NHS
Lambeth
Clinical Commissioning Group

Report on NHS Lambeth CCG 4-year equalities objectives

Year 3, 2017-18

Annual equalities update 2017-18

1. Lambeth context

As we plan services to meet the health needs of all Lambeth people we are mindful of the diverse nature of Lambeth's population. Our borough is:

- **Young and mobile:** we have a higher proportion of young adults and a smaller proportion of people aged 55+ than the rest of England. 20-39 year-olds make up 44% of the total population, while just 8% of Lambeth people are aged over 65. About 20 per cent of Lambeth's population moves into or out of the borough each year

- **Densely populated and growing:** our population of 327,600 will reach 355,200 by 2025, a rise of 9% from 2015

- **Ethnically diverse:** 60% of Lambeth's population (3 in 5) describe their ethnicity as other than white British. People from black and other minority ethnic groups will make up 41% of our population by 2025 and the main languages spoken after English are Spanish and Portuguese

- **Struggling with high levels of deprivation and rising inequalities:** 27% of Lambeth children live in poverty.

With our partners in GP practices, the local authority, hospitals and in the community we have made progress to improve health and wellbeing and have much to celebrate. Life expectancy has steadily increased over the last twenty years and we have reduced avoidable deaths from major killers such as cancer, heart disease and stroke. However, significant challenges remain to make sure that all our citizens can enjoy the highest levels of health and wellbeing.

2. About this report

This report summarises the progress we have made as a CCG in developing and progressing our equality objectives during 2017-18.

Publication of this report fulfils a legal duty for us as a public body. As such it captures a fraction of the huge amount of work we undertake, within the CCG and with our partners in health, care and the public sector across Lambeth to address inequalities.

Promoting equality and human rights and reducing health inequalities is a continuous process, requiring regular review. This report is one stage in this

process. We welcome the involvement of local people in all areas of our work and we are always keen to have comments and suggestions about how to improve.

3. The Public Sector Equality Duty

The Public Sector Equality Duty is set out in the Equality Act 2010. The General Duty applies to all public bodies and organisations providing public services. It requires all public bodies to have 'due regard' to the need to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

The Act outlines nine characteristics that are protected for the purposes of the Public Sector Equality Duty:

Categories protected under the Equality Act (2010)

- age
- disability
- gender reassignment
- pregnancy and maternity
- race – this includes ethnic or national origins, colour or nationality
- religion or belief – this includes lack of belief
- sex (gender)
- sexual orientation
- marriage or civil partnership

All public bodies are required to publish evidence of compliance with the Public Sector Equality Duty at least annually. Organisations must also agree and publish a set of one or more Equality Objectives at least every four years, starting from 2012.

4. Our equalities objectives 2015-18

Objective 1: Equality data	To use data more effectively to promote equality in all decisions made by the CCG
Objective 2: Engagement	To strengthen stakeholder, community and patient engagement and work in partnership to advance equality and reduce health inequalities
Objective 3: Health inequalities	**Adults** Focus on adults with controlled and uncontrolled hypertension: to determine differences across age, sex and ethnicity and to determine if interventions we commission for hypertension management meet the needs of our population when looking specifically at age, ethnicity and sex **Children and young people** Focus on children and young people using mental health services: to understand service data and improve the transition in care for children transitioning from primary to secondary school and from child and adolescent mental health services to adult services across equalities groups **Mental health** Focus on the physical health of people with mental health concerns: to reduce the number of people on the serious mental illness register who are smokers **Primary care** Focus on vulnerable adults: improving access and patient experience of primary care for vulnerable adults - health checks and care plans for people with learning disabilities and people with diabetes - improving the experience of carers Focus on economic disadvantage: to reduce the proportion of smokers from routine and manual employment groups who set a quit date and are quit at four weeks
Objective 4: Workforce	To maintain a well-supported, empowered, motivated and engaged workforce
Objective 5: Leadership	To ensure that leadership is inclusive at all levels

5. Progress 2017-18

5.1 Data

We reviewed data requirements for 2017/18 target setting and action plans against equalities objectives and ensured that measurable targets and reporting through programme boards was in place.

We ensured that equalities discussions had an appropriate data focus in Clinical Quality Review group meetings with NHS providers we commission, including Guy's and St Thomas' NHS Foundation Trust.

We ensured that demographic data was more systematically collected in our engagement and consultation activity, particularly in online surveys. This helped hugely in understanding the likely impact of proposals on particular groups.

5.2 Engaging diverse voices

Equalities is embedded into engagement planning support processes including templates, enabling us to identify and target priority groups. We ensured that demographic data was more systematically collected in our engagement and consultation activity, particularly in online surveys, and this helped us to understand the likely impact of proposals on particular groups, for example, during our consultation on proposals for NHS prescriptions. We were able to include detailed demographic data on those we consulted to demonstrate that we had reached some of the groups most likely to be affected, and more vulnerable people.

5.3 Health inequalities

During 2017/18 we measured progress made to achieve our equalities objectives by looking closely at health outcomes amongst different population groups, to ascertain whether services were impacting equally across the population. To do this we measured gender, ethnicity and age variations among those with certain health conditions, using data from the clinical systems of our 44 GP practices.

The measures taken have included:

5.3.1 For people with diabetes aged over 65 – *is a care plan in place?*

We raised our target from 50% in 2015 to 75% for 2017-18 and are close to achieving this, reaching 69% by March 2018

We are maintaining the target of 75% for 2018-19 and are currently developing an action plan with the CCG GP clinical lead for diabetes, linking

with our medicines optimisation team. We plan to include this equality indicator in our Practice Information Pack for regular discussion and to encourage learning and the sharing of challenges and successes. We will promote also through our regular GP bulletins.

5.3.2 For people with a learning disability – *is a care plan in place and is an annual health check carried out?*

We are still a way off achieving our target of 95% for health checks but raised our performance from just over 30% in 2015/16 to 71% by March 2018. This has generated interest from the National Clinical Director for learning disabilities at NHS England and from the leadership of South-East London's Transforming Care Partnership. We have increased the numbers of people who have a care plan to 68% from a very low start of 15% in 2015.

For 2018-19 the Learning Disability Taskforce will continue to meet and consider ways to narrow the gap even further between the target and our achievement, and between the percentage of people who have a health check and the percentage of people who have a care plan in place.

Closer analysis of practice success rates will be used to narrow down the focus and it is likely that concentrated effort will be on increasing uptake in the 11 practices where the number of people with learning disabilities who have not had a health check is still in double figures. Closer analysis of differences in uptake across age and ethnic groups will also be a focus.

Communications will continue to focus on GP practices but additionally, 2018-19 will see the further development of a campaign targeting people with learning disabilities themselves as well as their carers.

5.3.3 For people who care for a relative – *is that fact officially recorded in the person's GP record and are NHS services responding appropriately to need?*

We have worked hard to improve the recording of carer status in GP records across Lambeth, raising awareness with primary care colleagues and through patient and carer groups too; we continue to use the film we produced last year to help people to identify themselves as carers and access support.

This year with Lambeth Council we have launched the Framework for Action which commits us as a partnership to deliver four key outcomes for Lambeth carers:

- being respected and involved as a carer; having a life of one's own alongside the caring role;
- not being forced into financial hardship by having a caring role;

- being supported to stay well;
- and, for young carers, a fifth outcome: to enjoy a thriving childhood and be supported to learn, develop and be protected from inappropriate caring roles

5.3.4 For people with a serious mental illness – *can the numbers of these people who smoke be reduced?*

Recording of smoking status of people on GPs serious mental illness registers has been a priority in our focus within primary care as part of our broader work to improve the physical health of people with ongoing mental health concerns.

Despite additional support to this group to stop smoking, our figures show a small rise in the percentage of people with a serious mental illness who are smokers, 58.7% in March 2017 to 59.6% in March 2018. We continue to work with health service providers to keep a focus on the physical health status of people using mental health services and over time to begin to turn the trend downward

5.3.5 For manual workers – *could the numbers encouraged to quit smoking be increased?*

We do not underestimate the difficulty for people from routine and manual occupational groups to quit and are aware that, compared with some other areas of London, we have room to make substantial progress from our 32% success rate in the second quarter of the year, the latest data we have available.

We have worked with colleagues in public health to ensure that, within reprioritised health promotion services, this group remains a priority for stop smoking support commissioned by Lambeth Council. The local authority recommissioned this service mid-year, now commissioning support from pharmacies and GSTT community services rather than from Lambeth GP Federations.

5.3.6 For people with hypertension – *what proportion of people have their hypertension effectively controlled to a level of 160/100 or less?*

Our detailed analysis every three months of people with controlled and uncontrolled high blood pressure in Lambeth helps us identify, monitor and develop support to address any differences in engagement or outcomes for patients of different ages, ethnicities and genders.

During 2017-18 we saw a rise in the numbers of people, particularly men, on the hypertensive register. Since we first began to look at this data, the proportion of people with high blood pressure that is well-controlled has risen by a fraction, from 91.3% in January 2016, to 92.6% in March 2018; correspondingly, there has been a decrease in the proportion of people with high blood pressure that is poorly controlled, from 8.4% to 7.3%.

Control of blood pressure has improved for men by around 1.6% but the improvement for women is less marked at 0.9%.

Among different age groups, control has improved for all groups apart from those aged 100+, but this is based on very small numbers of people in this cohort of patients. Among other age groups, control has improved for 4.4% for those aged 10 to 19 years (again small numbers), and by 0.5% for those aged 30 to 39.

Among eighteen different ethnic groups recorded, all but two have seen an improvement since 2016 in the proportion whose blood pressure is controlled to the target level. There was a deterioration of control in blood pressure among 'White Irish' and 'White other' groups, and these differences will be explored further in 2018-19.

5.4 Workforce

The Workforce Race Equality Standard is mandatory on NHS providers and commissioners. It includes the requirement to collect information, report on and develop actions plans to address race equality in the workplace. It includes indicators derived from workforce data, staff survey data and data on the profile of Board members.

CCGs are expected to monitor and report internally on their own performance (numbers are presumed too small to guarantee anonymity) and to hold their providers to account for their WRES performance. NHS England assesses CCG performance against the WRES according to the performance of their local Trusts, rather than according to the CCG's own workforce race equality performance, though the requirements of the Public Sector equality Duty still apply to CCG's own workforce.

The CCG WRES score is based on the performance of their local trusts on the NHS staff survey. It is made up of a weighted average of trust level scores for one of the questions in the staff survey. Weights are given by the spend of the CCG to each of its providers. This was introduced in 2017-18 and so there is only one data point to date.

Data sources are:

- NHS annual staff survey and the question (21): 'Percentage [of staff] believing that trust provides equal opportunities for career progression or promotion'
- NHS financial flows

In 2018-19, Lambeth CCG's WRES score places the organisation in the bottom quartile of CCGs, based on the WRES performance of local trusts. This and other equalities issues are scheduled for discussion with GSTT in the autumn of 2018, through the CQRG meetings, where Lambeth is lead commissioner. In turn, we have representatives at CQRGs for other local trusts where neighbouring CCGs are lead commissioners, eg King's and SLaM.

5.5 Leadership

We have inclusive recruitment procedures and processes and collect equality data on applications and appointments to governing body and senior management positions. We routinely ensure that equalities is included in new Governing Body member inductions

Vacancies on our Governing Body this year were advertised openly to the eligible CCG membership. Adverts for lay member roles were distributed widely through diverse networks in Lambeth including vcs organisations working with groups that share protected characteristics. We also used a recruitment agency to widen the field.

6. Oversight of equalities

Information on these measures is produced every three months and reported to CCG programme boards, where the data are scrutinised and action plans are agreed. Delivery of NHS Lambeth CCG Equalities Strategy is overseen by the Engagement, Equalities and Communications Committee which reports directly to the Governing Body and provides CCG leadership with assurance on work in this area. The Committee is chaired by a Lambeth GP, includes patient group, voluntary sector and Healthwatch representation and meets four times a year. Members discuss equalities at each meeting.

We have a nominated clinical lead for equalities on our Governing Body and support at director and manager level to drive forward our equalities agenda.

7. Conclusions and plans for 2018-19

This report updates on our progress during 2017-18 in addressing equalities issues for the health of Lambeth people. It highlights areas where we have made significant progress towards achieving our equality objectives. However, it also shows that there remains much work to do if we are to have a lasting impact on inequalities in health for Lambeth. Appendix 1 sets out our broad priorities for equalities during 2018-19.

Our equalities objectives for 2017-18 are part of our longer-term equalities strategy. 2018-19 will be Year 4 of the CCG Equalities Strategy and so a review of aims and objectives is due during the forthcoming year. We propose to link this closely with the development of the CCG's commissioning strategy, which also runs to 2018-19 and is due for review. Increased collaboration with Lambeth Council and in particular with public health colleagues is likely to be a key feature of the CCG equalities work in future as partnerships and increasingly integrated approaches are developed.

As we refresh our objectives for 2019-23, we will involve a range of Lambeth stakeholders in discussions on our performance and about how we can together best tackle our joint task to reduce inequalities in the health of Lambeth people. We will use the NHS Equality Delivery System as a framework to support us in assessing our performance and in setting our priorities.

Core aims and objectives in 2018/19

- To enact the Public Sector Equality Duty

Key Performance Indictors/targets	Target
Progress against workforce race equality standard [IAF163b]	Performance against the England average (0.12 as at 2016). CCG performance 0.19. No national target set.

Key Tasks	Start Date	End Date
Strategy refresh • Refresh CCG equalities strategy for 2019/20, setting new equalities objectives and developing associated action plans	Sept 2018	Mar 2019
Data use • Review data requirements for 2018/19 target setting and action plans against equalities objectives. • Ensure equalities has appropriate (data) focus in CQRG specs. • Robust use of data in equality analyses for programme plans	1 Apr 2018 1 Apr 2018 1 Apr 2018	30 Jun 2018 31 Mar 2019 Ongoing
Engaging diverse voices • Engagement plans and activity - focused planning identifying target groups to involve at programme and corporate level to support development and delivery of CCG strategy and plans. • Use agreed templates for planning involvement activity to highlight equalities focus. • Introduce reimbursement policy to reduce/remove financial barriers to involvement. • Record equality data concerning participants in engagement activity including PPVs • Equality analysis - identify and carry out engagement activity with affected groups to support other evidence as part of equality analysis of programme plans.	1 Apr 2018	31 Mar 2019
Health inequalities • Ensure CCG programmes have clear and measurable equalities objectives and targets and work plans in place.	1 Apr 2018 1 Sept 2018	30 Jun 2018 31 Mar 2019

• Review and refresh programme health equalities objectives as part of equalities strategy refresh.		
Workforce • Implement WRES, reporting internally, and ensure there is discussion with Trusts on their WRES performance. • Complete equality analysis of any new/refreshed HR policies.	1 Apr 2018 1 Apr 2018	31 Mar 2019 Ongoing/ as required
Leadership • Ensure inclusive recruitment procedures and processes. • Collect equality data on applications and appointments to governing body and senior management.	1 April 2018	31 March 2019
Reporting • Produce statutory compliance report(s) as required (annual).	31 Mar 2019	31 Mar 2019
Ongoing support to the development of Lambeth Together, integration with Lambeth Council and collaborative work across SEL CCGs.	1 April 2018	31 March 2019