

Greater Glasgow and Clyde NHS Board

Board Meeting

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Board Paper No. Paper No 15/64

Director: Catriona Renfrew

**EQUALITY COUNTS:
USING DATA TO UNDERSTAND AND TACKLE INEQUALITY IN NHSGGC**

RECOMMENDATIONS:

Collecting data is one way to raise awareness of the diverse nature of our population with staff and to enable us to know when and where we are making a difference to improving differential health outcomes. It has been challenging to find measures that will enable us to assess whether we are closing the health gaps between groups even though we routinely collect data on sex, age and socio-economic status. This is further compounded by a lack of disaggregated data in many NHS data collection systems on other protected characteristics covered by the Equality Act 2010 (disability, ethnicity, religion and belief and sexual orientation).

The Board is asked to receive this update on using data to understand and tackle inequality in NHSGGC and support the recommendations for action, which are that:-

- New data systems or migrated data systems always include fields to collect equality data and an improvement programme to update existing data systems is undertaken;
- The Performance Framework for NHSGGC will develop measures based on identified gaps in health outcomes for people with protected characteristics and by SIMD and seek to show improved health outcomes through related measures;
- Data collection and performance measures will be put in place to track progress on the mainstreaming and equality outcomes for the Board for 2016-19;
- Meeting patients additional support needs will be mainstreamed into data systems and practice reviewed in primary care and at ward level;
- Actions to target differentials in screening uptake and health outcomes will be followed up to ensure action has taken place;

- The Board will seek to influence national systems to include equalities data.

1. INTRODUCTION AND PURPOSE OF THIS PAPER

Tackling inequality is one of NHSGGC's five priorities. Patterns of inequality are evident in the way NHSGGC's population make use of health services. Certain groups in the population are:-

- more likely to have multiple and complex health conditions;
- die younger and suffer longer periods of life limiting illness;
- make high use of certain types of health service (for example emergency care), and;
- are more likely not to attend appointments.

Historically, health and social care services have largely been planned without taking into account patients' needs in relation to inequality and discrimination. Sometimes this has been because everyone in the target group is considered excluded or vulnerable or simply because the data is not available to identify the needs of groups within groups. In order to understand the population we serve and develop better services, we need to collect and use a wide range of evidence to help us build up a more complete picture. Data on patients' use of services and health outcomes by protected characteristics, patient/client feedback by equality groups and equality impact assessment can be used to build this picture.

Collecting data by protected characteristics is part of the requirements of equality legislation and, ideally, we should ask and record patients' ethnicity, sex, disability, age, sexual orientation and religion or belief. The Scottish Index of Multiple Deprivation (SIMD), based on postcode, is used as a proxy for socio-economic status. To achieve routine collection of equality data we need the following:-

- data collection systems which have the necessary fields so that staff can input the data;
- staff trained to ask for this information from patients;
- the ability to analyse the data we collect so that we can improve services and make them more efficient.

This report looks at where we collect data on the protected characteristics, how we use it to make improvements in our services to tackle inequalities and where we still need to make progress. The report covers:

- collection of patient data by protected characteristic and actions required to improve the collection;
- using patient information on additional support needs to improve access and quality of service in acute;
- using equality data to monitor performance on tackling inequality and to drive change which will improve health outcomes;
- using equality data to prevent ill-health through screening;
- using equality population data to plan services, and;
- a set of recommendations to achieve improvements.

2. COLLECTION OF PATIENT DATA BY PROTECTED CHARACTERISTIC AND ACTIONS REQUIRED TO IMPROVE THE COLLECTION IN 2015-17

2.1 Review of Current Data Collection

The Corporate Inequalities Team (CIT) carried out a review of NHSGGC equalities data collection by protected characteristic to identify possible uses of existing data and any gaps.

2.1.1 Sex, age and SIMD

Data on sex, age and SIMD are, generally speaking, available in most of our data collection systems. However, this does not necessarily mean that the data is used to identify differential health needs or to plan and commission services differently to meet those needs. The issues, which we could identify from this data, include-

- Sex- there are different health needs for women and men, different uptake of services, different health outcomes and differential life experiences e.g. lone parents are mostly women and have been very badly hit by welfare reform changes, the health and social needs of carers who are mostly women and the differential impact of gender based violence.
- Age- there are specific areas of legal risk for equalities legislation (e.g. age based criteria for service access need to be objectively justified) and human rights risks for

older people in health and care settings. There is some evidence of differential use of services, treatment, access and outcomes by age group. For example in a study of stroke patients only 4% of patients over 75 were given an MRI scan, compared to 26% of those under 75. Age Concern and other organisations report that older people often feel that people delivering their care treat them like children.

- SIMD- there are geographic disparities in health, which we are well aware of in relation to health outcomes. The impacts of social circumstances on health, such as poverty, are also well documented and can be identified in differential use of services, treatment, access and outcomes.

2.1.2 Ethnicity data

Ethnicity data is collected from Scottish Medical Records (SMR) data sets. The number of records which contain ethnicity, which has improved in recent years, is as follows:-

	Apr 2013	Mar 2015
Outpatients	70%	75%
Discharge	80%	82%

Despite an increase in the data collection on ethnicity, it is still difficult to systematically understand the differential health needs or outcomes of BME people. Including ethnicity in the CHI number has been mooted but not ever implemented at national level. Collecting ethnicity at death registration was introduced in 2012 and could potentially be linked to disease patterns over time however current data is showing lower than expected rates of non-white people, so the data needs to be used with caution. However, we do know much more about population data in relation to BME communities and research shows different health needs and disease patterns. For example: Pakistani and Bangladeshi groups report poorer health compared to the rest of the population; they experience poorer mental health, disabilities and long term conditions (possibly related to a worse socio-economic position); and they find it harder to access or communicate with their GPs.

The effect of discrimination on BME people has an impact on access to services and quality of service. For example, at most of our engagement events with non- English speakers we are told that patients have been refused an interpreter, despite the fact that we have one of the most comprehensive interpreting services in Scotland. When

interpreters are not booked it can lead to re-booking of appointments or misuse of medication. To tackle this issue CIT have given patients information on their rights to an interpreter and done training with staff on using interpreters, including the development of an e-module.

2.1.3 Sexual Orientation

None of our patient data collection systems have the necessary fields to collect data on sexual orientation, apart from some specialist services e.g. Sandyford Sexual Health Services. Some systems collect data on relationship status, however, this can only give very partial data on sexual orientation. Some Primary Care Mental Health Teams have started to ask about sexual orientation routinely, and this is working well. The learning has been shared with other areas in mental health services to consider options. The Scottish Government estimate that between 6% and 10% of the population are Lesbian, Gay and Bisexual (LGB). Using the 6% estimate this equates to the following numbers of people who will grow up as LGB in each Health and Social Care Partnership area:-

Area	Male population	Female Population
Glasgow	17,433	18,496
Renfrewshire	4,909	5,329
Inverclyde	2,270	2,482
West Dunbartonshire	2,578	2,843
East Dunbartonshire	3,024	3,249
East Renfrewshire	2,585	2,805
NHSGGC	32,799	35,204

Recent research by Stonewall shows that LGB people still face discrimination in our services. For example, the research showed that staff make assumptions of heterosexuality for all patients and do not feel equipped to challenge discrimination. The study, which was carried out with 2500 staff, reported that 7% or 1 in 14 had witnessed bullying, abuse or harassment towards a patient by another member of staff because of their sexual orientation. Staff have reported that they are uncomfortable asking people about their sexual orientation in order to collect data on their use of services. This reflects the continuing prejudice against LGB people and people's discomfort with the issue. CIT ran a campaign in GP surgeries and at Pride to encourage people to tell their GP about their sexual orientation- see appendix 3.

2.1.4 Religion and Belief

Although this data is collected in some cases it is not done comprehensively enough to compare groups. However, it is important that our services are aware of patients' religion and beliefs when devising treatment and care, for example bereavement, food and religious clothing and customs. Guidance on this is available for staff- [see here](#) and further advice is available from CIT and the chaplaincy service, which offers support on all religions and beliefs.

2.1.5 Gender reassignment

NHSGGC has the busiest transgender services in Scotland, many based at the Sandyford Sexual Health, and provide a number of specialist services that are recognised as being amongst the best in the UK. However, there are still barriers experienced by transgender people using mainstream NHS services. People's sex should be recorded in their medical records in the person's stated gender. Recording people's status as transitioning is more complex. Our gender reassignment policy states that:-

In all matters, members of staff should be aware that disclosing a person's gender reassignment status to a third party without first gaining their express permission to do so might constitute a breach of legislation. The Gender Recognition (Disclosure of Information) (Scotland) Order 2005 provides a limited exception permitting disclosure for medical purposes of the protected information about someone's gender recognition history ONLY where the following three criteria are ALL met:

- the disclosure is made to a health professional;
- the disclosure is made for medical purposes;
- the person making the disclosure reasonably believes that the subject has given consent to the disclosure or the subject cannot give such consent (for example, unconscious).

CIT are working with Scottish Transgender Alliance to balance the need to ensure services are being accessed by transgender people against the requirement to protect inappropriate disclosure of someone's gender reassignment status.

2.1.6 Disability

Some services collect information on sensory impairment, mental health, cognitive impairment and physical disability status. However, collecting data on disability is complex because it can cover all of the following:-

- access needs (e.g. the need for communication support);
- diseases (e.g. long term conditions which can be socially patterned by socioeconomic status or ethnicity);
- fluctuating conditions (e.g. many of us will have a mental health condition at some point in our lives);
- or people's identity as a disabled person (e.g. an impairment which last for more than 12 months which substantially affects the person's day to day living including physical, mental health or learning disability).

In addition, many people who would be considered disabled using the criteria in the Equality Act 2010, do not identify themselves as disabled. It is important that people's identity is self-determined.

From other sources, we have some information on numbers of disabled people in the population. For example:-

- 1 in 5 of us report a disability or life limiting illness at some time in our lives and this is related to life circumstances such as an increased likelihood of poverty;
- In NHS GGC an estimated 13,000 people have severe to profound deafness. Within this group there are a number of deaf people with British Sign Language (BSL) as their first language, estimated at 1,400 in NHS GGC, however it may be as high as 3,000. It is important to remember that British Sign Language users do not have English as a first language;
- It is difficult to estimate the number of people who are deafblind. There is thought to be approximately 1,000 deaf blind people in NHS GGC. Most of these people are not entirely deaf and blind, but may have a little sight and / or hearing.
- 41,400 people in NHS GGC have significant sight loss. Of these 8,500 are voluntarily registered as partially sighted or blind, however research indicates that as few as 23 - 38% of eligible people are registered. By 2021, 40% of the population will be over 50. A significant proportion of sight loss is related to age: one in eight over-75s and one in three over-90s have serious sight loss. Around

80% of people with a learning disability have some form of sight loss – often this sight loss is significant and in most cases was not previously detected.

There are several pieces of work underway to improve access to services for people with disabilities in NHS GGC including: an improvement plan to improve services for hearing and visually impaired people ([see here](#) pp 54- 56); an Equal Minds plan to reduce the stigma of mental health; Disability Discrimination Audits of new buildings; and a wide range of specific projects for particular disabilities.

2.1.7 Inequalities Sensitive Practice

Inequalities Sensitive Practice is a way of working which responds to the life circumstances that affect people's health. Evidence shows that if these issues are not taken into account by health services, opportunities are missed to improve health and reduce health inequalities. Sensitively enquiring about people's life circumstances and experiences as part of core health practice means that health workers can consider these issues when devising treatment and care. NHS GGC has had a programme of work in place since 2008 to ensure staff know and understand their responsibilities in identifying and responding to gender-based violence.

The plan incorporates the Scottish Government Health Department CEL 41 (2008) and, along with work programmes on Financial Inclusion and Employability, is part of NHS GGC's wider work to embed inequalities sensitive practice into health services.

From 2008 until the present, significant progress has been made in equipping staff with knowledge, skills, guidance, policies and protocols to embed enquiry and response to patient experience of GBV within core practice. However, the capability of our services to report on measures for GBV is compromised within many services due to limitations of their electronic data collection systems. With the exception of Sexual Health Services, all services have used manual audit of the records to provide information on the measures.

Following publication of the report, a series of discussions are underway with senior managers in key settings to review and agree GBV performance measures and improvement trajectories for 2015-16.

The proposed performance measures for 2015-16 are:

Measures	Target
Enquiry	% of patients asked about past or current experience of gender-based violence
Disclosure	% of patients who disclosed past or current experience of gender-based violence
Action recorded	% of care plans where action taken in response to disclosure had been taken.

Progress to date on these discussions is set out below:

Alcohol and Drug Recovery Services- Care First 6 can record disclosures but the recorded number is very low. However, a snapshot audit in 2014 showed that, of those who were asked, 50% disclosed domestic abuse, 40% disclosed involvement in prostitution and 42% reported experience of child sexual abuse. Tools and processes to enable ADRS to record and report on proposed measures will be developed over next 3-4 years. In the interim, snapshot audits of new referral case notes will be undertaken and will report on enquiry, disclosure and action in place.

Children and Families Services- Routine enquiry has been added to the Wellbeing Universal Assessment, which means staff will be prompted to ask about GBV. However, this does not mean we will be able to collect data on disclosure unless this is reported on by the service. The potential for adding data on disclosures, and whether action has been taken, is still under discussion.

Emergency Care Medical Services- Additions to Trakcare to capture enquiry, disclosure and actions are being explored. This is likely to take minimum of 6 months and this is competing with other requests for additions to the Trakcare system.

Mental Health- A pilot was carried out in Glasgow CHP South Sector, which recorded enquiries but not disclosures. Mental Health is moving from recording data on PIMS to EMIS and it is important that the new system has the ability to record enquires, disclosures and actions.

Sandyford Sexual Health Services- An electronic data system (NASH) is in place, which enables regular recording and reporting on the numbers of enquiries on GBV and the number of disclosures, disaggregated by form of abuse.

Maternity- An annual audit of 10% paper records is carried out on routine enquiry on GBV. This will be the only way of collecting data until the planned move to an electronic record system by end of 2017.

Learning Disability Services- Although there have been attempts to identify routine enquiry this is not currently available. However audits have shown that individuals are most at risk from relatives. Development of exemplar to test implementation in 2 HSCPs : Inverclyde and East Renfrewshire HSCP are interested in developing work in this area.

It has not proven possible to track referrals to services for support on gender-based violence. This is being tested in a GBV pilot with 8 GPs practices linked to a national pilot to strengthen identification and referral to advocacy support within primary care services.

NHSGGC's Action Plan to improve our responses to Female Genital Mutilation (FGM) is being delivered. Care pathways are being refreshed or developed for sexual health, mental health, children and families, obstetrics and gynaecology and clinical revision of FGM. NHSGGC is actively contributing to national developments on this issue. Scottish Government guidance on data collection on FGM has been disseminated across our system. More than 60 staff from within our Partnerships and Acute Services have attended awareness raising sessions on FGM.

The report to the October Board Meeting on Financial Inclusion showed that we have the ability to track referrals and outcomes of our financial inclusion work. From this data, we have been able to show that since 2011 NHSGGC staff have made over 32,000 referrals to Money Advice Services with £37 million financial gain for many vulnerable patients. Collecting this data has had an impact on buy-in from staff to routine enquiry on money worries by showing the concrete outcomes for patients, although work remains to make the recording of enquiry, referral and outcome routinely collected.

2.2 Data issues identified in our Equality Impact Assessments (EQIAs)

Since 2014, we have been using an on-line system to carry out EQIAs. We have reviewed all the EQIAs published on this system to see how EQIA leads are using equality data. 21 EQIAs have been published via the on-line system since 2014. Most of these EQIAs reported on some data on age, sex, ethnicity and postcode. However, their ability to record disability and religion and belief was very limited. Only one EQIA (Adult Community Nursing Service) included information relevant to sexual orientation (i.e. relationship status) and action to make improvements. 14 EQIAs identified the need to make improvements in their use of equalities data. In addition to the Adult Community Nursing Service, there are a number of other examples of where using data improved targeting of services. For example, the Mental Health Discharge and Resettlement Team increased engagement to ensure men were accessing the service and Nuclear Medicine found a pattern in a younger cohort of patients, which they addressed.

15 of the EQIAs were in Acute Services. Most of these EQIAs highlighted that the Trakcare data collection system, which they use, is limited in terms of all equalities data collection, but particularly sexual orientation and disability. An example of this is the pre-assessment service at the children's hospital, which indicated that Trakcare does not have the functions to include all disability information, and although this information may be available from previous notes, this is an issue for childrens' treatment and care. Trakcare is a national system and there has been considerable effort to develop it to make it fit for purpose. However, there are limited plans in place to improve equalities data in Trakcare.

3. USING PATIENT INFORMATION ON ADDITIONAL NEEDS TO IMPROVE ACCESS IN ACUTE SERVICES

3.1 Meeting Patients Additional Support Needs

Over that past few years it has become increasingly apparent that hospitals are not considering or preparing for patients' additional support needs when offering appointments. This was highlighted by Audit Scotland in 2010 and 2013 and subsequently by the Parliamentary Public Audit Committee. There are a number of national directives to improve NHSGGC's response to additional support needs, including in the 18 week RTT. To ensure that the 18 week RTT is fairly accessed by all patients it has been proposed

that in the longer term there is mandatory sharing of additional needs information between primary and secondary care using ISD codes. NHSGGC has processes in place for information on patients' needs for language interpreters and BSL interpreters to be transferred between primary and secondary care. However, there is still a need to improve how people's needs are communicated to their clinicians and carers so that people are not left without essential support when they are admitted to hospital.

3.2 Proposed action on Additional Support Needs for 2015-16

The NHSGGC Equalities Data Group has proposed the following action on additional support needs:

Replace the current "Patient has additional support needs" question in the referral to hospital services with the following question "Patient needs staff assistance" with a corresponding drop down list:

- Deafblind
- Hard of Hearing
- Learning Disability
- Speech Impairment
- Severe Mental Health problem
- Visual Impairment
- Requires bariatric equipment
- Unknown

If the question is completed with a positive response then a flag should appear on the front page of the SCI Gateway referral letter to display the requirement for staff assistance and the reason why, in addition to an entry under "Additional Relevant Information". Dialogue will be undertaken with relevant clinicians on the proposed changes and any changes required to existing guidance (e.g. primary care referral guidance directory). A small test of change will be conducted with a high volume service to assess impact on day-to-day practice, with a view to rolling this out if the approach is successful.

Patients and staff posters will highlight rights and responsibilities around the following issues for 'Patient needs staff assistance':

- Hard of hearing
- Visually impaired
- Learning disability
- People with a severe mental health problem
- People requiring bariatric equipment
- Speech impaired
- Deafblind patients

Patient and staff posters will include the following tips:

- The patient needs to be accompanied by staff from waiting areas to reception desks or clinics;
- The patient needs extra time to explain themselves;
- The patient wishes to write things down to communicate;
- The patient needs private space in a waiting area;
- Staff need to recognise a Deafblind guide communicator is the main way a Deafblind person can communicate. If the Deafblind guide communicator is unavailable, check if BSL interpreter could help;
- Staff should book bariatric equipment when required.

3.3 How we will support staff

Improving our response to people's additional support needs is an ongoing piece of work and falls under the remit of learning and education, medical records, person centred care, clinical governance, general practice and frontline staff and managers. CIT work with several groups to improve our response to people's additional support needs and in 2016 will deliver awareness sessions to referral management staff, reception staff and staff in high use service areas.

4. USING DATA TO MONITOR PERFORMANCE ON TACKLING INEQUALITY

4.1 Performance Measures Since 2011

For the past five years we have included Key Performance Indicators on tackling inequality in our performance management reviews. Appendix I shows the range of measures we have used since 2011. Organisational Performance Reviews also included measures based on NHSGGC's mainstreaming and equality outcomes which have been reported on

annually in our equality monitoring reports [see here](#). This has given us the ability to show where we are making a difference or where we need to take action.

4.2 Using Performance Measures to Drive Change and Show Improved Health Outcomes

Very few national targets drive change on the gap in health outcomes for equality groups. However, the antenatal care measure was based on evidence that those women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and/or have poorer experience of that care. The measure requires NHSGGC to ensure that 80% of women across the five SIMD groups receive antenatal care as a way of closing this gap. The evidence suggests that improving early access to antenatal care services supports mothers-to-be to breastfeed, improves maternal and infant nutrition, reduces harm from smoking, alcohol and drugs, and improves healthy birth weight.

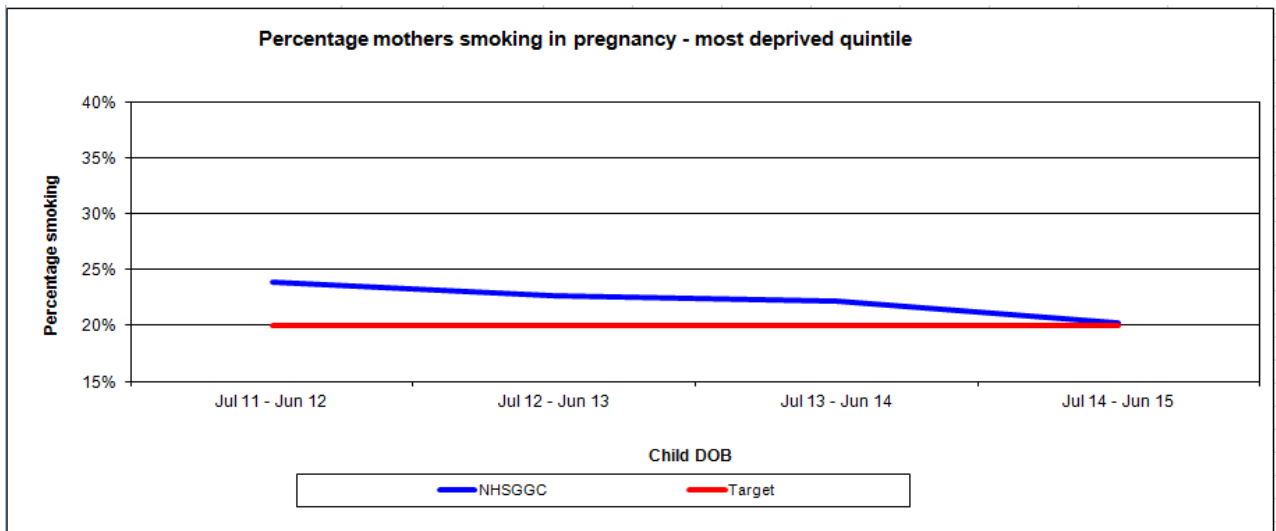
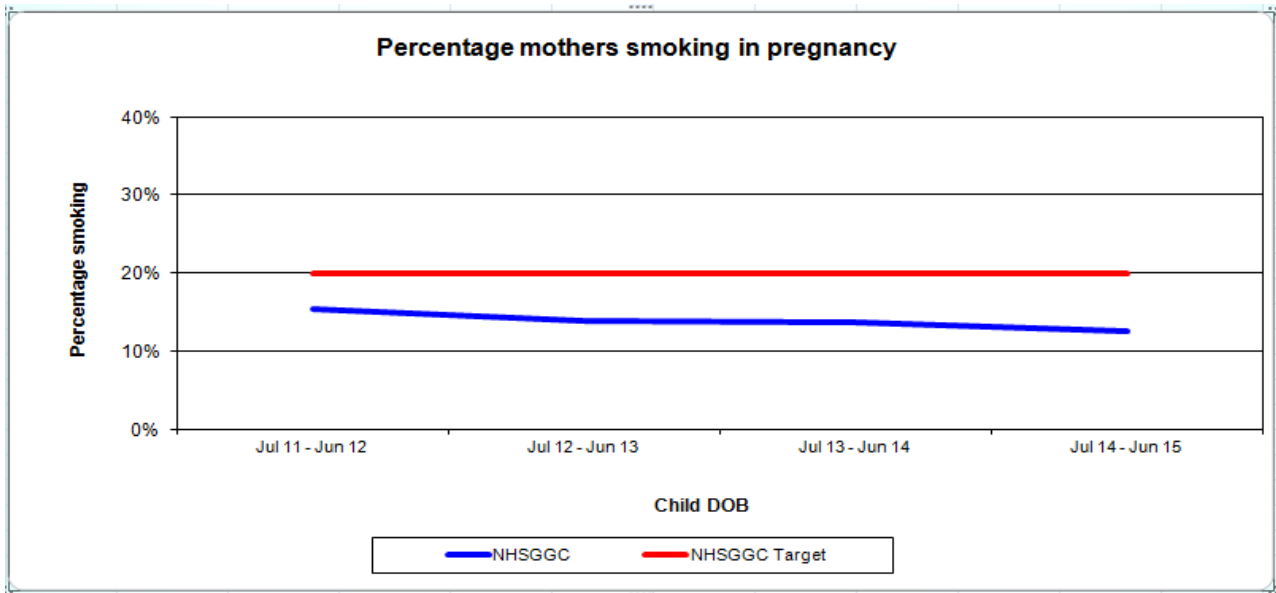
Based on the data available there is some evidence that the antenatal care measure has led to improvements in the context of smoking in pregnancy and exclusive breastfeeding at 6 – 8 weeks.

Smoking in Pregnancy

As seen from the table below there has been an overall decrease in the percentage of women smoking during pregnancy, decreasing from 15.3% for the period July – June 2012 to 12.5% for the same period in 2015. This decrease in the percentage of women smoking in pregnancy can also be seen for those mothers living in the most deprived quintiles, decreasing from 23.9% for the period July to June 2012 to 20.2% in for the same period in 2015.

Measures	Jul – June 2012	Jul – June 2013	Jul – June 2014	Jul – June 2015
Smoking in pregnancy	15.3%	13.8%	13.7%	12.5%
Smoking in pregnancy in deprived areas	23.9%	22.7%	22.2%	20.2%

*Please note that a boundary change came into effect in 2014.

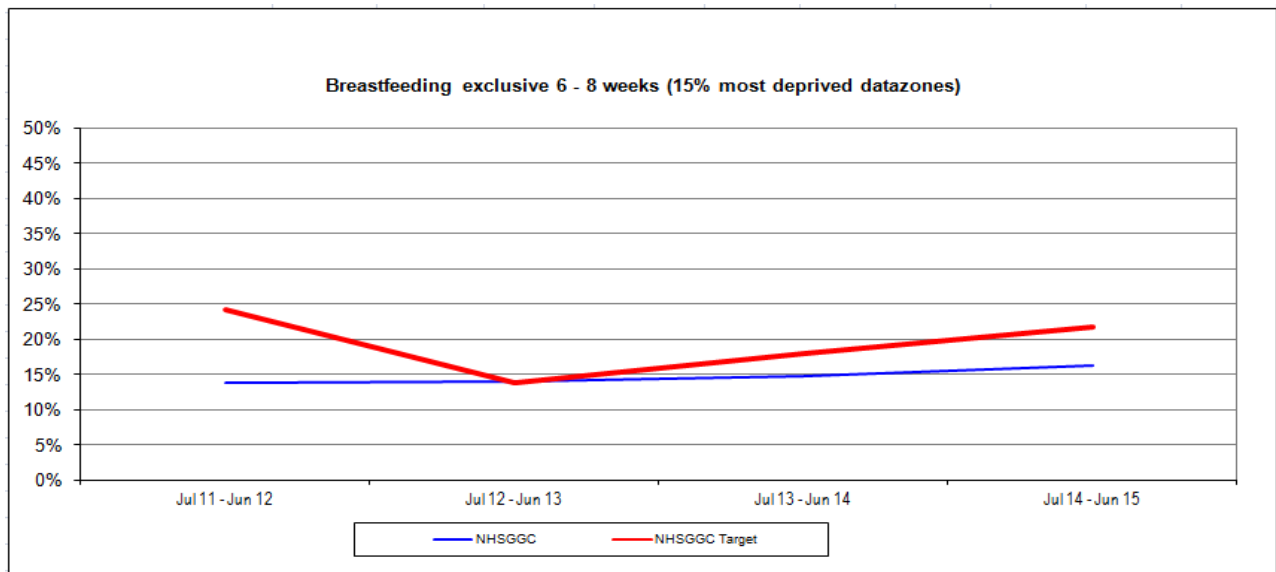
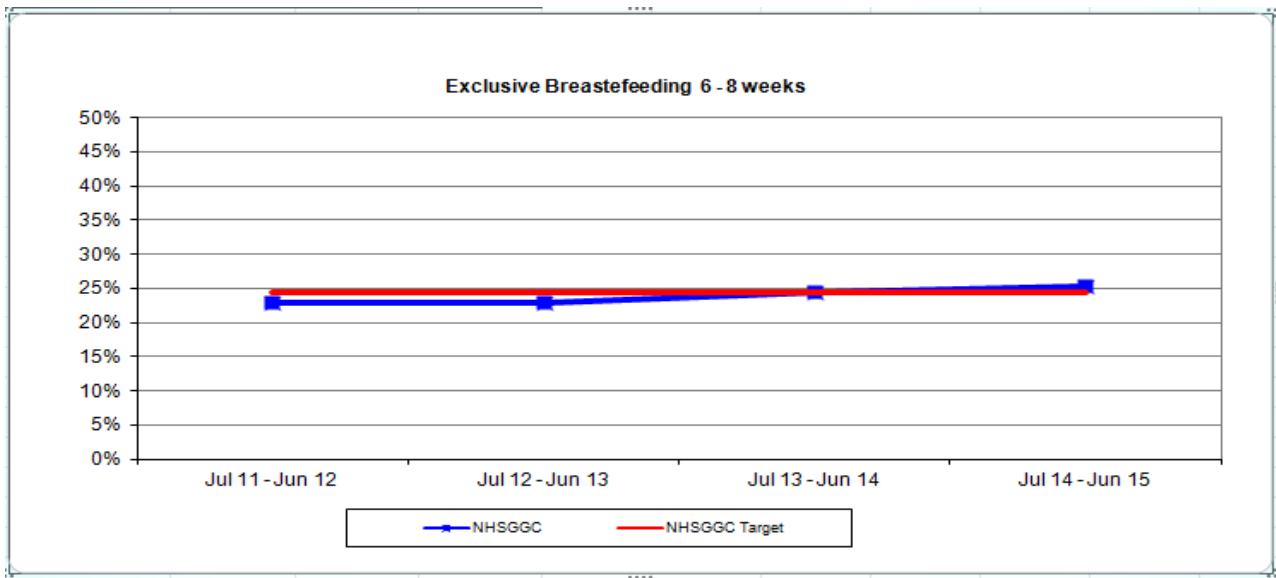


Exclusive Breastfeeding at 6 – 8 weeks

As seen from the table below there has been an overall increase in the percentage of women exclusively breastfeeding at 6 – 8 weeks increasing from 22.8% for the period July – June 2012 to 25.2% for the same period the in 2015. This increase can also be seen for those mothers living in the most deprived quintiles increasing from 13.8% of women exclusively breastfeeding at 6-8 weeks during the period July to June 2012 to 16.3% for the same period in 2015.

Measures	Jul – June 2012	Jul – June 2013	Jul – June 2014	Jul – June 2015
Breastfeeding at 6 – 8 weeks	22.8%	22.9%	24.5%	25.2%
Breastfeeding at 6 – 8 weeks in deprived areas	13.8%	14.0%	14.8%	16.3%

*Please note that a boundary change came into effect in 2014.



Alcohol Brief Interventions in Antenatal Care Settings

More recently, there has been a significant increase in the number of Alcohol Brief Interventions carried out in an antenatal care setting. The most recent figures show that the number of interventions carried out has increased from 10 for the period April – September 2014 to 220 for the same period during 2015.

Conclusion

The antenatal care measure shows that we can use performance to drive change and see how that change improves health outcomes for patients from equality groups.

4.3 Future Performance Measures in Acute Services

From April 2016, onwards the Board will develop a set of mainstreaming and equality outcomes in acute services that we are required to publish as part of our responsibilities under equality legislation. These outcomes will be based on a review of the evidence and extensive engagement with people from equality groups. The data to measure progress on the outcomes will come from a range of sources including patient data, EQIAs, patient engagement and audits. It is important that we improve our data collection by protected characteristic to develop robust equality measures. A paper was been prepared for the Acute Services Strategic Group which sets this out in more detail.

4.4 Future Performance measures in Health and Social Care Partnerships

From April 2016 the Board will introduce new performance measures in Health and Social Care Partnerships. In order to measure performance on NHSGGCs mainstreaming and equality outcomes the following measures are under discussion:-

- Number of published EQIAs
- Staff trained in GBV
- Staff trained on equality and diversity
- Inequalities Sensitive Practice routine enquiry and referrals (GBV, financial inclusion and employability).

Health and Social Care Partnerships will develop their own performance measures based on the specific equalities issues they identify for their population. The process to develop their Equality Outcomes for 2016 onwards will inform the measures required.

4.5 Employee Data on Equality and Diversity

Equality legislation also requires us to collect data on our staff in relation to the diversity of the workforce and their ability to understand their role in delivering equitable services. Employee data is regularly published and reported on at the Staff Governance Committee and the Area Partnership Forum. The workforce data is published on the staff intranet (StaffNet) and on the external Equalities in Health website. Reviewing this data led to the development of the 'Release Potential' campaign to raise awareness of disability for managers and staff.

In 2014 NHSGGC commissioned research to improve our collection of staff data. The smart metrics and equality and diversity monitoring report was published in October 2014 and went to the Staff Governance Committee in November 2014. The report considers the background to equality and diversity data monitoring and management (using the acronym EDDMM) incorporating data collection, data analysis, findings and dissemination before summarising and making recommendations to NHSGGC on future practice. The report defines 'smart metrics' as the intelligent use of HR data supported by a line of reasoning (logic) to inform effective decision making, thus linking EDDMM to key organisational objectives. The report recommendations will be taken forward by the Workforce Statistics Group.

Reports on our equality workforce statistics can be found [here](#).

5. USING EQUALITY DATA TO PREVENT ILL-HEALTH THROUGH SCREENING

5.1 Public Health Screening and Inequalities in Health

Public Health have reviewed their screening data to see where they can disaggregate the data they collect by the protected characteristics. The data has been used to identify low levels of uptake and late uptake by some groups in the population, which can then be targeted with specifically tailored approaches.

5.1.1 Pregnancy and Newborn

Pregnancy and newborn screening is supported by local Pregnancy Newborn Bloodspot Screen (PNBS) electronic system application. PNBS information is available by ancestry, SIMD, age. A change request has been submitted to the PNBS User group to redevelop the booking screen to record disability and interpreter needs. Any trends using SIMD, learning disability and age will be highlighted in the 2014/2015 Annual Screening Report.

5.1.2 Pre-school children vision screening

Preschool vision screening is supported by the national IT application called CHSP-S. National data is disaggregated by age and SIMD. Ethnicity is not recorded on CHI. Preschool vision screening is carried out in nurseries and children not attending a nursery are invited to clinics in either a health centre or hospital. A significant number of children (3,296) are not registered in a nursery so will miss preschool vision screening which can have a major impact on their educational attainment. Work is underway to understand who is not registered and this will include by SIMD and Black and Minority Ethnic children.

5.1.3 Cervical Screening

Cervical screening is supported by a national application called SCCRS and women are identified and invited using CHI data, which does not record ethnicity. The national data is disaggregated by SIMD and age.

Public Health screening programmes annual report showed that uptake was lowest in the younger age group 20 -35, particularly in NW Glasgow. Research was commissioned to segment the women by type using CACCI ACORN consumer research data. Data was used to plan a social marketing campaign in 2013-14. The data showed that of the 4,589 women who did not take up screening in NW Glasgow, 52.1% were grouped as educated urbanites; 5.2% were burdened singles; 8.4% were living in areas of high-rise hardship and 8% were living in inner city adversity. The social marketing campaign aimed to target these groups and was able to increase their uptake. The campaign information was also issued in British Sign Language.

Work is underway by health improvement staff and Primary Care Engagement Team to support practices with high BME populations to identify barriers and improve uptake.

On the 26th June 2015, screening was extended to transgender people. CHI has been changed to record gender reassignment and uptake will be monitored.

In April 2016, screening will be extended to women over 60 up to 64 and it will be important to monitor uptake. Screening for women under 25 will be withdrawn due to the HPV vaccine although a small number of women may still appear in the Invasive Cancer Audit.

The cervical skills training programme includes a discussion on equality and diversity. The programme is due to be updated and will include discussion on transgender and dealing with women aged over 60.

Engagement work with Lesbians suggests that Lesbians are still being erroneously told that they do not need cervical screening. Sandyford are making improvements to their new website to make sure Lesbians know they should be screened. However, work needs to be done with health practitioners so that they do not give the wrong advice.

5.1.4 Breast Screening

Breast screening is supported by the national IT application called SBSS. The national data is disaggregated by SIMD and age. The national data comes from CHI, which does not record ethnicity.

On the 26th June 2015, screening was extended to transgender people. CHI has been changed to record gender reassignment and uptake will be monitored.

Health Improvement Teams and Primary Care Engagement Team are working with practices to profile populations and identify areas of low engagement.

Action to improve screening uptake is being led by a Short Life Working Group that includes representation from Breast Screening Service, Pharmacy and Health Improvement and Primary Care Engagement Team and third sector agencies. The remit is to better co-ordinate activities to coincide with screening vans being in specific areas.

5.1.5 Bowel Screening

Bowel screening is supported by a national IT system called BOSS. The national data is disaggregated by SIMD and age. Participants are invited using the CHI, which does not record ethnicity.

The NHSGGC local bowel screening IT application records patients' requirements for an interpreter and any additional support needs. A request has been submitted to include these fields in the business objects reporting tool.

People with learning disability have poor uptake of bowel screening. Screening data can be linked to the learning disability register, which means that we have been able to show an increase in uptake between 2013 and 2014 following local work to make improvements.

Public Health Screening Programmes Annual Report 2013/14 reported that uptake by men is low, at 48.9%, compared to women where uptake is 53.9%. Overall uptake for 2013/14 was 51.1% and is below the minimum target of 60%.

Health improvement teams and the Primary Care Engagement Team are working with the Shields Centre to develop activities to encourage men from BME backgrounds to improve uptake in the Pollokshaws area.

5.1.6 Diabetic Retinopathy Screening

Diabetic retinopathy screening is supported by a national IT system called SOARIAN. Local NHSGGC data from SCI Diabetes is disaggregated by age, sex, ethnicity, faith and SIMD. As diabetes is prevalent in SIMD 1 and in South Asian people these will be reported in the 2014/2015 Annual Screening Report.

5.1.7 Abdominal Aortic Aneurism (AAA)

AAA screening is supported by a national system called AAA and data is disaggregated by SIMD and age. Participants are invited using CHI, which does not record ethnicity. Uptake for 2013/14 has increased to 81.2%. The lowest uptake is in SIMD1 areas at 74.7%.

5.1.8 Improvements Required

A key improvement would be for the CHI register to include ethnicity. However, this would require action at national level. We are carrying out a boosted Black and Minority Ethnic sample study of the Health and Wellbeing Survey and we will include questions on screening, for example:-

- Have you taken up any of the following (list screening offered)?
- What can we do to help you to uptake in the future?

Actions to target differentials in screening uptake and health outcomes are included in the above report and these will be followed up to ensure action has taken place.

6. USING POPULATION DATA TO PLAN SERVICES

6.1 Population Health Indicators

The latest Director of Public Health report “attempts to prioritise and summarise the large amount of data and information that is currently available” on NHSGGC’s population. This includes data on men and women, ethnicity, age, SIMD and poverty. There is some information on disability but, given the limitation of national datasets, no information is available on sexual orientation, transgender people or religion and belief. With some further analysis, using an inequalities lens, the data could be used to understand the patterns of inequalities in NHSGGC. For example:-

- Child poverty- most single parents are women and they have been particularly badly affected by welfare reform changes;
- There is evidence that some other groups are also significantly adversely affected by welfare reform, particularly people with disabilities;
- Young people’s sense of disconnect and experience of discrimination comes through in some of the data;
- There is evidence of some of the particular issues affecting refugees and asylum seekers;
- The increase in the older population will increase social isolation and loneliness and will result in more people taking on caring responsibilities.

Public Health have prepared a set of indicators for Health and Social Care Partnerships which includes disaggregated data where it is available and a breakdown of the 2014 Health and Wellbeing Survey. The Health and Wellbeing Survey clearly shows that there is a health gap between the 15% most deprived people and the rest of the population and that the gap is increasing. The data was also analysed by sex and age and this highlighted some differences, for example, women are more likely to have long term limiting illness and to report their physical and emotional wellbeing as less positive. A follow on survey with BME people in Glasgow is now underway so that we can see if there are any differences in their perceptions or health outcomes.

6.2 Miniature Cities

Glasgow Centre for Population Health has worked with the forming Glasgow Health and Social Care Partnership to use existing data to illustrate the diversity in the City. This data shows that:-

- The ethnic minority population in Glasgow is growing with 27% of children aged between 0-4 being non-white/ non-British compared to 19% of school age children and 3% of adults aged over 75;
- 74% of people over 75 have a health condition which limits their daily activity;
- 30% of school age children require additional learning support.

Examples of the data presentation using the Miniature Cities approach can be seen at Appendix II.

7. RECOMMENDATIONS

Collecting data is one way to raise awareness of the diverse nature of our population with staff and to enable us to know when and where we are making a difference to improving differential health outcomes. It has been challenging to find measures that will close health gaps between groups even though we routinely collect data on sex, age and socio-economic status. This is further compounded by a lack of disaggregated data in many NHS data collection systems on other protected characteristics covered by the Equality Act 2010 (disability, ethnicity, religion and belief and sexual orientation).

The Board is asked to receive this update on using data to understand and tackle inequality in NHSGGC and support the recommendations for action, which are that:-

- New data systems or migrated data systems always include fields to collect equality data and an improvement programme to update existing data systems is undertaken;
- The Performance Framework for NHSGGC will develop measures based on identified gaps in health outcomes for people with protected characteristics and by SIMD and seek to show improved health outcomes through related measures;
- Data collection and performance measures will be put in place to track progress on the mainstreaming and equality outcomes for the Board for 2016-19;
- Meeting patients additional support needs will be mainstreamed into data systems and practice in primary care and at ward level;
- Actions to target differentials in screening uptake and health outcomes will be followed up to ensure action has taken place;
- The Board will seek to influence national systems to include equalities data.

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Author: Jackie Erdman with support from Denise Lyden, Patricia Mullen and CIT.

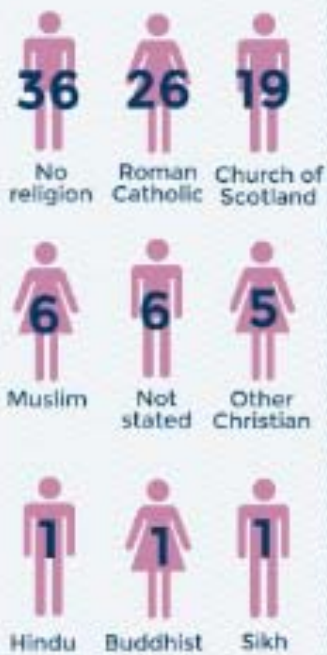
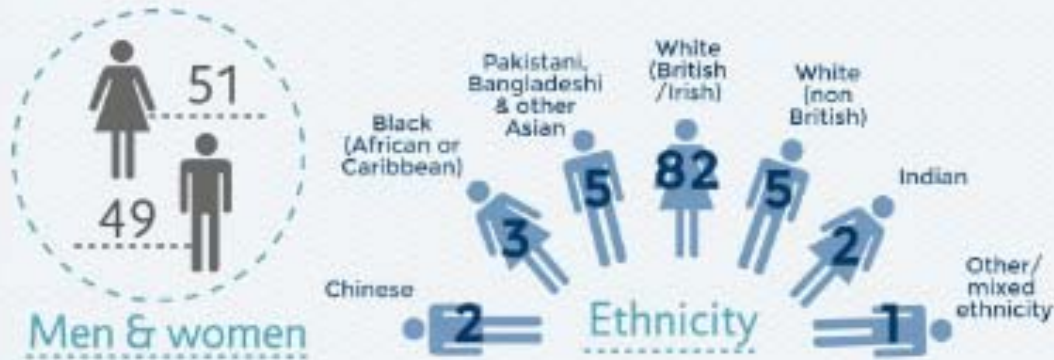
Appendix I - Performance Measures to Tackle Inequality Using Disaggregated Data

EQUITABLE							
Type	Measure	As At	Same Period 2013-14	Current 2014-15	Target 2014-15	Performance Status	Direction of Travel
HT	Smoking Cessation (40% most deprived areas within Board SIMD)						
	Number of quits at 1 month (provisional data)	Apr – Dec 14	—	2,185	4,572	RED	—
	Number of quits at 3 months (provisional data)	Apr – Dec 14	—	698	1,695	RED	—
HT	Antenatal Care (SIMD)	Oct – Dec 14	70.3%	72.7%	77.9%	RED	▲
HT	Number and proportion of 3 year olds who have had 2 or more fluoride varnish applications:*						
	SIMD 1	Apr – Mar 14	35.3%	—	35%	GREEN	—
	SIMD 2	Apr – Mar 14	30.0%	—	35%	RED	—
	SIMD 3	Apr – Mar 14	23.0%	—	35%	RED	—
	SIMD 4	Apr – Mar 14	25.4%	—	35%	RED	—
	SIMD 5	Apr – Mar 14	17.0%	—	35%	RED	—
HT	Number and proportion of 4 year olds who have had 2 or more fluoride varnish applications:*						
	SIMD 1	Apr – Mar 14	47.0%	—	35%	GREEN	—
	SIMD 2	Apr – Mar 14	37.9%	—	35%	GREEN	—
	SIMD 3	Apr – Mar 14	25.5%	—	35%	RED	—
	SIMD 4	Apr – Mar 14	29.1%	—	35%	RED	—
	SIMD 5	Apr – Mar 14	14.6%	—	35%	RED	—
LKPI	Workforce profile: as a % of workforce:						
	Ethnicity (% disclosed race/ethnicity opted for non-white categories)	Mar 15	4.5%	4.52%	—	GREY	▲
	Disability (% disclosed a disability)	Mar 15	0.5%	0.5%	—	GREY	▶
LKPI	% of new outpatient appointment DNA**	Mar 15	11.3%	11.4%	11.3%	AMBER	▼
	% of new outpatient DNA – Female SIMD1	Jan - Dec 14	15.3%	14.9%	—	NEW DATA	▲
	% of new outpatient DNA – Female SIMD5	Jan - Dec 14	6.9%	6.2%	—	NEW DATA	▲
	% of new outpatient DNA – Male SIMD1	Jan - Dec 14	18.6%	18.1%	—	NEW DATA	▲
	% of new outpatient DNA – Male SIMD5	Jan - Dec 14	7.6%	6.9%	—	NEW DATA	▲
LKPI	Number of inequalities legal cases against NHSGG&C	Apr 15	0	0	0	GREEN	▶
Narr	Equalities - monitoring legal precedents	Apr 15	See Commentary				—
Narr	EQIA's of cost savings programmes	Apr 15	Complete for 2014-15 and EQIAs underway				—



What if Glasgow was a village of 100 people? What would the population look like?

There are 344,040 adults aged between 18 and 54 living in Glasgow - represented in 100 people the adult population looks like this:



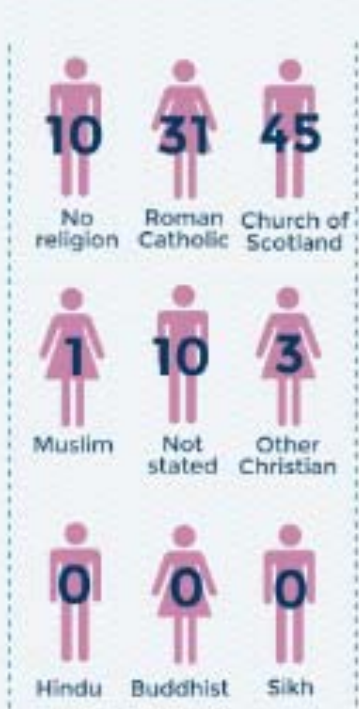
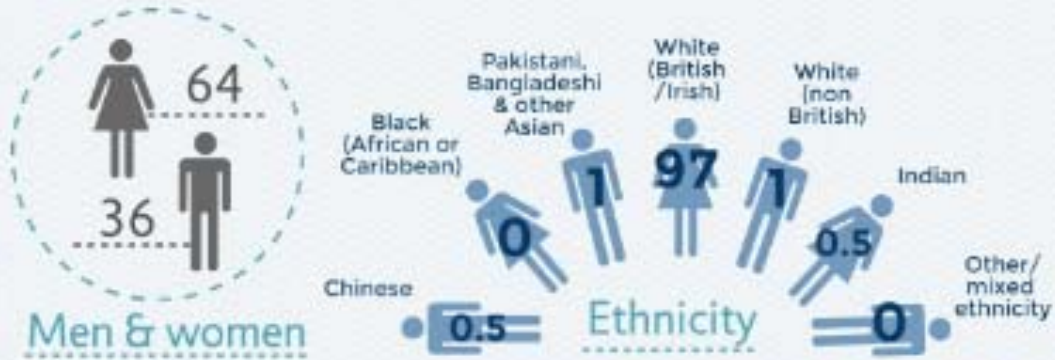
Find out more about Glasgow's population: www.understandingglasgow.com





What if Glasgow was a village of 100 people? What would the population look like?

There are 39,697 adults aged 75 and over living in Glasgow - represented in 100 people the elderly adult population looks like this:



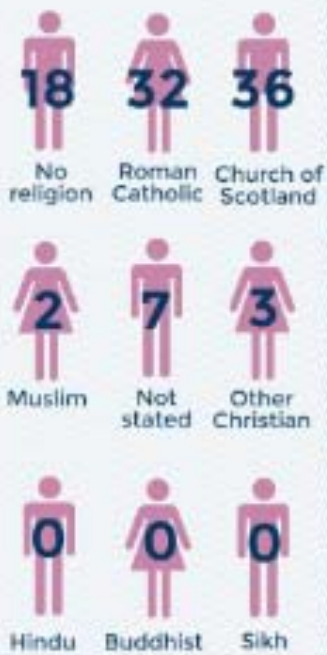
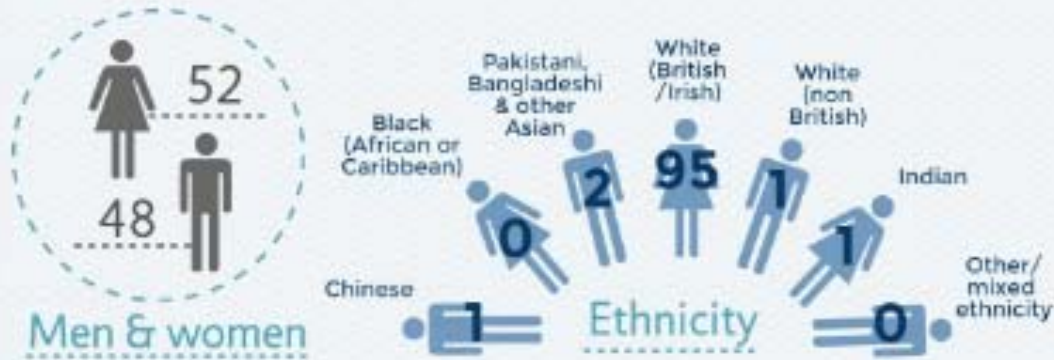
Find out more about Glasgow's population: www.understandingglasgow.com





What if Glasgow was a village of 100 people? What would the population look like?

There are 106,667 adults aged between 55 and 74 living in Glasgow - represented in 100 people the older adult population looks like this:



Disability



English language proficiency



Sexuality

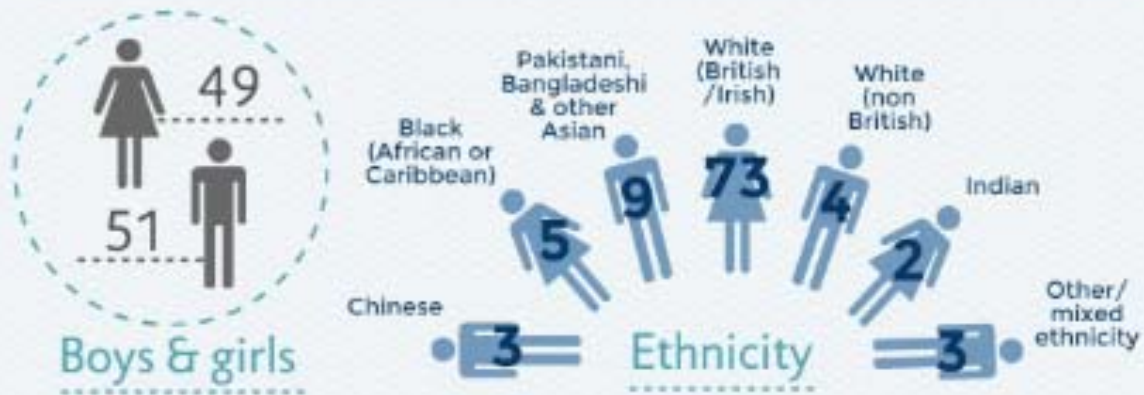
Find out more about Glasgow's population: www.understandingglasgow.com





What if Glasgow was a village of 100 people? What would the population look like?

There are 35,053 pre-school children (aged 0-4) living in Glasgow - represented in 100 people the pre-school population looks like this:



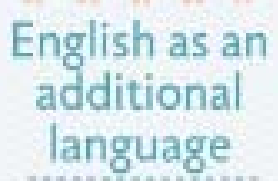
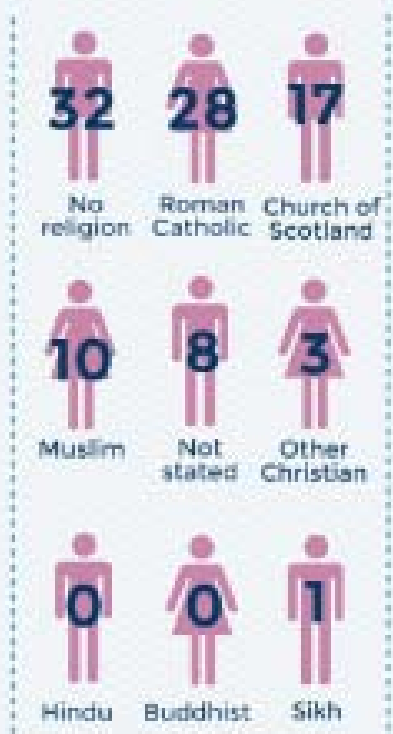
Find out more about Glasgow's population: www.understandingglasgow.com





What if Glasgow was a village of 100 people? What would the population look like?

There are 74,193 school-aged children (aged 5-17) living in Glasgow-
represented in 100 people the school-age population looks like this:



Find out more about Glasgow's population: www.understandingglasgow.com

Appendix 3.

Sexual Orientation GP Posters

The poster features a collage of five photographs: a man and a woman smiling together, a close-up of two women's faces, a man and a woman sitting on a bench outdoors, a woman in a white lab coat, and a woman in a dark jacket. The NHS logo and 'Greater Glasgow and Clyde' text are in the top right. A blue box on the left contains the text 'We're not just being nosy.' The bottom section has a pink background with white text and the 'Equalities In Health' logo.

NHS
Greater Glasgow
and Clyde

We're not
just being
nosy.

Knowing your sexual orientation allows us to give you the most appropriate advice and treatment. And that means you're more likely to feel healthier for longer. Only NHS services get to see this information. By law, no one else can.

So please
tell us.

Equalities
In Health