Merton Clinical Commissioning Group

Draft Equality and Diversity Strategy

2012 – 2016

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1. Introduction

Merton CCG has a clear commitment to providing equal access to the information and services we commission, as well as, working to ensure that these services are accessible and responsive to the diverse needs of all the people of Merton.

The purpose of this strategy is to establish a framework to strengthen and advance compliance with The Equality Act 2010 including the public sector equality duties and Human Rights Act 1998 in commissioning health services and employment practices. The strategy will help us to embed inclusion in all our activities:

- We recognise that people can experience inequalities, discrimination, harassment and other barriers to participation and access to health services as a result of different aspects of their identity or equality status such as race, disability, gender, age, sexuality, religion and belief.

- We believe that patients should be at the centre of our decision-making and we will work in partnership with individuals, patient representative groups, families, carers and stakeholders to deliver high quality, accessible services that tackle inequalities and respond to personal needs.

- We will strive to create and maintain an environment where dignity, tolerance and mutual respect is experienced by all and where patients, staff and members feel able to challenge discrimination and unacceptable behaviour

2. Context

Merton CCG is in transition until 1st April 2013 when, subject to authorisation, it takes full legal responsibility. In the transition to authorisation the CCG is required to demonstrate how it will meet the legal requirement of compliance with the Equality Act 2010 and the associated Public Sector Equality Duty (PSED).

From April 2013, as a statutory organisation we will be required to deliver our legislative responsibilities as a public body, an employer, and a commissioner of services. This Strategy is intended to ensure that the CCG is fully aware of and understands its equality and diversity duties and that it operates within the law

3. Our Vision

Merton Clinical Commissioning Group will put patients, their carers and families first and foremost in decision making; empower people to know about their rights; and increase the ability and accountability of individuals and institutions that are responsible for respecting, protecting and fulfilling those rights.

Our vision is to improve health outcomes for the population of Merton by commissioning services tailored to the needs of individual patients whilst addressing the diverse health needs of our population

Human rights based approach is at the heart of the NHS Constitution and brings together in one place what staff, patients and the public can expect from the National Health Service. It also sets out the rights of patient with regard to how they access health services, the quality of care they receive, the treatments and programmes available to them, how they can be treated in a confidential way, and who they can complain to if things go wrong.

The legal requirements and statutory responsibilities require Merton CCG to eliminate discrimination and promote equality in partnership with local communities, other statutory and voluntary sector partners.

Merton CCG has adopted the overarching objectives of:

- Delivering quality and equality through commissioning and service delivery;
- Ensuring equality of opportunity for its staff and potential staff;
- Developing strong and consistent leadership where equality and human rights is every ones business.

4. Our equality goals

In delivering our vision, we aspire to become a leader for equality and diversity achieving the highest standards, leading on innovative approaches to equality and diversity. We intend not just to implement national standards and legislation but to demonstrate best practice and be recognised as an employer of choice.

Our goals:

- To commission services that are designed to be accessible to all sections of the population and equal in outcome regardless of: race, disability, sex (male/female), age, religion or belief, sexual orientation and gender reassignment, marriage and civil partnership and pregnancy and maternity
- To develop services in partnership with patients, carers and the public that meet the needs of Merton's diverse population
- To work with health services providers, partners and stakeholders to ensure that their services are fully accessible to all individuals and that inequalities in health outcomes are minimized
- To ensure that the promotion of equality becomes a mainstream activity and is visible in its core business and day to day activities
- To ensure there is clear and visible commitment and leadership at Board level
- To support the development of an appropriately trained and motivated workforce, working from a healthy and safe environment

Our equality objectives

Merton CCG is committed to promoting equality and diversity through our objectives:

- Ensure that MCCG Board members and staff receive training on the Equality legislation and its application and are encouraged to attend specific awareness training on individual equality groups as and when available
- Ensure that all staff involved in developing and commissioning services are trained to complete an Equality Analysis and ensure that this is embedded into the local commissioning process
- Develop HR, recruitment and employment policies in line with the Equality Act 2010

Ensure that all commissioned and contracted services deliver better outcomes for the population of Merton as a whole and those with protected characteristics.

- Involve service users at the start of commissioning, design and procurement of services, ensuring that the commissioned services meet the health needs and promote wellbeing and reduce health inequalities
- Complete Equality Analysis for new service developments, and any significant change to a service, and continue to engage and involve members of the public in decisions on service changes
- Ensure information and data arising from the Joint Strategic Needs Assessment is used in a systematic way to commission services effectively and equitably across the population of Merton. See Appendix 4 - JSNA extract – Merton Demographics and inequalities.

To identify gaps in uptake of services in priority health areas and for equality and diversity monitoring to ensure health needs are integrated into the planning of local services

- Establish baseline E&D data of the service user population for each strand
- Monitor and report changes in population demographics and service user profile
- Monitor take up of health services across the equality strands, identify gaps and recommend appropriate action and outcomes

To complete Equality Analysis (EA) on all business plans and projects and incorporating findings into contracts with providers.

- Create a generic pro forma and process that will be used in the initial stages of the new organisation.
- Use EA as a tool to minimize and eliminate any negative impact and maximise positive impacts and opportunities to promote equality

To develop aware, empowered, engaged and included staff

- Ensure the recruitment and selection process is fair and equitable for all job applicants
- Staff are supported to carry out their roles, receiving training and personal development to ensure they are competent to do so
- Staff to completed appraisals and personal development plans, with yearly reviews taking place
- Implement a training and development programme to develop equality and diversity awareness and cultural competency for staff
- Promote a culture of ‘zero tolerance’ to abuse, harassment, bullying and violence

The E&D Strategy sets out the direction of travel for MCCG and a draft action plan is attached as Appendix 5, which sets out lead responsibilities and timescales for the objectives.

5. The Equality Act 2010

As a publicly-funded body, we are required to ensure that diversity, equality and human rights are embedded in all our functions and activities as per the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution. In performing our functions, we will:

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

Merton CCG is fully aware that the legislative framework protects individuals from unfair treatment and promotes a fair and more equal society.

The Equality Act 2010 came into force on 1st October 2010 and replaces the previous range of anti-discrimination legislation with a single act that simplifies the law, removes inconsistencies and makes it easier to understand. It also strengthens the law to help tackle discrimination and inequality, increases the definitions of those protected characteristics covered by the legislation, and expands the Public Sector Duty placed on public bodies.

The new duty covers the following nine protected characteristics:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race (ethnic or national origin, colour, nationality)
- Religion or belief (including lack of belief)
- Sex
- Sexual orientation
- Marriage and civil partnership

The new Public Sector Equality Duty came into force on April 6th 2011. The Equality Duty aims to embed equality considerations into the day to day work of all public bodies, and those carrying out public functions, so that they tackle discrimination and inequality. Its aim is to ensure that public bodies play their part in promoting a fair and more equal society.

The duty requires public bodies to engage with the diverse communities affected by their activities and decisions to ensure that policies and services are appropriate and accessible to all and meet different people's needs.

The duty consists of a general duty and specific duties – the specific duties are designed to enable public bodies to meet the general duty.

The legal requirements and statutory responsibilities require Merton CCG to eliminate discrimination and promote equality in partnership with local communities, other statutory and voluntary sector partners.

6. Reducing inequalities

Health outcomes for people in Merton are generally better than those in London and largely in line with or above the rest of England. However, there are stark differences between different areas within the borough. In all wards but one (West Barnes) men experience a shorter than average life expectancy than women but there is a stark difference between some of the most deprived communities in the east of the borough compared to the communities in the west.

There are a wide number of factors that influence and determine good health, so there is no single definitive measure to tell us if we or our communities are healthy. However, birth weight, infant mortality and life expectancy are good indicators of long term health and are often used as measures of comparative health and therefore of the inequalities between different communities. The links between deprivation and health inequalities are strong, with the most deprived areas broadly correlating to the areas with lowest life expectancy. These areas also tend to have a higher prevalence of smoking, obesity, unhealthy eating and risky drinking behaviour. The schools with a higher proportion of children eligible for free school meals are located in the most deprived electoral wards.

Overall, life expectancy at birth in Merton is higher than the England average, but there is a difference of about 9 years for men and about 11 years for women between the most and least deprived areas within the borough. In Merton life expectancy has increased by 5 years for men and 3 years for women (from 1994-96 to 2007-09) compared to an average across London of 4.7 years for men and 3.4 years for women. Estimates suggest life expectancy will continue to increase.

Low birth weight is an important predictor of future health; a child with a low birth weight is more likely to die early or have poorer life outcomes than a child with an average birth weight. In Merton there are generally fewer babies who are born with a low birth weight and relatively low levels of infant mortality, but again this masks inequalities within the borough with the more deprived areas having higher numbers of babies born with low birth weight and higher levels of infant mortality.

Ethnicity is also a key factor for infant mortality and low birth weight, Pakistani and Caribbean groups have particularly high infant mortality rates, 7.9 and 8.4 deaths per 1,000 live births respectively. This is double the rate of babies born in the White British group which is 4.2 deaths per 1,000 live births (ONS, 2009). This is of particular significance in Merton, where some wards in the east of the borough have ethnic minority populations exceeding 30% of the ward population.

For a detailed breakdown of inequalities, see Appendix 4 – Demographics and Inequalities in Merton

Key Commissioning Implications for Services to Help Reduce Inequalities

There are clear inequalities in terms of life expectancy for both gender and according to where people live.

Differences in the populations within Merton mean differences in need and delivery of services. With limited resources a much more targeted approach will be required. Merton will need a greater focus on services for younger people and ethnic diversity.

Existing inequalities need to be addressed through ongoing service improvement and development to target existing needs more effectively. As Commissioners, we need to work with providers to ensure more robust data is captured on the population accessing services and better use of this data needs to be made in planning and commissioning services with

other agencies. A robust programme of Equality Impact Assessments and Health Equity Audits would support understanding this need.

The MCCG and other Commissioners need to look at commissioning more targeted services to reduce future need. These services should be aimed at reducing risk factors such as smoking, obesity and risky drinking behaviour. Reducing smoking and exposure to tobacco will have a great single impact on inequalities in infant mortality and life expectancy. However, although deprived populations are more at risk of poor health and well-being, ill-health exists within all social groups and across the whole community regardless of deprivation. Therefore efforts need to be spread **proportionally by need** across all social groups and not just targeted to a single social group or geographical area. Therefore, partnerships need to focus on approaches to support people of all ages across all communities making healthy life choices. For instance, supporting or enabling people to stop smoking, maintain a healthy weight and reduce risky drinking behaviour is more likely to be achieved through working with partners including local businesses to improve access to affordable healthy food, improve uptake of physical activity and reduce availability of cut price alcohol. Services aimed at prevention of the major killers (circulatory diseases and cancer) to the over 50's will have the greatest short-term impact.

Although levels of infant mortality and low birth weight remain below the regional average, the inequality that exists within Merton require commissioners to focus on key interventions to reduce infant mortality and low birth weight. These include:

- Improving the quality and accessibility of antenatal care and support during the first year of life, particularly in disadvantaged areas
- Reducing smoking in pregnancy
- Improving nutrition in pregnancy and infancy, including improving further the number of mothers who breastfeed
- Preventing teenage pregnancy where possible and supporting teenage parents to remain in education or in employment
- Improving housing conditions, especially for children in disadvantaged areas
- Making services culturally sensitive to meet the needs of ethnic minority women and families

7. Roles and responsibilities

Board Members

All Board members have a collective and individual responsibility to ensure MCCG compliance with the public sector equality duty, which will in turn secure the delivery of successful equality outcomes for us, both as a commissioner and an employer.

The Board will provide strategic leadership to the equality and diversity agenda, which is in part achieved by establishing and embedding this Equality and Diversity Strategy, and also by:

- Agreeing the organization's equality objectives for improving its equality performance and monitoring effectiveness
- Ensuring that equality is included in Board discussions and decisions
- Leading by example by actively championing the equality and diversity agenda and attending staff forums and meetings of patient and community groups

A Lay Member is being appointed to the CCG's Board to lead on patient and public involvement. The Lay Member has oversight responsibility for ensuring that the voice of the local population is heard in all aspects of the CCG's business, and that equal opportunities are created and protected for patient and public involvement and engagement.

Chief Officer

The Director of Quality has responsibility for ensuring that the necessary resources are available to progress the equality and diversity agenda within the organisation and for ensuring that the requirements of equality legislation and the equality framework are consistently implemented and monitored.

The **Chief Operating Officer** has operational responsibility for:

- Developing and monitoring the implementation of robust working practices that ensure that equality and diversity requirements form an integral part of the commissioning cycle
- Working with the CCG's Commissioning Support Service to ensure that equality and diversity considerations are embedded within their working practices
- Ensuring that provider equality performance is assessed as part of routine contract monitoring arrangements
- Ensuring that the Board, staff and member practices remain up to date with the latest thinking around diversity management and have access to appropriate resources, advice, and informal and formal training opportunities

Line Managers

All line managers have responsibility for:

- Ensuring MCCG compliance with the Equality Act 2010, public sector equality duty and Human Rights Act
- Making staff and teams aware of equality and diversity: expectations, frameworks, principles, toolkits, policies, standards and competencies

- Creating a culture and working environment where dignity, tolerance and mutual respect is experienced by all and where patients, staff and members feel able to challenge discrimination and unacceptable behaviour
- Ensuring that employees have equal access to relevant and appropriate promotion and training opportunities.
- Highlighting any staff training needs arising from the requirements of this framework and associated policies and procedures.

Staff

All staff have responsibility for:

- Being inclusive and treating everyone with dignity and respect and must not discriminate or encourage others to discriminate
- Ensuring health services are accessible to all sections of the population and equal in outcome regardless of: race, disability, sex (male/female), age, religion or belief, sexual orientation and gender
- Maintaining an environment where dignity, tolerance and mutual respect is experienced by all and where patients, staff and members feel able to challenge discrimination and unacceptable behaviour

8. The Equality Delivery System (EDS)

The EDS provides a helpful framework for engagement and inclusion with patients, staff and the public when considering the impact of decision making and to provide a better working environment. Merton CCG has an excellent track record of leading the equality and diversity agenda by engaging practices and local communities as part of the Health Diversity initiative contributing significant evidence to the EDS grading of NHS Sutton and Merton (Appendix 1).

Using the EDS as a partnership approach to managing and monitoring equality compliance under the legislation and embedded positive actions into mainstream business, Merton CCG will continue to review and benchmark its equality performance in order to identify future priorities, actions and demonstrate positive outcomes across all areas of equality, diversity and human rights.

The Governance arrangements include local and national reporting and accountability mechanisms that monitor delivery of the objectives. Merton CCG leadership will continue to drive this agenda, linking patient engagement with commissioning plans, taking into account national issues and local requirements.

Progress of actions and commitment to the Equality and Diversity agenda will be led through the CCG's corporate governance arrangements, Sub-committees of the CCG governing body with scrutiny provided by the Accountable Officers of the National Commissioning Board. The CCG will identify an executive lead to ensure it has the capacity and capability to function effectively in their role. The NHS Equality and Diversity Competency Framework (Appendix 2) sets out clearly the competencies required for the relevant posts.

At the heart of the EDS is a set of 18 outcomes grouped into four goals (Appendix 3):

The four overarching goals are:

Goal 1	Better health outcomes for all.
Goal 2	Improved patient access and experience.
Goal 3	Empowered, engaged and included staff.
Goal 4	Inclusive leadership at all levels.

These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that CCG performance will be analysed and graded annually.

During the transition year 2012/13 and up to the point when Merton CCG is a statutory organisation, Merton CCG will base its E&D objectives and action plans on those set out by NHS Sutton and Merton and SW London Cluster. However, Merton CCG will publish its own Equality and Diversity action plan on annual basis from April 2013.

Merton CCG will continue to monitor performance using the same scorecard for 2012/13 as set out by SW London in the table below. From April 2013, Merton CCG will be in a position, as a fully authorised public body, to set out its own Equality and Diversity priorities and action plan. The current action plan (set out in Appendix 4) has been drafted to ensure that Merton CCG as a new statutory organisation will meet its legal and statutory responsibilities from 2013 against a four-point rag rated scale as a mechanism to assess progress.

Excelling	**PURPLE**	**For all (9) protected groups**
Achieving	**GREEN**	**For most (6-8) protected groups**
Developing	**AMBER**	**For some (3-5) protected groups**
Undeveloped	**RED**	**No evidence at all or few (0) of the protected groups**

EDS Grading for 2012/13

During 2012, NHS Sutton and Merton undertook the EDS grading analysis of the 18 outcomes for each protected group, based on comprehensive engagement, using reliable evidence in collaboration with emerging CCG leaders. This showed much existing good work including significant evidence from the Health Diversity Initiative in Merton and also identified gaps from which the grades and objectives for 2012-13 have been derived. It reflected where Merton CCG's commitment to equality and diversity in reducing inequalities in health and health care for people in Merton.

The EDS process provided grades against the EDS goals and outcomes and two objectives to be achieved during 2012-13.

Equality Objectives - for the period April 2012 to March 2013

	Outcome	**Agreed grade with stakeholders**
Goal 1 Better health outcomes for all	1.1Services are commissioned, designed and procured to meet the health needs of local communities, promote wellbeing, and reduce health inequalities	Developing
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways	Developing
	1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly	Underdeveloped
	1.4 The safety of patients is prioritized and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	Developing
	1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	Achieving

	Outcome	**Agreed grade with stakeholders**
Goal 2 Improved patient access and experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds	Achieving
	2.2 Patients are informed and supported to be as involved as they wish to be in their diagnosis and decisions about their care, and to exercise choice about treatments and places of treatment	Developing

	2.2 Patients are informed and supported to be as involved as they wish to be in their diagnosis and decisions about their care, and to exercise choice about treatments and places of treatment	Developing
	2.3 Patients and carers report positive experiences of their treatments ace care outcomes and of being listened to and respected and of how their privacy and dignity is prioritized	Developing
	2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently.	Developing

EDS Objectives for 2012-13

The following objectives have been developed to ensure NHS Sutton and Merton (a two borough team) and have a clear set of equalities priorities. These objectives have been developed in partnership with stakeholders.

Objective 1: Develop data collection and analysis systems to capture information across protected groups, to improve monitoring of public health and commissioning activity to ensure equitable access to healthcare.

Objective 2: Ensure that information arising from the Joint Strategic Needs Assessment is used in a systematic way to commission services effectively and equitably across the population of Sutton and Merton.

NHS Sutton and Merton's grading based on the overall two boroughs will be separated into individual grading for Merton CCG and an action plan will be disaggregated following this process by March 2013.

Reviewing and Monitoring

Merton CCG will review this document annually during 2012-2016 to ensure that it will support:

- the implementation of the EDS Objectives
- the structures for the collection of EDS and PSED evidence
- the development of the required engagement structures
- Equality compliance for Merton CCG

The review will aim to evidence Merton CCG's progress, benchmark its achievements; identify gaps and implement remedial actions.

8.Equality Analysis

We are committed to promoting good health and reducing health inequalities for our population regardless of age, ethnic origin, gender, ability, religion or faith, or sexual orientation. To turn this vision into a reality, we are determined to promote equality of access and identify and eliminate any discrimination in what we do.

An equality analysis is a review of a policy, function or service which establishes whether there is a negative effect or impact on particular social groups. In turn this enables MCCG to demonstrate it does not discriminate and, where possible, it promotes equality.

MCCG will develop a check list that will help clinical and non-clinical staff and members think carefully about the likely impact of their work on equality groups and take action to improve services and projects for local people where it has a positive or negative impact.

An Equality Analysis (EA), formerly called Equality Impact Assessment, is a systematic method of assessing the effects of core functions, policies and activities on people depending on their race, disability, age, gender, faith or belief, or sexuality. EAs allow the CCG to avoid exclusion or marginalisation of groups or individuals. Assessing for equality in this way is a legislative requirement. The CCG will task its Equality Lead to develop an EA template and guidance for 2013.

By carrying out EAs, the CCG aims to ensure that all our policies and procedures take into account the diverse needs of the service, population and workforce, and that no one is placed at a disadvantage.

Appendix1- Health Diversity outline

Merton and Sutton Health Diversity Initiative 2009-2013

The motivation to progress the Health Diversity Initiative in 2009 in Merton was based on outcomes of an analysis of A&E activity across 12 practices within Merton Healthcare PBC group in 2008/2009. It highlighted the need to improve communication and meet the education needs of new migrant population whose first language is not English. GP practices identified some patient groups who used emergency services inappropriately during weekday and opening hours of GP practices locally.

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The Health Diversity work streams in Merton were funded by Government Office London for the period September 2009 to March 2012. It then combined with the initial project with NHS Sutton and Merton Public Health Bi-Lingual Health Advocacy to become the Health Diversity Initiative, serving patients and communities across Merton up to March 2012.

In March 2012, NHS Sutton and Merton Public Health funded and expanded the Initiative for Hard to Reach and Migrant Communities across Merton and Sutton for a period of twelve months, including increasing uptake of early year's immunisation and cancer screening.

The Initiative aims to:

1. Strengthen and champion the health of hard to reach and migrant communities within their community.
2. Tackle major killers smoking, obesity and heart disease using dynamic health interventions in collaboration with Merton and Sutton GP Practices, NHS SW London Public Health Teams, Merton and Sutton Local Authorities, charities and patient groups.
3. Support younger migrants who are less likely to register with a GP and to develop initiatives to address this.
4. All of the work to date and in progress is guided by Merton and Sutton data i.e. areas of socio-economic deprivation for "hard to reach and migrant communities". NHS Public Health support the interventions from locality based population analysis, the Joint Strategic Needs Assessment is critical in guiding the work as well as GP based reviewing A&E attendances and patient flows.

Work is supported by a wide range of stakeholders across Merton and Sutton including NHS South West London and London Ambulance Services, Merton GP Clinical Commissioning Group and Sutton CCG, Sutton and Merton Local Authorities and a diverse group of NHS clinicians, local charities and patient groups.

The Initiative is managed by Merton CCG on behalf of NHS SW London; the team comprises of an experienced health project manager with a team of three Bi-lingual Health Advocates (Tamil, Polish and Urdu/Gujarati/Hindi) working with patients, communities and organisations to enhance wellbeing, health education and NHS signposting. The service is supported by 0.4wte administrator. The team is based at James O Riordan GP Practice in Sutton.

Our guiding principles are to:

- *Know our community – understand the hard to reach and migrant communities wellbeing needs in Merton and Sutton.*
- *Promote wellbeing in a community centred way at grass roots using dynamic interventions.*
- *Register new patients in new ways gathering meaningful ethnicity data to inform service development and delivery*
- *Empower and educate patients to use pharmacy, GP and A&E better*

- *Respond to new drivers for the health community e.g. immunisation and cancer prevention targets*

The team manage provide and facilitate innovative NHS signposting and education for hard to reach communities across Merton and Sutton.

The focus on the major killers and closing the health inequalities gap remains the focus of Health Diversity Initiative with commitment from NHS Sutton and Merton, Clinical Commissioning groups and Merton and Sutton Local Authorities.

Interventions to date include the following:

- Bi-Lingual Advocacy services in Tamil, Polish, Urdu, Gujarati and Hindi within GP Practices and NHS clinics

- Facilitating Help Yourself to Health workshops across wide range of communities; the dynamic 6 week. Programme covers self care strategies, NHS signposting, and first aid in the home, accessing pharmacy services, nutritional advice as well as falls, smoking, immunisation and screening as appropriate to the target audience.

  Help Yourself to Health 6 week programme 2012

  This programme was designed to meet the needs of patients whose first language is not English, in particular Polish, Tamil and Urdu patients the largest ethnic group within Merton and Sutton localities. The programme has shown participants use the emergency services more effectively and widen

  - Dynamic 6 week Health program – Increasing awareness about health, managing illness and using NHS Health Services effectively
  - Focus on hard to reach migrant communities in Merton and Sutton 2012
  - Multi-Disciplinary team supporting program i.e. Health Coach, Paramedics, Pharmacists, Midwives and other champion speakers nutritionists and falls specialists
  - Programs to date have been facilitated in Hindu temples, schools, libraries, children centres, mosques, homeless and community centres
  - Participants become mentors in their communities to multiply the learning
  - Nutrition and self care session covers smoking and alcohol
  - Other key health messages include immunisation and screening streamlined for each group

  Participant's feedback

  - *" thank you for helping me to become more aware of my families health needs, the program has given me a new lease of life" Tamil participant at Wilson Hospital*
  - *"I now know how to stay fit and well and have no excuses anymore and can help family more with first aid and understanding NHS services" Urdu participant on "Programme Morden".*
  - *"I know now how I do not need to go to GP with my children's minor ailments , I can see and have used pharmacy a lot more in recent weeks" Polish Participant on "Programme Mitcham".*

- Stop smoking clinics in patients own languages in GP Practices, Community Centres and Library
- Weight management clinics in GP Practices, Community Centres, community colleges and libraries
- Resources for education and health promotion within the heart of communities targeting diabetes, smoking related diseases, heart disease, obesity and stroke in family centred locations that are dynamic and engaging.

- Programmes are managed in a diverse range of settings including libraries, mosques, temples, community centres, children centres, community colleges and libraries.
- Interface with other NHS Public Health projects i.e. Live Well to optimise on interventions
- Outreach work with Merton Homeless in collaboration with Faith in Action for an increasing population base: signposting with GP registration and accessing appropriate services and flu clinics.

Patient feedback 2011-2012

> • *"The Tamil Bi-lingual Advocacy lead has helped my family to get fitter, healthier and talking to each other. The diet sessions on the Help Yourself to Health program have given me a renewed confidence to try different things and I have managed to stop smoking too". Tamil Patient Central Medical*
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> • *"The help that my family have received from the Bi-lingual Advocacy service has been brilliant, our son has very complex needs, we were not able to understand how the UK system works, and Agnieszka has helped with a GP home visit and at the GP practice. We now know how to use services, understand the drugs and have become more confident parents". Parent requiring GP and school support*
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> • *"The Polish advocacy service has enabled me to register with a GP and to access treatment, I have been in the UK for 6 years now living on the street, but only now do I understand how services work". Polish Homeless patient from Faith in Action.*

Goals 2012 – 2013

- Project outcomes have enabled a new Health Diversity framework to be developed for hard to reach and migrant communities in Merton and Sutton to meet the Equality and Diversity Scheme standards.
- High user satisfaction from participants, patients and all stakeholders
- Work streams meet Equality and Diversity Scheme standards for CCGs
- Project team now expanded to Sutton and Merton health communities
- Collaborative frameworks developed with key and critical partners
- A&E data being closely reviewed reduction in episodes in the areas where the team have worked
- New patient registrations across practices now include ethnicity data
- Project managed within the financial framework and new funding for 2012- 2013 has enabled work progress across Merton and Sutton.

More Information

The Health Diversity and Bi-Lingual Advocacy team are based at James O Riordan GP Practice in Sutton. Contact the Project Manager Annie Ford on 0208 254 8390 or email annie.ford@smcs.nhs.uk

Appendix 2

The link for Competency Framework for Equality and Diversity Is

http://help.northwest.nhs.uk/storage/library/Competency_Framework_final.pdf

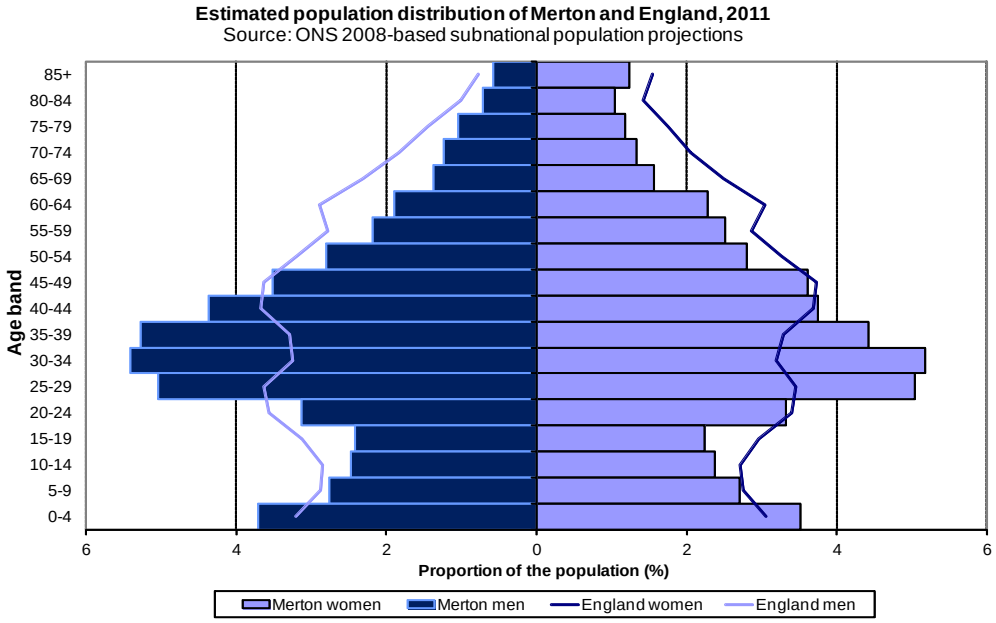
Appendix 3 - EDS Goals and Outcome

Outcome	Goal	Narrative
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results.	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways 1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly 1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should 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 can readily access services, and should not be denied access on unreasonable grounds 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well-supported staff	The NHS should 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 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) 3.6 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
4. Inclusive leadership at all levels	NHS organisations should ensure that 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 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination 4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes

Appendix 4 – Merton demographics and inequalities

1. Our Population: Demographics

Population: The 2011resident population of Merton is 211,000. The population profile is younger than England overall, and more in line with London. The population in Merton is increasing and it is predicted that by 2021 it will have increased by about 11%. The number of births increased by 39% between 2002 and 2010. As well as the increase in population size, the age profile is rising and by 2021 the number of over 65 year olds is predicted to increase by 15.3%.



Figure

1: Population of Merton by Gender

Births: The map below (Figure 2) shows the variation in birth numbers for each ward. High numbers of births are important when they occur in the localities where deprivation is greatest (Figure 3). Services need to ensure that those children and families most in need (i.e. the most deprived who are more likely to have poorer health) are being targeted effectively.

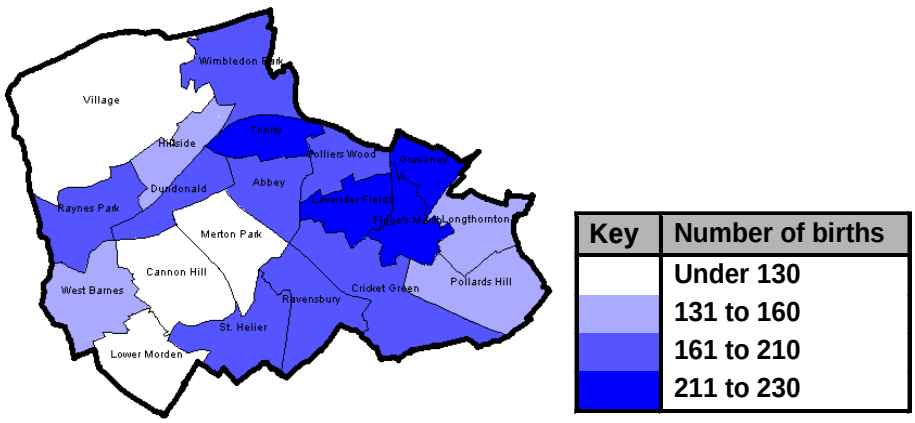


Figure 2: Live births by ward, 2009
Source: ONS Annual District Birth File, 2009

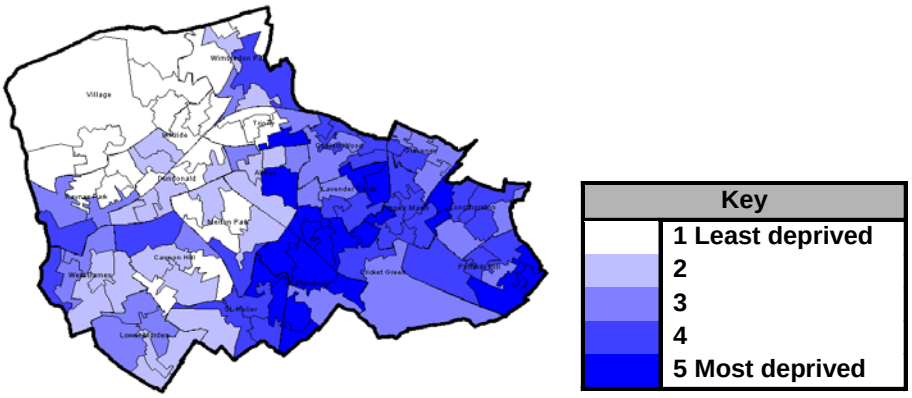
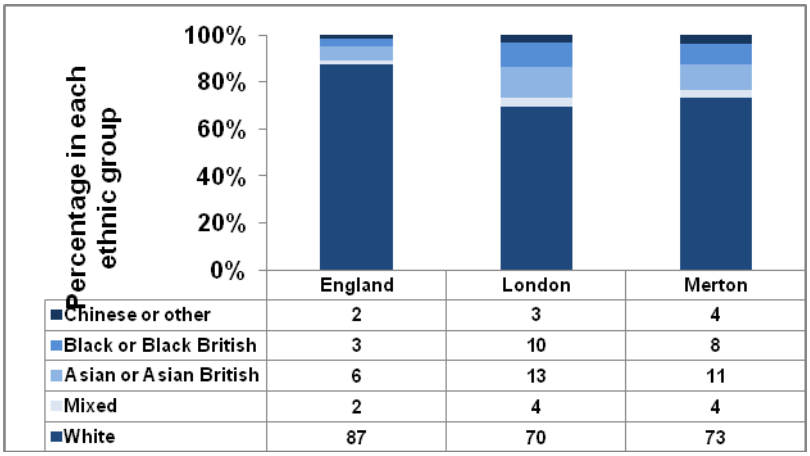


Figure 3: Income Deprivation Affecting Children Index 2010
Lower Super Output Areas (SOAs) by National Rank Quintiles. Source: http://www.communities.gov.uk/

Ethnicity: In addition to Merton's increasing and ageing population its local communities are becoming more diverse and multicultural. It is important to understand the different needs of all communities so that when care is needed, people can access the right service at the right time and improve the outcomes of care received. Merton is ethnically diverse with a profile reflective of London. The extent of diversity has increased markedly over the last ten years with emerging new Polish and Tamil communities in the borough (based on junior school census data).

Resident population by ethnic group, mid-2009 Source: ONS 2011, Table EE1



	England	London	Merton
Chinese or other	2	3	4
Black or Black British	3	10	8
Asian or Asian British	6	13	11
Mixed	2	4	4
White	87	70	73

Figure 4: Population of Merton by Ethnic Group

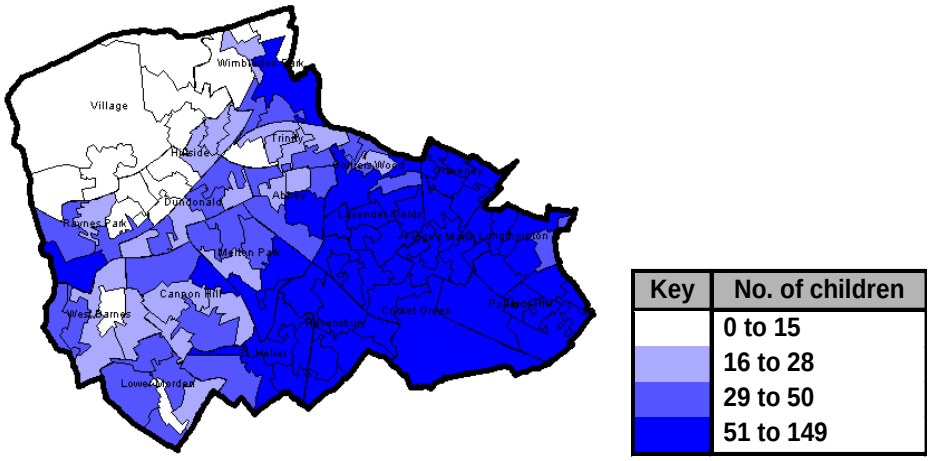


Figure 5: Number of primary school age children whose first language is *not* recorded as English by LSOA, Merton
Source: School Census 2011

2. Inequalities in Merton

Life Expectancy: Life expectancy at birth is a well-recognised measure of comparative health. It is an estimate of how long a child born today might expect to live if current age and gender specific death rates applied throughout their life.

Merton health outcomes are among the best in London, and largely in line with, or above, the England average. Based on figures for 2007-09, life expectancy in Merton for men is 80.5 years (compared with 78.3 for the national figure) and for women is 83.8 (compared with 82.3 nationally). However, there are stark differences between electoral wards (Figures 6 and 7). For instance, while life expectancy at birth across Merton is higher than the England average, there is a difference of nearly 9 years for men and 11 years for women between small areas (ward level) within the borough overall.

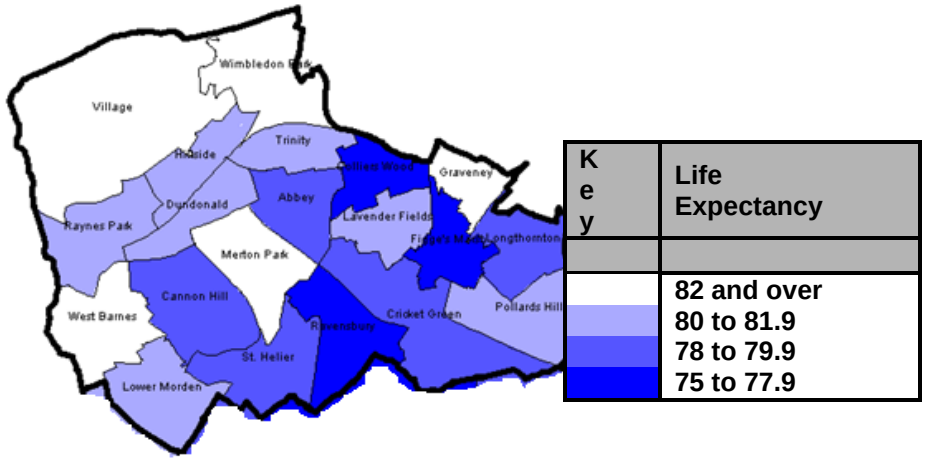


Figure 6: Male Life Expectancy at birth by electoral ward, Merton

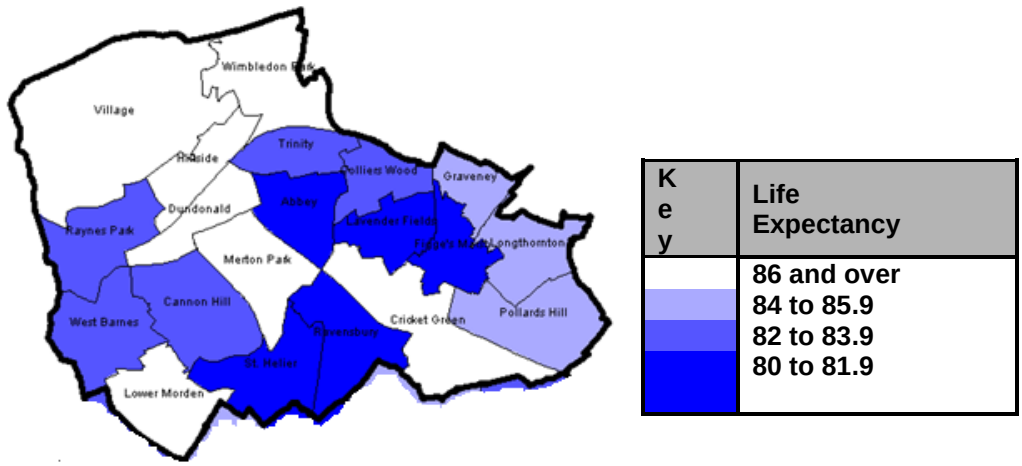


Figure 7: Female Life Expectancy at Birth by Electoral Ward, Merton. Source: London Health Programmes HNA Toolkit – ward based data 2005-09

Deprivation: is commonly measured using the Index of Multiple Deprivation 2010 (IMD 2010) which combines a number of indicators that cover a range of economic, social and housing measures into a single deprivation score for each small area in England.

In Merton, at borough level the rank for IMD 2010 is 208 out of 326 boroughs (where 1 is the most deprived and 326 the least deprived). Since the previous IMD 2007, overall a greater number of small areas in Merton became relatively *less* deprived than those that became more relatively deprived. In terms of overall deprivation, Merton has no LSOAs

in the 10% most deprived areas in England, while there are 16 LSOAs in the least deprived 10%. The electoral ward with LSOAs in the most deprived quintile is Figge's Marsh. The most marked positive changes are two LSOAs in Cricket Green.

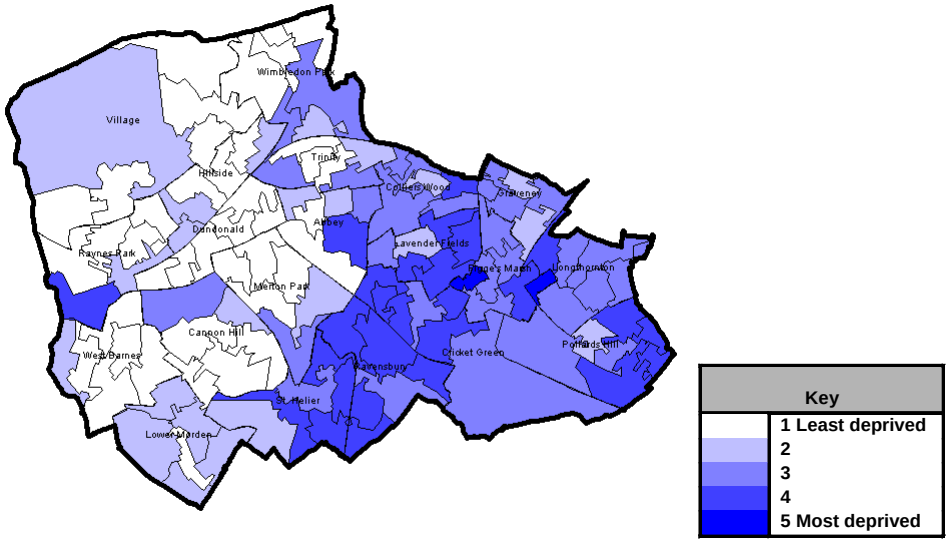


Figure 8: Indices of Multiple Deprivation 2010 Overall
Lower Super Output Areas (SOAs) by National Rank Quintiles. Source: IMD 2010

Premature Mortality: Deaths in people aged under 75 years are often taken as a proxy measure for avoidable mortality. In other words many of the deaths that occur in this age group are potentially preventable. Overall, there were fewer deaths in the under 75 year age group between 2004 and 2009 in Merton which has contributed to the increase in life expectancy.
Cancer is still the biggest cause of death in this age group, but numbers have reduced comparing 2004 and 2009, as have deaths caused by circulatory disease. There has conversely been a slight increase in deaths caused by respiratory conditions which needs further investigation to identify if this is within or outside of a reasonable variation.

Smoking, being overweight, and harmful levels of alcohol consumption are the key preventable causes of cancer, circulatory and respiratory disease. Therefore a focus on lifestyle choices that contribute to avoidable harm should continue to be high priority for local commissioners of health and social care services.

Main causes of deaths in Merton in people aged under 75
Source: ONS Mortality Files 2004, 2009

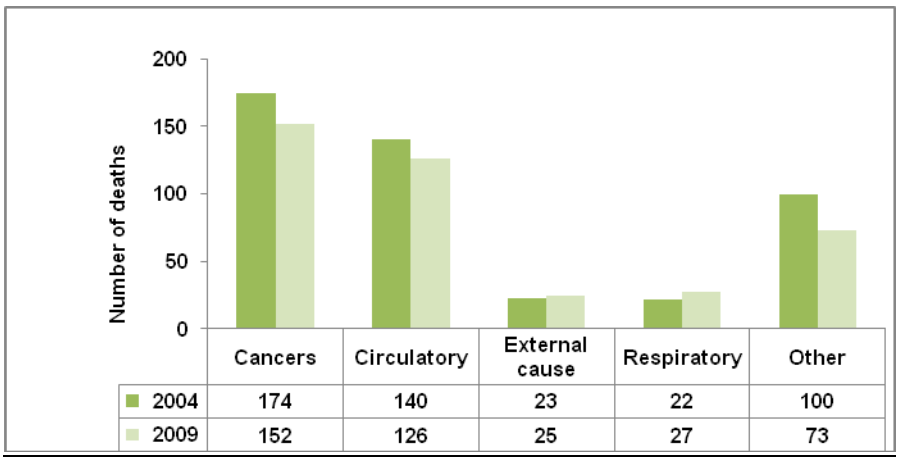


Figure 9: Cause of Mortality in People Aged under 75 in Merton

Infant Mortality: There is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation's health as well as a predictor of health inequalities.

For the three years 2007 to 2009 Merton ranked 8th lowest out of the 32 boroughs of London and had a significantly lower rate of infant mortality than both London and England. While the Infant Mortality Rate has shown quite large variation, likely to reflect the small numbers, the overall reduction in IMR over the last two decades has been in line with the regional trend.

3. Our Lifestyles

Lifestyle choices can have a very significant impact on future health and wellbeing. Circulatory Disease (including Stroke) and Cancer are still the major killers in Merton and consequently these diseases along with Diabetes are among the main causes of long term illness and disability. Key risk factors are smoking, obesity and risky drinking behavior and therefore many of the resulting illnesses and conditions are potentially preventable.

Smoking: Adults who smoke lose an average of 13-14 years of their lives, and more than 100 people die each year from smoking related causes in Merton. Although Merton has lower than average levels of smoking overall (estimated prevalence 16%), some areas within the borough have significantly higher rates than regional and national averages (up to 24%), suggesting in future there are likely to be increased numbers of people with potentially avoidable circulatory disease and cancer. This is supported by a slower decrease in mortality for circulatory disease compared with national trends.

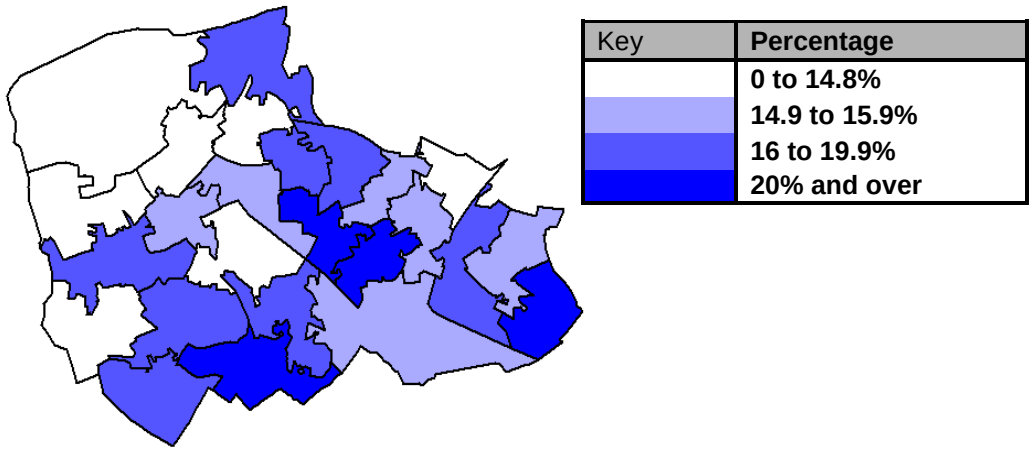


Figure 10: Smoking rates Across MSOAs in Merton, 2006-08. Source: APHO, Estimates of Adults' Health and Lifestyles, Percentage of the adult population who are current smokers, 2006-08, by MSOA

Obesity: The cause of obesity is complex having behavioural, genetic, environmental and social components. As such it is a key health inequality issue. In Merton 19.4% of 4/5 year olds are overweight or obese (lower than England average), by age 10/11, 35.8% are overweight or obese (higher than England average). Just over 19% of 10/11 year olds are obese and just over 19% of adults are estimated to be obese, but for adults this ranges from 10.6% to 28.4% by area - associated with deprivation. Obesity costs the NHS in Merton about £50m per year.

Figure 11: Estimated Proportion of the adult population who are obese. Source: APHO by MSOA. **©Crown copyright 2012. All rights reserved. ©1994-2012 ACTIVE Solutions Europe Ltd.**

Eating a healthy, balanced diet is key to maintaining good health. In general people in Merton eat more healthily compared to the rest of England, but this masks significant variation between the east and west of the borough.

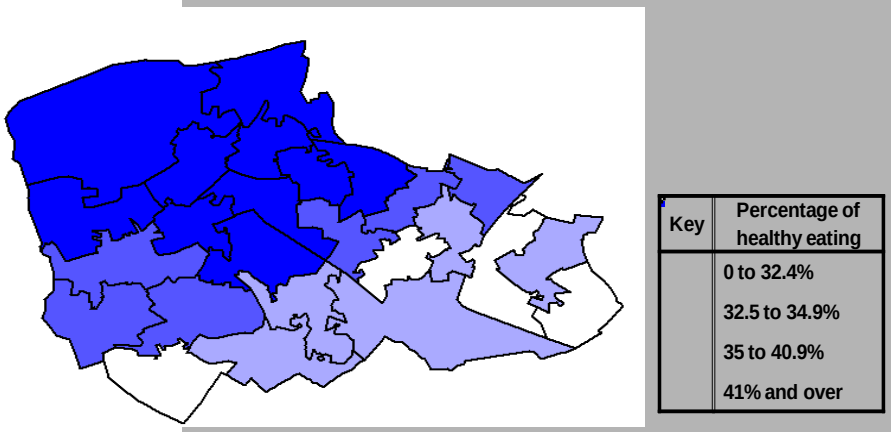


Figure 12: Estimated Proportion of Healthy Eating (Adults) Source: APHO by MSOA **©Crown copyright 2012. All rights reserved. ©1994-2012 ACTIVE Solutions Europe Ltd.**

Physical Activity: In Merton the levels of activity and fitness in adults are lower than regional and national averages (physical inactivity and being overweight increases the risks of diabetes, cardiovascular disease and cancer). Only 10.1% of residents take part in enough physical activity to benefit their health (30 minutes on at least 5 days a week), and 44.3% of residents reported that they had not taken part in any physical activity in the past 4 weeks. However, 58% of children take part in three hours of physical activity or sport per week.

Alcohol: The picture of risky drinking behaviour in Merton is complex. Information from modelled estimates on binge drinking does not suggest a link with deprivation in Merton. However, this may reflect more on how the estimates have been modelled and does not reflect the pattern of health services use which suggests that higher risk drinking is more widespread, occurring in both deprived and affluent areas, and also that high level of risky drinking are also occurring at home.

In Merton the estimated prevalence of binge drinking is estimated at 10.7%, compared to 14.3% in London and 20.1% nationally. However, for small geographic areas within the borough, at middle super output area level, the range is 7% to 20%. The estimated levels of drinking at 'increasing risk' are higher than London or England levels. Merton has lower rates of alcohol related hospital admissions compared to the London and national rates. However, this has increased over the last 5 years although the rate of increase in Merton is in line with that of London and national increases.

Sexual Health - Teenage Conceptions: Overall in Merton, the under 18 conception rate is below that of London but in line with national rates. However, this masks significant variation across the Borough with the rates of some wards in line with inner London. The electoral wards with the highest under 18 conception rates (aggregated data for 2006-08) are Longthornton, Pollards Hill and Ravensbury. As ward conception numbers are relatively small (even when aggregated for three years) rates may vary markedly from year to year and should be interpreted with some caution.

Substance Misuse: It is estimated that in 2011in Merton 4,914 people aged 18-64 are dependent on drugs and of these approximately two-thirds are male. By 2020 it is predicted that the number of people dependent on drugs will increase by 9%. This includes all drug users and is based on a national prevalence rate of 3.4%, which includes 2.5% dependence on cannabis (source: PANSI 2011).

In Merton there was an estimated 1,007 opiates or crack cocaine users (OCUs) in 2008/09. Of these just over 38% (n=378) were injecting drug users. The estimates regarding the number of opiate and/or crack cocaine users and all drug users over 18 have been adjusted in the past 12 months with the numbers falling slightly. However, of those starting treatment the proportion of those in effective treatment is over 80% and there is a high planned exit rate from treatment which shows successful completions. The percentage of OCUs that are in effective treatment is 38%.

Childhood Immunisations: Child immunisation statistics published by the NHS Information Centre indicate that by their second birthday the percentage of children immunised against Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) is 91.8%, compared to 96% nationally and 92.9% for London. In addition the percentage of children in this age group immunised against MMR is 81.6%, compared to 89.1% nationally and 83.8% for London. Therefore, the percentage of childhood immunisations achieved is lower for Merton than for regional and national comparators. Although these published figures are for Sutton and Merton combined, local practice level data shows that there is little difference between the immunisation percentages in Merton from those in Sutton.

4. Our Main causes of Death and Poor Health

The burden of disease and measures of prevention: The burden of disease in Merton concerns cancer, circulatory disease, diabetes, and respiratory disease across the borough and between genders. The relevant lifestyle factors in terms of prevention are smoking, risky alcohol consumption and obesity. In addition, further health needs indicated in the JSNA for Merton indicate high rates of fractured neck of femur in Merton, Excess Winter Deaths in Merton, and the potential for more people to have the opportunity to die in their own home (End of Life Care).

Cancer: Cancer is one of the biggest killers nationally and second only to circulatory disease as a cause of death in Merton for the under 75 age group. In terms of incidence for all cancers, Merton rates are in line with regional and national averages. Based on GP registers, the prevalence of cancer in Merton is 1.4%; that is about 1 in 71 people have had a cancer compared to 1.6% nationally, which is 1 in 63 people.

Some cancers can be cured if detected early enough, therefore high achievement in screening programmes is vitally important to be able to detect the early presence of cancer and treat appropriately. Screening rates for Merton are broadly in line with levels in other South West London PCTs but lower than national levels.

In Merton, currently levels of screening services such as cervical screening are lower than national levels. This is potentially reflected in mortality figures since although variation in terms of mortality for Merton is greater than regional and national averages, due to small numbers, the rate of decline is flatter than regional and national trends.

Circulatory Disease - Coronary Heart Disease: The term Coronary Heart Disease (CHD) is generally considered to be narrower than circulatory disease as it does not include people who have had a stroke or who have peripheral vascular disease, but still CHD accounts for the majority of circulatory diseases.

CHD is the single most common cause of premature death in the UK and the single largest cause of mortality in those over 65 years in Merton. It is also the leading cause of emergency admissions in the over 50s. In terms of mortality, comparing causes of death suggests there has been a significant proportionate reduction in death due to circulatory disease. Nevertheless, it remains the single leading cause of death in the older age groups and data indicates that for the under 75 age group overall in the most recent time period the rate of reduction is slowing. Higher levels of CHD are associated with areas of deprivation. In Merton the wards with a mortality rate higher than the England average tend to be areas that are relatively more deprived locally.

Circulatory Disease, Stroke: Stroke mortality rates for females under 75 years in Merton show an overall decline in line with London and national figures. However, mortality rates for males under 75 years have been more variable.

The main risk factors for stroke are smoking, obesity, poor diet (including high salt intake), hypertension, diabetes and high alcohol intake. People who are over 65 years of age are most at risk, but one in four strokes affect those aged under 65, including children. People of African-Caribbean descent are at higher risk due to a genetic predisposition to the risk factors. Approximately 25% of people who recover from a stroke will have another episode within five years, most occurring in the 30 days following the first stroke. Recurrent strokes are a major contributor to stroke disability and death. The risk of severe functional restrictions or death increases with each recurrence.

Respiratory Disease: There are more than 40 conditions which affect the lungs and/or airways and impact on a person's ability to breathe. They include lung cancer, tuberculosis, asthma, Chronic Obstructive Pulmonary Disease (COPD), and cystic fibrosis. It has been estimated that one person in every seven in the UK is affected by lung disease.

In Merton, overall, figures available for Sutton & Merton PCT indicate that there is a prevalence of 1.2% for COPD compared to 1% in London and 1.6% nationally, and 5.2% prevalence for asthma compared to 4.7% in London and 5.9% nationally. Mortality from pneumonia and COPD combined was the third major cause of death in under 75 year olds. Given that the biggest risk factor for COPD is smoking and that many pneumonias could be prevented by vaccination it is likely some of this mortality is avoidable. From 2004 to 2009 there was an increase in deaths in people under 75 years caused by respiratory disease and pneumonia in Merton. In terms of emergency hospital admissions, respiratory related conditions (excluding cancer) for all age groups accounted for 10% of all emergency admissions in 2010/11. The biggest impact is on the 0-10 years and over 60 year olds.

Diabetes: Based on GP registers, prevalence of diabetes (type 1 and type 2, but only adults) in Merton is 5.1% compared to 5.5% nationally. Comparing modelled expected prevalence to registered prevalence suggests that a proportion of the population is likely to have diabetes but remain undiagnosed with many people not accessing the services that could improve management and prevent future illness. The key risk factor for diabetes is obesity, caused by poor diet and physical inactivity. However, diabetes is also more common in certain ethnic and social groups who have a genetic predisposition to the condition, and among people with severe mental health conditions. Moreover, the complications of diabetes, such as heart disease, stroke and kidney disease, are more common among people in lower socio-economic groups, further exacerbating health inequalities.

Falls: The ageing process can increase fragility, making older people less physically stable and increasing the risk of falling. The consequences of falling can be minor, but with increased frailty and osteoporosis the consequences can be significant resulting in, for example, a fractured neck of femur (thigh bone). Recovering from such a fracture can take time, increasing dependence on health and social care services. Experiencing a fracture

can represent a turning point for older people threatening their independence and reducing their quality of life.

Fractures resulting from falls are also a major cause of mortality and disability among older people. Falls are generally multi-factorial, with osteoporosis as a major risk factor for fracture. The level of fractured neck of femur is often used as a proxy for the level of falls and can indicate the need for preventive measures. The level of mortality from fractured neck of femur in Merton is disproportionately high compared to South West London neighbours.

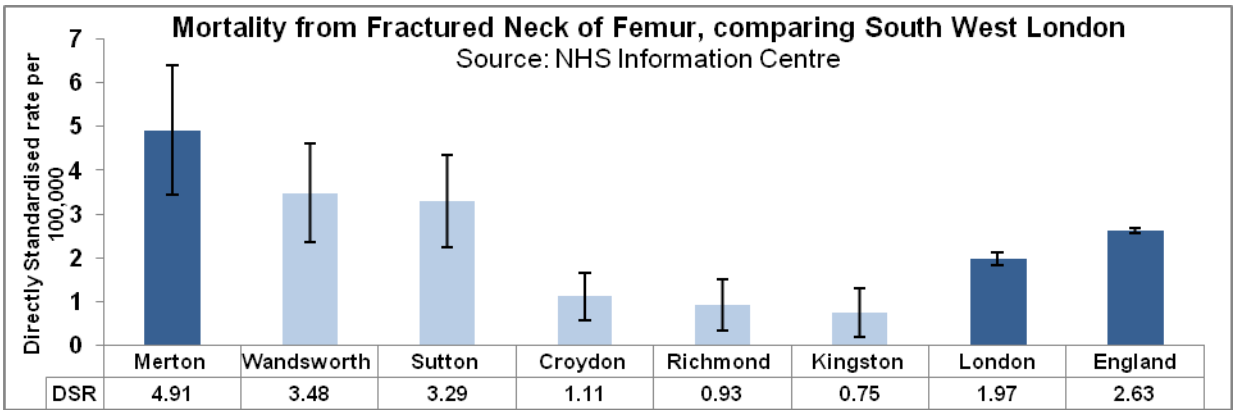


Figure 13: Mortality Rates, Fractured Neck of Femur, Merton & South West London

End of life Care: With an ageing population we are facing an increasing number of people needing significant support in the last days and hours of life in order to achieve dignity and comfort. For people approaching the end of their lives, as well as for their carers, families and friends, having choice in determining where they receive care is an important element in achieving a 'good death'.

The greatest difference between where people say they wish to die and where they end their lives relates to deaths at home. For Merton levels are low compared to other areas. In 2007-2009, 16.6% deaths in Merton occurred in the home, although it is important to note that this classification does not include care homes, but rather refers to the home address. This is in contrast to the results of a national survey in 2006 which indicated that 57% of respondents preferred a home death.

Excess Winter Deaths: Excess winter deaths (EWD) is a measure of the number of deaths in the four winter months (December to March) compared to the average number of deaths during the non-winter months. Locally, between 2006 and 2009 there was an average of 101 excess winter deaths per year in Merton, which is 26.5 % more deaths in the winter months than the average, expected in non-winter months. In England during the same period there were 18.1% more deaths than the non-winter months.

Data indicates that in Merton about 8-9 more people per month die in winter than if the borough had same Excess Winter Death Index as the England average, although this is offset by the low age standardised mortality rate. The Excess Winter Death Index (2002-2009) in Merton is significantly higher than the England average for people aged over 85 years, and for people whose underlying cause of death is chronic lower respiratory disease.

1. Mental Health and Dementia

Mental Health is generally applied on a spectrum ranging from conditions almost entirely managed in Primary Care (such as depression, anxiety) to those that are almost exclusively managed by specialists (such as Schizophrenia). The key inequalities experienced by people with mental health problems are low levels of employment, social exclusion, barriers

to accessing health services and poorer physical health and increased mortality from some diseases.

In Merton, Schizophrenia, Psychoactive substance use and Mood Disorders are the most common causes of mental health admissions. However, it is unclear what proportion of these admissions are readmissions and so it is not possible to identify the prevalence of mental health conditions locally from this data. Schizophrenia and mood disorders account for most mental health cases for the Community Mental Health Teams (CMHTs) in Merton. There appears to be a gender difference in conditions with a higher proportion of the schizophrenia caseload being male, and a higher proportion of the mood disorders caseload being female. A breakdown of acute admissions data by ethnic group suggests that compared to the expected proportion of the population Asian and Black populations are well-represented. This may reflect the ethnically diverse population in Merton or a greater increase in prevalence for mental health issues in ethnic minority groups.

Dementia is by far the biggest issue for mental services for people over the age of 65. Old age is the largest risk factor and prevalence doubles every decade after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have co-morbid conditions and illnesses that result in physical impairment. In Merton, over time the prevalence of dementia in the older male population is projected to rise slightly from 5.2% in 2007 to 5.6% in 2012, whilst in the female population it is projected to decrease from 7.3% to 6.7% by 2021.

6. Wider Determinants of Health

Access to Health and Social Care Services: The biggest pressure on health and social care comes from the impact of long term conditions and therefore supporting older people. In Merton, projected population increases over the next 10-15 years suggest both health and social care will need to provide care or services for an additional 4,000-5,000 older people by 2025. However, with the projected decrease in resources forecast, the impact could be significantly mitigated as many of the long term conditions are preventable. There needs to be a focus by social and health services on supporting preventative services (primary and secondary) now to reduce the potential increases in the next 5-10 years. Consideration needs to be given to the type of services that will be required to support the ageing population to remain independent for as long as possible.

Education: Educational qualifications are a key determinant of future employment and income, and educational attainment (or lack of it) is a key risk factor in teenage pregnancy, offending behaviour, truancy, and alcohol and drug misuse. There are also clear links between attainment, absenteeism and both current and future health outcomes for children and young people. Figure 10 identifies the extent of deprivation in education, skills and training in Merton. There are 2 areas that fall within the 20% most deprived for education. These areas fall in the overall most deprived areas and reflect an inequality in educational attainment which is being addressed within the Borough.

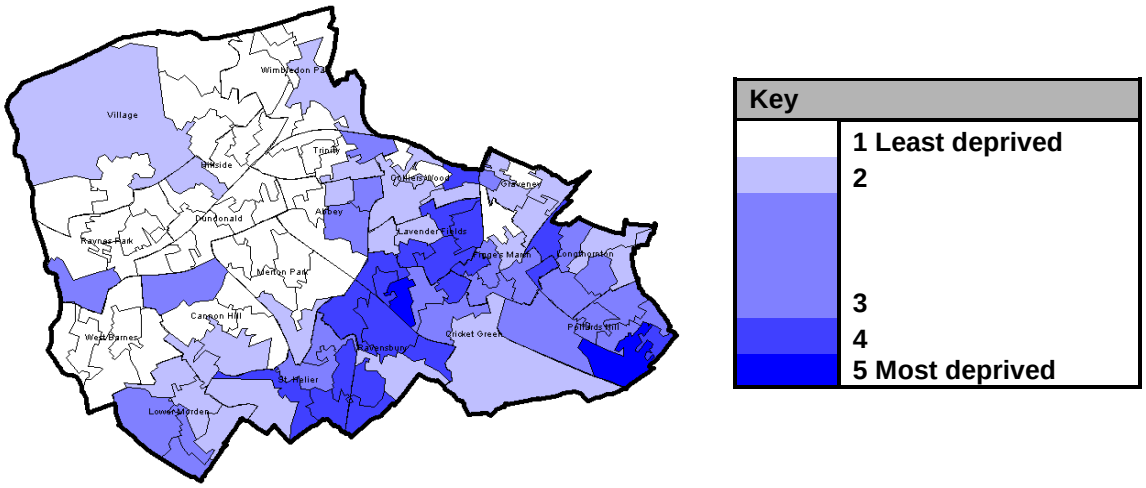
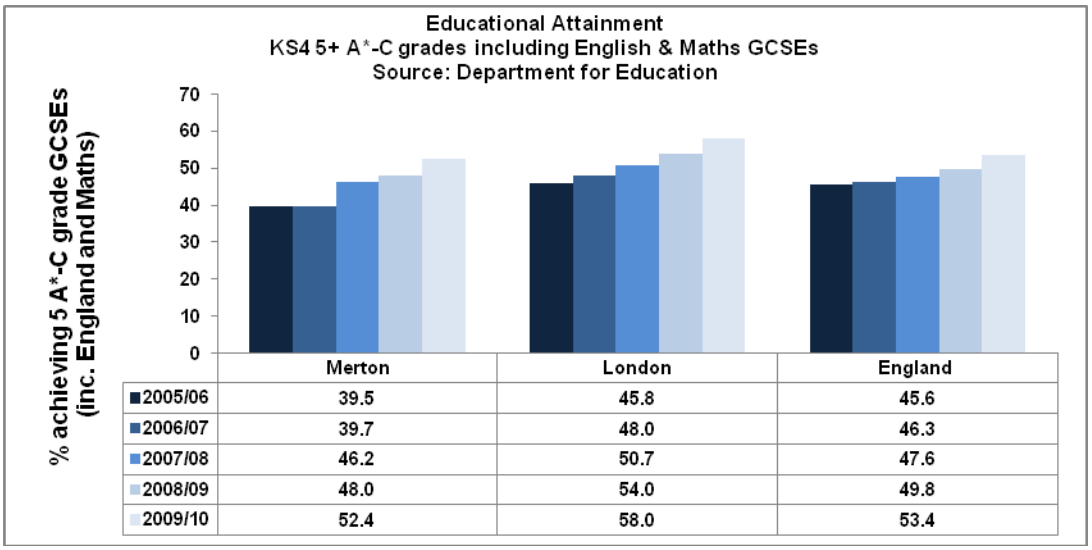


Figure 14: Indices of Multiple Deprivation 2010, Education Domain
Lower Super Output Areas (SOAs) by National Rank Quintiles. Source: http://www.communities.gov.uk/

In Merton, Key Stage 2 attainment (11 year olds) has increased year on year. Attainment rates are above the national average, in 2010 by 3%. At KS4, GCSE level, between 2007 and 2011, Merton's 5+ A*-C GCSE including english and maths has increased from 40% to 60% (provisional data), between 2007 and 2010 the national increased by 6%, compared to 12% in Merton. This places Merton as one of the most improved. Published 'Value Added' (pupil progress) scores show top quartile progress in 2009 and 2010 in Merton schools.

Merton has closed the gap on a number of pupil groups across the key stages; activity is ongoing to close the gap for all pupil groups in Merton. At GCSE the borough's free school meal attainment gap is smaller than the national average; for special needs the gap is in line with other authorities. In terms of ethnicity, a number of groups outperform the white British cohort; however challenges remain amongst some Black British ethnic groups.



	Merton	London	England
2005/06	39.5	45.8	45.6
2006/07	39.7	48.0	46.3
2007/08	46.2	50.7	47.6
2008/09	48.0	54.0	49.8
2009/10	52.4	58.0	53.4

Figure 15: Educational attainment in Merton

Income and Employment: Being in good employment is generally protective to health, and people who are unemployed have higher rates of limiting long term illness, cardiovascular disease and health problems. Employment levels are higher in Merton than the London and national levels. 72.6% of the population aged 16-64 years are in employment, with 6.6% of the economically active unemployed. Although the unemployment level rose from 5.1% to 6.5% between 2008 and 2009, the level had stabilised in 2010.

Housing: Where people live and their type of accommodation can have a profound effect on their health, wellbeing and quality of life, and ability to be independent. Data on housing stock by tenure shows that the proportion of owner occupied and private rented dwelling stock was 87% in 2010. The corresponding percentage in London was 76% and in England it was 82%. Based on the 2001 census, the proportion of households classified as overcrowded in Merton was 12.4%. At ward level this ranged from 6.2% in Village to 20.5% in Lavender Fields. This profile tends to correspond to areas of deprivation. In London 17.3% of households were considered as overcrowded and in England the figure was 7.1%.

Crime: Anti-social behaviour, public disorder, race crime, violent crime, vandalism, fly-tipping and the misuse of drugs and alcohol are identified as key issues which impact on the health of the population. Fear of crime and concern for personal safety also impacts on well-being and can lead to vulnerability and isolation.

In terms of a measure of overall crime, the British Crime Survey (BCS) is useful in benchmarking a set of comparator offences. Clearly results only reflect reported crime and therefore the level of unreported crime could significantly affect the findings. However based on the BSC, Merton has the same comparator crime rate as the England average (41 comparator offences per 1000 population). In the borough, between 2009-10 to 2010-11 there was a decrease in violent crimes but an increase in reported robberies and burglaries.

Domestic Violence is a serious crime and has a significant impact on the overall health and wellbeing of individuals, families and their communities. It is an often hidden crime which crosses all social, racial and religious boundaries. One in four women will suffer domestic violence at some stage during their life, victims suffer emotional and psychological trauma as well as actual physical harm. In Merton, Domestic Violence Victimisation Rates as reported to the Police for 2010-11 for Women were 8.6 per 1,000 Adult women (18+) and for Men, 1.9 per 1,000 Adult men (18+).

Anti-Social Behaviour (ASB) in Merton is perceived to be less of a problem than in London as a whole, but more so than nationally. In terms of how well the police are perceived to be dealing with ASB, Merton rates significantly better than the regional and national averages. Alcohol (drunk and rowdy behaviour) is perceived to be a bigger problem than drugs. What is not clear from national figures is the level of the contribution that alcohol makes to behaviours/activity such as domestic violence and its impact on local communities.

Environment: In Merton the index of multiple deprivation identifies 44 small areas that fall within the 20% most deprived for the' Living Environment'. This includes an assessment of measures of both 'indoor' living environment and the quality of housing, and 'outdoors' living environment, which contains two measures relating to air quality and road traffic accidents.

Risk of death and serious injury on the roads: The total number of casualties on the roads of Merton in 2009 was 475. People in cars represented the biggest number of casualties (205, 43% of all casualties). The annual average number of people killed or seriously injured (KSI) for 1994-1998 was 127 people. In 2009 this had reduced by 57% to 55, 2 of whom were pedestrians who died. Of those in the KSI category, 2 were child pedestrians, compared with an average of 21 per year in 1994-1998. There were 20 pedestrians, 17 motor cyclists, 7 pedal cyclists and 10 car occupants seriously injured in Merton in 2009.

Source of all data and more information can be found at: Sutton and Merton Joint Strategic Needs Assessment 2011: www.jsna.suttonandmerton.nhs.uk

Appendix 5 – Action Plan

Merton CCG Equality and Diversity Action Plan

Issues 1.1	Actions	Outcomes	Timeline	SW London EDS outcome	Measures of Success
Introduce robust governance structures and the EDS equality assurance framework	Set up governance structure to ensure equality performance, monitoring and reporting on compliance. Ensure all internal and external documents and policies include reference to compliance with the Equality Act 2010 via the Equality Delivery System (EDS).	Processes are in place to monitor and record the process of decision-making that have involved a wide range of stakeholders Commissioning plan demonstrates where evidence, data and patient information has been analysed to inform decision making Published reports and equality analysis demonstrate an impact on communities of decision making and where taken into account Equality measures are incorporated into all provider contractual and procurement arrangements. Ensure robust contract management processes are in place to drive quality services	Progress to be reviewed on an annual basis/1st review due March 2013.	1 2 3 4	Continue work to ensure equality monitoring is taking place. Evidence of Patient Surveys and evaluation with findings reported Implementation of the EDS demonstrating that 4 or more protected groups have been consulted Governance Group established. Equality Impact Assessment, qualitative and quantitative activity evidenced in JSNA Publish equality objectives and annually report on positive outcomes demonstrating an upward indicator

Issues 1.2	Actions	Outcomes	Timeline	SW London EDS outcomes	Measures of Success

Build strong relationships with diverse groups and communities to understand their needs, priorities and experiences.	Work towards the collection of robust and consistent patient data disaggregated across the protected groups to full understanding their experience, impact of commissioning and services delivery. Develop appropriate communications and engagement plans that recognise the value of feedback from patients, carers and their communities Develop strategies in line with local CCGs and partners e.g. local authorities, Public Health, LINKS/Health watch, voluntary and third sector organisations Proactively engage in the development of JSNAs and joint health and wellbeing strategies – integrate findings into commissioning plans and decision making	Protected groups involved in engagement and consultation processes Active patients in partnership groups engaged in the development of key documents and plans. Communications become more meaningful and communities feel engaged and empowered Engagement forums with patient representatives for all major care pathways, service redesign work streams and systems. Actively communicate commissioning decisions and respond to feedback Work with communities and local health advocates to co-design outreach activities to address priority areas of low uptake e.g. teenage pregnancy rates, childhood immunisation for MMR booster at age 5	Progress to be reviewed on an annual basis/1st review due March 2013.	2.1 2.2 2.3 2.4		The CCG has a robust engagement strategy which includes the provision of reasonable adjustments they will need to employ in engaging effectively e.g. range of formats of documents, ensuring interpreter support where required, times of engagement etc CCG has a clear understanding of the demographics of the people they are serving, identifying any groups which are marginalised or seldom involved in engagement Evidence shows that the whole of the local community is equally able to access services and has the same quality of experience. Evidence shows that all sections of the local community are able to make informed choices and that the benefits of this are being felt through improved health outcomes.

Issues 1.3	**Actions**	**Outcomes**	**Timeline**	**SW London EDS outcomes**		**Measures of Success**
Develop the following systemic issues and target early intervention and self management programmes	CCG commissioning national targets and develop provision for local needs that are evidence based. Use disaggregated JSNA for Merton to identify priority areas	Programmes demonstrate equity in access, improved take up from targeted groups, with prevalence decreasing over time, national and local target being met and where possible exceeded, patient experience survey demonstrate increased confidence and self-management. Decrease in hospital admissions Equality monitoring is taking place. Evidence of Patient Surveys and evaluation with findings reported with demonstrated improvements	Progress to be reviewed on an annual basis/1st review due March 2013	1.1 1.2 1.3 1.4 1.5		Experience consists of actual monitoring results (e.g. Acute patient experience by protected group dashboard, performance data, PALS data, etc.) showing how commissioners/ Providers have developed a baseline for each Equality Target Group, has closed data gaps through contract management and has disaggregated data to an appropriate level

Issues 1.4	Actions	Outcomes	Timeline	SW London EDS Outcomes	Measures of Success
Equality in contractual performance management as the Commissioner of services as CCG core business	Ensure the Equality Act and requisite duties (where appropriate) are an integral part of any existing and new contractual arrangement for all healthcare providers within the locality. (All organisations that are carrying out public functions on behalf of CCGs are also subject to the general equality duty when they carry out procurement in the exercise of those public functions. i.e. secondary care and the voluntary and private sectors) Building equality analysis into the appropriate stages of your procurement processes. Staff involved in procurement will need to have a good understanding of the equality duty.	Through the existing performance management arrangements CCG monitor positive outcomes and patient experience. Where performance falls short, CCG to consider the issue of notices to providers for any equality breach via poor patient experiences surveys, feedback or complaints	Progress to be reviewed on an annual basis/1st review due March 2013	1 2 4	CCG role model what good Equality performance looks and feels like for patients, carers, staff and the community The equality of choice, access and experience of patients are shown to be developing or better

Issues 1.5	Actions	Outcomes	Timeline	SW London EDS outcomes	Measures of Success
Develop an inclusive working culture which values diversity and supports staff to feel confident to challenge any harassment, bullying or perceived victimisation	Ensure robust equality and diversity analysis is integral in the staff transition programme Develop effective communication and engagement plan to promote staff participation in the Equality Delivery System for themselves and service users Include session on Equality, diversity and Culture and values into staff training to support the improvement of staff survey results	Staff feel consulted and engaged in the transition process. Feedback suggests that staff feel fairly treated as evidenced by robust impact assessment and ultimately the right individuals get the right jobs. CCGs able to evidence that through the collection and user of staff profiling data that staff from all protected groups have equity in the level of personal development The CCG workforce planning assesses the overall capability and capacity within its existing workforce to deliver the Equality Human Rights outcomes set out in the authorisation workbook, EDS and the NHS Outcomes Framework.	Progress to be reviewed on an annual basis/1st review due March 2013	3.1 3.3 3.4 3.5 4.2 4.3	The workforce profile substantially matches the local demographic for all communities at all levels. Created a respectful environment at work where people are confident that senior managers are committed to upholding respect and values. Published annual equality data and information e.g. annual EDHR report, workforce profile demonstrating progress Developed Competency Framework for E&D leaders at all levels. Ensure the delivery of a robust open and transparent approach to the agenda

Issues 1.5 continued	Actions	Outcomes	Timeline	SW London EDS outcomes	Measures of Success
Develop an inclusive working culture which values diversity and supports staff to feel confident to challenge any harassment, bullying or perceived victimisation	Ensure CCG identify Competent Equality, Diversity and Human rights Leadership that can consistently deliver within its Board and team structures.	EDHR Specialist to support the CCG by providing strategic visioning, leadership and operational delivery competence e.g. a. Be able to respond to diverse and changing community needs b. Apply robust equalities analysis to service planning and improvement	Progress to be reviewed on an annual basis/1st review due March 2013	3.1 3.3 3.4 3.5 4.2 4.3	Developed Competency Framework for E&D leaders at all levels. Ensure the delivery of a robust open and transparent approach to the agenda