Update for Healthcare for London on the Rapid Evidence Review and Appraisal as part of the Health Inequality Impact Assessment and Equalities Impact Assessment

Prepared by Ben Cave Associates
on behalf of the London Health Commission

February 2008

Prepared by
Ben Cave Associates Ltd

Contact details
T: 0870 850 4947
W: www.bcahealth.co.uk
E: information@bcahealth.co.uk

Date
29th February 2008

Prepared by	Liza Cragg Paul Iggulden
Approved by	Ben Cave
For	London Health Commission

1. Purpose and background of this report

1.1 The purpose of this report is to update Healthcare for London on the progress of the health inequalities and equalities impact assessment (HIIA/EqIA) on the proposals contained in *Healthcare for London: consulting the capital*. The HIIA/EqIA is being undertaken by the London Health Commission (LHC).

1.2 Specifically, this report provides details of progress with the rapid evidence review and appraisal of the health inequalities and equalities impacts that the LHC commissioned Ben Cave Associates (BCA) to undertake on 19th December 2007 and the emerging findings from that work.

1.3 In addition to the rapid evidence review and appraisal, the HIIA/EqIA process also includes a baseline profile of health inequalities in London prepared by the London Health Observatory and findings from a stakeholder workshop held on 27th February.

1.4 On 17th March the LHC will present a final report of the HIIA/EqIA to Healthcare for London. This report will include findings and recommendations based on the rapid evidence review, the stakeholder workshop and the baseline profile.

1.5 The HIIA/EqIA process has been overseen by a Steering Group, which includes representatives of the LHC and London Equalities Commission and other key stakeholders including the GLA, LHO, NHS London, Local Authorities, London Development Centre/CSIP. The Steering Group have met regularly to design the HIIA/EqIA process, define the scope of the HIIA/EqIA and review emerging findings. The Steering Group will sign off the final report of the HIIA/EqIA.

Aim of the HIIA/EqIA

1.6 The aim of the integrated HIIA/EqIA as defined by the Steering Group is "to deliver evidence-based recommendations, which will inform future development of the strategy and the decision-making process, to maximise health gains, to reduce or remove negative impacts and reduce inequalities".

Scope, structure and methodology of the rapid evidence review and appraisal

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

1.8 An initial assessment was carried out by the Steering Group on *Healthcare for London: consulting the capital* (1) to identify which of the proposals were most relevant for equality equalities groups and health inequalities. The following policies were identified as being of most relevance and this report focuses on these policies:

- Primary care;
- Maternity care; and
- Stroke pathway.

1.9 Therefore, the rapid evidence review and appraisal has examined the proposals relating to these areas.

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

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

1.12 As the proposals concern healthcare, discussion on health inequalities has focussed on health status and outcomes, including life-expectancy and morbidity, and health services, including access and patient experience.

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

1.14 The methodology of the rapid evidence review and appraisal has six key stages: project start-up; scoping; identifying and reviewing of key documents and evidence; undertaking the initial appraisal and preparing the interim report; participating in the stakeholder workshop; and undertaking the final appraisal and preparing the final report.

1.15 Public organizations have statutory responsibilities to assess and consult on the likely impact of proposed policies on equalities groups. These responsibilities arise from section 71 of the Race Relations (Amendment) Act 2000 (2), Section 3 of the Disability Discrimination Act 2005 (3) and Part 4 of the Equality Act 2006 (4).

1.16 The rapid evidence review and appraisal has been undertaken in line with GLA (5;6) and Commission for Race Equality (7) best practice. This will assist NHS London and the London Commissioning Group to fulfill their statutory duties and it will contribute to the examination of whether NHS London and the London Commissioning Group have given proper consideration to the likely impact on equalities groups.

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

Findings and emerging issues

Overall findings

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

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

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

1.21 *The inverse care law must be reversed*. More deprived areas must receive resources, including funding, staffing and infrastructure, in line with the higher levels of health need in those areas.

1.22 Models for *assessing and meeting unmet health* need should be developed and incorporated into PCT planning and performance management. There is a danger that vulnerable groups who currently cannot access healthcare will be left out of the improvements promised by the proposals, further increasing health inequalities between the most marginalized groups and the population as a whole.

1.23 New models of healthcare must take account of the needs of equalities groups, vulnerable groups and those with the worst health by *addressing the barriers that have historically prevented equalities groups and deprived communities accessing health care* and benefiting from health improvement initiatives. These barriers for different equalities groups include physically inaccessible services, a lack of language support and the cultural insensitivity of services. For deprived communities barriers also include poor access to healthy lifestyle choices, stress, social isolation, low aspirations and the affects of multiple deprivation such as poor housing, crime and fear of crime, unemployment, and poor access to services.

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

Emerging issues relating to primary care

- Clarification is needed from NHS London on the modelling on the location and average distance to polyclinics used in *Healthcare for London: consulting the capital*. Ensure physical proximity and ease of travel by public transport is prioritised in the development of polyclinics. This means avoiding an ad-hoc development based solely on the location of existing healthcare infrastructure and ensuring that polyclinics are situated where there are good public transport facilities.
- Healthcare for London and Transport for London should jointly issue guidance to primary care trusts outlining the transport planning issues to be considered in developing polyclinics. Transport accessibility indicators should be developed. Each polyclinic should develop of a travel plan. Patients should be made aware of how to get to the polyclinic, for example through leaflets.
- Ensure that in implementing the proposals, investment patterns are shifted to reverse the inverse care law. Areas with the highest levels of need must receive adequate levels of funding to meet these needs.
- Ensure ways continuity of care can be protected, for example by including this as an explicit feature of polyclinics.
- Polyclinics should include co-located non-healthcare services such as advice and support on employment, housing and welfare, exercise facilities, adult education and community organisations.
- Put in place mainstream services to ensure the recruitment and retention of sufficient staff in the most deprived areas of London.
- Explore models of primary care that specifically target those who have very poor existing access such as homeless people, refugees and asylum seeks or those living in deprived areas that are underserved by existing services.
- Include a commitment that the polyclinic model will include the development of premises to replace existing physically inaccessible and unsuitable GP surgeries.
- Build measures to improve the accessibility of all primary care services into the proposals. These should include adequate and consistently available language support and support for those with sensory impairment, learning disabilities and mental health problems. They should also include measures to ensure the sensitivity of services to lesbians and gay men. As a first step Healthcare for London should obtain and make public up to date information on the accessibility and suitablity of GP premises and how they are dispersed across London.
- Build in language support and accessibility for people with disabilities as a core part of any new telephone service.

- Ensure that new health improvement initiatives take into account the stress, isolation and disempowerment and lack of access that prevent many vulnerable groups from benefiting from existing initiatives.
- Ensure that preventative services are targeted at deprived and vulnerable groups and provided at a level which reflects their need.
- Ensure that PCTs commission immunisation services to cover services that were provided by GPs who have since opted out.
- Obtain further data on which equalities groups and vulnerable groups are most affected by being unable to register with a GP.
- Ensure primary care offers adequate and appropriate support to women experiencing domestic violence. This will require working in partnership with other agencies. It will also require proper training and support for staff.
- Primary care services need to ensure they take active steps to support carers in their caring roles but also to ensure that carers own health needs are meet.

Emerging issues relating to maternity care

- In view of the poor performance of London trusts in the Healthcare Commission's recent review of maternity services, urgent attention should be given to improving maternity care across the capital.
- Pre-conception advice and support should be built into the proposals.
- Women from disadvantaged groups and deprived communities should be targeted to ensure early ante-natal booking. Health equity audits of women booked for ante-natal care by 12 weeks and >22 weeks should be undertaken across London as recommended by the DH.
- The development of maternity services should include direct access to community midwives.
- Interpretation services should be available to support the whole range of maternity services from pre-pregnancy care to post-natal care. Women should not be expected to use children, partners of other family members as interpreters.
- Maternity services need to take account of the particular needs of women experiencing domestic violence.
- Culturally sensitive and appropriate care should be available to women living with Female Genital Cutting/Mutilation (FGC/M). Women from counties where this is likely to be practiced should be sensitively asked about this during pregnancy and management plans agreed during the antenatal period. Adequate training and support should be available for midwives, obstetricians and other healthcare staff to ensure they can provide this support.

Emerging issues relating to stroke pathways

- Participte in further research to better understand the increased susceptibility of minority ethnic groups to stroke, including which communities have an increased susceptibility and why, so as to better design prevention, treatment and rehabilitation to meet the needs of these communities.
- Ensure that stroke prevention initiatives are culturally sensitive to the needs Black and Minority Ethnic groups and targeted to them in view of the higher incidence of stroke amongst these communities.
- Ensure that stroke prevention initiatives address the factors that have historically prevented vulnerable groups and deprived communities from benefiting from health improvement measures.
- Ensure that stroke prevention initiatives actively target vulnerable groups and deprived communities, as well as groups at a higher risk of stroke and that funds are made available to support this targeting.
- At a local level commissioning must be informed by accurate information about local communities and needs, including the extent of deprivation and vulnerabily in the local population and which groups are currently not accessing services. This will require local health equity audits and health inequality impact assessments.

- Ensure that measures are in place to identify and support carers.
- Ensure that home based rehabilitation is adequately resourced, and that there is adequate funding for local authorities' socal care services. This will require close joint working.

Emerging issues outside the scope of the rapid evidence review and appraisal

- Because the economic and employment impacts of the proposals are potentially significant, more detailed modelling needs to be done to explore the net job loss or gains, which areas they are likely to occur in, which equalities groups may be affected and how these could impact on health and health inequalities.
- The environmental and economic impacts of redeveloping NHS sites on health and health inequalities, including how the affect the equalities groups, need to be considered as part of local impact assessments on proposals to dispose of and redevelop individual sites.

Key groups at risk of experiencing continued health inequalities

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

Summary of emerging recommendations

- The implementation of Healthcare for London needs to reverse the inverse care law. Deprived areas need high quality health services and a level of provision that reflects the higher level of health need their popuations' experience. This will require substantial shifts in resources, including funding and staffing, and investment in infrastructure.
- At a local level commissioning must be informed by accurate information about local communities and needs, including the extent of deprivation and vulnerability in the local population and which groups are currently not accessing services. This will require local health equity audits and health inequality impact assessments.
- More information is needed about groups that are not currently accessing healthcare and the extent of this unmet need.
- Monitoring and addressing unmet need should be included in the performance management of healthcare commissioners and providers.
- Mainstream services must be designed to meet the needs of traditionally-under-represented groups by taking account of the low income, stress, social isolation, cultural sensitivities, lack of transport, poor access to exercise facilities.
- Mainstream services must be targeted at traditionally-under-represented, deprived and vulnerable groups.
- Extra funding and incentives must be made available to ensure healthcare commissioners and providers do target these groups.
- Reducing health inequalities should be included as an explicit objective in local plans for implementation. Healthcare for London needs to agree indicators for this objective.
- Service infrastructure developments and reconfigurations must re-provide existing inadequate and inaccessible premises, rather than incorporating them.
- Planning for accessibility by public transport must be included in an early stage of the development of polyclinics. Transport plans should be developed for each polyclinic and other major healthcare facilities. Transport for London and Healthcare for London should work together to provide PCTs with guidance on how to do this.
- When planning the reconfiguration of services Primary Care Trusts must be aware of, and have capacity to meet, the requirements of section 71 of the Race Relations (Amendment) Act 2000, Section 3 of the Disability Discrimination Act 2005 and Part 4 of the Equality Act 2006.

- Healthcare for London should ensure that the local reconfiguration of services takes full and proper account of the effects of the proposals on the physical and social environment.

2. Reference list

1. NHS London. Healthcare for London: Consulting the Capital. 2007.

2. HM Government of Great Britain. Race Relations (Amendment) Act. 2000. Available at www.opsi.gov.uk

3. HM Government of Great Britain. Disability Discrimination Act. 2005. Available at www.opsi.gov.uk

4. HM Government of Great Britain. Equality Act. 2006. Available at www.opsi.gov.uk

5. Greater London Authority. Equality impact assessments (EQIAs): how to do them. 2003. Available at www.london.gov.uk

6. Greater London Authority. Equalities Impact Assessment: Strategies and Reviews. Guidance Notes 2006. Available at www.london.gov.uk

7. Commission for Racial Equality. The duty to promote race equality: a guide for public authorities. 2008.