Equalities Analysis

NHS South East London

Scoping report

September 2016

Our Healthier South East London

Improving health and care together

MOTT MACDONALD

Review and approvals

Revision	Date	Originator	Checker	Approver	Description
A	25 July 2016	Hannah Grounds Katy Field Frances Parrott	Frances Parrott	Kerry Scott	Draft scoping report for internal review.
B	28 July 2016	Hannah Grounds Katy Field Frances Parrott	Frances Parrott	Kerry Scott	Scoping report for client issue.
C	16 August 2016	Frances Parrott	Kerry Scott	Kerry Scott	Updated scoping report following client comments.
D	5 September 2016	Frances Parrott	Kerry Scott	Kerry Scott	Second update following equalities steering group feedback

Contents

1. Our Healthier South East London

NHS commissioners and providers are working in partnership with local authorities on a five-year plan for services across six boroughs in south east London: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark collectively known as 'Our Healthier South East London' (OHSEL).

The approach undertaken by OHSEL has been to look in detail at a number of clinical areas where significant challenges are faced. One of these areas is planned care, of which elective orthopaedic services has been identified as an area for potential reconfiguration.

Elective orthopaedic surgery is currently carried out at eight different sites in south east London. OHSEL has identified the following reasons for improving the care currently available:

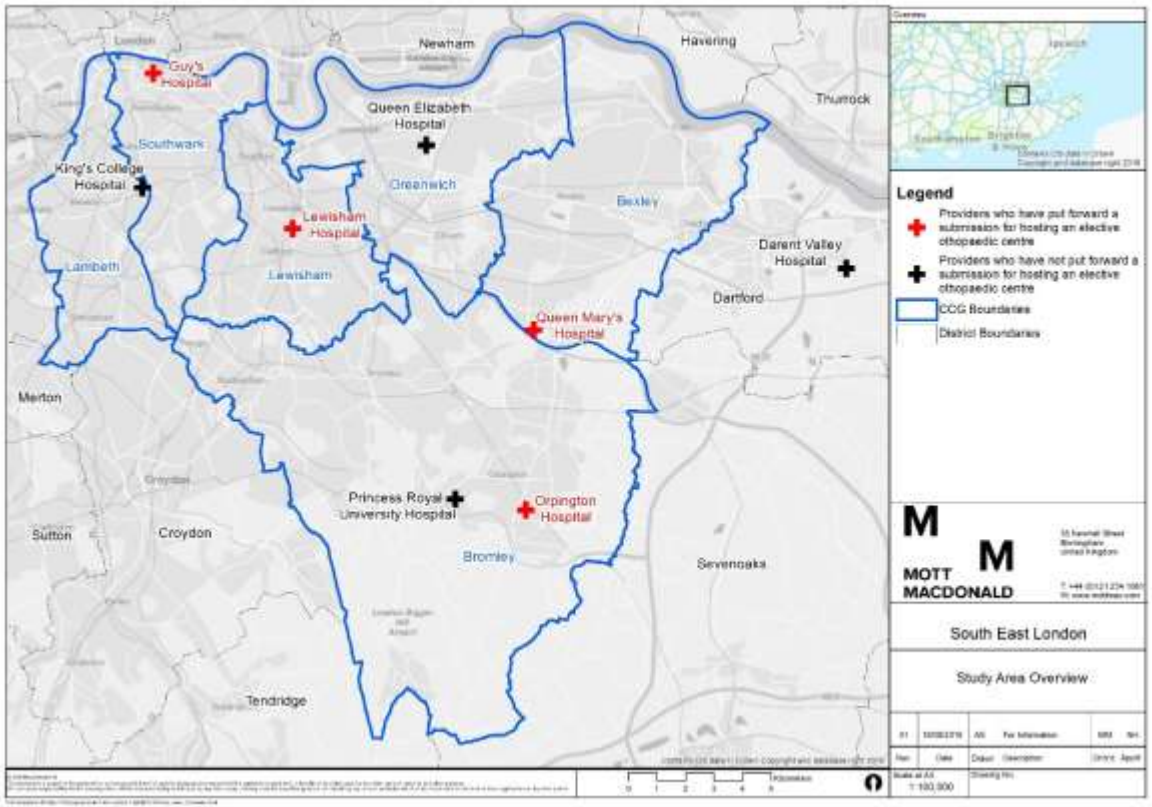
- Quality of care and outcomes for patients accessing orthopaedic care varies across south east London.
- Too many procedures are cancelled and there are unnecessary delays in the patient journey.
- Demand is increasing; the report by Professor Tim Briggs 'Getting it right first time' published in March 2015 shows that by 2030 over 15.3 million people in the UK will be over the age of 65 and consequently, the need for planned care including orthopaedic procedures is likely to increase.
- OHSEL wants to find a more reliable and consistently high standard of care for patients while increasing capacity to care for larger numbers of people.

OHSEL is exploring the benefits and feasibility of a consolidated elective orthopaedic service for inpatient operations in south east London. It is proposed that some elective operations should be provided from two centralised centres in future, while outpatient and emergency services remain at local hospitals as is the structure currently.

Seven sites currently offer inpatient elective orthopaedic care to patients from south east London. Through the submission process, four providers have come forward to describe sites that could host an elective orthopaedic centre within the model.

The sites are; Guy's Hospital, Lewisham Hospital, Queen Mary's Hospital and Orpington

The map below shows the sites that currently provide elective orthopaedic care to south east London residents, it should be noted that at present Queen Mary's Hospital provides elective orthopaedic day case surgery not inpatient surgery for south east London patients. Sites in red are those which providers have put forward submissions for hosting an elective orthopaedic centre.



2. Equalities analysis overview

Equalities analysis
To support the public consultation and to fulfil the need to ensure that OHSEL has considered the potential impacts on those characteristics protected under the Equality Act 2010[1], those classified as deprived and carers. Mott MacDonald was appointed to undertake an equalities analysis of the proposals for elective orthopaedic services.

It is important to note that the purpose of this work is not to determine the decision about which option is selected by OHSEL; rather this analysis is to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

Scope and objectives
The objectives of this equalities analysis are to:

- Identify the positive and any negative impacts for the population of OHSEL as a result of the proposed reconfiguration.
- Identify which (if any) of the protected characteristics groups are more likely to be affected by the proposals due to their propensity to require different types of health services.
- Set out conclusions about the extent to which proposals accord with the three aims of the Public Sector Equality Duty (PSED): (to eliminate unlawful discrimination; advance equality of opportunity; and to foster community good relations).
- Develop conclusions on the comparative advantages and disadvantages of the different options.
- Provide recommendations on ways in which positive impacts can be maximised and ways in which to mitigate or minimise any adverse effects.

The equalities analysis has been designed to be an iterative process that can be revisited and take on board evidence over the course of the option-development and consultation process. Work is structured around three principal stages.

The table overleaf sets out each stage of the equalities analysis.

1. The protected characteristics are; age, disability, pregnancy and maternity, race and ethnicity, sexual orientation, gender reassignment, religion and belief, marriage and civil partnership and gender.

2. Equalities analysis overview

Stage	Description and deliverables
One: Scoping	**Description** • Desk research into demand for elective orthopaedic services by each protected characteristic group and deprivation and carers. • Socio-demographic profiling of all six CCG localities. • Strategic and community stakeholder engagement through one-to-one telephone interviews. • Confirmation of issues, geographical areas and population groups on which to focus during the next stage of work. **Deliverables** • Interim presentation delivered to the OHSEL Equalities Steering Group. • Scoping report.
Two: Consultation	**Description** • Expert equality advice provided to OHSEL during the public consultation. • Continuing engagement with community stakeholders either through engagement fora or focus groups, to be decided. • Staff engagement through one-to-one telephone interviews. • Equalities training workshop delivered to NHS staff on data required to fulfil Public Sector Equality Duty (PSED). **Deliverable** • Interim report.
Three: Post consultation	**Description** • Review of public consultation findings. • Re-engagement with strategic and community stakeholders through a final workshop. **Deliverable** • Final report.

Please note that the phrase community stakeholders refers to community groups and representatives. Strategic stakeholders include CCG and Trust equality leads, clinical and project leads and directors of public health. A list of stakeholders contacted and invited to share their views is included in appendix A1.

3. Overview of the scoping report

The objectives of the scoping report are to:

- Identify existing health inequalities, access barriers and equality issues to be considered.
- Identify which of the 11 groups have a higher need for orthopaedic services and therefore more likely to experience positive or negative impacts.
- Provide recommendations about key groups to target during consultation.
- Provide advice on equalities questions for inclusion in public consultation.

Evidence for the scoping report has been gathered through:

1. Demographic analysis which sets out the characteristics of the south east London population, and particularly the distribution of residents from different equality groups.
2. An evidence review of available literature which identifies population groups who may have a disproportionate need for services.
3. Strategic and community engagement.

Please note that this report is not inferring that social groups not scoped in have no need for elective orthopaedic services, rather it suggests that there does not presently exist a body of clinical evidence indicating a disproportionate need amongst groups not presently scoped in. This scoping opinion will be supplemented as further evidence is gathered throughout stages two and three.

4. South East London population profile

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

Total population

The table below shows the total population of each of the six CCGs, as well as wider area comparators[2].

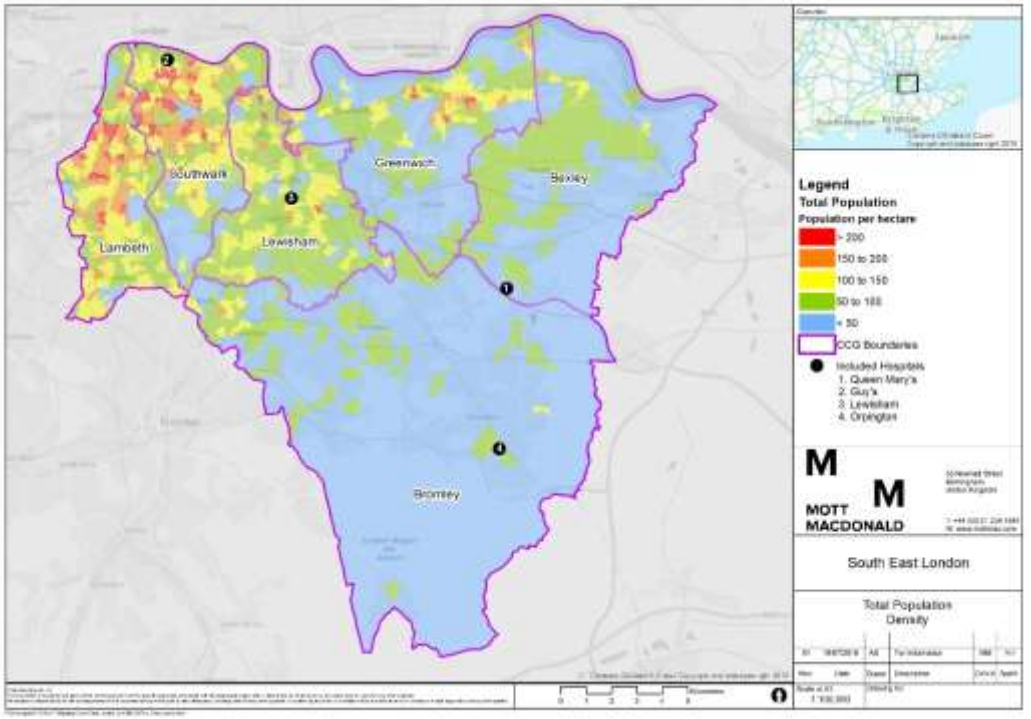
Area	Total population
Bexley	239, 900
Bromley	321, 300
Greenwich	268, 700
Lambeth	318,200
Lewisham	291,900
Southwark	302, 500
South East London	1,742,500
Greater London	8,538,700

Source: ONS, mid-year population estimates, 2014

The table indicates that the largest numbers of people live in the boroughs of Bromley (with 321,300 people) and Lambeth (with 318,200) while the least populated is Bexley (with 239,900). The total population of the study area is over 1.7 million.

The map indicates that there are higher densities of population in the inner London Boroughs of Lambeth and Southwark. Bromley has much lower density of population, despite being the most populated CCG.

Population density



2. Population figures have been rounded to the nearest one hundred.

5. Breakdown of protected characteristic groups

This section of the report considers each of the nine 'protected characteristic' groups in turn, as well considering other disadvantaged groups specifically deprived communities and carers. This includes:

- Age
- Disability
- Pregnancy and maternity
- Race and ethnicity
- Gender
- Sexual orientation
- Gender reassignment
- Religion and belief
- Marriage and civil partnership
- Deprived communities
- Carers.

For each group, it is noted whether there is evidence of disproportionate or differential need for elective orthopaedic services and a summary of this evidence is provided. By differential need, that is to say there is evidence that different sub sections of a protected characteristic group have different needs. For example, females and males have different needs to access a service, but there is no evidence to suggest that either females or males have a disproportionate need.

At the beginning of analysis for each scoped in characteristic, tables on the left hand side of the page are provided to show the total number of that characteristic in each CCG area and the percentage of the total population. On the right hand side of the page, socio-demographic maps are used to demonstrate the density (or distribution) of these population groups across south east London.

Larger versions of these maps and are available in appendix A2.

In the final sections, a summary of the in-scope groups is provided alongside a commentary as to the profile of these population groups across south east London. Other equality impacts are explored and an overview of the next steps provided.

5.1 Age (Older people)

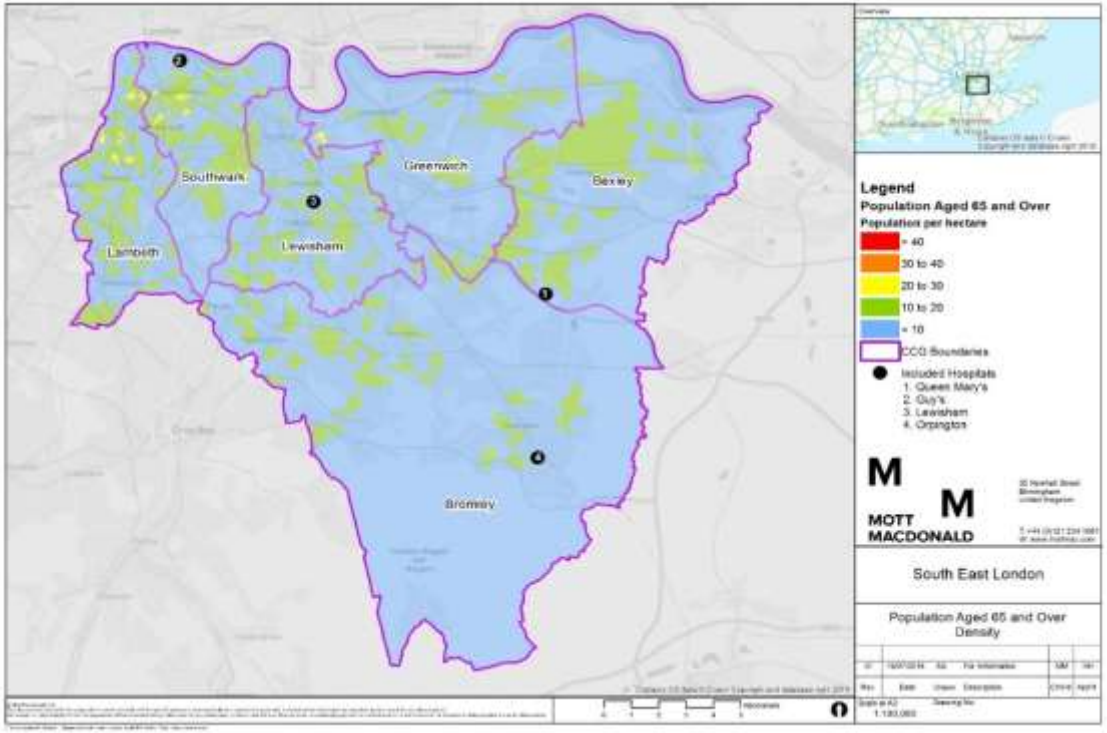
Population aged 65 or over and 75 or over

Area	Aged 65 and over	%	Aged 75 or over	
Bexley	39,800	17	19,600	8
Bromley	56,300	18	27,300	8
Greenwich	28,200	10	12,700	5
Lambeth	24,800	8	11,400	4
Lewisham	27,400	9	12,900	4
Southwark	24,000	8	10,800	4
South East London	200,500	12	94,700	5
Greater London	982, 900	12	459,100	5

Source: ONS, Mid-year Population estimates, 2014

The analysis shows that Bromley has the highest volume of those aged 65 and over and those aged 75 and over. Bromley has significantly more older people than any of the other CCGs. Bexley also has high volumes and proportions of older people.

Population density aged 65 or over



Source: ONS, Mid-year Population estimates, 2014

Evidence to demonstrate disproportionate need for elective orthopaedic care

Osteoporosis, a condition treated with elective orthopaedic care, becomes more likely the older that people get. Around 50% of people over the age of 75 are affected by the condition, and after the age of 50 one in two women and one in five men will break a bone as a result of poor bone health arising from osteoporosis *(Age UK (No date): Osteoporosis: Could you be at risk?).*

Evidence surrounding specialised orthopaedics services in adults also points towards older people having a disproportionate need for revision joint procedures in later life, thereby increasing the demand for elective orthopaedic care with older people . This is because the average age for arthroplasty procedures is falling, and so people are likely to need revision procedures as they are having initial surgery younger. The average age for knee arthroplasty has fallen from 70.6 in 2004 to 67.5 in 2010, and from 68 in 2004 to 6.2 in 2010 for hip arthroplasty patients. It is worth noting that these figures come in a time when the population is ageing. *NHS England (2013): NHS Standard Contract for Specialised Orthopaedics (Adults).*

5.1 Age (Older people) - Continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care[3]

Older people are more predisposed to osteomyelitis than the general population as they disproportionally suffer from associated disorders (such as diabetes). *(Biomed Central, 2010: Osteomyelitis in elderly patients).*

Bursitis also disproportionately effects older people due to the joints, muscles and tendons near the bursae being overused *(NHS Choices 2014, Causes of bursitis) .*

The NHS website reports that most people who have a total knee replacement are over 65 years old. The most common reason for knee replace surgery is osteoarthritis. *NHS Choices 2015*

Changing population trends of older people

In line with the national trends, all CCGs will experience an increase in the number of people aged 65 or over. Southwark will experience a doubling of its aged 65 or over population by 2039. Lambeth, Lewisham and Greenwich will also experience increases for the aged 65 or over greater than the OHSEL or Greater London average. Bexley and Bromley will experience an increase of less than the OHSEL or greater London average. However, it is important to note that Bexley and Bromley will still have higher numbers of older people overall .The CCGs with the greatest numbers of people aged 65 or over in 2014 remain the same CCGs in 2039. For further information, please see appendix A3.

3. Please note, that the although we are seeing a significant increase in joint replacement in the young population, it continues to be the older population that is most reliant on orthopaedic services and driving the increasing workload. *Briggs , T (2015)* 'Getting it right first time'

5.2 Disability

Population with long term illness or disability.

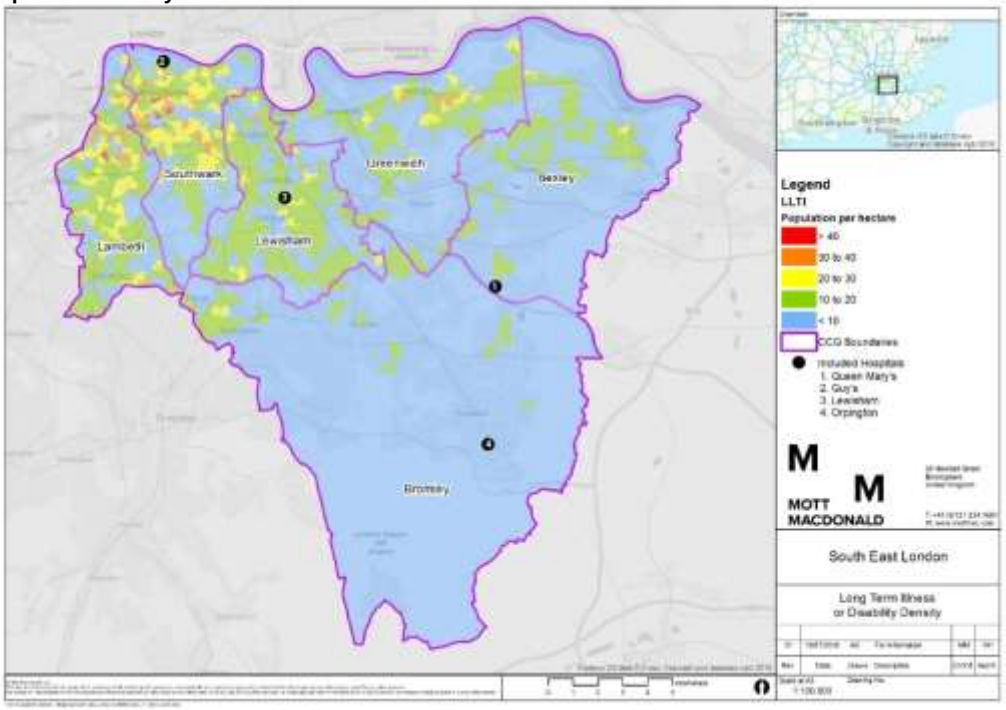
Area	Long term illness or disability	%
Bexley	37,100	16
Bromley	46,300	15
Greenwich	38,400	15
Lambeth	38,700	13
Lewisham	39,700	14
Southwark	39,000	14
South East London	239,200	14
Greater London	1,157,200	14

Source: ONS, Census 2011

Bromley has the most people living with a long term illness or disability. There is relative consistency across the other CCG areas in terms of overall numbers of people with a long term illness or disability.

Lambeth and Southwark have higher densities of those with a long term illness of disability.

Population density



Source: ONS, Census 2011

Additional data on the number of people living in each borough with a learning disability has been gathered using disability living allowance data. This is detailed in appendix C1.

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

A UK report supported by the Department of Health states that people with learning disabilities may have increased prevalence of osteoporosis and lower bone density than the general population. Contributory factors include their possible lack of weight-bearing exercise, delayed puberty, entering menopause at an earlier-than-average age for women, poor nutrition, being underweight and use of anti-epilepsy medication. The report notes that people with learning disabilities have a greater prevalence of some of the risk factors associated with osteoporosis than other people *(Emerson, E. et al. (2012): Health Inequalities & People with Learning Disabilities in the UK: 2012).*

5.2 Disability - Continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Studies have suggested that people who take epilepsy medicine for long periods of time are at higher risk of thinning and breaking bones than those who do not take epilepsy medicine. In 2009, the Medicines, Healthcare Products Regulatory Authority (MHRA) advised that people still taking the following older epilepsy medicines on a long-term basis were at risk of osteoporosis or broken bones; Carbamazepine, Phenytoin, Primidone and Sodium valproate. However, there is little research exploring whether some of the newer types of epilepsy medicines can cause bone problems (*Epilepsy Action (2013): Bone health).*

Epilepsy is also more common in people with a learning disability than in the general population. It is estimated that 1 in 3 people who have a mild to moderate learning disability also have epilepsy, and around 1 in 5 people with epilepsy also have a learning disability. The more severe the learning disability it, the more likely that the person will have epilepsy as well *(Epilepsy Society (2016): Learning disability and epilepsy).*

Orthopaedic surgery may also be necessary for people with cerebral palsy to correct problems with bones and joints. *NHS Choices website 2015*

Finally, there is also evidence suggesting that people with HIV may have a disproportionate need for elective orthopaedic surgery. Particularly:

- Low bone mineral density is prevalent in people with HIV *(McComsey, GA et al (2010) 'Bone Disease in HIV* infection)
- Inflammatory arthropathy and avascular necrosis is common in HIV patients *(Reis MD, Barcohana B, Davidson A et al . Association between human immunodeficiency virus and osteonecrosis of femoral head. J . Arthroplasty 2002; 17: 135-9)*
- Factors that may increase the risk of osteoporosis in people living with HIV include HIV infection itself and some HIV medicines (for example tenofavir disoproxil fumarate) *(Brown T, Qaqish RD Antiretroviral therapy and the prevalence of osteopenia and osteoporosis: a meta-analytic review. AIDS 20 (17): 2165-2174, 2006).*

Changing population trends of those with a disability

Although national datasets are not available for the likely population change of those with disability in the longer term. Local data reports that:

- There are about 5,740 people with learning disabilities in **Southwark,** of whom about 1,230 (21%) have moderate or severe learning disabilities. The number of people in the borough with learning disabilities is projected to increase by 22% to 7,000 by 2030. Looking specifically at adults with moderate or severe learning disabilities, the greatest relative increase is also projected to be seen in the 55 to 64 year age group (a 59% rise over 20 years). *Southwark JSNA (2013): Adults with a learning disability*.

Please note that local data forecasting future trends for other CCGs is not currently available. As engagement continues, stakeholders are being asked if they have access to data pertaining to population trends of people with the disabilities outlined above.

5.3 Gender: Female

Population demographics have not been provided for gender due to the approximate 50/50 split of males/females across all boroughs. Females have been scoped in as having a disproportionate need. The evidence for this is provided below.

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Osteoporosis is more common in women than men. Women tend to live longer, with age leading to an increased likelihood to develop osteoporosis (see section 5.1). In addition, at around the age of 50, women experience the menopause, at which point their ovaries almost stop producing the sex hormone oestrogen, which helps to keep bones strong (*National Osteoporosis Society (No date): Risk factors for osteoporosis and fractures).* A woman's risk of having osteoporosis is also heightened if she has an early menopause or a hysterectomy with removal of the ovaries prior to the age of 45 (*Age UK (No date): Osteoporosis: Could you be at risk?).*

Joint pain is common in the condition lupus, especially in the small joints found in hands and feet. The pain normally moves from joint to joint and is often described as 'flitting'. Joint pain and swelling are often the main symptoms for some people, although it is unusual for Lupus to cause joints to become permanently damaged or deformed. About 1 in 20 people with lupus develop more severe joint problems, and less than 1 in 20 have joint hypermobility or a form of arthritis called Jaccoud's arthropathy, which can change the shape of the joints (*Arthritis Research UK (No date): What are the symptoms of Lupus?).* Lupus is more common in women than men, with around seven times as many women as men having the condition. Whilst drugs are often prescribed to Lupus suffers, some also undergo elective orthopaedic surgery.

Up to 50% of women develop Carpal tunnel syndrome (CTS) during pregnancy. CTS in pregnant women often gets better within three months of the baby being born, although it may need surgical treatment if symptoms fail to subside. In some women, symptoms can continue for more than a year. CTS is also common in women around the time of the menopause. (*NHS Choices, 2014, Causes of carpal tunnel syndrome*). Evidence also suggests that more women than men develop CTS, possibly because women naturally have smaller carpal tunnels *(Bupa (No date): Carpal tunnel syndrome).* Occasionally, some medications can also cause the condition. Exemestane and Anastrazole are both medications used for the treatment of breast cancer, thus taken by a disproportionately large number of women. Both drugs are said to potentially cause carpal tunnel syndrome *(Arthritis Research UK (2012): Carpal tunnel syndrome).*

Finally, women are likely to live longer than men and therefore more likely to use elective orthopaedic care (see section 5.1 on age). The average life expectancy at birth for each of the CCGs according to gender and a south east London average is provided below.

Area	Females	Males
Bexley	84.4	80.3
Bromley	84.5	81.0
Greenwich	82.2	78.5
Lambeth	83.0	78.2
Lewisham	82.6	78.2
Southwark	83.1	78.0
South East London	83.3	79.0

5.4 Gender reassignment

Population demographics are not available for the numbers of people undergoing, or who have undergone, gender reassignment. However stakeholders have noted that the number of gender reassignment procedures is increasing. This is support by figures obtained under a Freedom of Information request, which shows that there has been increases in the number of referrals to all of the UK's gender identity clinics (GIC). The London GIC in Charing Cross is the largest adult clinic. The number of referrals has almost quadrupled in 10 years, from 498 in 2006-07 to 1,892 in 2015-16. In 2015-16, NHS England has provided an additional £3m towards funding adult GIC clinics. *'Gender identity clinic services under strain as referral rates soar' Guardian newspaper 10 July 2016*

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Trans men (female-to-male) and trans women (male-to-female) may be at risk of developing osteoporosis because of the need to take hormones that change the balance of oestrogen and testosterone in the body. After gender reassignment surgery, the level of hormones may decrease and this may also affect bone density. The degree to which either of these factors affect the risk of breaking a bone, however, remains uncertain. Replacement sex hormones (testosterone for trans men and oestrogen for trans women) are necessary to maintain bone strength and are generally continued long-term. The risk of developing osteoporosis may increase if sex hormone replacement is discontinued, or if levels of replacement are too low (*National Osteoporosis Society (2014): Transsexual people and osteoporosis*).

Research has also found that the male-to-female trans population who have their testicles removed can affect bone density as the body's natural levels on testosterone are too low. However, evidence suggests that taking oestrogen instead compensated for the decrease in testosterone. Some trans men who aren't able to take testosterone use Depo-Provera to stop their periods from occurring, and, there is some concern that using Depo-Provera can negatively affect bone density (*Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition (2006): Trans people and osteoporosis).*

It must be noted that the research available on this issue is limited, however, due to the evidence presented above, gender reassignment has been scoped in as a protected characteristic that may have a disproportionate need. This will be explored further with clinicians and Lesbian, Gay, Bisexual and Trans (LGBT) community groups.

5.5 Race and ethnicity: White

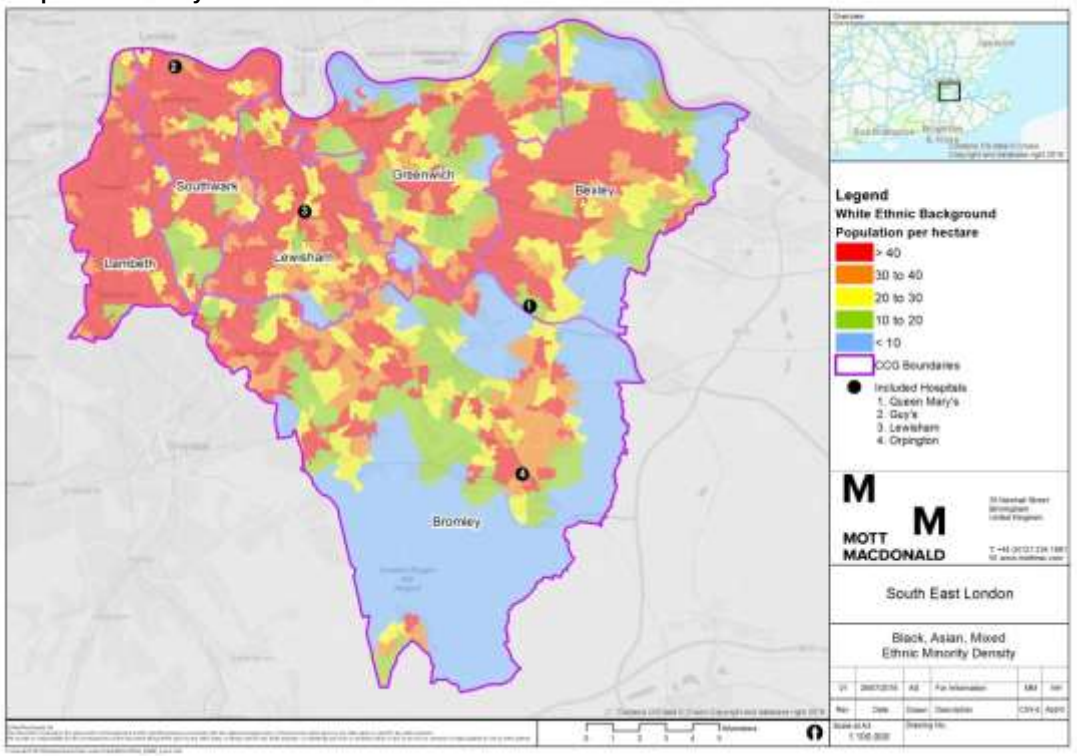
Population with a white ethnic background

Area	White ethnic background	%
Bexley	189,962	82
Bromley	260,870	84
Greenwich	159,002	62
Lambeth	173,025	57
Lewisham	147,686	54
Southwark	156,349	54
South East London	1,086,894	62
Greater London	4,887,435	60

Source: ONS, Mid-year Population estimates, 2014

Bromley and Bexley have the highest volumes and proportions of people from a white ethnic background. Lambeth, Southwark and Lewisham all have high densities, though this is due to their smaller geographies.

Population density



Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note that this report is suggesting a differential need amongst ethnic groups, rather than a disproportionate need. This is because there is evidence to suggest that those from different ethnic backgrounds have need for different types of elective orthopaedic care services. The evidence on this page highlights issues pertaining to those from a white ethnic background.

The National Osteoporosis Society states that those from Caucasian background are at higher risk of osteoporosis than Afro-Caribbean people. This is because people from an Afro-Caribbean background tend to have bigger bones. *National Osteoporosis Society (No date): Risk factors for osteoporosis and fractures. See:* https://www.nos.org.uk/healthy-bones-and-risks/are-you-at-risk . In addition, a US study founded that Afro-Caribbean American women's femoral neck bone mineral density (BMD) was 10% to 25% higher when compared to US white women, thereby lessening their risk of developing osteoporosis or hip conditions in their life course *(Dempster, D. et al (2013): Osteoporosis Fourth Edition)*. Data from a UK- cohort of the European Male Aging Study (EMAS) also compared White-British men to a group of Afro-Caribbean British and South-Asian British men. The Afro-Caribbean British group had higher BMD at all sites when compared to South-Asian British and White-British, both before and after adjustment for body size (*Zengin. A. et al (2015): Ethnic differences in bone health).*

5.5 Race and ethnicity: White - Continued

Changing population trends of those from a white ethnic background

Although national datasets are not available for the likely population change. Local data reports that:

- In **Lambeth** the older white population is projected to grow by about 12%. *Lambeth Council State of the Borough 2014*
- By 2020, the white population of **Lewisham** is set to decrease by 2.1%. *Lewisham's Public Health Information Portal*

Please note that white background data includes the following sub-groups 'White: British, White: Irish, White: Gypsy or Irish Traveller and White: Other White' . '

5.5 Race and ethnicity: Black ethnic background

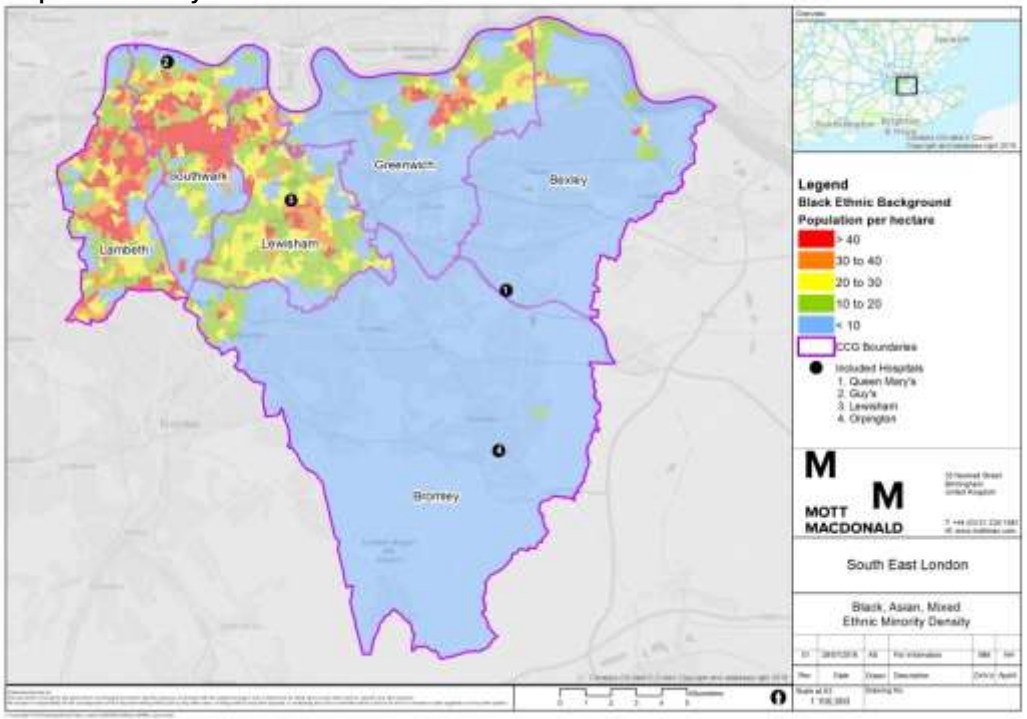
Population with a black ethnic background (BAME)

Area	Black ethnic background	%
Bexley	19,624	23
Bromley	18,686	23
Greenwich	48,655	48
Lambeth	78,542	61
Lewisham	74,942	59
Southwark	77,511	60
South East London	317,960	20
Greater London	1,088,640	13

Source: ONS, Mid-year Population estimates, 2014

The table above shows large proportions and numbers of people from a black ethnic background in the inner London Boroughs of Lambeth, Lewisham and Southwark. The map shows very high densities of people from a black ethnic background in the inner London boroughs. In contrast, Bromley and Bexley have relatively low proportions, populations and density.

Population density



Source: ONS, Mid-year Population estimates, 2014

Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note that the report is suggesting a differential need amongst ethnic groups, rather than a disproportionate need. This is because there is evidence to suggest that those from different ethnic backgrounds have need for different types of elective orthopaedic care services. The evidence highlights evidence pertaining to those from BAME backgrounds.

Scientists at the London School of Hygiene and Tropical Medicine discovered that people of non-white ethnicity tend to have more severe disease and have suffered with arthritis for longer by the time they undergo surgery. *(Arthritis Research UK (2012): Socio-demographic factors influence timing of joint replacement surgery).* In addition, reports in the US on differences in knee osteoarthritis between African-Americans and Caucasians report a higher prevalence knee osteoarthritis in African-Americans, as well as more symptomatic knee osteoarthritis in African-Americans than Caucasians. Gait patterns can also differ between ethnic groups in osteoarthritis prevalence. A study has reported that that African-Americans were possibly more prone to lateral compartment knee osteoarthritis than Caucasians *(Chaganti, R. et al. (2011): Risk factors for incident osteoarthritis of the hip and knee).*

Lupus is also more common in some ethnic groups as well, particularly those of African origin (*Arthritis Research UK (No date): Lupus*).

5.5 Race and ethnicity: Black ethnic background - Continued

Changing population trends of those from a BAME background

Although national datasets are not available for the likely population change. Local data reports that:

- **Southwark** is predicted to have a 41% increase in 'Black Other' population over the next 10 years. *Southwark Council (2015): Southwark Demographic Factsheet May 2015*
- The Black Caribbean population in **Southwark** is projected to decrease by 1% in the next 10 years. *Southwark Council (2015): Southwark Demographic Factsheet May 2015*
- In **Lambeth** the black Caribbean 60+ population is projected to grow by almost 40%. Similarly, the older black African population, which is currently small, is projected to nearly double. *Lambeth Council State of the Borough 2014*
- The GLA 2013 Round Ethnic Group Projections estimate that, in 2015, the ethnic minority population of **Bromley** is 17.9%, and this is projected to rise to 20% by 2025. The greatest proportional rise is in the Black African group. *Bromley joint strategic needs assessment 2014 - The Population of Bromley: Demography*
- Between 2015 and 2025 it is projected that the largest increases in **Greenwich** will be in: Black African: +10,400 (26.3% increase), Other Asian: +6,800 (37.7% increase) and Chinese: +2,200 (+35.5% increase). By 2041 it is estimated that nearly half of the boroughs residents will be from a BAME background (45%). R*oyal Borough of Greenwich (No date): Ethnic Groups Projections for Royal Greenwich (2001-2041)*
- By 2020, the Black African population of **Lewisham** is set to increase by 16.8% *Lewisham's Public Health Information Portal*

5.6 Deprivation

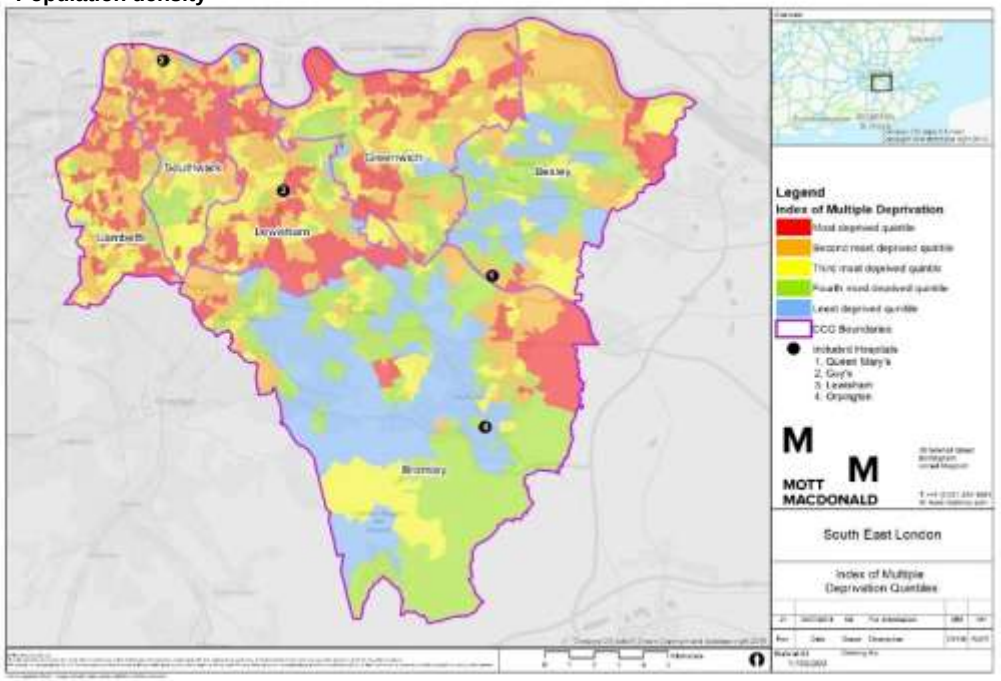
Population classified as deprived[4]

Area	Classified as deprived	%
Bexley	65,900	27%
Bromley	82,300	26%
Greenwich	163,300	61%
Lambeth	232,900	73%
Lewisham	209,00	72%
Southwark	225,700	75%
South East London	979,100	56%
Greater London	4,598,500	54%

Source: IMD, 2015 using Mid-Year Population Estimates, 2014

The data shows that the inner London boroughs are proportionally far more deprived, have higher densities of deprivation and have higher overall numbers of people who are deprived. However, there are also pockets of deprivation in the outer London boroughs too, notably in the north east of Bromley and the north east of Bexley.

Population density



Source: IMD, 2015 using Mid-Year Population Estimates, 2014

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Deprivation is associated with greater need for total hip and knee replacement surgery. Moreover, more deprived patients remain in hospital longer, without morbidity, because of a lack of social support available to them in the community. *(Major elective joint replacement surgery: socioeconomic variations in surgical risk, postoperative morbidity and length of stay, Journal of Evaluation in Clinical Practice, 2009)*

Scientists at the London School of Hygiene and Tropical Medicine also discovered that people from lower socioeconomic backgrounds, tend to have more severe disease and have suffered with arthritis for longer by the time they undergo surgery. The researchers looked at data on 117,736 patients, all of whom underwent hip or knee replacement surgery in England in 2009-10 *(Arthritis Research UK (2012): Socio-demographic factors influence timing of joint replacement surgery).*

4. Deprivation is calculated using the indices of multiple deprivation (IMD). Indices of deprivation are based across seven distinct domains (employment deprivation, health deprivation and disability, education, skills and training deprivation, crime, barriers to housing and services and living environment deprivation.) This overall measure of multiple deprivation is calculated for every lower layer super output area (LSOA) neighbourhood in England. Every neighbourhood is then ranked according to its level of deprivation relative to that of other areas. Deprivation is identified when the LSOA is either in the most deprived or second most deprived quintile.

5.6 Deprivation- continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Evidence suggests that malnutrition increases the risk of developing osteomyelitis, as a weakened immune system makes it more likely for infections to spread to the bones *(NHS Choices, 2014, Osteomyelitis – Causes).* Moreover, osteomyelitis is more likely to occur if for some reason an individual's bones are susceptible to infection. Pre existing health conditions, such as diabetes, can cause this. In this instance bones may not receive a steady blood supply, meaning infection-fighting white blood cells cannot reach the site of injury within the bone *(NHS Choices (2014): Osteomyelitis – Causes).* Diabetes prevalence increases with greater levels of deprivation. *Public Health England (2014) Adult obesity and type 2 diabetes.*

In addition, obesity prevalence increases with greater levels of deprivation. *Public Health England (2014) Adult obesity and type 2 diabetes.* Obesity is a strong risk factor for knee osteoarthritis, with obese people 14 times more likely to develop the condition than those of a healthy weight. '*Osteoarthritis and obesity' Arthritis Research Campaign 2013.* Although the main treatments for osteoarthritis include lifestyle measures, in some cases, surgery to repair, strengthen or replace damaged joints is preferred.

Local evidence supports the population demographics shown above. Lambeth is the 14th most deprived Local Authority in England; Greenwich is the 19th most deprived; Southwark is number 41, and Lewisham is the 31st most deprived Local Authority in England. Although Bexley and Bromley (ranking 174 and 203 respectively) score well compared to other south east London Boroughs, they still have significant areas of poor health, exclusion and deprivation. *(Southwark Council (2015): Southwark Demographic Factsheet, Lewisham JSNA: Index of Multiple Deprivation. Joint Strategic Needs Assessment 'Life, Health and Wellbeing in the London Borough of Bexley', Bromley Joint Strategic Needs Assessment 2012, 'Socio-demographic profile of Greenwich' Royal Borough of Greenwich, Documents Lambeth – State of the Borough 2014)*

5.7 Carers

Number of population providing 1-20 hours of care per week and percentage of overall population.[5]

Area	Carers providing 1-20 hours care per week	%
Bexley	14,700	6
Bromley	21,200	7
Greenwich	13,000	5
Lambeth	13,000	4
Lewisham	13,900	5
Southwark	12,400	4
South East London	14,700	5
Greater London	433,400	5

Source: Census, 2011

The percentages of carers in each CCG area are broadly similar to each other and to the greater London average, however Bromley has a significantly higher volume of carers than any other area.

Due to the similar distribution of carers across the six study areas, a density map is not available for carers as it shows no critical mass in any of the six study areas.

Please note that whilst the most up-to-date data on carers is from the 2011 census, figures may have changed since then. In addition, carer figures tend to be under-reported as data requires carers to self-identify. A proportion of those whom the NHS would deem to be carers do not identify themselves in this way. This will be further explored with stakeholders in the next stage of the analysis.

Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note here that we are not stating carers have a disproportionate need for elective orthopaedic care, rather they have a differential need due to their caring responsibilities, which is different to non-carers. As older people are more likely to require carers, and they are the greatest users of elective orthopaedic care, carers are likely to be impacted by any service changes.

A report by Carers UK indicated that failing to consider post-hospital support and carers' needs had counterproductive consequences, such as increased readmission *(Carers' UK, 2016: Response to the Public Administration and Constitutional Affair Committee Inquiry into Unsafe Hospital Discharge)*

5. Information is also available on carers providing over 20 hours of care per week. Please refer to appendix A2. There is a reduction in the number of carers providing over 20 hours a week, though trends remain similar in terms of density and proportion of carers within the six boroughs.

6. Summary of ‘scoped in’ groups

Outlined below is a summary of the groups who have been scoped in as having a disproportionate or differential need for elective orthopaedic care.

Characteristic	Disproportionate need	Differential need
Age: Young people		
Age: Older people	✓	
Disability	✓	
Gender: Female	✓	
Gender: Male		
Gender reassignment	✓	
Marriage and civil partnership		
Pregnancy and maternity		
Race and ethnicity: White		✓
Race and ethnicity: BAME		✓
Religion and belief		
Sexual orientation		
Deprivation	✓	
Carers		✓

It is important to note that the report is not suggesting that other groups will not need these services, rather it is to suggest that there does not presently exist a body of evidence indicating a disproportionate or differential need. This will continue to be updated in subsequent phases of work.

6. Summary of the geographical distribution of 'scoped in' groups

At the CCG level, volume and proportion are used as helpful measures to understand the population of each scoped in group and to understand the relative presence of a particular group.

At a pan south east London level, it is useful to look at density as a measure by which to understand where the greatest concentration of scoped in groups are located. This is important because this helps to indicate where impacts, both positive and negative, are more likely to be realised across the study area without the analysis confined to administrative boundaries.

In the case of this equality analysis and its ability to inform the decision making process, it is crucial to look at future service provision across south east London, rather than at a CCG level.

It is important to note that this summary does not take into account which hospitals are being short listed as they is yet to be decided or travel impacts.

Data on how populations are changing has been excluded from this analysis. This is because for age, the boroughs with the largest volumes of people aged over 65 will remain the same in 2039. Please see appendix A3 for further information.

Scoped in groups	Volume	Proportion	Highlight comments at CCG level	Density	Highlight comments at south east London level
Age (Older people)	Bromley has the highest numbers of those aged 65 or over and aged 75 or over. Bexley also has high volumes.	The greatest proportions of older people are in Bromley (18%) and Bexley (17%), both of which are higher than the greater London average (12%).	Bromley and Bexley are areas with high volumes and proportions of older people.	Density of older people is highest in areas of Lambeth and Southwark.	The inner London boroughs in the north west of the study area have the highest density of older people.
Disability	Bromley has the most people living with a long term illness or disability.	As a proportion of the population, greater proportions of disabled people are in Bexley (16%), Bromley (15%) and Greenwich (15%), all of which are higher than the greater London average (14%)	Bromley, has high volume and proportion of those living with a long term illness or disability.	Lambeth and Southwark have higher densities of those with a long term illness of disability, though pockets of high density also exists in Greenwich.	The inner London boroughs in the north west of the study area have the highest density of those with a long term illness of disability.
Gender: Female					

6. Summary of the geographical distribution of 'scoped in' groups continued

Scoped in groups	Volume	Proportion	Highlight comments at a CCG level	Density	Highlight comments at south east London level
Race & ethnicity: White	Bromley has the greatest volume of people from a white ethnic background. It is significantly greater than any other area.	Bexley (82%) and Bromley (84%) have the highest proportion of people from a white ethnic background.	Bromley has the highest volume and proportion of people from a white ethnic background. Bexley is also an area with high volume and proportion of people from a white ethnic background.	Lambeth has the highest density of those from a white ethnic background, Bromley the lowest.	Pockets of high density of people from a white ethnic background exist across the study area.
Race and ethnicity: BAME	The greatest volume of BAME communities is in Lambeth, followed by Southwark and then Lewisham.	Lambeth (61%) and Southwark (60%) have the highest proportion of people from a BAME background.	Lambeth, has the highest volume and proportion on those from a BAME background. Southwark and Lewisham are also areas with high volume and proportion	The greatest densities people with a BAME background is in Lambeth.	The inner London boroughs in the north west of the study area have the highest density of people from a BAME ethnic background. Pockets of high density also exists in the north of the study area.
Gender reassignment					
Deprived communities	The volume of people classified as deprived is far greater in Lambeth, Lewisham and Southwark.	Southwark (75%), Lewisham (72%) and Lambeth (73%) also have the highest proportions of deprivation, all of which are significantly higher than the greater London average (54%).	Lambeth, Southwark and Lewisham all have very high volumes and proportions of people classified as deprived.	Lambeth, Lewisham and Southwark have higher densities of deprivation, though pockets also exist in the north east of Bexley and the north east of Bromley.	The north and north west of the study area has the highest density of people living in deprivation.
Carers	Bromley has the largest volume of carers and is much higher than the other areas.	Bromley (7%) has the highest proportion of carers, though all are similar or identical to that of the greater London average of 5%	Bromley has significantly more carers than any other CCG area. It is also has the highest proportion of carers. This is consistent with the fact that Bromley also has the largest volumes of older people.	N/A	N/A

7. Concluding observations

7.1 Equalities analysis

Our analysis to date shows that the following groups need to be further considered as our research progresses; older people, disabled people, females, people undergoing gender reassignment, people from a white ethnic background, people from a BAME background, people in economic and social deprivation and carers.

It is understood that disability is a heterogeneous category and that people with different disabilities have different needs. This report focuses on those with learning disabilities, epilepsy or cerebral palsy as this is where evidence exists to demonstrate disproportionate need. This will be further explored with stakeholders representing disability as engagement continues.

It is important to note that individuals may have more than one of the protected characteristics scoped into this report. However, this does not necessary make their need greater than an individual with one of the protected characteristics scoped in. By way of example, we can not quantify or specify that a woman over the age of 65 has double the level of need than a woman under the age of 65.

7.2 Recommendations for OHSEL consultation

In the public consultation phase of the work, it is suggested that OHSEL considers asking questions on issues such as the location and access of services, the design of services and monitoring and feedback. This will enable OHSEL to understand to what extent location, the design of services and how feedback is captured is important to patients. This is to be discussed with OHSEL prior to the consultation phase.

The social demographic analysis demonstrates difference in population groups across the CCGs. The north west of OHSEL, including Lambeth, Southwark and Lewisham tend to have higher densities of deprivation and those with a disability. In comparison, the south of the study area tends to have higher densities of the older people and carers. In planning the programme of public consultation, OHSEL may want to undergo consultation activities focused on certain groups in specific areas, according to the trends identified in this paper.

We are happy to discuss these issues in more detail with communications and engagement leads at OHSEL and the constituent CCG areas as necessary.

8. Next steps

The next steps in this equalities analysis are as follows:

- Continue with a programme of engagement with stakeholders. These will take the form of individual one-to-one telephone interviews with strategic and community stakeholders. It has been challenging to engage with stakeholders to date, in order to ensure that we provide stakeholders with the maximum chance to participate, we are extending this engagement phase into stage two of the work.

- In advance of commencing the second phase of work, a meeting will be held with OHSEL to discuss the findings of this report. The engagement strategy going forward into stage two will also be discussed with OHSEL and relevant stakeholders. One-to-one interviews with community groups have failed to engage large numbers of stakeholders to date. Whilst the scope of work originally suggested holding engagement forums in stage two involving community and patient groups, alternative ways to engage communities scoped in will be explored. Specifically, the use of focus groups comprising of participants with one or more of the characteristics identified as having either disproportionate or differential need.

- To date stakeholders have highlighted some potential overarching equality impacts, which we will look to explore in more detail in stage two, namely:
    - **Patient experience and quality of care:** Some vulnerable groups find it more challenging to understand and accommodate change in service provision, either due to challenges in terms of comprehension, anxiety around unfamiliar journeys or venues and/or a lack of independence. This may affect patient experience before and during service receipt.
    - **Travel and access for certain protected characteristic groups:** Centralisation of some services will require longer journey times for some patients. Understanding the extent to which these longer journey times affect the protected characteristics will be critical. This is particularly the case because several equality groups have a higher reliance on public transport than the general population which can compound any accessibility impacts. It is recommended that OHSEL might want to consider this issue quantitatively using travel and access analysis, based on different service options. We can discuss the benefits of this with OHSEL in more detail

- Stage two of the equalities analysis will then begin. Stage two consists of the following activities:
    - Providing expert advice to OHSEL during the public consultation phase.
    - Continuing engagement either through engagement for a or focus groups, to be decided.
    - Undergoing staff engagement through one-to-one interviews.
    - Delivering an equalities training workshop to NHS staff on the data required to fulfil the PSED.

An interim report will then be produced by the end of November 2016.

Appendices

A1. Stakeholders contacted during phase one engagement

The following community stakeholder groups have been contacted by Mott MacDonald. This is in addition to stakeholders contacted directly by OHSEL. Stakeholders highlighted green have responded to the opportunity for interview and have been engaged as part of this process. Stakeholders representing disability (Lambeth Mencap), race (Greenwich Race Inclusion Project and Greenwich Migrant Hub) and sexual orientation (Southwark LGBT Network) have been engaged. OHSEL are continuing to extend invitations to engage in the process particularly with groups scoped into this research via their existing contacts and relationships.

Age Exchange	Lambeth Youth Council	Bridge Mental Health	Trans London	Greenwich Race Inclusion Project
Age UK Bromley	Carers Bromley	British Lung Foundation Breatheasy Group, Lambeth	Bexley Maternity Services Liaison Committee (MSLC)	Multifaith forum, Southwark
Basaira Pensioners Forum	Carer's Hub Lambeth	Bromley Mencap	Bromley MSLC	Faiths Together in Lambeth
Bexley Youth Service	Carer's Hub Lewisham	Greenwich Association for Disabled People	Greenwich MSLC	Greenwich Peninsula Chaplaincy
Bromley and Greenwich Age UK	Carers Lewisham	Greenwich Mind	Lambeth MSLC	Brimley Inter Faith Forum
Bromley Childrens and Families Voluntary Forum	Carers Support Bexley	Lambeth Learning Disability Assembly	Lewisham MSLC	Bromley Gay and Bisexual Men's Group
Danson Youth Centre	Greenwich Carers Centre	Lambeth Mencap	Southwark MSLC	Community Empowerment and Support Initiatives, Greenwich
Elders People Support Group	Lambeth Young Carers	Lewisham Disability Coalition	Bexley Multicultural Centre CIC	Haven, Bexley
Greenwich Older Voices	Lewisham Parent Carers Forum	Lewisham Mencap	Ethnic Health Foundation	Lambeth LGBT network
Lambeth and Southwark Integrated Care Citizens' Forum	Southwark Parent Carers Council	Mind in Bexley	Federation of Refugees from Vietnam in Lewisham	Metro
Lambeth Youth COOP	Southwark Young Carers	Mosaic Clubhouse	Indo-Chinese Community Centre,Lewisham	LGBT Community Plan London
Lewisham Youth Aid	Young Carers, Greenwich	Thamesreach Lambeth	Lewisham Ethnic Minority Partnership	Southwark LGBT Network
Oakwood School	Association for Disabled Children, Bexley	Voluntary Organisations Disability Group, Lambeth	Lewisham Irish Community Centre	999 Club
Southwark Young Council	Bexley Deaf Centre	FTM London	Lewisham Turkish Elders Club	Bench outreach project

A1. Stakeholders contacted during phase one engagement continued

Blenheim Nexus Outreach

Bromley and District Osteoporosis Group

Bromley Homeless Shelter

Community Options, Bromley

CRI Lewisham Young People Substance Misuse Service

Deptford Reach

Emmaus Greenwich

Give us a buzz, Greenwich

Greenwich Migrant Hub

Indoamerican Refugee and Migrant Organisation, Lambeth

Lambeth Resolve

SHP-Lambeth Projects

St Mungos

Thames Reach Employment Academy

Thamesreach Greenwich

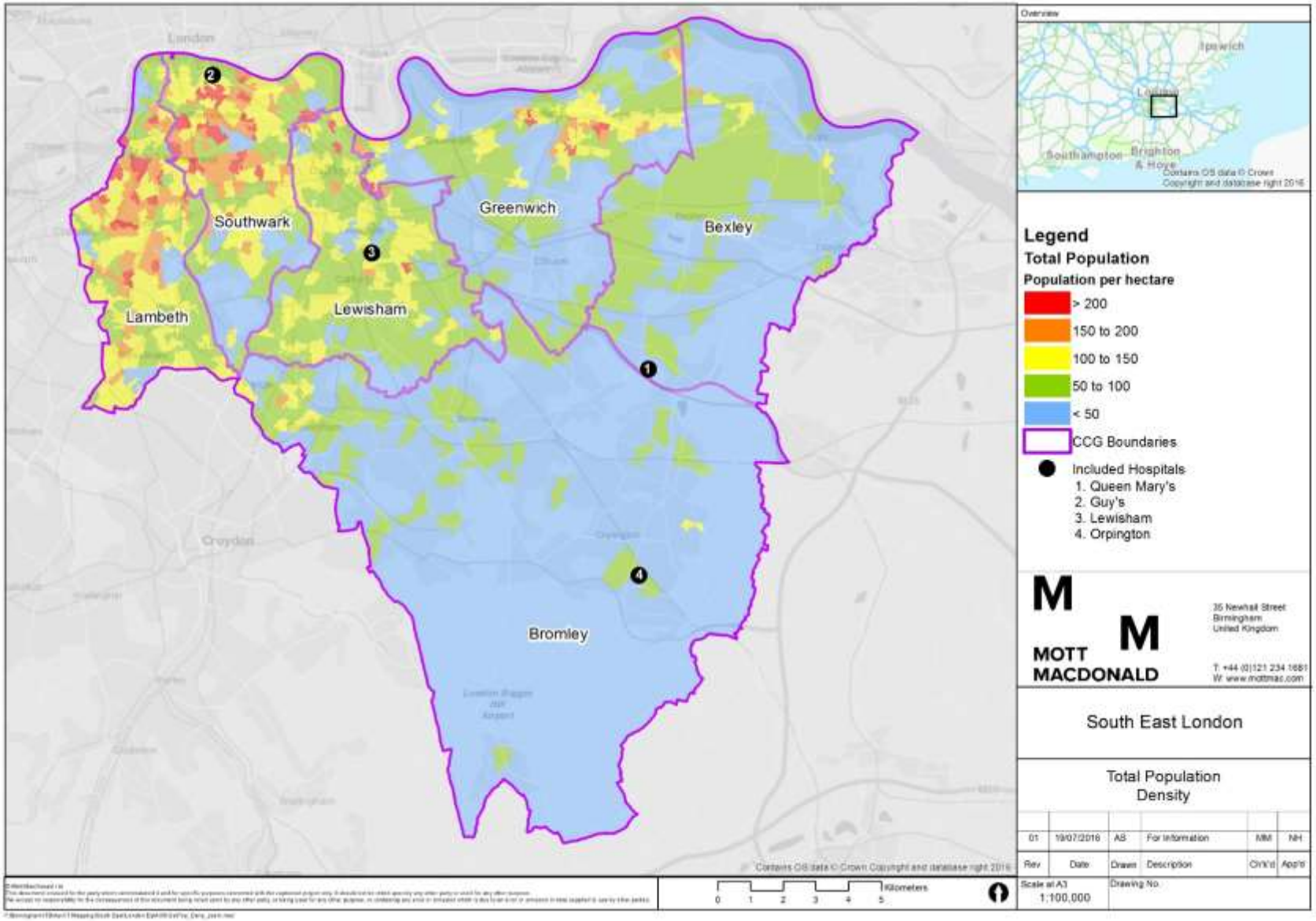
Thamesreach Lewisham

The Scarlet Centre, Greenwich

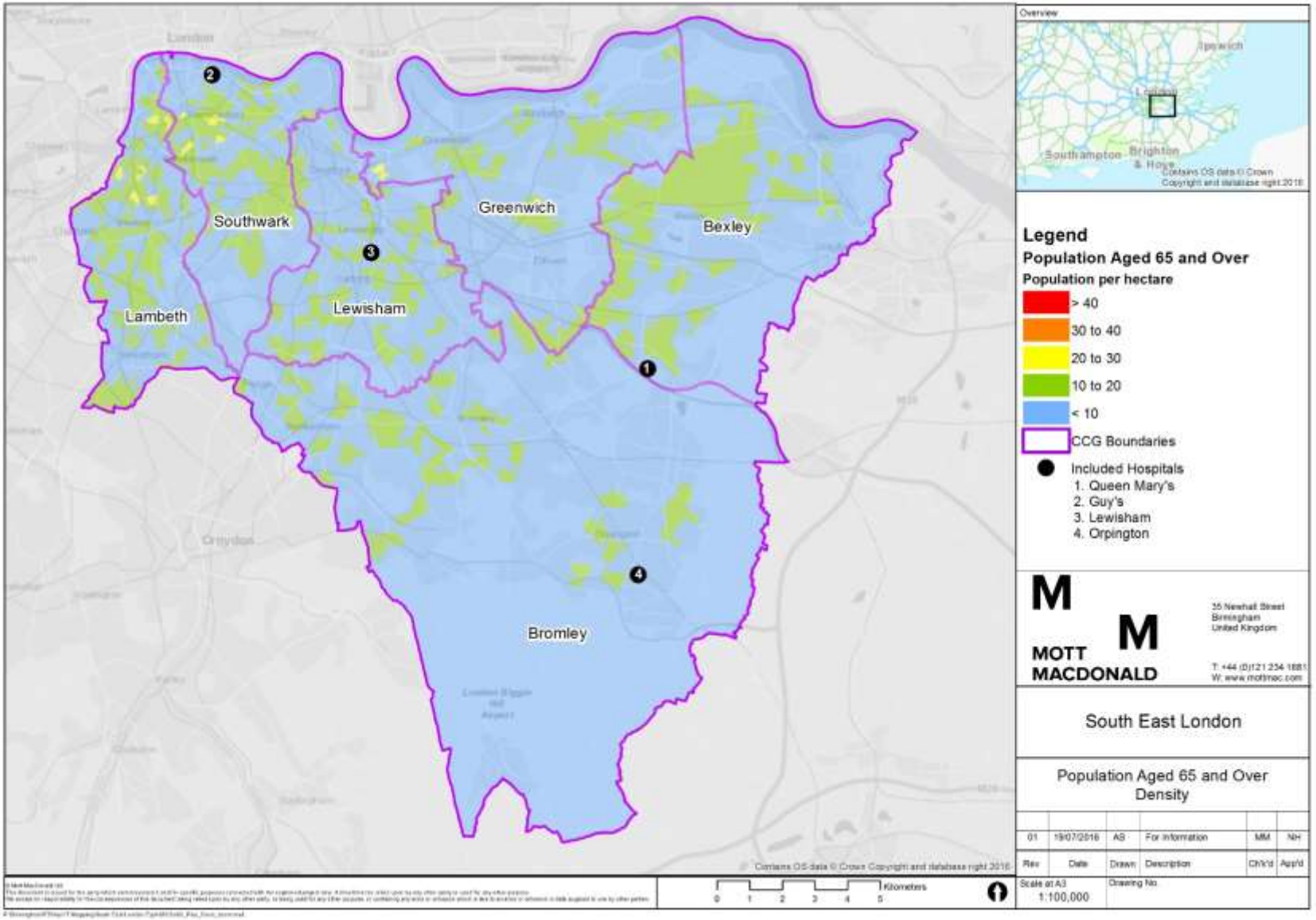
In addition to the community stakeholders, strategic stakeholders from all six CCGs have been contacted. These include equality, engagement and

clinicians from the six CCGs.

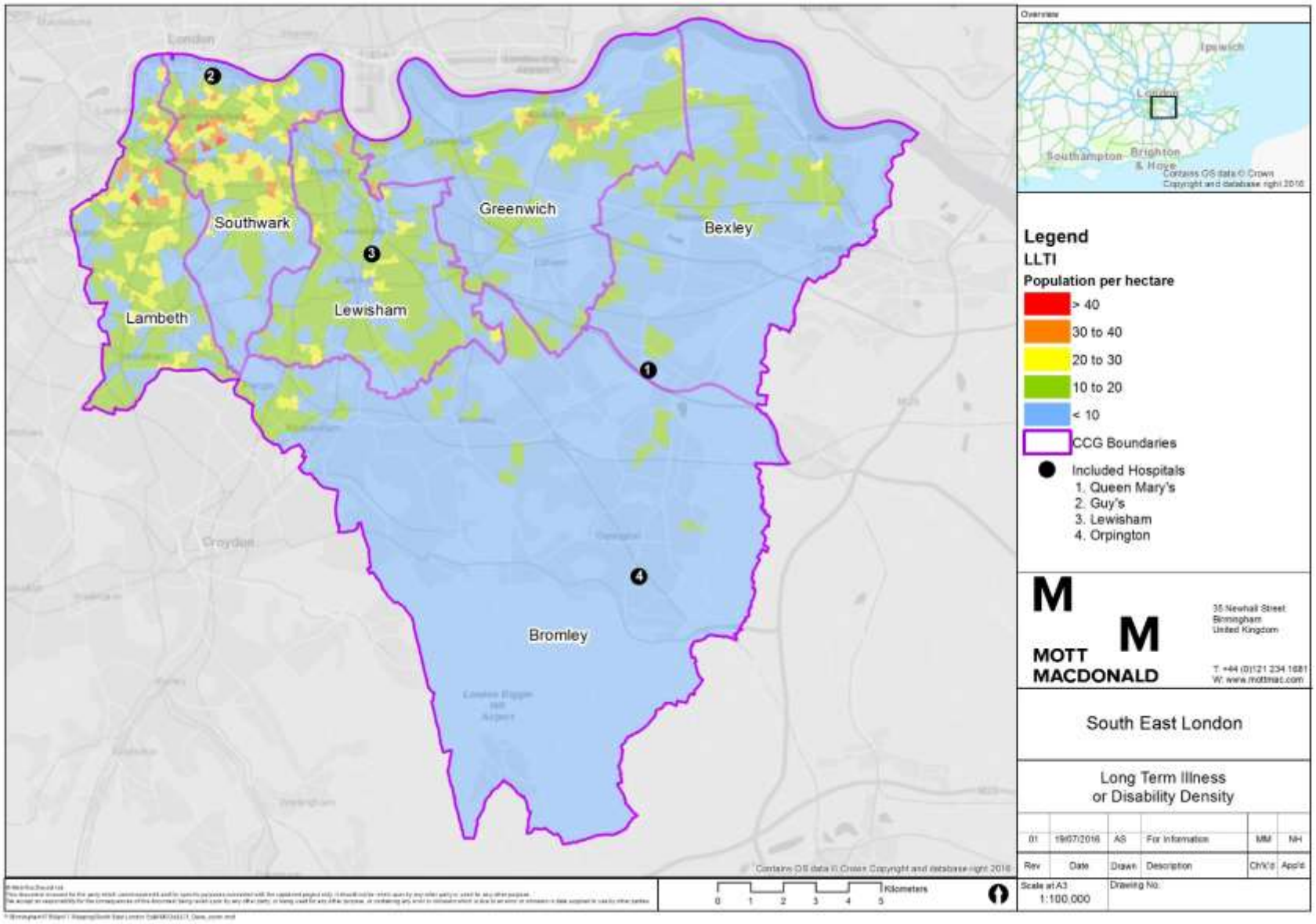
B2.1 Population density OHSEL



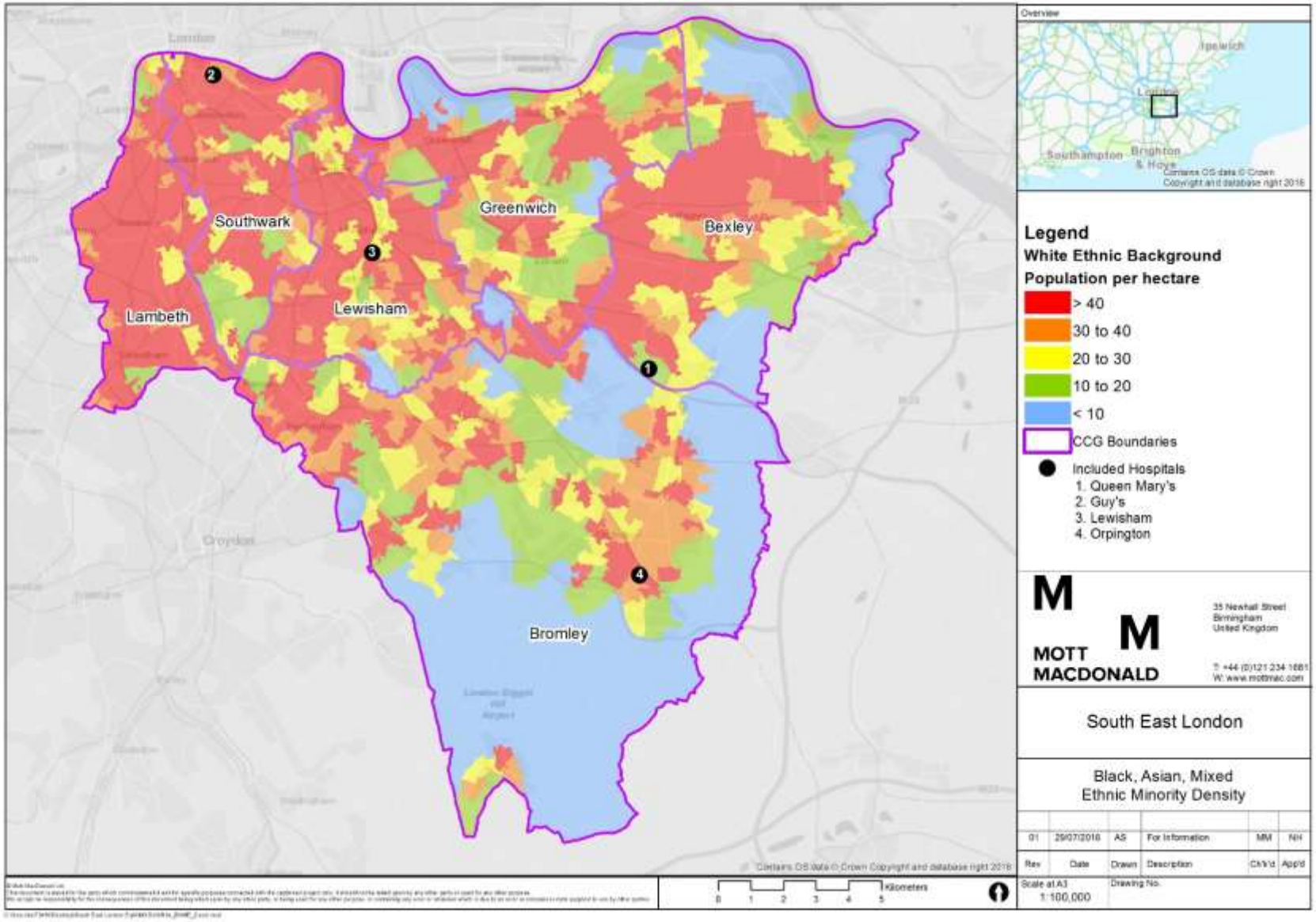
B2.2 Population density older people (aged 65 or over)



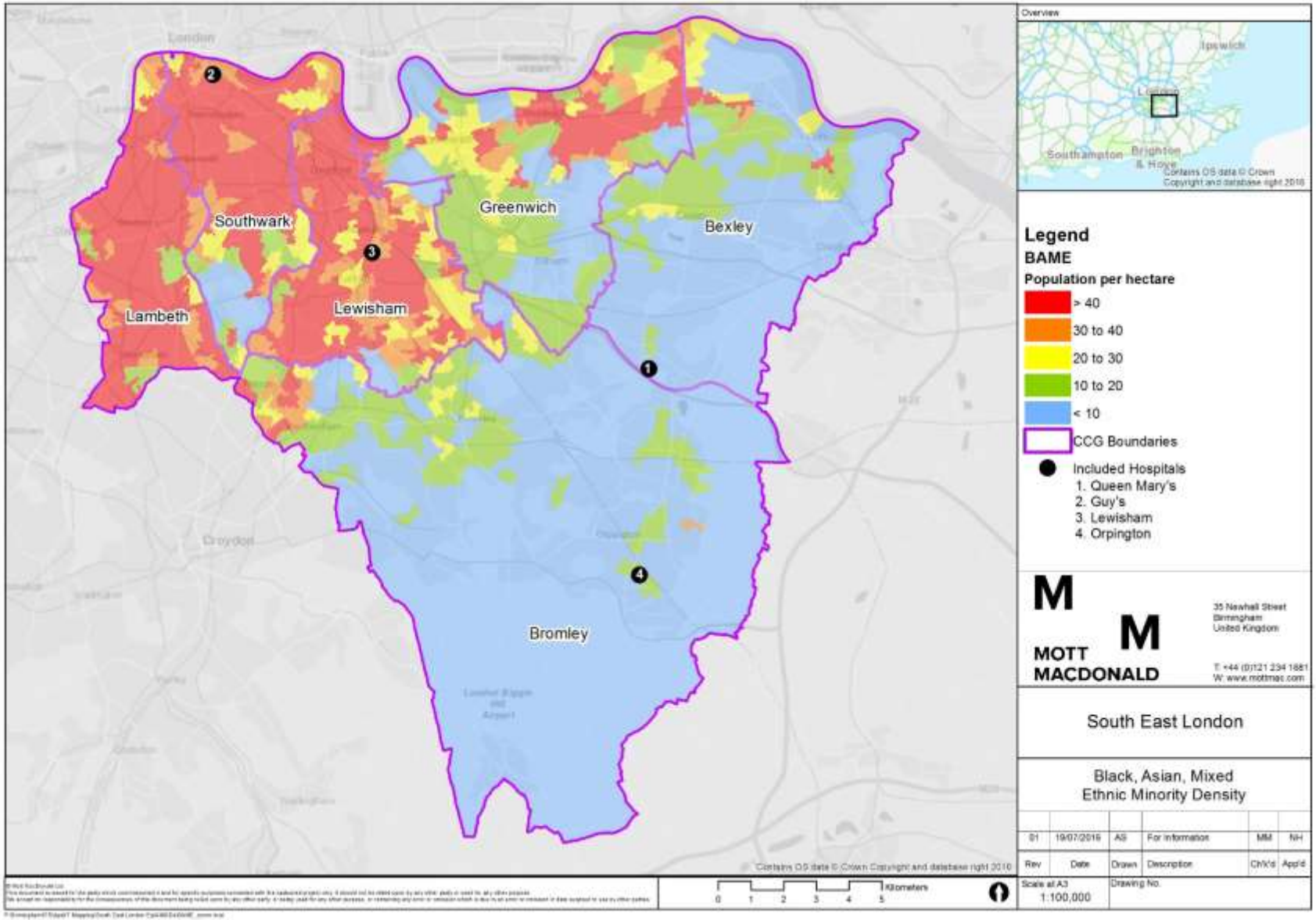
B2.3 Population density disability



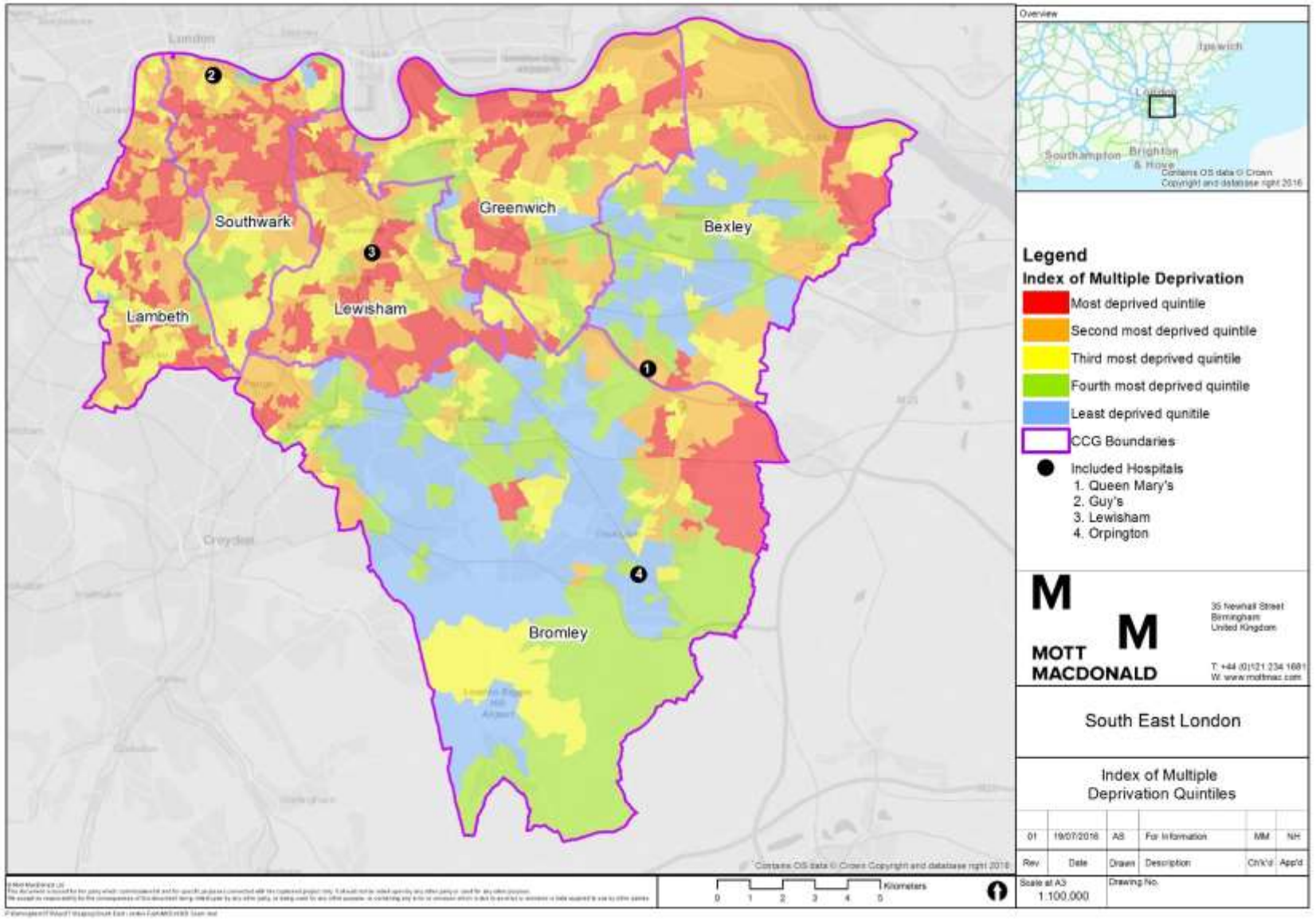
B2.4 Population density white ethnic background



B2.5 BAME


Overview
Legend
BAME
Population per hectare
> 40
30 to 40
20 to 30
10 to 20
< 10
CCG Boundaries
Included Hospitals
1. Queen Mary's
2. Guy's
3. Lewisham
4. Orpington
Southwark
Lambeth
Lewisham
Greenwich
Bexley
Bromley
Croydon
MOTT MACDONALD
South East London
Black, Asian, Mixed
Ethnic Minority Density
Kilometers
Scale at A3
1:100,000
Drawing No.

B2.6 Population density deprivation



C1 Disability Living Allowance (DLA) claimants

CCG	Claiming for learning disability	Total claiming DLA	Proportion of DLA claimants that claim for learning disability
Bexley	1,850	9,590	19%
Bromley	2,270	10,730	21%
Greenwich	2,080	12,230	17%
Lambeth	1,940	12,010	16%
Lewisham	2,640	12,600	21%
Southwark	2,050	12,580	16%
South London	12,830	69,740	18%

Source: ONS data, 2016

Please note that this data has been included to provide additional detail. This data should not be seen as the sole indictor for the numbers of people in each CCG area who have learning disabilities as it details those claiming DLA only. In phase two of the works, stakeholders will be engaged on issues of reliably identifying the numbers of people living with learning disabilities in the study area.

A density map has not been produced for these statistics as the numbers of those claiming DLA for learning disabilities is too small to demonstrate any critical mass.

D1 Population trends: Older people volume and percentage change

	Aged 65+ 2014	Aged 65+ 2039	Total Population % Change	Aged 65+ % Change
Bexley	40,000	62,000	28%	55%
Bromley	56,000	88,000	28%	56%
Greenwich	28,000	52,000	32%	86%
Lambeth	25,000	48,000	23%	94%
Lewisham	27,000	52,000	31%	89%
Southwark	24,000	48,000	29%	100%
South London Average	33,000	58,000	28%	75%
Greater London	983,000	1,775,000	29%	81%

Source: ONS Population Projections, 2014