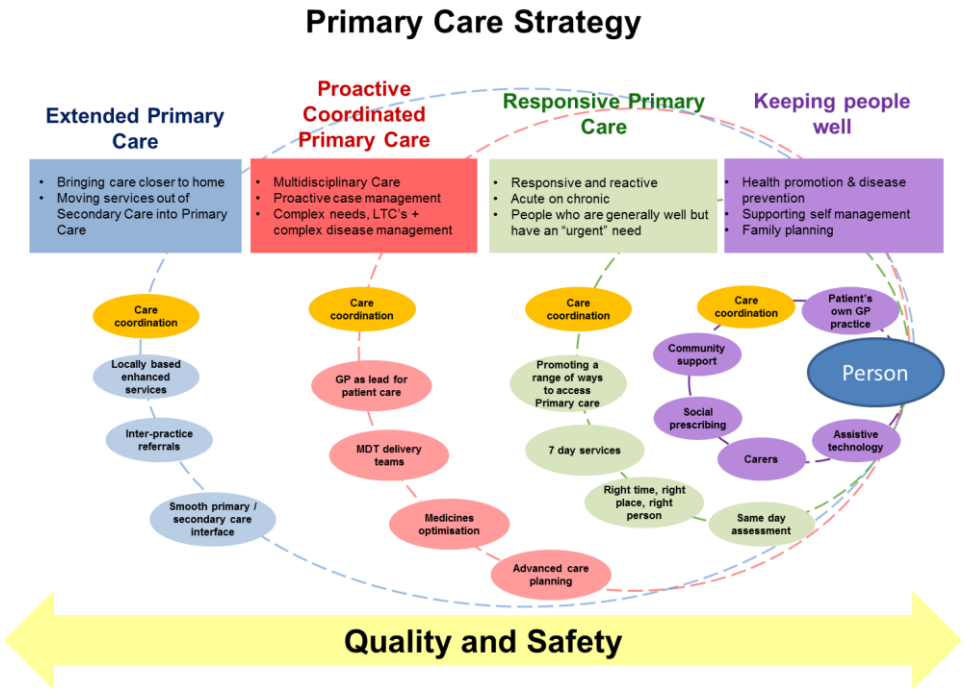
NHS
Doncaster
Clinical Commissioning Group

Equality Analysis Form

Subject of equality analysis	Primary Medical Care Commissioning – strategy and plan		
Type			**Tick**
	Policy		
	Strategy		X
	Business case		
	Commissioning service redesign		
	Contract / Procurement		
	Event / consultation		
Owner	**Name:**	Primary Care Team & Equalities Team	
	Job Title:	As above	
Date	November 2016		
Assessment Summary	NHS Doncaster CCG received delegated responsibility for primary medical care commissioning from 1 April 2016. After 6 months of this delegated authority we have a fuller understanding of the challenges and opportunities this presents and we are developing a draft plan against the national GP Five Year Forward View. It was therefore felt that this is an appropriate time to undertake a deep dive analysis of inequalities in primary medical care access, experience and outcomes in order to inform the Primary Care Commissioning Committee and the draft GP Five Year Forward View plan submission.		
Stakeholders			**Tick**
	Staff		
	General public		
	Service users		X
	Partners		X
	Providers		X
	Other		

Data collection and consultation	**Data** CCG Primary Care Strategic Model: • NHS Doncaster CCG (DCCG) has developed a Primary Care Specification and Commissioning Framework ("Framework") which takes learning from the 5 Year Forward View and the Prime Ministers Challenge Fund (now known as GP Access Fund) sites & New Care Models vanguard sites to inform and support Primary Care transformation in Doncaster. This Framework sets out the ambitions of DCCG and its member practices to position Primary Care at the heart of system transformation through the following agreed principles: ○ People, not organisations and services, must be at the centre of health and care service delivery so that the patient experience is that it is one service ○ People have access to high quality clinical care in a responsive and timely manner ○ Primary Care services should be proactive and focussed on early diagnosis and interventions, and support independence ○ People have good information to enable them to make informed choices about their health care ○ The population of Doncaster has access to a clear offer of high quality services as close to home as possible ○ Health services in Doncaster move towards proactive primary prevention and health promotion rather than reactive treatment and secondary prevention • To complement the Framework the CCG devised its Primary Care Strategic Model, below.  • The strategic approach is comprised of four pillars of care (underpinned by the CCG's Quality and Safety Strategy), which represent the enhanced patient offer in the areas of self-management and prevention, responsive and accessible care, proactive co-ordinated care, and extended services in primary care. Each of these pillars will be commissioned via a dedicated service specification, with the required additional investment in primary care. Health Inequalities in General Practice, Royal College of General Practitioners, May 2015: • The contribution of a strong primary care sector to health outcomes is well

established.

- General practice is also the only part of the service that is truly universal in that the vast majority of patients are registered with a GP practice, and GPs do not 'discharge' patients from their care. As such, continuity of care and preventative care — two important tools in combatting health inequalities — form a fundamental part of the work of a GP and their team.
- It is important to recognise that general practice can only ever be one part of the solution to tackling health inequalities. All parts of the health and social care system need to work together to combat health inequalities, and much of the work that GPs can do to make a difference in this area needs to be taken forward in collaboration with other professionals
- Difficulties accessing the healthcare system are one of the major drivers behind health inequalities. Traditionally socially excluded groups often struggle to engage with the healthcare system and consequently have significantly worse health outcomes than equivalent individuals within the wider society.
- Homelessness is one of the biggest indicators of a lack of engagement with the health system. The impact of rough sleeping on the wider health and life expectancy of individuals is well recognised: an evaluation by Crisis found that the average life expectancy of the homeless in England is 47, as opposed to 77 for the general population.
- Gypsies or Travellers are another section of society that experience markedly worse health outcomes than the general population, with 42 per cent of English Gypsies suffering from a long term condition, as opposed to 18 per cent of the general population. As with homelessness, this can be partly explained by a lack of engagement with primary / non emergency health care, due in part to administrative barriers but also in part to social and cultural barriers.
- Recent immigrants and asylum seekers may also have trouble navigating the health system as they often have little awareness of available services and speak limited English, while the provision of translation services is patchy and underfunded. The need for a translator can also add extra time to a GP consultation, time which is in short supply in under-doctored areas (which traditionally are associated with high levels of immigration and poverty).
- A lack of patient engagement with their own health and care has a well understood impact on relative health outcomes, with research showing that patients who have so called low 'health activation' are two to three times more likely to have unmet medical needs and to delay medical care compared with more highly activated patients, even after controlling for income, education and access to care.
- The paper suggests that action is needed in the following six areas:
    - As part of measures to increase the overall size of the GP workforce, put in place incentives to attract more GPs to currently underdoctored areas, ensuring that there is sufficient GP workforce capacity in areas where patient need is highest.
    - As part of a wider rebalancing of resources towards general practice, direct more NHS funding into GP and wider primary care services in those areas where health inequalities are currently worst.
    - Ensure that the process of piloting and delivering new models of care integrated around patients in each of the four nations of the UK serves to tackle, rather than exacerbate, health inequalities.
    - Create a supportive environment for GPs and their teams to take a more proactive population based approach to preventing ill health in their communities, working with other professionals to tackle the underlying causes of health inequalities. However, this cannot be taken forward without an increase in workforce capacity and resources, and must be led by GPs and other professionals from the bottom-up, rather than through imposing top-down interventions.
    - Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP — particularly areas where a high number of patients are living with multiple morbidities.
    - Fund outreach programmes to help often excluded groups such as those

with mental health problems, learning disabilities and the homeless to access general practice.

http://www.rcgp.org.uk/policy/rcgp-policy-areas/health-inequalities.aspx

Tackling inequalities in general practice, King's Fund, 2011:

- General practice is well positioned to have a positive impact on health inequalities at a number of levels: through clinical care, wider patient advocacy, community engagement and influencing the wider political agenda.
- One factor that may contribute to health inequalities is that there are fewer GPs in areas of deprivation.
- Good clinical practice involves GPs being aware of key demographic data pertinent to health inequalities and actively seeking to address these when opportunities arise.
- GP computer systems are rich in data that could support the monitoring of inequalities in general practice.

https://www.kingsfund.org.uk/sites/files/kf/Health%20Inequalities.pdf

Risk Stratification:

- Risk Stratification is a systematic process of using existing information to stratify a population to identify those who are most likely to have a specific outcome.
- Risk stratification tools have found that in general terms the more long term conditions a person reports living with, the greater their likelihood of utilising health and social care services. Multi-morbidity is more strongly related than age to health care social care costs, with the highest costs being related to acute non-elective hospital care. In addition to multiple long term conditions, people living with frailty are also high intensity users of health and social care services.

NHS England (2015) Using case finding and risk stratification: A key service component for personalised care and support planning https://www.england.nhs.uk/wp-content/uploads/2015/01/2015-01-20-CFRS-v0.14-FINAL.pdf

A picture of Doncaster by protected groups:

http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/08/A-picture-of-Doncaster-Census-2011.pdf
http://www.teamdoncaster.org.uk/Doncaster_Data_Observatory/Profiles/community_profiles_2014.asp
http://www.teamdoncaster.org.uk/Doncaster_Data_Observatory/joint_strategic_needs_assessment.asp

Consultation

GP Patient Survey:

- The GP Patient Survey (GPPS) is an England-wide survey, providing practice-level data about patients' experiences of their GP practices. The survey measures patients' experiences across a range of topics, including making appointments, waiting times, perceptions of care at appointments, practice opening hours, and out-of-hours services.
- Ipsos MORI administers the survey on behalf of NHS England. In NHS Doncaster CCG, 11,656 questionnaires were sent out across our 43 Member Practices, and 4,829 were returned completed. This represents a response rate of 41%.
- The overall experience of GP surgeries across all 43 Practices was generally positive, with 83% of patients rating their experience as good or very good (national comparator 85%). Overall 7% of patients rated their experience as poor or very poor (national comparator 5%). 10% rated their experience neither good nor poor.
- The data is available at practice level and it is apparent that there are a number of Doncaster GP practices which score lower than other Doncaster practices across several questions.
- There are a number of practices where patients struggle to get through by telephone.
- Other access options would benefit from further promotion such as online access and telephone consultations.
- Practice Nurses are generally regarded positively.

	• There is wide variation in responses between Practices. Substantial improvements in overall patient experience across the borough would be gained from improving the patient experience within a small number of GP Practices.
	
	Health Ambassadors (Summer 2016):
	• Consultation on access to and experience of primary medical care with our Health Ambassadors representing the following groups:
	  ○ Cancer service users and survivors
	  ○ Homeless people
	  ○ Deaf community
	  ○ Gypsy Traveller community
	  ○ People with learning disabilities
	  ○ Refugees and asylum seekers
	  ○ Sex workers
	  ○ Lesbian, Gay, Bisexual and Transgender
	  ○ Armed Forces / Veterans
	• Feedback:
	  ○ We received over 400 individual views from some of our most seldom heard groups in Doncaster. This is a statistically significant response rate.
	  ○ The following common themes emerged from across all the groups:
	  ▪ It can be difficult for the groups to make an appointment on the phone.
	  ▪ The biggest priority for the groups is easy access to timely appointments.
	  ▪ When members of the groups need a referral, they want to talk to a GP or a Nurse, not a trained receptionist.
	  ▪ The groups were not generally aware of alternative primary care options to GP appointments.
	
	Engagement approach with general practice in Doncaster:
	• Monthly slots at TARGET ring-fenced to practice networking, engagement with CCG on current commissioning topics and issues, and developing practice collaboration.
	• Monthly meeting of Primary Care Provider Engagement Group, open to all practices, predominantly focused on working up the specifications behind the 4 pillars in the strategic model.
	• Monthly/bi-monthly meetings of the 5 CCG commissioning localities, attended by member practices of the CCG.
	• Bi-monthly meetings of the CCG Clinical Reference Group, membership includes Governing Body GPs (x10), plus wider system partners (acute trust, community trust, local authority).
	• Regular 1:1s between CCG Chief of Primary Care and LMC & LPC secretaries respectively to maintain positive relationships.
	• 2-3 practice-wide events per annum hosted by the CCG to allow continuous awareness, participation and influence in strategic direction.

Protected characteristic	Positive	Neutral	Negative	Negative: What are the risks? Positive: What are the benefits / opportunities?
Age	X			Primary medical care is generally accessed most by older people, and by parents for children. People of working age may sometimes struggle to access primary medical care services outside of their normal working hours.

Protected characteristic	Positive	Neutral	Negative	Negative: What are the risks? Positive: What are the benefits / opportunities?
				A focus on primary care access as part of the primary care strategic framework would be likely to have a positive impact upon these groups.
Disability	X			Primary medical care is generally accessed most by people with disabilities. Parts of these populations may be less able to come to the surgery and rely on home visits, which is likely to reduce the number of proactive contacts with housebound patients. The proactive care specification may help to mitigate this for the practices who have focussed on their housebound populations. A focus on disability as part of the primary care strategic framework would be likely to have a positive impact upon these groups.
Gender			X	There is evidence than men tend to present later to GPs with symptoms than women, and diagnosis may therefore be delayed, with potential implications for treatment options and long term outcomes. The availability of appointments with male or female GPs may potentially affect how early certain genders may present with specific problems, however we hold no evidence of adverse impact.
Race			X	Evidence shows that access, experience and outcome is affected by race/ethnicity. Factors include communication and awareness of services. Availability of interpretation services can improve this. Gypsies or Travellers experience markedly worse health outcomes than the general population, with 42 per cent of English Gypsies suffering from a long term condition, as opposed to 18 per cent of the general population. Contributing factors can include lack of access to non-emergency healthcare, due in part to administrative barriers but also in part to social and cultural barriers. Recent immigrants and asylum seekers may have trouble navigating the health system as they often have little awareness of available services and speak/read limited English, while the provision of translation services is patchy and underfunded. The need for a translator also adds extra time to a GP consultation, time which is in short supply in under-doctored areas (which traditionally are associated with high levels of immigration and poverty). The use of family members or

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				friends as informal interpreters and may impact on the quality of the consultation and result in important information about sensitive topics not being shared.
Religion & Belief		X		There is very little evidence of research undertaken with religion/belief groups and inequalities in their healthcare experiences. The only exceptions are findings that some groups may accept diagnosis and outcomes more positively than others, purely due to their belief system. The availability of appointments with male or female GPs may potentially affect how early people from certain cultures/religions may present with specific problems, however we hold no evidence of adverse impact.
Sexual Orientation		X		There is some evidence from parts of the UK of a reluctance to undertake certain procedures and services due to the manner in which a partner may be treated in relation to next of kin etc. This indirectly affects the experience and outcome of the patients in this group also.
Gender reassignment		X		The majority of the evidence relates to conditions stemming from mental health issues. However, there is evidence that access, experience and outcome are affected by general healthcare policy of potentially excluding this group from specific procedures and services e.g. certain cancer screenings.
Pregnancy & Maternity		X		Primary medical care is generally accessed well by expectant mothers.
Marriage & Civil Partnership		X		N/A
Social Inclusion / Community Cohesion			X	Difficulties accessing the healthcare system are one of the major drivers behind health inequalities. Traditionally socially excluded groups often struggle to engage with the healthcare system and consequently have significantly worse health outcomes than equivalent individuals within the wider society. Homelessness is one of the biggest indicators of a lack of engagement with the health system. The impact of rough sleeping on the wider health and life expectancy of individuals is well recognised: an evaluation by Crisis found that the average life expectancy of the homeless in England is 47, as opposed to 77 for the general population.

Protected characteristic	Positive	Neutral	Negative	Negative: What are the risks? Positive: What are the benefits / opportunities?
				A lack of patient engagement with their own health and care has a well understood impact on relative health outcomes, with research showing that patients who have so called low 'health activation' are two to three times more likely to have unmet medical needs and to delay medical care compared with more highly activated patients, even after controlling for income, education and access to care.

Conclusion & Recommendations including any resulting action plan	When designing specifications to deliver the Primary Care Strategic model, particular consideration should be given to addressing potential inequalities due to: • Age: access for the working age population. • Gender: men generally tend to present later with medical conditions. • Race: issues with communication needs and awareness of primary medical care services. • Social Isolation (e.g. homelessness, substance misusers, sex workers, people on probation): potentially preventing timely access to primary medical care.
Review date	In accordance with primary care strategic developments.