Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors

14th March 2012

(BDA/)

Equalities objectives 2012/13

Status:	A Paper for Information
History:	Ongoing update – annual report

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Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors Meeting

14th March 2012

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Equalities objectives 2012/13

1.0 Aim

1.1 Guy's and St Thomas' NHS Foundation Trust serves nearly 1 million patients each year and employs more than 12,000 staff in one of the most diverse communities in the world. Our activity has the potential to significantly contribute to reducing inequity and inequality, for staff, patients and the public. In a place as diverse as South London, and with partners and stakeholders locally, regionally, nationally and internationally, it is important to set a range of equalities objectives that capture the diversity of experience, need and population group.

1.2 This document sets out the Trust's equalities objectives. The new Equality Act and subsequent revised Public Sector Equalities Duties places a requirement on all public bodies to set objectives that meet the general duties, whilst reducing inequality.

2.0 Background

2.1 The Trust provides a huge range of services. Some are specialist services, aimed at supporting specific populations groups (i.e women's services, older people's services, people with learning disabilities etc) with their own targets, standards and strategic objectives to improve the patient safety and experience. The equality objectives 2012/13 are not designed to capture every single initiative or activity that occurs across the Trust, but rather to focus on important and achievable outcomes across a range of services and across the overall business of the Trust.

2.2 The Trust's objectives will be set out under the umbrella of the Equality Delivery System objectives and outcomes. The Trust went through a consultative process to set objectives that were locally determined, to resonate with staff, patients and the public, whilst supporting the Trust core business.

2.3 The objectives are not isolated from the strategic objectives set at the Trust, as they they are included and support broader strategic priorities. The new Public Sector Equalities Duties explicitly states that an organisations equalities objectives must demonstrably inform an organisations core business.

2.4 It is important to note that the objectives are to be read in conjuncture with the Equality Act and the legal protected characteristics. The objectives are applicable to each protected characteristics. The Equality Act protects people from unfavourable treatment because of the following characteristics:

- ❑ Age
- ❑ Disability
- ❑ Gender re-assignment
- ❑ Marriage and civil partnership
- ❑ Race including national identity and ethnicity
- ❑ Religion or belief
- ❑ Sex (that is, is someone female or male)
- ❑ Sexual orientation

2.5 However, the Trust wants to go beyond compliance with legislation. We recognise that people are a set of multiple identities. Inequality and discrimination can affect very specific population groups that do not fit neatly into the legislative framework. This is when we have to also consider socioeconomic factors as determinants of inequality and inequity.

2.6 The objectives are not an exhaustive list of what the Trust will do to ensure equitable and fair access too services, or how the Trust will be a fair and inclusive employer. There is a range of activity that should be termed 'business as usual' and are core to what the Trust does each day. This includes examples such as making reasonable adjustments for patients or supporting staff to get back to work after a long term health conditions.

2.7 The objectives set out some of our most important initiatives for 2012/13. In addition to publicly setting out what our objectives are, we are also required to publish evidence demonstrating how we are achieving against these at the start of 2013/14. The objectives also provide a framework to begin discussions with our local interests, led by the LiNK, who will grade the Trust on how it is meeting its objectives, as required under the Equality Delivery System.

2.8 As noted earlier, the objectives have been developed after consultation with staff and local health organisations, both statutory and within the third sector. The objectives have also been informed by regional and national drivers, with particular reference to the new partnerships needed to reduce health inequalities and the renewed drive to improve care for vulnerable patients. after recent national reports by the Care Quality Commission highlighting the failure to meet the needs of people with learning disabilities and older people within parts of the Health and Social Sector.

Guy's and St Thomas' NHS
NHS Foundation Trust

Equality objectives 2012/13

- To work in partnership with local partners and stakeholders to help reduce health inequalities. Development of joint partnership arrangements with the local authorities, through Health and Wellbeing boards and other committees, to map and protect vulnerable people in the population.

- Continue to develop and improve our provision of accessible information and how we communicate with patients.

- Support vulnerable population groups to participate in public life, by widening access to employment and skills.

- Ensure we provide a positive patient experience for all patients regardless of their identity. Develop metrics through the year to track patient experience by protected characteristic.

- Demonstrate that the Trust is a fair and inclusive employer. This will include ensuring:

    - Equitable career progression for staff
    - Training and development is accessible
    - Ensuring that any approaches to talent management are fair and inclusive
    - The recommendations and actions from the statutory annual diversity monitoring report are published.

- Continue to support and protect vulnerable patients and those at significant socio-economic disadvantage.

- Improve how we monitor and report all complaints from patients and the public made because of a protected characteristic.

- Ensure that when there is a transformation project, an equality analysis is completed, with a revised and updated tool to better support the project management teams. This will include more information on health inequalities.

To work in partnership with local partners and stakeholders to help reduce health inequalities. Development of joint partnership arrangements with the local authorities, through the health and wellbeing board and other committees, to map and protect vulnerable people in the population.

The Trust has a number of local partners who are committed to and tasked with protecting vulnerable groups.

The local authorities will soon take responsibility for delivering public health interventions. Locally, councillors have begun to consider how they can do this strategically in partnership with health providers and third sector organisations.

The Trust will work in partnership with local authorities in mapping those groups who are most vulnerable, and in coordinating partnership events that resolve to work more collaboratively in meeting need, raising awareness, sharing knowledge and understanding amongst the workforce and setting actions that are jointly owned.

Through consulting and collaborating with our Local Involvement Networks (LiNK), public health professionals and consultants, local authority officers and councillors, and representatives from third sector organisations, there has been a recognition that better coordination and sharing of information would benefit to the local population and our patients.

Continue to develop and improve our provision of accessible information and how we communicate with patients.

In order to be able to provide safe patient care with a positive patient experience, it is imperative that the Trust continues to provide accessible information for patients, staff and carers. Respondents to the consultation most often made reference to the importance of good and effective communication.

There are a number of projects in the Trust that support achieving this objective, ranging from the use of photosymbols to communicate more effectively with people with a learning disability or do not speak English as a first language, to using SignTranslate to better communicate with deaf patients. However, there is always more that needs to be done, as our patient profile is one of the most diverse in the world.

Providing accessible information also means consideration of developing messages that resonate with particular population groups. For example, this might mean demonstrating more explicitly gay friendly information for a media campaign. There are also a range of local organisations who work with specific population groups, and can act as a provider of information to patients, on behalf of the Trust.

Support vulnerable population groups to participate in public life, by widening access to employment and skills.

The Trust has a proud history of widening access to employment and skills for those who are vulnerable, or have difficulty entering the jobs market. For example, working in partnership with the Princes Trust we make a contribution to tackling long term youth unemployment.

The Marmott Review makes clear that the social gradient of health is inextricably linked to socioeconomic status. This is particularly pertinent for our local area where there is significant socioeconomic inequality and variance. This shows itself with

pockets of severe poverty and unemployment that results in a range of social issues that are familiar to many Trust staff, ranging from drug addiction, obesity to poor mental health and high levels of smoking.

Any contribution a local employer can make to encourage work, reduce unemployment and widen access and routes to employment for groups who suffer from chronic disadvantage is also a direct contribution to improving the health of the local population.

In addition to projects supporting young people, the Trust has schemes to support people with autism and disabilities and those who have been long term unemployed. The Trust will expand that offer in 2012/13 and will publish outcomes of success.

To ensure we provide a positive patient experience for all patients regardless of their identity, we will develop metrics through the year to track and understand patient experience by protected characteristic.

To ensure that no group is being left behind, the Trust will develop a baseline and metrics to track patient experience for both inpatients and outpatient services across protected characteristics. Reporting will occur quarterly, and for the beginning of 2013/14, the Trust will have developed a set of metrics to drive improvement in experiences if there are significant differences between different population groups.

The Trust is particularly keen to develop a better understanding of the patient experience of groups were there is less reporting nationally and locally. The Trust is located in an area that has the highest lesbian, gay and bisexual populations in the UK, and is ideally placed to capture, monitor and analyse the experiences of gay patients in order to ensure we are delivering responsive services, and making sure every feels Safe in our Hands.

Demonstrate that the Trust is a fair and inclusive employer. This will include ensuring:

- **Equitable career progression for staff.**
- **Training and development is accessible to all**
- **Ensuring that any approaches to talent management are fair and inclusive**
- **The recommendations and actions from the statutory annual diversity monitoring report are published.**

There are a range of safeguards, policies and initiatives that protect employees, promote equality and inclusion, and support the achievement of this objective. However, to ensure the Trust meets its duty to be a fair and inclusive employer, it is important to demonstrably show what we will do to achieve this.

There is a wide range of training and professional development available to staff. It is important that the offer and its coverage is constantly interrogated and revised. The Trust will more regularly review the take up of training and development by protected characteristic.

Externally, there are a number of learning and development initiatives that are targeted at particular groups that are underrepresented in certain roles. It is important that the offer of external programmes and initiatives is regularly made available to all staff, and the Trust will want to see increased take up in those programmes and initiatives.

Continue to support and protect vulnerable patients and those at significant socio-economic disadvantage.

Supporting and safeguarding vulnerable groups is an important element of the Trust Quality Strategy 2012/13. Some groups are vulnerable due to the nature of their protected characteristic. The Trust will continue to demonstrate how we will meet those needs and drive improvements in management of their care.

The Trust provides services to patients who suffer from significant socioeconomic disadvantage. Through improved partnership working, there will be increased training, awareness raising and support offered to staff to better understand some of the complexity of need of different patient groups, and the services that are locally available.

Improve how we monitor and report all complaints from patients and the public made because of an individuals protected characteristic.

By understanding the nature of complaints, providers of services can continually drive improvements in service delivery. There is already a good understanding of the nature of complaints, and this supports the Trust to instigate reviews and adaptations and innovations that improve services. However, improving how we capture complaints by protected characteristic, and monitoring complaints made *because* of a protected characteristic, will support the Trust in monitoring trends, and help to put in reasonable and timely measures to mitigate against any unintentionally discriminatory practices.

In doing so, we will safeguard patients, and provide assurance to a very diverse patient population that we will learn from experiences that may affect a particular population group. The development of improved monitoring of complaints by protected characteristic is underpinned with the Trust's Safeguarding principles:

- **Empowerment –** I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens
- **Protection -** I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able
- **Prevention -** I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help
- **Proportionality** - I am confident that the responses to risk will take into account my preferred outcomes or best interests
- **Partnership** - I am confident that information will be appropriately shared in a way that takes into consideration its personal and sensitive nature. I am confident that the agencies will work together to find the most effective responses for my own situation.
- **Accountability** – I am clear about the roles and responsibilities of all those involved in the solution of the problem

Ensure that when there is a transformation project, an equality analysis is completed, with a revised and updated checklist to better support the project management teams. This will include more information on health inequalities.

The Trust is constantly seeking new ways to innovate and improve service delivery. Transforming services is an opportune moment to fully embed considerations of

equality and equity across a range of projects across the Trust. To be able to do that, a co-produced equality analysis assessment tool will be developed to support project management teams. This will also include relevant health equity information to support managers.

How will the Trust will demonstrate progress in meeting each objective at the end of 2012/13

The Trust will publish evidence and progress of how it has met each objective that will be publicly available towards the end of 2012/13. The Trust will also work alongside the LiNK or Local Healthwatch to help grade the Trust on how it is meeting the objectives set out above. The Trust has adopted the principles of the EDS, and has begun working with the LiNK to develop a relationship where they are better informed and supported to play the crucial role of the critical friend, as set out at the heart of the EDS.

The Trust is also committed to responding to the Southwark and Lambeth LiNK's on how the views of patients and their members informed the development of the equalities objectives in May 2012.

The objectives are also part of existing work programmes at the Trust where governance and assurance is the responsibility of different sub committees to the Board. Each sub committee regularly produces reports on progress against each workplan that are available to the public on the Trust internet page www.gstt.nhs.uk . The main sub committees of the Board relevant to tracking progress made against the objectives will be the Workforce committee and Quality committee.

Recommendation

The Board is asked to note the Trust's equalities objectives 2012/13.

A further paper outlining governance arrangements will be presented for discussion at a future Board meeting

Ann Macintyre
Director of Workforce and Organisational Development **7th March 2012**

Staynton Brown
Associate Director Equalities and Human Rights **7th March 2012**

Annex 1

The Equality Delivery System

The DH Equality and Diversity Council, chaired by Sir David Nicholson, has sponsored the development of the EDS, to achieve greater consistency, transparency and alignment across the NHS in reducing inequalities and promoting equality for the workforce and patient and the public.

The development of the EDS ran concurrently with the development of the new public sector equalities duties, ensuring that if organisations meet the EDS, by proxy they will be able to assure themselves that the legal duties are being met.

Who is the EDS designed for

The Equality Act protects people from unfavourable treatment because of the following characteristics (as enshrined in law)
:

- ❑ Age
- ❑ Disability
- ❑ Gender re-assignment
- ❑ Marriage and civil partnership
- ❑ Race including national identity and ethnicity
- ❑ Religion or belief
- ❑ Sex (that is, is someone female or male)
- ❑ Sexual orientation

However, the Trust recognises that promoting equality and reducing inequality must not be confined to only addressing the needs of each protected equality characteristic. The very nature of the workforce and the local population demand that the EDS and the setting of equality objectives must:

- Not assume that each single protected characteristic has a set of homogenous needs.
- Recognise that staff, patient and the public have a set of multiple identities that fluidly interact through the course of an individuals life.
- Pay due regard to the fact that some individuals suffer from compound and multiple disadvantage and are often in greatest need.
- Ensure the wider determinants of poor health are considered.

The implementation of the EDS and the development of Equality objectives will go beyond the Equalities duties, to provide a proper representation and reflection of the complexity of meeting diverse need.

Design

The EDS has been designed for the NHS by the patients and staff of NHS, and other interests, at over a range of national and regional engagement events. The EDS regional consultation events have engaged with over 2,000 people, who have contributed to the design of the EDS.

Scope

The EDS applies to both NHS Commissioners and NHS providers – both in the current NHS and the new NHS as set out in the White Paper and Health Bill. This means that the EDS will apply to PCTs until they are abolished, and to Clinical Commissioning Groups that emerge to take over the commissioning work of PCTs.

The EDS applies to NHS providers including Foundation Trusts, all of whom are registered to provide services by the CQC.

It may also be applied to all those healthcare organisations that are not a part of the NHS, but which may work to contracts issued by NHS commissioners.

System alignment

NHS Operating Framework 2011/12

The NHS Operating Framework for 2011/12 advises the NHS as follows : "NHS organisations will need to comply with the public sector duty of the Equality Act 2010, due to come into force in April 2011. The NHS Equality and Diversity Council is developing an Equality Delivery System to advise boards on how to maintain progress and demonstrate compliance with the Act".

NHS Outcomes Framework

The five domains of the Outcomes Framework are built into the EDS outcomes, and organisations should use the Outcomes Framework indicators, disaggregated by equality group wherever possible, as evidence of their performance. The five domains are reflected in the Trust Quality strategy, and areas follows:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

In the guidance issued to the NHS about the Outcomes Framework, the Department of Health advises that "In selecting outcomes and determining how they should be measured, active consideration has been given to how the indicators can be analysed by equalities and inequalities dimensions to support NHS action on reducing health inequalities. In addition to the legally protected characteristics, particular consideration has been given to socio-economic groups and area deprivation as these are key drivers of poor health outcomes." (DH, December 2010)

Quality, Innovation, Productivity and Prevention (QIPP)

The Trust is asked to improve the quality of care delivered while making efficiency savings that can be reinvested in services to deliver year on year quality improvements. In meeting the challenge, DH reminded all Trust's that "it is crucial that we do not lose momentum in improving the standard of care we deliver. We need to protect and promote quality while releasing savings everywhere. In doing so we will continue to ensure that NHS values are at the heart of what we do and we remain committed to tackling inequalities and promoting equality" (DH, 2010)

When analysing the Trusts performance using the EDS, the organisations four elements of QIPP will need to be analysed through an equality lens.

CQC Essential Standards

When evidencing performance for EDS purposes, the Trust will be able to use evidence provided to the CQC to demonstrate compliance with registration requirements. This specifically related to the "Essential standards for quality and safety" (March 2010). (This CQC guidance tells providers how they can achieve compliance with the Section 20 regulations of the Health and Social Care Act 2008.)

How it works

Analysis of performance

At the heart of the EDS is a set of nationally agreed Objectives and Outcomes. The Objectives are common for both NHS commissioners and NHS providers. They are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive Leadership at all levels

Within each Objective are a set of outcomes. There are 12 outcomes in total across the four Objectives.

The Trust will analyse performance against the Trust's objectives, using the EDS objectives and outcomes as a framework for assessment.

For the purposes of the EDS, local interests comprise and but are not restricted to :

- Patients and those local groups that represent them
- Communities and the public in general
- NHS staff and Staff-Side (that is, unions such as Unison)
- Voluntary and community organisations

CQC Essential Standards

When making any analysis and judgements the Trust will need to take account of the relevant outcomes cited in CQC's "Essential standards of quality and safety", and the evidence provided to CQC to demonstrate compliance with registration regulations.

Assessment under the EDS

The EDS is not a self-assessment. As a result of the analysis, the Trust, in partnership with our local interests and stakeholders, an assessment will be made on how the Trust has performed against the Trust's objectives, using the EDS objectives and outcomes as a framework for assessment of performance against the Trust's equalities objectives.

First and foremost the assessment will be designed to reflect the delivery of outcomes, with particular regard to the QIPP challenge, for protected groups and meeting the Equality Act duty. This approach means that :

- The better the delivery of outcomes, supported by evidence, the better the grade.
- The more that quality, innovation and prevention and cost-effectiveness can be proven in the delivery of these outcomes, the better the grade.
- The more, for example, the NHS fosters good relations between groups and communities, and can produce supporting evidence, the better the grade.

The assessment will reflect the extent to which, for protected groups :

- Good outcomes are delivered
- The QIPP challenge is met
- The Equality Act duty is met, including the fostering of good relations
- The NHS Constitution is delivered
- Effective use is made of JSNAs and other evidence
- Local interests are empowered, supported and actually take part.

EQUALITY DELIVERY SYSTEM - OBJECTIVES AND OUTCOMES

Objectives Menu	Narrative : the NHS is asked to …	Outcomes
1. Better health outcomes for all	Achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services and care pathways are commissioned or decommissioned, designed or re-designed, procured, provided and contractually monitored so that they meet the needs of patients, carers and local communities
		1.2 Public health outcomes are measurable, substantive and are developed through evidence-based strategies, developed with the involvement of patients, carers and local communities
		1.3 Patient safety outcomes are demonstrating measurable increases across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities
2. Improved patient access and experience	Improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities are effectively accessing services, taking into account barriers that historically hinder equality of access
		2.2 Patients, carers and communities are provided with appropriate communications support and information about services, so that they can make informed choices and be assured of diagnoses and treatments tailored to their needs
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected, and the services they receive are safe, effective and personalised to their specific needs
3. Empowered, engaged and well-supported staff	Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 A workforce that is diverse within all occupations and grade levels through fair and flexible recruitment, development, and retention practices
		3.2 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
		3.3 The workforce is confident, competent and feels empowered to deliver appropriate and, accessible services, and improved patient experience for all communities
		3.4 The workplace is free from actual and potential discrimination -from recruitment to retirement - and all staff are able to fully realise their potential
4. Inclusive leadership at all levels	Ensure that throughout the organisation, equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Corporate leadership demonstrates the commitment and knowledge to assure equality outcomes within the organisation and the local health economy
		4.2 The organisation develops and supports equality leaders and champions within the workforce to the standards of capability defined by the NHS Competency Framework for Equality and Diversity Leadership

Principles that informed the consultation

Finding evidence to set equality objectives could have been done by only analysing health inequalities data and studies. There are existing health inequalities and inequities faced by groups within the local population that are easily identifiable and well documented. Local health inequalities, as set out in appendix below provide a useful benchmark to inform. However, to develop meaningful and outcome orientated objectives the Trust captured the practical and real concerns of staff, patient and the public.

Across the Trust there are a significant number of drivers to sustain and make improvements in quality to both patient care and for our staff. The development of equality objectives should support the achievement of existing Trust priorities and will be directly aligned too the Trust Quality Strategy and NHS Outcome Framework. The principles will underpin the Trust's Quality Strategy are:

Principle 1

> *We will be the UK leader in reducing avoidable patient death or harm, and rank 'no.1' for in-patient experience across London**

Principle 2

> *We will demonstrate explicit board leadership, drive and commitment to patient safety and patient experience, placing it as the number one priority for patients and staff within GSTT.*

Principle 3

> *We recognise the enormous benefits of community integration, and will ensure our safety and experience systems follow the patient's journey at all times.*

Principle 4

> *We will ensure every member of staff is aware of their individual role and valuable contribution in achieving our quality objectives, aligning where possible to our Values Based Behaviours.*

Principle 5

> *Care will be consistent and delivered with dignity and compassion, respecting the diverse and complex needs of many across our local community.*

There are a number of sub-groups and forums within the Trust that indirectly contributed to the consultation through providing expertise and highlighting challenges and opportunities presented to the organisation.

The consultation paid due regard to the Trust's responsibilities to promote equality as an employer and how to ensure there is inclusive leadership at every level in the organisation.

The consultation and engagement exercise recognised the importance of engagement with patients and the local community as a means to innovate and seek improvement. This gave the backdrop for the LiNK event, where patients, public health professional, local councillors and leads from a range a third sector

organisations, shared their views and experiences that helped to inform the Trust's equality objectives 2012/13.

The Trust has a diverse and large workforce with huge reserves of knowledge, experience and understanding. The engagement and consultation tapped into the knowledge and experience of the workforce. Many of the answers to drive improvements and reduce inequalities are found by engaging with staff.

Annex 2

Equality and equity Health profiles and demographics in Lambeth/Southwark

Demography

Lambeth

Lambeth is an inner London borough comprising 21 wards located in six town centres, North Lambeth, Stockwell, Clapham, Brixton, Streatham and Norwood. The Office for National Statistics (ONS) estimates the resident population in Lambeth in 2007 at 273,249 (mid-year estimates) compared to the Greater London Authority (GLA) estimates of 286,893 for 2008. The General Practice registered population in March 2009 was 352,762. This significant difference in population predictions needs to be taken into account when analysing health inequalities.

Lambeth is one of the most densely populated boroughs in the country with a rapidly growing population. The GLA estimates the resident population in Lambeth will increase by over 15% to 327,000 by 2030. Southwark Southwark's population is expected to continue to grow over the next two decades. The Office for National Statistics (ONS) projects that by 2029 Southwark's population will be 294,200, a 12 percent increase, some 1,300 people per year.

The Greater London Authority (GLA) PLP (Post London Plan) predicts much greater growth with a Southwark 2029 population in the range 360,200 – 373,400. The PLP predicted growth (between 35% and 39%) is some three times the ONS estimate and represents an average annual increase of around 4,000 people.

In 2006, there were 269,000 Southwark residents, just over half of whom male (50.7%). Figure 2.2 compares the age and sex distribution of Southwark's population with that of England and Wales.

Age
Southwark has a young population with four in five people aged under 50 years against two thirds in the national population. Southwark has proportionately higher numbers under the age of ten and aged 20 to 50.

Lambeth's population is a young population, with 45% in the age group 20 - 39 years compared with 36% in London for the same age group.

Ethnicity
A third of patients registered with a GP in Lambeth are White British and one quarter is from black ethnic minority groups. Over half of the registered patients speak English and the next most common languages spoken are Portuguese (3 - 5%), Spanish and French.

Southwark has a diverse, multi-ethnic population with just over half of the population (52.2%) describing themselves as White British – a much lower percentage than is found in London or England and Wales. Consequentially, compared to England & Wales (2.3%) and London (10.9%), a higher percentage of Southwark's population is Black (25.9%) The largest minority ethnic groups in Southwark are Black African (16.1%) and Black- Caribbean (8%). The Asian population in Southwark is comparable to that of England & Wales, a third of the all-London average.

Migration and population movements

Migration movements in Lambeth both international and inter-regional are at the centre of demographic changes. Between 2005 - 07 both inflow and outflow from London have risen. The overall population turnover in Lambeth represents 27% of the local population.

Short term migrants defined as “migrants coming to Lambeth for a duration of 1 month to 12 months” were estimated at 17,770 for 2007 representing 7% of the Lambeth population (lower than the average of 9% for Inner London).
Southwark

From International Passenger Surveys, ONS estimated a net international migration gain in Southwark of 5,200 between 2005 and 2006. This figure included 110 migrants to the Republic of Ireland, an additional 120 asylum seekers and an additional 690 visitor switchers (short-term visitors, extending their stay beyond 12 months).

There are other sources of data. ONS hold data of GP patient registrations at postcode level. Between 2005 and 2006, 9,900 people previously living outside the UK registered with a Southwark GP (called „Flag 4" records held by NHAIS). Department for Work and Pensions (DWP) records show that in 2006 and 2007, 9,700 non-UK nationals living in Southwark registered for a National Insurance number.

Social and Economic profile of Lambeth

Southwark In the most recent IMD (2007, using 2005 data) Southwark borough ranked 26 against 354 local authority districts within England, and ranked 9 within London"s 33 boroughs. Four years earlier Southwark was ranked 17 nationally; and 6 within London. Therefore on this measure, on London and national rankings, Southwark is showing an improvement. IMD values for LSOAs show that Walworth, Camberwell Green, Peckham, Rotherhithe, South Bermondsey, Livesey, and The Lane and Nunhead wards are within the most deprived ten percent in England. They are located in East Southwark. In 2007 on average, full time working men in Southwark earned £576 per week, less than the London average (£596), by contrast women in Southwark earned £27 more than the London average of £506. Southwark’s employment rate is below that of England, in 2005/06 two-thirds of Southwark’s working age population were employed compared to around three quarters for England. In May 2007, just over 32,000 Southwark working-age residents claimed one or more Department for Work and Pensions (DWP) benefits. Incapacity Benefits made up the largest proportion of this total, followed by Lone Parents and Jobseekers Allowance (JSA). As a proportion of the resident working age population, 16.9 percent of the Southwark working age population claimed one or more benefits, several percent above the average rates for London and Great Britain. Lambeth

The employment rate in Lambeth has remained lower than London and England for the past 3 years reaching 69.4% in early 2009 compared to 70.5% for London and 74.5% for the rest of England. Lambeth has the lowest level of employment amongst the London boroughs.

Despite the relatively high level of skills available in the borough, there are also high proportions of economically inactive people living here, and among those adults seeking jobs, 21% have no qualifications.

Lambeth records 25% of users of community mental health services in employment from 2006-07 data, compared to the London value of 14.6% and an England average of 20%.

Unemployment is becoming more common as measured by the Job Seekers Allowance (JSA) claimant count. There were 9901 claimants in March 2009 compared to 7,216 a year before.

The proportion of resident working age people who claim Job Seekers Allowance is higher in Lambeth than in London or Great Britain (5% compared to 4%).

Unemployment affects mainly those with low or no qualifications.

Fifteen percent of working age people received out of work benefits in 2008. This figure includes the main out-of-work client group categories: unemployed people on Jobseekers Allowance, Lone Parents on Income Support, Incapacity Benefits customers, and others on income-related benefits.

One in twenty Lambeth residents lives in fuel poverty spending over 10% of their income to maintain a warm home (Source: State of the Borough).

Almost 2 in 10 Lambeth adults depend on benefits.

One in 3 children in Lambeth lives in a family on key benefits compared to 24% in London.

More children live „in care" in Lambeth than across the capital and the rest of the country (110 per 10,000 children under 18 were Looked After, compared to 70 in London and 55 in England).

Almost 4 in 10 secondary school pupils are eligible for free school meals, the fifth highest proportion in England.

Educational Attainment

Lambeth

Lambeth GCSE results have been improving steadily and between 1996 and 2006, the gap between Lambeth students and those in England gaining 5 or more A - C grades reduced from a 20 percentage point lag to just percentage points behind the national average score.

The achievement gap between pupils eligible for free school meals and their peers at GCSE level was 12% in 2007. The achievement gap at Key Stage between children who are eligible for free school meals and those who are not, is less than is recorded across London and England

Southwark

In 2005/06 at least 30% of pupils in all Southwark schools achieved five or more GCSE grades A*–C in 2005/06, a higher rate than England. However, there is still some way to go to improve grades at Key Stage 3 to reach targets in English, Maths and Science.

Compared to the rest of Great Britain more Southwark residents have higher qualifications (36.5%). There are more people in the borough with no qualifications – a third more than both the London and Great Britain average.

Infant Mortality

A national review of infant mortality (DoH 2007) showed that rates tended to be higher in Local authority areas with the worst health and deprivation indicators (e.g. Spearhead local authorities) babies of mothers born outside the UK (e.g. Pakistan, Africa or the Caribbean) babies of mothers aged under 20 years (60% higher than the rate for mothers aged (20 to 39) Both Lambeth and Southwark demographic profiles reflect these characteristics.

Premature Mortality from CVD and the Risk Factors
Lambeth

In Lambeth in 2007 there were 453 deaths caused by CVD. Over half of these deaths were in men (51.6%). Overall 4 in 10 CVD deaths occur in under 75 years old (37.2%).

Death from all circulatory diseases in under 75 years old population is more likely in Lambeth than in England, even after adjusting for difference in age structure.

It is also more common in women than men, while it is the same for men and women in England.

Southwark

The mortality rate for CVD is higher than the national average and rates are particularly high in some parts of Southwark

One in ten of adults in Southwark have diagnosed hypertension

Only half of the expected patients are diagnosed

Prevalence is highest in Peckham and Camberwell PBC group, which has the highest proportion of black ethnic groups and highest deprivation.

The age adjusted prevalence for CHD is low, indicating under detection of the condition.

Some of the individual level factors which affect the risk of premature deaths from CVD cannot be changed: increasing age, male sex, heredity including race. Risk factors relating to equality and equity

Tobacco consumption - smokers are 2 - 4 time more at risk of CVD than non smokers - and high level of alcohol consumption.

- High cholesterol.
- High blood pressure.
- Physical inactivity.
- Overweight or obesity.
- Diabetes mellitus – especially if poorly controlled.

These factors are themselves influenced by the place the person has in society, her/his socioeconomic status and access to primary care services. Ethnic minority populations may not be aware or understand the way services work in the NHS.

Premature Mortality from Cancer
Lambeth

In Lambeth there were 126.12 (2005 - 07) per 100,000 persons under 75 years old dying from cancer in 2005 - 07.

Overall there has been a 20% reduction in deaths from cancer in Lambeth (2005 - 07), with deaths for males reduced by 19% and for females by 20%.
Southwark

Incidence and mortality for lung cancer are significantly higher for Southwark compared with London and England

Mortality for prostate cancer is lower than London or England

Southwark has a higher incidence of cervical cancer compared with Lambeth and Lewisham. However when compared to other cancers the numbers are small – an average of 13 new cases per year. Risk factors relating to equality and equity

- Tobacco.
- Alcohol.
- Poor diet, lack of physical activity, or being overweight.
- Increasing age.
- Lack of cancer awareness.

Mental Illnesses

While mental illness is not a main cause of excess premature deaths in Lambeth, people with mental health problems are at high risk of CVD, diabetes and other physical health problems. Therefore, premature death in people with mental health problems is very likely.

GP records suggest about 4,000 people with severe mental illness (schizophrenia and bipolar disorder - SMI) are known to primary care in Lambeth. National research suggests about 0.5% adults may have SMI. Across the country this would vary widely. However, the figure from Lambeth GPs is about three times the national average.

National estimates suggest about 15.1% of adults over 15 years have symptoms of Common Mental Disorder at any one time. In Lambeth this equates to between 30, 000 to 53,000 people aged 16 – 74 years and at least another 1000 cases over 75 years at anyone time . About half of this group would benefit from some form of treatment such as talking therapy.

In Lambeth, similar to the national picture, deaths from suicide and possible self-inflicted injury have gradually decreased over the last 10 years. During 2004 - 2008 an average of 23 deaths a year were attributed to these causes in Lambeth (8.65/100,000 population; similar to the London average of 8.3/100,000). This is down from 33 deaths a year in 1995 - 97. Southwark

mild mental disorders affect approximately one in six adults in the population, accounting for one in four consultations with GPs

<ore 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. Risk factors relating to equality and equity:

- Low income households.
- Socioeconomic deprivation, including long term unemployment.
- Gender and ethnicity depending on the type of mental health problems. For example in women all CMDs (except phobias) are more common amongst the Asian group.

Disability

18 percent of all adults nationwide have a physical or sensory disability and three percent have a severe disability. Locomotor disability is the most common. 23,600 people of working age are disabled in Southwark, almost 20,000 in terms of the Disability Discrimination Act There is a strong association between disability and poverty; only 30 percent of disabled
people are estimated to be employed. There is evidence that benefits designed to help people cope with their disabilities are under claimed.

The majority of people appear to manage their condition independently with the help of health care services and benefits. Council, health and social care services need to actively support this independence and shift towards more preventive strategies.

HIV

HIV continues to be a major public health problem. In 2007 the estimated UK number of people living with HIV was 77,400, with over a quarter (28%) being unaware of their infection. London accounts for half of diagnosed HIV infections (HPA 2008). Lambeth is by far the worst affected borough in the UK accounting for 9.7% of the London and 4.3% the UK caseload.
Risk factors include**:**

- Sexual behaviour (unprotected sexual intercourse, multiple, sexual partnerships) and concurrent sexually transmitted infections.
- Disadvantaged and marginalized population groups.
- Intravenous drug use.

Black African heterosexuals account for the second most affected group in Lambeth. Twelve percent of Lambeth's population is estimated to be of Black African ethnicity. Black African heterosexuals are particularly affected by poor health outcomes associated with late diagnosis; 40% of new diagnoses continue to be diagnosed late over recent years. While HIV infections among MSM are largely acquired within the UK, the majority of infections in heterosexuals are thought to be acquired abroad, largely in Sub-Saharan Africa.

Smoking

Nationally, one fifth of all UK deaths (112,000 per year) are caused by smoking: Lambeth and Southwark

Smoking in pregnancy is a major modifiable risk factor of low birth weight. Based on data collected from the local acute trusts, 5.7% (2007 / 2008) of pregnant women report to be a smoker at the time of delivery.

People with mental health problems are also more likely to smoke than the general population. The rate of smoking in people with schizophrenia is two to three times that in the general population (high number in Lambeth and Southwark*).*

There are large differences between ethnic groups and between men and women in different ethnic groups (even after adjusting for age structures).

The proportion of the smoking population declines with age both because people give up and because smokers die younger.