Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Equalisation of Core General Practice Finances

Extraordinary Governing Body meeting

16 July 2015

Author(s)	Katrina Cleary, Programme Director Primary Care Tim Furness, Director of Business Planning and Partnerships St John Livesey, Clinical Lead, Primary Care
Sponsor	Idris Griffiths, Interim Accountable Officer

Is your report for Approval / Consideration / Noting

Consideration, Steer and Recommendation

Are there any Resource Implications (including Financial, Staffing etc)?

Financial

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? Yes

PPE Activity

How does your paper support involving patients, carers and the public? Patients value receiving the affected services at their local practice and have come to expect them to be delivered in this setting. Depending on the outcome of the Governing Body viewpoint, further patient engagement activity may be required.

Recommendations

The Governing Body is asked to:

- Discuss the issues raised in this paper;
- Support Option 2 and instruct Executive Directors to take the necessary action to implement this option accordingly; and
- Support the suggested approach to enable practices to demonstrate their special circumstances for consideration (for Options 1, 2 and 3 only).

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1. Introduction

NHS England is implementing a policy of equalising core contractual funding for GP practices for the delivery of core general medical services on to a weighted patient fee base, whether funded through General Medical Services or Personal Medical Services contracts. This approach will detrimentally affect 62 out of the 87 practices in Sheffield, with 40 practices losing more than £5 per weighted patient (11 of which will lose more than £20 per weighted patient).

One consequence of this policy is the release of PMS Premium funds, which are being made available for CCGs to reinvest in general practice. As a result, while the CCG has no direct responsibility for GP contracts, it does have some ability to respond to the pressures in primary care (see section 4 below).

This paper sets out options for the potential to use the funding available in a way that best supports the delivery of services to patients across Sheffield and that meets the aims of the CCG – improving the quality of care, reducing health inequalities, ensuring healthcare is affordable and sustainable at least at current levels.

2. Equalisation of core contractual funding for GP Practices

The Carr-Hill formula is used to distribute the core funding - called the global sum - to general practices for essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age, deprivation and patient turnover.

Since 2004, when the new General Medical Services (nGMS) contract was introduced, the Minimum Practice Income Guarantee (MPIG) has been used to top up the global sum payments for some practices, to match their basic income levels before the new contract.

The Personal Medical Services (PMS) contract was also introduced in 2004, with the key aim of enabling individual contracts to be agreed which would meet specific local needs.

Over recent years the differences between GMS and PMS contractual arrangements (and de facto the services provided) have diminished considerably.

The consequent inequity in funding (roughly between £73 per head of 'weighted' population and £128) manifests itself in variation in income for GPs and in variation in the range of services offered. The table below sets out the number and types of practices in Sheffield along with an indication of the current price per weighted

patient variation. It should be noted that there is no specific geographic spread of one type of contract against another within the city.

Type of Practice	**Number of Practices**	**Variation Price /Weighted Patient**	**Number of <u>gaining</u> practices (price/patient variation)**	**Number of <u>losing</u> practices (price/patient variation)**
APMS	**2** **(both subject to reprocurement by NHSE)**	**£109.32 - £123.90**	**0**	**2**
GMS	**38**	**£73.56 - £103.88**	**23** **(£0.10 - £4.97)**	**15** **(£0.15 - £25.35)**
PMS	**47**	**£75.32 - £115.19**	**4** **(£0.76 - £3.21)**	**43** **(£0.51 - £30.97)**

As part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven year period, starting in the financial year 2014/15. When the MPIG is fully reinvested into the global sum £78.53 per weighted patient will be offered to practices for the provision of core general medical services. A similar approach is to be taken with PMS practices except the pace of change will be over a four year period starting 2015/16.

The consequences of this are likely to include a reduction in personal income for some GPs, the cessation of some (non-core) services currently provided in general practice, and changes in the way practices run as businesses to manage with less income. This might include mergers of practices to achieve economies. Nationally, the expectation is that the vast majority of practices that are losing funding should be able to re-organise their business to manage, over the period the changes are being implemented.

However, there will be some practices for which the loss of funding would adversely affect their ability to continue to meet the needs of their patients. The CCG could use some of the funding released from the PMS premium to help manage that risk.

3. Freed Up PMS Premium

National guidance is clear that any sums freed up via MPIG reductions will be ploughed back into the global sum at a national level. However, any money freed up via the release of PMS premium reduction to practices should be reinvested into general practice locally and as determined by the local CCG. Sheffield CCG has recently been advised by NHSE that the total sum which will eventually be made available for this purpose is in the region of £2.8m, the release of which will be phased on the following basis:

- 2015/16: 12.5% from October 2015. This will release £352 891
- 2016/17: 50% (cumulative). This will release £1,411 563
- 2017/18: 75% (cumulative). This will release 2,117 345
- 2018/19: 100%. This will release £2,823 127.

4. Workload pressures facing all GP Practices

In considering how best to use the freed up PMS Premium monies we need to be mindful that all practices in Sheffield, and nationally, are facing the same pressures that the whole health and social care system faces – an aging population, with more incidence of long term conditions (including dementia), stubborn health inequalities, increasing patient expectation and a gap in care for people with mental illness and learning disabilities. It has been evidenced at a national level that over the last 5 years there has been around a 30% increase in unfunded activity at practice level. The impact of this pressure creates a risk to the continuation of the full range of services widely provided to patients by practices within the city. Many practices (GMS and PMS) are indicating that if necessary the will reduce their service provision to only reflect that within their core contracts.

For a number of months the CCG and the LMC have been in discussion as to the best way to reinvest the freed up PMS premium resource. CCG and LMC officers have reached a shared view that for the most part (i.e. unless there are overwhelming and demonstrable cases where a practice and its population is notably different from the 'norm') the money should be offered on an equitable basis to all practices in the city and in a way which helps address the increasing workload pressures within all practices.

We have been advised by NHS England that during the PMS Review meetings practices flagged up a number of 'non-core' services which they (and GMS practices) have been providing over the years which patients have come to expect of them but which, as funding reduces to 'core' levels, they will have to strongly consider ceasing, consequently referring patients to secondary care as the alternative provider in many cases. This would clearly have a detrimental effect on patient access to services, considerably increase the financial risk to the CCG, and potentially impact on secondary care's ability to achieve key performance targets such as those relating to waiting times.

For some time the Governing Body Assurance Framework has highlighted the risk of the contractual constraints being implemented potentially resulting in an inability of practices to delivery current (and expand future) service provision. Many of our key transformational aspirations assume the engagement of practices in practically supporting their delivery and, as practices start to understand the impact on their individual circumstances, this risk of reduced engagement is becoming more marked. We should be mindful of this when considering how best to proceed with the redistribution of the freed up PMS Premium.

5. Options

The CCG needs to determine how to use the £2.8m released (over the four year period) from PMS premium funds. Considering the impact of the equalisation policy, the pressures all practices are facing, and the CCGs strategic aims, four options present themselves:

1. Distribute the money across all practices, without strings, to support delivery of core services
2. Use the money to fund continuation of non-core services, to manage the pressures identified in section 5, offsetting some of the loss of income to many practices
3. Use the money to support addressing Health Inequalities in the city
4. Use the money to directly offset the loss of funding to practices

In options 1, 2 and 3, it is also proposed that a special cases mechanism is established, so that the CCG can respond where it is established that a practice cannot manage the loss of income without risk to patients (see section 5.5 below).

5.1. Distribute the money across all practices, without strings, to support delivery of core services

How it would work – most of the resource released would be made available to all practices (reserving an allocation for supporting special cases – see 5.5 below), using the Carr-Hill formula, using a locally commissioned service mechanism, but without requiring any additional service provision.

Pros

- Relatively easy
- On a simplistic level, fair to all practices
- Provides some funding to support losing practices

Cons

- Doesn't secure additional services for patients
- Doesn't address risk to non-core services, and resultant financial pressures
- Doesn't contribute to any of the CCGs strategic aims
- Doesn't fully replace the funding practices lose from the equalisation policy

5.2 Use the money to fund continuation of non-core services

How it would work – most the resource released would be made available to all practices (reserving an allocation for supporting special cases – see 5.6 below), using the Carr-Hill formula, using a locally commissioned service mechanism to secure the provision of services traditionally provided in primary care but outside of the core contract. The detailed service specification would need to be negotiated with the LMC and agreed with NHSE, but would be principally drawn from the list of services considered to be outside the core contract shown at Appendix A.

It is proposed via this option £5 per weighted patient is offered in a phased way over the next three years (commencing October 2015) with the following annual sums being offered:

- 2015/16: £2 per weighted patient (to reflect part year effect)
- 2016/17: £4 per weighted patient
- 2017/18: £5 per weighted patient

This would entail the CCG funding an extra £1.06m, £1.02m, £1.01m respectively, with a further £379, 221 being required in 2018/19.

In addition, it is recommended that the CCG's aspiration should be that the £5 per weighted patient offer by 2017/18 will be the minimum amount offered to practices and reflects the resourcing of non-core services currently being delivered in a primary care setting. As the CCG's commissioning plans come to fruition and it becomes increasingly clear on the expectation on practices in the delivery of those plans, our plans indicate that we will then look to resource any resulting workload requirements.

Pros

- Relatively easy
- On a simplistic level, fair to all practices
- Addresses the risk to non-core services identified in section 4 minimising financial risk
- Provides some funding to support losing practices
- Supports the CCG strategic aim of securing care closer to home

Cons

- Doesn't fully replace the funding practices lose from the equalisation policy
- Whilst it contributes to some of the CCG's strategic aims, does not address health inequalities, other than via the Carr Hill assumptions on deprivation.

5.3. Use the money to address Health Inequalities in the city

How it would work – most of the resource released would be made available to practices (reserving an allocation for supporting special cases – see 5.6 below), for the explicit purposes of addressing Health Inequalities. If this option was chosen, a detailed proposal would be developed for consideration by the Governing Body. This might consist of either

1. The adoption of a local formula for distributing funding to practices, perhaps excluding practices with populations with a life expectancy at or above the city average to ensure focus on those populations most at risk of early death, or
2. The creation of a Health Inequalities Fund against which practices would bid, with criteria for assessing bids that would aim to maximise reductions in health inequalities.

Pros

- Explicitly aims to address Health Inequalities in the city. We know that access to primary care and early diagnosis are key issues in tackling health inequalities and the impact could be significant.
- Could provide some additional funding to some, but not all, practices losing funding

Cons

- Not available to all practices, contravening NHS England's expectations
- Doesn't address the risk to non-core services and resultant financial risk
- Doesn't fully replace the funding practices lose from the equalisation policy
- Difficult to administer, e.g. which inequalities take precedence etc.
- Whilst it contributes to some of the CCG's strategic aims, does not address health inequalities
- Health inequalities are not the only cost pressure on practices and the current Carr Hill formula has been adopted nationally to reflect variation in practice need for funding.

5.4. Use the money to directly offset the loss of funding to practices

How it would work – the resource released would be made available to offset the loss of funding GMS and PMS practices will experience. Whilst this would not fully offset the loss, if including GMS practices, as the MPIG reductions are not being made available to CCGs, it would provide targeted financial support. It would be done using a locally commissioned service mechanism but without requiring any additional service provision.

Pros

- Relatively easy
- Does the most to replace the funding practices lose from the equalisation policy
- On one level, fair to practices, in that it offers an opportunity to offset losses. However, in doing so it could perpetuate current differences in practice funding and therefore be seen to be unfair to some practices too
- Provides some funding to support losing practices

Cons

- Doesn't secure additional services for patients
- Doesn't address risk to non-core services
- Doesn't contribute to any of the CCGs strategic aims
- Isn't fair to all practices – contravenes NHS England guidance
- Loss of funding does not necessarily relate to meeting unmet health needs.

5.5 Equality Impact Assessments

On the basis of the outline proposals above, a screening for equality impact has been undertaken, as shown at Appendix B. The conclusions of this are that:

Option 1: Neutral impact across all protected groups.

Option 2: Neutral impact across all protected groups. Whilst an EIA has not been carried out with regard to the ceasing of non-core services currently provided in general practice, Governing Body is asked to note that this action would result in a negative impact for all patients, including those within the protected EIA groups.

Option 3: Potential to have a positive impact in 3 of the protected groups (disability, race, religion/belief) on the basis that there is some evidence that people from these groups are more likely to be within populations identified on a practice level as deprived.

Option 4: Neutral impact across all protected groups.

As can be seen from the above each models has a number of pros and cons. However, in terms of supporting a fair approach to all patients and practices; mitigating the risk to practice based non-core services being lost to patients, recognising the increased needs of deprived communities (via the weighted patient offer) and supporting the overall strategic direction of travel, it is Option 2 - Use the Money to Fund the Continuation of Non-Core Services – which is the strongest option.

5.6. Special Cases

Options 1, 2 and 3 cannot be guaranteed to support losing practices sufficiently to protect services. It is therefore proposed that some funding is reserved to provide support to practices that demonstrate an exceptional risk to services to their patients.

GMS practices which were losing significant sums via the MPIG withdrawal were given the opportunity in 2014/15 to make a special case to NHSE for transitional funding using what is being called the London criteria. This requires practices to demonstrate:

Criteria	**Rationale**
There must be a reduction in GMS global sum funding greater than £3 per weighted patient in 2014/15 and 2015/16	There must be a negative financial impact on the practice
No doctor in the practice should have declared pensionable earnings in excess of £106,100 p.a. (Source: DDRB 2014 England Average 2011-12) (pro rata'd for	Support not designed to increase pensionable income of GPs

part time GPs)	
Practice expenses must be evidenced to be greater than 63%	National average ratio of expenses: profit is 63:37
No contract breaches for any reason issued since 1 April 2013	Marker of poorer quality practice
No “live” cases with NHS England performer machinery or GMC, including the Interim Orders Panel	Marker of poorer quality practice
Fewer than five outliers on the GPHLIs on current system	Potential marker of poorer quality practice
There must be evidenced extenuating circumstances within the practice population related to 1. Workload 2. Patient demographics …that impact practice business and patient services NHSE (L) defines this for the purposes of this exercise as there must be an IMD score of 35or higher for the practice population	Must be evidence that local demographics dictate workload that are not adequately reflected in Carr Hill IMD is a marker of deprivation with a consequential impact on a practice workload.

It is proposed that a similar opportunity, based broadly on the criteria above, should be offered to all practices which are set to lose significant sums and which feel they have a special case to be considered to enable, where appropriate, an alternative commissioning arrangement to be considered for identified patient groups. This sum would be used in the first instance to support the proving of the point, rather than funding of on-going service delivery. The financial model has assumed a fund on an ongoing basis to support practices deemed to have a proven case.

It is recommended that a small time-limited approvals group be established to consider applications received via this route and to recommend to Governing Body the applications to be approved. Alternatively we could establish the primary care committee. This group could comprise:

- 3 GPs(from within CET/Governing Body)
- 2 Lay members (so overall not a GP majority)
- 2 Executive Directors
- 1 Co-optee from NHSE

6. Recommendations

Governing Body is asked to:

- Discuss the issues raised in this paper;
- Support Option 2 and instruct Executive Directors to take the necessary action to implement this option accordingly; and
- Support the suggested approach to enable practices to demonstrate their special circumstances for consideration (for Options 1,2 and 3 only).

K Cleary, Programme Director, Primary Care

T Furness, Director of Business Planning and Partnerships

SJ Livesey, Primary Care Clinical Lead

July 2015

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Appendix 1:General Practice Work To Be Included within LCS

- Phlebotomy (1/3 core; 1/3 QOF; 1/3 LCS)
- supervision of, and prescribing on behalf of, secondary care employed specialist nurses in lieu of consultant supervision and secondary care prescribers
- ear care - syringing and toilet
- certification whist patient is under hospital care
- prescribing whilst hospital care continues
- spirometry
- ordering, reviewing, undertaking investigations for people under secondary care e.g. cytotoxic/rheumatology
- pre chemotherapy blood testing
- pre referral examination or investigation that does not influence the referral decision e.g. fertility clinics
- vault cautery (post op)
- depot injections (mental health)
- palliative care meetings
- serial PSA monitoring in non-cancerous patients
- in house 24 BP monitoring
- pre-op MRSA screening
- almost all dressings
- use of administrative staff/resources by community staff
- zoladex and contraceptive implants (*APG to advise)*
- IUS fitting - for HRT adjunct/menorrhagia
- ongoing provision of pharmacotherapy for malignant conditions without direct consultant supervision
- sole medical supervision of patients on antipsychotics or with eating disorders
- supervision or prescribing of secondary care started medications that require monitoring
- anticipated post-operative care
- walk in service
- gatekeeper/triage/telephone advice
- prescribing budget work
- admission avoidance work
- PSA monitoring in malignancy
- Pre-op preparation, eg blood pressure monitoring and control, continence checks etc
- Supervision of dementia patients on cognitive enhancers

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NHS Sheffield CCG
Equality Impact Assessment

Title of policy or service:	PMS Premium Redistribution Option 1. Distribute the money across all practices, without strings, to support delivery of core services	
Name and role of officer/s completing the assessment:	Tim Furness Director of Business Planning and Partnerships	
Date of assessment:	8/7/2015	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	The CCG has to determine how best to use £2.8m made available through the release of funding currently paid as PMS premiums to some practices in the city, as a result of the national policy to equalise core general practice funding. This option would distribute the money across all practices, using the Carr-Hill formula, which is weighted to reflect issues such as age, deprivation and patient turnover. Because of this, all residents of Sheffield will benefit from the option. Because of the use of the Carr-Hill formula, some populations will benefit a little more than others, but it seems unlikely to be to such an extent as to be described as a clear positive impact.

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.

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	How does this impact and what action, if any, do you need to take to address these issues?	What difference will this make?
Human rights	☐	☒	☐		
Age	☐	☒	☐		
Carers	☐	☒	☐		
Disability	☐	☒	☐		
Sex	☐	☒	☐		
Race	☐	☒	☐		
Religion or belief	☐	☒	☐		
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	☒	☐		
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative**' impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Is a 'Full' Equality Impact Assessment required:	☐ **YES** ***or*** ☒ **NO**

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

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Tim Furness**	**Date of next Review:**	If and when the option is chosen

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

EQUALITY IMPACT ASSESSMENT: Initial EIA 'Screening' and 'Full' EIA Processes

EIA FLOWCHART

STEP 1

SCREENING EIA

Lead Manager/Person to identify the policy or process (revised or new), strategy, business case or decision for EIA screening

If you require assistance, please contact Elaine Barnes, Equality & Diversity Manager: elaine.barnes3@nhs.net

Carry out an Initial Screening EIA to determine if a Full EIA (STEP 2) is required

Screening identifies whether the policy or process (revised or new), strategy, business case or decision is relevant to equality.

It outlines the purpose/aim of the policy, gives information or evidence relating to equality groups that may be affected and reviews type of impact (positive, neutral or negative) on equality and other relevant groups.

OUTCOME

POSITIVE OR NEUTRAL IMPACT: impact can be rectified by small actions being taken to the policy, strategy, business case or decision. Therefore **no Full EIA required.**

Forward completed EIA template to Elaine Barnes for sign off.

End of Process

Ensure any identified actions are completed and reported

NEGATIVE / ADVERSE IMPACT: where this is identified and impact cannot be rectified without significant changes to the policy, strategy, business case or decision, then a **Full EIA required needs to be considered (STEP 2).**

STEP 2

FULL EIA

If you require assistance, please contact Elaine Barnes, Equality& Diversity Manager: elaine.barnes3@nhs.net

Carry out Full EIA to explore the negative/adverse impact identified. Complete EIA form (same as screening form) showing actions to justify/minimise impact and promote equality.

(a) Assess likely impact in detail by collating information/evidence such as reports, quantitative and qualitative baselines, national or local data, consultations and engagement processes, focus groups, surveys, groups, discussions with relevant community or working groups, etc.
(b) Consider actions to mitigate discrimination, minimise negative/adverse impact and promote equality.
(c) Forward completed EIA template to Elaine Barnes for monitoring and quality assurance.

End of Process

Ensure any identified actions are completed and reported

NHS Sheffield CCG
Equality Impact Assessment

Title of policy or service:	PMS Premium Redistribution Option 2. Use the money to fund continuation of non-core services, to manage the risks identified in section 3, offsetting some of the loss of income to many practices	
Name and role of officer/s completing the assessment:	Tim Furness Director of Business Planning and Partnerships	
Date of assessment:	8/7/2015	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	The CCG has to determine how best to use £2.8m made available through the release of funding currently paid as PMS premiums to some practices in the city, as a result of the national policy to equalise core general practice funding. This option would distribute the money across all practices, using the Carr-Hill formula, which is weighted to reflect issues such as age, deprivation and patient turnover, to secure additional services for all patients. Because of this, all residents of Sheffield will benefit from the option. Because of the use of the Carr-Hill formula, some populations will benefit a little more than others, but it seems unlikely to be to such an extent as to be described as a clear positive impact.

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.

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	How does this impact and what action, if any, do you need to take to address these issues?	What difference will this make?
Human rights	☐	☒	☐		
Age	☐	☒	☐		
Carers	☐	☒	☐		
Disability	☐	☒	☐		
Sex	☐	☒	☐		
Race	☐	☒	☐		
Religion or belief	☐	☒	☐		
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	☒	☐		
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative**' impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Is a 'Full' Equality Impact Assessment required:	☐ **YES** ***or*** ☒ **NO**

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

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Tim Furness**	**Date of next Review:**	If and when the option is chosen

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

EQUALITY IMPACT ASSESSMENT: Initial EIA 'Screening' and 'Full' EIA Processes

EIA FLOWCHART

STEP 1

SCREENING EIA

Lead Manager/Person to identify the policy or process (revised or new), strategy, business case or decision for EIA screening

If you require assistance, please contact Elaine Barnes, Equality & Diversity Manager: elaine.barnes3@nhs.net

Carry out an Initial Screening EIA to determine if a Full EIA (STEP 2) is required

Screening identifies whether the policy or process (revised or new), strategy, business case or decision is relevant to equality.

It outlines the purpose/aim of the policy, gives information or evidence relating to equality groups that may be affected and reviews type of impact (positive, neutral or negative) on equality and other relevant groups.

OUTCOME

POSITIVE OR NEUTRAL IMPACT: impact can be rectified by small actions being taken to the policy, strategy, business case or decision. Therefore **no Full EIA required.**

Forward completed EIA template to Elaine Barnes for sign off.

End of Process

Ensure any identified actions are completed and reported

NEGATIVE / ADVERSE IMPACT: where this is identified and impact cannot be rectified without significant changes to the policy, strategy, business case or decision, then a **Full EIA required needs to be considered (STEP 2).**

STEP 2

FULL EIA

If you require assistance, please contact Elaine Barnes, Equality& Diversity Manager: elaine.barnes3@nhs.net

Carry out Full EIA to explore the negative/adverse impact identified. Complete EIA form (same as screening form) showing actions to justify/minimise impact and promote equality.

(a) Assess likely impact in detail by collating information/evidence such as reports, quantitative and qualitative baselines, national or local data, consultations and engagement processes, focus groups, surveys, groups, discussions with relevant community or working groups, etc.
(b) Consider actions to mitigate discrimination, minimise negative/adverse impact and promote equality.
(c) Forward completed EIA template to Elaine Barnes for monitoring and quality assurance.

End of Process

Ensure any identified actions are completed and reported

NHS Sheffield CCG
Equality Impact Assessment

Title of policy or service:	PMS Premium Redistribution Option 3. Use the money to address Health Inequalities in the city	
Name and role of officer/s completing the assessment:	Tim Furness Director of Business Planning and Partnerships	
Date of assessment:	8/7/2015	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	The CCG has to determine how best to use £2.8m made available through the release of funding currently paid as PMS premiums to some practices in the city, as a result of the national policy to equalise core general practice funding. This option would make the resource released available to practices for the explicit purposes of addressing Health Inequalities. Either by the adoption of a local formula for distributing funding to practices, perhaps excluding practices with populations with a life expectancy at or above the city average to ensure focus on those populations most at risk of early death, or the creation of a Health Inequalities Fund against which practices would bid, with a criteria for assessing bids that would aim to maximise reductions in health inequalities. This would be designed to significantly benefit those populations most at risk of early death and so would have a positive impact on some populations, as shown below.

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.

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	How does this impact and what action, if any, do you need to take to address these issues?	What difference will this make?
Human rights	☐	☒	☐		
Age	☐	☒	☐		
Carers	☐	☒	☐		
Disability	☒	☐	☐	Some evidence that people with disabilities may be more likely to be within populations identified on a practice level as deprived.	Additional support to access healthcare, to be determined.
Sex	☐	☒	☐		
Race	☒	☐	☐	Strong evidence that people from BME communities are more likely to be within populations identified on a practice level as deprived.	Additional support to access healthcare, to be determined.
Religion or belief	☒	☐	☐	Some evidence that people with some religious beliefs may be more likely to be within populations identified on a practice level as deprived.	Additional support to access healthcare, to be determined.
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		

Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	☒	☐		
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative**' impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Is a 'Full' Equality Impact Assessment required:	☐ **YES** ***or*** ☒ **NO**

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

3. Action plan

Issues/impact identified	Actions required	How will you measure impact/progress	Timescale	Officer responsible
Evidence that people from some population groups are more likely to be within populations identified on a practice level as deprived.	Additional support to access healthcare to be determined through the detailed proposal that will be developed if this option is chosen.	To be set out in the detailed proposal, if this option is chosen.		Tim Furness

4. Monitoring, Review and Publication

When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Tim Furness**	**Date of next Review:**	If and when the option is chosen

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

EQUALITY IMPACT ASSESSMENT: Initial EIA 'Screening' and 'Full' EIA Processes

EIA FLOWCHART

STEP 1

SCREENING EIA

Lead Manager/Person to identify the policy or process (revised or new), strategy, business case or decision for EIA screening

If you require assistance, please contact Elaine Barnes, Equality & Diversity Manager: elaine.barnes3@nhs.net

Carry out an Initial Screening EIA to determine if a Full EIA (STEP 2) is required

Screening identifies whether the policy or process (revised or new), strategy, business case or decision is relevant to equality.

It outlines the purpose/aim of the policy, gives information or evidence relating to equality groups that may be affected and reviews type of impact (positive, neutral or negative) on equality and other relevant groups.

OUTCOME

POSITIVE OR NEUTRAL IMPACT: impact can be rectified by small actions being taken to the policy, strategy, business case or decision. Therefore **no Full EIA required.**

Forward completed EIA template to Elaine Barnes for sign off.

End of Process

Ensure any identified actions are completed and reported

NEGATIVE / ADVERSE IMPACT: where this is identified and impact cannot be rectified without significant changes to the policy, strategy, business case or decision, then a **Full EIA required needs to be considered (STEP 2).**

STEP 2

FULL EIA

If you require assistance, please contact Elaine Barnes, Equality& Diversity Manager: elaine.barnes3@nhs.net

Carry out Full EIA to explore the negative/adverse impact identified. Complete EIA form (same as screening form) showing actions to justify/minimise impact and promote equality.

(a) Assess likely impact in detail by collating information/evidence such as reports, quantitative and qualitative baselines, national or local data, consultations and engagement processes, focus groups, surveys, groups, discussions with relevant community or working groups, etc.
(b) Consider actions to mitigate discrimination, minimise negative/adverse impact and promote equality.
(c) Forward completed EIA template to Elaine Barnes for monitoring and quality assurance.

End of Process

Ensure any identified actions are completed and reported

NHS Sheffield CCG
Equality Impact Assessment

Title of policy or service:	PMS Premium Redistribution Option 4. Use the money to directly offset the loss of funding to practices	
Name and role of officer/s completing the assessment:	Tim Furness Director of Business Planning and Partnerships	
Date of assessment:	8/7/2015	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	The CCG has to determine how best to use £2.8m made available through the release of funding currently paid as PMS premiums to some practices in the city, as a result of the national policy to equalise core general practice funding. The resource released would be made available to offset the loss of funding GMS and PMS practices will experience. Not all residents of Sheffield will benefit from the option. However, because there is no correlation between practice funding and population factors or health inequalities, it is likely that there will be a neutral net impact for population groups, some people from any specific group may have a significant positive impact, others from that same group may have a significant negative impact (compared to other options being considered)..

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.

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	How does this impact and what action, if any, do you need to take to address these issues?	What difference will this make?
Human rights	☐	☒	☐		
Age	☐	☒	☐		
Carers	☐	☒	☐		
Disability	☐	☒	☐		
Sex	☐	☒	☐		
Race	☐	☒	☐		
Religion or belief	☐	☒	☐		
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	☒	☐		
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative**' impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Is a 'Full' Equality Impact Assessment required:	☐ **YES** ***or*** ☒ **NO**

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

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Tim Furness**	**Date of next Review:**	If and when the option is chosen

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

EQUALITY IMPACT ASSESSMENT: Initial EIA 'Screening' and 'Full' EIA Processes

EIA FLOWCHART

STEP 1

SCREENING EIA

Lead Manager/Person to identify the policy or process (revised or new), strategy, business case or decision for EIA screening

If you require assistance, please contact Elaine Barnes, Equality & Diversity Manager: elaine.barnes3@nhs.net

Carry out an Initial Screening EIA to determine if a Full EIA (STEP 2) is required

Screening identifies whether the policy or process (revised or new), strategy, business case or decision is relevant to equality.

It outlines the purpose/aim of the policy, gives information or evidence relating to equality groups that may be affected and reviews type of impact (positive, neutral or negative) on equality and other relevant groups.

OUTCOME

POSITIVE OR NEUTRAL IMPACT: impact can be rectified by small actions being taken to the policy, strategy, business case or decision. Therefore **no Full EIA required.**

Forward completed EIA template to Elaine Barnes for sign off.

End of Process

Ensure any identified actions are completed and reported

NEGATIVE / ADVERSE IMPACT: where this is identified and impact cannot be rectified without significant changes to the policy, strategy, business case or decision, then a **Full EIA required needs to be considered (STEP 2).**

STEP 2

FULL EIA

If you require assistance, please contact Elaine Barnes, Equality& Diversity Manager: elaine.barnes3@nhs.net

Carry out Full EIA to explore the negative/adverse impact identified. Complete EIA form (same as screening form) showing actions to justify/minimise impact and promote equality.

(a) Assess likely impact in detail by collating information/evidence such as reports, quantitative and qualitative baselines, national or local data, consultations and engagement processes, focus groups, surveys, groups, discussions with relevant community or working groups, etc.
(b) Consider actions to mitigate discrimination, minimise negative/adverse impact and promote equality.
(c) Forward completed EIA template to Elaine Barnes for monitoring and quality assurance.

End of Process

Ensure any identified actions are completed and reported