Equality Impact Assessment	Please enter responses below in the right hand columns
TEMPLATE UPDATED SEPT 2015 **Date**	June 2016
Sign-off path for EIA (please add/delete as applicable) If you are conducting an EIA on a Cabinet decision, it should come to Corporate EIA panel for sign off.	Corporate EIA Panel
Title of Project, business area, policy/strategy	Commissioning intentions for Staying Healthy, Public Health Services 2016/17 relating to the re-design of Outreach NHS Health Checks
Author	Sarah McCulloch
Job title, directorate	Senior Commissioning Officer Public Health Commissioning Team, Children, Adults and Health.
Contact email and telephone	SMcCulloch@lambeth.gov.uk 020 7926 5137
Strategic Director Sponsor	Helen Charlesworth-May

London Borough of Lambeth Equality Impact Assessment	Please enter responses below in the right hand columns.
1.0 Introduction	
1.1 Business activity aims and intentions *In brief explain the aims of your proposal/project/service, why is it needed? Who is it aimed at? What is the intended outcome? What are the links to the political vision, and outcomes?*	This EIA assesses the impact of planned changes to the funding and delivery of outreach NHS Health Checks service in Lambeth. In summary the proposals set out below are that we intend to de-commission the Outreach NHS Health Check service, thus removing this function from the current Lambeth Early Intervention and Prevention Service (LEIPS) contract. We do however propose to retain the NHS Health Checks service offer in Primary Care (no reductions are proposed to this service) and to look to continue to support and encourage people to take up their offer of a health check within either their registered GP or a Community Pharmacy which is convenient to them. We have concluded that this proposal may have a negative impact upon some populations, however this is not considered to be significant in light of this involving relatively small numbers of the general public – In 2015/16 a total of 6003 health checks were completed, 5347 (89%) of which took place in Primary Care and 656 (11%) by the outreach health check team (data taken from Health Check Focus, 2015/16) Data shows us that in 2015/16 in terms of detection and identifying conditions as a result of the NHS health check, the outreach team detected 4% of people at high risk of Cardio Vascular Disease compared to 1% in GPs. Diabetes Mellitus Type 2 was identified in 36% of cases where a health check was completed by GPs compared to 20% in the Outreach team. Hypertension was identified in 56% of cases in GPs compared with 70% of those seen by the Outreach team. It must be noted however that the vast majority (79%) of health checks were delivered in the Primary Care settings as opposed to the Outreach team, so in terms of absolute numbers, there are far smaller numbers of people seen by the outreach team as opposed to those who have had their health check via primary care.

	Lambeth has a diverse population which has seen vast improvements in overall health over the last 10 years however we know that unfortunately health inequalities still exist and we still have to work hard to reduce and eliminate these. The 3 main causes of premature death in Lambeth are cancer, cardiovascular disease and respiratory disease. A large proportion of these are considered to be preventable in the main. Evidence suggests that lifestyle factors are strongly associated with developing preventable illnesses and diseases such as obesity, Cardio Vascular Disease diabetes and certain cancers. The aims of Staying Healthy Public Health services are to address health inequalities and reduce/ eliminate the development of preventable illnesses through the commissioning of effective lifestyle intervention and early identification services, including the NHS Health Check Programme. **NHS Health Checks** **Target:** All Local Authorities are mandated to provide access to the NHS Health Check for the eligible population (aged between 40-74, have not had a previous health check in the past 5 years and with no known pre exiting health conditions such as diabetes). Outcomes achieved during 15/16 are: 32% offered and 6% take up. It is a local priority to improve the health check take up numbers. **Current Service – Primary Care**: The health check is designed to help identify early signs of conditions such as diabetes, hypertension and cardio vascular disease in people aged 40-74. Primary Care deliver approx. 89% of the total number of health checks delivered. **Current Service – Outreach (Guys and St Thomas):** This consists of outreach sessions at events, workplaces, places of worship and community venues. Only approx. 11% of health checks are delivered by the Outreach Health Checks team (data taken Health Check Focus, 2015/16).

	We spend approximately £600,000 on health checks locally in both Primary Care and also on an outreach health check team. The reduction in the Public Health grant, which is used to pay for NHS Health Check services, has seen cuts having to be made to budgets across public health and Staying Healthy is no exception to that. The Public Health allocation was cut in year in 2015/16 by 1.9m and by c.£3m in 2016/17. It will be subject, on average, to a year on year 3.9% cut until 2020. This has meant we have had to thoroughly examine every element of our service offer to create efficiencies, reduce waste and get better value for money with a reduced spend. We continue to work closely with the Public Health Specialist Team, Lead Clinicians and the General Manager and Head of Health, Inclusion and Preventative Services at GSTT to identify how potential savings can be leveraged whilst maintaining access especially for the most vulnerable populations. In this case those who we deem to be vulnerable/ those most in need of this service are males (who we know are less likely to access a health check), people aged over 55, where we know we have lower health check uptake rates, people from BME populations as we know that certain ethnic groups are more at risk of developing diabetes for instance. We would also seek to target the offer at people who live in more socioeconomically deprived areas, as we know that these populations have higher rates of multi morbidities locally (Lambeth DataNet 2013/14), indicating that we should focus services such as the NHS Health Check on these areas where there may be people at higher risk and in need of a prevention service. The following principles have been agreed for the re-commissioning of Staying Healthy services overall: - Ensure patient safety and protect the most vulnerable; - Retain services which deliver the greatest public health impact; - Consultation with service users; - Focus on back office and fixed costs first, then reconfiguration or redesign, and lastly service and staff cuts.

	Proposals for this service are to: De-commission the Outreach NHS Health Check team, which sits as part of the overall LEIPS contract. To retain NHS Health Checks in Primary Care and to continue to support and encourage residents to engage with primary care for their health check and to increase overall uptake of health checks, specifically in target, key at risk populations. There are no planned reductions to the spend available for health checks delivered in primary care. However, as with stop smoking services we hope to engage in discussions with our GP Federations, Local Pharmacy Committee (LPC) and Local Care Networks in order to review how we can improve take up and engagement of residents with this service and ensure the service is outcomes focussed and better targeted at those groups who we most want to target in the Borough due to being most in need. In this case those who we deem to most in need are males (who we know are less likely to access a health check), people aged over 55, where we know we have lower health check uptake rates and people from BME populations as we know that certain ethnic groups are more at risk of developing diabetes. Also those who live in more socioeconomically deprived areas may be at higher risk of having a multi-morbidity (more than one long term condition) (Data sourced from Health Check Focus 2015.16 and Lambeth DataNet Multi Morbidity 2013/14). We wish to focus our resources at primary care delivery, which we believe has the greatest impact on the local NHS health check programme and outcomes achieved. The rationale for this is that significantly more people already access their health check via either their GP or Pharmacy and also that Primary Care have certain success areas in identifying conditions and subsequent referral onto appropriate clinical service pathways and programmes, including weight management and physical exercise –for instance we know that GP's make up the highest number of referrals into the Lambeth Early Intervention and Prevention Service. Through focussing more on Primary Care delivery of this service it may also reduce any potential duplication in people receiving an invite and having a health check both via their GP and then also being targeted and receiving a health check via the outreach service.

	For those not registered at a GP, they will still receive their invitation to have a health check and can have this at their local Pharmacy or choose to register with a GP, which we want to encourage and support. We are seeking to invest in a Health Champion role which will see locally recruited and trained community members who are based in the community to provide personalised health related support and advice, which could include supporting someone to register with a GP and/or go and receive their offer of a health check at their local GP or pharmacy. We are also looking into ways of targeting our health check invitation process, exploring more innovative methods (e.g. use of SMS reminders) and also improving our invitation process by making it more targeted at key populations, whereby we can target those most in need who will receive their invitation of a health check first, whilst still meeting our mandated responsibilities. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient stratification and identification of these populations.

2.0 Analysing your equalities evidence

2.1 Evidence

Any proposed business activity, new policy or strategy, service change, or procurement must be informed by carrying out an assessment of the likely impact that it may have. In this section please include both data and analysis which shows that you understand how this decision is likely to affect residents that fall under the protected characteristics enshrined in law and the local characteristics which we consider to be important in Lambeth (language, health and socio-economic factors).

IF YOUR PROPOSAL ALSO IMPACTS ON LAMBETH COUNCIL STAFF YOU NEED TO COMPLETE A STAFFING EIA.

Protected characteristics and local equality characteristics	Impact analysis **For each characteristic please indicate the type of impact (i.e. positive, negative, positive and negative, none, or unknown), and:** *Please explain how you justify your claims around impacts.* *Please include any data and evidence that you have collected including from surveys, performance data or complaints to support your proposed changes.* *Please indicate sources of data and the date it relates to/was produced (e.g. 'Residents Survey, wave 10, April 12' or 'Lambeth Business Survey 2012' etc.)*
Race	**Negative Impact** Data collected by the outreach service for Q2 15/16 shows that the majority of people being seen by the health check outreach team were White British (28%), followed by African (23%) and then Caribbean (17%), with a sizable amount of people preferring not to say (13%). As a comparison, data from health checks undertaken in General Practice during the same period shows that the largest ethnic group were British or Mixed British (33%), Any other White background 23%, African 12% and Caribbean 11%. (Data from Health Check Focus, Q2 2015/16). Certain ethnic groups e.g. Black African, Black Caribbean are more at risk of cardio-vascular disease and diabetes and data shows us that they are also less likely to access General Practice. The decommissioning of this service could potentially lead to fewer clients from these ethnic communities taking up the offer of a health check and therefore could be seen as having a potential negative impact. However the impact is not considered significant in light of the relatively small numbers of people reached by the outreach team currently. We will look to mitigate against any potential negative impacts through investing in an alternative invitation prioritisation process which will allow us to prioritise people to be invited for a health check at their GP or local community pharmacy based on factors such as race, socio-economic background and age. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient stratification and identification of these target populations.

	We will also be continuing discussions with our GP Federations, Local Pharmacy Committees (LPCs), Clinical Leads and Local Care Networks around the development of this service offer and how to improve take up and engagement within these target, most in need populations. We will also look to invest in a Health Champion role which will see local community members recruited and trained based in the community to provide personalised health related support and advice, which may include supporting someone to register with a GP and/or go and receive their offer of a health check.
Gender	**Negative Impact** Data collected by the NHS Health Check Outreach Team shows that during Q2 2015/16, there were more females than males accessing the service (174 and 135 respectively), which is in line with national trends, with more females accessing health checks than males. General Practice data over the same period shows that access to health check services were broken down as 45% (573) male and 55% (692) female, again mirroring the national trends. We know that men are more at risk of late detection of cardio-vascular disease and diabetes, they are also less likely to access general practice. Therefore the decommissioning of this service could potentially lead to fewer men receiving health checks. The impact however could be said to be limited in light of the relatively small numbers of men reached by the current outreach team. We will look to mitigate against potential negative impacts through investing in an alternative invitation prioritisation process which will allow us to prioritise people to be invited for a health check at their GP or local community pharmacy based on factors such as race, socio-economic background and age. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient identification and stratification of these target populations.

	We will also be continuing discussions with our GP Federations, LPCs, Clinical Leads and Local Care Networks around the development of this service offer and how to improve take up and engagement within at risk groups, including working age males. We will also look to invest in a Health Champion role which will see local community members recruited and trained based in the community to provide personalised health related support and advice, which may include supporting someone to register with a GP and/or go and receive their offer of a health check.
Gender re-assignment	**None:** There are neither data, nor any identified reasons to suggest that the closure of this service will disproportionately affect a single group under this equalities characteristic.
Disability	**Negative Impact** If we use Long Term Conditions (LTCs) as a proxy indicator for disabilities, in Lambeth we have increasing numbers of older people and adults living with LTCs and high numbers of avoidable admissions for people with certain LTCs particularly: Diabetes, Cardio Vascular Disease (CVD), asthma, and epilepsy. (Taken from NHS Lambeth Clinical Commissioning Group, Healthier Together Strategy). Disease prevalence models suggest that there are high numbers of undetected cases of diabetes, hypertension and heart disease in the Lambeth population. We know that people with disabilities are more at risk of cardio-vascular disease and diabetes, therefore there is potential for a negative impact upon these populations. It is however unlikely that the decommissioning of this service would lead to any significant impact on access and outcomes for this group in light of the relatively small numbers seen by the team Outreach team currently.

	We will look to mitigate this risk through developing services which target those who are most in need, work with the CCG to create joined up services across the patient pathway to ensure: • Early identification and intervention for those most in need • Additional wrap around services services for those with those with the most complex health needs We will mitigate against potential negative impacts through looking to invest in adopting an alternative invitation prioritisation process which will allow us to prioritise people to be invited for a health check at their GP or local community pharmacy based on factors such as race, socio-economic background and age. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient identification and stratification of these target populations. We will also be continuing discussions with our GP Federations, LPCs, Clinical Leads and Local Care Networks around the development of this service offer and how to improve take up and engagement within at risk groups, including working age males. We will also look to invest in a Health Champion role which will see local community members recruited and trained based in the community to provide personalised health related support and advice, which may include supporting someone to register with a GP and/or go and receive their offer of a health check.
Age	**Negative Impact** Data collected during Q2 2015/16 shows that the largest age group accessing outreach health checks were 50-54 (25%), followed 40-44 (23%) and 55-59 (19%). For health checks undertaken in General Practice during the same period shows that 33% of people in the age bracket 40-44 accessed a check, 25% aged 45-49, followed by 18% aged 50-54. Those of working age are more at risk of late detection of cardio-vascular disease and diabetes; and they are also less likely to access general practice. The decommissioning of

	this service could potentially lead to fewer men undergoing health checks. However the impact may not be significant due to the relatively small numbers of eligible working age people reached by the current outreach team. We will mitigate against potential negative impacts through looking to invest in adopting an alternative invitation prioritisation process which will allow us to prioritise people to be invited for a health check at their GP or local community pharmacy based on factors such as race, socio-economic background and age. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient stratification and identification of these target populations. We will also be continuing discussions with our GP Federations, LPCs, Clinical Leads and Local Care Networks (where there is representation from both healthcare settings and also key voluntary and social care agencies such as Age Concern) around the development of this service offer and how to improve take up and engagement within at risk groups, including working age populations. We will also look to invest in a Health Champion role which will see local community members recruited and trained based in the community to provide personalised health related support and advice, which may include supporting someone to register with a GP and/or go and receive their offer of a health check.
Sexual orientation	**None** There are neither data, nor any identified reasons to suggest that the closure of this service will disproportionately affect any single group within this equalities characteristic.
Religion and belief	**None** There are neither data, nor any identified reasons to suggest that the closure of this service will disproportionately affect any single group within this equalities characteristic.

Pregnancy and maternity	**None** There are neither data, nor any identified reasons to suggest that the closure of this service will disproportionately affect any single group within this equalities characteristic.
Marriage and civil partnership	**None** There are neither data, nor any identified reasons to suggest that the closure of this service will disproportionately affect any single group within this equalities characteristic.
Socio-economic factors	**Negative Impact** Whilst we currently have no local data pertaining to health checks and socioeconomic backgrounds, we know that people from more socioeconomically deprived areas have higher rates of multi-morbidities, which include diseases such as diabetes and Cardio Vascular Disease (CVD). The decommissioning of this service could potentially lead to fewer people from lower socioeconomic groups receiving their health checks. However the impact is not considered significant due to the small numbers of eligible people reached by the current outreach team. We will mitigate against potential negative impacts through looking to invest in adopting an alternative invitation prioritisation process which will allow us to prioritise people to be invited for a health check at their GP or local community pharmacy based on factors such as race, socio-economic background and age. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient identification and stratification of these target populations.

	We will also be continuing discussions with our GP Federations, LPCs, Clinical Leads and Local Care Networks around the development of this service offer and how to improve take up and engagement within at risk groups, including people living in more deprived areas within the Borough and also people residing in temporary and supported accommodation, where we know these groups have worse health outcomes. We will look to invest in a Health Champion role which will see local community members recruited and trained based in the community to provide personalised health related support and advice, which may include supporting someone to register with a GP and/or go and receive their offer of a health check.
Language	**None** There are neither data, nor any identified reasons to suggest that the closure of this service will disproportionately affect any single group within this equalities characteristic. A translation service is and will still be available which will see the health check invite letter translated as required. We will also continue to work with key agencies in the community where we can promote the health check service and look to provide support for someone to attend. We are seeking to invest in a Health Champion role which will see local community members recruited and trained based in the community to provide personalised health related support and advice, which may include supporting someone to register with a GP and/or go and receive their offer of a health check.
Health	**Negative Impact** Data shows us that people from lower socio-economic groups, black and minority ethnic communities and men are more at risk of late detection of cardio-vascular disease and diabetes; and they are also less likely to access general practice. The decommissioning of this service could potentially lead to fewer people from at risk populations (BME, males, lower socioeconomic groups) undergoing health checks. However the impact is not

	considered to be significant due to the relatively small numbers of eligible people reached by the current outreach team. We will mitigate against potential negative impacts through looking to invest in adopting an alternative invitation prioritisation process which will allow us to prioritise people to be invited for a health check at their GP or local community pharmacy based on factors such as race, socio-economic background and age. We are in discussions with our GP Federations as to the delivery of such a service model, which will allow for the efficient stratification and identification of these target populations. We will also be continuing discussions with our GP Federations, LPCs, Clinical Leads and Local Care Networks around the development of this service offer and how to improve take up and engagement within at risk groups, including working age populations. We will also look to reinvest some resources into the development of a local Health Champion service offer across the Borough. We anticipate that part of their role will be to signpost people to Primary Care (their GP or community pharmacy) to engage with the health check service offer available, targeting those at risk populations.
2.2 Gaps in evidence base *What gaps in information have you identified from your analysis? In your response please identify areas where more information is required and how you intend to fill in the gaps. If you are unable to fill in the gaps please state this clearly with justification.*	As set out above there are some gaps in our evidence base which have rendered us unable to perform a complete and detailed EIA for every equalities strand. The evidence base is limited for the needs of those from transgender, marriage and civil partnership, religion and belief and language protected groups in relation to cardiovascular disease and diabetes. We will work with providers to ensure accurate data capture and monitoring as far as possible and we are currently in discussions with our GP Federations as to their ability to assume responsibility for the data capture and analysis function, which would allow for an efficient data and quality management system to be implemented.

3.0 Consultation, Involvement and Coproduction	
3.1 Coproduction, involvement and consultation *Who are your key stakeholders and how have you consulted, coproduced or involved them? What difference did this make?*	Key Stakeholders for consultation include the following: • Service users • Healthwatch • Patient Participation Group • Providers • GP Federations • Local Pharmaceutical Committee • Lambeth Clinical Commissioning Group • Commissioning colleagues from within LBL Council To date one co-production workshop was held with Stakeholders (Stakeholders from across the above were invited) on the 4th Feb 2016. The aim of this initial workshop event was to inform and update our Stakeholders on the financial position of the Council and to discuss across the group and agree what Staying Healthy's service priorities and outcomes should be. A series of follow up consultation workshops is scheduled to be held in Summer 2016 with all Stakeholders. As part of a formal Public Health consultation period covering 6-8 weeks from April to the end of May 2016, Public Health (including Staying Healthy services) held a series and of the following events where Stakeholders, including members of the general public and service users were consulted upon our service re-design proposals: • Public event hosted by Healthwatch • Attendance at Local Care Network meetings • Public drop in sessions (e.g. Olive Morris House) • Online questionnaire • Workshop with a sample of LEIPS service users There was a general consensus of support from the general public for the proposals to Outreach NHS Health Checks. The online Public Health survey found that 27% of respondents strongly supported, 31% tended to support, 18% strongly opposed and 8%

	tended to oppose, with the remaining unsure or no opinion. In the workshop dedicated to discussing this proposal with LEIPS service users, it was found that there was a general lack of awareness that a health check is available to have in the community by an outreach team and of the programme in general, however people seemed to support that the checks be available in people's General Practices. We will mitigate against any potential negative impacts through the actions set out in the below Equality Action Plan section.
3.2 Gaps in coproduction, consultation and involvement *What gaps in consultation and involvement and coproduction have you identified (set out any gaps as they relate to specific equality groups)? Please describe where more consultation, involvement and/or coproduction is required and set out how you intend to undertake it. If you do not intend to undertake it, please set out your justification.*	The current proposals will be enacted by October 2016 and in line with contract notice requirements. In spite of the relatively tight timelines available for undertaking consultation with Stakeholders, it is considered that a comprehensive and robust consultation on these proposals was achieved satisfactorily. This was achieved through a mixture of drop in sessions in the in the community in order to get a representative sample of the general public's views and also by holding a specific workshop for service users to discuss health checks propsoals, whereby a sample of people who had received a health check via the outreach team over the last 6 months were invited to attend. We also spoke with our stakeholders in the CCG and Primary Care (GPs and Pharmacists). The online survey was used in order to get people's views where they could not attend a workshop. In addition, there will be continued and ongoing consultation and co-production undertaken with Stakeholders throughout Summer 2016, which will direct and inform our further commissioning plans for 2017/18 onwards.
4.0 Conclusions, justification and action	
4.1 Conclusions and justification *What are the main conclusions of this EIA? What, if any, disproportionate negative or positive equality impacts did you identify at 2.1? On what grounds do you justify them and how will they be mitigated?*	We conclude that the impacts associated with the changes will have a negative impact upon certain groups; Race, Gender, Age, Disability, Socioeconomic and Health. Whilst there are groups identified where there may be a negative impact, this is felt to be a relatively limited impact in light of the fact that the current numbers of the population being seen by the outreach team are low, particularly in comparison to those who have accessed a health check via the primary care route. For instance in 2015/16 out of 6003

	11% of people had their health check via the outreach team compared to a total of 89% having this via Primary Care. The removal of the outreach health check function will be mitigated by the fact that people can still continue to have their health check at their local GP or Community Pharmacy; we are not making any changes or reductions to that service in Primary Care. We acknowledge that there are some people who do not engage or visit Primary Care settings and so we will seek alternative ways in which to target these populations, including the reinvestment in a Health Champion role, whereby at risk populations will be supported in the community to be signposted to engage with Primary Care and the health check service offer. We will also be exploring the use of an alternative prioritisation invitation process whereby identified at risk populations can be invited for a health check as a priority and are in discussions with GP Federations in terms of their delivery of this function, allowing for more efficient identification and stratification of these in need populations. In spite of these mitigating actions, we do need however to be mindful of any unintended consequences by removing this service option, particularly on those populations more at risk of health inequalities. Health check activity and performance data will continue to be monitored on an ongoing basis via performance data review and evaluation of health checks in primary care; reviewing how we are targeting this offer at those most at risk and what outcomes are being achieved.
4.2 Equality Action plan *Please list the equality issue/s identified through the evidence and the mitigating action to be taken. Please also detail the date when the action will be taken and the name and job title of the responsible officer.*	
Equality Issue	**Mitigating actions**
Gaps in service provision	The development of a Health Champion role locally which will assist with signposting, supporting and encouraging take up of health checks in primary care.

Inequalities for certain at risk groups who would have accessed the outreach service	To continue to work with GPs, LPCs, Clinical Leads and LCNs to develop the NHS Health Check service offer in Primary Care. To adopt an alternative prioritisation invitation process whereby the most in need populations are prioritised to receive their health check. Working with GP Federations around their assuming responsibility and leadership over delivery of this function, allowing for more efficient identification and stratification of these in need populations. To continue to monitor and review the activity and performance of health check data across all Primary Care. Working with the GP Federations to develop and implement an outcomes based approach for both activity and performance monitoring in Primary Care, with GP Federations assuming a leadership role in this.

5.0 Publishing your results	
The results of your EIA must be published. Once the business activity has been implemented the EIA must be periodically reviewed to ensure your decision/change had the anticipated impact and the actions set out at 4.2 are still appropriate.	
EIA publishing date	
EIA review date	
Assessment sign off (name/job title):	

All completed and signed-off EIAs must be submitted to equalities@lambeth.gov.uk for publication on Lambeth's website. Where possible, please anonymise your EIAs prior to submission (i.e. please remove any references to an officers' name, email and phone number).