

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

**Final report
March 2008**

Key Contact for this report:

Gail Findlay, Coordinator, London Health Commission
gail.findlay@london.gov.uk; Tel. 020 7983 4768

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About the London Health Commission

The London Health Commission is *the* strategic partnership for health in London. We are a broad, independent alliance of organisations from all sectors that have a significant span of influence on health and the factors that affect it across the city. We create partnerships to reduce health inequalities in the capital and improve the health and wellbeing of all Londoners. We influence policy makers and practitioners, support local action, and drive priorities through specific joint programmes of work.

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Abbreviations and acronyms

A&E	Accident and Emergency
BSL	British Sign Language
CSIP	Care Services Improvement Partnership
DH	Department of Health
EqIA	Equality Impact Assessment
FGM/C	Female genital mutilation/cutting
GLA	Greater London Authority
HIIA	Health Inequalities Impact Assessment
HfL	Healthcare for London
IMD	Index of Multiple Deprivation
IMR	Infant Mortality Rate
LHC	London Health Commission
LEFM	Local Economic Forecasting Model
LHO	London Health Observatory
LTCs	Long-term conditions
NHS	National Health Service
NHSD	NHS Direct
NICE	National Institute of Health and Clinical Excellence
QOF	Quality outcomes framework
PCT	Primary Care Trust
RERA	Rapid evidence review and appraisal
TIA	Transient ischaemic attack
WHO	World Health Organization

1. Foreword

As Chair of the London Health Commission (LHC) I am delighted to present this report on the Health Inequalities and Equality Impact Assessment that we have led on the proposals for changes to NHS services which are set out in *'Healthcare for London-Consulting the Capital'*.

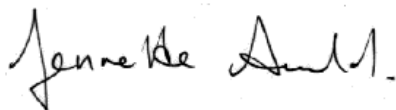
Health inequalities and equality impact assessments are powerful planning tools that support decision makers in all sectors to ensure policies, strategies and/or plans are designed in ways to maximise the beneficial effects, and minimise adverse effects, on health and inequalities. The London Health Commission has led the field nationally and internationally in the development of health impact assessment approaches. Our aim, in line with the European Commission's health strategy, is to ensure the integration of 'health in all policies'.

In leading this significant impact assessment we have drawn on our considerable experience and expertise in undertaking health and integrated impact assessments on a range of major pan London strategies, including each of the Mayor of London's statutory strategies.

'Healthcare for London' is a comprehensive and ambitious framework for change. It offers a unique opportunity to reverse the 'inverse care law' in London that has meant that for too long those people who most need healthcare are least likely to receive it, or receive poor quality services.

An important message in this report is that the process of health inequalities and equality impact assessment must be ongoing throughout the further development and implementation of the proposals in 'Healthcare for London' to ensure a positive impact on health inequalities and equalities.

The LHC, as *the* strategic partnership for health and health inequalities in London, is ideally placed, and looks forward to, continuing to work with the NHS in London to ensure the impact assessment process is ongoing and the recommendations from this report are carried out. This will ensure that the opportunities to reduce health inequalities and improve health outcomes for the most vulnerable and disadvantaged groups in London are maximised and that healthcare in London can be truly fit for our world class city.



Jennette Arnold, Chair London Health Commission

2. Executive summary and priority issues and actions

This is the final report of the integrated Health Inequalities and Equality Impact Assessment (HIIA/EqIA) on the proposals contained in *Healthcare for London: Consulting the Capital* (1), published on 30 November 2007.

NHS London and the London Commissioning Group requested that the London Health Commission (LHC) undertake this HIIA/EqIA. The HIIA/EqIA process was overseen by a steering group made up of members and representatives of the London Health Commission and the London Equalities Commission.

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.

The HIIA/EqIA was made up of five key stages:

- scoping;
- rapid review and appraisal of evidence;
- baseline health equity profile;
- stakeholder workshop; and
- preparation of the HIIA/EqIA report.

This report considers the impact on equality groups: it not only assesses the impact on race, disability and gender equality, as statutorily required, it also assesses the impact on age, faith and sexual orientation equality.

An initial scoping exercise was carried out on *Healthcare for London: Consulting the Capital* (1) to assess which of the policies were most relevant for equality across the six strands (age, disability, ethnicity, faith, gender and sexual orientation). The following policies were identified as being of most relevance and a full Health Inequalities Impact Assessment and Equality Impact Assessment has been carried out on these policies:

- Proposals for Primary Care; which will impact on *all* communities and groups. Access to good quality primary care is needed by *all* and is the gateway for access to more specialist healthcare services for those who need them.
- Proposals for Maternity Care; which will impact on *all* communities and groups. Good quality maternity care is important at the beginning of *all* new lives and is vital to maternal health.
- Stroke Pathway; as an example of how a new healthcare pathway could impact on health inequalities and equalities. We were particularly interested in the aspects of the pathway concerned with prevention, primary care and discharge back to community-based care.

This HIIA/EqIA report draws together the key findings and recommendations for each of these services made during the impact assessment process. These are provided in sections 6, 7 and 8 of this report.

The recommendations we make are strategic in nature and are intended to assist the NHS in London in addressing health inequalities and equality and improving health through the further development and implementation of Healthcare for London.

Healthcare for London is a strategic framework: the LHC recognise that the effects of Healthcare for London on equalities and on health inequalities are largely dependent on the way in which this framework is implemented. The proposed changes to models of care are likely to improve health outcomes. However, health inequalities are likely to increase and equality groups will suffer disproportionately if these improvements primarily benefit those who already have adequate levels of access to quality healthcare and healthy lifestyles.

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 need are often unmet.

At this stage the LHC recommends that Healthcare for London increases consideration of health improvement for all Londoners and has particular regard to equality groups.

As well as a comprehensive list of overall and specific recommendations, LHC has provided a priority issues and actions checklist (see Table 1 on page 7 below) as the basis for ongoing dialogue between the London Health Commission, other partners and stakeholders and Healthcare for London about improving health for all Londoners, and for all equality groups, and reducing health inequalities within London.

Healthcare for London should, in addition to the overall recommendations and priority issues and actions, ensure they address all the recommendations provided in the supporting documents and in particular *Scientific Annexe II: the rapid evidence review and appraisal (2)*; these include recommendations specific to primary care, maternity care and stroke pathways

We provide below the overall recommendations from the HIIA/EqIA and some important recommendations relating to areas which lie outside the scope of this HIIA/EqIA.

Overall Recommendations to Healthcare for London

- Ensure the implementation of Healthcare for London reverses the inverse care law. Deprived areas need high quality health services and levels of provision that reflect the higher level of health need their populations' experience. This will require substantial shifts in resources, including funding and staffing, and investment in infrastructure.
- Work throughout the NHS in London to improve data collection and analysis on health outcomes for equalities groups as a matter of high priority (see Table 2 on page 15 for a list of equality groups). 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.

- Ensure that 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 PCTs to undertake local health equity audits and health inequality impact assessments. Resources and services must then be targeted to meet this unmet need.
- Ensure that monitoring and addressing unmet need is included in the performance management of healthcare commissioners and providers.
- Ensure that mainstream services are be designed to meet the needs of traditionally-under-represented groups by taking account of low income, stress, social isolation, cultural sensitivities, lack of transport, poor access to exercise facilities.
- Ensure mainstream services are targeted at deprived areas, communities and vulnerable groups. Access is of paramount importance in London as the population is highly mobile: a model of passive service delivery will not reach all equality groups and the HIA/EqIA recommends service delivery that includes effective outreach.
- Ensure extra funding and incentives are made available to ensure healthcare commissioners and providers do target these groups.
- 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.
- Ensure service infrastructure developments and reconfigurations re-provide existing inadequate and inaccessible premises, rather than incorporating them.
- 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.
- Ensure that when planning the reconfiguration of services all Primary Care and NHS Trusts are fully aware of, and have capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000 (3), Section 3 of the Disability Discrimination Act 2005 (4) and Part 4 of the Equality Act 2006 (5).
- Ensure that the local reconfiguration of services takes full and proper account of the effects of the proposals on the physical and social environment.

The HIIA/EqIA also made a number of recommendations on issues outside the scope identified by the steering group. These are provided below.

Important recommendations to Healthcare for London on issues outside the scope of this HIIA/EqIA.

- 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.
- 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.
- Undertake more detailed modelling to explore the net job loss or gains, which areas they are likely to occur in and which equality groups may be affected.
- Ensure that PCTs undertake local impact assessments on proposed changes to individual services or sites to assess the effects on employment and local economies.
- 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.
- 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.

Priority Issues and Actions

LHC has provided, in outline, a priority issues and actions checklist (Table 1) to be addressed in the further development and implementation of Healthcare for London. Healthcare for London will need to develop this further to identify the most appropriate responsible bodies, milestones and timetable to address the issues and complete the actions.

In addition, LHC recommends that partner organisations involved in local discussions and scrutiny on Healthcare for London refer to these priority issues and actions in their ongoing consideration of the proposed NHS changes in Healthcare for London.

LHC will be seeking further dialogue with Healthcare for London about their plans for addressing the priority issues and completing the actions; including seeking assurances that health inequalities and equality impact assessment, monitoring and evaluation, will be ongoing throughout the further development and implementation of Healthcare for London.

Table 1: Priority issues and actions

Issue and action	Indicative Milestone
<p>Priorities and resources</p> <p>1.1 In the service reconfiguration associated with implementation of Healthcare for London (HfL), resource allocation and redistribution should be strongly needs led and reflect the higher levels of need in deprived communities and equality groups.</p>	<p><i>Resource allocation and redistribution to reverse the ‘inverse care law’, to reduce health inequalities and towards health improvement and prevention services, identified as a key feature of world class commissioning for the NHS in London.</i></p>
<p>1.2 Increase mainstream investment to ensure mainstream provision of preventive services and health promotion as an explicit strand through out each model of care and care pathway; and targeting those with greatest needs</p>	<p><i>HfL and PCTs to develop clear and robust plans to increase mainstream investment in prevention and health promotion</i></p>
<p>1.3 Provision of services that prevent ill health and promote good physical and mental health for equality groups should be strongly incentivised.</p>	<p><i>New incentives identified in further development and implementation plans for HfL.</i></p>
<p>1.4 Health improvement services to take account of the wider, social determinants of health, and work with target communities and groups to develop appropriate health improvement programmes.</p>	<p><i>Increase in investment in ‘community led’ models for health improvement based on community perceived needs and evidence based (or evaluated) solutions.</i></p>
<p>Assessing and meeting (diverse) needs</p>	
<p>2.1 The local NHS to take proactive steps to identify and include the (unmet) needs of equality and vulnerable groups in decision making, planning and implementation of HfL</p>	<p><i>Needs and unmet needs of equality and vulnerable groups prioritised within further development and implementation plans for HfL</i></p>
<p>2.2 Identification of and action to meet unmet needs to become an ongoing priority in routine planning and commissioning processes.</p>	<p><i>Mechanisms for identifying unmet needs of equality and other vulnerable groups explicit within mainstream planning and commissioning processes.</i></p>
	<p><i>All NHS services subject to regular Health Equity Audit</i></p>

Issue and action	Indicative Milestone
<p>2.3 Joint Strategic Needs Assessments, which are informed by public and patient experience, should specifically include the experience of equality and vulnerable groups</p>	<p><i>Experience of equality and other vulnerable groups is explicit within all JSNAs</i></p>
<p>2.4 Increase investment in awareness and capacity building programmes to ensure that all NHS Trusts are fully aware of, compliant with and proactively develop capacity to meet the requirements of section 71 of the Race Relations (Amendment) Act 2000, Section 3 of the Disability Discrimination Act 2005 and Part 4 of the Equality Act 2006.</p>	<p><i>All NHS Trusts in London fully compliant with RRA, DDA and EA</i></p>
<p>Monitoring and evaluation 3.1 NHS London should establish a set of routinely collected outcome indicators for PCTs to monitor improvements in health and well-being, and reduction in health inequalities, of equality groups.</p> <ul style="list-style-type: none"> • PCTs performance managed against these improvements • Mechanisms to be found to make better use of existing data; eg GP data (beyond QOF requirements) 	<p><i>Agreed indicator set and regular, accessible reporting as part of PCT performance management.</i></p>
<p>3.2 NHS commissioners should require all providers of NHS commissioned care to collect, evaluate and report accurate and comprehensive equalities data.</p>	<p><i>This requirement embedded in all contracts with service providers</i></p>
<p>3.3 Process of health inequalities and equalities impact assessment to be undertaken on all aspects of HfL; this should include, as first priority, the proposed new models of care relating to mental health and to children's services.</p> <p>HIIA and EqIA must be ongoing at all stages and levels of development and implementation of all aspects of healthcare for London and beyond</p>	<p><i>HIIA/EqIA to be completed on the proposals for Mental Health and for Children's services when they are published</i></p> <p><i>Coordinated programme of HIIA and EqIA to be agreed for the different stages and at the different levels; NB. LHC can advise on this forward programme of impact assessment</i></p>

Issue and action	Indicative Milestone
<p>4.1 Geographic proximity to services versus access to an increased range, more specialised and/or better quality services.</p> <p>Eg In relation to polyclinics, PCTs should identify who gains and who loses from the trade-off between geographic proximity to primary care versus access to an increased range of services and how this is managed to ensure equity and equality of access.</p>	<p><i>Consideration of these issues/trade-offs to be explicit in the plans for further development implementation of HfL</i></p>
<p>Workforce Skills and Capacity</p> <p>5.1 Prioritise innovative workforce development plans to support delivery of the HfL service strategies at pan-London and local levels</p> <ul style="list-style-type: none"> • Existing and new workforce and skills to be distributed across London according to health need...eg to improve access to primary care in disadvantaged communities • Local workforce plans designed to secure workforce which is reflective of the diversity in local populations and sensitive to their care and wider social and cultural needs 	<p><i>Health inequalities and equality issues explicitly addressed in workforce development plans that are sustainable, can be monitored and have clear lines of accountability.</i></p>
<p>Joint working with social services</p> <p>6.1 Acknowledge the impacts of HfL reforms on families, carers, community and social care services, particularly for equality groups, other disadvantaged and vulnerable groups.</p> <p>6.2 Proactively seek to ensure that adequate NHS resources are in place to enable good quality care in the community</p> <p>6.3 Maximise the opportunity to align with the social care reform agenda</p>	<p><i>Impact assessment and ongoing monitoring and evaluation to include consideration of impact on other local services</i></p>

Issue and action	Indicative Milestone
<p>Service accessibility</p> <p>7.1 All NHS funded care to be accessible to equality groups: including, but not limited to, physical access requirements, language support services and the needs of those with sight and hearing restrictions</p>	<p><i>HfL to go beyond the minimum statutory requirements for access and to set high standards for service accessibility for ALL disadvantaged and equality groups</i></p> <p><i>London PCTS and NHS Trusts to collectively sign up to and invest in the London Language Support Services Strategy (a cross public sector strategy developed by LHC)</i></p>
<p>7.2 Provide incentives and invest in outreach activity that:</p> <ul style="list-style-type: none"> • proactively seeks to increase access for the most disadvantaged and for all equality groups • engages people from these groups in initiatives that promote health and identify and respond earlier to health risks. 	<p><i>Mainstream models of outreach for key services (to reach equality and other disadvantaged groups) in place as part of implementation of HfL.</i></p>
<p>7.3 Work in partnership with other agencies to provide effective outreach services</p>	

3. Introduction and background

In this section we describe the background to the HIIA/EqIA.

- Section 4 describes the methodology used for the HIIA/EqIA.
- Section 5 provides key definitions.
- Section 6 summarises the findings and recommendations of the rapid evidence review and appraisal. For full report see Scientific Annex II
- Section 7 gives the key points from the baseline health equity profile. For full report see Scientific Annex I
- Section 8 summarises the key findings of the stakeholder workshop.
- Section 9 is the equality impact assessment prepared using the standard GLA format for strategic documents.

Background

Healthcare for London: Consulting the Capital (1) was published by NHS London and the London Commissioning Group on 30 November 2007. It seeks views on comprehensive proposals for fundamental changes in the way health care is delivered in London. These proposals were first put forward in *Healthcare for London: A framework for action* (6) published in July 2007. In November 2007 NHS London and the London Commissioning Group requested that the London Health Commission undertake an integrated health inequalities and equality impact assessment (HIIA/EqIA) on *Healthcare for London: Consulting the Capital* (1).

The HIIA/EqIA was made up of five key stages:

- A scoping exercise
- A rapid evidence review and appraisal
- A baseline profile
- A stakeholder workshop
- Preparation of the HIIA/EqIA report.

The aim of the integrated HIIA/EqIA 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'.

This report not only assesses the impact on race, disability and gender equality, as statutorily required, it also assesses the impact on age, faith and sexual orientation equality.

The relevant legislation is

- Race Relations (Amendment) Act 2000;
- Disability Discrimination Act 2005; and
- Equality Act 2006.

And the relevant statutory codes of practice are as follows

- Statutory code of practice on the duty to promote race equality, Commission for Racial Equality, 2002;

- Duty to promote disability equality, Statutory Code of Practice England and Wales, Disability Rights Commission, 2006; and
- Gender Equality Duty, Code of Practice England and Wales, Equal Opportunities Commission, 2006).

An initial assessment was carried out on *Healthcare for London: Consulting the Capital* (1) to assess which of the policies were most relevant for equality across the six strands (age, disability, ethnicity, faith, gender and sexual orientation). The following policies were identified as being of most relevance and a full impact assessment has been carried out on these policies:

- Proposals for Primary Care; which will impact on *all* communities and groups. Access to good quality primary care is needed by *all* and is the gateway for access to more specialist healthcare services.
- Proposals for Maternity Care; which will impact on *all* communities and groups. Good quality maternity care is important at the beginning of *all* new lives and is vital to maternal health.
- Stroke Pathway; as an example of how a new healthcare pathway could impact on health inequalities and equalities

This report describes the stages and pulls together the main findings of the assessment. It is supported by the following documents (available separately):

- The scoping paper describes the methodology and outcomes of the scoping exercise.
- The baseline study prepared by the London Health Observatory gives additional information on the health inequalities and the experience of equalities groups now. (Scientific Annex I)
- A more detailed discussion of the evidence, findings and recommendations can be found in the report of the rapid evidence review and appraisal, prepared by Ben Cave Associates. (Scientific Annex II)
- The write-up of the stakeholder workshop.

The HIIA/EqIA was overseen by a steering group that approved the findings and recommendations included in this report and the more detailed documents listed above. The steering group included representatives of the LHC and London Equalities Commission.

In addition to the activities undertaken by the LHC, Healthcare for London have commissioned Ipsos Mori to collate and analyse the public consultation responses. Health Link has also been commissioned to undertake face-to-face consultation with traditionally under represented groups. The outcomes of these consultations will need to be considered in the further development and implementation of Healthcare for London.

The HIIA/EqIA took place between November 2007 and 27 March 2008 when the final report was submitted to NHS London. HIIA/EqIA should be considered as an ongoing process throughout the development and implementation of the proposals. Because of the high level nature of proposals at this stage, the HIIA/EqIA process to date has not looked at specific NHS Trust service reconfigurations or the implementation of proposals in specific localities and their likely impact.

4. Methodology

First stage: scoping the HIIA/EqIA

In view of the comprehensiveness and wide ranging nature of the proposals included in *Healthcare for London: Consulting the Capital* (1), it was considered important to focus the HIIA/EqIA on those proposals most likely to impact on health inequalities and the equalities groups. The steering group met to undertake a scoping exercise that identified 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 three 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 wellbeing 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 ten years. A full report of the scoping exercise is also available separately.

The HIIA/EqIA, therefore, is limited to these eight areas. However, where issues outside this scope that are considered likely to impact on health inequalities and equalities groups have been identified in the course of the HIIA/EqIA, these are highlighted in this report.

Second stage: a rapid evidence review and appraisal

In December 2007 Ben Cave Associates were commissioned to undertake a rapid evidence review and appraisal (RERA) (2). Over 70 sources were identified that offered evidence of how the proposals could impact on health. The evidence included systematic reviews, grey literature and community intelligence.

Using this evidence, in conjunction with data provided by the Health Equity Profile, possible impacts on health inequalities and equalities groups were identified and recommendations made to maximise potential positive impacts and minimise potential negative ones.

The RERA is available separately as Scientific Annexe 2 to this report.

Third stage: preparation of the baseline profile

The London Health Observatory prepared a health equity profile bringing together and analysing up to date data on health inequalities and the health experience of the equalities groups (7).

Because of the inadequacy of data on the health experience of equalities groups, the baseline profile included a gap analysis of what data is and is not available for each of the equalities groups (see Table 6 on page 34).

The baseline profile was prepared at the same time as the RERA. It is also available separately as Scientific Annexe 1 to this report.

Fourth stage: Stakeholder workshop

On 27 February 2008, the LHC hosted a stakeholder workshop to discuss the potential impacts of the proposals on health inequalities and the equalities groups.

Over 50 people attended the workshop, including representatives from organisations and forums of equalities groups.

Fifth stage: Preparation and presentation of final report of the HIIA/EqIA

BCA prepared this report with guidance from, and on behalf of, the LHC.

5. Key definitions

Equalities

The HIA/EqIA has used the definition of equalities of the Greater London Authority (GLA). This definition is based on equality 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’ (8).

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 2: Equality groups

Equality Theme	Equality Group
Age	Children (0- 2 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

In addition to the equalities groups defined by the GLA, several other dimensions of equality and inequality are discussed in this report and the supporting documents.

Firstly, there is 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 equality 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, there is some discussion of 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, there is some discussion of health inequalities experienced by vulnerable groups where this has not already been captured under the equalities groups.

Finally, there is discussion of people with mental health and well-being problems because of its inclusion as an area of focus in the scoping paper.

Health inequalities

The potential scope of exploration and analysis of health inequalities is huge. The GLA Act 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’ (9).

Given the range of causes and consequences of health inequalities, there are many possible indicators including indicators of health such as 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.

Any discussion of health inequalities must also acknowledge the important role of the social determinants of health in shaping individual health and wellbeing. These social determinants include employment, education, housing, transport, community safety and wider community and social influences (10). Therefore, they could also be used as indicators of health inequalities.

Because the proposals this HIA/EqIA is concerned with primarily relate to health service provision, the main focus of this report is necessarily healthcare, itself one of the determinants of health. Therefore, discussion of health inequalities focuses on into health status and outcomes – which includes indicators such life expectancy, infant mortality and morbidity – and health services – which includes indicators of access and patient experience.

Life expectancy is defined as the number of years a baby would be expected to live if he or she experienced current mortality rates throughout their lifetime. Morbidity is the health or illness experience of the population including prevalence and incidence (11).

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.

Patient experience covers patient satisfaction, cultural sensitivity and reported appropriateness of services.

6. Key findings and recommendations of the Rapid Evidence Review and Appraisal

As directed by the scoping exercise undertaken by the LHC, the Rapid Evidence Review and Appraisal (2) focused on the primary care, maternity care and stroke pathway proposals included in *Consulting the Capital* (1), with additional information taken from the earlier report *A framework for action* (6).

The review identified and reviewed evidence to build understanding of how the proposals contained in *Healthcare for London: Consulting the Capital* (1) may impact on health inequalities and equality groups in London. It was 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 costs.

This Rapid Evidence Review and Appraisal drew on systematic reviews but was not 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 were used, including grey literature, systematic reviews, community intelligence and primary research. Over 90 sources of evidence were identified and reviewed.

The full report is available separately (2).

Overall Findings

A recurring theme throughout the impact assessment 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.

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.

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 properly monitor the impact of the proposals on equalities groups.

In order for the proposals to reduce health inequalities the improved models of care need to benefit those who currently have the worst health. This requires major changes to current healthcare models. The implications of these findings are listed below.

- In order to reverse *the inverse care law*, 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 to 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 marginalised 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 equality groups, vulnerable groups and those with the worst health and provided at sufficient levels to meet their needs. This will necessitate developing ways of giving incentives to healthcare providers to work with traditionally-under-represented 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.

Overall recommendations

NHS London and PCTs must ensure the implementation of Healthcare for London reverses the inverse care law. Deprived areas need high quality health services and a level of provision that reflects the higher health needs of their populations. 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 (see Table 2 for a list of equality groups). 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 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. Access is of paramount importance in London as the population is highly mobile: a model of passive service delivery will not reach all equality groups and the HIA/EqIA recommends a service delivery that includes effective outreach.

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 (3), Section 3 of the Disability Discrimination Act 2005 (4) and Part 4 of the Equality Act 2006 (5).

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.

Primary care findings and recommendations

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 disproportionately 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 housebound people 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

Proposal theme	Potential effect	Rationale
		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 patients value the extra time available for nurse led consultation.
	~	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	+	
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. <i>Good</i> 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. Patients value continuity of care offered by local practices 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) (12).
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. Patients value continuity of care offered by local practices and the RCGP

Proposal theme	Potential effect	Rationale
		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) (12).
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) (12).
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.

Primary care recommendations

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 that reflects their need.

NHS London and PCTs should work together to ensure ways continuity of care could 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 colocated 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 seekers 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 that 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 2 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 (13). 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.

Maternity care findings and recommendations

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 midwives.
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 the 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.

Maternity care recommendations

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 antenatal booking. PCTs should undertake health equity audits of women booked for antenatal 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 or 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.

Stroke care pathway findings and recommendations

The findings and recommendations specific to the stroke pathway proposals focus on the beginning (prevention) and end (resettlement) of a stroke pathway as being key to equalities and health inequalities. The RERA also examines the range of actions in between these two end points.

Table 5 summarises the expected direction of change resulting from the stroke 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 5: 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-Caribbean people.
	-	To ensure this proposal benefits equalities groups and has a positive impact on health inequalities, interventions need to be 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-disciplinary rehabilitation and home based rehabilitation – principle 2 'services should be localised where possible, or regionalised where that improves the quality of care'.	+	Evidence to support improved outcomes for the general population from specialist, co-ordinated multidisciplinary teams.
	-	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.

Stroke care pathway recommendations

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 adequately 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 the HIA/EqIA

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.

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.

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.

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.

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.

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.

7. Key findings of the baseline study

The London Health Observatory prepared a baseline study, 'the London Health Equity Profile' as part of the HIA/EqIA (7). The aim of the equity profile was to describe inequalities in health and in access to health services in London, using specific indicators of determinants of health and access to health care.

The equity profile is not comprehensive, but provides an overview of health and health services in London, with particular reference to *Healthcare for London* proposals and their potential impacts on equalities target groups and people living in the most deprived areas of London. The equity profile focuses on the following dimensions of inequality:

- age;
- gender;
- geography;
- ethnicity; and
- deprivation.

The baseline study included a gap analysis of routine sources of data on the equalities groups collected by healthcare agencies.

Equalities groups

- London is a very populous and diverse city.
- London is a predominantly young city, with two thirds of residents being 40 years old or younger.
- London is also ethnically and religiously diverse: a third of Londoners are of ethnic minority origin and a significant majority of residents of each borough belongs to a faith group.
- The capital is not uniform and individual boroughs are ethnically diverse to different degrees.
- Migration makes an important contribution to population change in London, but net migration cannot be measured.

Implications

- Targeted interventions will probably be required to ensure that the proposed changes result in services that provide services to meet the diverse needs of the diverse population of London.

Inequalities

- Inequalities in health mirror inequalities in general.
- There are both very affluent and very deprived areas and people in London.
- Levels of income deprivation and unemployment vary between boroughs, with unemployment ranging from seven per cent in Richmond, the most affluent area of London, to 24 per cent in Hackney, one of the most deprived.

- London has 11 of the 70 areas in England that are in the most deprived fifth of areas and that are in the worst fifth of areas for life expectancy and mortality from cardiovascular disease and cancer.
- The equalities target groups, which have historically been disadvantaged or subject to discrimination, tend to have poorer access to health services and worse health outcomes than the general population.
- Life expectancy is highest and all-age, all cause mortality is lowest in affluent Kensington and Chelsea, while highest all-age, all cause mortality occurs in more deprived areas, such as Barking and Dagenham, Islington and Newham.

Implications

- Local factors, both area factors and individual factors, must be considered when implementing the Healthcare for London proposals in any given area.

Primary care

- There is marked variation in several aspects of access to primary care services across London boroughs.
- Some boroughs are currently under-doctored, i.e. there are fewer GPs per weighted population than the England average.
- There is variation in PCT performance on providing GP access within 48 hours of requesting an appointment, ranging from less than 70 per cent in Tower Hamlets to over 90 per cent in Kingston.
- Seven PCTs appear to have a significant resident population (more than 10,000), who are not registered with a GP. This could represent a significant problem with access to primary care, but needs to be looked into further for full understanding.
- Primary care quality is even more variable than access, as measured by potentially avoidable emergency hospital admissions. These vary from just over 100 per 100,000 of population in Kensington and Chelsea to around 300 per 100,000 of population in Ealing.

Implications

- Reorganisation of primary care services needs to take into account the potential difficulty of recruiting GPs into certain areas.
- Making it easier to register with a practice or making provision for unregistered populations to receive adequate services will also be important.

Preventative health care

- There is variation in access to and uptake of preventive services, which could be explained in part by different health seeking behaviours of different groups, but also in part by inability of services to reach certain groups.
- London shows variation in access to and effectiveness of smoking cessation services.

- Variation in access occurs by age and by borough. The worst access/poorest uptake of smoking cessation services is among those under 18 years, while 18 to 34 years old have the highest uptake.
- In Ealing nearly 80 per cent of those smokers, who set a quit date with smoking cessation services remained quit at four weeks. Whereas, in Croydon only 40 per cent were converted to four week quitters.
- There are variations in uptake of childhood immunisations at all ages and across boroughs. The picture is complex, with coverage differing between individual vaccines and no clear relationship to deprivation or affluence.
- Variations in uptake of flu vaccine by older people are less than for childhood immunisations.

Implications

- Understanding local factors and more precisely targeting preventive interventions could help improve their uptake and effectiveness.

Maternity care

- High proportions of sole registered births, teen pregnancies and low birth weight occur in some of the most deprived London boroughs.
- Low birth weight shows marked variation across London with rates almost doubling from the lowest, in Richmond, to the highest, in Southwark.
- The infant mortality rate is three to four times higher in the areas with the highest rates than in the areas with the least infant deaths.

Implications

- To ensure the best outcomes, there might be more need for specialised obstetric units – or at least ready access to them – in the most deprived areas, with higher rates of risk factors for poor neonatal outcomes.

Stroke pathways

- Stroke is a major cause of death and disability, contributing to the gap in CVD mortality between the spearhead areas and the country as a whole.
- There are ethnic variations in prevalence of hypertension and occurrence of strokes. The incidence of stroke is 60 per cent higher in black people than in white.
- Stroke is primarily a disease of older people – 75 per cent of strokes occur in those over 65 years.
- Despite its importance as a risk factor for CVD, hypertension is poorly managed, with only 15 to 18 per cent of people being adequately treated.
- There is probably some under-recording of stroke in GP registers, meaning that opportunities for secondary prevention are being missed.
- Rates of both stroke and hypertension are lower across London than the England average, probably as a result of London's relatively young population.
- No routine dataset exists to enable us to determine what proportion of people who have had strokes were treated in specialist stroke units.

Implications

- Stroke prevention requires increased case finding for hypertension and better treatment.
- Recording of stroke in disease registers needs to improve, to enable more targeted secondary prevention.
- A single, national definition of a stroke unit and routine data collection is necessary to allow proper comparisons of treatment outcomes.

Table 6: Availability of routine datasets or indicators by different dimensions of inequality and for different equalities groups

Routine Data or Indicators	Age	Deprivation	Disability	Ethnicity	Faith	Gender (sex)*	Geography	Socio-economic status	Sexual orientation
Demographic	✓	✓	✓	✓	✓	✓	✓	✓	X
Life expectancy	N/A	X	X	X	X	✓	✓	X	X
Mortality	✓	X	X	X	X	✓	✓	X	X
GPs/population	□	X	X	X	X	✓	✓	X	X
Other primary care staff/population	X	X	X	X	X	X	✓	X	X
48hr GP access (sample survey data only)	✓	✓	X	✓	X	✓	✓	X	?
Registered/ resident population	X	X	X	X	X		✓	X	X
Avoidable admissions	✓	X	X	¥	X	✓	✓	X	X
Access to stop smoking services	✓	X	X	✓	X	✓	✓	X	X
Maternity data	✓	X	X	#	X	N/A	✓	✓	X
Prevalence of stroke, TIA and hypertension	✓			□	X	✓	✓	X	X
% hypertension controlled	□	X	X	□	X	□	✓	X	X

From Husbands (7)

* NB male/female: data not collected regarding transgender and transsexual people.

∞ Data collected at practice level, but not reported for routine datasets

¥ Incomplete recording and reporting of data at hospital level.

..... Mother's country of birth only, not actual ethnicity, nor ethnicity of father or infant.

8. Key findings and recommendations from the stakeholder workshop

On 27 February 2008 the LHC hosted a stakeholder workshop to discuss the potential impacts of the proposals on health inequalities and the equalities groups. Over 50 people attended the workshop, including representatives from organisations and forums of equalities groups.

After receiving presentations on the proposals, attendees broke into groups to discuss the potential impacts of the proposals on the equalities groups and health inequalities. Separate groups were held for the proposals on polyclinics, maternity care and stroke pathways. Groups were requested to identify potential negative impacts and concerns and potential positive impacts.

Primary care

Concerns and potential negative impacts:

- If polyclinics become a gateway to A&E, this may remove access to A&E for some disadvantaged groups who are not registered with a GP.
- It will not mean local community access if polyclinics are in hospitals.
- Proposals do not address access for those who are not registered with a GP, eg failed asylum seekers, those with expired visa, homeless people and some young men.
- BAME communities may feel more excluded by possible insufficient continuity of care.
- Polyclinics may cost more.
- Cultural competence not mentioned and racism and discrimination within the system is not addressed.
- There is a lack of appreciation of staff points of view.
- Setting up such services without proper training and support for staff will be counter productive.
- No one model can suite all minority groups.
- Will/can polyclinics adequately address wellbeing and prevention?
- There is a lack of connectivity with social services/ wider determinants.
- Specialist commissioning is not adequately covered.
- There were concerns about the financial drivers for commissioners.
- The proposals are biomedical. Do they fit with prevention/ health promotion?
- Primary care is not good at diagnosing in mental health problems amongst BAME communities.
- Fear of loss of patient/ doctor relationship.
- Fear of loss of hospital services and good primary care.
- Fear of loss of secondary care relationships.
- Confusion over the polyclinic concept.

- Will it promote quality as well as access?
- Inequalities issues are not adequately addressed in the framework and must be addressed at a local level.
- There is a lack of workforce capacity.
- Concerns about the 'downgrading' of hospital doctors by bringing them out into the community.
- We do not adequately understand the size of the needs burden.
- There was concern that money may be diverted from the third sector and other providers into primary care.
- Telephone services need to be seamlessly integrated with clinic services (Different languages).

Potential positive impacts and benefits of the proposals:

- Networking services will bring services to patients not vice versa.
- Polyclinics will be popular if they also provide and are a portal to non-statutory services i.e. voluntary and community sector, counselling services, housing support, employment advice, PACE and sexual health services.
- Concept of a 1-stop shop including ICT to support networking.
- Currently there is a poor connection between services for young people and people with gender dysphoria and GP and specialist services. If polyclinics could establish more expertise then there would be less need to rely on specialist clinics.
- Polyclinics open for longer/ greater range of flexibility.
- Relieving pressure on A&E departments for primary care type issues.
- Opportunities for improving care for people with long-term conditions, more self-management and support.
- It will be important to focus on particular fields as needed by communities.
- Potential for improved and more connected services for victims of domestic violence, which may be the underlying cause of mental health issues.
- Multiple practices that are under one roof. Increase access to GP's as well as polyclinics.
- The possibility to book appointments online.
- The non-prescriptive model allows flexibility.
- Improved access to emergency services.
- Prevention/ provision of healthy living.
- The potential to share good practice: Walk in service in Northwick Park in homeless and asylum seekers.
- Joined up care.
- Access to other services/ greater range.
- Services are more local, especially outpatients.

- Improved choice of clinicians, bringing together all primary care professionals not just GP's.
- Quicker appointments
- The focus on staying healthy.
- The evidence based approach.
- Could encourage primary care staff leavers to return.

Additional ideas:

- Evidence gathering is very important. This will require needs assessment in communities to influence opening hours and the types of services made available *ie.* LGBT service users may prefer to access a service based in a particular central geographical area, rather than a local area.
- Pharmacy service needs to be integrated into polyclinics.
- Better data recording on equalities groups/ strands for monitoring performance.
- Cost effectiveness analysis.
- Triage/ signposting to relevant services within polyclinics.
- Technology - especially electronic records and near patient testing.

Maternity care

Concerns and potential negative impacts:

- People who are not entitled to free NHS car *ie* people who are HIV + may not receive care that would prevent them from transmitting HIV to their baby.
- Many people do not know their rights and status regarding services.
- More peer education is needed within communities.
- Trust issues- lack of trust in NHS.
- Skilling-up local women.
- Who takes up home birth? Some people do not have a choice, as not all homes are places where you would want to give birth.
- Overlap in the role of health visitors and postnatal support, linking through from anti-natal to post-natal care.
- People are attached to their local maternity service regardless of whether it is good or not.
- How to make the choice real. Danger that this will be about maternity units and where they are located. It needs to be about empowering women across their pregnancy.
- A large percentage of women in Harrow book in late into their pregnancies. Those booking late need even more continuity of care.
- Need to be able to monitor by equality gap by care provider. Need to understand who is disadvantaged - need this to be 'action research'?
- Even with in maternity units there is stigma attached to patients with HIV.

- Cultural competence- certain communities do not access services. May be difficulties associated with the gender of clinicians, family planning. London's diversity needs to be represented in the workforce.
- One stop centres- needs to be whole person (not just pre-birth care)
- Need to do cultural awareness work with staff. Working one to one on staff attitudes, including midwives.
- Importance of sharing – different BAME languages.
- The women's Right to Choose needs to be included.
- Care for post natal depression needs inclusion
- Mental health and maternity- across the period
- Isolated groups fear of losing access.
- Cross London midwife ratio, London average 1:37.
- Homebirth and midwife shortages.
- Violence towards pregnant women
- The proposals need to link into pan London CSIP work regarding maternity (CSIP conference 13 March).

Potential positive impacts and benefits of the proposals:

- Local midwife led care shows great results where happening now ie Hackney.
- There are earlier bookings.
- Direct referrals are not necessary through GP's.
- There is greater choice
- There is 24/7 consultant cover, as problems can occur at any time.

Stroke pathways

Concerns and potential negative impacts:

- More emphasis is needed on prevention and education
- Not picking people up early enough and at particular points such as A&E.
- There is a need for more stories about how things can get better for individuals who are feeling unwell/susceptible to stroke.
- There is a need to focus on particular population groups including BAME groups and manual workers.
- There is a need to improve cultural awareness.
- Service professionals need to listen more to individual views/ concerns.
- Professionals can be precious about what works in terms of rehabilitation. There is a need to share knowledge with families and carers. This will help to get feedback into the system.
- Roll out expert patient/ carers programme.
- Need to hear more from people who have recovered.
- Educating staff in public services such as supermarkets about the key signs (FAST).

- Promote websites and the work of the Stroke Association.
- Better use of organisations involved in stroke care generally.
- Rehabilitation should refer individuals to information on benefits, advice, etc. Targets should be to integrate people back into society as close as possible to the level they were at before their stroke.
- Greater use should be made of the voluntary sector.
- Develop pre-stroke clinics in primary care.
- Rehabilitation must start as soon as possible.
- Language support/ translation services.
- Voluntary and community sectors are not communicating adequately with health sectors.
- Need support for families and carers.
- Concern about distance to stroke centres.

Potential positive impacts and benefits of the proposals:

- Rapid assessment. However, the response on arrival at hospital is variable.
- Broad agreement around stroke centres, but not all patients will go there so it is important that other centres have excellent response as well.
- Specialist centres are only one part of the pathway. Outpatient's appointments and rehabilitation need to be seamless and integrated.
- What works- Information and involvement of the whole family.

9. Equality impact assessment form for strategies and reviews

This form is a tool to help guide you through the process of carrying out an equality impact assessment of strategies and reviews and for obtaining the information needed in order to be able to prepare the statutory summary reports. You may find it helpful to also refer to the EqIA guidance document

NB: There is a different form for policies or projects

Name of strategy or review:

Healthcare for London: Consulting the Capital

Officer completing assessment:

Gail Findlay (to 31st March 2008)

Telephone number:

020 7983 4768

Part 1 – Information gathering

1. Aims and objectives

What are the aims and intended outcomes of the strategy/review?

The proposals put forward in *Healthcare for London: Consulting the Capital* aim to improve the quality, safety and accessibility of healthcare in London and to make Londoners healthier.

Proposals are presented for how care could be provided throughout life based on the following eight stages:

- Staying healthy
- Maternity and newborn care
- Children and young people
- Mental health
- Acute care
- Planned care
- Long-term conditions
- End-of-life care.

The proposals are underpinned by five core principles:

- 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.

2. Users/beneficiaries

Who will be the main users/beneficiaries of the strategy/review?

All users of services provided by the NHS in London will be affected by the proposals.

3. Needs, priorities and evidence

Use the table below to indicate any particular needs and/or different priorities each of the equality target groups have of the strategy/review. Also indicate, where available, sources of evidence of these needs/priorities.

The information on the needs and priorities of each of the equalities groups provided below is taken from the rapid evidence review and appraisal report prepared by Ben Cave Associates for the London Health Commission (2). This report identifies evidence to appraise the likely impacts of the proposals contained in *Healthcare for London: Consulting the Capital* on the equalities groups. The report, and therefore the summary below, uses evidence including systematic reviews, grey literature and community intelligence. It did not include primary needs assessment based on direct consultation with the groups or analysis of routine data.

Table 7: Needs, priorities and evidence

Equality group		Needs/priorities	Evidence ¹
Gender	Women	Women have different health needs from men and are prone to different conditions. Although women have on average higher life expectancy than men, there are significant geographical variations and differences between social classes in health related behaviours and health outcomes for women. In addition, some women have difficulty accessing healthcare services. The extent of this unmet need is difficult to quantify.	Rapid evidence review and appraisal report (BCA)
	Men	Men have different health needs from women and are prone to different conditions. There are significant geographical variations and differences between social classes in health related behaviours and health outcomes for men. In general, men tend to seek treatment later than women and are more likely to engage in certain behaviours at risk of damaging health.	Rapid evidence review and appraisal report (BCA)

¹ Sources of evidence could be in-house or from other sources and could be consultation activities (see Q4), surveys, research reports, academic research, complaints, grievances, legal cases, ombudsman cases, media reports ... (also see Q6).

Equality group		Needs/priorities	Evidence¹
Race ²	Asian or Asian British people	Asian people are more at risk of some health conditions such as high blood pressure and diabetes. They are more likely to suffer strokes than White people. Health improvement, screening and prevention programmes must be designed and targeted to meet the needs of this ethnic group. Primary care and other health care services can be difficult to access for those who do not speak English because of the inadequacy of interpretation services and information in community languages.	Rapid evidence review and appraisal report (BCA)
	Black or black British people	Black people are at more risk of certain conditions than white people, for example sickle cell anaemia. In addition, the incidence of strokes amongst black people in London is 60 per cent higher than white people. Health improvement, screening and prevention programmes must be designed and targeted to meet the needs of this ethnic group. Black African women including asylum seekers and newly arrived refugees have a higher maternal mortality rate than white women.	Rapid evidence review and appraisal report (BCA)
	People of mixed race	No specific issues relating to the health needs of this group have been identified in this review.	Rapid evidence review and appraisal report (BCA)
	Irish people	Irish-born men were the only migrant group whose mortality was higher in Britain than in their country of origin (1990 study cited in source 14)	Health in London (14)
	White British people	No specific issues relating to the health needs of this group have been identified in this review.	Rapid evidence review and appraisal report (BCA)
	Chinese people and other minority ethnic groups not listed above	Primary care and other health care services can be difficult to access for those who do not speak English because of the inadequacy of interpretation services and information in community languages. Refugees and asylum seekers and Gypsies and travellers have been identified as groups with poor access to health care services.	Rapid evidence review and appraisal report (BCA)
Disability	Disabled people*	Disabled people in general have worst health outcomes and poorer access to	Rapid evidence review and

² The categories used in the Race section are those used in the 2001 census. Consideration should be given to the needs of specific communities within the broad categories that do not appear as separate categories in the census, such as Bangladeshi people and other communities such as Turkish/Turkish Cypriot, Greek/Greek Cypriot, Italian and Polish. Faith groups cover a wide range of groupings, the most common of which are Christian, Muslim, Hindu, Jews, Sikhs and Buddhists.

Equality group		Needs/priorities	Evidence ¹
		<p>healthcare. 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 per cent of surgeries failed to meet the minimum standard for accessibility in the Disability Discrimination Act 1995.</p> <p>People with sensory disabilities report that they have difficulty in accessing healthcare.</p> <p>People with learning disabilities and mental health problems also have worst health outcomes and access to healthcare.</p>	appraisal report (BCA)
Age	Older people (60 +)	Older people are more likely to suffer from poor health and are the biggest users of healthcare services. 75 per cent of strokes occur in people over 65 years of age. Older people are also more likely to have longer inpatient care because adequate support for care in their own homes is not available.	Rapid evidence review and appraisal report (BCA)
	Children and young people (0-17)	There are marked differences among London boroughs in the Infant Mortality Rate (IMR). The IMR is also higher amongst infants registered by the mother alone and mothers aged under 20. Child obesity is particularly high in London. Many children and young people suffer from mental health problems. Rates of teenage pregnancy are also high in some parts of London. Some areas of London have dangerously low child immunisation. When they are ill children need specialist paediatric care.	Rapid evidence review and appraisal report (BCA)
	Young adults (18 - 25)	Rates of sexually transmitted diseases amongst young adults are rising. There are also high rates of mental illness amongst this group. In addition, lack of exercise and poor diet has resulted in a rise in obesity. This group is in need of health promotion and prevention services around mental health, lifestyle and sexual health.	Rapid evidence review and appraisal report (BCA)
Sexual Orientation	Lesbians, gay men and bisexual people*	Research has shown that some lesbian women, gay men and bisexual people 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 range of health conditions including mental health problems, substance abuse, eating disorders, some cancers and coronary heart disease. HIV/AIDS affects gay men disproportionately.	Rapid evidence review and appraisal report (BCA)

Equality group		Needs/priorities	Evidence ¹
Gender Identity	Trans people	Some trans people experience problems accessing appropriate healthcare.	Rapid evidence review and appraisal report (BCA) and HIIA/EqIA workshop
Belief	Faith groups and people of no faith*	There is very little information on health and faith groups. However, the 2001 census showed that certain people from some faith groups had worst self reported health and were more likely to report a limiting long-term illness than others. Muslim and Sikh women and women of 'any other religion' had the highest rates of reporting 'not good' health, with Jewish and Hindu men having the lowest rate.	Rapid evidence review and appraisal report (BCA)

* Where possible indicate specific differences for the sub-categories of a particular group. For example disabled people with mobility difficulties may have different needs/priorities to Deaf people, the impact of policies on lesbians may be different to the impact on gay men, activities on holy days and during religious festivals may have different impacts on faith groups.

4. Consultation

Has any consultation been carried out with the equality target groups on this strategy/project/policy?

Yes No

If yes, please state below which equality target groups have been consulted with.

There are a number of types of consultation being conducted on *Healthcare for London: Consulting the Capital* are currently ongoing. These consultations are:

- Health Link has been commissioned to undertaken outreach consultation with the following 26 groups who are traditionally under represented in public consultations.
 - Alcohol users
 - Older frail people living alone
 - BME groups
 - Older people
 - Carers
 - People on low incomes
 - Children
 - People with Dementia
 - Disabled children
 - Physically disabled people
 - Drug users
 - Prisoners
 - Faith groups
 - Refugees and asylum seekers
 - HIV Positive groups
 - Residents of care homes
 - Homeless people
 - Sensory impaired people (hearing/sight)
 - Learning disabled people
 - Long term medical cConditions sufferers
 - Lesbian and Gay people

- Travellers
 - MH service users (inpatient and community)
 - Women
 - Offenders
 - Young people
- 2 Ipsos MORI are undertaking public consultation based on a series of structured questions contained in *Healthcare for London: Consulting the Capital*. Responses are due by 7 March 2008.
- 3 PCTs are undertaking consultations with residents in the areas they cover.
- 4 Stakeholder workshop as part of the HIIA/EqIA.

We understand that it may not be possible to analyse the results of the Ipsos MORI consultation by equality target group. This suggests that explicitly including consideration of equality target groups is critical for future consultation, eg by PCTs when implementing Healthcare for London.

The outcomes of the Health Link and Ipsos MORI consultations are not yet available but they will be incorporated into the final Equalities Impact Assessment. Please note that Table 8 and Table 9 have been completed assuming that the Health Link and Ipsos MORI consultations have been completed successfully and that the results of these consultations have been fed into the final EqIA report.

5. Monitoring

Is there any internal or external monitoring data on what impact this, similar, or past strategies/reviews have had on each of the equality target groups?

Yes No

NHS service providers routinely collect data on patient outcomes. However, there is very little routinely collected and analysed data on patient outcomes broken down by equality group. Where research that incorporates analysis of routinely collected data according to gender, age, ethnicity and disability has been identified it has been included in the evidence review (see below). There is no routine data collection for faith groups and sexual orientation.

6. Other evidence

Are there any other sources of evidence that have provided information on what impact this or similar or past strategies/reviews have had on each of the equality target groups? (Possible sources of evidence are demographic profiles, research reports, academic research, benchmarking reports, consultation activities, staff surveys, customer surveys, public surveys, complaints, grievances, disciplinary cases, employment tribunal cases, ombudsman cases, media reports...)

Yes No

There is a range of different types of evidence on the health of equalities groups and the impact of particular models of care. This evidence includes systematic reviews, grey literature and community intelligence. Ben Cave Associates has undertaken a rapid review and appraisal of the evidence of the potential health impacts on health inequalities and the equalities groups of the proposals relating to primary care, maternity care and stroke pathways. Evidence examined by that review includes:

- The State of Equality in London, Greater London Authority, January 2007
- Equalities impact assessments, Strategies and reviews, Guidance notes, Greater London Authority, May 2006
- The duty to promote race equality, a guide for public authorities, CRE
- How to read a paper: papers that summarise other papers, T. Greenhalgh, BMJ 1997; 315 672-675
- Access to primary care: A joint London Assembly and Mayor of London Scrutiny Report, p 50, GLA, April 2003
- Sick of Suffering - Health Survey, St Mungos, 2006

- Interim Statement of the Commission on Social Determinants, World Health Organisation, 2007
- The Solid Facts, ed Richard Wilkinson and Michael Marmot, 2nd edition, World Health Organisation, 2003
- Still missing the point? Infant immunisation in London, GLA, September 2007
- Review of the First Wave Personal Medical Services in London, R Lewis, C Jenkins and S. Gillam, Kings Fund
- Primary care, self-rated health and reductions in social disparities in health, L Shi, B Starfield, R Politzer, J Regan, Health Services Research 37:3, June 2002
- The Partiality of Primary Care Intelligence and Structure. Platform Project Technical Report, Mackay D, Sutton M (2003), University of Glasgow, 2003.
- Deprivation, psychological distress, and consultation length in general practice, Stirling AM, Wilson P, McConnachie A. British Journal of General Practice 51: 467, 456-460, 2001.
- Building a health service fit for the future, NHS Scotland, 2005
- Tackling health inequalities – An NHS response, NHS Scotland, 2005
- Draft health equity profile for London, LHO, December 2007
- London Health Observatory, Born Equal? A briefing on inequalities in infant mortality in London, July 2007
- The future hospital: the progressive case for change, J Farrington-Douglas and R Brooks, IPPR. January 2007
- The case for hospital reconfiguration- not proven: a response to the IPPR's the future hospital, D Byrne and S Ruane, 2007
- The relationship between hospital volume and quality of health outcomes, Sowden AJ, Grilli R and Rice N. (1997), CRD report 8, part 1. York: Centre for Reviews and Dissemination
- The Relationship between Volume and Health Outcomes, Report of volume/Outcome Sub-Group to Advisory Group to National Framework for Service Change, NHS Scotland, G Murray, G Teasdale, February 2005
- London Child Poverty Commission, Interim Report, September 2007
- Health in London, Looking back - Looking forward, 2006/07 Review of trends, progress and opportunities, London Health Commission 2007
- Review of evidence for the Mayor's Health Inequalities Strategy, GLA, 2007
- Mapping for the Health Inequalities Strategy, Draft overview report/discussion paper. 2007.
- The Mayor of London's Health Inequalities Strategy. Working together to reduce health inequalities in London, GLA, 2007
- Report of the Maternity and Newborn Clinical Working Group, Healthcare for London: A framework for action, 2007
- Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer - 2003-2005, Confidential Enquiry into Maternal and Child Health, December 2007
- The Greater London Authority's Sexual Orientation Equality Scheme: From isolation to inclusion, GLA, December 2006
- Healthcare for London consultation with traditionally under represented groups, Health Link, Status update 16.01.08
- Healthcare for London: A Framework for Action Response from the Mayor of London, 2007
- London Equalities Commission response to NHS London's draft Single Equality Scheme 2007-2010
- Kings Fund. Claiming the Health Dividend. Kings Fund . 2002
- Comprehensive review of maternity services, Healthcare Commission, 2008
- Continuity of caregivers for care during pregnancy and childbirth (Review). Hodnett, Cochrane Collaboration, 2007.
- Infant Feeding Initiative: A Report evaluating the Breastfeeding Practice Projects 1999 – 2002, Dykes F. , Department of Health, 2003
- Routine postnatal care of women and their babies, National Institute for Clinical Excellence, July 2006
- Antenatal care: Routine care for the healthy pregnant woman, National Institute for Clinical Excellence, March 2007

- Staying Healthy Working Group Report for Healthcare for London: a Framework for Action, 2007
- Report of the Acute Care Clinical Working Group for Healthcare for London: a Framework for Action, 2007
- National Sentinel Stroke Audit, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians of London, April 2007
- Review of stroke rehabilitation, Young J , Forster A, BMJ 2007;334:86-90
- GLA Health Team. Commentary on written submissions - Greater London Authority 'Call for Evidence' on health inequalities. 2007
- Mayor of London. Review of evidence for the Mayor's Health Inequalities Strategy
- Skyers, S and Poorman, J. Greater London Authority - Health Inequalities Community Outreach Project, 2007
- London Travel Watch Access to Hospitals Task Force, Report 29.1.07
- Equal Treatment: Closing the Gap, A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems, Disability Rights Commission, 2006

If you have not been able to provide any sources of evidence of needs/priorities for one or more of the equality target groups in section 3 OR

- *have not consulted with all the equality target groups OR*
- *do not have monitoring data or other evidence on what impact this or similar or past strategies/reviews have had on all of the equality target groups*

please go to and complete part 2 of this form.

Otherwise go on to Part 3.

Part 2 –Assessment Plan

9.1 Name of strategy, project or policy:

Healthcare for London: Consulting the Capital

9.2 Summary of data gaps from part 1

9.3 ***On the table overleaf please put a cross***

- ***in column 3 against any group for which you have no evidence of their needs and/or priorities with regard to your strategy, review or scrutiny (see Q3 of Part 1).***
- ***in column 4 against any group that has not been consulted with, with regard to your strategy, review or scrutiny (see Q4 of Part 1).***
- ***in column 5 against any group for which there is no monitoring data on what impact this or similar or past strategies/reviews or scrutinies have had on the group (see Q5 of part 1).***
- ***in column 6 against any group for which there are no other sources of evidence on what impact this or similar or past strategies/ reviews or scrutinies have had on the group (see Q6 of part 1).***

Table 8: Data gaps

Equality target group	Put a cross (X) in the relevant box ³	(3) Needs/priorities	(4) Consultation	(5) Monitoring data	(6) Other evidence
Gender	Women				
	Men				
Race	Asian or Asian British people	X		X	
	Black or black British people	X		X	
	People of mixed race	X	X	X	X
	Irish people	X	X	X	X
	White British people	X		X	
	Chinese people and other minority ethnic communities not listed above	X		X	
Disability	Disabled people	X		X	
Age	Older people (60 +)				
	Children and young people (0-17)				
	Young adults (18 - 25)				
Sexual Orientation	Lesbians, gay men and bisexual people	X		X	
Gender Identity	Trans people	X	X	X	X
Belief	Faith groups	X		X	

[BC1]

9.4 The London Health Observatory has prepared a population profile. This includes a analysis of the gaps in the evidence regarding routine population data and equalities groups (see Table 6 on page 34) .

³ See explanations and refer back to your completion of Part 1

Action plan

9.5 *Please indicate how you intend to obtain any missing data. If no action is to be taken please give your reasons.*

Table 9: Activity to obtain missing data

ACTIVITY	ACTION	BY WHOM	WHEN	REASONS FOR INACTION
Identifying needs/priorities	PCTS to undertake local health profiling to better understand the health needs of their local populations	PCTS	Ongoing	
Consultation	Additional consultation to be undertaken by NHS London and PCTs on the implementation of specific proposals	PCTs/NHS London	Ongoing	
Evidence of impact (inc. monitoring)	Indicators to monitor the impact of the implementation of the proposals to be developed by NHS London and PCTs	PCTs/NHS London	Ongoing	

Part 3 – Impact assessing action plans

1. Assessing actions, activities and recommendations

9.6 All strategies, schemes and reviews which lead to the drafting of an action plan must give consideration to the equalities impact and implications of each of the proposed actions as follows

Table 10: Impact assessment: actions, activities and recommendations

ACTION/ACTIVITY	Could this lead to any of the equality target groups (ETGs) being discriminated against?	If yes, in what way and is it lawful?	Consider each of the ETGs in turn and indicate a) what the positive outcomes should be b) what the negative outcomes could be		What amendments can be made to remove any unlawful discrimination and/or negative outcomes or to improve the neutral and/or positive outcomes?
Proposals relating to primary care	Yes	Depends on implementation	Improved accessibility, sensitivity and quality of primary care for equalities groups, leading to an increased uptake of prevention, health improvement and curative services and resulting in better health.	There is a risk that general improvements in the quality and availability of primary care services will not benefit all the equalities groups. This could generate health inequalities between the general population and certain equalities groups.	Primary care services must be fully accessible to equalities groups. This requires physical accessibility and provision for those with sensory impairments, learning disabilities and mental health problems. Language support must be available for those who do not speak English. Services must be sensitive and appropriate to the needs of equalities groups. Funding provision and commissioning models must reflect the level of need amongst equalities groups. Prevention and health improvement programmes must be appropriately designed and targeted to ensure the inclusion of equalities groups.
Proposals relating to maternity care	Yes	Depends on implementation	Improved accessibility, sensitivity and quality of maternity care services, including pre-conception, ante-natal, labour and post natal care resulting in better outcomes for women and babies, including	There is a risk that general improvements in the quality of maternity care services will not benefit all the equalities groups. This could generate health inequalities between the general population and certain equalities	Maternity care provision needs to be fully accessible to women with physical, sensory and learning disabilities. Provision needs to be culturally sensitive and appropriate to the needs of women from ethnic minorities and faith groups. Interpretation services should be available to support the whole range of maternity services from pre-pregnancy care to post-natal care.

ACTION/ACTIVITY	Could this lead to any of the equality target groups (ETGs) being discriminated against?	If yes, in what way and is it lawful?	Consider each of the ETGs in turn and indicate a) what the positive outcomes should be	b) what the negative outcomes could be	What amendments can be made to remove any unlawful discrimination and/or negative outcomes or to improve the neutral and/or positive outcomes?
			teenage mothers, women from ethnic minorities, disabled women, women from faith groups and lesbian women.	groups.	Women should not be expected to use children, partners of other family members as interpreters. Culturally sensitive and appropriate care should be available to women living with FGC/M. Women from vulnerable groups and deprived communities should be targeted to ensure early antenatal booking.
Proposals relating to stroke pathways	Yes	Depends on implementation	Improved prevention, treatment and rehabilitation of stroke would lead to a reduction in death and disability resulting from stroke. This would benefit people from Black, Asian and minority ethnic and older people who suffer disproportionately from strokes.	There is a risk that general improvements in the quality of stroke services will not be accessible or culturally appropriate to the needs of ethnic minority groups. This could generate health inequalities between the general population and certain equalities groups.	Stroke prevention, treatment and rehabilitation initiatives must be culturally sensitive to the needs of and black, Asian and minority ethnic groups and accessible to those that do not speak English. Prevention services should be targeted in view of the higher incidence of stroke amongst these communities.

Where there are a number of actions which all contribute to achieving the same objective, these may be assessed together under the heading of the objective, provided the implications of each of the actions have been considered.

The outcomes of this process must be used to finalise the actions/activities.

It is advisable to share this with the Head of Diversity Performance so that the Equalities Team can act as a 'critical friend' to the process.

2. Impact assessment

Use the table below to indicate (using a tick or cross) what impact the strategy/review or scrutiny currently has or could have on each of the equality target groups.

Give the reason for your assessment based on the needs/priorities information (Part 1, Q3), the consultation responses (Part 1, Q4), the monitoring data (Part 1, Q5), other evidence (Part 1, Q6) and the assessment of actions (Part 3, Q1).

Table 11: Impact assessment: equality target groups

Equality Group		Impact				Reason
		Positive	Neutral	Negative	Unknown/ Inconclusive	
Gender	Women	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals will lead to health improvements in the general population.
	Men	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals will lead to health improvements in the general population.
Race	Asian or Asian British people	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals benefit people from ethnic minorities as long they are implemented in a culturally sensitive way, targeted where necessary and language support is available.
	Black or black British people	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals benefit people from ethnic minorities as long they are implemented in a culturally sensitive way, targeted where necessary and language support is available.
	People of mixed race	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. No specific evidence from the RERA but proposals are likely to benefit people of mixed race as long they are culturally sensitive and targeted where necessary.

Equality Group	Impact				Reason	
	Positive	Neutral	Negative	Unknown/ Inconclusive		
	Irish people	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. No specific evidence from the RERA but proposals are likely to benefit Irish people as long they are culturally sensitive and targeted where necessary.
	White British people	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals will lead to health improvements in the general population.
	Chinese people and other minority ethnic communities not listed above	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals benefit people from ethnic minorities as long they are culturally sensitive, targeted where necessary and language support is available. Refugees and asylum seekers may not benefit because of the difficulties they experience getting healthcare.
Disability	Disabled people*	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals will benefit disabled people but only if services are accessible to people with physical, sensory and learning disabilities.
Age	Older people (60 +)	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals will benefit older people.
	Children and young people (0-17)	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. Evidence from the RERA that proposals will benefit children and young people.

Equality Group		Impact				Reason
		Positive	Neutral	Negative	Unknown/ Inconclusive	
	Young adults (18 - 25)	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. No specific evidence from the RERA but proposals are likely to benefit this group as long their implementation takes into account the needs of this group.
Sexual Orientation	Lesbian, gay men and bisexual people*	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. No specific evidence from the RERA but proposals likely to benefit as long their implementation is culturally sensitive.
Gender Identity	Trans people	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. No specific evidence from the RERA but proposals likely to benefit as long their implementation is culturally sensitive.
Belief	Faith groups*	X			X	The effect of the proposed policy on this equality group depends upon implementation of the policy. No specific evidence from the RERA but proposals are likely to benefit as long their implementation is culturally sensitive.

3. Assessing impact of implementation

What monitoring/evaluation/review process has been set up to evidence the impact implementation of this strategy, review will have on each of the equality target groups over time?

Use the information you have obtained to produce the equality impact assessment summary report.

Sign this form, retain a copy and send a copy of the parts of the form, with the assessment summary report, to the Head of Diversity Performance.

Signed: 

Date: 31st March 2008

10. List of references

1. NHS London. Healthcare for London: Consulting the Capital. 2007.
2. Cragg, L., Iggulden, P., and Cave, B. Rapid evidence review and appraisal. Scientific Annexe 2: HIIA/EqIA of 'Healthcare for London: Consulting the Capital' 2008 Ben Cave Associates Ltd for the London Health Commission.
3. HM Government of Great Britain. Race Relations (Amendment) Act. 2000. Available at: www.opsi.gov.uk
4. HM Government of Great Britain. Disability Discrimination Act. 2005. Available at: www.opsi.gov.uk
5. HM Government of Great Britain. Equality Act. 2006. Available at: www.opsi.gov.uk
6. NHS London. Healthcare for London: A Framework for Action. 2007.
7. Husbands, S. Health Equity Profile for London. Scientific Annexe 1: HIIA/EqIA of 'Healthcare for London: Consulting the Capital' 2008 London Health Observatory for the London Health Commission.
8. Greater London Authority. The State of Equality in London. 2007. Available at: www.london.gov.uk
9. HM Government of Great Britain. Greater London Authority Act. 2007. Available at: http://www.opsi.gov.uk/acts/acts2007/pdf/ukpga_20070024_en.pdf
10. See for example the Interim Statement of the Commission on Social Determinants, World Health Organization, 2007 and The Solid Facts, ed Richard Wilkinson and Michael Marmot, 2nd edition, World Health Organisation, 2003
11. Pencheon D, Guest C, Melzer D, Gray JAM. Oxford handbook of public health practice. Second ed. 2006
12. Department of Health. Tackling health inequalities: what works? 2005. Available at: www.dh.gov.uk
13. Greater London Authority and London Health Commission. Overview of health and domestic violence report. 2007. Available at: www.london.gov.uk
14. Barer, R., Fitzpatrick, J., and Traoré, C. Health in London: review of the London Health Strategy high-level indicators. 2004 update. Focus on the health of London's Black and ethnic minority communities. A

Report prepared on behalf of the London Health Commission by the Greater London Authority in partnership with the London Health Observatory 2004. London. Available at: www.london.gov.uk