they have them they are less likely to survive for five years. Recent research has also shown that people with schizophrenia are twice as likely to experience bowel cancer as the general population (42).

8.13 People with learning disabilities earning disabilities are much more likely than other people to have significant health risks and major health problems including obesity and respiratory disease. They are more likely to die younger than other people (42). Mencap has estimated that only 3% of women with learning disabilities get a smear test, compared to 85% amongst women who do not have learning disabilities (34).

8.14 Some lesbian women, gay men and bisexual people (LGB) experience problems accessing appropriate healthcare. Treatment may fail to meet their needs because of homophobic and heterosexist assumptions and practice. In addition LGB are more likely to suffer from a particular health conditions. A report by Mind shows that gay men and lesbians reported more psychological distress than heterosexuals, despite similar levels of social support and quality of physical health as heterosexual men and women. Levels of substance use disorders were higher among gay men and lesbians, who reported that they were more likely than their heterosexual counterparts to have used recreational drugs. Lesbians were

more likely than heterosexual women to drink alcohol excessively. Domestic violence, eating disorders and cancers also all affect lesbians and gay men disproportionately (43).

General or geographic health inequalities

Access to health care and patient experience

8.15 The number of GPs per 100,000 population is measure of relative access to primary care and is a national headline inequalities indicator. An inverse relationship exists between GP distribution and health need in London, another example of the inverse care law (44). It has long been recognised that the most deprived boroughs are relatively underserved by GPs, while the populations of these areas have the greatest health needs. A borough is considered underserved by GPs if it has less than the national England average for its population. This is fewer than 57.44 GPs per 100,000 weighted population. In calculating this indicator populations are weighted according to an age-standardised, limiting long-term illness ratio and deprivation, to reflect need for GP consultations.

8.16 The map below shows the provision of full time equivalent GPs per 1000 age-need weighted population in 2004. The proportion of GPs per 1000 population (weighted for age and need) is significantly lower in the more deprived areas of north and east London.

Figure 1: Provision of full time equivalent GPs per 1,000 age-need weighted population in 2004

Source NHS London (14)

8.17 The London Health Observatory (45) state that London boroughs that are currently underserved by GPs include:

- Redbridge – 51.32 GPs per 100,000 population
- Havering – 51.21
- Waltham Forest – 56.66
- Greenwich – 52.87
- Bexley – 56.03
- Barking and Dagenham – 44.9.

8.18 In 2006 there were 1,579 general practices across London, 479, or 30%, of them were single-handed (46).

8.19 Another primary care access indicator to consider is 48 hour GP access. This is the percentage of the patients who can see a GP within 48 hours – a government access target. It is reported that 81% of people are able to get GP appointments within 48 hours across London and the majority of PCTs achieve above 70%, with the exception of Tower Hamlets (46).

8.20 Comparing the GP-registered population in a PCT with its respective borough population estimate provides an indication of the extent to which some populations do not have access to GP services. Enfield PCT, Harrow PCT, Lewisham PCT, Redbridge PCT, Sutton and Merton PCT, Southwark PCT and Tower Hamlets PCT have a significant number of residents (over 10,000) not registered for GP services (46).

8.21 Geographical variations in provision of services are accompanied by variations in the quality of care, in a further manifestation of the inverse care law. The Quality and Outcomes Framework (QOF) measures the performance of GP practices using a number of measures. Generally speaking, higher QOF scores suggest a higher quality of care. For coronary heart disease, the PCTs with the highest average QOF scores amongst their practices are those in the south and west of London (Quality, Prevalence and Indicator Database held by the Prescribing Support Unit in the Health and Social Care Information Centre, as quoted in source 14). This means a patient with coronary heart disease in Richmond is likely to get better care than a patient in Newham.

8.22 Another measure of primary care quality is potentially avoidable emergency hospital admissions. Emergency admissions for asthma and diabetes are potentially avoidable, if people receive high quality care in the primary care setting. Management of these conditions is representative of all chronic care management, so this indicator is a reflection of primary care quality generally. These vary from just over 100 per 100,000 population in Kensington and Chelsea to around 300 per 100,000 population in Ealing (46).

Health status and outcomes

8.23 Germany and the Netherlands spend more than three times as much per capita on prevention and health promotion as the UK spends, devoting a far higher proportion of their healthcare budget to the prevention of ill-health (OECD figures taken from (25, p.141)).

8.24 There is also an inverse relationship between spending on preventative care by PCTs and the needs of their populations: the PCTs serving the most deprived populations in London spend the least on preventative care (PCT Programme Budget Spend 2005/06, NCHOD indicators (14, p.51)). This is one example of the inverse care law whereby, fewer resources are available for population in areas with the highest level of need.

8.25 London's immunisation rates are far behind other world cities such as New York and Paris. Just 52 percent of the capital's children are fully immunised against measles, mumps and rubella, compared to 74 percent nationally (47). In 2006 there were 640 confirmed cases of mumps, 271 confirmed cases of measles and 16 confirmed cases of rubella in the capital.

8.26 London has 57% of England's cases of HIV and the highest rates in the country for new diagnosis of chlamydia, gonorrhoea and syphilis (48).

What does Healthcare for London propose: a summary of the proposals relating to primary care

8.27 Proposals for health improvement and prevention:

- More money needs to be spent on preventing ill-health, particularly in the most deprived areas of London. This could be done by shifting the balance of expenditure from hospitals to prevention and analysing where funding is proving most effective in preventing ill-health and concentrating our efforts in these areas.
- Health improvement should be part of the course for all students training to become health professionals and it should be an important part of professional development.

- Health improvement services also need to reach people who are not ill so they should be delivered by more people: for instance, pharmacists, dentists, opticians, community development workers, health trainers, environmental health officers, occupational health, teachers, school nurses, or health visitors; working in more places – for instance in schools, leisure facilities, the workplace or prisons.
- Tackle the rising rates of sexually transmitted infections by:
  - encouraging more people to use contraception and condoms;
  - improving information about healthy living and the services available;
  - improving access to services (for instance, longer opening hours);
  - improving the services themselves.

8.28 Proposals relating to health protection:

- London health organisations and their partners need to continue focusing on health protection – for instance, improving immunisation and vaccination programmes and planning for pandemic flu and terrorist attacks.
- High priority for ensuring all children are immunised.

8.29 A proposed new telephone service to call for urgent care advice, in addition to the existing 999 number. Proposals for the new service include:

- provide advice: professionally trained healthcare advisers would have access to up-to-date information and advice, tailored to an address;
- book appointments with GPs or other healthcare professionals;
- transfer you to a polyclinic, so you could speak to a healthcare professional such as a GP or community nurse;
- give directions to a polyclinic close to your home or workplace, a nearby pharmacy, or a hospital;
- transfer you to emergency services.

8.30 Proposals to increase choice for urgent care. While GPs will continue to provide most face-to-face urgent care through the appointments system, for more pressing needs people should have the choice of:

- Attending a same-site polyclinic or the hub of a network polyclinic in the community. Polyclinics would be open for extended hours and could house GPs, nurses, emergency care practitioners, mental health crisis-resolution teams, and social care workers.
- Attending a polyclinic attached to an A&E. These would be led by GPs and other healthcare professionals experienced in working in the community. They would have similar facilities to a community-based centre and be open all day, every day.

8.31 Proposals to increase access to GPs for routine appointments should be improved by extending surgery hours before 9am, in the evenings and at weekends.

8.32 Proposals to increase local care and reduce trips to hospital including:

- Routine diagnostics and outpatients should be shifted out of large hospitals.
- Increased use should be made of the day case setting for many procedures.
- Rehabilitation should be done at home wherever possible.
- GPs should have access to test facilities in the community to reduce waiting times and save patients unnecessary trips to hospitals.

8.33 Proposals to improve health care for people with long term conditions (LTCs) including:

- GPs, practice nurses and social care staff should be supported to develop effective ways of diagnosis and of finding undiagnosed people who do not present themselves to the healthcare system.
- LTCs should be prevented where possible by outreach and tailored advice to the most deprived.
- People with LTCs should be at the centre of a web of care.
- There should be more pro-active community care to reduce emergency admissions and lengths of stay.

- Integration of services should be improved.
- Community pharmacies can support people with long-term conditions too, by helping them with their medication.

8.34 A key mechanism for the delivery of these changes is the proposal to establish polyclinics, a new kind of community based care at a level that is between the current GP practice and traditional hospitals. The key features of polyclinics are described as:

- Offering a much wider range of high-quality services, over extended hours, to the community – reducing the need for patients to visit hospitals and other services.
- Moving a wide range of services out of hospitals and into the community (some of these services could be provided by hospital staff working in polyclinics);
- Providing a one-stop shop to access GP services, clinical specialists, community services, urgent care, healthy living classes, and other health professionals;
- Extended hours. Polyclinics based at hospitals would be open 24 hours a day; those in the community would meet the needs of their neighbourhood.

8.35 Three possible polyclinic models are proposed:

- A networked polyclinic: Existing GP practices would link to a local 'hub' for specialist clinics and services such as blood tests, scanning and plaster facilities. The 'hub' could be developed from an existing GP practice or other provider or a new building
- Same site polyclinics: GP practices could come together under one roof, sharing many services but being run as different practices, perhaps linking with some other practices GPs could merge into one large practice, again linking with other practices which are not on the same site.
- Hospital polyclinics: Based at the `front door' of local hospitals. These would be led by GPs and other healthcare professionals experienced in working in the community and they would provide the local population with the same range of services and staff as other polyclinics but be open 24/7. Every hospital A&E would have a polyclinic as its 'front entrance' so that patients who did not need to go to A&E or be admitted to a bed could receive care there.

8.36 The proposals include a recommendation for the development of ten pilot polyclinics, but in ten years time there could be 150 across London.

Discussion of the evidence and appraisal of potential impacts

The experience of equalities groups

Data constraints

8.37 The existing data on access to primary care and patient outcomes as a result of primary care interventions is inadequate as most routinely collected data is not broken down into equality groups. As such, consideration will need to be given as to how to baseline and subsequently monitor the impacts of any changes made.

Access to primary care services

8.38 There is little information currently available about which groups are not accessing or not able to access primary care. The Quality Outcomes Framework, the performance management system for primary care, looks at registered patients and their outcomes. More information is needed on unmet need in order for services to be redesigned to meet those needs. Without such a redesign, there is a danger that the most traditionally-under-represented and excluded groups will not benefit from any of the proposed improvements in primary care. This threatens to increase health inequalities between the majority of the population who are inside the primary healthcare system and the minority who are outside it.

8.39 Personal Medical Services (PMS) pilots were introduced by the 1997 NHS Primary Care Act (49). PMS are based on contracts negotiated with the PCT, in contrast to the nationally determined GP contract. Evidence based on a review of the first wave PMS pilots in London indicated that they were successful at increasing access to primary care. They were seen to

be especially effective in areas where access had been identified as a problem or where particular populations (eg homeless people or refugees) were perceived to be underserved by general medical services (GMS contracts) (50).

8.40 An argument put forward for the introduction of polyclinics is the need to extend opening hours for primary care. NHS Walk In Centres (WICs) first explored this approach. By September 2001, 39 WICs had been established nationally, nine of those in London. Research has shown than WICs do appear to improve access for young and middle-aged men, who generally access primary care less than other population groups. However, although WICs are filling a service gap (in that they are seeing patients who would not necessarily consult other primary care services) they appeared to attract the more affluent of our population and would therefore be unlikely to contribute to reducing inequalities in access, particularly if they employ staff who might otherwise work in conventional primary care settings in under-served areas (34).

8.41 However, it is important to acknowledge this research relates to WICs, rather than an extended hours approach to primary care as a whole. WICs are staffed by nurses supported by protocols for care and medical advice and do not have doctors or a wider range of diagnostic, prevention and long term condition management services on site.

8.42 Premises that are physically inaccessible for disabled people are clearly not acceptable. In addition, premises that fail to offer the necessary degree of space for confidentiality will be put off many patients but are likely to be particularly excluding to many equalities groups including women, people from BAME groups and lesbians and gay men. The proposals are clear that premises suitability is a driver for the development of polyclinics. However, under the hub model it is possible that existing inaccessible and unsuitable premises could be incorporated into a polyclinic. This will continue to exclude certain equalities groups from those services.

8.43 In addition to physical access, there are other problems of access which affect the accessibility of primary care services to certain equalities and vulnerable groups. These include language support, accessibility for those with sensory impairment, an understanding of the health needs of people with mental health problems and those with learning disabilities.

8.44 The proposals involve providing more services at the level of primary care than at present. Unless improvements are made in understanding and meeting the needs of these groups, they will be unable to access and benefit from these services which could exacerbate existing health inequalities.

8.45 It is not currently possible to draw quantifiable conclusions as to the impact that extending the hours that primary care services will have either on health inequalities or equalities groups. However, it will be important to ensure that equalities groups and other vulnerable groups, including those who do not currently have adequate access to services, benefit from the additional hours in addition to more affluent groups who would have used the services anyway.

Virtual / telephone services

8.46 Evidence suggests that NHS Direct (NHSD), the nurse led confidential telephone advice and on-line service indicates that it does increase access to health care advice for some population groups. In particular, NHSD appears to be an important service for parents of young children and for those who cannot easily leave their homes. However, it is not clear whether NHSD is providing a necessary service and whether it is successfully reaching already marginalized communities. NHSD callers appear to be the same people who already make use of pre-existing health services. NHSD appears to be under-used by older people, possibly reflecting a lack of awareness of the service, perceived incompatibility of the service with health needs or sensory difficulties. Richmond Community Health Council reported that an Age Concern Study conducted in their area showed that out of thirty-nine older people twenty-two had not heard of NHSD, and after an explanation of how it worked, fifteen people said they would still not use it (34).

8.47 Research undertaken for the scrutiny of primary care in London carried out by the London Assembly and the Mayor in 2003 indicated that there are inequalities of access to NHSD for

people whose English is limited and for those with sight, hearing or learning disabilities. Other research has found that the majority of a sample of people from Black and ethnic minority groups did not find NHSD sensitive to their needs, nor an appropriate source of health information. Concern was expressed about the difficulty of requesting an interpreter due to the inability to speak English particularly in an emergency. There was also a perception that NHSD nurses are not familiar with the symptoms or presentations of conditions such as thalassemia and sickle cell disease, which are more common among some BAME groups. NHS Direct is available in 30 languages and there are 200 languages that people can access (51). Therefore, it is not so much that there is no language support. Rather those who do not speak English do not seem to be accessing NHS Direct in the first place.

8.48 Based on the experience of NHS Direct, any new telephone advice and access point needs to have language support for non-English speakers as an integral part of the service to be fully accessible. The service also needs to be accessible for those with sight, hearing or learning disabilities. This accessibility needs to be advertised clearly from the start or there is a danger these groups assume they are excluded. Without such accessibility non-English speakers will not be able to use the service and may experience difficulties getting the healthcare they need. This will further disadvantage these already marginalised groups and could contribute to an increase in health inequalities.

8.49 Any new telephone service will also need to be free of charge or it may risk excluding people living in poverty or on low incomes.

Cultural sensitivity

8.50 Training is needed for all health professionals and front-line staff to ensure they identify and accept carers as a discrete group with their own special health needs, and adopt carer-sensitive practices as an integral part of routine patient care (38).

Particular vulnerable groups

8.51 Primary care has a crucial role to play in supporting women experiencing domestic violence. Women may visit their GPs for care for sustained injuries through domestic violence or other related physical and mental health problems. Furthermore, children bring many of the women at most risk of domestic violence into contact with health care workers. Since there is near universal contact with the health service, the NHS provides a key route to identification, risk assessment and appropriate health and other support for victims of domestic violence.

8.52 Recent DH initiatives on domestic violence include the updated Domestic Violence Resource Manual published in January 2006 and the Violence and Abuse Programme on Health and Mental Health, in partnership with the National Institute for Mental Health in England (9).

8.53 However, the NHS response to domestic violence is inadequate. It is a choice of individual PCTs to develop and implement domestic violence screening and response systems. In London there are only two known continuous domestic violence projects working within a health site (9). Furthermore, support for women identified as suffering domestic violence continues to be left to voluntary sector agencies, rather than seen as the responsibility of mainstream services (37).

8.54 The Disability Right's Commission formal enquiry into inequalities in physical health experienced by people with mental health problems and learning disabilities found that both groups were more likely to suffer from health risks and major health problems than the population at large. They are also more likely to die younger. While the social deprivation experienced by these groups contributes to this inequality it does not fully explain it. People with mental health problems and learning disabilities are less likely to get some standard checks and treatments (such as health screening and statin treatment for heart disease) and face huge access and attitude barriers in using health services (42).

8.55 A key recommendation resulting from the enquiry was that people with mental health problems and learning disabilities should receive regular health checks. However, one year on the Commission noted little progress on this in England (42).

8.56 When carer support workers in primary care services provided training they helped raise awareness of carers' issues. This would help deter professionals from allowing preconceived notions and assumptions about carers to stand in the way of referrals or the offer of particular treatments. Health care professionals taking on the role of 'champions' could help to change attitudes and spread good practice. Building up good relationships between carers and professionals, and treating carers as 'partners' in the provision of care, could also facilitate access for carers. Training is needed for all health professionals and front-line staff to ensure they identify and accept carers as a discrete group with their own special health needs, and adopt carer-sensitive practices as an integral part of routine patient care (38).

8.57 A review of the equalities experiences of transgender and transsexual people (31) identified training an support needs for healthcare providers, including ancillary and support service staff. For example:

- a staff development structure that regularly raises training about trans people's issues;
- an understanding that because someone is presenting with a trans issue, there is no basis, such as a conscience clause, for any doctor to refuse help whether referring onwards, providing regular hormone prescriptions, or ordinary health care;
- education on what it is to be a trans person, on trans patient's rights, including the right to dignity, decency and respect, and especially the right to privacy as afforded by the Gender Recognition Act 2004;
- training to ensure an awareness that once a person's trans issues have been addressed, they will still have the ordinary health problems that other people face;
- training on recognising that trans people, when presenting with non-trans related health problems, need treating equally alongside other patients; and
- simple education and leaflet guidance for doctors, nurses and other health care staff on how to work with trans patients on issues of dignity, particularly the right to be treated as a member of their new gender, and privacy obligations.

General or geographic health inequalities

The role of primary care

8.58 Good primary care experience is associated with better self-reported health including mental health. Importantly, there is also evidence that good primary care can help reduce the negative impacts of income inequalities on health for the whole population and for those with lower socioeconomic status. *Good* primary care experience was considered to encompass accessibility, interpersonal relationship and continuity (52).

8.59 This research is important as it indicates that the beneficial effects of primary care as they relate to self-reported health are dependent on the quality of the service. Self-reported health is an important measure as it has been shown to have predictive validity for with mortality and mental health (52;53). The quality of the service includes continuity of care and accessibility in terms of travel time and waiting time, as well as the service itself. If the proposals improve the range and quality of services available at primary care levels, the benefits of such improvements could be compromised if continuity of care and accessibility are reduced.

8.60 While the proposals explicitly recognise that continuity of care may be a concern and there is no reason why it cannot be protected, it is not explicitly included as a feature of polyclinics.

8.61 The DH have highlighted ensuring good availability of high quality NHS care, especially primary care, as a key action to reduce inequalities in health as measured by life expectancy (28). In particular, primary care should undertake prevention and effective management of risk factors in the general population and in high risk patients. These factors include poor diet, physical inactivity, hypertension, obesity and therapeutic interventions including use of anti-obesity drugs according to need. Key primary interventions proposed are:

- Improving access to diagnostics

- Reducing delay in patients in disadvantaged groups first going to see the GP (evidence that socio-economic groups have a greater delay in presentation)
- Reducing the delays in onward GP referral
- Increasing the uptake of screening.

8.62 Reducing smoking continues to be a crucial intervention. Smoking is responsible for the major part of mortality differentials by social class in middle age.

The polyclinic model

8.63 The proposals put forward a primary care model of a larger facility which offers more services in a single location – the polyclinic.

8.64 One of the objectives of this proposal is objective in many health-care systems is to shift specialist services from acute hospitals to the community and so bring care closer to home for patients in line with the second principle of Healthcare for London: A framework for action "services should be localised where possible, or regionalised where that improves the quality of care".

8.65 However, it is unclear that such a shift leads to improved outcomes for patients or greater efficiency. A recent review of 119 studies which sought to move hospital based services to primary care settings found "shifting care from hospitals to the community is a plausible strategy for improving patient access to specialist care but risks reducing quality and increasing cost" (54).

8.66 In particular, the review found that relocating specialists to primary care and joint working arrangements between primary care and hospital clinicians were largely ineffective. Transferring services from secondary to primary care and strategies intended to change the referral behaviour of primary care clinicians were often effective in reducing hospital outpatient activity. However, there is a risk to quality in that community practitioners may not be sufficiently skilled to undertake the work previously done by hospitals (54).

8.67 The proposals suggest the co-location of other non-health services with polyclinics. These services could include the provision of advice, information and support services for example welfare, debt, employment and housing services, as well as other well-being services such as exercise facilities, adult literacy, healthy eating classes and community development groups. This presents an opportunity to decrease health inequalities by addressing inequalities in the determinants of health.

8.68 Much of the argument put forward by the consultation document to support the development of polyclinics is based on the hypothesis that the co-location of services leads to an improvement in patient outcomes. However, the evidence on this is unclear. Some research indicates that patients prefer single-handed and small surgeries as they believe they offer greater continuity of care. In addition, according to the Royal College of General Practitioners there is no evidence that patients receive poorer services from single handed practice (55).

Travel times

8.69 There is evidence that the ability of primary care services to reduce negative health impacts associated with income inequality is dependent on a high quality of service. Travel time is a key characteristic of quality (52). The proposals state that high level modelling shows the vast majority of Londoners will live within one to two kilometres of a polyclinic serving a population of 50,000 (14). However, the assumptions behind that modelling are not fully explained so it is not possible to fully assess the possible impact on proximity to primary care facilities caused by the introduction of polyclinics. It is likely that many Londoners will live further from their polyclinic than they currently do from their GP. Ease and affordability of travel is key to access so locating polyclinics close to public transport will be important. As accessibility is a key issue, this is an area recommended for further exploration.

8.70 London Travel Watch has recently looked at public transport access to hospitals. Although the work looked at hospitals in particular, it is also relevant for major health facilities such as polyclinics. It found that although examples of good practice existed, there was "no

evidence that the concept of accessibility planning is recognised in the health service in London" (56).

8.71 It recommended a number of measures that could improve access to healthcare facilities. These included: NHS London and Transport for London should adopt accessibility planning when considering access to London's existing and planned healthcare facilities; accessibility indicators should be developed; NHS London and Transport for London should jointly issue guidance to primary care trusts outlining the transport planning issues to be considered to assure accessible hospitals and major healthcare centres in London and outside of London where they serve London residents (56).

8.72 Also important to ensuring access was the development of a travel plan, which should be independently audited for quality. In addition, Transport for London's leaflets 'Getting to the Hospital', were considered very useful (56).

Staffing levels in Primary Care

8.73 One of the major barriers to providing high quality, accessible primary care has been the shortage of properly qualified primary care staff. Although this report has not found recent data on primary care staff recruitment and retention, it is likely that this continues to be a problem, especially in deprived areas of London. Changing the model of provision will not resolve this unless measures are also taken to increase the numbers of staff. At worst, there is a danger of health inequalities increasing if a fully staffed polyclinic system improves primary care in one of the less deprived areas of London, but a shortage of staff prevents its full implementation in the most deprived areas. Therefore, a key threat to the improvements proposed by the consultation document is the lack of available staff.

8.74 The most recent available data on primary care premises indicates that many physically inaccessible and unsuitable premises are concentrated in deprived areas of London. If this is still the case and polyclinics are developed using such premises under the hub and spoke model, health inequalities could be further widened. The introduction of polyclinics using existing, and better quality, buildings in one of the less deprived areas could improve services for residents of those areas, while the successful implementation of the polyclinic model in more deprived areas could be compromised by the poor quality of existing buildings in those areas. This will combine with the differential rates of recruitment and retention for NHS staff across London.

8.75 A study carried out in the West of Scotland found the average GP consultation length was around 1-2 minutes longer for patients from an affluent background than for patients from deprived areas (57). A review of the Scottish NHS undertaken in 2005 found that patients from the most deprived areas were more likely to present for medical care with a number of significant conditions. The review (58) concluded:

patients from deprived areas therefore face a 'double whammy' of having more health problems and less time available to have them addressed.

8.76 In 2003 the GLA reported that patients were more satisfied with nurse-led care than with care from a GP (34). Patients reported receiving more information about their illness from the nurse practitioner than the GP, which is perhaps related to the fact that nurses gave longer consultations. Nurse practitioners also conducted more tests than GPs. Importantly, no differences were found in re-consultation or referral rates between nurse practitioners and GPs. No significant differences were found in health service costs for GP consultations and nurse consultations. Finally, nurses appeared to be much better than GPs in supplying information to patients to promote self-care and patient confidence which may improve uptake of health prevention measures such as in coronary heart disease (34).

8.77 However, it will be important for adequate interpretation services to be available for nurse led consultations, in addition to those led by doctors, if they are to be accessible to people who do not speak English. The same is true for all interventions by primary care staff.

Primary care infrastructure

8.78 Research undertaken in Glasgow has shown that the structure of general practices serving deprived areas had poorer structural and organisational conditions than other practices.

They tended to be smaller and were more likely to be staffed by less experienced GPs. They were also less likely to participate in voluntary schemes that promote quality care and open access to additional resources, such as Personal Medical Service pilots and training and accreditation by the Royal College (59).

Shifting investment to prevention and health improvement

8.79 People from more deprived communities are less likely to benefit from services to improve lifestyle, such as smoking cessation and health diet campaigns (60). There are several reasons for this. People living in poverty or deprived areas are less likely to be able to access the *building blocks* for healthy lifestyles. For, example there is little point in telling people they need to eat healthily if they have neither the physical access nor the income necessary to acquire healthy foods. In addition, poverty and deprivation causes stress and undermines self confidence. Interventions to encourage people to stop smoking are less likely to be successful without addressing the factors that might cause them to smoke place and that make it difficult for them to quit, for example stress, powerlessness and anxiety exacerbated by poverty, social exclusion and isolation.

8.80 Preventative interventions are less likely to benefit deprived communities. People in higher social classes are more likely to attend for health checks for cardiovascular disease and are more likely to use protective drugs such as statins. One study found that smokers were about half as likely to take statins than non-smokers and it has been suggested that since smoking prevalence is strongly correlated with socio-economic status, this close relationship may also create inequalities of access to prevention services for heart disease (61).

8.81 Proposals to target health improvement and prevention spending in deprived areas will improve the health of deprived communities only if the design of such services takes account of the experience, and knowledge, of people living in poverty. Vulnerable groups, such as single mothers, refugees and asylum seekers, people with mental health problems or homeless people, are likely to see little benefit from health improvement services unless issues such as stress, isolation and lack of control are also addressed. Health inequalities could actually widen as the general population benefits from new initiatives that exclude those currently experiencing the worst health.

8.82 An extension of preventative services has the potential to contribute to a reduction in health inequalities. However, a reduction can only be achieved if deprived communities and other vulnerable groups who do not currently benefit from such services at the same rate as more affluent groups are included at a level reflecting their needs for such services in view of their often less healthy lifestyles. Simply increasing the range of preventative services using existing approaches and infrastructure may well increase health inequalities by achieving an improvement in the health of the population at large which is not matched by an improvement in the health of deprived and vulnerable groups. Furthermore, a reduction in health inequalities would require an additional improvement in the health of the most deprived groups over and above the rate of improvement of the population in general to enable these groups to catch up.

Nurse led consultations

8.83 There is no evidence to suggest that nurse led primary care consultations lead to less favourable outcomes based on the types of consultations nurses have led to date. Patients are just as satisfied with these consultations (34). Therefore, there should be no adverse impacts from increasing the number of nurse led consultations. However, new research would be required to assess the possible impacts if nurse led consultations were to be introduced to cover types of care currently undertaken by GPs. Measures will also need to be put in place to ensure continuity of care and language support for nurse led consultations, just as for GP led ones.

Immunisation

8.84 Childhood immunisation is one of the safest, most cost-effective and evidence-based of all health interventions. Yet London's immunisation levels are low enough for the Health Protection Agency to believe that a serious outbreak of a disease such as measles is increasingly likely. Just 52 percent of the capital's children are fully immunised against

measles, mumps and rubella, compared to 74 percent nationally (62). 92-95 percent of the population must be immunised against measles to prevent a serious outbreak, and high coverage rates are also needed to prevent outbreaks of other diseases.

8.85 Some studies have shown that children from low-income families are less likely to be fully immunised than other children. However, other evidence shows that the relationship between deprivation and immunisation take-up is not a simple one. For example, Islington is one of the most deprived boroughs in London, but it has immunisation rates above the London average. Furthermore, a recent national study has shown that children of more highly qualified mothers are less likely to be vaccinated than other children (63). We have identified no information as to immunisation rates amongst ethnic minority groups and other equality groups.

8.86 London's high population mobility is also cited as a reason for low take-up. When people move, they may have difficulty finding a new GP, and their medical records may take time to follow them. These things may lead to immunisations being delayed, or even forgotten. However, although the scale of population mobility is higher in London than most other areas, it is important to note that high mobility does not always lead to poor immunisation coverage. Many of the major cities in England also have high mobility rates but achieve good immunisation coverage. It is therefore clear that although London's demographics do have an impact on immunisation rates, these issues cannot be the only explanations for the capital's low immunisation rates(64).

8.87 The London Assembly undertook a scrutiny of child immunisation rates in the capital in 2007. It identified problems around information reporting by GPs and collection by PCTs as contributing to the problem of patchy and low rates in London. However, it also found that around 10% of London's GPs had opted out of providing immunisation since the introduction of the new GP contract. It was unclear if PCTs were using the money saved to commission additional immunisations elsewhere (64).

8.88 The proposals include measures to improve immunisation rates. It is not possible to quantify the impact this could have on health inequalities and equalities groups as the evidence on immunisation rates is either unclear or non-existent. However, in the event of a major outbreak it is possible that children from deprived communities and vulnerable groups could experience worse outcomes than those from the general population because of poorer overall access to healthcare. The DH state that identifying improving uptake of immunisations in deprived populations is an intervention to reduce the gap in infant mortality between the routine and manual group and the population as a whole (65;66).

8.89 More information is needed on unmet need in order for services to be redesigned to meet the needs of equalities groups in general and people experiencing health inequalities. Without such a re-design, there is a danger that the most hard to reach and excluded groups will not benefit from any of the proposed improvements in primary care. This threatens to increase health inequalities between the majority of the population who are inside the primary healthcare system and the minority who are outside it.

Workforce challenges

8.90 The proposals are detailed in terms of infrastructure (buildings and technology). These represent important building blocks for service improvements and the appraisal suggests that well designed facilities will have a positive impact on accessibility for a number of equalities groups.

8.91 However, the evidence is clear that primary care workforce shortages are a major concern, particularly in deprived areas with poor health. The "Access to Primary Care" Scrutiny report (34) found that

... the biggest constraint to the improvement of health services in the capital is the significant shortfall in the primary care workforce. There are difficulties in recruiting and retaining the range of primary care staff including GPs, nurses, pharmacists and support staff such as receptionists and practice managers. In London this problem is likely to get worse before it gets better due to the high number of GPs who are due to retire in the next few years.

8.92 It is unclear how the Primary Care proposals will address these workforce issues.

Summary of the potential impacts of primary care proposals

8.93 Table 3 summarises the likely direction of change resulting from the primary care proposals. The symbols have the following meanings:

+ indicates a likely positive impact

– indicates a likely negative impact

~ indicates the likely impact will be neither positive nor negative or negligible

x indicates there is insufficient evidence to identify the likely impact

Table 3: Potential effects of the primary care proposals

Proposal theme	Potential effect	Rationale
Health improvement and prevention – principle 4 "prevention is better than cure"	+	Shifting the balance of spending away from hospital treatment towards health improvement provides opportunities for long term health gains.
	-	If we do what we've always done we'll get what we've always got. There is evidence that population wide messages are differentially received resulting in the potential widening of inequalities.
Principle 5 "there must be a focus on reducing differences in health and healthcare"	+	This will result in a reduction in health inequalities and would disproportionably benefit the equalities groups and vulnerable groups. However, it will require a significant shift in resources.
Polyclinic model - principle 2 "services should be localised where possible, or regionalised where that improves the quality of care".	+	Existing unmet need met as services are co-located therefore more accessible.
	-	Quality of care suffers as community practitioners may not be sufficiently skilled.
	-	People who are currently not accessing services may continue not to access services.
Urgent care telephone advice service	+	Parents of young children and the housebound have been shown to make good use of NHS Direct facilities.
	-	Older people, those with limited English language, sight hearing and learning disabled have been found to make limited use of existing telephone health facilities. BAME have found facilities to lack cultural sensitivity.
Choice for urgent care	~	We identified no evidence of the likely effect of this element of the primary care proposal.
Extending GP hours	~x	Research has shown that NHS Walk-in Centres do appear to improve access for young and middle-aged men, who generally access primary care less than other population groups. However, although WICs are filling a service gap they appeared to attract more affluent members of our population and would therefore be unlikely to contribute to reducing inequalities in access, particularly if they employ staff who might otherwise work in conventional primary care settings in underserved areas.
Practice nurse led consultations	+	Research commissioned by the GLA suggests that the extra time available for nurse led consultation is valued by patients.
	~	More evidence is required to assess impacts of nurse led consultations covering new types of care currently undertaken by GPs.
Improving care for those with LTCs	+	

Proposal theme	Potential effect	Rationale
Polyclinics	~	Good primary care experience is associated with better self-reported health including mental health Importantly, there is also evidence that good primary care can help reduce the negative impacts of income inequalities on health for the whole population and for those with lower socioeconomic status. *Good* primary care experience was considered to encompass accessibility, interpersonal relationship and continuity.
Polyclinics – networked	~–	Access to, and quality of, primary care for equalities groups needs to be improved and poor access is a factor in health inequalities. A networked polyclinic model provides some limited opportunity for the hub to address accessibility issues, but leaves the majority of the infrastructure unchanged. We are unclear how this approach would address primary care workforce challenges. Continuity of care offered by local practices is valued by patients and the RCGP reports no evidence of poorer services from single handed practices. It is unclear how this would support the pressing need for reducing the delay in patients in disadvantaged groups first going to see the GP (evidence that socio-economic groups have a greater delay in presentation) (28).
Polyclinics – co-located (same site)	X	Access to, and quality of, primary care for equalities groups needs to be improved and poor access is a factor in health inequalities. A 'same site' polyclinic model provides some limited opportunity for the single site to address accessibility issues, but at the expense of increased journey times. Furthermore, it is unclear how this approach would address primary care workforce challenges. Continuity of care offered by local practices is valued by patients and the RCGP reports no evidence of poorer services from single handed practices. It is unclear how this would support the pressing need for reducing the delay in patients in disadvantaged groups first going to see the GP (evidence that socio-economic groups have a greater delay in presentation) (28).
Polyclinics – hospital based	~X	It is unclear what the effect of this model would be on existing primary care facilities. It is possible that this will divert staff from other primary care services. It is unclear how this would support the pressing need for reducing the delay in patients in disadvantaged groups first going to see the GP (evidence that socio-economic groups have a greater delay in presentation) (28).
Co-location of services at polyclinic sites	~+	The provision of advice , information and support services for example welfare, debt, employment and housing services, as well as other well-being services such as exercise facilities, adult literacy, healthy eating classes and community development groups. This presents an opportunity to decrease health inequalities by addressing inequalities in the determinants of health.

Recommendations on primary care

8.94 NHS London should clarify the modelling with regard to the location and average distance to polyclinics. NHS London and PCTs should work together to ensure physical proximity and ease of travel by public transport is prioritised in the development of polyclinics. Consideration also needs to be given to the convenience of the location of primary care services, for example proximity to shops and/or other services. This means avoiding an ad-hoc development based solely on the location of existing healthcare infrastructure and ensuring that polyclinics are situated where there are good public transport facilities.

8.95 NHS London and Transport for London should jointly issue guidance to Primary Care Trusts, and transport providers outlining the transport planning issues to be considered in developing polyclinics. Transport accessibility indicators should be developed. Under Local Area Agreements transport services should be planned jointly with public transport providers. Patients should be provided with information about how to get to the polyclinic, for example through personalised travel planning. Each polyclinic should develop a Green Travel Plan to minimise carbon emissions associated with patient and staff travel .

8.96 NHS London and PCTs should work together to ensure that in implementing the proposals, investment patterns reverse the inverse care law. Areas with the highest levels of need must receive funding to meet these needs.

8.97 NHS London and PCTs should ensure a greater investment of mainstream NHS resources in prevention services. This increased investment should be appropriately targeted to deprived areas and communities and provided at a level which reflects their need.

8.98 NHS London and PCTs should work together to ensure ways continuity of care can be protected, for example by including this as an explicit feature of polyclinics.

8.99 NHS London and PCTs should work together to ensure that polyclinics include co-located non-healthcare services such as advice and support on employment, housing and welfare, exercise facilities, adult education and community organisations.

8.100 NHS London and PCTs should work together to put in place services to ensure the recruitment and retention of sufficient staff in the most deprived areas of London.

8.101 NHS London and PCTs should work together to explore models of primary care that specifically target those who have very poor existing access such as homeless people, refugees and asylum seeks or those living in deprived areas that are underserved by existing services. These will need to include models that allow for flexibility of registration or care without registration.

8.102 NHS London and PCTs should commit to ensuring that the polyclinic model will include the development of premises to replace existing physically inaccessible and unsuitable GP surgeries. As a first step NHS London should obtain and make public up to date information on the accessibility and suitability of GP premises and how they are dispersed across London.

8.103 NHS London and PCTs should work together ensure the availability of adequate and consistent language support services for people who do not speak English as a first language and Deaf and hard of hearing people and British Sign Language (BSL) users. This should include pan London co-ordination on needs-assessment, commissioning, financial management, planning, quality standards and user involvement.

8.104 NHS London and PCTs should work together to build measures to improve the accessibility of all primary care services into the proposals. These should include services which meet the needs of people with learning disabilities and mental health problems. They should also include measures to ensure the sensitivity and appropriateness of services to trans people and to lesbians and gay men.

8.105 NHS London and PCTs should build in language support for people who do not speak English as a first language and Deaf and hard of hearing people and BSL users as a core part of any new telephone service.

8.106 NHS London and PCTs should ensure that proposed new health improvement services take into account the stress, isolation and disempowerment and lack of access that prevent many vulnerable groups from benefiting from existing services.

8.107 PCTs should commission immunisation services to cover services that were provided by GPs who have since opted out.

8.108 NHS London and PCTs should obtain further data on which equalities groups and vulnerable groups are most affected by being unable to register with a GP. PCTs need to better understand groups that are not currently accessing healthcare and the extent of this unmet need by undertake local assessments. Resources and services must then be targeted to meet this unmet need.

8.109 NHS London need to ensure that monitoring and addressing unmet need is included in the performance management of healthcare commissioners and providers.

8.110 London PCTs should explore with NHS London the possibility of using the QOF system to negotiate a London-wide incentive system to report equalities data as part of their reporting systems. PCTs and NHS London must prioritise improving routine data collection and analysis on the equalities groups.

8.111 NHS London and PCTs should work together to ensure primary care offers adequate and appropriate support to women experiencing domestic violence. This should include the implementation of recommendations in the DH Domestic Violence Resource Manual, the Mayor of London's minimum standards for all agencies (9). PCTs should also work towards the specific standards for PCTs. This will require working in partnership with other agencies and ensuring adequate funding is available for the support of women identified as experiencing domestic violence so this is not left to inadequately resourced voluntary agencies. It will also require proper training and support for staff.

8.112 PCTs should work with primary care services need to ensure they take active steps to support carers in their caring roles but also to ensure that carers own health needs are meet.

8.113 NHS London and PCTs should ensure that people with learning disabilities and mental health problems receive regular health checks. If necessary greater use could be made of Local Enhanced Services agreements and these checks should be incorporated into the QOF system.

8.114 NHS London and PCTs must ensure that community practitioners have the necessary training and support to provide additional services from primary care settings.

9. Maternity care

Where are we now: an overview of the experience of equalities groups and health inequalities relating to maternity care

The experience of equalities groups

Access to health care and patient experience

9.1 An increasing number of migrant women are seeking maternity care in the UK. Women who have recently arrived from countries around the world, particularly those from Africa and the Indian sub-continent, but also increasingly from central Europe and the Middle East, may have relatively poor overall general health and are at risk from illnesses that have largely disappeared from the UK, such as TB and rheumatic heart disease. Some are also more likely to be at risk of HIV infection. All of these conditions, alone or in combination, contributed to a number of maternal deaths in the period 2003-2005. None of the women who died of these causes had a routine medical examination during their pregnancy and the opportunity for remedial treatment was lost.

Health status and outcomes

9.2 The IMR in London is even higher in infants registered by the mother alone (sole registered) than the routine and manual group at 8.9 deaths per 1,000 live births. The IMR for infants born to mothers aged under 20 is also high at a rate in London of 8.7 per 1,000 live births. This includes a high proportion of sole registered births.

9.3 London has more than twice the proportion of births to mothers born outside England & Wales compared to England & Wales as a whole – 47% compared to 20%. In London, deaths in the first year of life are more common among infants born to mothers born outside England & Wales, a rate of 5.9 per 1,000 in London, and as high as 10.9 in births to mothers born in West Africa (67).

9.4 Black African women, including asylum seekers and newly arrived refugees have a maternal mortality rate nearly six times higher than White women. To a lesser extent, Black Caribbean and Middle Eastern women also had a significantly higher mortality rate (68).

9.5 Other women more vulnerable to maternal death include those experiencing domestic violence and those with substance abuse problems.

9.6 The prevalence of female genital cutting/mutilation (FGC/M) amongst the pregnant population is increasing due to inward migration of women from countries or cultures where it is still routine practice, despite almost universal international condemnation at government level. It can affect women's pregnancies in a number of ways and the deaths of at least four women were directly or indirectly associated with the consequences of such procedures in the period 2003-2005 (68).

General or geographic health inequalities

Access to health care and patient experience

9.7 Early booking of the first antenatal appointment is a good precursor of better health of the mother and child. The percentage of early bookings compared to all births varies greatly between PCTs, ranging from 3.7% to 64.1%. Greenwich, Bexley, Hillingdon, Barnet and Kingston PCTs had below 10% of deliveries with early first antenatal appointments for 2005-6 (69).

9.8 Around 20% of women who died from direct or indirect causes related to their pregnancy either first booked for maternity care after 20 weeks' gestation, missed over four routine antenatal visits, did not seek care at all or actively concealed their pregnancies. Some of the women who died were let down because, although the GP referral was timely, they did

not receive a first maternity service appointment until they were around twenty weeks gestation (68).

Health status and outcomes

9.9 Currently around 115,000 women deliver in NHS hospitals within London each year. Between 1998 and 2005, there has been an increase in women delivering of around 2% per annum, although this has varied considerably across London. The majority (97%) of women deliver in obstetric or co-located midwifery units in hospitals and about 2% deliver at home. Half a percent of women in London give birth in stand alone midwife-led units (70).

9.10 More than 10% of births in Croydon, Haringey, Islington, Barking & Dagenham, City of London & Hackney, Greenwich, Lewisham and Lambeth and Southwark were registered by the mother alone in 2001-2003 (71). The target for reduction in inequality in infant mortality rates introduced in November 2001 compares the rate in the 'routine and manual' group in the new National Statistics Socio-Economic Classification (NS-SEC) to the rate in the general population. As classification into groups is based on father's occupation, births registered to the mother alone are excluded. This is a very significant group in London.

9.11 There is a wide variation in the number of births to teenage mothers across London boroughs. In 2001-2003 Barking & Dagenham, more than 8% of births were to mothers aged under 20, while in Harrow, Westminster, Kensington and Chelsea and Richmond Upon Thames, the proportion was less than 3% (72).

9.12 Birth weight is related to social status and to other factors such as smoking. It is a marker for indices of deprivation and represents an accumulated risk over generations. The proportion of births in each London borough under 2,500 grams (including low birth weight and very low birth weight – under 1,500 grams) varies between 11% and less than 6%. Between 2001 and 2003, the highest proportions were in Southwark, Tower Hamlets, Newham, City of London and Hackney, Lambeth and Brent; all over 9.5%. The lowest were in Richmond upon Thames, Havering, Kingston upon Thames, Merton, Kensington and Chelsea, Wandsworth, and Sutton; all less than 7% (73).

9.13 The Infant Morality Rate (IMR) is the number of deaths in children aged under 1 year per 1000 live births. Between 2003 and 2005, there were marked differences among London boroughs: Haringey, Harrow and Southwark had the highest infant mortality rates – 8.1, 7.1 and 7.0 per 1000 live births respectively. These were almost three times higher than the boroughs with the lowest rates (74).

9.14 There are currently highly variable rates of breastfeeding across London There is also variation in postnatal care in the community. Postnatal care in the community is highly valued by women and high-quality postnatal visiting is associated with a reduction in maternal and neonatal morbidity. However, the availability of postnatal care seems to be more dependent on availability of midwives than on assessment of need (75).

9.15 In January 2008 the Healthcare Commission published a comprehensive review of maternity services. Trusts in the north of England performed relatively well, while trusts in London performed most poorly. In the north, 33 out of 44 trusts were 'better performing' or 'best performing' (75%), while 19 out of 27 London trusts were 'least well performing' (70%) (76). The review found significant variations in quality of care between London's trusts. It also found London leads the country on Down Syndrome screening although the take-up of best screening practice still varies between trusts. The review covered clinical effectiveness and women centred care, as well as the efficiency and capability of services.

9.16 Data on episiotomy rates which shows a high degree of variation with some hospitals having rates as high as 17% and others as low as 3%, 2% and 0% (77).

9.17 In London, the routine and manual socio-economic group have an IMR of 6.7 per 1000 live birth – 29% higher than the rate in the general population (5.2 per 1000 live births). This compares with a rate 22% higher in England, 6.2 and 5.1 per 1000 live births respectively.

9.18 Maternal deaths are extremely rare in the United Kingdom. The maternal mortality rate for 2003-05 calculated from all maternal deaths directly or indirectly due to pregnancy was 14 per 100,000 maternities. This means 295 women died from causes directly or indirectly

related to their pregnancy, out of more than two million mothers who gave birth in the United Kingdom between the years 2003-05. However, though statistically small, the impact of these deaths is enormous and they are often preventable. Therefore, they deserve consideration.

9.19 There is a clear gradient between maternal mortality rates for the least and most deprived areas. Mortality rates in the most deprived quintile were around five times higher than in the least deprived quintile (68). The rate for women whose partners were unemployed or whose occupations were unclassifiable was over seven times higher than that for all women with partners in employment.

What does Healthcare for London propose: a summary of the proposals relating to maternity care

9.20 It is proposed all expectant mothers should be offered:

- an early assessment by a midwife to ensure their care is right for them; and further assessments during the course of the pregnancy;
- information to enable them to make informed choices, for instance, about the relative benefits and risks of different locations to have their baby and about pain relief;
- care before birth provided at local one-stop centres;
- services that meet their choice of where they give birth – for instance, at home, in a midwifery unit, or in an obstetric (doctor-led unit);
- care with the same team from early pregnancy until after the birth whenever possible;
- one-to-one midwifery care during established labour;
- care following birth in local, one-stop centres as well as at home.

9.21 The implementation of the above will include:

- Maternity networks – involving maternity commissioners and all providers – should be formally established across London and be linked with neonatal networks.
- There should be a significant increase in the number of midwifery units, with each obstetrics unit having an associated midwifery unit, either co-located or standalone depending on local circumstances.
- Obstetrics units should have at least 98 hours a week consultant presence.
- There should be slightly fewer doctor-led units in London than currently, the exact number to be determined by a detailed examination of specific services is needed.

Discussion of the evidence and appraisal of potential impacts

The experience of equalities groups

9.22 ***Data collection***

9.23 The existing data on existing access to maternity services and outcomes for mothers and babies is inadequate to fully appraise the potential impact of the proposals for equalities groups. Most routine data is not broken down into these groups. Where possible, research based upon user experience and other forms of community intelligence together with one off research studies have been used to understand the equalities groups' experiences of maternity care now and the potential impacts of the proposed changes.

9.24 More information is needed on unmet need in order for services to be redesigned to meet the needs of equalities groups in general and people experiencing health inequalities. Wiithout such a re-design, there is a danger that the most traditionally-under-represented and excluded groups will not benefit from any of the proposed improvements in maternity care. This threatens to increase health inequalities between the majority of the population who are inside the primary healthcare system and the minority who are outside it.

Access to maternity services

9.25 Of the 295 women who died from causes directly or indirectly related to their pregnancy, thirty-four spoke little or no English. Very few had access to translation services and in

most cases family members or friends were used as interpreters (68). Several of these were the woman's own children, who may have been the only family members who could speak English. The use of family members or friends as translators causes concern because women are often not willing to share personal or potentially worrying information with their children or other relatives. In some cases the partners of women experiencing domestic violence are used as interpreters. This is clearly inappropriate as it will prevent the woman discussing the abuse and other information relevant to her medical condition with the professional.

9.26 The availability of adequate interpretation would increase access to care for women who do not speak English. This would positively impact on outcomes for mothers and babies.

9.27 The DH has highlighted the need for the provision of culturally sensitive advice and support for BAME women as being essential to meeting the health inequality target starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual group and the population as a whole.

Cultural barriers

9.28 Training is needed for all health professionals and front-line staff to ensure they identify and accept the needs of equalities groups and the social circumstances of those with poor maternal outcomes.

9.29 **Particular vulnerable groups**: Teenagers at risk of becoming pregnant are also identified as in need of targeted prevention work. Pregnant teenagers and teenage parents are identified as in need of targeted support (65).

9.30 Because of the increasing prevalence of women living with FGC/M in London and the potential negative impacts of FGC/M for the mother and baby, midwives and obstetricians and specialist services need to available to advise, help and support pregnant women living with FGC/M during pre-pregnancy care, ante-natal care, labour and post-natal support.

9.31 Women who are experiencing domestic violence are particularly vulnerable. Ante-natal care and other maternity services offer an important opportunity for identification, risk assessment and appropriate health and other support for victims of domestic violence.

General or geographic health inequalities

Access to maternity services

9.32 The Healthcare Commission's recent review of services found once a woman has contacted the NHS, the maternity service should fully assess and book her in a reasonable time for her full maternity care. Trusts that did well on this indicator averaged 1.5 weeks or less for the time between the woman making contact and having her first booking appointment. At the other extreme, in nine trusts the average time from contact to booking was 4.1 weeks or more, all these were London trusts (76).

9.33 The DH have proposed a number of improvements in access to maternity services that it expects to contribute to a reduction in infant mortality. These include increasing direct access to community midwives; providing 24/7 maternity direct line for advice and access; implementing NICE antenatal and postnatal guidelines; undertaking health equity audits of women booked by 12 weeks and >22 weeks and commissioners and maternity service providers agreeing improvement plans in contract (65).

Pre-conception care

9.34 Many of the women who died from pre-existing diseases or conditions which may seriously affect the outcome of their pregnancies, or which may require different management or specialised services during pregnancy, did not receive any pre-pregnancy counselling (68). Improving the quality and availability of and access to pre-pregnancy health care and information would contribution to a reduction in these deaths. Although these deaths are statistically small, their impact is devastating.

Ante-natal care

9.35 The health inequalities national target to reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth is supported by the objective to reduce by at least 10 per cent the gap in mortality between routine and manual group and the population as a whole starting with children under one year, by 2010.

9.36 The three main causes of death in infancy and which also account for most of the gap are:

- Immaturity related conditions
- Congenital anomalies
- Sudden Unexpected Death in Infancy.

9.37 Maternal smoking increases the risk of a wide range of adverse outcomes including death from Sudden Infant Death Syndrome and infections in infancy. Obesity, nutritional status, and other maternal health factors contribute to infant mortality.

9.38 Failure to breast feed is also known to contribute to poorer infant outcomes. Human breast milk provides complete nutrition for the first critical months of life and protects against common childhood infections and diseases, including gastro-enteritis and respiratory infection. Breastfeeding shows a strong social class gradient. Only 59% of mothers from social class V initiated breastfeeding in 2000 compared to 91% of mothers from social class I. Guidance has been issued to all midwives and health visitors in the form of a resource pack Infant Feeding and Child Nutrition to help promote good practice in infant feeding particularly breastfeeding.

9.39 The DH also emphasises the importance of joint working to tackle child poverty, poor housing and low maternal educational achievement which also contribute to differential infant mortality rates between social classes.

9.40 The Healthcare Commission's review of services found that although all trusts ask women about their mental health at a woman's first antenatal appointment, however only 55% conduct all the mental health checks identified in NICE guidance. Furthermore, while all women are getting a foetal anomaly scan, but only 61% of trusts' scans include all of the 11 items recommended by NICE, such as checks on the babies heart function, and the babies face and lips, and only 11% of trusts are meeting the NICE quality requirements for Down's syndrome screening in April 2007 for all women, meaning that in the remainder of cases, women are receiving inferior screening. These figures are based on a national analysis as figures are not analysed for London as a whole (76).

9.41 Work by the London Health Observatory indicates that if babies born to the more deprived routine and manual socioeconomic group had the same chance of surviving their first year of life as those in the general population, then 41 lives would be saved in the capital every year (67).

9.42 The NICE guideline on antenatal care states that a schedule of antenatal appointments should be determined by the function of the appointments. For a woman who is pregnant with her first child with an uncomplicated pregnancy, a schedule of ten appointments should be adequate. For a woman who has previously given birth with an uncomplicated pregnancy, a schedule of seven appointments should be adequate. Pregnant women should be offered evidence-based information and support to enable them to make informed decisions regarding their care. Information should include details of where they will be seen and who will undertake their care. Addressing women's choices should be recognised as being integral to the decision-making process (78).

9.43 High quality ante-natal care has the potential to improve maternal health and reduce infant mortality. In addition to ante-natal care, pre-conception care should be available as many women need advice and support around smoking, weight, diet and other health conditions before becoming pregnant.

9.44 As part of work on a project to reduce infant mortality in Hackney (79), women identified the following barriers in accessing ante-natal care:

- long waits in antenatal clinics
- a lack of continuity of care
- issues around language and communication
- a desire for community-based service provision.

9.45 Ante-natal care also presents an important opportunity for identification, risk assessment and appropriate health and other support for victims of domestic violence. Surveys of women indicate that they see the health sector as an appropriate site for intervention. Most women, including victims and non-victims do not mind being asked about their experiences of violence (80). Therefore, routine enquiry should be implemented in ante-natal care and all maternity services, in line with the recommendations in the DH Domestic Violence Resource Manual.

Care during birth

9.46 Future numbers of women delivering in NHS hospitals within London are expected to increase by about 7% over the next 10 years to give a total of around 124,000 in 2015/16 (81).

9.47 The Healthcare Commission's recent review of services found variations in performance on readmission rates and on the level of midwife support. A quarter of trusts had a readmission rate for babies from jaundice or dehydration of 12 per 1,000 babies or greater while the better performing trusts had rates of 4.8 per 1000 babies or lower.

9.48 The average number of contacts by midwives per woman was 3.7 or less for a quarter of trusts but the top scoring 25% of trusts had an average of 5 or more contacts.

9.49 The review also found on average, the level of midwife staffing in maternity units is 31 midwives per 1,000 deliveries. However, nine trusts had only 26 midwives per 1,000 deliveries or fewer. Two thirds of these trusts scored weak, suggesting that very low staffing levels may be associated with poor overall performance. These figures are based on a national analysis as figures are not analysed for London as a whole (76). The royal colleges recommend 36 per 1,000 to enable one to one care in labour.

9.50 The review supported the intention outlined in the proposals to increase the number of mid-wife deliveries. It identified benefits to be gained, such as better continuity of care and reduced costs, by identifying women who only require midwife care during the antenatal period and ensuring that this is offered. In a quarter of the trusts, 76% of women or more received antenatal care from both a doctor and a midwife.

9.51 The Healthcare Commission's recent review found nationally 62% of trusts were not able to provide complete data on the effectiveness of interventions to manage the level of caesareans and eight percent of trusts were unable to provide any information from which the review could assess the effectiveness of interventions (76).

9.52 Current caesarean section rates are 27% on average across London, though there is considerable variation – North West London had a rate of 33% compared to 25% in North East London. There are similar variations across units despite similar populations. The variation in rates across London supports the evidence that clinical practice and professional attitudes impact on rates. There is evidence that a change in culture can have a dramatic impact on the caesarean section rate – for example, the section rate at Northwick Park Hospital has recently fallen from 33% to 25%. Caesarean sections are associated with higher use of resources, for example, longer postnatal lengths of stay in hospital than vaginal births. The World Health Organization has set a target of no more than 15% of births by caesarean section (81).

9.53 There is evidence that high quality obstetric care requires consultant presence on the labour ward (82). The review into maternal deaths at Northwick Park Hospital identified that of the ten maternal deaths, six did not have consultant obstetrician input. High caesarean section rates have also been associated with lack of consultant presence ((83;84) cited in (81)).

9.54 Therefore, the Royal College of Obstetricians and Gynaecologists (RCOG) proposed in their submission to the Maternity and Newborn Working Group of Healthcare for London that units should be moving towards 168 hours of consultant presence per week on the labour ward (81). Given the numbers of obstetricians that will be required to provide this level of presence, this will necessitate fewer obstetric units than at present to be sustainable with the available workforce and the cost of maintaining the necessary numbers, particularly under the European Working Time Directive.

9.55 A recent study has compared maternal and neonatal outcomes for 592 women receiving caseload care with all women receiving standard care. The planned target caseload was 36 births a year per midwife. There were no differences in parity or mean age between the women in the caseload practices and the rest of Guy's and St Thomas', though the caseload women live in more deprived areas. Over one year, the home birth rate increased from 2% to 9%, and 20% of women gave birth in the home from home unit based in Guy's and St Thomas' hospital. The group achieved high rates of continuity of care with a total of 62% of women attended during birth by a midwife/partner and 90% by one of the practice midwives. Compared to women receiving standard care, women receiving caseload care had a higher vaginal birth rate (62% vs. 58%) and lower caesarean section rate (27% vs. 29%), lower rates of instrumental births (11.6% vs. 13%), a higher breastfeeding rate (82% vs. 77%) and lower induction (12 % vs. 14%) and epidural anaesthesia rate (33% vs. 27%). The antenatal missed appointment rate was lower (1.6% vs. 18%) as was the pre-term birth rate (5.6% vs. 8%) (81).

9.56 A Cochrane Collaboration review found that women who had continuity of care by a team of midwives were more likely to discuss antenatal and postnatal concerns, attend prenatal classes, give birth without painkillers, feel well prepared and supported during labour, and feel prepared for child care. Resuscitation was also less frequently required for their babies (85).

9.57 A NICE review has suggested that between 4% and 20% of women in labour will transfer from a midwifery unit to an obstetric unit. Data from the Edgware Birth Centre shows about 12% of women in labour will transfer to the obstetric unit (86).

9.58 The RCOG, in its evidence to the working group, has highlighted that, if women need to transfer from home or a stand alone midwifery or an alongside midwifery led unit this should ideally take place within 15 – 20 minutes.

9.59 The evidence identified to date indicates that the proposed move to increased mid-wife led care, one to one care during established labour and an increase in senior doctor presence on labour wards has the potential to improve health outcomes for mothers and babies. If these changes were implemented across London this could contribute to a reduction in health inequalities. However, partial implementation with trusts serving less deprived areas improving at a faster rate than trusts serving more deprived areas could lead to an increase in health inequalities.

9.60 Furthermore, it is vital that any proposed changes in the capital lead to improved compliance with NICE guidance.

Post natal care

9.61 NICE guidance published in 2006 states a documented, individualised postnatal care plan should be developed with every woman ideally in the antenatal period or as soon as possible after birth. The guidance is based on extensive evidence of how the health of mothers and babies can be promoted, including breast feeding promotion. The guidance states care and information should be appropriate and the woman's cultural practices should be taken into account. A coordinating healthcare professional should be identified for each woman. The Plan should include: relevant factors from the antenatal, intrapartum and immediate postnatal period; details of the healthcare professionals involved in her care and that of her baby, including roles and contact details; and plans for the postnatal period (87).

Workforce challenges

9.62 The maternity care proposals require increases in the number of midwives. It is unclear whether there are sufficient suitably skilled midwives waiting to be recruited and uncertainty as to whether these can be funded.

9.63 The Royal College of Obstetricians and Gynaecologists proposal of 168 hours per week consultant presence on labour wards suggests the need for consolidation of consultant obstetrician cover at fewer sites to comply with EU Working Time Directives.

Summary of the potential impacts of the maternity care proposals

9.64 Table 4 summarises the expected direction of change resulting from the maternity care proposals. The symbols have the following meanings:

- \+ indicates a likely positive impact
- – indicates a likely negative impact
- ~ indicates the likely impact will be neither positive nor negative or negligible
- x indicates there is insufficient evidence to identify the likely impact

Table 4: Potential effects of maternity care proposals

Proposal theme	Potential effect	Rationale
Early midwife assessment and during course of pregnancy	+	Potential for reducing maternal deaths amongst migrant women.
	+/-	Good evidence to support this at general population level. Needs to be targeted at, and delivered appropriately to, areas with high levels smoking and deprivation to lead to positive impact on (mother and child) health (inequalities) and equalities groups.
Post natal care at one stop shop or home	+/-	Again good evidence of benefit at overall population level including NICE guidance. This needs to be targeted at areas of deprivation (poor breast feeding initiation) and equalities groups where maternal and child outcomes (i.e. low birth weight) are poor. Services need to be sensitive to the needs of these target groups. Failure to address the particular needs of these target groups lead to the possibility of widening health inequalities.
One: one midwife during established labour	+	Good evidence to support this proposal; concerns relate to feasibility in terms of numbers of midwifes.
Same team care	+	Again evidence at general population level to support this as leading to good outcomes. Concerns centre on workforce issues; both capacity and training around t he needs of equalities groups and the issues faced by those whose health outcomes tend to be worse (lower social classes).
Increased number of midwifery units (and fewer Doctor led units)	+	Strongly supported by Healthcare Commissions recent review at overall population level.
	-	High levels of transfer rates from midwifery to obstetric units and the importance of rapid transfer, along with high caesarean rates suggest a significant shift of resources, emphasis and perceptions is required to enable the move towards fewer doctor led units and more stand alone midwife units.

Recommendations on maternity care

9.65 In view of the poor performance of London trusts in the Healthcare Commission's recent review of maternity services, NHS London and PCTs should give urgent attention to improving maternity care across the capital. In particular, attention should be focused on how the good practice and outcomes achieved by some Trusts in London can be shared with those that were rated as least well performing.

9.66 NHS London and PCTs should ensure pre-conception advice and support is built into the proposals.

9.67 PCTs should ensure women from disadvantaged groups and deprived communities are targeted for early ante-natal booking. PCTs should undertake health equity audits of

women booked for ante-natal care by 12 weeks and >22 weeks as recommended by the DH.

9.68 NHS London and PCTs should ensure the development of maternity services include direct access to community midwives.

9.69 PCTs should ensure interpretation services should be available to support the whole range of maternity services from pre-pregnancy care to post-natal care. Women should not be expected to use children, partners of other family members as interpreters.

9.70 PCTs should ensure maternity services take account of the particular needs of women experiencing domestic violence. In particular, routine enquiry should be implemented in all maternity services, in line with the recommendations in the DH Domestic Violence Resource Manual.

9.71 PCTs should ensure culturally sensitive and appropriate care is available to women living with FGC/M. Women from counties where this is likely to be practiced should be sensitively asked about this during pregnancy and management plans agreed during the antenatal period. Adequate training and support should be available for midwives, obstetricians and other healthcare staff to ensure they can provide this support.

9.72 PCTs must ensure that at a local level commissioning is informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require local health equity audits.

10. Stroke pathways

Where are we now: an overview of the experience of equalities groups and health inequalities relating to stroke pathways

The experience of equalities groups

Access to health care and patient experience

10.1 People who have suffered a stroke are often supported by informal carers such as family members. A shift towards ore home based care could, therefore, increase the numbers of carers. Carers are a vulnerable group who have been shown to experience barriers in accessing health services. There are over 606,000 carers in London (88). We consider the needs of carers in section 8 of this report as part of the discussion of primary care.

Health status and outcomes

10.2 In 2005/06 more than 6,000 Londoners suffered a stroke (89). Table 5 shows the prevalence of hypertension and stroke in London. Incidence of stroke has been reported to range from 81 to 150 per 100,000, doubling every decade after 55 years of age. 75 per cent of strokes occur in people over 65 years of age (90). 37 per cent of pensioners in London live alone which has implications for supporting home based rehabilitation.

10.3 The incidence of stroke is higher in Black people than in White people and it occurs at a younger age, with Black people in London having a 60% higher incidence than White people (91).

10.4 Strokes are the single most common cause of severe disability amongst adults. More than 250,000 people in the UK live with disabilities caused by a stroke (92).

Table 5: Prevalence of hypertension and stroke in London

	Sum of List Sizes	Sum of Register Counts	Unadjusted Prevalence – London	England average prevalence	Min Prevalence per practice	Max Prevalence per practice
Stroke	8,440,321	85,508	1.01%	1.61%	0.00%	23.48%
Hypertension	8,440,321	870,445	10.31%	12.49%	0.00%	51.74%

Data Source: QMAS database - 2006/07 data as at end of June 2007, Data prepared by ERPHO

Access to health care and patient experience

10.5 In 2006 no hospital trust in London gave at least 90 per cent of stroke patients a scan within the less-than-ideal benchmark of 24 hours (91). Patients who receive treatment with clot busting drugs within 90 minutes of the attack are twice as likely to survive or have less disability than those that do not. At the moment many people are not even having the initial scan within 24 hours.

What does Healthcare for London propose: a summary of the proposals relating to stroke pathways

10.6 Prevention of stroke through an increased focus on staying healthy though working with other organisations on health promotion, more investment in health improvement, pan-London initiatives and training and incentives for health care organisations and staff.

10.7 Changes in early diagnosis and treatment including:

- rapid assessment by ambulance staff using the FAST (face, arm, speech test) criteria and it should be determined whether the onset of their symptoms was within the treatment window of three hours;

- if that is the case, stroke patients should be taken direct to a hospital providing CT (computerised tomography) scans and interventional treatment. The stroke team at the hospital should take the patient directly to the CT scanner, so that they can be scanned as soon as the equipment is free. All patients should have a CT scan before being admitted to a stroke treatment unit. This should take place at one of seven stroke specialist centres;
- the CT scan will reveal if thrombolysis (the use of clot-busting drugs) is appropriate – thrombolysis can be used on ischaemic stroke patients but harms people with a haemorrhagic stroke. The aim should be that if a patient is suitable for thrombolysis they should receive it within one hour of the onset of stroke (although thrombolysis is effective within three hours of the onset of a stroke its impact diminishes within that time).

10.8 It is proposed that approximately seven hospitals should provide 24/7 care supported by full neuroscience expertise. Other hospitals could provide treatment during the day and rehabilitation services closer to people's homes. To decide on the best location of these specialist units a London-wide stroke strategy is proposed.

10.9 Improvements in the quality of rehabilitation, such as rapid access to a swallow screen (an assessment to test whether a patient is having difficulty swallowing) and prompt assessment and treatment by both physiotherapists and speech and language therapists in the days following a stroke.

10.10 Secondary prevention and education for patients and carers should also be part of the rehabilitative process. Rehabilitation and it should take place as close to their homes as possible. In some cases rehabilitation will be in patients' local hospital or polyclinic, and in many cases in their homes.

10.11 A London stroke strategy should be developed to work up these proposals and decide on the best location of these specialist units.

Discussion of the evidence and appraisal of potential impacts

The experience of equalities groups

Data collection

10.12 The existing data on the incidence of strokes, treatment interventions and outcomes for patients is inadequate to fully appraise the potential impact of the proposals for equalities groups. Most routinely collected data is not broken down into these groups. There is some information broken down according to gender, age, ethnicity and disability but this is not consistently collected and analysed. Where possible, research based upon user experience and other forms of community intelligence together with one off research studies have been used to understand the equalities groups' experiences now and the potential impacts of the proposed changes.

Access prevention services

10.13 Evidence has shown that deprived communities and vulnerable groups are less likely to benefit from health improvement and preventative services. Therefore, new services must address the factors that have prevented deprived communities and vulnerable groups from benefiting from earlier measures. These factors include lack of access to the building blocks of healthy lifestyles due to low income and poor physical access due to distance and lack of transport, isolation, stress, poor housing and low aspirations. If these services are targeted at deprived communities and vulnerable groups, they may be able to reduce the difference in lifestyles factors that constitute stroke risk factors between these groups and the population as a whole.

10.14 The costs of effective interventions for traditionally-under-represented groups are generally higher than untargeted interventions. For instance, Islington PCT has estimated that the cost per smoking cessation for certain hard-to-reach BAME groups is three times higher than the average. Unless extra funds are made available to target traditionally-under-represented groups, healthcare providers have an disincentive to do so (93).

10.15 However, health improvement and prevention services that do not target deprived communities and vulnerable groups may increase health inequalities. This is because they may improve healthy lifestyle factors in the population as a whole, thus potentially reducing the incidence of strokes, while the lifestyle factors and, therefore, susceptibility to stroke are either not improved or are improved at a lesser rate for deprived communities and vulnerable groups than for the population as a whole.

Incidence of stroke amongst different BAME groups

10.16 People from the South Asian community are more likely to have high blood pressure and diabetes and are therefore at greater risk of stroke.

10.17 African-Caribbeans are estimated to be twice as likely to have a stroke as Europeans and in London the incidence is 60% higher (91). They are also more likely to have their first stroke at a younger age. It may be due to health problems that are ore common amongst African-Caribbean's – such as high blood pressure, diabetes and sickle cell disease, as well as lifestyle factors such as smoking, drinking and obesity. In addition some studies have suggested that African-Caribbean people may possess genes that make them more prone to high blood pressure. Further research is currently underway to explore the causes of this higher incidence in more detail and to ascertain if some stroke subtypes are ore common amongst BAME communities than others (94).

10.18 As Black people are more likely to suffer strokes than White people, this equality group would benefit in particular from an improvement in the treatment of strokes. As BAME groups experience worst health than the population according to some indicators, this improvement could contribute to a reduction in health inequalities.

10.19 As Black people are at a higher risk of stroke, improvements in prevention could reduce health inequalities between these ethnic minority groups and the population as a whole. However, in order for this reduction to be realised prevention services should be targeted at BAME groups. They should also ensure they are properly designed to take account of any particular needs that this group has and be culturally sensitive.

10.20 Strokes are the single most common cause of severe disability amongst adults. Improvement in the prevention, treatment and rehabilitation could significantly impact on disability. Some people who would have suffered disability as a result of a stroke may avoid having a stroke because of improvements in the effectiveness of prevention. Others who experience strokes may have the degree of disability they suffer as a result, reduced because of improvements in diagnosis, treatment and rehabilitation. As 6,000 people in London suffer a stroke every year, the impact of this is potentially significant.

General or geographic health inequalities

Prevention

10.21 Poor diet, smoking, lack of exercise, high alcohol consumption and unhealthy lifestyle factors are thought to be risk factors for strokes. As people living in deprivation and other vulnerable groups generally have less healthy lifestyles, they may be more at risk of suffering a stroke. If this is the case, enabling these groups to improve their lifestyles and take advantage of other preventative measures could contribute to a reduction in health inequalities.

10.22 Reductions in smoking rates have a rapid impact on stroke, CVD and respiratory disease and a longer term impact on mortality from lung cancer.

10.23 The health inequalities element of the heart disease and stroke target is to narrow the gap in inequalities by at least 40% in the spearhead group compared to the national average by 2010. The Department of Health have highlighted treatment approaches for those who already have cardiovascular disease or who are at high risk of developing cardiovascular disease as key to meeting this target (28). In addition to reducing smoking rates the key interventions are:

- Managing high blood pressure in patients with disease and at high risk of disease (including patients with diabetes), using blood pressure drugs supported by advice and support on diet, exercise and smoking;

- Reducing cholesterol levels in patients with disease and at high risk of disease (including patients with diabetes), with dietary advice, statins and support;
- Ensuring effective emergency care and treatment for heart attack, including prompt thrombolysis and prescribing of aspirin, ace-inhibitors, beta-blockers and statins on discharge from hospital;
- Improved management of atrial fibrillation, reducing the risk of stroke.

10.24 The London Health Observatory has recently analysed trends in life expectancy and mortality to see if in London the 2010 targets will be met. Of the major causes of premature mortality, London is predicted to be on target for cancer. However, the inequality gap is widening for heart disease and stroke (95).

10.25 A study published in 2004 showed a 40 per cent reduction in stroke incidence in Oxfordshire over the past 20 years. The researchers suggested that the fall in stroke incidence was closely linked to the increased use of preventative treatments for stroke, and better control of risk factors in general. Preventative treatments included drugs that thin the blood, blood pressure and cholesterol lowering drugs. Patients who did not have strokes were also less likely to be regular smokers (96). This study indicates that effective prevention can have very significant impacts on the numbers of people suffering strokes.

10.26 Studies indicate that as many as one in five people who have a 'mini-stroke' or Transient Ischemic Attack (TIA), will go on to have a major stroke within a month. The risk of stroke during the seven days after a TIA appears to be highly predictable. However, there is variation between hospitals in the way in which they manage patients with suspected TIA immediately following the TIA event. In addition, public awareness of the symptoms of TIA and the need to seek medical attention urgently is poor. Improvement in the identification and management of patients who have suffered a TIA could improve stroke prevention (97).

Diagnosis and treatment

10.27 Improving access to fast diagnosis and treatment would improve outcomes for people who have strokes. Patients who receive treatment with clot busting drugs within 90 minutes of first symptoms are twice as likely to survive or have less disability than those that do not but in 2006 no hospital trust in London gave at least 90 per cent of stroke patients a scan within the less-than-ideal benchmark of 24 hours (98). As 6,000 people suffered strokes in 2005/2006, the impact of this improvement in treatment is potentially significant.

10.28 However, as it is not known how many of the stroke victims suffered ischaemic strokes which benefit from clot busting drugs, as opposed to haemorrhagic strokes which do not. Given that the existing proportion of patients that receive CT scans within 90 minutes is currently so low, it is reasonable to conclude that many patients could benefit.

10.29 A key rationale for the establishment of stroke centres put forward by the proposals is based on the hypothesis that concentrating interventions in the same facility and thereby increasing the volume, improves patient outcomes. This hypothesis is contested and has produced significant debate. It is often referred to as the volume and outcomes debate.

10.30 On the one hand those in favour of increasing volume argue that the complex demands of modern medicine require more skills and expertise from doctors and other medical professionals. To achieve this level of skill and expertise requires more specialization. It also requires that clinicians have a sufficient flow of patients in order to maintain and update their skills. In addition to the need for a sufficient patient flow, clinicians need to have access to expensive diagnostic and treatment tools that cannot be provided in every hospital because of the prohibitive costs. Therefore, hospital care must be specialised in fewer, larger units, rather than delivered in a greater number of district general hospitals. This way patient outcomes can be improved and better value for money obtained (99).

10.31 Others have pointed out that the evidence to support this argument is weak or non-existent (100). An important source of evidence is the systematic review of the evidence available on the volume/outcome relationship in health care, based upon data available up to 1996 published by the NHS Centre for Reviews and Dissemination at the University of York in 1997 (101). Although this review identified many studies that showed a volume/outcome association, the conclusion reached was that the bulk of research evidence was

methodologically flawed and of little value in forming decisions about the planning of the delivery of health services. There were three main conclusions on volume/outcome relationships:

- Case-mix: 'Most of the existing research, because it does not sufficiently take account of differences in case-mix, probably overestimates the impact of volume on the quality of care' (Summary Report, page 10, source 101).
- Causation: '... because none of the research indicates that increasing activity over time leads to improvements in clinical outcome, it is difficult to infer from results of cross-sectional studies which show better outcomes in higher-volume units that similar differences in outcomes can be expected by the expansion of an existing unit' (Summary Report, page 10, source 101).
- Thresholds: 'The most that the research evidence can support is a conclusion that if there are significant quality gains from increased volume, these gains appear to be exhausted at relatively low threshold levels. Volumes of activity above these thresholds should be achievable without significant structural changes, but may require a more sharply defined internal division of labour across consultant staff (which may be consistent with increased sub-specialisation within disciplines) (Summary Report, page 11, source 101).

10.32 Because of the important implications of this debate, the NHS Scotland commissioned a review of the research evidence, in particular looking at research published since 1997. Although this was not a systematic review, over 500 abstracts were scanned and 50 full papers reviewed in detail (102).

10.33 This review found "there is now a strong core of methodologically sound papers which use high quality data and appropriate statistical methods to explore volume/outcome relationships." It also found "very strong evidence of an association between volume and outcome in the direction that high volume surgeons and high volume hospitals tend to have superior outcomes compared to low volume surgeons and hospitals" (102).

10.34 The review referred to research that highlighted absolute differences in mortality rates of the order of 10% when high volume units are compared to low volume units in a number of complex high risk surgical procedures. Furthermore, it concluded the relationship between increased volume and improved outcome is likely to be continuous, with improvement even at relatively high levels of experience. For more common, less complex procedures, the improvement in outcome with increasing volume is likely to diminish beyond a certain threshold.

10.35 However, the review pointed to evidence that if the volume becomes excessive, the penalties of "overwork" lead to deterioration in outcome (102).

10.36 In addition to the review carried out for NHS Scotland, there is other evidence of better performance for larger units with bigger throughputs in relation to emergency interventions (103).

10.37 Although this evidence does not examined stroke services specifically, the diagnosis and treatment of strokes are emergency interventions. Therefore, the evidence pointing to improved outcomes with higher volume is applicable.

10.38 In addition, a Cochrane review has provided conclusive evidence that patients who receive organised inpatient care such as that provided by a multidisciplinary specialist team in a stroke unit, are more likely to be alive, independent, and living at home one year after stroke ((104) cited in (105)).

Rehabilitation

10.39 A Cochrane review has shown that for selected, moderately disabled stroke patients, early supported transfer of care from hospital to home using specialist stroke teams can reduce the length of hospital stay (on average by eight days), improve outcomes (reduction in risk of death or dependency by six patients per 100 patients treated), and improve patient satisfaction. A further Cochrane review has shown that stroke patients newly transferred home benefit from continuing contact with specialist therapy services, mainly in terms of

less deterioration seven patients do not deteriorate per 100 patients treated ((106;107) cited in (105)).

10.40 It is important to note that the strongest evidence for effective stroke rehabilitation relates to better outcomes associated with specialist, coordinated, multidisciplinary teams, both during early inpatient recovery and for resettlement at home. This means specialist care by multidisciplinary teams must continue after discharge (105).

10.41 While there is broad support for home based care and rehabilitation, this needs to be adequately funded. A survey by the Local Government Association found that earlier discharge of patients from NHS hospitals is resulting in an increased need for home or residential care. London is already spending significantly more than it is allocated for adult social care services (108).

10.42 If a shift to earlier discharge and home based rehabilitation for those who have suffered a stroke is not accompanied by an increase in funding for social care services, there is a danger that outcomes for these people will suffer. It is this case it is also likely that informal carers will have to assume the responsibility for supporting family members recovering from a stroke. Without proper support, caring responsibilities can negatively impact on the health of carers as well as the people for whom they care.

10.43 It is also important to bear in mind that while NHS services are universal and free at the point of use, social services are increasingly restricted to those with the highest need and means tested. Therefore, outcomes for people who are not entitled to social care services free of charge could deteriorate. This could also increase the reliance of those people on informal care, with associated negative impacts on the carer's health.

A summary of the potential impacts of stroke care pathway proposals

10.44 Table 6 summarises the direction of change expected to result from the stroke care pathway proposals. The symbols have the following meanings:

+	indicates a likely positive impact
–	indicates a likely negative impact
~	indicates the likely impact will be neither positive nor negative or negligible
x	indicates there is insufficient evidence to identify the likely impact

Table 6: Potential effects of stroke care pathway proposals

Proposal theme	Potential effect	Rationale
Increased emphasis on healthy living - principle 4 "prevention is better than cure	+	Good evidence that healthy lifestyles reduce risk of strokes in the population overall but in particular for deprived and vulnerable groups and equalities groups with high stroke prevalence – South Asian and African-Caribbeans.
	-	To ensure this proposal benefits equalities groups and has a positive impact on health inequalities, interventions need to tailored to and targeted at the needs of those groups. There is evidence that preventative work has higher costs with traditionally-under-represented groups.
Early diagnosis and treatment	+	Population level evidence to support this proposal. Concerns centre on 'tailoring and targeting' to ensure those most at need receive these improved services.
Increased quality of multi-	+	Evidence to support improved outcomes for the general population from specialist, co-ordinated multidisciplinary teams.

Proposal theme	Potential effect	Rationale
disciplinary rehabilitation and home based rehabilitation – principle 2 "services should be localised where possible, or regionalised where that improves the quality of care".	-	Concerns here centre on 'tailoring and targeting' to those most in need and training of specialists. In addition, adequate funding and provision of social care services is essential. Outcomes for those who are not eligible for free social care services could deteriorate.
Centralisation to seven hospitals with 24/7 care supported by full neuroscience – principle 2 "services should be localised where possible, or regionalised where that improves the quality of care".	+	In line with evidence for centralisation of specialist and emergency services.
	-	Adverse impacts of service centralisation include increased journey times and a loss of community 'ownership' of local services. The location of services as part of the London Stroke Strategy will determine the full extent of impact on equalities groups and health inequalities.

Recommendations on stroke pathways

10.45 PCTs should participate in further research to better understand the increased susceptibility of BAME to stroke, including which communities have an increased susceptibility and why, so as to better design prevention, treatment and rehabilitation to meet the needs of these communities.

10.46 PCTs should ensure that stroke prevention services are culturally sensitive to the needs of BAME groups and targeted to them in view of the higher incidence of stroke amongst these communities.

10.47 PCTs should ensure that stroke prevention services address the factors that have historically prevented vulnerable groups and deprived communities from benefiting from health improvement measures.

10.48 PCTs should ensure that stroke prevention services actively target vulnerable groups and deprived communities, as well as groups at a higher risk of stroke and that funds are made available to support this targeting.

10.49 PCTs must ensure that at a local level commissioning is informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require local health equity audits.

10.50 PCTs need to work with local authority social services and voluntary groups to ensure that measures are in place to identify and support carers.

10.51 Moves to earlier discharge and increased home based support will require shifts in funding from the NHS to social care agencies. NHS London and PCTs need to work closely with local

authority social services to ensure that home based rehabilitation is adequate resourced. It will also be important to ensure that social care is available to those discharged earlier free of charge. If adequate funding for social care is not available, health outcomes for stroke victims and their carers will suffer.

11. Issues outside the scope of this work

11.1 In London, the NHS contributes 10% of GDP and will spend £7 billion on new capital building projects in the next 7 years (NHS data quoted in source 93). The proposals in *Consulting the Capital* (1) would involve significant changes in the way that healthcare services are organised and delivered. This would have major implications for NHS employees. Some NHS sites may require more or less staff as a result of the proposals. Some new facilities may open and others close. The proposed changes in the models of care would also involve some more of some types of staff and less of others.

11.2 In addition to directly employed staff, many other people are employed by businesses and organisations that provide services to the NHS, such as premises maintenance, provision of meals and transport.

11.3 The employment provided by the NHS and its contractors makes an important direct contribution to local economies. It also provides an indirect contribution as many businesses depend on the custom of these employees. In deprived areas the NHS the significance of the NHS as a contributor to local economies may be even greater because there are few other major employers.

11.4 As income and employment are important social determinants of health, changes to employment could have significant impacts on health, particularly in deprived areas. The proposals could offer opportunities for increase employment and economic opportunities for deprived communities and equalities groups. Alternatively, if the net employment change results in a reduction of employment in deprived areas communities living in areas could be adversely affected.

11.5 The change in the professional requirements as a result in different models of care could also have positive benefits if effort is put into recruiting new staff from equalities groups. However, if the types of jobs which are now undertaken by members of equalities groups are those which are reduced, unemployment could increase amongst those groups with the associated negative health impacts.

11.6 The NHS is a major landowner. The proposals may involve the disposal of some NHS sites. There will be environmental and economic implications resulting from the disposal of and re-development of these sites. These environmental and economic implications can be expected to impact on health inequalities and the health of the equalities groups.

11.7 This rapid evidence review and appraisal has focused on the primary care, maternity care and stroke pathway proposals in *Healthcare for London: Consulting the Capital* (1) in line with the outcomes of the scoping exercise carried out as part of the HIIA/EqIA. The potential impacts of the proposals this report has not looked at also need to be assessed as they are likely to affect the equalities groups and health inequalities.

11.8 In view of the fact that four out of 10 children in London are living in poverty using the poverty threshold of 60% of median income, measures to improve child health and development are likely to have potential to reduce health inequalities amongst children (10). As childhood experiences are an important determinant of health and health related behaviours in adulthood, improving child health could also reduce health inequalities in adults. Because children from certain BAME communities, notably Bangladeshis and Pakistanis, are more likely to live in poverty, they are more affected by the health impacts of child poverty (10). In view of the high rates of child poverty, proposals in *Consulting the Capital* (1) relating to child health and development warrant particular attention to ensure they adequately address the health needs of children living in poverty.

11.9 The travel and transport implications of the reconfiguration of services need to be taken into account in further impact assessment work. At present, staff, patients and visitors to the NHS travel over 25 billion km a year and over 80% of these vehicle kilometres are by car (109). In London, the NHS is responsible for 5% of all journeys (NHS data quoted in source 93). The Sustainable Development Commission (109) state that

... walking, cycling and using public transport make an important contribution to tackling obesity and heart disease, and NHS organisations are in a good position to promote healthy methods of transport. Public transport offers a lower carbon option to car use, resulting in less pollution and a reduced contribution to climate change. Fewer and shorter car journeys can decrease road traffic, accidents, congestion, noise and air pollution, in turn reducing the pressure on health services. As an employer, the NHS could take the lead in tackling incentives such as heavily subsidised car parking and generous car user allowances, negotiating better public transport links, and promoting alternative ways of travelling to and from NHS premises.

11.10 The NHS is a major employer and landowner (110) and can reduce its carbon footprint and conserve biodiversity through a range of measures.

- The Sustainable Development Commission provides information and links to resources (111).
- The COHAB initiative looks at biodiversity and health (112)

Emerging recommendations on issues outside the scope of this work

11.11 Because the economic and employment impacts of the proposals are potentially significant, NHS London and the London Commissioning Group need to undertake more detailed modelling to explore the net job loss or gains, which areas they are likely to occur in and which equalities groups may be affected.

11.12 PCTs and NHS London need to undertake local impact assessments on proposed changes to individual services or sites to assess the potential impacts of affects on employment and local economies on health and health inequalities.

11.13 PCTs and NHS London need to ensure that the environmental and economic impacts on health and health inequalities, including how the affect the equalities groups, are considered as part of local impact assessments on proposals to dispose of and redevelop individual sites.

11.14 NHS London and the London Commissioning Group need to ensure that the potential impacts on health and health inequalities of the proposals included in *Healthcare for London: Consulting the Capital* (1) that are outside the scope of this rapid evidence review and appraisal are examined.

11.15 NHS London and the London Commissioning Group need to ensure that proposals relating to child health and development take account of the high rates of child poverty in London and address the health needs of children living in poverty.

11.16 NHS London and Primary Care Trusts work with the NHS Sustainable Development Unit to identify how the reconfiguration allows physical, social and environmental sustainability a core part of the NHS business case.

12. Key messages

Overall findings

12.1 A recurring theme is that the proposals could either increase or reduce health inequalities depending on *how* they are implemented. The changes to models of care proposed are likely to improve health outcomes. However, if these improvements primarily benefit those who already have adequate levels of access to quality healthcare and healthy lifestyles at the expense with those who currently have poorer access, health inequalities will increase.

12.2 In addition, while the implementation of the proposals *in full* is likely to improve health outcomes, their *partial* implementation could further exacerbate health inequalities. For example, a move to earlier discharge after stroke without an improvement in home support could lead to an addition burden on carers, who are themselves a vulnerable group whose health needs are often unmet.

12.3 In order for the proposals to reduce health inequalities the improved models of care need to benefit those who currently have the worst health. Broadly speaking this will involve several major changes to current healthcare models.

- *The inverse care law must be reversed*. More deprived areas and communities must receive resources, including funding, staffing and infrastructure, in line with the higher levels of health need.
- Models for *assessing and meeting unmet health* need should be developed and incorporated into PCT planning and performance management. There is a danger that vulnerable groups who currently cannot access healthcare will be left out of the improvements promised by the proposals, further increasing health inequalities between the most marginalized groups and the population as a whole.
- New models of healthcare must take account of the needs of equalities groups, vulnerable groups and those with the worst health by *addressing the barriers that have historically prevented equalities groups and deprived communities accessing health care* and benefiting from health improvement services. These barriers for different equalities groups include physically inaccessible services, a lack of language support and the cultural insensitivity of services. For deprived communities barriers also include poor access to healthy lifestyle choices, stress, social isolation, low aspirations and the affects of multiple deprivation such as poor housing, crime and fear of crime, unemployment, and poor access to services.
- New models of healthcare must be *targeted* at equalities groups, vulnerable groups and those with the worst health and provided at sufficient levels to meet their needs. This will necessitate developing ways of incentivising healthcare providers to work with traditionally-under-represented groups.

12.4 The lack of routine data collection and analysis on health outcomes for equalities groups means it is not possible to assess the likely impact of key proposals on some of the equalities groups. The inadequacy of the data will make it impossible to adequately monitor the impact of the proposals on equalities groups. NHS London and PCTs must work together to improve data collection and analysis on health outcomes for equalities groups as a matter of high priority.

12.5 Key groups at risk of experiencing continued health inequalities

- Carers
- People not currently registered with a GP
- Refugees, asylum seekers and newly arrived people who may have existing unmet health needs
- People with physical and sensory disabilities, reflecting the high numbers of inaccessible primary care premises based on most recent information
- People with mental health problems
- People with learning disabilities

Overall recommendations:

- NHS London and PCTs must ensure the implementation of Healthcare for London needs to reverse the inverse care law. Deprived areas need high quality health services and a level of provision that reflects the higher level of health need their populations' experience. This will require substantial shifts in resources, including funding and staffing, and investment in infrastructure.
- NHS London and PCTs must work together to improve data collection and analysis on health outcomes for equalities groups as a matter of high priority. London PCTs should explore with NHS London the possibility of using the QOF system to negotiate a London-wide incentive system to report equalities data as part of their reporting systems. PCTs and NHS London must prioritise improving routine data collection and analysis on the equalities groups.
- At a local level commissioning must be informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require PCTs to undertake local health equity audits and health inequality impact assessments.
- PCTs need to better understand groups that are not currently accessing healthcare and the extent of this unmet need by undertake local assessments. Resources and services must then be targeted to meet this unmet need.
- NHS London need to ensure that monitoring and addressing unmet need is included in the performance management of healthcare commissioners and providers.
- PCTs need to ensure that mainstream services are be designed to meet the needs of traditionally-under-represented groups by taking account of the low income, stress, social isolation, cultural sensitivities, lack of transport, poor access to exercise facilities.
- NHS London and PCTs need to ensure mainstream services are targeted at deprived areas and communities and vulnerable groups.
- NHS London and PCTs need to ensure extra funding and incentives are made available to ensure healthcare commissioners and providers do target these groups.
- NHS London must ensure that reducing health inequalities is included as an explicit objective in local plans for the implementation. NHS London needs to agree indicators for this objective. The focus of these indicators should be should be on better outcomes for client groups.
- NHS London and PCTs must ensure service infrastructure developments and reconfigurations re-provide existing inadequate and inaccessible premises, rather than incorporating them.
- NHS London and PCTs must ensure planning for accessibility by public transport must be included in an early stage of the development of polyclinics. Transport plans should be developed for each polyclinic and other major healthcare facility. Transport for London and NHS London should work together to provide PCTs with guidance on how to do this.
- When planning the reconfiguration of services Primary Care Trusts must be aware of, and have capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000 (6), Section 3 of the Disability Discrimination Act 2005 (7) and Part 4 of the Equality Act 2006 (8).
- NHS London and the Primary Care Trusts should ensure that the local reconfiguration of services takes full and proper account of the effects of the proposals on the physical and social environment.

13. Appendices

Appendix 1: Integrated impact assessment on the Healthcare for London strategy: defining the scope of the assessment

Purpose of the paper
This paper sets out the proposed scope of the integrated impact assessment of the *Health care for London* strategy, outlining the rationale for determining its scope. In this paper the scope refers to the limits of the assessment and does not refer to 'scoping' in the sense of setting out the process, timelines for the process, those involved or terms of reference. The scope forms part of the terms of reference of the steering group.

Introduction
The vision in *Health care for London: a framework for action* is to improve health services in London to provide better quality care for the people of London and reduce the inequalities of health that exist in the capital.

The strategy is based on 5 principles:
1. focusing on individual needs and choice;
2. localising services where possible, and centralising where necessary;
3. joined-up care and partnership working, maximising the contribution of the entire workforce;
4. prevention is better than cure;
5. reducing health inequalities.

The main recommendations in the strategy are about changing the structure of clinical services and introducing new models of care. The strategy is now out for consultation.

We need to consider the NHS not only as the main provider of health care services to people who are sick and at risk of ill-health, but also as a provider of employment and training opportunities to local communities. The impact of moving these opportunities to and from different geographical areas will have health consequences for the communities. Also NHS premises sometimes act as hubs in the community, e.g. health centres and healthy living centres. The social impact on communities of relocating the activities to different sites also needs to be considered.

Healthcare for London is a high level, 10-year strategy that does not include details of exactly where and how services should be reconfigured, some of which must be left to local decision-makers during implementation. Each locality will, therefore, need to carry out further health impact assessments and equalities impact assessments on their local plans. Therefore, this integrated impact assessment – combining a health inequalities impact assessment and equalities impact assessment – will focus on the detail in the consultation document, rather than on the initial framework.

Aim
The aim of this integrated impact assessment is to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process, to maximise health gains, to reduce or remove negative impacts and reduce inequalities.

The process
The impact assessment process is being overseen by the steering group, which will define the scope of the assessment, engage consultants to carry out the impact assessment, receive the report from the consultants and advise the London Commissioning Group accordingly. The

consultants will review the evidence, in the context of a baseline profile of health inequalities in London provided by the London Health Observatory.

Defining the scope

As an integrated impact assessment, there are two major themes:

1. reducing health inequalities
2. reducing negative impacts and promoting positive impacts for equalities target groups.

The scope of this integrated impact assessment defines the depth of the assessment, geographical boundaries and time limits, the communities and groups and determinants of health to be considered, and unit of analysis. It is proposed that we focus this impact assessment on the areas of the strategy with the potential to have the greatest impact on health and health inequalities. To determine which areas these are, we asked and tried to answer the following questions:

1. Which geographical areas will be affected?
   - The strategy sets out a vision for healthcare across the whole of London, but different areas will be affected differently. In which areas could health inequalities be reduced by implementing this strategy? In which areas could health inequalities be increased by implementing this strategy?
   - Will services improve or worsen in deprived areas by implementing this strategy?

2. Which proposals in the strategy are likely to evoke the greatest political and public interest?
   - All aspects of this strategy are likely to evoke public and political interest, especially if it is perceived as trying to close local hospitals and other local health facilities.
   - However, reconfigurations of primary care potentially affect everyone. Negative impacts could result from making it more difficult for some people to travel to GP premises. Conversely, positive impacts could result from the reconfiguration, or from a changed model that enables people who are not registered with a GP to receive care.
   - Hospital reconfigurations will affect a much smaller proportion of the population.

3. Where are the greatest inequalities currently in terms of models of care, geography, and communities or groups?
   - Which communities are most likely to be affected by the proposed changes?
   - How will each of the equalities target groups* be affected by the proposed changes?
   - How can we ensure that the inverse care law is reversed rather than reinforced by the proposed changes?
   - Are there areas that are currently poorly-served by health care services?

4. How do we ensure that this strategy leads to improvements in health and health outcomes, and not just service reconfiguration?

5. Which of the proposed structural changes are likely to have the greatest impact on inequalities?
   - Polyclinics?
   - Home care?
   - Local hospitals?
   - Elective centres?
   - Major acute hospitals?
   - Specialist hospitals?

6. Which of the proposed models of care are likely to have the greatest impact on inequalities?

- Changes to maternity services?
- Stroke care?
- Centralised trauma care?
- Changes to primary care services?
- Primary care is needed by everyone, those in good health as well as the ill; it impacts on all communities.
- Maternity services are required across all communities. Improving maternity care can ensure the best start in life for all.

It is also proposed that the impact assessment should focus on the 5 principles of the strategy.

Principle 1: focusing on individual needs and choice
- Will efforts to increase choice in health care increase choice for some Londoners, while reducing choices for others?
- How will choice of provision affect quality of care, especially for maternity services?

Principle 2: localising services where possible, and centralising where necessary
- What are the potential geographical health impacts, both in terms of access to health care services, and the wider determinants of health, such as access to NHS employment?
- Could making 'better use of' NHS premises actually worsen access to care or increase inequalities?

Principle 3: joined-up care and partnership working
- What are the potential health impacts of closer working between general practices?
- What are the potential health impacts of linking health service provision more to other services, such as social care, housing, careers advice and employment, benefits advice, etc.?
- What are the potential health impacts of linking primary care services to other services on the same premises, such as diagnostic and outpatient medical services, therapy services, such as psychological therapies, dietetics, physiotherapy and occupational therapy, etc.?
- How can we ensure more effective and more equitable care across the whole care pathway – from primary prevention to treatment and discharge – through stronger partnerships?

Principle 4: prevention is better than cure
- How can access to preventive services be improved by implementing this strategy?
- How can health promoting activities, as well as screening and immunisation, be built into the new care models and new service configurations?

Principle 5: reducing health inequalities
- This is one of the two overarching themes for the impact assessment.
- It is imperative that there is a specific focus on the potential impacts for each of the equalities target groups.

Scope

In light of the above, it is proposed that we limit the scope of this assessment to:

1. examining the proposed models of primary care delivery and their potential impact on health inequalities and, in particular, on the equalities target groups;
2. understanding the impacts of polyclinics, especially with regards to primary care and wider health-related services;
3. understanding the impacts of the proposed changes to maternity care, bearing in mind the very emotive nature of this area of care,
4. considering the impact on health inequalities and equalities groups of a new model of care; taking examples from parts of the stroke pathway, assessing the impacts from prevention, through primary care, to discharge back to community-based care;
5. focusing on the impacts of these 3 proposed changes on the equalities target groups;

6. focusing on the impacts of the proposed changes to primary care and maternity services on people with mental health and well-being problems;
7. focusing on those areas of London which are most deprived and have the greatest inequalities;
8. considering the likely impacts of these changes over the next 10 years.

Baseline Profile
The London Health Observatory is providing a profile of health inequalities in London, focusing on those areas that will underpin this impact assessment.

Data are available or can be provided (with some refinement) in the following:

<u>Access to primary care</u>
- GP-registered population vs. resident population
- GPs per 100K population
- Other primary care staff per 100K population
- Location maps of GP premises, housing density, IMD and/or social segmentation data, and public transport
- Avoidable emergency admissions for asthma, COPD, and diabetes mellitus

<u>Access to diagnostic services</u>
- Location maps of district general hospitals (DGH), independent sector treatment centres (ISTCs) and other acute sector premises

<u>Maternity</u>
The following indicators are those that are associated with poorer outcomes. They may be provided by borough/PCT, by country of mother's birth, and by mother's age. Where data are available, analysis by socio-economic group or ethnicity will also be provided.
- Births sole-registered by mother
- Births to teenage mothers – proportion by area
- Numbers of low birth weight babies
- Infant mortality.
- Gestational age at booking

<u>Mental health and well-being</u>
- Number of full-time posts dedicated to mental health promotion per PCT
- Prevalence and incidence estimates of common mental health problems and severe mental illness

<u>Stroke</u>
- Stroke prevalence
- Proportion of people who've had a stroke who were cared for in a specialised stroke unit
- Hypertension prevalence: actual vs. expected
- Treated hypertension

<u>Others</u>
- Unemployed as proportion of economically active
- Percentage claiming key benefits
- Percentage of people claiming disability benefits
- Older people supported to live in their own homes
- Availability of child care places

Appendix 2: List of vulnerable, disadvantaged and marginalized groups in London

Older people
Lone Parents
Families
Children
Young people (including students)
Pregnant Women
Unemployed people
People on low incomes (including shift workers)
Homeless People (including street homeless and homeless families in temporary accommodation)
Black and Minority Ethnic groups
Refugees and Asylum seekers
People with physical disabilities
People with learning disabilities
Carers (including child carers)
Gypsies and Travellers
Prisoners
Young Offenders
People with Mental Health issues
Mobile populations
People living in deprived areas

Modified from Rapid Appraisal Tool for Health Impact Assessment. Faculty of Public Health.

Appendix 3: Documents reviewed in the preparation of the interim report

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