

**Equality Impact Assessment**

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| **Title of policy or service:** | Urgent Primary Care Transformation: **Option 1** | |
| **Name and role of officer/s completing**  **the assessment:** | Sue Berry – Senior Quality Manager Urgent Care, Richard Kennedy- Engagement Manager, Helen Mulholland – Engagement Manager | |
| **Date of assessment:** | 26th July 2017 | |
| **Type of EIA completed:** | **Initial EIA ‘Screening’**  ***or*  ‘Full’ EIA process** |  |

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| **1. Outline** | |
| **Give a brief summary of your policy or service**   * Aims * Objectives * Links to other policies, including partners, national or regional | It is now recognised both nationally and locally that in the face of increasing demand for services, changing expectations of patients, changing healthcare policy regarding seven day services, workforce challenges and financial pressures that commissioners must seek to develop innovative ways of delivering high quality and safe services that continue to meet patient need.  Nationally a review of urgent and emergency care has been let by Sir Bruce Keogh with the aim of ensuring that patients nationally have access to integrated 24/7 urgent care services. This review is now in its implementation phase and supported by national guidance and explicit commissioning standards for integrated urgent care (September 2015) and also the recently published urgent and emergency care 10 point delivery plan (February 2017) which is further supported by the Stevens and Mackey letter ‘Action to get A&E performance on track’ (March 2017). It should be noted that a further iteration of standards for urgent treatment centres reflecting the need to commission integrated care has also been published (March 2017) by the NHS England UEC Programme.  **Key areas highlighted in current guidance that are of most relevance to the services and pathways within the scope of this programme of work are:**  • The need to standardise walk in centres, minor injury units and urgent care centres so that they offer a consistent high quality services and are less confusing for patients to access.  • Simplify access to local services through a single entry point (NHS 111) to fully integrated urgent care services collaborating to deliver high quality clinical assessment, advice and treatment with shared standards and processes.  • Deliver the requirements of the GP Forward View with regard to rolling out pre-bookable and same day evening and weekend GP appointments.  A key area of focus for this programme of work as it develops will be to ensure that any local developments are closely aligned with the national strategy, standards and implementation timescales.  **Sustainability and Transformation Plans (STP) and Urgent and Emergency Care Networks (UECN)**  Urgent care is highlighted as a priority within local STP plans with the overarching aim of simplifying urgent and emergency care and making it easier or patients to access the right services closer to home. This is supported by the local UECN and West Yorkshire Emergency Care Network Vanguard which are focussed on delivering the key elements of the national strategy at pace.  However, it should be noted that whilst any potential changes will be consistent with national requirements and developments in the wider region, they will focus and impact primarily on Sheffield’s patients. For example, regional pathways trauma pathways fall outside of the scope of this work.  **Sheffield’s Local Strategy for Urgent Care**  A strategy for urgent care in Sheffield has been developed with key local stakeholders and is supported by the Governing Body. The strategy outlines a clear strategic direction for urgent care over the next five years and is underpinned by a number of key principles. Delivery is structured around four key programmes all of which support the development of urgent care services and pathways system wide.  **The Strategic Direction of Urgent Care in Sheffield over the next five years:**  Over the next five years funding must be redistributed away from high intensity and high emergency care to less costly and earlier interventions. This will mean the reducing the numbers of hospital admissions and by doing so release funding for other areas of the system.  Sheffield’s patients and population will be supported by a system which is most appropriate for their needs and responds promptly rather than services that are easiest for the system to provide.  Reflecting that an urgent care system operates across a range of organisations a ‘Whole System Active Management’ approach will be adopted moving towards operationally managing the capacity of the whole system from a single point.  This will be enabled by a educating the local workforce in new and best practice ways of working and underpinned by robust and operational contractual measures.  **The Four Key Programmes Ensuring the Delivery of the Local Urgent Care Strategy are as Follows:**  **Ensuring patients’ needs are met in primary care where appropriate**.  This element of the strategy focusses on ensuring that patients only access acute care when needed and wherever appropriate their care is provided in primary care and is the key focus of this area of work.  **Improving assessment and step up solutions**.  This ensures that well established assessment pathways are in place to ensure that wherever appropriate alternative non acute services are accessed and unplanned admissions avoided and that that patients who may need additional support (above and beyond that which can be provided in their own home) receive this in a timely manner.  **Patients stay no longer than they need in bed based care**.  This programme ensures that patients are discharged from hospital as soon as they no longer require active support from an acute hospital and that their ongoing care is provided as appropriate in the community.  **Improving onward handover.**  The focus of this programme is to ensure that all patient discharges are actively planned and in effect handovers ensuring continuity of care and effective clinical partnership working between providers along care pathways.  **The 4 Key Overarching Aims**:  With regard to the first programme of work ensuring that patients’ needs are met in primary care where appropriate there are four key overarching aims.  **To simplify access to local services (for patients and professionals).**  This will be described in more detail later in the paper but feedback from both patients and professionals is that currently local services are often duplicated and confusing to access.  **To ensure the best use of professions and the local workforce**.  Again, this will be described in more detail later in the paper but feedback (especially from primary care) is that it is becoming increasingly difficult to recruit clinical staff.  **To shift resources to Primary care.**  Redistribution of funding from high intensity and high emergency care to less costly earlier interventions will reduce the number of hospital admissions and release funding to other areas of the system (primary/community services).  **Reduce Inequalities.**  Significant inequalities remain across Sheffield with difference of life expectancy across the city of over ten years. It is therefore of crucial importance that wherever possible any future developments look to supporting the reduction in existing inequalities and do not exacerbate them.  **Links with the GP Five Year Forward View and Sheffield’s Out of Hospital Strategy**  There are clear overlaps between Sheffield’s Urgent Care and Out of Hospital strategies and the GP Forward View. Key to enabling the successful delivery of all three areas will be the successful development and implementation of Sheffield’s neighbourhood model for GP practices. This approach will provide a structure and collaborative framework at sufficient local scale to ensure that:  • Primary Care in Sheffield is resilient during times of high demand.  • Primary Care services (both individual practice and neighbourhood) dovetail effectively with acute pathways as they develop (supporting admission avoidance and timely discharge).  • Primary Care access requirements are met.  • Ensure the most effective use of key members of the workforce and that best practice and emerging models of care such as clinical pharmacists supporting practices are adopted.  **Local Need & Demand and Addressing Inequalities**.  As briefly described above, Sheffield is facing similar problems to the rest of the UK with regard to increasing pressures on local health services. Additional local issues are highlighted within the Joint Strategic Needs Assessment (JSNA).  **Key Issues Highlighted by the Joint Strategic Needs Assessment (JSNA).**  The local Joint Strategic Needs Assessment (JSNA) highlights the following areas of concern:  The Sheffield JSNA is presently being refreshed in support of the Sheffield Public Health Strategy. This identifies ten priorities for focused improvement, all of which have a potential to contribute to reducing expressed demand for unscheduled care:  • Early years  • Work and health  • Inclusive growth  • City for all ages/age friendly city/ageing well  • Transport and healthy urban planning  • Air quality  • Prevention components of the STP / PBP  • Outdoor/green spaces  • Housing and health  • Mental wellbeing  An emphasis on a significant expansion of social prescribing provision in the Sheffield Based Plan is of particular note in terms of the prospect for short-term impact on unscheduled care.  Over and above disease burden and morbidity, the principal factors of population need underpinning demand for urgent care in the city are likely to be related to age profile, ethnicity / migration and deprivation.  Owing to the large number of university students in Sheffield we have a strong young age bias in the population. The working age population is therefore much higher than the England average, giving Sheffield a falsely low economic dependence ratio (proportion not in the productive age range), and this skews the need and demand profile.  Being born outside the UK, non-English as first language and recent migrants are factors militating in the direction of unscheduled care use relative to primary care / planned care.  Estimates of non-British nationals per 1,000 resident population is substantially higher than the region but much lower than the national average; the largest single group being Pakistani (4.0% vs 2.1% England); the broader Asian group accounting for the largest growth over the last decade. However, of the eight English core cities, Sheffield is the 3rd highest for international inward migration. Romania is the predominant migrant country of origin followed by Poland and China.  In 2014, 20 in every 1,000 new GP registrations in Sheffield were made by people who previously lived abroad. This is the highest rate across the region whose average is 9 per 1,000. Whilst the fertility rate in Sheffield is among the lowest in the region, births to mothers who were born outside the UK are among the highest (26% of all births compared to 20% for the region). Only Bradford is higher.  In deprivation terms, circa 35% of Sheffield LSOAs appear in the bottom 20% of LSOAs nationally, and the overall IMD2015 deprivation score is significantly higher than England (27.6 vs 21.8).  **Understanding local need for urgent and on the day primary care.**  The population factors outlined in and the student / young age bias and migration influences in particular, render population need for unscheduled care especially difficult to gauge. Our in-depth analysis of the makeup of expressed demand experienced in A&E, walk-in clinics and primary care out-of-hours satellite clinics show characteristically different profiles in terms of the principal ‘need’ factors of age, morbidity, proximity and deprivation. It’s clear from this that the different options available for unscheduled care in the city – A&E, walk-in centre and satellite hubs – are addressing very different population segments and different needs; and they should not be treated as expressions of a common characteristic of need.  **Current demand on services**.  Whilst the JSNA highlights a number of key issues and concerns, a key element to informing this work has been the development of a clear understanding of demand for current local services both in terms of types of care sought, volumes of patients using these services and which areas of the city are the highest users.  In order to inform this work and develop a clear understand of current need and demand activity data from the key services falling within the scope of this programme of work has been completed.  **This EIA is based on the following Urgent Primary Care Access solutions for Sheffield Option 1:**   1. Patient /carer call NHS111 or local GP surgery and are signposted to appropriate care 2. 8am – 8pm Weekdays – access to 16 primary care hub sites/ an Urgent Treatment Centre (UTC hereafter) based at the Northern General Hospital for Adults / Child injuries at the Sheffield Children’s Hospital (SCH hereafter) and UTC for children at the SCH. 3. 8pm – 11pm Weekdays and weekends – access to 2 primary care hubs/ an UTC for adults based at NGH/ Child injuries department at the Children’s Hospital and UTC for children at the SCH. 4. 11pm – 8am access is via the Urgent treatment centre which is only for booked appointment |

**Identifying impact:**

* **Positive Impact:** will actively promote or improve equality of opportunity;
* **Neutral Impact:** where there are no notable consequences for any group;
* **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as

possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a ‘full’ EIA process.

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|  |  | **IMPACT** | | | | |
|  |  | **1** | **2** | **3** | **4** | **5** |
| **LIKELIHOOD** | **1** | 1 | 2 | 3 | 4 | 5 |
| **2** | 2 | 4 | 6 | 8 | 10 |
| **3** | 3 | 6 | 9 | 12 | 15 |
| **4** | 4 | 8 | 12 | 16 | 20 |
| **5** | 5 | 10 | 15 | 20 | 25 |

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| **LIKELIHOOD** | | **IMPACT** | |
| **1** | RARE | **1** | MINOR |
| **2** | UNLIKELY | **2** | MODERATE / LOW |
| **3** | MODERATE / POSSIBLE | **3** | SERIOUS |
| **4** | LIKELY | **4** | MAJOR |
| **5** | ALMOST CERTAIN | **5** | FATAL / CATASTROPHIC |

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| **Risk score** | **Category** |
| 1 - 3 | Low risk (green) |
| 4 - 6 | Moderate risk (yellow) |
| 8 - 12 | High risk (orange) |
| 15 - 25 | Extreme risk (red) |

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| **2. Gathering of Information**  This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*. | | | | | | | | | | |
| **(Please complete**  **each area)** | **What key impact have you identified?** | | | | | | | | **For impact identified (either positive and**  **or negative) give details below:** | |
| **Positive**  **Impact** | | | **Neutral**  **impact** | **Negative**  **impact** | | | **Overall score** | **How does this impact,**  **and what action, if any, do you need to take to address these issues?** | **What difference**  **will this make?** |
| **Likelihood** | **Impact** | **Overall** | **Likelihood** | **Impact** | **Overall** |  |  |
| **Human rights** |  |  |  | 0 |  |  |  |  |  |  |
| **Age** |  |  |  | 0 |  |  |  |  |  |  |
| **Carers** | 3 | 2 | 6 |  | 4 | 3 | 12 | Negative 6 | There is a potential that carers may have to travel slightly more or indeed less if the hubs are closer to their homes. The cost of travel and the distance/public transport links need to be considered and addressed. The public engagement feedback will be used to inform Neighbourhoods who will then be expected to complete their own individual EIA and implement any mitigating actions.  Evaluate the travel implications of the 16 sites that will be used utilising public engagement feedback. Individual Neighbourhoods to undertake as part of their service delivery an EIA, which is to include local people who have caring responsibilities.  Equally there could be a positive impact as carers may be able to access GP appointments in a more timely manner for their relative and with their own practice if the patient has on-going or complex needs.  Carers/parents of children could find this model easier to navigate as there is only one centre/place to go for children’s emergencies. This would help with having the right care in the right place at the right time. It would reduce travel costs due to potentially only having to go to one place rather than 2. The location for carers/parents would be the same as the current system. Therefore this would be seen as a strong positive.  This model would simplify access for both Adults and Children and clearly identifies where to go for what and for whom. | Relatives/patients of carer will be able to be seen in a more timely manner and with their own GP due to more appointments being available |
| **Disability** | 3 | 2 | 6 |  | 3 | 3 | 9 | Negative 3 | This could have a positive impact as the practices will be prioritising complex patient to be seen on site and this delivery model will potentially free up more appointments with their own GP.  Equally this could have a negative impact due to the potential increase in travel distance, modes of transport available and therefore also increased financial burden in terms of the cost of travel.  Neighbourhoods to undertake as part of their service delivery an EIA.  Potential negative impact if access to the hub’s sites within the Neighbourhoods is limited for disability including mobility, hard of hearing. There is currently no difference now as all GP practices have to have disability access  Individuals with a hearing impairment may not be able to access a telephone. Neighbourhoods should be aware that access to their hubs should include methods other than solely telephone access.  Individuals with a sight impairment may experience significant challenges navigating to different and unfamiliar sites for their care. | The cost of this travel and public transport links should be taken into account. The public engagement feedback will be used to inform Neighbourhoods who will then be expected to complete their own individual EIA and implement any mitigating actions  The public engagement feedback will be used to inform Neighbourhoods who will then be expected to complete their own individual EIA, alongside local people who live with a disability and implement any mitigating actions. Any buildings used as a hub should be compliant with the Disability Discrimination Act (2005). |
| **Sex** |  |  |  | 0 |  |  |  |  |  |  |
| **Race** | 0 | 0 | 0 |  | 2 | 3 | 6 | Negative 6 | Additional potential negative impact could be for those patients whose first language is not English, particularly if required to use the 111 service. | The neighbourhoods would be expected through normal core working to ensure that interpreters were available as per normal routine practice. This would be a requirement of all Neighbourhoods and identified as part of their EIA |
| **Religion or belief** |  |  |  |  |  |  |  |  |  |  |
| **Sexual orientation** |  |  |  |  |  |  |  |  |  |  |
| **Gender reassignment** |  |  |  |  |  |  |  |  |  |  |
| **Pregnancy and maternity** |  |  |  |  |  |  |  |  |  |  |
| **Marriage and civil partnership** (only eliminating discrimination) |  |  |  |  |  |  |  |  |  |  |
| **Other relevant groups** | 0 | 0 | 0 |  | 4 | 4 | 16 | Negative16 | Asylum Seekers, those in temporary accommodation, or having no fixed abode are less likely to have access to a telephone. Neighbourhoods should be aware that access to their hub should include methods other than solely telephone access. In addition, the needs of those people who speak minority languages where there is a national shortage of interpreters should also be considered.  Through previous engagement activity, it has been highlighted that asylum seekers and other communities new to the City tend to use services that are recommended by family, friends and other members of their community.  Upon any change to how urgent care services work, significant efforts should be made to work with these communities to make them aware of the changes and where they can access urgent care.  This model has the potential to simplify access and therefore improve the care that patients receive due to having the right care in the right place first time. This would help to reduce the burden of travel cost as care is delivered in core sites and not spread over 3 or 4 areas, making it easier to navigate.  Consideration should be made for people who access VCF sector support services that are based in the city centre and their lack of means / ability to meet the cost of travel to alternative sites in different areas of the city. | . |
| **OVERALL SCORE** | | | | | | | | 7.75 - MODERATE NEGATIVE RISK |  | |
| **HR Policies only:**  **Part or Fixed term staff** |  |  |  |  |  |  |  |  |  |  |

Having detailed the actions you need to take please transfer them to onto the action plan below.

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| **3. Action plan** | | | | |
| **Issues/impact identified** | **Actions required** | **How will you measure impact/progress** | **Timescale** | **Officer responsible** |
| Travel | Each individual Neighbourhood to undertake an EIA and public consultation on proposed site options for the hubs. This will include transport links, availability, affordability and schedules of public transport | Patient feedback and public engagement will inform the Neighbourhoods choice of venue. Ongoing post implementation via patient feedback, PPGs | Post consultation and as part of the Sheffield wide mobilisation plan | Neighbourhood Lead and Locality managers |
| Access | Each individual Neighbourhood to undertake an EIA and public consultation on proposed site options for the hubs including disability access, safety of location accessible via bus routes | Patient feedback and public engagement will inform the Neighbourhoods choice of venue. Ongoing post implementation via patient feedback, PPGs | Post consultation and as part of the Sheffield wide mobilisation plan | Neighbourhood Lead and Locality managers |
| Language | Each individual Neighbourhood to undertake an EIA and public consultation on proposed site options for the hubs to ensure adequate interpreters are available for the population covered | Patient feedback and public engagement will inform the Neighbourhoods choice of venue. Ongoing post implementation via patient feedback, PPGs | Post consultation and as part of the Sheffield wide mobilisation plan | Neighbourhood Lead and Locality managers |

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| **4. Monitoring, Review and Publication** | | | | |
| **When will the proposal be reviewed and by whom?** | **Lead / Reviewing Officer:** | Sue Berry | **Date of next Review:** | Post approval of neighbourhood models, by Neighbourhoods |

To fulfil the requirements of the Public Sector Equality Duty, we need to capture how due regard has been shown to the need to eliminate discrimination, ensure equality for people with protected characteristics and promote good relations between all people in the community

Please could you therefore provide the following information from your planning processes:

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| Confirm that you have used local demographic  data to plan your approach to delivering services |  |
| Summarise steps taken to ensure equal access to services and treatment for people with a protected characteristic, or sectors of the community with specific needs |  |