NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Quality Impact & Equality Analysis Policy

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Quality Impact & Equality Analysis Policy		
EA Author	Debbie King – Head of Quality & Transformation	**Team**	Quality
Date Started	21/12/18	**Date Completed**	21/12/18
EA Version	V0.1	**Reviewed by E&D**	16/01/19

What are the intended outcomes of this work? Include outline of objectives and function aims

This policy outlines the arrangements for BSol CCG's to undertake quality impact & equality analysis on changes to services delivery which may impact the quality for patients, through safety, effectiveness and patient experience. Where there is a negative impact on patients the tool allows for commissioners and quality staff to identify mitigations to reduce the impact and ensure high quality services for patients.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

- All staff involved in redesign of commissioned services across the CCG
- The Nursing directorate
- Health and social care service providers
- Patients in contact with visiting teams

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
	Best practice guidance from NEW Devon CCG as part of wider NHSE programme	

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

- Birmingham has a younger population with 66% under 45 years and 17% in the 20-29 age group. 13% of the population is over 65 years old and is set to remain stable with many retirees continuing to move out of the City. The health needs of young people show that they

3. Impact and Evidence:

have a relatively unhealthy start in life. The health of children in Birmingham is worse than England overall. This is reflected in a high level of infant mortality, low birth weight babies and high childhood obesity rates. Birmingham's teenage conception rate is one of the highest in the country.

- Conversely, Solihull is characterised by its older population. Between 1995 and 2015 the population aged 65 and over increased from 16% to 21% of the total so that there are now 9,200 more residents aged 65 to 84 years and 3,500 more aged 85 years and over than 20 years ago. Population projections based on the 2014 population estimates indicate the relative ageing of the Solihull population will continue and by 2033 those aged 65 and over will account for one in four of the borough population, with those aged 85+ numbering nearly 12,000 (5% of total). The growth in the numbers of those aged 85 and over represents a significant and growing challenge in terms of health and social care.

This policy provides the framework for staff to assess the quality impact and equality elements of any proposed changes to services through investment or disinvestment or where schemes for QIPP may impact on patients.

Use of a single assessment tool will support commissioning managers to identify in a systematic way the impact on patients of service changes and document any mitigations required to minimise risks to patients where identified.

Use of the QIEA tool should have a positive impact on age ensuring quality of care for all age groups.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

- 9.1% of the Birmingham population reported a life limiting condition or disability, with a further 9.3% of the population classified as their day to day activities were limited a little by a life limiting condition; with significant prevalence for those aged 65 years and over. Birmingham has 3.6% of children under the age of 15 years claiming disability living allowance. Mental illness is associated with one in every five people occupying a hospital bed each day in Birmingham. The percentage of the population who suffer from a mental health condition in Birmingham is 1% compared to the NHS England's indicator of 0.8%.

- The most common mental health problems in Solihull are neurotic disorders and depression. Large numbers of people in Solihull, over 24,000, are estimated to be suffering from these conditions - this represents 1 in 6 of the population aged 15-74. These conditions are more common in women and affect all age groups. 45.5% of Birmingham population has very good health compared to 47% of Solihull population. Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020.

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Use of the QIEA tool should have a positive impact ensuring quality of care for all patients including those with a disability.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

- Birmingham Lesbian Gay Bisexual Transgender (LGBT) organisation stated (in their report 'Out and About: Mapping LGBT lives in Birmingham') that whilst there are no agreed figures as to the percentage of the LGBT population, estimates of between 6% and 10% are popularly used. There is evidence that indicates LGBT people experience discrimination when using health services and report having a poorer patient experience.

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Use of the QIEA tool should have a positive impact ensuring quality of care for all patients including those who are transgender.

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

There are no known impacts on marriage and civil partnership.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

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Use of the QIEA tool should have a positive impact ensuring quality of care for all patients who are pregnant.

3. Impact and Evidence:

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

- Birmingham is characterised by its ethnic diversity with a Black and Minority Ethnic (BAME) profile of around 42% and a range of languages spoken. Around 22% of Birmingham's residents are born overseas and 15% of the population is classified as having a main language other than English. There is a recognised link between poor health outcomes and English language needs. In Solihull, the BAME population has more than doubled since the 2001 Census and now represents nearly 11% of the total population.
- GP registration data on new patients who are recorded as being born outside the UK (Flag 4 data) shows an increase of 81,314 in overseas migrant registrations within Birmingham between 2013-2016 - Poland followed by Pakistan and India. The highest number of new registrations were from those from Romania (11,715), followed by Pakistan (6,704) and China (6,095). Migrant health priorities include tackling Female Genital Mutilation (FGM), communicable diseases such as HIV and TB, access to screening and vacs, and mental health.

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Use of the QIEA tool should have a positive impact on race ensuring quality of care for all communities within BSol area.

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

- In Birmingham, Christianity is the largest religion at 46%, followed by Muslim at 22%.
- The majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%).

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Use of the QIEA tool should have a positive impact on patient's religion or belief ensuring quality of care for all.

3. Impact and Evidence:

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

- Both Birmingham and Solihull have a gender breakdown of 51% female and 49% male.

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Use of the QIEA tool should have a positive impact on sex ensuring quality of care for all.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

- Birmingham Lesbian Gay Bisexual Transgender (LGBT) organisation stated (in their report 'Out and About: Mapping LGBT lives in Birmingham') that whilst there are no agreed figures as to the percentage of the LGBT population, estimates of between 6% and 10% are popularly used. There is evidence that indicates LGBT people experience discrimination when using health services, experiencing poorer mental health, and report having a poorer patient experience.

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Use of the QIEA tool should have a positive impact on sexual orientation ensuring quality of care for all.

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

- The 2011 Census indicated that 107380 people in Birmingham provide unpaid care (10% of usual resident population). Of those who provided unpaid care over 26% provided 50 or more hours a week.
- There are nearly 21,000 carers in Solihull equating to 10.5% of the total population, higher than the national average of 9.9%. This correlates with the larger 65+years population in Solihull
- Unpaid Carers - data shows that a higher proportion of the CCG's population are undertaking care for family / relatives than the England average, this can be linked to the diverse

3. Impact and Evidence:

communities identified within the population and must be considered in Commissioning decisions.

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Use of the QIEA tool should have a positive impact on carers ensuring quality of care for all.

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

No impacts identified.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	
Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	

How will you ensure the proposals reduce health inequalities?

The tool will require a thorough review of the commissioning proposal taking into consideration patient safety, experience, effectiveness and equality. Where negative impacts or concerns are identified the tool requires mitigating actions to be identified. Use of the tool should prevent/pre-empt any unintended consequences of commissioning decisions, particularly on disadvantaged groups.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	An evaluation and analysis of impact in relation to fairness is included within the tool as part of the equality analysis.
Respect – right to have private and family life respected	How will the person's right to respect for private and family	An evaluation and analysis of impact in relation to respect is included within the tool – both

	life, confidentiality and consent be upheld?	in relation to patient experience and also the equality analysis.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	An evaluation and analysis of impact in relation to equality is included within the tool –as part of the equality analysis.
	How will this affect a person's right to freedom of thought, conscience and religion?	An evaluation and analysis of impact in relation to equality is included within the tool –as part of the equality analysis.
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	An evaluation and analysis of impact in relation to dignity is included within the tool – both in relation to patient experience and also the equality analysis.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	An evaluation and analysis of impact in relation to autonomy is included within the tool – both in relation to patient experience and also the equality analysis.
Right to **Life**	Will or could it affect someone's right to life? How?	An evaluation and analysis of impact in relation to right to life is included within the tool –as part of the equality analysis.
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	An evaluation and analysis of impact in relation to liberty is included within the tool –as part of the equality analysis.

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	This policy is not subject to procurement activity; however, when completing the QIEA tool the commissioning manager will be required to consider what actions they could take.
Create fair employment and good work for all	
Create and develop health and sustainable places and communities	
Strengthen the role and impact of ill-health prevention	

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

No engagement activity undertaken – policy provides a tool for use by staff to assess impacts and analyse equality issues.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

The tool will ensure that commissioning staff fully consider and record the impact of service changes and QIPP schemes. It will require identification of mitigations and changes where disproportionate or negative impacts are identified.

The tool provides a robust assurance process to follow which will assess quality of services delivered to patients and allows for risks to be identified and minimised.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

No changes identified.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

N/A – policy will not result in a contract.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):
N/A – no procurement activity to be undertaken.

12. Publication

How will you share the findings of the Equality Analysis? This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.
The Equality Analysis will be presented to the Clinical Policy Sub Group in February 2019 and published on the CCG web pages.
Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee

	Name	Date
Quality Assured By:	*M K Dunne*	22/01/19
Which Committee will be considering the findings and signing off the EA?	Clinical Policy Sub Group	March 2019
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net