NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Provision of APMS Procurements for Primary Medical Services in Poplar Primary Care Centre and Hodge Hill Family Practice

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	Provision of APMS Procurements for Primary Medical Services in Poplar Primary Care Centre and Hodge Hill Family Practice		
EA Author	Ruth Smith/ Michelle Dunne	**Team**	Primary Care/ Equality & Diversity
Date Started	20/11/18	**Date Completed**	
EA Version	V0.2	**Reviewed by E&D**	

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

There are three contractual routes that commissioners can use to contract primary medical services for the population:

- Personal Medical Services (PMS) agreements – these agreements are time-limited and are locally agreed between the commissioner and the GP Practice. They allow for a 'PMS premium', this is additional funding for services that are above the standard contractual requirements.
- Alternative Provider Medical Services (APMS) contracts – these contracts are also locally agreed, time limited contracts and are usually awarded as a result of a procurement exercise.
- General Medical Services (GMS) contracts – these contracts are held for in perpetuity, are negotiated nationally and do not allow for any local flexibility.

The CCG use the GMS contract to commission the majority of primary care services. The CCG also hold fifteen PMS contracts and eight APMS contracts. Two of these APMS contracts are due to expire on 31 December 2019 and are the subject of this Equality Analysis.

The CCG have identified a need for both services to continue, however the CCG cannot extend the contracts due to the procurement laws and the risk of legal challenge from potential providers. Therefore, the CCG are planning to re-procure both services under one procurement process using two different lots for each practice, the market will be able to bid for either lot or both lots if they wish.

Birmingham's health and social care organisations use a locality model to deliver services across the city. Birmingham has 5 localities each made up of 2 constituencies. The two lots fall into two different localities. Information on the health profiles of the two relevant localities are attached to this equality analysis.

Lot 1 – Poplar Primary Care Centre:

- 5,836 patients registered at the practice
- Practice located in Poplar Primary Care Centre, Kings Heath – in the Central locality
- Property managed by NHS Property Services

Lot 2 – Hodge Hill Family Practice

- 4,585 patients registered at the practice
- Practice located in Hodge Hill Primary Care Centre, Hodge Hill – in the East locality
- Property managed by Community Health Partnerships
- The contract is between the commissioners and 'The Practice Group', a private provider who provide healthcare services.

The aim of the re-procurement is to ensure that patients are able to access primary care services from Poplar Primary Care Centre and Hodge Hill Primary Care Centre.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.
• The staff employed by Poplar Primary Care Centre • The patients currently registered at Poplar Primary Care Centre • The staff employed by The Practice Group working at Hodge Hill Family Practice • The patients currently registered at Hodge Hill Family Practice

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
Identifying need for GP Practices: The CCG have identified a need for both services due to lack of alternative primary care services in the local area and this is evidenced by both practice's raw list size increasing by 25% since April 2016.	The commissioner's Primary Care Commissioning Committee have given permission to re-procure the services.	Dr Nick Hall, independent GP will give expert advice on the service specification and be on the moderation and evaluation panels for the tendering process.
Identifying need for GP Practices: Warstone Tower Surgery closed in 2016. Practice list dispersed and patients registered with surrounding practices. (This accounts for approximately 13% of the list size increase noted above)		Jane Hubble, CCG's practice nurse will give expert advice on the service specification and be on the moderation and evaluation panels for the tendering process.
Birmingham Health Profiles – Birmingham City Council (Public Health)		

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:

Lot 1 – Poplar Primary Care Centre:

3. Impact and Evidence:

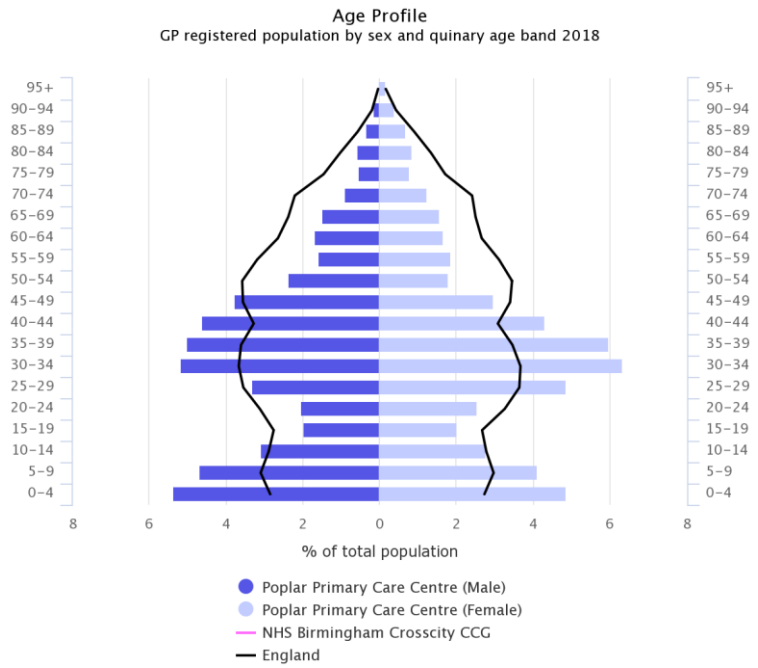
Research:

Poplar Primary Care Centre has a relatively young population when compared national averages. The graph below evidences:

- the high number of patients registered at the practice who are under 10 years of age
- the low number of patients in their teens or early adulthood
- the number of registrants between 25-49 of age is much higher than national averages
- the number of registrants over 50 is significantly lower than national averages

Analysing the data shows that the practice demographic appears to be mainly young families.

Figure 1 - Age Profile - Poplar Primary Care Centre (Public Health England)



The data above shows that the number of patients over 50 is significantly lower than national averages, however the practice have a high percentage of patients residing in nursing homes.

Figure 2 - Number of Nursing Home Patients - Poplars Primary Care Centre (Public Health England)

Period	Number of Patients	Poplar Primary Care Centre – Percentage	Birmingham CrossCity CCG Average – Percentage	England Average – Percentage
2010/11	56	2.0%	0.4%	0.5%
2012/13	63	1.9%	0.3%	0.5%
2013/14	67	1.9%	0.3%	0.5%
2014/15	63	1.6%	0.3%	0.5%

Please note: this is the latest information available

Lot 2 – Hodge Hill Family Practice:

Research:

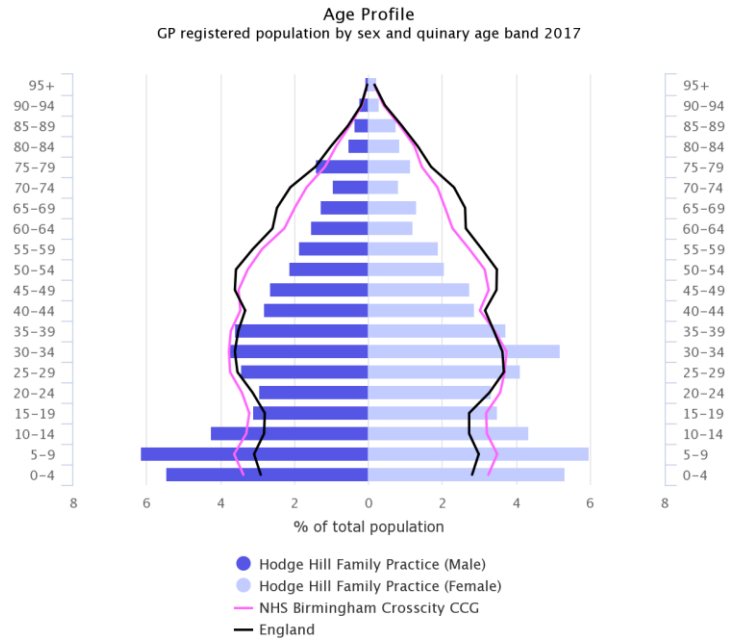
3. Impact and Evidence:

Hodge Hill Family Practice has a relatively young population when compared the CCG and national averages. The graph below evidences:

- the high number of patients registered at the practice who are under 14 years of age
- the number of registrants under 39 years is comparable to CCG and national data, with the exception of 30-34-year-old women
- the number of registrants over 40 years of age is much lower than CCG and national averages
- the number of registrants over 85 is comparable to CCG and national averages

Analysing the data shows that the practice demographic appears to be mainly young families, who may potentially have multiple children.

Figure 3 - Age Profile - Hodge Hill Family Practice (Public Health England)



The data above shows that the number of patients over 40 is significantly lower than national averages, however the practice have a high percentage of patients residing in nursing homes.

Poplar Primary Care Centre are signed up to the Nursing Home local improvement scheme (LIS), which provides primary care services to two local nursing homes. Highbury Nursing Home has 38 beds and Anita Stone Court Nursing Home has 33 beds. The data above was collected until 2014/15, however the practice began to provide services to Anita Stone Court Nursing Home in 2017/18, therefore it is anticipated that this number will be higher. This service is offered over and above the core contract and Poplar Primary Care Centre are paid for this in addition to the core contract through a LIS. The CCG will consider how this service will be commissioned going forward.

Figure 4 - Number of Nursing Home Patients - Hodge Hill Family Practice (Public Health England)

Period	Number of Patients	Hodge Hill Family Practice – %	Birmingham CrossCity CCG Average – %	England Average – %
2010/11	0	0.0%	0.4%	0.5%
2012/13	51	2.1%	0.3%	0.5%
2013/14	65	2.2%	0.3%	0.5%

3. Impact and Evidence:

2014/15	86	2.6%	0.3%	0.5%

Hodge Hill Family Practice are not signed up to the Nursing Home LIS and provide primary care services to any patients living within their practice boundary that have registered with the practice.

Impact:
The NHS commission primary care services so they are accessible to all members of the public. There are no barriers in accessing primary care services because of a person's age and this should not be taken into account when registering a new patient.

The commissioners are planning to hold a market engagement event, where the bidders will be informed of the young practice demographic and high number of nursing home patients at both practices. This information will enable the new service provider(s) to make initial decisions on how they will tailor their clinics to meet the needs of their patients and may inform their responses to the tendering process. For example, more midwife clinics may be needed and there may need to be extra availability of same day appointments for children.

The commissioners plan to mandate signing up to the Nursing Home LIS, to ensure that all patients currently receiving care continue to do so.

There has been no negative impact identified, patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis.

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:

Lot 1 – Poplar Primary Care Centre:

Research:
Census information from 2011 for Moseley and Kings Heath Ward:

- 8.53% of resident's state that their day-to-day activities are limited a lot and
- 8.69% of resident's state that their day-to-day activities are limited a little

Census information from 2011 for Birmingham:

- 9.15% of residents stating that their day-to-day activities are limited a lot
- 9.29% of residents stating that their day-to-day activities are limited a little

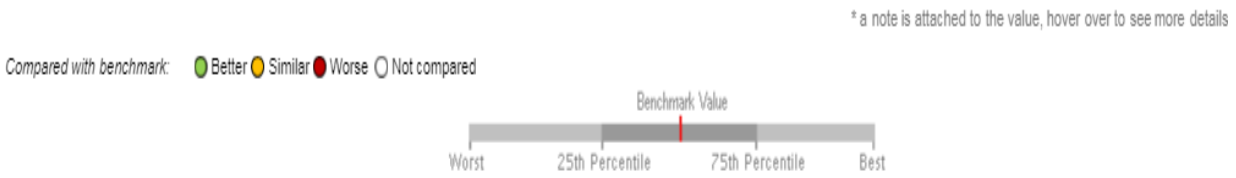
The data above does not evidence a higher prevalence of disability in Moseley and Kings Heath compared to the remainder of Birmingham. Therefore, the commissioners do not need to consider commissioning additional services for the disabled population, which is over and above the standard primary care offer to patients.

Poplar Primary Care Centre is easy to access. There is on-site parking with disabled spaces and the access into the building is step-free. There are lifts within the building.

Poplar Primary Care Centre is accessible by bus. There is a bus stop 0.12 miles away, which is serviced by three buses.

3. Impact and Evidence:

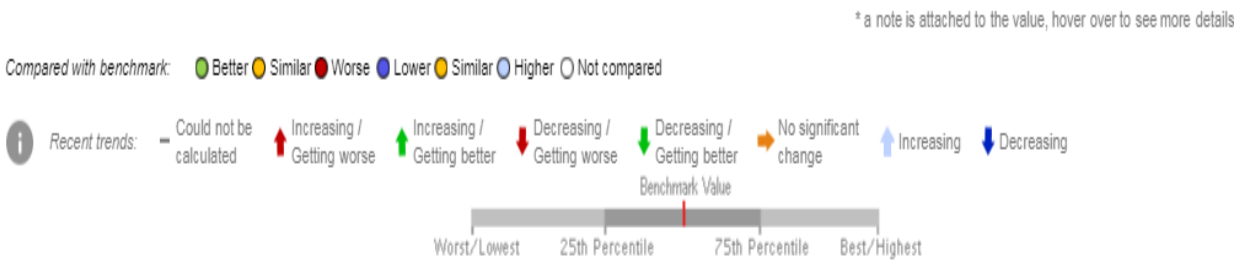
Learning Disability Prevalence (PHE – Fingertips data)



Indicator	Period	Y02571 - Poplar Primary Care Centre		CCGs (2017/18)	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Learning disability: QOF prevalence	2016/17	28	0.6%	0.6%	0.5%	4.3%		0.0%

Poplar Primary Care centre has a similar (same) LD prevalence to the rest of Birmingham.

Mental Health Prevalence (PHE – Fingertips data)



Indicator	Period	Y02571 - Poplar Primary Care Centre			CCGs (2017/18)	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		84	2.1%	1.6%*	1.6%	0.0%		15.4%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		492	12.2%	9.6%*	9.9%	0.0%		57.6%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		99	1.79%	1.17%*	0.94%	0.00%		19.13%

All three indicators (above) show a higher rate of recorded prevalence/incidence than Birmingham practices as a whole.

Lot 2 – Hodge Hill Family Practice:

Research:
Census information from 2011 for Hodge Hill Ward:

- 9.76% of resident's state that their day-to-day activities are limited a lot and

3. Impact and Evidence:

- 8.87% of resident's state that their day-to-day activities are limited a little

Census information from 2011 for Birmingham:

- 9.15% of residents stating that their day-to-day activities are limited a lot
- 9.29% of residents stating that their day-to-day activities are limited a little

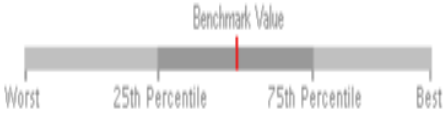
The data above does not evidence a higher prevalence of disability in Hodge Hill compared to the remainder of Birmingham. Therefore, the commissioners do not need to consider commissioning additional services for the disabled population, which is over and above the standard primary care offer to patients.

Hodge Hill Primary Care Centre is easy to access. There is on-site parking with disabled spaces and the access into the building is step-free. There are lifts within the building. The procurement will use Hodge Hill Primary Care Centre as a base for the newly procured service.
Hodge Hill Primary Care Centre is accessible by bus. There is a bus stop 0.2 miles away, which is serviced by two buses. There is also a bus stop 0.3 miles away which is services by six buses, including the two buses mentioned above.

Learning Disability Prevalence (PHE – Fingertips data)

* a note is attached to the value, hover over to see more details

Compared with benchmark: Better Similar Worse Not compared

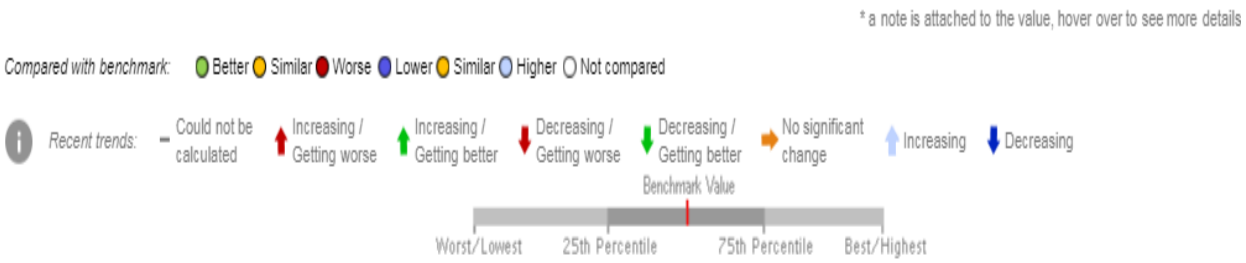


Indicator	Period	Y02567 - Hodge Hill Family Practice		CCGs (2017/18)	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Learning disability: QOF prevalence	2016/17	36	0.8%	0.6%	0.5%	4.3%		0.0%

Hodge Hill Family Practice has a higher LD prevalence (0.8%) than Birmingham (0.6%).

3. Impact and Evidence:

Mental Health Prevalence (PHE – Fingertips data)



Indicator	Period	Y02567 - Hodge Hill Family Practice			CCGs (2017/18)	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression recorded incidence (QOF): % of practice register aged 18+	2017/18		48	1.7%	1.6%*	1.6%	0.0%		15.4%
Depression recorded prevalence (QOF): % of practice register aged 18+	2017/18		328	11.4%	9.6%*	9.9%	0.0%		57.6%
Severe mental illness recorded prevalence (QOF): % of practice register all ages	2017/18		48	1.07%	1.17%*	0.94%	0.00%		19.13%

Hodge Hill Family Practice has a higher depression recorded incidence and depression recorded prevalence than Birmingham as a whole and lower than Birmingham (but higher than the England rate) for severe mental illness recorded prevalence.

Impact:
The NHS commission primary care services so they are accessible to all members of the public. There are no barriers in accessing primary care services if a person is disabled and this should not be taken into account when registering a new patient.

Procuring the service should have a no negative impact on people with disabilities and the services will remain similar to what is currently commissioned and in the current location.

There has been no negative impact identified, patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis.

All NHS (and social care) organisations are required to implement the Accessible Information Standard (see: https://www.england.nhs.uk/ourwork/accessibleinfo/) which requires providers to:

1. Ask people if they have any information or communication needs, and
2. find out how to meet their needs.
3. Record those needs clearly and in a set way.
4. Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how to meet those needs.
5. Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.

3. Impact and Evidence:

6. Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

The Standard says that patients, service users, carers and parents with a disability, impairment or sensory loss should:

- Be able to contact, and be contacted by, services in accessible ways, for example via email or text message.
- Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print.
- Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign Language interpreter.
- Get support from health and care staff and organisations to communicate, for example to lip-read or use a hearing aid.

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

Lot 1 – Poplar Primary Care Centre and Lot 2 – Hodge Hill Family Practice

Research:
Neither practices nor the Census collect data on gender reassignment, however national evidence shows that referrals to adult transgender services have increased by 240% over the past five years (The Independent https://www.telegraph.co.uk/news/2018/08/26/womens-minister-cautious-number-teenagers-undergoing-gender/).

Research:
Trans patients experience of primary care

To date, there has been very little good-quality evidence on the specific needs of trans people accessing primary care. Despite decades of trans people receiving gender identity therapies in the UK, no studies have ever evaluated the long term impact of such treatment in this group. There is also very little data available on the potential size of the transgender population, which can lead to difficulties in commissioning services.
In contrast, substantial evidence is emerging on the experiences of transgender people in accessing healthcare. These experiences seem to be primarily negative, with around 65% of trans people reporting discriminatory experiences when trying to access even basic healthcare (McNeil et al, 2012, Trans Mental Health Study).

The term 'trans' includes a diverse group of people. Not all trans people will require the same support or expect the same outcomes and there is no need to treat trans patients differently to other patients at the practice for the majority of their health needs. In some cases, however, there will be occasions where a GP might need specific knowledge or understand to provide best for a trans patients' needs.

Statistics on Trans people and healthcare include:

3. Impact and Evidence:

- Three in four trans people have been called the wrong name or pronoun by a health professional. (J. McNeil, 2012)
- Over half of trans people feel they need to pass as non-trans to be accepted by health professionals. (J. McNeil, 2012)
- If LGBT people have experienced discrimination at any point, their fear of further discrimination will often prevent them from speaking out. (Dihedral 2013)

Source for below: https://phescreening.blog.gov.uk/2018/01/24/new-phe-screening-leaflet-for-trans-and-non-binary-people-has-improved-awareness/

Trans people are more likely to report not being in good health, being disabled or having a long-term illness. Many have had experiences that suggest that being trans has affected their access to mainstream healthcare services, typically in a negative way due to transphobia. As a result, some trans people have developed a lack of trust in healthcare professionals.

Research indicates that trans people may be at higher risk of cancer due to risk factors, such as higher rates of smoking and alcohol consumption. But many healthcare professionals report they feel they lack the skills and knowledge required to meet the needs of these patients.

Cancer screening and treatment, which involves discussing body parts and intimate examinations, can be distressing for some trans people. Information about cancer screening has therefore not always extended to trans patients due to a lack of awareness in healthcare services

Impact:
The NHS commission primary care services so they are accessible to all members of the public. There should be no barriers in accessing primary care services if a person identifies as trans or wishes to have gender reassignment surgery.

The incumbent practice will be expected to follow Birmingham and Solihull's commissioning policy when dealing with patients who wish to be considered for gender reassignment surgery and to be aware of the findings of this equality analysis. The service provided should be respectful, with appropriate screening advice provided and result in high levels of positive patient experience and satisfaction.

There has been no negative impact identified, patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis.

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:

Lot 1 – Poplar Primary Care Centre:

Research:
The data below is taken from the Census 2011 and demonstrates that over one third of the residents in Moseley and Kings Heath who are aged 16 and over are married.

3. Impact and Evidence:

Figure 5 - Marital Status – Moseley and Kings Heath Ward - Census 2011

Status	Percentage
Single	47.72%
Married	36.81%
In a registered same-sex civil partnership	0.53%
Separate (but legally married or still legally in a same-sex civil partnership)	2.58%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	7.09%
Widowed	5.26%

Lot 2 – Hodge Hill Family Practice:

Research:
The data below is taken from the Census 2011 and demonstrates that almost half of the residents in Hodge Hill who are aged 16 and over are married.

Figure 6 - Marital Status – Hodge Hill Ward - Census 2011

Status	Percentage
Single	34.43%
Married	47.39%
In a registered same-sex civil partnership	0.05%
Separate (but legally married or still legally in a same-sex civil partnership)	3.63%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	6.76%
Widowed	7.74%

Impact:
The NHS commission primary care services so they are accessible to all members of the public. There are no barriers in accessing primary care services that are dependent on marital status.

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

Lot 1 – Poplar Primary Care Centre:

Research:
The data in the figure 1 of this document indicates that the number of women registered with the practice who are of child bearing age is higher than national averages.

The number of children aged under 10 is considerably higher than local averages.

These two pieces of information infer that there are a higher than average number of families registered at the practice which may increase the need for maternity services at the practice.

Lot 2 – Hodge Hill Family Practice:

Research:
The data in the figure 2 of this document indicates that the number of women registered with the practice who are of child bearing age is comparable to local and national averages.

3. Impact and Evidence:

The number of children aged under 14 is considerably higher than the local and national averages.

These two pieces of information infer that women are having multiple children or pregnancies and registering their children with the GP Practice. This will increase the need for maternity services at the practice.

Impact:
The commissioners will ensure that this information is readily available throughout the procurement process to ensure that potential bidders are aware of the potential additional workload created by potential high levels of women experiencing pregnancy whilst registered at the practice. There will also be a need for the practice to consider putting on additional midwife clinics to deal with the potential demand for services.

The NHS commission primary care services so they are accessible to all members of the public. There are no barriers in accessing primary care services if a woman is pregnant.

There has been no negative impact identified, patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis.

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

Lot 1 – Poplar Primary Care Centre:

Research:
Moseley and Kings Heath have a population that is comparable to the Birmingham population in relation to race, see table below:
Figure 7 - Ethnic Makeup of Moseley and Kings Heath - Census 2011

Percentage of population who classify themselves as each ethnic group			
	Moseley and Kings Heath	Birmingham	England
White: English/Welsh/Scottish/Northern Irish/British	54.25%	53.14%	79.75%
White: Irish	3.25%	2.05%	0.98%
White: Gypsy or Irish Traveller	0.06%	0.04%	0.10%
White: Other White	3.83%	2.70%	4.58%
Mixed/multiple ethnic groups: White and Black Caribbean	2.24%	2.30%	0.78%
Mixed/multiple ethnic groups: White and Black African	0.29%	0.30%	0.30%
Mixed/multiple ethnic groups: White and Asian	1.61%	1.04%	0.63%
Mixed/multiple ethnic groups: Other Mixed	1.08%	0.79%	0.53%
Asian/Asian British: Indian	6.18%	6.02%	2.63%
Asian/Asian British: Pakistani	15.06%	13.48%	2.10%
Asian/Asian British: Bangladeshi	1.05%	3.03%	0.82%
Asian/Asian British: Chinese	0.85%	1.18%	0.72%
Asian/Asian British: Other Asian	2.19%	2.90%	1.55%
Black/African/Caribbean/Black British: African	1.26%	2.79%	1.84%

3. Impact and Evidence:

Black/African/Caribbean/Black British: Caribbean	3.19%	4.44%	1.11%
Black/African/Caribbean/Black British: Other Black	1.15%	1.75%	0.52%
Other ethnic group: Arab	1.46%	1.02%	0.42%
Other ethnic group: Any other ethnic group	1.00%	1.02%	0.62%

After White British, the second largest ethnic group is Asian Pakistani, with at 15.06% is higher than Birmingham (13.48%) as a whole. Other notable groups (which are over-represented when compared to Birmingham as a whole) are White Irish, White Other and Mixed/Multiple ethnic groups.

Lot 2 – Hodge Hill Family Practice:

Research:

Figure 8 - Ethnic Makeup of Hodge Hill Ward - Census 2011

Percentage of population who classify themselves as each ethnic group			
	Hodge Hill	Birmingham	England
White: English/Welsh/Scottish/Northern Irish/British	41.61%	53.14%	79.75%
White: Irish	1.45%	2.05%	0.98%
White: Gypsy or Irish Traveller	0.06%	0.04%	0.10%
White: Other White	1.42%	2.70%	4.58%
Mixed/multiple ethnic groups: White and Black Caribbean	2.41%	2.30%	0.78%
Mixed/multiple ethnic groups: White and Black African	0.29%	0.30%	0.30%
Mixed/multiple ethnic groups: White and Asian	0.99%	1.04%	0.63%
Mixed/multiple ethnic groups: Other Mixed	0.61%	0.79%	0.53%
Asian/Asian British: Indian	1.73%	6.02%	2.63%
Asian/Asian British: Pakistani	32.73%	13.48%	2.10%
Asian/Asian British: Bangladeshi	2.46%	3.03%	0.82%
Asian/Asian British: Chinese	0.47%	1.18%	0.72%
Asian/Asian British: Other Asian	3.71%	2.90%	1.55%
Black/African/Caribbean/Black British: African	3.35%	2.79%	1.84%
Black/African/Caribbean/Black British: Caribbean	3.42%	4.44%	1.11%
Black/African/Caribbean/Black British: Other Black	1.99%	1.75%	0.52%
Other ethnic group: Arab	0.71%	1.02%	0.42%
Other ethnic group: Any other ethnic group	0.59%	1.02%	0.62%

The biggest difference between the patient demographics is the higher than average number of people who identify as Asian Pakistani and the lower than average of people who identify as White British. Other notable findings include higher Asian Other and Black African residents (when compared to Birmingham population as a whole).

Research shows that the British-Bangladeshi and -Pakistani people are five or six times more likely to have type 2 diabetes than the general population. Pakistani men have the highest rate of heart disease in UK. The risk of South Asian women dying early from heart disease is 65% higher than the general population. These are all risk factors that need to be considered when procuring service as additional support may be needed to support this group of patients.

3. Impact and Evidence:

In addition to the differences in health, there may be language barriers which need to be taken into consideration, therefore the new provider will need to ensure they have a contractual arrangement with an interpreting service or they may wish to recruit from the population.

Language Proficiency
Data taken from the 2011 Census:

Hodge Hill Ward area: - there were 1,498 people who said they did not speak English well or at all, this represents 5.7% of the population aged 3 years or older. This is higher than the Birmingham average of 4.6%. Where English was not the main language, the most commonly spoken languages were Urdu, Pakistani and Panjabi.

Moseley and Kings Heath Ward area: - there were 859 people who said they did not speak English well or at all, this represents 3.5% of the population aged 3 years or older. This is lower than the Birmingham average of 4.6%. Where English was not the main language, the most commonly spoken languages were Urdu, Panjabi and Arabic.

Impact:
This information will be readily available to any potential bidders to ensure they are aware of the patient demographic before tendering to provide the service.

The NHS commission primary care services so they are accessible to all members of the public. There should be no barriers in accessing primary care services because of race or language proficiency.

Patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis.

All GP practices should record patients' needs for an interpreter/translated materials and have facilities in place to meet these requirements. Additionally, they should also ensure that when these patients are referred into other NHS services that their language/communication needs are identified and flagged. This forms part of the service specification for this contract.

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

Lot 1 – Poplar Primary Care Centre:

Research:
The information below has been taken from the Census 2011:

Figure 9 - Religious Makeup of Moseley and Kings Heath Ward - Census 2011

Percentage of population who classify themselves as each religion		
	Moseley and Kings Heath	Birmingham
Christian	35.84%	46.07%
Buddhist	0.69%	0.45%
Hindu	2.05%	2.08%
Jewish	0.64%	0.21%
Muslim	21.73%	21.85%
Sikh	2.30%	3.02%

3. Impact and Evidence:

Other religion	0.63%	0.53%
No religion	28.63%	19.27%
Religion not stated	7.50%	6.53%

The religious demographic of the GP practice is broadly similar to the remainder of Birmingham's population. The main difference being 10% more people in Birmingham identify as Christian, compared to Moseley and Kings Heath and 10% less people in Birmingham identify as no religion compared to Moseley and Kings Heath. After Christianity (35.84%), the second largest religion is Islam (21.73%).

Lot 2 – Hodge Hill Family Practice:

Research:
The information below has been taken from the Census 2011:

Figure 10 - Religious Makeup of Hodge Hill Ward - Census 2011

Percentage of population who classify themselves as each religion		
	Hodge Hill	Birmingham
Christian	37.79%	46.07%
Buddhist	0.18%	0.45%
Hindu	0.42%	2.08%
Jewish	0.04%	0.21%
Muslim	41.48%	21.85%
Sikh	0.59%	3.02%
Other religion	0.19%	0.53%
No religion	13.04%	19.27%
Religion not stated	6.27%	6.53%

The biggest difference between the Hodge Hill population and the Birmingham population is significantly higher percentage of people who identify as Muslim (41.48% compared to 21.85% in Birmingham as a whole).

Impact:
Both practice areas have a significant population who report to be either Christian or Muslim.

The proportion of Muslims in the Hodge Hill area is significantly higher than Birmingham. Research shows that an individual seeking healthcare can have faith-based worries regarding their modesty; such as receiving treatment from someone of the opposite sex. Also, certain faiths have daily required prayers, which could ultimately affect the scheduling of someone's treatments. Diets also are a large influence on many cultures and beliefs, which can lead to problems regarding healthcare treatment. Some patients might need special accommodations to be made with their food, and potential medications, to make sure they fall in line with their beliefs.

The high proportion of people who identify as Muslim in Hodge Hill may have an impact on the procurement. Many women, especially Muslim women may prefer to be seen and treated by a female clinician; healthcare assistant, nurse or GP. Therefore, there needs to be some consideration of how the practice will meet this need in the procurement process.

There has been no negative impact identified, patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis. Service providers will need to ensure that the faith and cultural needs are met.

3. Impact and Evidence:

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

Lot 1 – Poplar Primary Care Centre:

Research:

Figure 11 - Sex of patients - Poplar Primary Care Centre - Public Health England

Poplars Primary Care Centre	
Male	**Female**
48%	52%

Lot 2 – Hodge Hill Family Practice:

Research:

Figure 12 - Sex of patients - Hodge Hill Family Practice - Public Health England

Hodge Hill Family Practice	
Male	**Female**
49%	51%

Impact:
The NHS commission primary care services so they are accessible to all members of the public. There are no barriers in accessing primary care services due to a person's sex.

There has been no impact identified.

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:

Lot 1 – Poplar Primary Care Centre and Lot 2 – Hodge Hill Family Practice:

Research:
The GP Practice and the Census do not collect data on sexual orientation.

Impact:
Statistics surrounding LGBT people and healthcare indicate that:

- One in five lesbian, gay and bisexual patients report that their sexual orientation is a factor in them delaying accessing health services. (Richardson, Jo. 2010)
- One in four lesbian, gay and bisexual people are not out to any health professionals. (NHS Wirral, 2012)
- Lesbian, gay and bisexual patients are twice as likely to report they have no trust or confidence in their GP. (National GP Survey, 2012)

3. Impact and Evidence:

General practice is available for all patients regardless of sexual orientation and re-procuring the service will not affect access, however outcomes and experience can be affected through a lack of knowledge in terms of patients' sexual orientation.

Sexual Orientation describes who an individual is emotionally and sexually attracted to. Some of the most common orientations are heterosexual or straight, lesbian, gay and bisexual, but these are by no means exclusive.

Current estimates of the LGB population in the UK range from 1.7% - 2.5% with other research indicating up to 5.74%. LGB people collectively are a significant minority. However, comparatively little is known about LGB people's experiences and needs, often due to a lack of comprehensive monitoring. However, research suggests that LGB people will face multiple disadvantage, as examples:

- poorer health outcomes
- negative experiences
- fear of discrimination
- drug and alcohol abuse
- offending
- mental health issues

Understanding a patient's background and current needs can help practitioners to deliver person-centred care. Like someone's ethnicity, age or marital status, sexual orientation is a characteristic that doesn't define but can have an impact on their health risks and outcomes and so is useful information in the care and treatment of the individual.

Recording sexual orientation across health and social care can enable providers to better identify health risks at a population level. This will support targeted preventative and early interventions work to address health inequalities, which is shown to reduce expenditure linked to treatment costs further down the line.

Research shows that that LGB people experience greater health inequalities compared to heterosexual people, such as being at higher risk of poor mental health, or missing out on routine health screening. If a healthcare service collects information on patient sexual orientation, they will be able to target specific health promotion and services to LGB patients: for example, promoting cervical screening to lesbian and bisexual women; or referring young LGB people experiencing poor mental health to a specific LGB young people's service.

The gap in understanding patients sexual orientation (and adoption of the Sexual Orientation Monitoring Information Standard, which is detailed here (https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/) and (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb2094-sexual-orientation-monitoring) could lead to LGB people experiencing greater health inequalities when compared to heterosexual people.

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

3. Impact and Evidence:

Lot 1 – Poplar Primary Care Centre:

Research:
The Census 2011 data evidences that the percentage of people with caring responsibilities living in Moseley and Kings Heath is comparable to the Birmingham population.

Figure 13 - Carers - Moseley and Kings Heath Ward - Census 2011

Percentage of population who provide unpaid care		
	Moseley and Kings Heath	Birmingham
Provides no unpaid care	89.8%	90.0%
Provides 1 to 19 hours unpaid care a week	7.0%	5.7%
Provides 20 to 49 hours unpaid care a week	1.4%	1.6%
Provides 50 or more hours unpaid care a week	1.8%	2.7%

Lot 2 – Hodge Hill Family Practice:

Research:
The Census 2011 data evidences that the percentage of people with caring responsibilities living in Moseley and Kings Heath is comparable to the Birmingham population.

Figure 14 - Carers - Hodge Hill Ward - Census 2011

Percentage of population who provide unpaid care		
	Hodge Hill	Birmingham
Provides no unpaid care	89.7%	90.0%
Provides 1 to 19 hours unpaid care a week	5.4%	5.7%
Provides 20 to 49 hours unpaid care a week	1.8%	1.6%
Provides 50 or more hours unpaid care a week	3.1%	2.7%

Impact:
There are many ways that primary care services provide services to support the needs of carers appointments will be offered between 8am-6.30pm Mon-Fri and appointments are bookable online. Patients are also able to access appointments at local extended access hubs until 8.00pm.

There has been no negative impact identified, patients are likely to benefit from service providers being able to more effectively tailor services to meet local needs based on the information/data obtained for this equality analysis.

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)

Deprivation:
Research:
Lot 2 – Hodge Hill Family Practice:

3. Impact and Evidence:

Population by Deprivation Decile and Age Category			
IMD Decile	Child (0-19)	Adult (20-64)	Over 65
Most Deprived	1,048	1,394	209
2	317	404	99
3	147	239	80
4	190	276	36
5	2	4	
6		3	
7	8	13	2
8	4	4	
9		1	
Least Deprived			

Hodge Hill Family Practice is located within the most deprived decile. The table below evidences 61% of children, 59% of adults and 49% of over 65's are located in the most deprived decile.

There is a 9-year gap in male life expectancy between the most and least deprived areas of England, and a 7-year gap for females. The CCG have many schemes and initiatives that aim to reduce health inequalities. The new practice will not have the ability to change the deprivation levels within their local area, however they should be aware of the levels of deprivation when bidding and tendering for the service.

Roma gypsies and travellers, homeless people and refugee's/asylum seekers

The above 3 disadvantaged groups experience high levels of health inequalities and barriers. There are some similarities in terms of poor mental health, and reported barriers in terms of accessing and registering with a GP. We are unable to access data at a very local level (GP/Ward level) as this is often not collected.

Roma Gypsies and Travellers

Birmingham has a substantial Gypsy Roma Traveller (GRT) community, with estimates of more than 1000 GRT people living in Birmingham and a planned traveller site located in Aston.

Source: Progress report by the ministerial working group on tackling inequalities experienced by Gypsies and Travellers (Department for Communities and Local Government, April 2012)

Gypsies and Travellers are a small but significant group who continue to suffer from poor health and lower life expectancy.
Studies consistently show differences in life expectancy of over 10% less than the general population, although a recent study stated that the general population were living up to 50% longer than Gypsies and Travellers. Research also shows that the health of Gypsies and Travellers starts to deteriorate markedly when individuals are over 50.
Other health issues such as high infant mortality rates, high maternal mortality rates, low child immunisation levels, mental health issues, substance misuse issues and diabetes are also seen to be prevalent in the Gypsy and Traveller communities.

3. Impact and Evidence:

Gypsies and Travellers, along with other vulnerable groups, experience a range of health needs, which are exacerbated by social factors. Those with multiple complex needs make chaotic and greater use of health care services than other groups and experience a range of barriers, in particular when accessing primary care services. Gypsies and Travellers often lack trust in health professionals to provide appropriate care and to engage with their community on equitable terms. Gypsies and Travellers can fear hostility and/or prejudice from healthcare providers.

National data are not collected about the needs of Gypsies and Travellers, or the services they receive. As a result, evidence of the health of Gypsies and Travellers is relatively weak. However, studies have found that their health status is much poorer than that of the general population and other marginalised groups:

- 39% of Gypsies and Travellers have a long-term illness compared with 29% of age and sex matched comparators, even after controlling for socio-economic status and other marginalised groups
- Travellers are 3 times more likely to have chronic cough or bronchitis, even after smoking is taken into account
- 22% of Gypsies and Travellers reported having asthma and 34% reported chest pain compared to 5% and 22% of the general population
- Gypsies and Travellers are nearly three times more likely to be anxious than average and just over twice as likely to be depressed
- Irish Travellers are 3 times as likely to die by suicide than the general population
- There is an excess prevalence of miscarriages, stillbirths and neonatal deaths in Gypsy and Traveller communities and high rates of maternal death during pregnancy and shortly after childbirth
- A high prevalence of diabetes has been reported in Gypsy and Traveller communities, and a lack of community knowledge of the risk factors
- Studies show that Gypsy and Traveller women live 12 years less than women in the general population and men 10 years less, although recent research suggests the life expectancy gap could be much higher.

Common challenges faced by Gypsies and Travellers accessing primary care services can include:

- Registration. One of the most commonly reported barriers is GPs' insistence on having proof of identity and proof of a permanent address.
- Poor literacy and, for recently migrant Roma communities, poor English, can make it very difficult to navigate the health system.
- Anticipation of discrimination from GP practices or at A&E. As a result, some, particularly those living in bricks and mortar accommodation, will not identify their ethnicity.
- Health professionals lack the knowledge, confidence and expertise about the beliefs and culture of the Gypsy and Traveller communities.
- Those who are mobile have an increased reliance on A&E and walk-in centres, which can lead to problems with follow up and continuity of care.

3. Impact and Evidence:

- Local Involvement Networks (LINks) have not ensured the diversity of representation needed to ensure all members of a community, including Gypsies and Travellers, can have their say or get involved in influencing local services.

Homeless

Birmingham accounts for almost half of all homelessness acceptances in the West Midlands and 9 per cent of the national total. In comparison with neighbouring authorities and core cities, rates of homelessness are disproportionately high.

Source: Report of the Health and Social Care Overview and Scrutiny Committee, 7th July 2015 – Birmingham City Council

Homelessness and health are inextricably intertwined. Being homeless is physically and mentally difficult and homelessness has significant negative consequences on health with the result that people who are homeless experience some of the worst health problems in our society. They are vulnerable to illness, poor mental health and drug and alcohol problems and are more likely than the general population to have multiple and complex physical and mental health needs.

Those who experience homelessness are also more likely to have unhealthy lifestyles which can cause long-term health problems or exacerbate existing issues. Analysis of the latest data found that 77% of homeless people smoke, 35% do not eat at least two meals a day and two-thirds consume more than the recommended amount of alcohol each time they drink.

In spite of suffering worse health than the general population, homeless people often struggle to access healthcare services. There are many reasons for this which need to be understood if inequalities in service access are to be addressed.
Some of the barriers include difficulty in accessing primary care such as the inability to register with a GP. This is often due to lack of proof of identity or inability to prove permanent residence in the catchment area or to provide other documentation required to register with a GP.

Health services are designed to treat one condition at a time but homeless people often experience multiple and complex health problems. This means that support needs to be accessed through different parts of the health system which can be difficult to navigate for people who are often leading chaotic lifestyles and dealing with issues relating to mental health and substance misuse and who may also not trust and not understand the system.

Undiagnosed or untreated mental health problems can also be a barrier to seeking help as can fear and denial of ill health, difficulty communicating health needs and fear of stigmatisation or of being labelled. People with complex problems can often find it difficult to comply with treatment and fail to attend appointments which can then lead to them being excluded from services.

In order to improve the healthcare that homeless people receive staff need to be able to identify and understand and work with homeless patients. Sometimes healthcare staff remain unaware that a patient is homeless, either because the patient has not been asked or because they are afraid of admitting to being homeless and sometimes staff may lack the skills to deal with people who are exhibiting challenging behaviour.

Homeless people are often living more transient lives than other people which can make it difficult to maintain engagement with health services especially where staff may not have had the opportunity or time to be able to build up a trusting relationship with a homeless patient.

3. Impact and Evidence:

In addition to suffering worse health than those living in settled accommodation, homeless people face significant inequalities in accessing health services. This is starkly illustrated by the shocking fact that, in spite of recent improvements in the health of the general population, the average age of death for homeless people is just 47 years old with the average age for homeless women being even lower at just 43, compared to 77 for the general population.

NHS Guidelines say 'If a patient cannot produce any supportive documentation but states that they reside within the practice boundary then practices should accept the registration'.
Please be aware that a homeless patient cannot be refused registration on the basis of where they reside because they are not in settled accommodation. For safety reasons they may need to change the places where they sleep rough on a daily basis. There is no regulatory requirement to prove identity, address, immigration status or an NHS number in order to register as a patient and no contractual requirement for GPs to request this.
Those who are homeless, vulnerably housed or 'of no fixed abode', asylum seekers, refugees and overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice even if they have to pay for NHS services outside of the GP practice.
The patient MUST be registered on application unless the practice has reasonable grounds to decline. GP practices have limited grounds on which they can turn down an application and these are; if

- The commissioner has agreed that they can close their list to new patients.
- The patient lives outside the practice boundary. (N.B. As this relates to patients in settled accommodation, it is not an applicable ground to refuse to register a homeless patient.)

Migrants, Refugees and Asylum Seekers

Figures for the West Midlands region shows the top three country of origin for international migrants arriving before 1961 were Ireland, India and Jamaica. For each subsequent decade until 2001, Pakistan, India and Bangladesh were the most reported countries of origin. Since 2001, it has been Poland followed by Pakistan and India. 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. The highest number of new registrations were from those from Romania (11,715), followed by Pakistan (6,704) and China (6,095). Most applications for work come from Romania, Poland, and Bulgaria. Migrant health priorities include tackling Female Genital Mutilation (FGM), communicable diseases such as HIV and TB, access to screening and vacs, and mental health.

Migrant Health
The profile of migrants within Birmingham is changing and growing. There is evidence that many migrants are relatively healthy upon arrival but that good health can deteriorate overtime in the receiving society. A number of factors impact on migrant health including mental health, social isolation, dispersal into society, and poverty:

- There are higher rates of unmet mental health needs including depression, post-traumatic stress disorder, anxiety and psychosis. There are different cultural perspectives on mental health which may not be expressed.
- Barriers to primary care include being unable to register due to inability to provide documentation, a lack of trust in GPs due to a lack of agency and knowledge of the healthcare system, and different cultural expectations of care and treatment.
- Language barriers

3. Impact and Evidence:

- Communicable diseases such as HIV, TB and Measles
- Access to screening and vaccinations – particularly for pregnant migrant women
- Female Genital Mutilation (FGM) impacting on migrants from some African countries
- Fears about healthcare charging, confidentiality, and confusion in the system

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	Potential – but mitigated by implementing Sexual Orientation Monitoring Information Standard. Potential – access to interpreter services is not referenced	Whilst health inequalities cannot be created by having access to primary care services it is noted that sexual orientation monitoring is not part of current practice which has implications as identified above for LGB patients. Similarly, no reference is made to the provision of interpreter services, which could lead increased health inequality due to poor communication/ understanding.
Is there any impact for groups or communities living in particular geographical areas?	Yes	There may be a small change for patients, as the people providing their care may change. There will also be a change to the opening hours to bring this in line with the national directive from NHS England.
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	No, by re-procuring the services the CCG will use the purpose built space to provide primary care, which is easy to access and close to patient's homes.

How will you ensure the proposals reduce health inequalities?

Primary care is used for many reasons and can provide a range of services including but not limited to; health checks, health advice, treatment and onwards referral when needed. These services provide the opportunity for clinical staff to identify health or social care issues that may need addressing such as smoking or poor living conditions. The clinical staff can then make onwards referrals to smoking cessations services or social services (for the examples given above).

Limited access to health services is one way of creating health inequalities. The CCG have no plans to remove the primary care services already provided by Poplar Primary Care Centre and Hodge Hill Family Practice. This re-procurement supports patient's access to health services and has a neutral impact on health inequalities as the patients are already able to access these services. There is an opportunity to have a positive impact on health inequalities experienced by LGB residents through the implementation of sexual orientation monitoring, to improve access and communication for disabled patients through implementation of the Accessible Information Standard and improved communication through the provision of interpreters.

5. FREDA Principles/	Question	Response

Human Rights		
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	There will be no changes in the way people can access primary care services. Any patient living within the contractual boundary will be able to register with the practice. Appointments will be bookable via telephone, online or in person.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	Provider will be expected to uphold patients right to have private and family life respected.
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?	Through the completion, publication and implementation of the recommendations of this equality analysis. The CCG will engage with patients to find out what is working well with the current service and what changes they feel could be made. This information will then feed into the new service specification. The new provider will be expected to follow the contract and the law in respect to discrimination.
	How will this affect a person's right to freedom of thought, conscience and religion?	Service providers will be expected to demonstrate respect for patients religious and cultural needs; adapting approach, medication etc. to meet needs.
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?	The new provider will be expected to follow the contract and the law in respect to treating patients with dignity.
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?	All patients will have the opportunity to be involved in the decisions about their care. Clinical staff at the practice should discuss the patient's options before providing treatment, medication or onwards referral. This will be routinely monitored by the annual GP survey.

Right to **Life**	Will or could it affect someone's right to life? How?	This procurement will not affect a person's right to life.
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	This procurement not deprive a person of their liberty.

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	All decisions about a patient's treatment should be made with the patient. This will be a contractual requirement.
Create fair employment and good work for all	Ensuring the successful provider has HR policies in place. There will be HR questions in procurement.
Create and develop health and sustainable places and communities	GP Practices are community hubs for improving health.
Strengthen the role and impact of ill-health prevention	GP Practices local to patients, makes them accessible to their patients.

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
Drop-in session at Poplar Primary Care Centre	All patients registered at Poplar Primary Care Centre	Friday 14th December 2018
Drop-in session at Hodge Hill Family Practice	All patients registered at Hodge Hill Family Practice	Tuesday 18th December 2018
Drop-in session at Hodge Hill Family Practice	All patients registered at Hodge Hill Family Practice	Tuesday 8th January 2019
Online patient survey	All patients registered at Poplars Primary Care Centre	Live between Monday 10th December 2018 to Thursday 10th January 2019
Online patient survey	All patients registered at Hodge Hill Family Practice	Live between Monday 10th December 2018 to Thursday 10th January 2019
Paper copies of patient survey available at the practice	All patients registered at Poplar Primary Care Centre	Friday 14th December 2018 – Thursday 10th January 2019
Paper copies of patient survey available at the practice	All patients registered at Hodge Hill Family Practice	Thursday 18th December 2018 – Thursday 10th January 2019

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 …..):

The survey results completed at the drop-in sessions have been collated with the online patient survey results.

Lot 1 – Poplar Primary Care Centre
95.94% of respondents rated their overall experience as fairly good or very good. The CCG plan to keep consistency by setting a similar service specification and finding staff eligible for TUPE.

79.17% felt the appointment times available met their needs. The practice is currently open between 8am-8pm on Monday and 8am-6.30pm Tuesday to Friday and 7.30am and 10.30am on Saturday. The CCG plan to open the practice Monday to Friday between 8am-6.30pm, outside these hours the CCG have commissioned an extended access hub, which is located Hall Green Health and open between 6.30pm and 8.00pm. This is a national directive from NHS England. Hall Green Health is 2.5 miles away from Poplar Primary Care Centre and is accessible via public transport, however this is two buses. Despite this, Hall Green Health does sit within Poplar Primary Care's contractual boundary, therefore it may be easier for some patients to access. Hall Green Health will offer appointments Monday to Friday 6.30pm-8.00pm, Saturday 9.00am-1.00pm and Sunday 10.00am to 2.00pm.

86.96% of respondents felt that the practice staff definitely treat them with care, dignity and respect, with the remaining 13.04% also agreeing with that to some extent. The CCG's Quality Team will assist in developing the service specification, to ensure that all patients feel they are treated with dignity and respect. The patient's views on this will be monitored through the annual GP survey, the friends and family test responses and through monitoring complaints to the CCG.

The comments received from patients regarding the service were mostly positive. One trend was picked up from the negative comments, which highlighted the need for additional nursing appointments, the commissioners do not intend to mandate the number of staff of each role within the practice, the reason for this is the practice will be in the best position to devise it's staffing structure to meet the needs of patients.

Lot 2 – Hodge Hill Primary Care Centre
63.04% of respondents rated their overall experience of the practice as fairly good or very good. The CCG plan to put a new service specification in place, which will be consistent with the service specification in place at Poplar Primary Care Centre. This consistency should drive up the quality of the service and improve the patient satisfaction.

23.92% of respondents feel that booking an appointment is very easy or fairly easy. The CCG plan to address this by mandating an online booking system which patients will be able to utilise. There should also be telephone access to the surgery with a local number (0121), patients will also be able to book appointments face-to-face. The new provider will decide the staffing levels needed to operate on reception to answer the phone and reception desk to book appointments. The patient satisfaction will be monitored through the annual GP survey, the friends and family test responses and through monitoring complaints to the CCG.

58.70% felt that the appointment times available met their needs. The practice is currently open between 8am-8pm on Monday, 8am-6.30pm Tuesday and Wednesday, 8am-8pm on Thursday, 8am-6.30pm on Friday and 9am-2pm on Saturday. The CCG plan to open the practice Monday to Friday between 8am-6.30pm, outside these hours the CCG have commissioned an extended access hub, which is located at Harlequin Surgery and open between 6.30pm and 8.00pm. This is a national directive from NHS England. Harlequin Surgery is 1.7 miles away from Hodge Hill Family Practice and is accessible via public transport, however this does include a 0.7 mile walk. Despite this, Harlequin Surgery does sit within Hodge Hill Family Practice's contractual boundary, therefore it may be easier

for some patients to access. Hall Green Health will offer appointments Monday to Friday 6.30pm-8.00pm and Saturday morning.

68.89% of respondents felt that the practice staff definitely treat them with care, dignity and respect, with 6.67% of respondents felt they were dealt with no care, dignity and respect. The CCG's Quality Team will assist in developing the service specification, to ensure that all patients feel they are treated with dignity and respect. The patient's views on this will be monitored through the annual GP survey, the friends and family test responses and through monitoring complaints to the CCG.

The comments received from patients varied, there were a number compliments about staff and equal number of complaints. The main trends identified were the lack appointments, the CCG hope to improve this by reducing the opening hours, so more appointments will be available in core hours, appointments outside of this will be offered at the extended access hub. The comments also identified the method of booking appointments as an issue by asking all patients to call on the morning they need an appointment, Hodge Hill Family Practice have confirmed that they no longer use this method of booking appointments and patient opinion should change in due course, to make further improvements in the new service specification the patients will be able to book appointment via phone, online or telephone. The final trend identified was the lack of a consistent GP, the CCG have investigated this and found that Hodge Hill Family Practice have had issues recruiting staff, which has resulted in the use of locums, the practice is now up to full staffing and the patients should begin to see consistency. To mitigate this in the future, the CCG are planning to procure a contract for a minimum term of seven years, which should attract staff to the practice and create consistency for the patients.

8. Summary of Analysis

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

The work will have limited impact on patients as the CCG plan to procure primary care services in line with the GMS contract, which is used for 86% of our GP contracts and is nationally agreed by NHS England.

In general, there will be little change for existing patients registered with these practices. The patients will continue to be registered with their GP Practice and will need to take no action in registering with the new provider. Patients will also be free to move to another practice, if they wish. There will no changes in location, therefore if patients are currently able to access the surgery they will continue to be able to do so.

The CCG will publish the patient demographics with the tender documentation to ensure that the bidders are aware of the patients' needs prior to placing a bid for the contract. The CCG plan to mandate signing up to the Nursing Home LIS, to ensure that patients continue to receive the care.

There are opportunities to make improvements to services based on the findings of the equality analysis and the engagement activity.

The decision to change the opening times has occurred for a number of reasons:

- Standardisation: The GMS contract states that practices need to be open 8.00am-6.30pm. The CCG wish to align the two new APMS contracts to the GMS service offer.
- Commissioned services: In September 2018, the CCG commissioned 24 extended access hubs across Birmingham and Solihull, which provide primary care services between 6.30pm-8.00pm

Monday to Friday and at weekends (weekend opening hours vary between each extended access hub). The two APMS practices will be able to access the appointments offered at the extended access hubs, mitigating any loss of appointments.

Issues highlighted through the equality analysis include:

Poplar Primary Care population:

- High numbers of patients registered who are under 10 years of age;
- The number of registrants between 25-49 of age is much higher than national averages;
- The number of registrants over 50 is significantly lower than national averages;
- High percentage of patients residing in nursing homes;
- A similar Learning disability prevalence to the rest of Birmingham;
- A higher rate of recorded prevalence/incidence of depression/severe mental illness when compared to the rest of the CCG;
- Trans people are more likely to report not being in good health, being disabled or having a long-term illness;
- Number of women registered with the practice who are of child bearing age is higher than national averages, which may impact on maternity, pre & post-natal care requirements;
- Whilst the area's ethnic make-up is broadly comparable to that of Birmingham, the Asian Pakistani community is larger than Birmingham as a whole;
- Research shows that British Bangladeshi and Pakistani people are five or six times more likely to have type 2 diabetes than the general population. Pakistani men have the highest rate of heart disease in the UK. The risk of South Asian women dying early from heart disease is 65% higher than the general population.
- For this ward area, 3.5% of the population (at the time of the 2011 Census) indicated that they did not speak English well or at all, this is lower than the Birmingham average of 4.6%.
- The religious demographic of the area is broadly similar to Birmingham's population. The second largest religion, after Christianity is Islam (21.73%); consideration is required on how to meet faith and cultural needs;
- The GP practice was unable to provide sexual orientation data. Research shows that LGB people experience greater health inequalities compared to heterosexual people, such as being at higher risk of poor mental health and missing out on routine health screening.
- Roma gypsies and travellers, homeless people and refugee's/asylum seekers are three disadvantaged groups that experience high levels of health inequalities and barriers. There are some similarities in terms of poor mental health, dying younger, some language difficulties and reported barriers in terms of accessing and registering with a GP.

Hodge Hill population

- High number of patients registered aged under 14 years of age; high numbers of women aged 30 to 34
- High percentage of patients residing in nursing homes;
- 9.76% of people in the ward of Hodge Hill indicated in the 2011 Census that their day to day activities were limited a lot (high than Birmingham as a whole at 9.15%);
- The practice has a higher learning disability prevalence (0.8%) than Birmingham (0.6%);
- The practice has a higher depression recorded incidence and depression recorded prevalence than Birmingham; the practice has a lower than Birmingham (but higher than England) of severe mental illness prevalence;
- The number of women registered with the practice who are of child bearing age is comparable to local and national averages; though the number of children aged under 14 is considerably higher than the local and national averages. These two pieces of information may infer that women are having multiple children or pregnancies and registering their children with the practice. This can impact on the need for maternity, pre and post-natal care.
- In terms of race demographics, the area served by the practice has significantly less White British population than Birmingham (41.61% to 53.14% respectively); the Asian Pakistani population is significantly larger than that of Birmingham as a whole (32.73% to 13.48% respectively).
- 5.7% of the population at the time of the 2011 Census said that they did not speak English well or at all, compared to the figure for Birmingham as a whole of 4.6%.
- The Hodge Hill ward areas has a significantly higher percentage of people who identify as Muslim (41.48%) when compared to Birmingham as a whole (21.85%);
- Hodge Hill practice is located within a highly deprived area.

Registration issues - In spite of suffering worse health than the general population, Roma gypsies and travellers, homeless people and refugee's/asylum seekers are three disadvantaged groups that experience barriers. There are some similarities in terms of poor mental health, dying younger, some language difficulties and reported barriers in terms of accessing and registering with a GP.

Equality Monitoring: Understanding a patient's background and current needs can help practitioners to deliver person-centred care. Like someone's ethnicity, age or marital status, sexual orientation is a characteristic that doesn't define but can have an impact on their health risks and outcomes and so is useful information in the care and treatment of the individual.

Recording sexual orientation across health and social care can enable providers to better identify health risks at a population level. This will support targeted preventative and early interventions work to address health inequalities, which is shown to reduce expenditure linked to treatment costs further down the line.

Research shows that that LGB people experience greater health inequalities compared to heterosexual people, such as being at higher risk of poor mental health, or missing out on routine health screening. If a healthcare service collects information on patient sexual orientation, they will be able to target specific health promotion and services to LGB patients: for example, promoting cervical screening to lesbian and bisexual women; or referring young LGB people experiencing poor mental health to a specific LGB young people's service.

The gap in understanding patients sexual orientation (and adoption of the Sexual Orientation Monitoring Information Standard, which is detailed here

(https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/) and (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb2094-sexual-orientation-monitoring) could lead to LGB people experiencing greater health inequalities when compared to heterosexual people.

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.

Recommendations - Contract:

A review of the service specification has been undertaken in light of the findings of the equality analysis and the wording related to equity of access and patient registration have been revised with the wording below and **recommended** for inclusion

Service Specification - Schedule 2 – Part 1

1 Equity of Access

1.1 The Contractor shall:

1.1.1 not discriminate against any Patient on the grounds of their protected characteristics (age, disability, sex, sexual orientation, race, religion or belief, gender reassignment, marriage and civil partnership status or pregnancy and maternity status) or any other medical or non-medical characteristics;

1.1.2
meet the requirements laid out in the Accessible Information Standard which sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss (section 250 of the Health and Social Care Act 2012);

1.1.3 utilise available professional translation services as required for all non-English speaking Patients during all consultations

1.1.4 utilise available British Sign Language (BSL) services as required for all deaf or hearing-impaired Patients during all consultations;

1.1.5 To provide appropriate translations of materials describing procedures and clinical prognosis, where it is normal procedure to provide such materials in English, for the languages spoken by Patients who use your services.

1.1.6 Take reasonable steps to proactively deliver health promotion and disease prevention activities to all Patients including those from disadvantaged groups. The Contractor acknowledges that a disadvantaged group may include but not be limited to the following:

xiii. those who do not understand written or spoken English;

xiv. people with disabilities including hearing, sight, learning and mental ill health disabilities;

xv. single parents;
xvi. asylum seekers and refugees;
xvii. migrants
xviii. those who have no permanent address;
xix. Gypsy Roma Traveller communities
xx. black or minority ethnic communities;
xxi. adolescents;
xxii. elderly and/or housebound people;
xxiii. those who misuse alcohol or illicit drugs; and
xxiv. those who are unemployed.

1.1.7 The Contract acknowledges that to improve equity of access for all it is important to collect equality monitoring information on patients protected characteristics and to act appropriately on that information; providing services which are responsive to needs, eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

1.1.8 The Contract is required to take all reasonable measures to ensure that its services are fully accessible in respect of physical access to the building and navigation within the building, digital access and in terms of all communication and contact with its patients.

Part B

Services

4 Patient Registration Area

4.3 The Provider shall make services available to disadvantaged groups for example: migrants, asylum seekers, refugees, the homeless and Gypsy Roma Travellers, and shall ensure that requests for patient registration are dealt with on an individual basis, in accordance with guidance produced by NHS England (Patient Registration – Standard Operating Principles for Primary Medical Care (General Practice), Gateway Ref. 04191) and acknowledge that refusal to accept must be based on non-discriminatory grounds.

21 Cervical Screening Services

Revise wording to ensure that Trans men with a cervix are included in terms of eligibility for cervical screening.

Procurement Recommendations:

To understand how providers will address the issues highlighted in Section 3 (other disadvantaged groups) and Section 8 (summary of analysis) procurement should explore how those bidding for the contract will ensure that people who are homeless, migrants, refugees, asylum seekers or Gypsy Roma Traveller are able to register with the practices.

It is also recommended that the procurement is used as an opportunity to understand how bidders will address the issues of capturing equality monitoring data (Section 3 – Impact and Evidence – Race and Sexual Orientation; Section 4 – Health Inequalities and Section 8 – Summary of Analysis).

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):

GP services do not use the NHS Standard Contact and this APMS contract will not include any Key Performance Indicators

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):

The procurement questions should focus on the following equality, diversity, inclusion and health inequalities issues:

- Provision of patient centred and responsive care to vulnerable/disadvantaged patients with a poorly managed long-term condition;
- How organisation will identify vulnerable groups and improve their access to preventative health services;
- Policies to ensure equality, fairness and adherence to the Equality Act 2010/employment legislation in recruitment and employment practices.
- Procedures to deal with discrimination, bullying, harassment and victimisation in the workplace;
- Staff equality and health inequality training (including meeting needs of diverse and vulnerable patient groups);
- Capturing, recording and using patient's protected characteristics and local demographics to address health inequalities;
- Establishment and sustaining engagement with local population, including those identified as vulnerable, seldom heard and/or disadvantaged;
- Elimination of barriers around registration experienced by vulnerable groups.
- Meeting the communication and information needs of patients with a disability and those with English as a second language.

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.

This report will be included in the public session of the CCG's Primary Care Committee.
Following ratification 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 and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:	M K Dunne	2nd April 2019
Which Committee will be considering the findings and signing off the EA?		
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