North Central London Sustainability and Transformation Plan
Equality Impact Assessment

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1. Identification

Workstream	Primary care
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Date	4 January 2017 (reviewed June 2018)
Person completing this document	
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2. Brief description of workstream scope

This programme will develop primary care services which will include services currently provided by:

- General practice services, including those provided “at scale”
- Community pharmacists
- Other community based clinical services including nursing and therapy services
- Social care services as part of an integrated team at local level
- Wider community based services including third sector service

Primary care transformation doesn’t only cover GP surgeries, but all areas where primary care is delivered.

3. Key workstream activities

Improving and extending general practice access: Improved access through extended opening hours. Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm all seven days of the week. Patients will also be able to access consultations through a variety of means such as e-consultations and telephone consultations.

Care Closer to Home Integrated Networks (CHINs): Integrated care teams delivering: risk stratification of patients (to identify those most at risk of health deterioration and/or admission to hospital as an emergency), proactive care management and care coordination with care planning through a multi-disciplinary team fully integrating health and social care with single/shared assessments, shared budget and shared operating model. The teams include care navigation and social prescribing along with increased patient education and support, reaching into communities to build resilience and greater selfcare using asset based (also known as strength based) models. The CHINs also include consultant specialists providing faster access to advice and support on elective care to GPs and their patients along with specialist nurses, particularly caring for patients with chronic diseases.

Quality improvement support teams (QISTs): These GP-led teams will provide hands-on practical help working with and in practices to develop consistent standards and service offer to all patients, introducing and delivering with/for practices agreed new ways of working and best practice models of care. The teams will help to build resilience in and across general practices and enable general practices to fully play their part in the delivery of the health, patient experience and system efficiency outcome goals shared with the CHINs.

Alignment of Locally Commissioned Services (LCS) and Personal Medical Services (PMS) contracts to the above programme of action: The CCGs will, over time, need to align their LCS and PMS contracts to ensure the funding is used to pay GPs and their teams to work effectively with the CHINs and QISTs to deliver the agreed outcomes.

4. Equality impact

Please consider what are the equality impacts of your workstream for NCL residents. This must take into consideration each of the eight protected characteristics described in the Equality Act 2010 (outlined below).

Consider whether the activities proposed in this workstream are likely to be **discriminatory**, to have a negative impact on equality of **opportunity**, or a negative impact on good **relations** between communities with protected characteristics and the rest of the population.

Please provide **data** and information relevant for your analysis, including sources. These may include (but are not limited to): profile of service users and staff, recommendations from previous inspections or audits, research results, comparisons with similar activities in other contexts, results of any past consultation and engagement activities (such as complaints, mystery shopping, survey results, focus groups, meetings with residents, etc).

Please identify and detail the identified impacts for each protected characteristic.			
Characteristic	**Impact**	**Details** *Consider discrimination, opportunity and relations between communities; consider patients, carers, staff and public. Describe details regardless of type of impact (positive, negative or none).*	**Data source(s)**

Disability *Consider attitudinal, physical and social barriers; physical, visual, and aural impairment; mental or learning difficulties.*	☒ Positive ☐ Negative ☐ None	**<u>This section in bold applies to all the groups with protected characteristics:</u>** **One of the explicit goals of the CHINs and QISTs is to address inequalities in health and so their plans will need to demonstrate how they will do this. Each CHIN and QIST will be provided with public health information showing where there are inequalities in health in their population which need to be addressed and they will be monitored on how effectively they deliver this outcome.** **Investing in primary care services, including increasing the numbers of GPs by establishing Quality Improvement Support Teams, is proven to reduce inequalities in health and particularly improves the health of people from ethnic minorities.** **The research[1] highlights:** **"…evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies."** **And:** **"Specifically, a greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services, and reduce the inequities in the population's health."** **There is further evidence[2] from the UK showing:** **"…the high salience of primary care for in-hospital mortality; the primary care physician supply was more powerfully associated with reductions in in-hospital standardised mortality than the number of doctors per 100 hospital beds. A later study showed that, after controlling for social class, deprivation index, ethnicity and limiting long-term illness, each unit increase in GP supply per 10 000 population was significantly associated with a decrease in hospital admission rates of about 14 per 100 000 for acute illnesses and about 11 per 100 000 for chronic illnesses.**	

1. "**Contribution of Primary Care to Health Systems and Health**" Starfield, B. Shi, L. and Macinko, J. in "The Milbank Quarterly", September 2005. See: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

2. "**The Effectiveness of Primary Healthcare**" Starfield, B. Chapter in "A Celebration of General Practice" Edited by Lakhani, MK. The RCGP 2003

		Evidence[3] from the World Health Organisation highlights the following important features of primary care (and specifically general practice) which enable improved outcomes: • **Comprehensiveness and integration** • **People centred** • **Regular point of entry** • **Direct and enduring relationships of trust (continuity of care)** **This evidence also demonstrates the following benefits from expanding and integrating general practice services:** **i. Improved health outcomes for patients in terms of long term morbidity and mortality** **ii. Lower hospitalisation rate** **iii. Improved recruitment and retention of GPs** **iv. Improved mobilisation of community resources to improve health and wellbeing locally** **v. Reduced inequalities in health in terms of long term morbidity and mortality across different communities** **vi. Improved system efficiency in terms of the proportion of care delivered in cost effective settings** **vii. Reduced pressure on Accident and Emergency services** **There are high levels of A&E attendances across NCL compared to national and peer averages, and also very high levels of first outpatient attendances, suggesting that there may be gaps in primary care provision.** **Better integrated care will enable people with complex needs such as those with disabilities to have their needs more proactively assessed and met and to experience more joined up care.** **A new emphasis on asset based (also known as strength based models) approaches to build the resilience and enable greater selfcare of individuals, families and communities should lead to a more tailored approach which**	

3. "***Primary Health Care – Now More Than Ever: The World Health Report 2008***" The World Health Organisation, 2008 (see Chapter 3 in particular)

		benefits patients who may traditionally have felt the service has not adapted to or provided for their needs. **Greater involvement of and working with voluntary sector services at local level in the planning and delivery of care and support, including specific measures for patient education and support should help local CHIN and QIST teams to become more responsive to the diverse needs of the communities they serve. Teams will need to develop, implement and monitor action plans with their communities and the increasing transparency of performance which is being designed into the operating principles of these teams should also help them to focus on demonstrating an impact on addressing health inequalities.**	
Sex *Consider male and female*	☒ Positive ☐ Negative ☐ None	This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities. Reducing preventable premature mortality from chronic diseases is a key outcome goal for CHINs and QISTs. Men are generally more likely to die prematurely from chronic diseases than women and so CHINs and QISTs will inevitably need to redesign services to make them more accessible to men and to find ways of engaging them earlier and to build resilience and selfcare more effectively.	
Race *Consider language and cultural factors of different ethnic groups, nationalities, Roma gypsies, Irish travellers.*	☒ Positive ☐ Negative ☐ None	Barbara Starfield, who is described in Wikipedia as "the co-founder and first president of the *International Society for Equity in Health*, a scientific organisation devoted to the dissemination of knowledge about the determinants of inequity in health and finding ways to eliminate them. Her work thus focuses on quality of care, health status assessment, primary care evaluation and equity in health." has found: "In the United States, an increase of 1 primary care doctor is associated with 1.44 fewer deaths per 10,000 population. The association of primary care with decreased mortality is greater in the African-American population than in the white population." [4] Whilst the US represents a radically different model of health care there is evidence to suggest that the association of increased GP capacity with reduced inequalities is also reflected in England, as Starfield also states:	

[4] "**The Primary Solution: The Case for Primary (Health) Care**" Starfield, B (presented at the RNZCGP Annual Quality Symposium, New Zealand), 2009

		"…evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies." [6] This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	
Age *Consider across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*	☒ Positive ☐ Negative ☐ None	Better integrated care will enable frail older people to have their needs more proactively assessed and met and to experience more joined up care. For children and young people the new emphasis on health outcomes at local (CHIN) level will support a new emphasis on addressing public health needs such as obesity in children and sexual health in young people. This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	
Gender reassignment (including transgender) *Consider on transgender and transsexual people. This can include issues such as privacy of data and harassment.*	☒ Positive ☐ Negative ☐ None	This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	
Sexual orientation *Consider on heterosexual people as well as lesbian, gay and bi-sexual people.*	☒ Positive ☐ Negative ☐ None	This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	
Religion or belief *Consider on people with different religions, beliefs or no belief. Consider practices of worship, religious or cultural observance.*	☒ Positive ☐ Negative ☐ None	This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	

Pregnancy and maternity *Consider on working arrangements, part-time working, infant caring responsibilities.*	☒ Positive ☐ Negative ☐ None	This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	
Other identified groups *Consider different socio-economic groups, area inequality, income, resident status (migrants), marriage and civil partnership, and other groups experiencing disadvantage and barriers to access.*	☒ Positive ☐ Negative ☐ None	This group should experience the same benefits as the rest of the population: improved access to more proactive and integrated care and the benefits of an increased emphasis on delivering public health measures better tailored to the needs of diverse local communities.	

5. Action

Please summarize your action plan in the table below. This must include all the **negative impacts** identified. Please outline steps you plan to take to mitigate these impacts.

Impact: which impact was identified?	**Action**: what needs to be done to mitigate the impact?	**Person / Institution**: who will be responsible for doing this?	**Timescale**: when should this be done (during the current planning stage, implementation stage, etc.)?
Actions to mitigate negative equality impacts			
The only negative impact would be if the investment needed to develop the primary care services planned was not fully available. This would potentially create a huge negative impact on groups with protected characteristics because: 1. Hospital services are already planning service reductions as part of the STP and when service pressure increases it is the most vulnerable group such as those with protected characteristics that are most badly affected. If the primary care services are not developed to provide the better alternative then health inequalities will increase. 2. Generally NCL currently has relatively low investment in primary care compared to other areas which has led to poorer health outcomes which	Funding must be found from other areas to invest in the primary care STP proposals. Without this the pressure on hospitals will continue and ***the existing health inequalities will widen***.	The STP Transformation Board	This needs to be done now so that planning and mobilisation to build the primary care CHINs and QISTs can start.

are inevitably suffered disproportionately higher by vulnerable groups. Evidence from Starfield[4] shows: "Many other studies done WITHIN countries, both industrialized and developing, show that areas with better primary care have better health outcomes, including total mortality rates, heart disease mortality rates, and infant mortality, and earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer, and melanoma. The opposite is the case for higher specialist supply, which is associated with worse outcomes." By failing to invest in primary care we will perpetuate and increase the existing health inequalities.			

Please send the completed Equality Impact Assessment to ines.campos-matos@islington.gov.uk.

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