

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

Leaders, staff and partners mainly described addressing equity in terms of service delivery and digital-equality for the rural population and the deaf community, with very little description about other groups that could be affected. Ethnic minority communities made up a very small proportion (<4%) of the population. Staff and leaders told us about eastern European communities and post-mining communities. Partners and leaders said they wanted to do more to reduce health inequalities and address barriers to care in the population. The Joint Strategic Needs Assessment (JSNA) captured this which fed into Integrated Care Board (ICB) and the Health and Wellbeing Strategy. There was a Black and Minority Ethnic (BME) partnership forum in place which provided engagement and feedback on policy and service developments.

The ICB was part of a pathfinder programme with National Health Service England (NHSE). The Director of Public Health was engaged in this project around health inequalities in terms of race. We heard the Black and Minority Ethnic (BME) local authority staff forum, worked with the health and social care sector and involved the carers organisation. Staff described working for an inclusive organisation where they felt accepted and able to be themselves and we heard about work-place networks such as the neurodiversity group. Staff asked people using services about protected characteristics which was introduced into conversations from the first point of call. The local authority had several over-50s groups in localities and it recognised the challenges and opportunities arising from a rising older population in the county. People attending these groups told us they felt listened to and involved.

The carers organisation offered a telephone befriending service for isolated carers in the rural population. We heard they intended to support more seldom-heard carers from ethnic minorities, Lesbian, Gay, Bisexual and Transgender (LGBT) carers and those caring for people with substance misuse issues. They did have a male carers support group.

Equality and diversity considerations were included in providers contracts and there was a quarterly monitoring tool providers completed, demonstrating how they supported people with cultural needs. Staff told us the equality impact assessment (EIA) process was actively used by managers across adult social care. We heard an example where colleagues across the local authority had used adult social care as a good example of an EIA.

Derbyshire local authority had not always communicated and coproduced with groups effectively and some seldom-heard groups reported the relationship with social workers could be improved. However, we saw efforts had been made to liaise with groups and direct payments had been used to support individual outcomes.

The local authority committed to adult care and health participation by people using services, or requiring care, in their strategy. It stated they would inform, consult, involve, co-produce and empower people. The inclusion strategy also described how the gap between the most and least deprived had widened, citing the Covid-19 pandemic as one reason for deepening inequalities. A workstream for each of the priorities had been established, however progress on this was not clear.

It was positive to see neuro-development hubs had been provided in the county to support autistic people.

Inclusion and accessibility arrangements

There was mixed feedback on inclusive accessibility arrangements. Some staff felt able to access interpreters and information in different formats, and other staff reported difficulties. Some people said speed of access to accessible information was an issue. Responses about access for people centred around rurality and we heard examples of individuals offering translation services themselves. Staff working with health colleagues described using them to source interpreters and we heard one example of a health professional being used as an interpreter, during a mental health act assessment. Some communication barriers had been difficult with people seeking asylum, in for example using international sign language.
