

Improving health services in Dulwich and surrounding areas: Initial Equalities Impact Assessment

Verve Communications

Gemma Novis, Associate Director, July 2013

Contents	Page Number
1. The Purpose of our Assessment	3
2. Description and Aims of Policy / Service (including relevance to equalities)	4
3. Brief Summary of Research and Data (relavant to Equalities)	5
4. Methods and outcome of research, involvement and consultation	7
5. Results of Initial Equality Impact Assessment	9
6. Decisions and Recommendations	10
7. Reasonable Adjustments to Promote Equality, Value Diversity and Protect Human Rights	11
8. Monitoring and Review Arrangements (including date of next full review)	19
Appendix One: Full Impact Assessment Evidence and Key Issues	20
Appendix Two: Embedding Equality and Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development	41

Development Timetable	Date	Responsible Manager
Date of completion – Version 1.0:	28 Feb 2013	Rebecca Scott Programme Director NHS Southwark
Date of Review (Mid-Consultation) – Version 2.0:	13 May 2013	As above
Date of Review (Post-Consultation) - final Version 3.0:	5 July 2013	As above
Proposed Date for Annual Review:	5 July 2014	As above

1. Purpose of our assessment

In February 2013, NHS Southwark¹ commissioned Verve Communications to undertake an independent initial Equalities Impact Assessment (EqIA) of a series of suggested improvements and changes to health services in the Dulwich area of the London Borough of Southwark.

This report represents the opinions of Verve Communications and is our independent advice to the NHS Southwark Clinical Commissioning Group (NHS Southwark CCG) and the Dulwich Programme Board (DPB).

Verve Communications is a specialist company which supports organisational and service change with a particular emphasis on engaging citizens in development of public services, particularly in health and local government. We also work in partnership with the Afiya Trust: a national charity that works to reduce inequalities in health and social care provision.

The author of this report, Gemma Novis, is the former Equality and Diversity Manager for NHS Lewisham where she co-ordinated Equality Impact Assessments in areas such as Urgent Care services and Improved Access to Psychological Therapies. In addition to this work Gemma was a finalist for Community Leader of the Year in the NHS Leadership Awards 2010.

Gemma has recently completed an Equality Analysis of the NHS South East London Commissioning Strategy Plan 2012–2014 and an equalities impact assessment of the proposed NHS SE London 111 Service. Other relevant equalities work undertaken by Verve includes an Equalities Impact Assessment on Shaping the Future of Healthcare in NHS Berkshire and analysis of the effectiveness of the Equalities Delivery System (EDS) for Bromley Healthcare.

The objective of this initial EqIA is to identify potential positive and negative impacts that may result as a consequence of the proposals outlined in the Southwark Clinical Commissioning Group (Southwark CCG) consultation document titled: *Improving health services in Dulwich and the surrounding areas - A consultation about local services*, with a particular emphasis on enhancing the local fulfilment of the Public Sector Equality Duties (PSED) within which NHS Southwark CCG has a duty to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Equality Act 2010;
2. Advance equality of opportunity between people who share a protected characteristic and those who do not;
3. Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The focus of this report will be on assessing the potential impact of the proposals to improve health services in Dulwich and the surrounding areas on individual patients and relatives/carers who share one or more of the following nine protected characteristics (in no particular order):

- **Age**
- **Race**
- **Disability**
- **Sex**
- **Sexual Orientation**
- **Religion / Belief**

¹ On 1st April 2013 NHS Southwark will cease to exist and its role in commissioning most health services in Southwark will become the responsibility of the NHS Southwark Clinical Commissioning Group (NHS Southwark CCG)

- **Marriage & Civil Partnership**
- **Gender Reassignment**
- **Pregnancy and Maternity**

This Equality Impact Assessment process seeks to align outcomes with the vision of the NHS Southwark CCG as identified in local commissioning plans. The local commissioning plans (the Integrated Plan) seek to deliver the CCG's vision to secure the best possible health outcomes for people in Southwark by ensuring that:

- People live longer, healthier, happier lives no matter what their situation in life
- The gap in life expectancy between the richest and the poorest in the population continues to narrow
- The care local people receive is high quality, safe and accessible
- The commissioned services are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
- To make effective use of resources available and always act to secure the best deal for Southwark.

The CCG's first Integrated Plan, 2012/13 -2014/15, builds upon the strategic objectives of the most recent commissioning strategy plan for south east London: '*Better for you*' and prioritises action in the seven areas listed below:

- Better outcomes for people with Long Term Conditions
- Supporting more people to stay healthy and prevent ill-health
- Improving patient experience of outpatients and delivering value for money
- Improving rates of early diagnosis and to provide better quality of life for people with cancer and at the end of life
- Improving outcomes for people with mental health needs
- Developing a well-integrated and high quality system of urgent care
- Embedding clinically and cost-effective prescribing across care settings.

2. Description and aims of policy / service (including relevance to equalities)

This assessment considers the proposals set out in the pre-consultation business case for Health services in Dulwich and the surrounding area dated 24 January 2013 which has been formally consulted on since 28 February 2013. The ward areas in the London Borough of Southwark affected by these proposals are:

- College
- East Dulwich
- Nunhead
- Peckham Rye
- South Camberwell
- The Lane
- Village

The overall vision for the future of community based health care in these wards has been encapsulated in the four points below:

1. Ensuring that individuals have access to healthcare advice and diagnostic services at a number of local sites including GP surgeries, pharmacies or at a local health centre. Reducing the length of time people have to wait for treatment and the need to visit the hospital

2. Detecting health problems early by improving the availability of screening, immunisation and prevention services in pharmacies, GP surgeries or a health centre in the locality, making it more convenient for people to use these services.
3. Providing health services that are close to home for expectant mothers and young children and joined up in local community facilities so that care is personalised and tailored to peoples needs
4. Helping people with on-going health conditions to manage them and remain independant by ensuring care is provided in the community and centralised in one place. Providing more joined up care and reducing the need to visit the hospital.

The main aspect of the proposal is to reconfigure the range of current and proposed health services across Dulwich and the surrounding area to meet the diversity of local health needs in a way that can be sustained into the future.

Specifically there are two proposed models for the delivery of community based healthcare services for those living in Dulwich and the surrounding areas:

- A. **A centralised model** - which includes the development of a central health centre or 'hub' to provide a wide range of health services, with GP surgeries providing only core GP services (some, perhaps, less than currently).
- B. **A networked model** - which includes the development of a health centre or 'hub' (offering a limited range of extra services) and GP surgeries, some of which would offer a wider range of service than they do at present. This approach would mean patients could receive a lot of non-hospital based health services from their GP surgery, or another GP surgery nearby or in a health centre.

In both cases a health centre will be designed and developed to meet local need, keeping in mind the broader vision for community health services as listed above, the only location that has been identified as a possible site for this health centre is the current Dulwich Community Hospital in East Dulwich Ward. Should other options emerge, these will be considered.

The proposals also aim to cause a significant shift in where individuals access services, reducing the need to go into acute settings and instead access services at home, via their GP, via pharmacies and in other community based settings.

3. Brief summary of research and data (relevant to Equalities)

It is important that all providers of community / home based health services give due regard to the differential needs, perceptions and experiences of individuals who share one or more protected characteristics. Most importantly it is necessary for all staff to have an understanding of how they promote and implement dignity and human rights i.e. 'live the spirit of the NHS constitution' in everything they do.

Across disability as a protected characteristic the 'centralised model' presents less immediate barriers in terms of access and continuity of care as individuals care packages will operate across less locations. The individuals will be registered at their choice of GP - one they can access, where there is parking and/or public transport routes that they are familiar with, for example - and then attend the central hub for other healthcare needs. This is particularly relevant for those with learning disability, sensory and/or physical disabilities. The 'centralised model' offers a wider range of services in one location than the networked model. Some older people might also prefer visiting fewer sites for their care and overall the 'centralised model' might be less confusing for them. However, the 'networked model' does present opportunities for services to be closer to where people live more generally and will include elements of patient choice regarding location of services.

Opportunities will emerge with a redevelopment of a new or refurbished building and it is recommended service development takes into account best practice. There is a need for ongoing organisational commitment to 'plan-in' access and communication for those who share protected characteristics. For example, maximising physical access for those who use mobility aids (i.e. disabled people, older people, people with long term conditions), having clear signage for people with learning and / or sensory disabilities and also ensuring staff within the improved service / buildings are trained and aware of their responsibilities to fulfil the requirements of the public sector equality duty.

Other planning might include ensuring spaces for family / carers to wait in comfort and with appropriate support, acknowledging religion / belief and a commitment to ensure dignity for service users at all times. The current proposals present opportunities to plan-in mental health, for example linking up with national programmes like '*Dementia Friendly Communities*' which can attract additional investment and foster good relations between those who have dementia and those who do not.

Regardless of which model is implemented it is recommended that older and disabled people are invited to inform the planning and design process for the new health hub and other sites that might be developed from the outset. Overall the proposed development of a new health hub holds opportunities to build social networks for local people; design services in a way that contributes positively to people's mental and physical health and enable individuals in the community to make connections with others that they would not normally come into contact with². This contributes to the local fulfillment of the Public Sector Equality Duty to foster good relations.

Of the nine protected characteristics the following four hold particular vulnerabilities and thus have a greater need for specific assurances to be in place during the proposed service reconfiguration process:

Age - specifically ensuring positive health and wellbeing outcomes for older people in terms of patients and their carers. There is a growing population of older people across the borough generally and the diversity of older adults needs to be considered in a range of areas, e.g. relationships with staff; accessibility of buildings; accessibility and cost of transport and overall experience of local healthcare. It is also important to 'design out' isolation of older people as this is known to be a major factor leading to common mental illness in this age group.

Race - especially those who have specific cultural needs as well as past experiences of discrimination/receiving less than best care. In general Black, Asian and Minority Ethnic (BAME) patients with long term conditions may be younger than their white counterparts; this is due to prevalence of some health conditions like stroke and dementia occurring at younger age, especially in Black Caribbean / African communities. Needs assessments of the BAME community in the locality should continue to be incorporated into commissioning decisions.

Disability (inc. Long-term Conditions & Mental Health) – it is important to consider how the needs of individuals with Physical, Learning and/or Sensory disabilities are met across services. It is also crucial to consider the roles and needs of carers and this can be scoped into either proposal e.g. support and advice for those in a caring role. There is a high need to improve the quality of healthcare in the locality to better support people with Long-term conditions. It is known that there are many people with long term conditions (for example, hypertension, diabetes, coronary heart disease and chronic obstructive pulmonary disease) who are undiagnosed and/or not placed on disease registers. There are also great variations between GP practices in the extent to which they identify and treat their patients with long term conditions.³

² Morris, D and Gilchrist, A (2011). *Communities connected: Inclusion, participation and common purpose*. RSA, London.

³ The Annual Report of the Southwark Director of Public Health, 2010

Pregnancy and maternity - it is important to take into account the diversity of women who become pregnant and require local maternity services e.g consider needs by ethnicity, age, sexual orientation and religion / belief. It is also important to support those who care for them - whether partners, guardians or next of kin. It is therefore a recommendation to consider more of the detail of service delivery and quality within the proposed reconfiguration (which should have a positive impact overall if specific and cross cutting assurances are in place). It is a recommendation that some 'mystery shopping' take place in elements of the ante-natal and post-natal services, particularly by women who identify as lesbian / bisexual, teenage mothers and those who are Black or Asian and speak English as a second language.

More generally this report has also recommended some reasonable adjustments to support improvements to service delivery for those who share one or more of the remaining five protected characteristics:

Sexual Orientation - specifically ensuring that sites are delivering to equally high standards in terms of service quality for individuals and their relatives who identify as Lesbian, Gay or Bisexual (LGB), including the provision of adequate training for all staff. Little is known about the local LGB population so providers will need to be monitored on their delivery of quality services to this group.

Gender Reassignment - As above

Sex - it is recommended that efforts be made to engage more men of working age in the formal public consultation process to inform how these proposals can encourage more men to understand and use community health services.

Religion and belief - steps have already been taken to encourage faith groups to engage in the formal public consultation process. Responses will need to be analysed by religion & belief to better inform local developments and service delivery, particularly in terms of minority religious and belief groups

Marriage and Civil Partnership - specifically in terms of staff being aware of the equal legal rights of those who are married and those same sex couples who have a civil partnership (e.g. information sharing, visiting, involvement in care planning etc).

4. Methods and outcome of research, involvement and consultation

This initial Equality Impact Assessment has drawn insight from a range of sources including but not limited to:

National and regional research led by relevant organisations and public bodies such as:

- Age UK
- Better Health UK
- Department of Health
- Equality & Human Rights Commission.
- Joseph Rowntree Foundation
- Men's Health Forum
- MENCAP
- NHS Southwark / Southwark Clinical Commissioning Group
- Princess Royal Trust for Carers
- Southwark Lesbian, Gay, Bisexual & Trans Network
- Stonewall
- Women's Resource Centre

Local demographic data relevant to the proposals to improve health services in Dulwich and the surrounding areas has been utilised, as well as local key documentation as detailed in the table below:

Key Documentation	Publication Date
Improving Health Services in Dulwich and the Surrounding Areas Consultation Report (prepared by Opinion Leader)	5 July 2013
Draft Consultation Document - Improving Health Services for Dulwich and the surrounding areas	1 Feb 2013
Health services in the Dulwich area - Pre-Consultation Business Case	24 Jan 2013
NHS South East London 111 Service - Equality Impact Assessment	1 Nov 2012
Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG	Sept 2012
Dulwich Locality Health Profile: NHS Southwark Public Health Intelligence Team	July 2012
Report of an Equality analysis of the NHS South East London Commissioning Strategy Plan 2012/13 - 2013/14	1 Mar 2012

Between 8th February and 11 May 2012 NHS Southwark undertook a three month engagement exercise - Developing Health Services in the Dulwich Area. This engagement exercise enabled community and health partners, clinicians and staff to share their perspective on the development of proposals for the commissioning of health services in the Dulwich area into the future.

Engagement activities included:

- ✓ Surveys distributed in paper and online formats
- ✓ Community road shows
- ✓ Drop-in sessions in the locality for informal one-to-one discussions
- ✓ Discussions with existing patient and public participation groups
- ✓ Presentations to the Community Councils of Dulwich, Camberwell, Peckham and Nunhead
- ✓ Semi-structured discussions with community groups
- ✓ Semi-structured discussions with service users individually and in groups
- ✓ Briefings to partner organisations, local Members of Parliament and Councillors
- ✓ Direct work with local media and specifically those publications that are delivered to every household locally.

All of the above activities have enabled the set of proposals for health services in the Dulwich Area to be developed and NHS Southwark CCG have taken these proposals to formal public consultation. Stakeholder engagement activities have continued and the following promoted the formal public consultation process among those they represent:

- Members of NHS staff within local providers
- Local GP's and other clinicians
- Local politicians (Council, Assembly and MPs) and local authority partners
- Community and voluntary sector organisations
- Home and neighbouring Health Overview & Scrutiny Committees
- Relevant Boards and Committees.

Between 20th February – 1st June 2013 residents and individuals that received healthcare in Dulwich, Nunhead, Herne Hill, south Camberwell and south Peckham areas were invited to participate in a 13-week formal consultation process. The number of individuals who participated in the process are detailed below:

- An estimated 667 people attended public meetings
- 568 people engaged in discussion meetings and events organised by NHS Southwark CCG
- 209 people responded to the formal consultation questionnaire
- 6 letters or emails were received from members of the public commenting on the proposals
- 14 stakeholder organisations sent in a written response
- 60 people attended round-table public events

All of the results of the engagement activities are described in the *“Improving Health Services in Dulwich & the Surrounding Areas Consultation Report”* prepared by Opinion Leader, dated 4th July 2013. Some of the feedback can also be found in Appendix One, the evidence section, from Page 20 of this Initial Equality Impact Assessment document.

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5. Results of Initial Equality Impact Assessment – Summary Impact Tables

KEY FOR TABLES

- Green** Positive impact subject to specific assurances and reasonable adjustments being in place, including governance to report on their fulfilment. No additional research or engagement required.
- Yellow** Positive impact subject to specific assurances and reasonable adjustments being in place, including governance to report on their fulfilment and additional engagement efforts required if proposal goes ahead as planned or with changes
- Orange** Full Impact unknown. Further engagement with individuals who share the identified characteristic and / or population of focus recommended.
- Red** Negative. Proposal does not fulfill the legal requirement of the public sector equality duty.

Table 1A: Summary impact table of proposals as considered prior to and within the Formal Public Consultation Process dated 28th February – 1st June 2013

Service Element	Age	Race	Sex	Sexual Orientation	Marriage & Civil Partnership	Disability (inc. Mental Health & Learning Disabilities)	Religion & Belief	Gender Reassignment	Pregnancy & Maternity
Centralised Model	**Older people	**BAME	**Men	**LGB	*	*	*	*	*
Networked Model	**Older people	**BAME	**Men	**LGB	*	*	*	*	*
Improvements to ante and post-natal services	*	**BAME Women	*	**Lesbian or Bisexual Women	*	*	*	*	*
Development of Health Hub	*	*	*	*	*	*	*	*	*

**Positive Impact subject to specific and cross-cutting assurances being in place – see reasonable adjustments*

***Where a population of focus is identified this means the whole population who shares that characteristic in all their diversity e.g. Some older people might also have a disability, identify as Lesbian, Gay or Bisexual and be Black, Asian or from a minority ethnic group. It is important to seek to understand the different needs for the diversity of the population of focus.*

Table 1B: Summary impact table of proposals as assessed after the Formal Public Consultation Process and prior to the Implementation Phase

Service Element	Age	Race	Sex	Sexual Orientation	Marriage & Civil Partnership	Disability (inc. Mental Health, Sensory, Physical & Learning Disabilities)	Religion & Belief	Gender Reassignment	Pregnancy & Maternity
Centralised Model	**Older people	*	*	*	*	*	*	*	*
Networked Model	**Older people	*	*	*	*	*	*	*	*
Improvements to ante and post-natal services	** Teenage Mothers	*BAME Women	*	** Lesbian & Bisexual Women	*	*	*	*	*
Development of Health Hub	**Older People	*	*	*	*	*	*	*	*

**Positive Impact subject to specific and cross-cutting assurances being in place – see reasonable adjustments*

*** Where a population of focus is identified this means the whole population who shares that characteristic in all their diversity e.g. Some older people might also have a disability, identify as LGB and be Black, Asian or from a minority ethnic group so it is important to seek to understand the different needs for the diversity of Older People*

6. Decisions and Recommendations

Do the proposals breach equalities legislation?

No, however assurances must remain in place and all agreed actions be implemented with care and due diligence

Do the proposals prevent discrimination or inequality?

Yes - with assurances in place and as reasonable adjustments take place

Do the proposals promote equality and foster good relations?

Yes - with assurances in place and as reasonable adjustments take place

On the basis of this impact assessment the following recommendations are proposed:

If the proposal goes ahead *without any changes* this EqlA proposes the following recommendations:

To make the reasonable adjustments outlined in this document and to add further adjustments as the programme progresses. Some opportunities exist to maximise positive impacts for individuals and groups and this outcome should be strongly sought after for all service users and those that care for them.

If the proposal goes ahead with some changes this EqlA proposes the following recommendations:

To review this EqlA in view of the proposed changes in terms of reasonable adjustments to ensure all foreseeable and potential negative impacts to the local population are mitigated. Any review of this EqlA needs to be completed with involvement from staff and service users / service user representatives, particularly staff and service users who share protected characteristics (identified in this EqlA screening).

7. Reasonable Adjustments to Promote Equality, Value Diversity and Protect Human Rights

The tables below list the recommended reasonable adjustments that can be considered for the formal consultation phase (Table 2) and those for Implementation for which the Dulwich Programme Board are responsible (Table 3). Some further reasonable adjustments / assurances have been listed that fall within the responsibility of Southwark Clinical Commissioning Group (Table 4).

Table 2: Reasonable Adjustments for the Formal Public Consultation

Ref:	Protected Characteristic	Function	Recommendations for Formal Public Consultation Phase	Status: Complete / Scheduled / Under Discussion
1	Disability / Age	Accessibility	Check issues that emerge regarding access, transport and building redesign to ensure all those relevant to access for disabled people are mitigated in terms of the new development	Complete
2	All	Equality Impact Assessment / Public Sector Equality Duty	Revisit this Equality Impact Assessment Report after the formal public consultation has been completed as findings will enable a second phase of assessment to take place which will include more detailed perspective from the local population across protected groups	Complete
3	Sexual Orientation	Formal Consultation	Invite national / regional organisations that represent those who identify as Lesbian, Gay or Bisexual to share their view within the formal consultation process.	Complete
4	All	Formal Public Consultation	To encourage responses from those who have a long-term health condition, in particular to seek their perspective of what needs to be in place to achieve best quality community based health care services	Complete
5	Sexual Orientation	Formal Public Consultation	To encourage lesbian, gay and bisexual people to attend local public consultation events, and collect monitoring data to enable robust analysis to take place to better meet their needs	Complete
6	Age / Disability / Race / Sexual Orientation / Religion & Belief	Formal Public Consultation	Encourage older people, disabled people, pregnant women and carers to engage with the formal consultation process – particularly those from BAME communities, who identify as Lesbian, Gay or Bisexual and who experience low income (who all face additional barriers when accessing services) in a way that is representative of local demographics	Complete
7	Gender Re-assignment	Formal Public Consultation	Invite regional or national organisations who might represent individuals who are / have undergone gender reassignment to share their perspective within the formal consultation process	Complete
8	Carers	Formal Public Consultation	To seek experiences from those who currently care for individuals who have / are using local health services and explore further what should be in place to support their changing needs, including a check on local support services and their ability to cater for an increase in demand	Complete

Ref:	Protected Characteristic	Function	Recommendations for Formal Public Consultation Phase	Status: Complete / Scheduled / Under Discussion
9	Pregnancy & Maternity / Race	Formal Public Consultation	To seek experiences from women who care for very young children via support of local services to seek their views and experience regarding choice, service quality, and other aspects of their care. Ensure representation of women from BAME communities, those with disabilities, and include those who live furthest away from hospital-based services.	Complete
10	Disability / Age/ Socio-Economic	Formal Public Consultation	To seek experiences from individuals in terms of public transport requirement with a particular focus on encouraging participation from disabled people, older people with mobility needs, those from areas of high economic deprivation and those families with young children without access to a vehicle.	Complete
11	Sex	Formal Public Consultation	Actively encourage men of working age to participate in the formal public consultation process through a range of methods	Complete
12	Sexual Orientation	Monitoring & Evaluation	To collect data regarding sexual orientation of respondents to the formal consultation process, or take steps to invite national / regional organisations that represent those who identify as Lesbian, Gay or Bisexual to share their view within the formal consultation process.	Complete

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Table 3: Reasonable Adjustments for the Implementation Phase (Responsibility of the Dulwich Programme Board)

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / To be Scheduled / Under Discussion
13	Disability / Age	Access Audit	Involve older and disabled people themselves in the design / planning for new and modern facilities to ensure full accessibility from the outset	To be scheduled
14	All	Communication	To seek to improve the way information is made available to the public, taking into account diversity and difference. To continue to make use of varied communication methods to ensure messages are communicated clearly, in good time and in a way that is appropriate to audience	On-Going
15	All	Communication	Clear communication with service users about building changes throughout the redevelopment process at the Dulwich Community Hospital site	To be scheduled
16	All / Sexual Orientation / Religion & Belief	Communication & Community Engagement	Seek opportunities to fulfil requirements of the public sector equality duty throughout the redevelopment process. In particular to foster good relations e.g. create a service that maximises social capital and promote the service to various religion/belief groups, and to individuals who identify as lesbian, gay and bisexual.	To be scheduled
17	Disability / Race / Religion & Belief	Communication / Community Engagement	To involve local people in developing effective and appropriate communication tools, for example the 'Speaking Up' group to better reach and support those with learning disability, and faith groups to build local understanding and partnerships	To be scheduled
18	All	Service Audit	To conduct a local service audit of organisations which already exist that can support integrated approaches to community based healthcare	Under Discussion
19	Age / Disability	Service Development	Consider how to link local development with national programme of creating Dementia Friendly Communities	Under Discussion
20	Disability	Transport Audit	To involve disabled people themselves to test transport routes from potential hot spots	To be scheduled
21	Age - Older People / Disability	Transport Audit	To hold a focus group on transport experiences and requirements, with a particular focus on encouraging participation from disabled people, older people with mobility needs, those from areas of high economic deprivation and those families with young children without access to a vehicle.	To be scheduled

Table 4: Reasonable Adjustments for the Implementation Phase (Wider Responsibilities of NHS Southwark Clinical Commissioning Group)

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / Scheduled / Under Discussion	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
22	Sex	Access / Service Development	Address men's historic under-use of GPs, pharmacies, smoking cessation, weight management services and health trainers throughout the local service improvement plans	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
23	Carers	Commissioning	Continued support for carers and the organisations that provide support services for them (working with Local Authority)	Scheduled- in Operating Plan	See Appendix Two for further information about wider NHS Southwark CCG activities
24	All	Commissioning	Rigorous monitoring and evaluation of local health system to test outcomes for those who do and do not share protected characteristics e.g. patient experience, service quality, reducing health inequalities etc	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
25	All / Older people	Commissioning	Use opportunities to promote and protect human rights in the way that services are commissioned, procured and monitored. In particular those services that are to be delivered in peoples own homes	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
26	Sex	Commissioning	Embed improving men's health and tackling gender equalities into the commissioning process.	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
27	Race / Sexual Orientation / Religion & Belief / Disability	Community Engagement	Community engagement to continue with a focus on individuals / groups / representatives of those who share protected characteristics, with a particular focus on finding and responding to the needs of new and transient BAME communities, the LGB population and to continue the community engagement/partnership work with local faith groups	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
28	All	Community Engagement	Explore avenues to enable continuous feedback from those who share or represent those who share protected characteristics throughout the implementation of the programme (e.g. establish an Equality Reference Group or something similar)	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / Scheduled / Under Discussion	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
29	All	Equality Impact Assessment	Whilst this assessment focuses on service users and the general population, it is recommended that an assessment of impacts of NHS staff should take place once the final changes are agreed following the formal public consultation in 2013.	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
30	All	Monitoring & Evaluation	Providers to continue to be required to provide monitoring data across the protected characteristics to enable robust monitoring of access and appropriate/responsive services to take place (in partial fulfilment of the local Equality Delivery System)	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
31	Sexual Orientation	Monitoring & Evaluation	Continue to monitor the sexual orientation of service users to increase local intelligence of how accessible, appropriate and responsive local services are for those who identify as lesbian, gay or bisexual.	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
32	All	Public Health	Seek to influence a refresh of the Joint Strategic Needs Assessment and ensure it assesses local health needs by protected characteristics (as relevant) as this will assist future Equality Impact Assessment Processes. Continue local Health Needs Assessments to look into differing needs of service users taking into account protected characteristics and commissioners to take proactive steps to address the diversity of needs.	Under discussion – Public Health now in LA	See Appendix Two for further information about wider NHS Southwark CCG activities
33	All	Public Sector Equality Duty	All providers to fulfill requirements of the Public Sector Equality Duty, CQC criteria and local NHS Equality Delivery Systems	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
34	All	Public Sector Equality Duty	Providers to ensure all staff comply with Equality and diversity practice and policies, as well as adhere to the spirit of the NHS Constitution	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
35	Dignity & Human Rights	Public Sector Equality Duty	All staff are trained on the principles of human rights - fairness, respect, equality, dignity and autonomy	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / Scheduled / Under Discussion	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
36	Sexual Orientation / Marriage & Civil Partnership	Public Sector Equality Duty	To ensure all staff are aware that those who are married and those who have civil partnerships share the same legal rights and that all relevant policies regarding staff and service users reflect this recent legislative change. This might affect change to local guidelines regarding 'next of kin', visiting guidelines, attendance to appointments etc.	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
37	All	Public Sector Equality Duty	Human Rights/implementation of the NHS Constitution to be integral to providing high quality care within patients own homes for groups including: older people; people with mental health conditions; BAME groups (including recognition of cultural diversity); offering adequate support for carers (e.g. family or friends); protecting the rights of those who are lesbian, gay or bisexual in civil partnerships (equal rights of those who are married)	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
38	All	Public Sector Equality Duty	Equality, Diversity and Human Rights training will continue for all NHS staff (commissioners and providers have a policy in place)	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
39	All	Public Sector Equality Duty	Formal Public Consultation results to inform PSED objectives 2013-15	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
40	Gender Reassignment	Research / Commissioning	Commission local research on the health needs/ service requirements for those who have gone through / are considering gender reassignment	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
41	Pregnancy & Maternity / Race	Service Development	To revisit service provision as local demand increases in line with increasing birth projections.	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
42	Pregnancy & Maternity / Sexual orientation / Race	Service Development	Service to invite 'mystery shoppers' to visit providers of local maternity (Ante and post natal) services. In particular young single mothers, those who identify as being lesbian or bisexual and also BAME	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities

8. Monitoring and Review Arrangements (including date of next full review)

This Equality Impact Assessment process will run until mid-June 2013 in 3 stages:

1. Initial draft of an EqlA report to consolidate current understanding / intention and be made publically available via the website on 28th February 2013 and provide a list of Reasonable Adjustments to inform the Formal Public Consultation Process.
2. To seek further understanding of communities via the Formal Public Consultation process which has been designed to maximise local fulfilment of the Public Sector Equality Duties (some of the reasonable adjustments to enhance the consultation process for equalities are listed in this assessment report)
3. To refresh this full Equality Impact Assessment report in view of the deeper understanding gained through the formal public consultation process and recommend a long-list of reasonable adjustments to inform the implementation of improvements to healthcare in Dulwich and the surrounding areas.

This Equality Impact Assessment Report will be reassessed once a decision has been made regarding the final and agreed plans for improving healthcare in Dulwich and the surrounding areas and reviewed annually there after.

Agreed reasonable adjustments will be integrated into the local implementation plan which will be monitored by the Dulwich Programme Board and NHS Southwark Clinical Commissioning Group.

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Appendix One: Full Impact Assessment Evidence and Key Issues

This section presents a range of evidence, including but not limited to local demographic and population data; anecdotal evidence; findings in national and regional research and comments received from individuals and groups during local community engagement activity in a way that highlights some key factors relating to each protected characteristic as well as information regarding 'Dignity & Human Rights' and 'Supporting Carers'. It should be noted here that this section is not 'fixed' and will be added to / amended as new findings emerge. The current evidence is presented in the following order:

1. **Age**
2. **Sex**
3. **Race**
4. **Disability**
5. **Sexual Orientation**
6. **Gender Reassignment**
7. **Religion & Belief**
8. **Marriage & Civil Partnership**
9. **Maternity & Pregnancy**
10. **Dignity & Human Rights**
11. **Carers**

In July 2012 the Dulwich Locality Health Profile provided the following key headlines regarding local health and wellbeing data which have underpinned the proposals to improve healthcare for the population in Dulwich and the surrounding areas:

1. Early (under 75 years) death rates are particularly high in Nunhead ward. For males, early death rates are also high in The Lane. Early death rates in all other wards (College, East Dulwich, Peckham Rye, South Camberwell, Village) are not significantly different to the England average.
2. The early death rate from cardiovascular disease is higher than the England average in the North East of the area – towards Nunhead, Peckham Rye and The Lane.
3. Early death rate from cancer is high in two wards – Nunhead and College.
4. As elsewhere in the borough, there are people with long term conditions (for example, hypertension, diabetes, coronary heart disease and chronic obstructive pulmonary disease) who are undiagnosed and/or not placed on GP disease registers.
5. As elsewhere in the borough, there is great variation between GP practices in the extent to which they identify and treat their patients with long term conditions.
6. Between 2002 and 2009, there has been an increase in the birth rate in the East Dulwich ward.
7. In Southwark, there is projected to be an increase in the number and proportion of older people (65 years and older) living in the borough.

In 2012 Southwark Clinical Commissioning Group completed a pre-consultation engagement exercise to inform the current proposals. Of the 157 survey respondents (which make up approximately one third of those engaged in the exercise), 21% of respondents chose not to answer the questions about themselves such as their age, sex, ethnicity etc. The sharing of personal information in this way enables a more robust local analysis to take place which in turn offers opportunities for the local health system to further remove barriers in access to high quality health care whilst the respondents remain anonymous. The Formal Public Consultation Process

from 28th February – 1st June 2013 encouraged further Personal Information Sharing and the evidence in this section will incorporate statistical data arising from this process where relevant.

1. Age

Emerging data from the 2011 census states that the London Borough of Southwark has a population of 288,283. In 2009 there were 29,700 older people in Southwark, which is 10.4% of the population, lower than London (13.7%) or England (19.3%). By 2020 numbers of older people are predicted to increase by just over 8%, a slower rate of increase than Southwark's population overall. According to 2007 ethnicity estimates, 68.5% of Southwark's older people are 'White British', a greater proportion than Adults (51.7%) and Children (46.5%), but a smaller proportion than older people in London (72%) or England (91.8%). All 'White' ethnicities make up 80.4% of the older population. 'Black' ethnicities make up 14%, and of these 9.2% are 'Black Caribbean,' which contrasts with Adults and Children where 'Black African' is the largest Black ethnic group.

The Dulwich Locality Health profile dated 2006 highlighted that:

- The projected resident population for Dulwich in 2006 is 70,187, making it a similar size to Borough & Walworth locality.
- 18.8% of the population are under 15 years of age and 9.6% of its' residents are 65 years or over.
- Like most of London, Dulwich locality has a large young adult population (25-44 years), which is very different from the national age structure.
- Compared to Southwark, Dulwich locality has fewer people in their twenties, fewer babies and toddlers (0-4 years) but slightly more females in their thirties and early forties. However this varies greatly by ward.

Since 2001 the population of the Dulwich Community Council area and the Nunhead & Peckham Rye Community Council area has increased, most of the increase has been due to more babies being born in Nunhead & Peckham Rye Community Council area than people moving into the area. The Southwark JSNA lists the following evidence regarding need amongst older people in the locality:

- About 9% of people in Southwark are over 65 years, and 81% of these are from white ethnic groups.
- Death rates have been reducing for the past twenty years and life expectancy at 65 in Southwark exceeds that for London and England. However this masks wide inequalities within the borough.
- Long term conditions and dementia are more prevalent in older people, and many are not recognised by general practitioners, for example under half of people with dementia are known to GPs.
- Just under a third of older people used their Accident & Emergency department at least once in 2010, and also make up a high number of emergency admissions, the likelihood of emergency admission rising with age.
- Most people wish to remain independent in their own homes for as long as possible. This is made more difficult because 11% of older people in Southwark live in homes hazardous to health (cold, damp and fire risk) and 12% live in non decent homes. There are long waiting lists for making minor adaptations to older people's home in order to prolong independent living.
- Older people will remain the highest users of health and social care.

In general terms older people can be marginalised in society, and older people from BAME communities can face additional barriers to appropriate and effective services. Some of these barriers are specific to older people with mental health problems, others to the particular circumstances of minority groups. For instance, some older people from BAME groups have specific communication difficulties that limit the usefulness of written material in their own language. In addition, the higher risks of physical and mental health problems among specific ethnic and cultural groups requires more and seamless packages of care that address service users' needs holistically.

It has been estimated that 4.6 per cent of people over 75 are deafblind, a group that faces particular barriers in terms of access to information and involvement in social activities (Sense, 2008). This figure may be a significant under-representation as it excludes adults with profound learning disabilities or multiple disabilities and older people in nursing homes. This reminds us that many older people will have more than one disability or long-term condition and that there will be interplay between these 'multiple conditions'. People with learning disabilities experience higher rates of dementia (King, 2004); some of those with dementia will also be deaf (according to research by Professor Alys Young;); and so on. (Joseph Rowntree Foundation, 2010).

In their report, Close to Home (2011) the Equality and Human Rights Commission drew the following key conclusions from the inquiry evidence which can inform the delivery and design of local healthcare which is delivered in peoples homes:

“Many older people are very happy with the home care service they receive and value the autonomy it gives them to carry on living the lives they want. However there were many instances of home care where human rights were breached or put at risk because of the way care was delivered. Many of these problems could be resolved by local authorities using opportunities to promote and protect older people’s human rights in the way they commission home care and the way they procure and monitor home care contracts. Older people are very reluctant to make complaints, even when they are aware of how to do so. Therefore more sophisticated ways are needed to create an easy dialogue and flow of information between older people and the services that support them so that any threats to human rights can be picked up and resolved as early as possible.”

In the 2012 pre-consultation engagement exercise all ages from 24 to 85 were well represented. There were some responses from people who were aged below 24, although that age group are less likely to be regular users of health services. As well as managing long term conditions including mental health (especially depression and dementia) respondents through this engagement activity felt that as part of managing services for older people, having audiology testing, hearing aid support and batteries available was important. Within the 2013 formal public consultation process 31% of participants were aged over 55 with more than half of this being aged 65 and older. Some participants aged over 60 highlighted a desire to have sexual health services in community settings and noted the reported increase in STIs among older people (Opinion Leader, 2013).

References for the protected characteristic of Age:

1. EHRC (2011) Close to Home: An inquiry into older people and human rights in home care. Equality & human Rights Commission
2. Joseph Rowntree Foundation (October 2010) Equality and diversity and older people with high support needs (contains an annotated list of national and regional organisations from which NHS can seek advice as part of informing decision making processes)
3. National Council on Ageing and Older People (2006) health and Social services for older people. Consulting older people with mental health problems on health and social services: A survey of service use, experience and needs
4. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG.

5. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG
6. The Princess Royal Trust for Carers (2011) Always on call, always concerned: A survey of the experiences of older carers

2. Sex (Male or Female)

Just over half 51.8% of residents in the Dulwich locality are female. (Southwark PCT 2006) however during the 2012 pre-consultation engagement exercise 79% of the survey respondents were women, a characteristic possibly explained by the very high interest in antenatal care, maternity services, and services covering the first year of life. The disproportionate level of engagement in the pre-consultation could also be symptomatic of men not utilising community based health services more generally. In their policy briefing paper for National Men's Health Week in 2009 the Men's Health Forum reported:

"In Great Britain, men visit their GP 20% less frequently than women. The difference in usage is most marked for the 16-44 age group – women of this age are more than twice as likely to use services as men. Women have higher consultation rates for a wide range of illnesses, so the gender differences cannot be explained simply by their need for contraceptive and pregnancy care.

Men, especially young men, are much less likely than women to have regular dental check-ups or to use community pharmacies as a source of advice and information about health. Just 10% of NHS community contraception service users are male.

NHS smoking cessation programmes are less well used by men than women and the same is true of NHS and commercial weight management services, health trainers and of disease-specific helplines run by third sector organisations. Male uptake was markedly lower than female uptake in the pilot programmes for the NHS Bowel Cancer Screening Programme.

Men's reluctance to seek help is an underlying cause of their poor use of primary health services. This is a result of the way men are brought up to behave. Men are not supposed to admit to personal problems, weakness or vulnerability. Embarrassment leads many men to delay seeking help with prostate disease (intimate examinations are perceived as a particular threat to the male image) and many want to appear strong, independent and in control in front of a male GP. As a consequence, men often wait until they are in considerable pain or are convinced they have a serious problem.

Men's unwillingness to seek help is reinforced by a number of practical barriers, including the demands of long working hours and problems with accessing primary care services near the workplace. Anecdotal evidence suggests that some men are deterred by a perception that GP and pharmacy services are aimed mainly at women and children and feel like 'feminised' spaces.

Lack of familiarity with the health system may also be a factor. Women are much more likely to use health services routinely – for contraception, cervical cancer screening (after the age of 25), pregnancy, childbirth and for their children's health. When they are ill, they are more likely to know how to access services, and which services to use, and to feel more comfortable with a healthcare professional.

Older men often do not feel that services run specifically for their age group are appropriate for their needs except perhaps as a last resort. They tend to avoid services where

participants (and staff) are mostly women and consider that attendance at a day centre suggests that they have 'given up'."

There is growing awareness that one of the factors governing access to primary care is that the opening hours at local surgeries make it more difficult for certain population groups to gain access to services. Evidence suggests that this may be a particular problem for people who work longer hours – a problem that is a clear issue of gender equity, since men are twice as likely as women to have a full-time job and are more than three times as likely to work over 45 hours per week (ONS, 2008a). It seems probable that people with significant caring responsibilities (a majority of whom are women) may also experience problems of access (The Gender and Access to Health Services Study - 2008, DoH, Men's Health Forum & University of Bristol).

All of the above evidence indicates that efforts to engage men (in all their diversity) within the process of developing community health services are required for those who live and work in Dulwich and the surrounding areas. Of particular importance is to encourage the participation of men in the formal public consultation process to inform local decision making regarding the range of services locally and where they are based.

References for the protected characteristic of Sex:

1. Davidson K., Arber S. (2003), 'Older men's health: a life course issue', Men's Health Journal 2(3):72-75.
2. George A., Fleming P (2004), 'Factors affecting men's help-seeking in the early detection of prostate cancer: implications for health promotion, Journal of Men's Health and Gender 1(4):345-352.
3. Juel K., Christensen K. (2008), 'Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005', Journal of Public Health 30(1):111-3.
4. Keating F. (2007), African and Caribbean men and mental health. A Race Equality Foundation Briefing Paper.
5. Men's Health Forum (2005), Hazardous Waist? Tackling the epidemic of excess weight in men.
6. Men's Health Forum (2005), Men tell us why they don't go to the doctor's.
7. Men's Health Forum (2007), Men and long term health conditions: a policy briefing paper.
8. Men's Health Forum (2008), Improving male health by taking action in the workplace: A policy briefing paper.
9. Men's Health forum (2009) Challenges & Choices - Improving Health Services to Save Men's lives
10. National Statistics (2000), Adult Dental Health Survey: Oral Health in the United Kingdom 1998.
11. PAGB and Reader's Digest (2005), A Picture of Health: a survey of the nation's approach to everyday health and well-being.
12. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG
13. Sharpe S. (2002), 'Attitudes and beliefs of men and their health', Men's Health Journal 1(4):118-120.
14. Weller D, et al. (2006), English Pilot of Bowel Cancer Screening: an evaluation of the second round.
15. Wilkins, D (2008) The Gender and Access to health Services Study. Department of Health & University of Bristol

3. Race

The population figures for 2001 show that the people in Dulwich and surrounding areas are predominantly White British (comprising 69% of the total population), while the proportion of Black, Asian and Minority Ethnic (BAME) population is 31% (ONS, 2001). Dulwich Community Council Area has a more ethnically diverse population than the national average, however the population is less diverse than Southwark as a whole. Nationally, the White and BAME population breakdown, based on the 2001 Census, is 90% and 10% respectively. The Black Caribbean and Black African population comprise an estimated 12.3% of the total population in Dulwich Community Council Area and 25.5% in Nunhead and Peckham Rye. Of the Black African population across the London Borough of Southwark over two-thirds are from Central and Western Africa with approximately half of these being Nigerian. Asian, Chinese, and other groups are estimated to

represent 4% and 1.5% of the total population respectively. There are also other sizeable minority ethnic populations within the borough, such as Polish and Turkish communities. Emerging figures from the 2011 census suggest an increase in the ethnic diversity of the population in Southwark which underlines the importance of making reasonable adjustments to ensure equity in healthcare for all ethnic groups in Dulwich and the surrounding areas from now into the future.

Over 53% of children under the age of 16 are Black, Asian or from a minority ethnic group. The current trend of growth in local BAME populations across Southwark, including Dulwich and surrounding areas, is set to continue and so the ethnic diversity of older people and people managing long term conditions, for example, needs to be taken into account in local commissioning. Diabetes, stroke, TB and HIV have been experienced disproportionately by those who are Black or Asian and such conditions have been diagnosed among individuals of a younger age on average than their white counterparts. This is also the case with the prevalence of conditions such as dementia. Steps need to be taken to promote services effectively to individuals who identify as BAME and to challenge inequalities in access to local healthcare services.

An important implication of the ageing of the black and minority ethnic population in the United Kingdom (UK) is the increase in the number of people with dementia from minority ethnic backgrounds (Moriarty *et al.*, 2010). There is some evidence that people from BME groups are more likely to suffer from dementia at a younger age. While 2.2% of the general population with dementia are of early onset, the proportion is 6.1% in BAME groups (Alzheimer's Society, 2011). The Dementia Strategy (Department of Health, 2009), issued by the last Labour government but taken forward by the Coalition government (Department of Health, 2010), calls on dementia care services to ensure that these groups achieve equal access to services and also highlights the need for specially tailored approaches to reach out to some ethnic groups. (Better Health Care Briefing Update 2011). With an ageing BAME population in the Dulwich locality, in particular Black Caribbean is important to ensure local services are equipped to meet this increasing need. There is an opportunity in the current proposals to consider creating a dementia friendly community in Dulwich and the surrounding areas.

Refugees and asylum seekers face particular barriers to accessing and using mental health services. As well as experiencing the issues associated with the BAME groups to which they belong, refugees have often been exposed to severe physical and psychological trauma as a result of war, imprisonment, torture or oppression. In their new host country they can then experience social isolation, homelessness, language difficulties, hostility and racism, all of which are strong predictors of poor mental health.

It is also acknowledged that Gypsies and Travellers experience significantly poorer health than the general population, along with greatly restricted access to health and social care services. In the formal public consultation process some members of the traveller stakeholder groups reported difficulty in accessing GP services at convenient times when juggling the conflicting demands of family life. This led some to use out-of-hours GP as their default primary care service, rather than waiting for an appointment with their GP practice (Opinion Leader, 2013). There is an opportunity through future developments to seek improvements to community and home based services e.g. placing higher expectations on providers in regards to training; cultural competency and awareness; equality, diversity and human rights training and all of these are necessary with the development of a new local model of service delivery in Dulwich.

The emerging results of the 2011 Census show that approximately 10,000 individuals in the London Borough of Southwark do not speak English well or very well. The following languages are spoken by people who speak English as a second or third language (listed in descending order - where the borough hosts over 900 speakers of each): French, Portuguese, Spanish, Polish, Italian, Turkish, Arabic, Bengali, Greek, Russian, Vietnamese, Somali, Akan, Yoruba.

In the Dulwich Project 2012 pre-consultation engagement exercise 85% of the survey respondents identified themselves as white. This is against a resident population of 69% white. This was noted

during the reviews that were undertaken, and as a result further work was undertaken to reach black and minority ethnic populations via churches, voluntary sector organisations and discussion groups. In the 2013 Formal Public Consultation Process 74% of respondents identified themselves as White British (which included 1% being White Irish and 8% being White Other). Of the 26% of respondents that identified themselves as being Black, Asian or from a Minority Ethnic Group near 10% identified themselves as being Black British of Caribbean or African descent. There were no significant differences in the responses given by BAME groups and individuals who engaged with the consultation, however some BAME participants were particularly interested in seeing an increase in prevention / health promotion services available in community settings (Opinion Leader, 2013).

References for the protected characteristic of Race:

1. Better Health Briefing 18 (2010) Effective methods of engaging with black and minority ethnic communities within healthcare settings. Race for Health
2. Better Health Briefing 2 (2007) Effective communication with Service Users. Race for Health
3. Better Health Briefing 9 (2012) The Health and Social Care experiences of Black and minority ethnic older people. Race for Health
4. Better Health Briefing Paper 20 (2010) Improving Health and Social Care support for carers from black and minority ethnic communities. Race for Health
5. HFT (2012) A guide to meeting the needs of people with learning disabilities and family carers, from newly arrived, Black, Asian and other Minority Ethnic (BME) Communities. Dept of Health
6. Lawrence, V., Samsi, K., Banerjee, S., Morgan, C. and Murray, J. (2010) 'Threat to valued elements of life: the experience of dementia across three ethnic groups'
7. Moriarty, J, Sharif, N & Robinson, J (March 2011) Black and minority ethnic people with dementia and their access to support and services. SCIE
8. NHS Executive (1998) Tackling Racial Harassment in the NHS. London: NHSE
9. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG
10. Rawaf, S. & Bahl, V (1998) Assessing health needs of people from minority ethnic groups. Royal College of Physicians & Faculty of Public Health Medicine: London
11. Southwark Analytical Hub (2008) Dulwich Community Council Population: Now and the future.
12. Southwark Analytical Hub (2008) Nunhead & Peckham Rye Community Council Population: Now and the future.

4. Disability

The Annual Population Survey 09/10 estimates there are 36,600 people in Southwark with a disability, 17.5% of the adult population, more than Lambeth (14.6%), Lewisham (15.2%) and London (16.2%) but less than England (19.2%). 19,700 (54%) of adults with a disability in Southwark are considered economically active, a higher proportion than near neighbour boroughs and London (52%) but slightly less than England (55%). Of those people 2,700 (13.7%) are unemployed, this rate is higher than near neighbours and England (10.8%) but similar to London (13.9%). In Southwark there are more adult women with disability (19,300 (19.4%)) than men (17,300 (15.9%)), this is broadly consistent with other areas⁴. In the 2012 pre-consultation engagement exercise 20% of survey respondents regarded themselves as being disabled- whether or not registered. More recently within the formal consultation process completed in 2013, 29% of participants reported having a disability or long term condition, of these 23% experience Sensory Impairment (Sight & Hearing); 29% experience a physical disability affecting their mobility which included 5% using a wheelchair; 13% experience mental ill health and 3% experience a moderate to severe learning disability (Opinion Leader, 2013).

⁴ Southwark Joint Strategic Needs Assessment 2013

4.1 Physical disabilities

There is no single recognised data source for prevalence of disability. It is estimated that just under 6% of the population in the London Borough of Southwark are disabled, of whom 1.4% of the population have a severe disability. It is clear that an area with high levels of deprivation is likely to experience higher rates of disability. In terms of the formal public consultation, Whilst some respondents who experience a physical disability which affected their mobility highlighted the need for buildings to be fully accessible, in terms of location, most groups did not express strong opinions regarding location as they would access patient transport or use private transport to travel to services (Opinion Leader, 2013).

4.2 Sensory Impairment

In 2008 there were 750 people registered as blind in Southwark, 310 aged 0 - 64 and 440 aged 65 and over. Therefore, 0.12% of the 0 - 64 population are registered blind, a slightly higher proportion than London (0.09%) and England (0.09%), and 1.8% of the 65+ population, in line with London (1.7%) and higher than England (1.3%). There were also 520 people registered as partially sighted, 200 aged 0 - 64 and 320 aged 65 and over. Therefore, 0.08% of the 0 - 64 population are registered as partially sighted, in line with London (0.08%) and England (0.09%), and 1.3% of the 65+ population, slightly less than London (1.4%) and England (1.4%). Emerging data from the 2011 census highlighted that 153 individuals in LB Southwark use sign language. The incidence of mental health problems in the deaf population is reported to be 40%, compared to 25% in the general population. Within the formal public consultation process in 2013 some members of stakeholder groups with severe hearing impairment raised concerns about their ability to quickly access their services at their GP practice or health centre. This meant that it was difficult to access unplanned care services independently (Opinion Leader, 2013).

4.3 Learning disabilities

- Approximately 20 people per 1000 in England have a learning disability.
- There are approximately 707 to 809 adults with moderate/severe learning disabilities and 5,287 adults with mild learning disabilities in Southwark
- The number of people with severe learning disabilities is likely to increase by one percent per annum as a result of improved health care and increased life expectancy
- The health conditions affecting people with learning disabilities (PWLD) are different to the general population: more PWLD die from respiratory disease and congenital heart disease (rather than ischaemic heart disease)
- Four times as many PWLD die of preventable causes than the general population. Obesity is more common than in the general population and PWLD are more likely to live sedentary lifestyles. (Southwark JSNA, 2013)

The Learning Disabilities Profile 2012 for the London Borough of Southwark identifies that some work needs to be done regarding improving the identification of people with learning disabilities in hospital and in-patient statistics. It was also highlighted that the emergency admissions rate as a percentage of total population known to have learning disability was very high. This suggests that more needs to be done in the Borough to plan in for people with Learning disability and opportunities for this could be sought in local proposals.

Some GP's have begun to use the notes section of Choose and Book system to flag up additional needs of their patients e.g if they need a longer appointment time, have additional communication needs so that providers can be better prepared with new referrals.

Table 1 Barriers to the access of people with learning disabilities to health care services (Lindsey, M (2002)

Barrier	Addressed by:
The learning and communication difficulties of people with learning disabilities	Providing opportunities for service users to learn about health issues and to self-advocate
Lack of carer and professional awareness of the health needs of people with learning disabilities	Provision of suitable training for carers and health professionals
Discriminatory attitudes of carers and professionals	Disability awareness training Explicit organisational policies and codes of conduct
Physical barriers and inflexible administrative and care procedures	Involvement of service users and carers in planning; implementation of adaptations and changes; Awareness of consent issues
Poor awareness of other factors that can create disadvantage	Sensitivity to social, ethnic, cultural and economical needs of individuals

Physical barriers to access may be present and these include not only unsuitable buildings but also unsuitable signs, support, information about appointments, timing of appointments and information about treatment. Sometimes people with learning disabilities need careful preparation for appointments or admissions and opportunities to familiarise themselves with places and procedures (Linsay, M 2002). Within the formal public consultation process some members of stakeholder groups with learning disabilities reported concern about the ability of primary care staff to communicate with them and understand their needs. One suggestion was that learning disability groups might be involved in delivering training events to help staff gain new skills and knowledge. Familiarity of environments, continuity of care – specifically with seeing the same clinicians on an ongoing basis – was also of particular concern (Opinion Leader, 2013).

4.4 Long term conditions

In the pre-consultation engagement exercise completed in mid-2012 48% of respondents identified themselves as having a ‘long term condition’, with a wide variety of additional conditions (over and above diabetes, heart disease and lung disease) being named, and a number of people with more than one condition. When asked about the support they had received, apart from GP input and Kings out-patients, most had not received any other support. The numbers of people who did receive support were small, which makes analysis difficult. However, where it was received, practice nurse and physiotherapy support was well regarded, and OT and equipment moderately well. Foot health was not, on the whole, so well regarded, although this is likely to be because of the access issues that remain. Interestingly, 19% said they had received enough support at home, and 40% said they had to some extent. However, 25% said they hadn’t received enough support.

Overall community based support for people with long-term conditions was broadly welcomed ‘as long as it works as planned’ some further suggestions from local people regarding support needs for people with long term conditions are listed below:

- A local directory of services available would be very useful
- Care packages need to be put into place quickly as continuity of care is crucial. Local care can still be disorganised e.g. lack of follow -ups from consultations, delays in getting results from tests and poor organisation of follow-up appointments. Various

care providers need to work in more integrated ways to ensure no one falls through any gaps between services

- There needs to be more clarity over the care pathway patients are following, with the clinicians looking after them able to explain where everything fits in. There needs to be much better communication and co-ordination between professionals/services and between them and the patients.
- There was a strong call for foot health services to be more easily available.
- People wanted to see prompt access to equipment to enable people to stay at home, and their carers to be able to manage.
- The palliative care model is seen as being excellent – responsive and understanding, and people wanted a service more like that.
- There was strong support for the concept of a 'hub' supporting long term conditions care. As well as there being a hub for services, patients would like there to be a way of co-ordinating appointments to reduce journeys and journey time.

4.5 Mental Health

In 2006 Southwark ranked third in the Local Index of mental health need which ranks boroughs in London from highest health need to lowest. Similar findings are reported by the Eastern Region Public Health Observatory (2008) who consistently place Southwark in the top quintile for greatest mental health needs nationally:

- mild mental disorders affect approximately one in six adults in the population, accounting for one in four consultations with GPs
- more severe but less common conditions such as schizophrenia, affect approximately one in a thousand people
- Southwark has statistically significantly higher rates of hospital admissions under general psychiatry than the national average.

It is estimated that 3 million older people in the UK suffer from symptoms of mental health problems that affect the quality of their lives. It is believed that 25% of all people over the age of 65 (one in four) living in the community have symptoms of depression that are serious enough to warrant intervention, however only a third of older people with depression discuss it with their GPs, and only half of them are treated for depression. Of those who are offered treatment, only a very small proportion receives psychological therapy. Older people have some of the highest suicide rates compared to other age groups. National evidence also suggests that the incidence of depression and anxiety is higher in older people than in the population as a whole, so we would expect to high use of local mental health services by older people in Dulwich and surrounding areas:

During the 2012 pre-consultation engagement exercise the following issues were raised by local people regarding mental health:

- There was a strong sense that mental health should be considered to be a 'Long Term Condition' and that a local hub should have some mental health services provision.
- People felt there needed to be far more access to 'talking therapies' for people with mild-moderate depression/anxiety.
- The mental health pathway is not easily accessed- especially in crisis, especially since there is no longer an emergency clinic at the Maudsley.
- Not all GPs are able to manage or support patients with mental health issues.
- There is a need for better early detection of dementia, and more support for people and their carers.
- The impact of mental health problems on people's lives can be easily underestimated.

- The substance misuse care pathway is not easily understood by either patients or health professionals – especially in crisis, when sometimes they can't even get out of the house.
- There is lots of scope for a more organised approach to using the voluntary sector better, with the provision of support and activities for people with mild-moderate depression/anxiety.

Within the 2013 Formal Public Consultation some people using mental health services highlighted concerns regarding the knowledge and experience of GP's and other primary care staff to recognise, diagnose and manage mental health. They also highlighted the need to understand the relationship between physical and mental health. Respondents who identified as being Lesbian, Gay or Bisexual highlighted the need for those providing mental health services to have access to specific LGB groups where appropriate. The need to develop dementia friendly communities was highlighted by some older people's groups (Opinion Leader, 2013).

References for the protected characteristic of Disability:

1. HFT (2012) A guide to meeting the needs of people with learning disabilities and family carers, from newly arrived, Black, Asian and other Minority Ethnic (BME) Communities. Dept of Health
2. Learning Disabilities Profile (2012) Improving Health and Lives: Learning Disabilities Observatory
3. Linsay, Mary (2002) Comprehensive Healthcare services for people with learning disabilities. Advances in Psychiatric Treatment Journal.
4. MENCAP (2012) Death by indifference: 74 deaths and counting - A progress report 5 years on
5. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG
6. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. NHS Southwark CCG

5. Sexual Orientation

In England and Wales, under the Equality Act 2010, it is unlawful to treat people unfairly because of their sexual orientation. This means that service providers have a duty to ensure that their services and their staff do not discriminate against people on the grounds of their sexual orientation. Although it is known that Lesbian, Gay and Bisexual (LGB) people make up over 10% of the population in greater London. Approximately 6% of the adult population in LB Southwark identify as being LGB (estimated as 16, 464).

Research from the national charity Stonewall, focusing specifically on the health of lesbians and bisexual women found discrimination and negative attitudes towards lesbians and bisexual women within health services. Examples included inappropriate comments from healthcare professionals and unwelcoming attitudes to same-sex partners. Black and Asian LGB people may face double discrimination, being at risk of negative perceptions and treatment on the basis of both their sexuality and their visible ethnicity. LGB people whose minority ethnicity is less visible (for example, Eastern European people) are less likely to experience some forms of racial discrimination.

It is likely that older lesbian, gay and bisexual people are over-represented amongst those needing formal support as they are less likely to have children, more likely to be out of touch with their birth families and their own children, and 2.5 times more likely than heterosexual older people to be living alone (Age Concern, 2006). Evidence suggests that the older lesbian, gay or bisexual population has a higher incidence of certain health conditions and health-related behaviours than the general older population, including higher levels of smoking, drinking, mental health problems, cervical and breast cancer amongst women, and HIV infection amongst men (Musingarimi,

2008a). It is also likely that many older people in this group who do have support needs are 'hidden' from service providers and policy-makers since their fears and experiences of discrimination can act as a barrier to seeking help. In addition, often individuals in this group, when they do access services, decide not to disclose their sexuality (Musingarimi, 2008b). The current generation of older lesbian, gay or bisexual people may have experienced incarceration and 'corrective' treatments in the past, and some will have moved to the UK from countries which continue with punitive or medical approaches to their sexuality.

Further research completed by Stonewall indicated that only a quarter of gay and bisexual men said that healthcare workers had given them information relevant to their sexual orientation. The research recommended that patients should be asked about sexual orientation as part of patient records (to give individuals the opportunity to share their sexual orientation and thus receive more appropriate services). The introduction of a new service provides an opportunity to enhance equality between those who identify as lesbian, gay or bisexual and those who do not in terms of perceptions to quality services and opportunities to receive appropriate care.

In a 2006 survey targeted at the LGBT community in Lambeth the following statistics came to light: Overall, 15% of respondents indicated they had a long-term illness, health problem or disability which limited their daily activities or the work they could do. This did not vary by living in Lambeth or not, being a Trans person or not or ethnicity. It did vary by gender, with more men (17%) having a disability or health problem than women (10%). 14% of respondents had diagnosed HIV infection. Having HIV did not vary by Trans status, residence or ethnicity, but did vary by gender. All but one of those with HIV were men, which meant 20% (64/324) of males had HIV compared to 1% (1/132) of females. 70% of respondents described their ethnicity as white british. Southwark has the second highest prevalence of HIV in London 1039/100,000. Every borough in South East London had higher rates than the England average. There were 702 new diagnoses in SE London in 2008, with the majority being amongst white males and African women. (Director of Public Health, NHS SE London). Difficulties with mental and emotional health were the most common problems reported in the last year (41% of all respondents). Moreover, a high proportion of respondents felt their LGBT identity was relevant to the problem (54%). This meant mental and emotional health stood out from all other areas as being the greatest source of LGBT related suffering.

Some recent findings from research around the perceptions and experiences of healthcare by older Lesbian, gay and bisexual people indicate a need for extra efforts to eliminate discrimination, enhance equality and foster good relations between those who identify as LGB and those who do not. It is recognised that the local NHS has a role to play in these efforts. Local assurances need to be in place to ensure community services, including home based services value and offer quality outcomes for such individuals. In 2011 Stonewall commissioned YouGov to survey a sample of 1,050 heterosexual and 1,036 lesbian, gay and bisexual people over the age of 55 across Britain. This survey asked about their experiences and expectations of getting older and examined their personal support structures, family connections and living arrangements. It also asked about how they feel about getting older, the help they expect to need, and what they would like to be available from health and social care services. Some key findings included:

Lesbian, gay and bisexual people over the age of 55 are:

- More likely to be single. Gay and bisexual men are almost three times more likely to be single than heterosexual men, 40 per cent compared to 15 per cent.
- More likely to live alone. 41 per cent of lesbian, gay and bisexual people live alone compared to 28 per cent of heterosexual people.

- Less likely to have children. Just over a quarter of gay and bisexual men and half of lesbian and bisexual women have children compared to almost nine in ten heterosexual men and women.
- Less likely to see biological family members on a regular basis. Less than a quarter of lesbian, gay and bisexual people see their biological family members at least once a week compared to more than half of heterosexual people.
- Three in five are not confident that social care and support services, like paid carers, or housing services would be able to understand and meet their needs.
- One in six are not confident that their GP and other health services would be able to understand and meet their needs.

During the formal public consultation process in 2013 many individuals who identified as LGB and LGB stakeholder groups advocated for more comprehensive recording of data about service users sexual orientation to help better identify the specific needs of LGB service users in the future (Opinion Leader, 2013). It is therefore recommended that local organisations begin to monitor sexual orientation of service users to increase local intelligence of how accessible, appropriate and responsive local services are for those who identify as lesbian, gay or bisexual. At present very little data exists and even some anecdotal data would go a long way to enable commissioners to be absolutely sure services are meeting local need.

References for protected characteristic of Sexual Orientation:

1. Age UK's (previously Age Concern and Help the Aged) Opening Doors programme addresses the needs of older LGBT people, service users and carers. www.ageuk.org.uk/health-wellbeing/relationships-and-family/older-lesbian-gay-andbisexual.
2. Briefing 12: Lesbian, Gay and Bisexual (LGB) People from Black and Minority Ethnic Communities, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347
3. Hunt, R. and Fish, J. 2008, *Prescription for Change: Lesbian and bisexual women's health check 2008*, Stonewall.
4. Keogh.P, Reid.D & Weatherburn.P (2006) Lambeth LGBT Matters: The needs and experiences of lesbian women, gay men, bisexual and Trans men and women in Lambeth. Lambeth Council
5. King, M. and McKeown, E. 2003, *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*, Mind.
6. King, M. et al 2007, *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people*, British Association for Counselling and Psychotherapy.
7. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG
8. Stonewall (2008) Prescription for change: Lesbian and Bisexual Women's Health Check – South Central SHA Data report
9. Stonewall (2011) Report on health and social care perceptions & experiences of Lesbian, Gay and Bisexual People in Later life.
10. Stonewall (2012) Gay & Bisexual Men's Health Survey 2012: South Central data report by Local authority area of residence
11. Warner, J. et al 2004, 'Rates and predictors of mental illness in gay men, lesbians and bisexual men and women', *British Journal of Psychiatry*, vol.185, pp.479-485.

6. Gender Reassignment

Individuals who identify as Transgender have rights under the NHS Constitution, which describes the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the service. These rights cover access, quality of care and environment, access to treatments, medicines and

screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS, and complaints and redress. NHS bodies, primary care services, and independent and third sector organisations providing NHS care in England are required by the Health Act 2009 to have regard to the NHS Constitution. In practice, this means that NHS services should be provided in a non-discriminatory way and there should be no absolute absence or refusal of service.

Older transgender people constitute another emerging ageing community as, although previous generations have experienced gender 'dysphoria', treatments and surgery have been made available only relatively recently. Research conducted by Whittle et al. (2007) estimate that 7 per cent of the transgender population are over 61, and 4 per cent of those who underwent gender reassignment surgery in England in 2005/6 were aged 60–74 (Age Concern, 2008). This group face considerable prejudice and, in social care, may have various needs around their personal care, for example, the need to shave, catheterise or find appropriate gender clothing in the right size (Age Concern, 2007b). The barriers which trans people have described in accessing services with dignity, may raise human rights issues and cause distress to them at a vulnerable and sensitive point in their lives.

The Human Rights Act (HRA) 1998 is also relevant to the provision of gender reassignment services. The Act requires public bodies carrying out public functions to take account of the human rights dimensions of services for which they are responsible. Article 8 of the Convention, the right to a private and family life, is particularly applicable to NHS gender reassignment services. The concept of the right to a private and family life covers the importance of personal dignity and autonomy and the interaction a person has with others, both in private or in public. Respect for one's private life includes respect for individual sexuality, the right to personal autonomy and physical and psychological integrity. Providers of NHS gender reassignment services should therefore be taking account of the human rights dimensions of those services. The barriers which trans people have described in accessing these services with dignity, may raise human rights issues and cause distress to them at a vulnerable and sensitive point in their lives.

In the 2006 survey based in Lambeth Trans people were more likely to have a problem with mental and emotional health (67%) than others (40%) and if they did have a problem were more likely to think their LGBT identity was relevant (81% v 52%).

In terms of engagement with the formal public consultation process, no individual or organisation raised concerns about the proposals in terms of gender reassignment. Some discussion however has taken place regarding local data including a suggestion of revisiting the 2006 survey of Trans people in Lambeth by working together across SE London Boroughs.

References for for the protected characteristic of Gender Reassignment:

1. Dept. of Health (2010) An Introduction to Working with Transgender People;
2. Dept. of Health (2010) Bereavement: A guide for transsexual, transgender people and their loved ones;
3. Dept. of Health (2010) Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People: Briefings for health and social care staff.
4. Dept. of Health (2010) Transgender Experiences – Information and Support;
5. Dept. of Health (2011) Trans: A practical guide for the NHS;

7. Religion and Belief

The London Borough of Southwark has over 360 faith groups. The following table highlights the number of people in the London Borough of Southwark who identified that they practiced the following religion and beliefs in the 2011 census:

Religion / Belief	Number of people
Christian	151462
No Religion	77098
Muslim	24551
Buddhist	3884
Hindu	3668
Other	1350
Jewish	1006
Sikh	653

Generally, individuals from black and minority ethnic communities in the UK are more likely than the white majority to be practising their religious faith. In one study a higher proportion of African Caribbean people affirmed a religious (predominantly Christian) belief than that of the white population or other minority ethnic communities.

Efforts to engage local faith groups in the formal public consultation process....

References for the protected characteristic of Religion & Belief:

1. Ellison C and Levin J (1998) The religion-health connection: evidence theory and future directions Health Education and Behaviour 5(6) 700-720
2. Friedli L (2000) A matter of faith: religion and mental health International Journal of Mental Health Promotion 2(2) 7-13

8. Marriage & Civil Partnership

Same-sex couples can currently have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.

If two people of the same-sex are civil partners, they have the same rights as a heterosexual married couple. A civil partnership also gives the right to be your partner's nearest relative. This means that they can make certain decisions about healthcare, such as making an application for their partner to be admitted for assessment. If a couple are not in a civil partnership or marriage, the ethical approach of many healthcare teams is to ask patients who they would like as their point of contact (rather than using the term 'next of kin'). This is so that their wishes are recognised by the healthcare team.

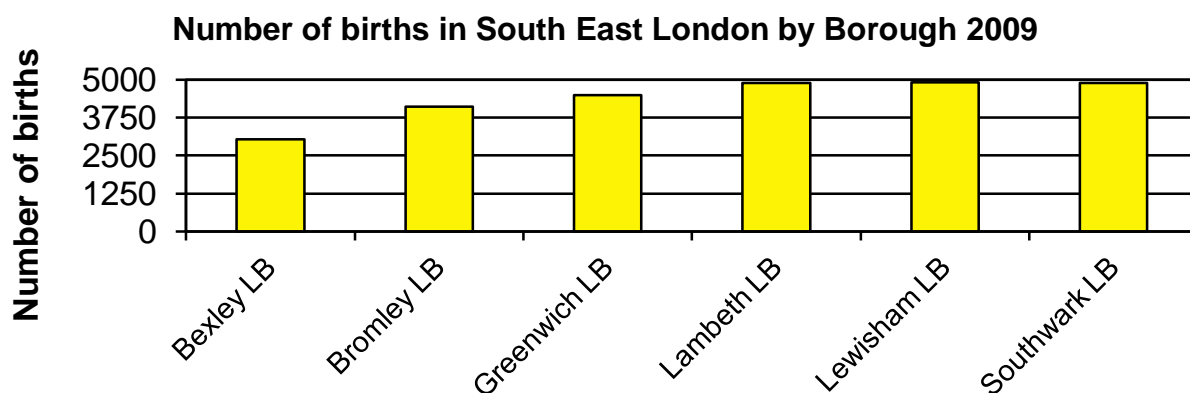
References for the protected characteristic of Marriage and Civil Partnership:

1. NHS Choices: Next of kin (www.nhs.uk)

9. Maternity & Pregnancy

Between 2002 and 2009, there has been a significant increase in the birth rate in the East Dulwich area (2002 to 2009). In 2009, Lambeth, Lewisham and Southwark had the highest number of births in SE London with approx 4700 births in each borough. South East London has a comparatively high birth rate compared to other areas in England. The Teenage Conception rate across Southwark in 2007 was 76.7 per 1000 this is high when compared to the London rate of 45.7 per 1000 (ONS, 2007). Although the Teenage Conception rate in Dulwich Community Council

area is lower than the Southwark wide ratio it is important to ensure the service developments include due consideration for how teenage mothers/parents will be supported by the system locally. This support might include sign-posting and advice for relating to other services in the Borough.



Overall, findings from a large scale national survey (Journal of the Royal Society of Medicine, 2010) show that there are some significant differences between subgroups of women in their experiences of maternity services, including in aspects of care where NICE guidance applies – such as seeing a healthcare professional within 12 completed weeks of pregnancy and having a scan at 20 weeks. Women at risk of poorer maternal and infant outcomes are among those accessing services late, and often reporting poorer experiences of services when they do – such as those from black and minority ethnic groups, women from poorer educational backgrounds, and single mothers.

“Research has highlighted some important differences in the way that women from BAME backgrounds may access and utilise maternity services compared to their white counterparts. Such differential receipt of services is identified as a factor contributing to adverse maternal and neonatal outcomes (Lewis, 2004, 2007). Notwithstanding important diversity within and between minority ethnic groups, national surveys indicate that, as a whole, women from BAME groups are more likely to ‘book late’ (i.e. receive their first antenatal checkup beyond the recommended twelve weeks’ gestation), are less likely to receive antenatal care regularly and therefore also tend to receive fewer antenatal check-ups (Redshaw et al ., 2007; CHAI, 2008). Overall, women from BME backgrounds are also less likely to have discussed breastfeeding with the midwife, although they are significantly more likely to initiate breastfeeding and are more likely to be exclusively breastfeeding following birth (Redshaw et al ., 2007).

Evidence also suggests that some women from some minority groups are less likely than the majority White British to have dating or anomaly scans and to be offered or to undertake screening (Ahmed et al ., 2002; CHAI, 2008). Findings from investigations identify a range of barriers to receipt of high quality care and satisfaction with services among minority women. Minority women continue to voice concerns about a lack of adequate and appropriate information and a consequent inability to exercise their right to choice in relation to their care (Bharj, 2007; Redshaw et al ., 2007).

Although commissioners of maternity services should actively engage in undertaking health needs assessment, accessing adequate and appropriate data to inform decisions is a challenge (Dixon-Woods et al., 2005; CHAI, 2008). Nonetheless, health needs assessment data are critical in forecasting demand as well as in identifying ethnicity-related gaps in

services. Commissioners and providers of maternity services need to work together to ensure that data on ethnicity and other pertinent information (particularly language and interpretation needs) are collected robustly and routinely. They must maximise the use of proposed frameworks as well as information technology programmes (DH, 2008) to commission and deliver world-class maternity services. Effective use should also be made of consultation with local providers (statutory and voluntary), health care professionals and, most importantly, women who use services, and their families.: - Better Health Briefing 2008

In 2001 it was estimated that between 12% and 35% of lesbian women have children and there is a significant and growing number of LBT women wanting to have children or having, adopting or fostering children. However, LBT women who are parents may face a variety of negative attitudes and have little support. One study in 2001 found that lesbian women receiving maternity care reported high levels of anxiety about the implications of disclosing their sexual orientation, together with acute awareness of midwives' personal attitudes and prejudices which led to discomfort, and included inappropriate service delivery and even hostility. This demonstrates the extent to which these issues may negatively impact on quality of care, and 'booking in' and antenatal education were identified as the two areas where service delivery is least effective in meeting the needs of these women. Assumptions of heterosexuality are a barrier to accessing services and have particularly been reported with fertility, maternity and post-natal services which are services commonly used by lesbian and bisexual women. (Womens Resource Centre, 2010)

During the Dulwich project 2012 pre-consultation engagement exercise respondents shared their perspective on local services for people who have (or are about to have) very young families, interestingly much of the content of responses echoes that detailed above: 55 people said that they, or someone close to them had or who were about to have very young families. 50 of those people went on to give more detail about their views on the services, including some extensive comments. Ante-natal care was, largely considered good, although parentcraft classes were less highly rated. Post-natal care was not rated nearly so highly.

- There were a number of comments saying that the advice from Health Visitors is not always consistent, evidence-based or up to date.
- People felt it should be possible that Health Visitors could organise their time better so that they can give a time when they say they will arrive and then come at that time. Voicemail messages didn't always get returned, and between the patients and the health visitor things got forgotten.
- Post-natally, there were a number of comments about the space available in both general practices and at Townley Road for running baby clinics, with the view that they were too cramped and too busy.
- Better communication between professionals would improve the diagnosis and management of post-natal depression.
- Many people didn't know what Children's Centres offered, and who could use them.
- People felt that there was not enough health visiting. They wanted the professional support and advice for breast feeding, weaning, sleep issues, etc. This could be either as 1:1 support or as a support group.
- People liked having the opportunity to 'drop in' to baby clinics, either for weighing or reassurance or where they had questions to ask.
- There was a lot of support for greater integration between the ante-natal and post-natal services – closer working between midwives, GPs and Health Visitors.
- Women who had experienced a service where there was close working between midwife, GP/practice nurse and Health Visitor valued this highly.
- People felt that continuity was important – someone who knows you and your history. Caseload midwifery is very highly valued, with a large number of very positive

experiences reported. Those women who had continuity of care throughout their pregnancy and birth valued that very highly. Some women received some inconsistent advice – where they were not receiving caseload midwifery services.

- Sometimes there could be room for improvement in the systems for making referrals, booking parent-craft classes.
- Some women said they would definitely support the idea of a midwife-led birthing centre.
- For births, a large number of people reported that the services at both King's and at St Thomas' are overcrowded and overstretched, with women reporting being turned away in labour despite being booked.

The Southwark Clinical Commissioning Group has already embarked on discussions with King's about increasing capacity for maternity services. They are looking at a number of options, including a Midwife-led Birthing Centre on the Denmark Hill site. All the comments about post-natal care services have been given to the commissioners and the provider of those services. There are national changes in train about how Health Visiting works, and there are additional investments being made in Health Visiting over the next three years. There is also a local commitment to make sure that people know what is available at Children's Centres and how that can be accessed.

References for the protected characteristic of Maternity & Pregnancy:

1. Better Health briefing paper 11 (2008) Addressing ethnic inequalities in maternity service experiences and outcomes: responding to women's needs and preferences
2. Connelly, A (2011) Equality and Health: Presentation. NHS SE London
3. D'Souza, L., Garcia, J. and Turner, A. (2001–2002) Access to Care for Very Disadvantaged Childbearing Women: Report of a descriptive survey of services for women from non-English speaking backgrounds, asylum seekers and women at risk from domestic violence, Oxford: National Perinatal Epidemiology Unit.
4. Department of Health (DH) (2007a) Maternity Matters: Choice, access and continuity of care in a safe service, London: The Stationery Office.
5. Dixon-Woods, M., Kirk, D., Agarwal, S., Annadale, E., Arthur, T., Harvey, J. et al. (2005) Vulnerable Groups and Access to Healthcare: A critical interpretive review, London: NCCSDO.
6. DoH (2009) Improving Access to Urgent Care Services (3DN) - Equality Impact Assessment, Initial Screening. Crown Copyright
7. Gerrish, K., Chau, R., Sobowale, A. and Birks, E. (2004) 'Bridging the language barrier: the use of interpreters in primary care nursing', Health and Social Care in the Community, 12, 5, pp. 407–13.
8. Harper-Bulman, K.H. and McCourt, C. (2002) 'Somali refugee women's experiences of maternity care in West London: a case study', Critical Public Health, 12, 4, pp. 365–80
9. Jenkins, M. (2006) No Travellers – Gypsy and Traveller pack. A report for Gypsies and Travellers with maternity care, Bristol: Midwives Information and Resource Service (MIDIRS).
10. Jomeen J, Redshaw M (2012) Ethnic minority women's experience of maternity services in England. Faculty of Health and Social Care, University of Hull, Hull, UK
11. Raleigh VS, Hussey D, Seccombe I & Halt, K (2010) Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. Journal of the royal society of medicine
12. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG
13. Sivagnanam, R. (ed.) (2004) Experiences of Maternity Services: Muslim women's perspectives, London: The Maternity Alliance.
14. Womens resource Centre (2010) Briefing 16: Lesbian, Bisexual and Trans womens services in the UK

10. Dignity & Human Rights

The Human Rights Act (HRA) 1998 requires public bodies carrying out public functions to take account of the human rights dimensions of services for which they are responsible. Article 8 of the Convention, the right to a private and family life, is particularly applicable to gender reassignment. The concept of the right to a private and family life covers the importance of personal dignity and autonomy and the interaction a person has with others, both in private or in public. Respect for

one's private life includes respect for individual sexuality, the right to personal autonomy and physical and psychological integrity. Providers of NHS services should therefore be taking account of the human rights dimensions of services.

All those who share protected characteristics also have rights under the NHS Constitution, which describes the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the service. These rights cover access, quality of care and environment, access to treatments, medicines and screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS, and complaints and redress. NHS bodies, primary care services, and independent and third sector organisations providing NHS care in England are required by the Health Act 2009 to have regard to the NHS Constitution. In practice, this means that NHS services should be provided in a non-discriminatory way and there should be no absolute absence or refusal of service.

Relevant articles include:

- Right not to be discriminated against
- Right to confidentiality of personal data etc
- Rights to live free from inhuman and degrading treatment
- Rights to respect for privacy and family life
- The right to liberty and security.

The proposal holds the potential to increase local knowledge and awareness about human rights including rights for confidentiality and around access to services – the action plan should include steps to maximise this potential

‘There are many codes of conduct and clinical guidelines that detail the way the NHS and its staff should work. The essence of such standards is captured in the opening words of the NHS Constitution: *‘The NHS touches our lives at times of basic human need, when care and compassion are what matter most’*. Adopted in England in 2009, the Constitution goes on to set out the expectations we are all entitled to have of the NHS. Its principles include a commitment to respect the human rights of those it serves; to provide high-quality care that is safe, effective and focused on patient experience, to reflect the needs and preferences of patients and their families and to involve and consult them about care and treatment. Users of NHS services should be treated with respect, dignity and compassion⁵ Training of staff needs to take in account the principles of human rights – fairness, respect, equality, dignity and autonomy – as reflected in the NHS Constitution.

References for Human Rights:

1. NHS (2009) The NHS Constitution: The NHS Belongs to Us All.

11. Carers

Census data indicates that there are 20,000 to 25,000 carers in the London Borough of Southwark making a substantial and unpaid contribution to the local health and social care workforce. In 2001, 37 percent of carers in Southwark provided care for more than 20 hours a week. Being a carer may impact adversely upon health, especially those putting in long hours; caring for people with challenging behaviour, or who are themselves sick or disabled.

⁵ Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people Health Service Ombudsman for England February 2011

Census data for Southwark showed that 45 percent of carers of working age combine paid work with caring. Working carers are an important group but as research from Carers UK shows, many feel poorly supported, suffer impacts on their health and financial position, and would like more help from formal services.

Other carers are unable to undertake as much paid work as they would wish because of the demands of their role. Caring for a relative or partner can leave people isolated and on a low income. (Southwark JSNA)

Research carried out by the Princess Royal Trust for Carers in 2011 discovered that:

- almost 70% of carers aged 60 and over said that looking after someone else had damaged their health.
- Nearly half (49.2%) admitted that their health has deteriorated in the last year because of their caring duties.
- Nearly two-thirds (65%) of those polled said they had health problems or a disability of their own, while only half of these felt confident lifting the person they care for.
- The respondents also revealed that caring for another person also took its toll mentally, with 68.8% saying being a carer had damaged their psychological well-being, and 42.9% reporting that their mental health had worsened in the past year.
- Subsequently, the Princess Royal Trust for Carers wants GPs to provide health checks and screening for depression to carers once a year, and home visits where needed.

We know that some equality groups are over-represented amongst those who provide care to older people with high support needs, both in a paid and in an informal capacity. Younger family members caring for older relatives are more likely to be women, and Bangladeshi and Pakistani people are three times more likely than white British people to provide care (Carers UK, 2009). Although 70 per cent of those receiving family care are aged under 65, 11.5 per cent of those providing care are over 65, and those providing high levels of care are twice as likely to be 'permanently sick or disabled' as those not caring (Carers UK, 2009). Older spousal carers are more likely to be men, are more likely to be from white or Indian backgrounds (Buckner and Yeandle, 2005) and are more likely to be from lower socio-economic groups, reflecting the higher levels of disability and the reduced opportunity to buy in formal care (Lloyd, 2008).

Carers from refugee and new migrant communities are likely to have difficulty understanding health and social care systems and to lack social networks. Access to support and services may be further complicated by language barriers and lesser rights for non-citizen members of black and minority ethnic communities. This highlights the need for further research and for outreach work to ensure equal access to services from now into the future.

Research suggests that an increasing number of people with learning disabilities are taking on a caring role (Mencap, 2010). A large proportion are living with older parents and providing mutual care, while the move towards independent living implies that others may be supporting a partner. Black and minority ethnic people in this position may be unaware of their caring role, while professionals often fail to identify those with a learning disability as carers (Mencap, 2010). These carers may not have English as a first language and are likely to require information and assessments in appropriate formats, together with assistance to identify and access culturally sensitive support.

Black and minority ethnic LGBT carers are likely to be affected by the prevalence of both racism and heterosexism in health and social care and the assumption that LGBT identity is predominantly a White British issue (Fish, 2006). Carers may lack community support because of the taboo around LGBT orientation and there are few, if any, mainstream projects that address the

specific needs and circumstances of LGBT carers from black and minority ethnic backgrounds. Research suggests that black and minority ethnic LGBT people are disproportionately affected by homophobic violence, abuse and harassment and the costs of disclosure are likely to be higher than for their White British counterparts. These carers may not identify with the terms 'gay' or 'lesbian' (Fish, 2007).

In the 2012 pre-consultation exercise respondents stated that support for carers, including respite care is crucial and stakeholder groups representing carers during the formal public consultation process in 2013 highlighted concerns that carers still find it difficult to access carers services available from diverse voluntary sector groups in Southwark and a need to develop improved sign-posting mechanisms to support them (Opinion Leader, 2013).

References for Information about Carers:

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2. National Council on Ageing and Older People (2006) health and Social services for older people. Consulting older people with mental health problems on health and social services: A survey of service use, experience and needs
3. Opinion Leader (2013) Improving Health Services in Dulwich and Surrounding Areas Consultation Report. NHS Southwark CCG.
4. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG
5. The Princess Royal Trust for Carers (2011) Always on call, always concerned: A survey of the experiences of older carers

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1. Alzheimers Society (2012) Dementia 2012 : A National Challenge
2. Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people Health Service Ombudsman for England February 2011
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5. Morris, D and Gilchrist, A (2011). Communities connected: Inclusion, participation and common purpose. RSA, London.
6. Office for Disability Issues (2010). The life opportunities of disabled people: Qualitative research with learning, memory and neuro-diversity impairments. HM Government, London.
7. Princess Royal Trust for Carers and Crossroads Care (2009). No breaks for carers. Princess
8. Rowson, J, Broome, S and Jones, A (2010). Connected communities. RSA, London.

Appendix Two: Reasonable Adjustments for the Implementation Phase – Wider responsibilities and Updates from the NHS Southwark Clinical Commissioning Group (NHS Southwark CCG)

Ref.	Recommendations for Implementation Phase	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
22	Address men's historic under-use of GPs, pharmacies, smoking cessation, weight management services and health trainers throughout the local service improvement plans	<ul style="list-style-type: none"> • The Men's Health Forum, currently funded by the Guy's and St Thomas' charity for one year to scope men's health needs has identified a number of key themes pertinent to Southwark as part of the Men's Health Improvement Programme for Lambeth and Southwark. The top 5 health issues for men in Lambeth and Southwark were: <ol style="list-style-type: none"> 1. Stress 29% 2. Cancer 24% 3. Heart Conditions 18% 4. Diabetes 14% 5. Depression 14% Other Key themes identified by Men's Health Forum include the fact that: <ul style="list-style-type: none"> • Male Hospital admissions rates in Southwark are both significantly higher than the England rate • Southwark hospital admission rate for prostate cancer is the highest in London • HIV- Lambeth and Southwark account for almost 25% of cases in England • STI's – Southwark has the highest Acute amongst all London Boroughs • The Men's Health Forum is putting together a business case for additional funding for implementation of initiatives to address the above issues with the support of local partners including the CCG • Men's health is an on-going issue nationally compounded by differential access to services by race, religion and cultural factors. The CCG will continue to work with its partners, the local Council and the Public Health teams to address these issues through better and targeted health promotion and other initiatives.

23	Continued support for carers and the organisations that provide support services for them (working with Local Authority)	<ul style="list-style-type: none"> • Work to develop strategies to support carers in Southwark is led jointly by the CCG, local authority and voluntary groups. • The CCG has agreed a Carers Strategy (Vision and Direction of Travel) with Southwark Social Services, this is published on the website. The CCG and Southwark Council are committed to working together to develop services to meet the diverse needs of carers, including child carers of adults. • The Head of Continuing Care and Safeguarding is the lead for carers within the CCG and has worked jointly with the SCCG Chief Finance Officer during the budget setting process in March 2013 to identify the total budget to support carers and the indicative number of breaks available within this budget. • Personal Health Budgets are in place for clients in receipt of Continuing Healthcare to support both clients and carers to have more control and choice in planning care and meeting health outcomes • Ongoing improvement in identification and recognition of carers and ensure all carers in receipt of NHS Fully Funded Care have a carers assessment. • Budgets have been agreed with the Health & Wellbeing Board (HWB) and voluntary groups to support carers • Ongoing joint working with Southwark local authority to review and implement recommendations from the Carers UK review of carers needs in Southwark • Ongoing work to support Carers to be embedded into new care pathways for all long term conditions with primary care staff to receive carer awareness training and on-going engagement with carer support services. Carers to be supported to fully engage in the process of hospital discharge. • Ongoing work to reduce the waiting time for Improving Access to Psychological Therapies (IAPT), and to ensure the service reaches Carers
24	Rigorous monitoring and evaluation of local health system to test outcomes for those who do and do not share protected characteristics e.g. patient experience, service quality, reducing health inequalities etc	<ul style="list-style-type: none"> • The CCG continues to make good progress on meeting the General Duty under the PSED and compliance with the Human Rights Act. • The learning from the Dulwich Health Services Consultation will inform the CCG's revised equality objectives to be published by 31 Oct 2013 • The CCG is a partner in the Southwark Winterbourne Working Group, which reports to the Southwark Older People's Partnership Board and Southwark CCG Safeguarding Executive and has a reporting line to the Southwark Learning Disabilities Partnership Board. • The CCG is also cultivating a culture of quality and compassionate care across the organisation, workforce, member practices and partners. It has produced a challenging equality, human rights, quality and compassionate care workplan to Dec 2013 • The CCG has established a quality working group (which incorporates the Francis Report recommendations) and endorsed the Commissioning for Quality approach and begun to develop enhanced quality reports to provide a wider and deeper source of intelligence in relation to the quality of

		<p>commissioned services underpinned by equality and human rights outcomes. Typically, the CCG Quality Report includes:</p> <ul style="list-style-type: none"> • CQC information relating to local providers • Commentary on the key quality issues identified with each provider and a summary of commissioner actions in respect of these. • Detail on patient experience, including summaries of provider data on patient experience, patient surveys, local intelligence from Healthwatch and the CCG's patient engagement structure, and issues raised by patients and the public. • A summary of Quality Alerts raised by Southwark practices, including key themes and actions. • Summaries of any site visits or clinical audits undertaken. • A log of quality issues identified in the report and a reference to their inclusion in the CCG Risk Register.
25	<p>Use opportunities to promote and protect human rights in the way that services are commissioned, procured and monitored. In particular those services that are to be delivered in peoples own homes</p>	<ul style="list-style-type: none"> • The CCG has recognised that dementia and care of older people is a key challenge and is working with Southwark Council to continue to provide access to a highly responsive and timely memory services • The CCG is working towards reducing the waiting time for Improving Access to Psychological Therapies (IAPT), and to ensure the service reaches isolated older people including those from the BAME communities • The CCG is working towards ensuring increased availability of specialist home care to enable people with dementia to stay in their own homes for longer. • The CCG is working towards ensuring reduction in the use of antipsychotic drugs through greater access to non- pharmacological management of behavioural disturbances, e.g. enhanced home treatment for older adults and management services. • The CCG is working towards improving the accommodation pathway for adults with mental health problems, so that it provides more effective support and recovery to service users in a community setting • The CCG has agreed a joint vision with the council and providers for raising the quality and compassionate care standards for care homes in Southwark • During 2012/13 the CCG developed and implemented registers of older people at risk, holistic health assessments (including mental health) and a system of case management for older people through GP practices, urgent access telephone lines and geriatric outpatient clinics for rapid diagnosis • A one year pilot of a Home Treatment Team (HTT) for Older Adults is underway which aims to reduce the number of admissions into acute services • The CCG is a partner in the Southwark Winterbourne Working Group, which reports to the Southwark Older People's Partnership Board • People's Partnership Board and Southwark CCG Safeguarding Executive • See also comments above in row (24)

26	Embed improving men's health and tackling gender equalities into the commissioning process.	<ul style="list-style-type: none"> • See comments above in row (22) • See comments below in row (40) • See comments below in row (41) • Gender Reassignment remains a hard to reach group because local data on Gender Reassignment is limited, but over the coming year the CCG working with stakeholders, member practices, provider services, public health and the LGBT network aims to improve local intelligence and feedback into the commissioning cycle
27	Community engagement to continue with a focus on individuals / groups / representatives of those who share protected characteristics, with a particular focus on finding and responding to the needs of new and transient BAME communities, the LGB population and to continue the community engagement/partnership work with local faith groups	<ul style="list-style-type: none"> • See comments below in row (28)
28	Explore avenues to enable continuous feedback from those who share or represent those who share protected characteristics throughout the implementation of the programme (e.g. establish an Equality Reference Group or something similar)	<ul style="list-style-type: none"> • The Membership, Engagement and Communications Team has a full programme of community engagement activities with stakeholders, member practices and the voluntary and community sector • As part of the Authorisation process the CCG developed and implemented a robust communications and engagement strategy for consulting, engaging and involving patients, carers and stakeholder organisations to develop and improve service access/delivery across the nine protected characteristics (Objective 5 of the communications and engagement strategy). • As part of the Everyone Counts 2013/14 guidance, the CCGs and local communities have identified three locally- defined outcome indicators to be used to assess the commissioning impact on the outcomes of the targeted patient groups • The CCG's enhanced quality reports provide a wider and deeper source of intelligence in relation to the quality of commissioned services underpinned by equality and human rights outcomes • The CCG is currently in the process of developing a Primary and Community Care Strategy (PCCS). There is a plan in place to focus engagement with stakeholders in the production of this strategy. • A steering group has been set up to oversee the development of the PCCS – members include Healthwatch, GP Commissioning leads, CCG officers, Public Health and NHS England. • The CCG has committed to a co-production approach to developing the strategy, working with patients and the public. In particular, the input of patients has been sought to co-produce the PCCS priorities and options for developing primary and community care. • Engagement plans with a range of stakeholders include:

		<ul style="list-style-type: none"> • Patients, carers and members of the public Southwark GP practices and their staff • Provider organisations, including community, acute, mental health, both NHS, independent and third sector • Pharmacists (via the LPC) • Public Health • Social Care • NHS England • The Local Medical Committee • South London Integrated Care • Exceptions/issues are reported to the Engagement and Patient Experience Committee (EPEC), IG&PC or the CCG Board
29	<p>Whilst this assessment focuses on service users and the general population, it is recommended that an assessment of impacts of NHS staff should take place once the final changes are agreed following the formal public consultation in 2013.</p>	<ul style="list-style-type: none"> • The impact assessment on NHS staff will follow the usual equality and employment law practices and Human Resources policy and procedures.
30	<p>Providers to continue to be required to provide monitoring data across the protected characteristics to enable robust monitoring of access and appropriate/responsive services to take place (in partial fulfilment of the local Equality Delivery System)</p>	<ul style="list-style-type: none"> • Generally all providers have their own service access/delivery strategies and policy and procedures in place to ensure they comply with equality and human rights legislation outcomes • Over the coming year the CCG aims to review commissioned contracts to ensure that the specifications contain reasonable clauses that comply with Equality Act 2010, public sector duty, the Human Rights Act 1998. • The CCG has established a quality working group (which incorporates the Francis Report recommendations) and endorsed the Commissioning for Quality approach and begun to develop enhanced quality reports to provide a wider and deeper source of intelligence in relation to the quality of commissioned services underpinned by equality and human rights outcomes.
31	<p>Continue to monitor the sexual orientation of service users to increase local intelligence of how accessible, appropriate and responsive local services are for those who identify as lesbian, gay or bisexual.</p>	<ul style="list-style-type: none"> • This will continue to be a challenge for certain sexual orientation (i.e. LGBT) because of the reluctance to declare sexual orientation, however, the CCG is working with the LGBT network to develop better local intelligence • Case law, however, is very clear that someone's "human condition" (age, disability, gender reassignment, race, sex or sexual orientation) cannot be compromised by someone's "lifestyle choice" (i.e. religion or belief) • There is also a hierarchy of rights in an employee/service user relationship – an employee's "lifestyle choice" cannot compromise a service user's "human condition". In other words, a service user cannot be denied a service (or given poorer quality service) because of an employee's lifestyle choice

32	<p>Seek to influence a refresh of the Joint Strategic Needs Assessment and ensure it assesses local health needs by protected characteristics (as relevant) as this will assist future Equality Impact Assessment Processes. Continue local Health Needs Assessments to look into differing needs of service users taking into account protected characteristics and commissioners to take proactive steps to address the diversity of needs.</p>	<ul style="list-style-type: none"> • Southwark and Lambeth public health work with the CCG. Since April 2013, local authorities took over responsibility for public health services. Lambeth and Southwark councils run a shared public health service with a single Director of Public Health. The overall goal of public health is to: <ul style="list-style-type: none"> • Protect and promote health and wellbeing • Minimise risks to health and wellbeing • Prevent disease and their complications • Reduce health and healthcare inequalities • The CCG and Southwark Council, through their collaborative work with statutory agencies, voluntary sector and communities, will continue to influence the wider determinants of health, reduce health inequalities and promote healthy lifestyles to Southwark people as well as shaping the provision of local health services.
33	<p>All providers to fulfill requirements of the Public Sector Equality Duty, CQC criteria and local NHS Equality Delivery Systems</p>	<ul style="list-style-type: none"> • Generally all providers have they own service access/delivery strategies and policy and procedures in place to ensure they comply with equality and human rights legislation and CQC outcomes • Over the coming year the CCG aims to review commissioned contracts to explore enhanced equality, human rights, quality and compassionate care specifications • The CCG as part of the work planned by the response to the publication of the Francis Report and the Report on Winterbourne View, has begun to develop the CCG's reports to provide a wider and deeper source of intelligence in relation to the quality of commissioned services. In essence, the enhanced quality report includes: <ul style="list-style-type: none"> • Care Quality Commission information relating to local providers • Narrative commentary on the key quality issues identified with each provider • Issues associated with quality and patient experience as identified by Healthwatch • More detail on patient experience, including summaries of provider data on patient experience, national patient surveys and intelligence on issues raised by patients and the public • A summary of Quality Alerts raised by Southwark practices, including key themes and outcomes from alerts • Summaries of any relevant site visits or clinical audits
34	<p>Providers to ensure all staff comply with Equality and diversity practice and policies, as well as adhere to the spirit of the NHS Constitution</p>	<ul style="list-style-type: none"> • Generally all providers have they own workforce and organisational development strategies and policy and procedures in place to ensure they comply with equality and human rights legislation and CQC outcomes • As part of the CCG's quality reports it will seek assurances that providers' equality and human rights policies are in place and compliance with the NHS Constitution

35	All staff are trained on the principles of human rights - fairness, respect, equality, dignity and autonomy	<ul style="list-style-type: none"> • The CCG's Mission, Values, Goals and Priorities are all grounded in the human rights principles known as the "FREDA Principles". This means that commissioning decisions about care pathways for Southwark people are subject to: Fairness; Respect; Equality; Dignity; Autonomy • The CCG is refreshing its equality and human rights training/learning tools/action learning sets which is underpinned by compassionate care • All CCG staff are required to attend refreshed instructor-led equality, human rights and quality compassionate care training by end of Dec 2013 • Specialist monthly themes via new bulletin and or articles on E&HRs in relation to OD, Workforce and Patients to be disseminated widely
36	To ensure all staff are aware that those who are married and those who have civil partnerships share the same legal rights and that all relevant policies regarding staff and service users reflect this recent legislative change. This might affect change to local guidelines regarding 'next of kin', visiting guidelines, attendance to appointments etc.	<ul style="list-style-type: none"> • See comments above in row (31) • See comments above in row (35)
37	Human Rights/implementation of the NHS Constitution to be integral to providing high quality care within patients own homes for groups including: older people; people with mental health conditions; BAME groups (including recognition of cultural diversity); offering adequate support for carers (e.g. family or friends); protecting the rights of those who are lesbian, gay or bisexual in civil partnerships (equal rights of those who are married)	<p>The CCG has made equality and human rights 'everyone's business' because taking a "human rights based approach" to commissioning is the key to delivering high quality, compassionate and personalised care pathways.</p> <ul style="list-style-type: none"> • The CCG's commitment to protect human rights and enhance quality and compassionate care is integral to its core business and reflected throughout the Business and Operating Plan 2013/14. • The CCG's Mission, Values, Goals and Priorities are all grounded in the human rights principles known as the "FREDA Principles". This means that commissioning decisions about care pathways for Southwark people are subject to: Fairness; Respect; Equality; Dignity; Autonomy • The current CCG equality objectives are in the process of being refreshed and the Dulwich Health Services consultation results will also inform the equality objectives which the CCG will need to set in place by 31 Oct 2013 <p>See comments in rows 22-42 to support the implementation of the PSED</p>
38	Equality, Diversity and Human Rights training will continue for all NHS staff (commissioners and providers have a policy in place)	<ul style="list-style-type: none"> • Southwark CCG (including in its previous shadow form) has a strong track record of integrating and delivering on equality and human rights. From the outset, Southwark PCT pioneered human rights in healthcare with its participation in the Department of Health's pilot project and publication of "Human Rights in Healthcare: A Framework for Local Action". That pioneering spirit continues to be embodied in the new CCG. • All CCG staff are required to attend refreshed instructor-led equality, human rights, and quality

		<p>compassionate care training by end of Dec 2013</p> <ul style="list-style-type: none"> The CCG will seek assurance from providers that they have equality and human rights policy in place as well as the provision of training for staff
39	Formal Public Consultation results to inform PSED objectives 2013-15	<ul style="list-style-type: none"> The current CCG equality objectives are in the process of being refreshed and the Dulwich Health Services consultation results will also inform the equality objectives which the CCG will need to set in place by 31 Oct 2013
40	Commission local research on the health needs/ service requirements for those who have gone through / are considering gender reassignment	<ul style="list-style-type: none"> Gender Reassignment remains a hard to reach group because local data on Gender Reassignment is limited, but over the coming year the CCG working with stakeholders, member practices, provider services, public health and the LGBT network aims to improve local intelligence and feedback into the commissioning cycle
41	To revisit service provision as local demand increases in line with increasing birth projections.	<ul style="list-style-type: none"> The CCG works collaboratively with South London Commissioning Support Unit and other CCGs in respect of maternity, and this will be increasingly important as it begins to implement the changes proposed by the Trust Strategic Administrator The CCG will continue to work with providers of maternity services, health visitors and primary care to ensure that maternity services deliver high quality care. In particular, in 2013/2014 the CCG will be focusing on ensuring that there is sufficient capacity in local services to deliver safe care which supports a positive maternal experience, and offers a choice of location of birth.
42	Service to invite 'mystery shoppers' to visit providers of local maternity (Ante and post natal) services. In particular young single mothers, those who identify as being lesbian or bisexual and also BAME	<ul style="list-style-type: none"> The CCG's has made it a priority to ensure that Southwark women are supported in accessing ante- natal care at an early stage so that they can receive the necessary screening, assessment and support. Over the coming months the CCG will: <ul style="list-style-type: none"> Review Maternity Specification in KCH and GSTT contracts and agree any changes to quality monitoring arrangements. Review Trust capacity plans for Maternity services, including provision of midwifery led birth choice. Review Trust action plans for delivery of ante-natal access by 12 weeks 6 days. As part of Reviewing Maternity Specification KCH and GSTT contracts specification the CCG could consider 'mystery shoppers' in relation to LGB and the BAME communities <p>See also comments above in row (41)</p>

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