For more information about the equality impact assessment process in commissioning, please see the EIA Guidance located in *Y:\HULLCCG\Corporate Templates and Forms\Equality and Diversity Information* before completing your EIA.

Equality Impact Assessment - Service Review / Evaluation			
What service is being reviewed?		Faith House service relocation	
What is the purpose for the service review? (If this is described in another document please add cross reference link)		C.F 'Proposal on relocation and consolidation of GP services' and comprehensive equalities analysis in engagement report (appendix 1)	
Date of review:		17.06.19	
Name & roles of person / people completing the EIA:		Ruth Wilson, National Strategy and Project Implementation Manager; Caroline Rawcliffe, General Manager	
Health Needs	What data sources do you have about the population, disaggregated by protected characteristic?	Limited data READ coded onto practice clinical systems. Public Health GP Profiles from Public Health England Findings from our engagement activities, analysed by protected characteristic https://fingertips.phe.org.uk/profile/general-practice . The Joint Strategic Needs Assessment of Hull City Council www.hullcc.gov.uk/pls/hullpublichealth/jsna2018_s1html . The Kingston Upon Hull Data Observatory http://109.228.11.121/IAS_Live/ and the Primary Care Portal https://www.primarycare.nhs.uk/default.aspx all used to gather information about the populations of the affected practices.	
	Do you have any information about people who share protected characteristics that is relevant and applicable to this service review?	**Race**	According to the information available the biggest BME group at Faith House is the Asian community 2.9%. The majority of engagement survey respondents identified as White British / English / Irish/ Northern Irish / Welsh / Scottish (93.76%, 1,217). The next most common responses were Prefer not to say (2.85%, 37) and White other (2.00%, 26). Asian / Asian British and Black / Black British had a low response rate with only 1 respondent identifying as each.

		Many of our registered BME patients are students, which is expected to reduce the response rate of this demographic somewhat. Numbers of respondents identifying as other than White British / English / Irish/ Northern Irish / Welsh / Scottish or Prefer Not to Say were comparatively low, at 35. An additional 9 people selected 'Other' of which the relevant free text responses were 'Chinese' and 'European'. Although the respondents identifying as BME were low, there are several potentially contributing factors. The majority of respondents were from Faith House, which was expected within the context of this engagement and this site has the lowest BME numbers of those affected by the proposals. People aged over 55 were the most likely to respond (over 50% of survey respondents were over 55). When patient data of those registered at Faith House is analysed, of those who have registered as other than 'White – British' only 30.75% were over 55. As over 55s were most likely to respond, and over 55s represents our lowest percentage of BME patients, this may explain some of the lower number of BME responses. There were no new themes identified in responses by individuals who identified as BME. Both Newland Group Medical Practice and New Hall surgery serve a larger BME population than Faith House. Staff there are regular users of interpreter services, and deal with people from a wide variety communities regularly. There is no evidence that

		patients will be disproportionately affected based on race. There is a risk that non-native English speakers would be less likely to respond with site location, but this would not prevent them being able to access services. Contact numbers will also remain the same and interpreter services continue to be available.
	Disability	Hull City Council Joint strategic Needs Assessment 2018 notes 10% of the population identify their day-to-day activities as limited a lot by a long term health condition or disability. York University Health Needs of People with Learning Disabilities (2016) identify that people with Learning disabilities see their GP's less often, are less likely to undergo screening and find it difficult to communicate their health needs. Structural heart defects in some people with learning disabilities also make them more likely to have cardiovascular disease. We are in the process of recruiting a Learning Disabilities specialist nurse, which will further enhance how we support patients with a learning disability. The majority of engagement survey respondents (51.64%, 644) did not report a health condition that affects their day to day activities which has lasted, or is expected to last at least 12 months. However 13.59% (174) reported being limited a lot and 27.42% (351) limited a little. This indicates that the engagement was effective at reaching people with a disability or health condition. There was no major variation in the frequency with which health issues were reported based on the respondents registered sites, except those registered at ''Other' were more likely to leave the

		response blank, or be limited a lot. The priorities of survey respondents did not vary substantially when compared to respondents who did not consider themselves to have a condition that limited them. The only area with a difference in number of people rating it most highly was that 11.5% more people with a limiting condition rated 'seeing the same doctor, or a doctor that knows you' as 1/most important than those without a health condition. This places a higher priority on continuity of care. Patients will need to be given accurate information about where clinicians will be based to enable them to see their clinician of choice. For patients with mobility issues, both New Hall Surgery and Alexandra Road Health Centre have higher accessibility than Faith House, including wider corridors.
	Gender / Sex	Engagement activities were varied to maximize access, including at different times of day and days to facilitate access to those with work, caring or other commitments. The majority of respondents identified as Female (65.54%, 852). 31.23% (406) identified as Male, 2.62% (34) Prefer not to say and 0.62% (8) identified as other. Female patients were more likely to report themselves as having a health condition that limited them a lot than males, but percentages with a health condition of some type were similar. The engagement did not identify any specific

		actions relating to gender, or that the proposal would disproportionately disadvantage anyone based on gender. The engagement specifically sought to increase engagement with men, including through meetings with Men in Sheds.
	Gender identity (gender reassignment)	Measuring or estimating the size of the trans population at both sites is difficult. There are no government surveys or census data on this population. Of the respondents who identified as other in response to the question on Gender there were 3 respondents who suggested an alternate gender identity. Their free text responses were as follows: “Gender fluid”, “Nonbinary” and “I don't have a gender, my sex is female XX”. Treating people with dignity and respect who identify as trans, who have transitioned or are transitioning, or in any other way identify as a gender other than male or female means practices avoid using codes that might identify their status. On transition records have to re-summarised removing all reference to previous status and new NHS numbers are allocated. No respondents of the survey specifically identified as trans, however there may have been transgender respondents captured under male and female responses. Numbers selecting ‘other’ and specifying an alternative gender were too low for a meaningful analysis. No reference was made to gender identity or reassignment issues in the free text areas of response.

		There are a range of health access issues that are likely to affect trans-individuals both specifically and at a higher rate than other people, but there is no evidence to suggest this is exacerbated by the proposals.
	Sexual orientation	There is currently no reliable estimate of Lesbian, Gay and Bisexual (LGB) population size with estimates varying from 0.3% to 10.0%. The Office of National Statistics Sexual Identity survey 2016 suggests a figure of 2% of the population. Of the 1282 respondents who answered this question, 89.39% identified as heterosexual. 0.7% identified as Bi-Sexual, and 1.48% identified as Gay/Lesbian. 6.86% respondents answered 'Prefer not to say'. Of the 20 respondents selecting 'Other', please specify, the most common responses were questioning why this was relevant. One respondent identified as Pansexual. This places the 2.15% of respondents identifying as LGB slightly above the 2% ONS figure. Analysis of responses did not identify variations in responses for respondents identifying as LGB. The health needs of the LGB community are similar to the general population. Awareness of barriers facing LGB individuals should always be raised wherever possible, but there is no evidence to suggest this group will be disproportionately affected by the proposed changes.
	Religion or belief	Little data is available about the religions or beliefs of patients attending the two practices. Census and other survey data suggest that the UK is becoming an increasingly secular society. However there is little data on how religion and belief affects lifestyle including accessing

		health care. However it is worth noting that Faith House has historically identified itself as a Christian practice with some of the staff and patients choosing it for that reason. The value placed on this ethos was represented in free text responses (there were 15 mentions of 'Christian values' or 'Christian ethos' within the free text areas, although some of these mentions were by the same respondents. Additional work should be undertaken with the PPG to understand what elements of the practice's values/ethos are valued.
	Age	Faith House has a falling number of young people with rising numbers of older people.This was reflected in engagement results, as 51.84% of respondents were aged 55 or older. However, reasonable numbers of respondents were still apparent across other age groups; 14% of respondents where aged under 35, and 14.92% were aged between 35 and 45 suggesting a reasonable cross section of respondents replied. When analysed by age, the key differences in health reporting and service usage were that a lower number of young people reported impairments or limiting health conditions. Younger respondents were less likely to visit their surgery once a month or over. There were three key areas where differences in priorities occurred when responses were analysed by age. Patients in the older age bracket (65+) were more likely to rate location as most important than those under 35. Patients will need to be given maximum choice on location of appointments.

		The priority placed on opening times decreased with age, This is expected due to the increased likelihood that those over 65 will have retired than younger respondents. Initiatives that Modality Partnership is currently trialling, particularly digital appointments through Push Doctor, can meet the needs of patients for whom access to a doctor is the most important factor (50% of respondents in all age groups). Digital Appointments through Push Doctor will increase patient's access to doctor appointments at flexible times, from anywhere. This is additional to traditional in-person appointments. Opening times will expand as the new primary care contract is implemented, increasing evening opening. The priority placed on 'Seeing a doctor that knows you' increased with age. Different priorities were identified by age, as identified above. To mitigate impact propose: - To support continuity of care it will be important to provide clear information to patients about any changes of location for clinicians, including details of where each GP would be moving to. - Continue with flexible access initiatives, including Push Doctor.
	Pregnancy and maternity	Both sites currently offer services to pregnant woman prior to and after delivery of their babies. The engagement activities did not specifically identify any questions around pregnancy or maternity status. Pregnancy was referenced once in a free text response, regarding access to a midwife. Respondents did reference children as reasons for more frequent visits. One relevant trend was that some respondents found Faith House waiting room difficult to

		access with a pram, although others did not have an issue with this. Provision will need to continue to take into account pregnancy and maternity needs. New Hall Surgery and Alexandra Road Health Centre are both accessible standard buildings for prams, with larger waiting rooms and wider corridors.
	Marriage or civil partnership	Marriage status is routinely recorded by both practices. There is no evidence to suggest that marriage status would affect people's ability to participate in any engagement activity. Some survey responses noted that they were responding on behalf of their husband or wife as well as themselves, with 52 separate responses referring to husband / wife. These were predominantly responses in the over 55 category, and the most commonly noted concerns in these responses related to seeing a doctor who knows your medical history, and access to the surgery location in terms of parking and bus travel. These concerns will be addressed in the general access / location recommendations. There is no evidence that people's marital status will disadvantage them in these proposals compared to any other group.
	Socio-economic disadvantage	Hull is identified as one of the most deprived cities in the country. Faith House is in the 4th most deprived centile according to the 2015 Index of Multiple Deprivation and Newland Group in the 3rd most deprived. Our engagement survey did not ask respondents questions relating to socio-economic disadvantage. However, we have taken actions to ensure that participation in the

			engagement activity was cost neutral, seeking to remove cost barriers from participation. This included free postage of the survey, and availability on line. We will ensure this approach is replicated in actions moving forwards, including providing a free post return address with letters sent to patients when asking for them to respond with preferred branch site.
Current service review	How does the current service promote equality? (Are there examples of good practice or have you identified any gaps?)	Equality and Diversity Awareness is part of the Mandatory Training of all staff in Modality Partnership Hull. Newland Group Surgery are high users of the CCG Interpreter Service.	
Outcomes and demand	How does the current service evidence improved health outcomes for different groups of people? (e.g. by age, gender disability, ethnicity, sexual orientation, religion or belief, pregnancy & maternity)	Modality Partnership Hull aims to deliver excellent care and improve patient care for the entire patient population. As part of our service delivery we monitor improved health outcomes for our entire patient population and do not traditionally stratify by different groups as identified. That said, we offer programmes of care and support that affect these groups in terms of condition specific care and screening programmes. These are monitored to ensure we maximize uptake of care and implement best practice through the Quality Outcomes Framework.	
	What can you tell about the demand for the service by different groups? Is there an over or under-representation of particular groups, relative to the population?	Demand for our services is driven by patient need therefore patients who have higher levels of ill health utilize a greater proportion of our services. Our experience of patient demand aligns to the general assumptions that can be made regarding care, for example children, young people and older people have a greater need for, and therefore access, greater levels of care than working age adults. Similarly, pregnant women utilize more health care services than the average woman who isn't pregnant. There is nothing specific in relation to this proposal to add nor do we believe the demand for our services from different groups to be atypical when compared to local demand.	

Benchmark	How does the service compare to other comparable services with respect to evidencing improved outcomes across different groups?	The practices have high level data comparing performance across indicators such as prescribing, vaccinations given, screening undertaken and use of secondary care services. This allows us to compare ourselves within the Modality Partnership and other practices within the CCG. It is not routinely monitored across the different groups.
Communication and Engagement	How are you going to engage with different groups and communities and show that their feedback informs your service review?	We advertised our engagement activities extensively, with 16.06% of patients aged 16+ registered at Faith House responding to the survey. Feedback has been analysed by protected characteristics and recommendations used to inform our proposals.
	Is information provided to your target market appropriate and accessible?	Information will be sent to every patient registered at Faith House. Interpreter services are available by phone. Changes will be posted on service website, social media and in the practices.
	Does your options appraisal clearly Does your options appraisal show any differential impact on protected characteristics groups for each option?	Our recommendations take into account protected characteristics to identify any group particularly affected by their protected characteristic.
Options appraisal	Is further engagement needed?	The only farther engagement proposed is with the Patient Participation Group to understand what elements of the practice's values/ethos are valued, in relation to Faith House's historical Christian ties.

Follow up actions		
Action required	**By whom?**	**By when?**
Engagement with the Patient Participation Group to understand what	Sarah Warriner (Patient Liaison	Dependent on when

elements of the practice's values/ethos are valued, in relation to Faith House's historical Christian ties.	Officer)	decisions on proposals are made.
Communication to patients regarding proposed changes to locations to note accessibility information for sites, and detail where GPs will be based to support continuity of care,	Ruth Wilson	Dependent on when decisions on proposals are made.

Signoff			
Signed off by: **Name & Role**	Caroline Rawcliffe, General Manager	**Date**:	**19/06/19**