Equality Impact Assessment in respect of the National Health Service (General Medical Services Contracts) Regulations 2015 and the National Health Service (Personal Medical Services Agreements) Regulations 2015

Introduction

1. NHS Primary Medical Services are provided by around 40,584 general practitioners (GPs) in England[1], working largely out of around 8,000 GP practices. These practices directly employ around 23,832 nurses. GP practices act as both the gateway to and coordinator of patient access throughout their care journey.

2. GP practices hold contracts with NHS England to undertake this work for the NHS. There are three contracting routes for delivering NHS primary medical services. These are General Medical Services (GMS) contracts, Personal Medical Services (PMS) agreements and Alternative Provider Medical Services (APMS) contracts. This Equality Impact Assessment relates only to changes to the regulations underpinning GMS contracts and PMS agreements.

3. Approximately 60% of general practice is currently provided under GMS contracts, which are negotiated nationally. PMS agreements may reflect some of the terms agreed as part of the national negotiations for the GMS contract, but will also include local variation.(A smaller proportion of practices, around 40%, hold an APMS contract.)

4. The GMS contract is negotiated annually by NHS Employers (on behalf of NHS England) and the British Medical Association's General Practitioners' Committee (GPC). The GMS contract terms are reflected in the PMS agreements. While amendments to PMS regulations are not negotiated nationally – PMS agreements are locally negotiated – any amendments are consulted on with others – that is NHS England, National Association of Primary Care, NHS Alliance and the Family Doctors Association.

5. The Health and Social Care Act 2012 creates a legal duty on the Secretary of State for Health, NHS England and clinical commissioning groups (CCGs) to have regard to the need to reduce health inequalities. This duty sits alongside the Public Sector Equality Duty (PSED) to which all public bodies are subject.

6. The PSED requires public bodies to have due regard to the need to:

   - eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;

   - advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

   - foster good relations between people who share a protected characteristic and people who do not share it.

[1] http://www.hscic.gov.uk/catalogue/PUB16934/nhs-staf-2004-2014-gene-prac-rep.pdf

7. The Department of Health's Equality Objectives Action Plan[2] states that:

    - As a Department of State and the system leader of the reformed health and social care system: the new direction for health and social care set requires some fundamental changes to functions right across the health and care system, the Department and its arm's length bodies. Equality remains an integral and vital part of this transition.

    - As a policy maker: the Department is committed to ensuring that equality and human rights is at the heart of policy, based on the best available evidence and understanding of the people we serve.

    - As an employer: the Department has an on-going commitment to promoting and achieving equality and diversity in the workplace. We aim to attract, retain and develop people who are the best in their field, with the right skills and competencies from a diverse range of backgrounds.

8. This Equality Analysis builds on the Equality Assessments and Equality Impact Assessments prepared for the different policy areas that are brought together within the consolidating regulations. It will consider the potential impact on groups with protected characteristics as defined in the Equality Act 2010, namely:

    - Age
    - Disability
    - Gender reassignment
    - Marriage and civil partnership
    - Pregnancy and maternity
    - Race
    - Religion or belief
    - Sex
    - Sexual orientation

9. Carers are also considered in this Equality Impact Assessment 'by association' with some of the people with protected characteristics, for example disability and age. Some carers are required to speak for patients, for example if they are very young or people who are unable to communicate. It is therefore important that carers are considered in the Equality Impact Assessment, as they will also feel any benefits or negative impacts.

[2] Equality Objectives Action Plan: September 2012- December 2013 - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216801/DH-Equality-Objectives-Action-Plan.pdf

10. The National Health Service (General Medical Services Contracts) Regulations 2015 and the National Health Service (Personal Medical Services Agreements) Regulations 2015 ("the consolidated regulations") consolidate National Health Service (General Medical Services Contracts) Regulations 2004 and the National Health Service (Personal Medical Services Agreements) Regulations 2004 ("the 2004 Regulations") with the amendments made to those regulations since they were enacted. They are not intended to make substantive changes. However, we expect that the consolidated regulations will mean that general practitioners are clearer about the services that they must provide and patients are clearer about the services that they can expect to receive. The regulations will therefore have a marginally positive effect as far as the Public Sector Equality Duty (PSED) is concerned, and may contribute positively to the reduction of health inequalities.

11. Many of the provisions contained in the regulations were introduced by way of amendments to the 2004 Regulations and were considered in Equality Impact Assessments at the time. Links to these assessments are included at the end of this document. The Department has reconsidered those assessments and sees no reason to change the assessments made at the time.

12. However, there are some provisions in the consolidated regulations that pre-date the coming into force of the PSED and the relevant duties in the NHS Act 2006 such as the health inequalities duty in section 1C of that Act. The Department considers that these provisions in the consolidated regulations are at least neutral and in some cases positive in their impact as far as those duties are concerned.

13. In some areas, equality data is unavailable so we cannot say with certainty how some groups would be affected. Where data is not available, we have considered potential impacts to the best of our ability.

Equality analysis

Aims and objectives

14. The GMS contract is renegotiated annually. This often leads to changes in regulations, which, until now, have been published separately to those that went before. The publication of the consolidated regulations aims to simplify the understanding of the regulations to ensure that general medical practitioners and practice staff are aware of their current responsibilities. By consolidating the regulations, contractors and potential contractors are more clearly able to see the legal basis for the terms for the services they are required to provide and patients are able to identify what services they can expect to receive from their GP practice. Similar amendments are made to the regulations underpinning PMS agreements to reflect, where possible, the amendments to GMS contracts regulations.

15. The GMS contract regulations and PMS agreements regulations aim to ensure that everyone is treated fairly and the provision of high quality healthcare to everyone irrespective of age, disability, gender identification, sex, race, religion or belief, sexual orientation or whether they are married or in a civil partnership, or receiving pregnancy or maternity care. The aim of this equality analysis is to identify any potential inequalities or barriers to access for specific groups.

Evidence

16. This Equalities Analysis brings together Equality Analysis and Equality Impact Assessments that have been prepared for the policy areas included in the contract. All references are set out at the end of the document.

GP Patient Survey

17. This Equality Assessment relies on data from the GP Patient Survey. The survey assesses patients' experiences of the access to and quality of care they receive from their local GPs, dentists and out-of-hours doctor services. The results support a number of indicators in the NHS Outcomes Framework and are used to assess how well the NHS is performing, leading to quality improvements throughout the primary medical health care service in England. The GP Patient Survey questionnaire is mailed out twice a year to around 1.32 million adults who are registered with a GP in England. In total, around 2.6 million patients are invited to take part over the course of the year and in July 2015 858,381 patients participated across the two waves. The survey results can be found here: http://www.gp-patient.co.uk

Protected Characteristics

18. There are nine protected characteristics (disability, sex, race, age, gender reassignment, sexual orientation, marital status, religion or belief, pregnancy and maternity) and carers of those that fall into protected characteristics. Some elements of the contract concern all patients equally.

19. It is a contractual requirement that contractors comply with all relevant legislation including the Equality Act 2010 and the Human Rights Act 1998 thereby reinforcing the legal obligations that contractors have to their patients outside of those terms set out in their contract with NHS England.

20. The requirement for GP practices to publish the mean net earnings of the doctors working in the practice is in the public interest but does not specifically concern any single group. This has a neutral impact is for information only.

21. The opt-out clauses in the consolidated regulations, relating to additional services and out of hours services, are designed in such a way as to provide all patients with notice that some services may be withdrawn and support provided to locate an alternative provider should it be required. These measures should ensure that no patient is without services that are required for their health. Contractors may not opt out of additional services either temporarily or permanently without providing written notice to NHS England and receiving their consent. This provision ensures that all patients have access to additional services even where their own GP practice does not provide one or more of those services and that patients have access to primary medical services out of hours.

22. The implementation of the Friends and Family Test in 2014 will provide all patients with the opportunity to give feedback on their experience at their GP surgery by indicating whether or not they would recommend their practice to their friends and family. There are several ways to participate in this simple survey including by text and email, but also in person at the surgery. This will afford those who are unable to use text messages or who do not have access to email to have their voices heard, and thus there should not be any limitations on who can provide feedback. This provides a positive impact for all patients but particularly those with disabilities and their carers.

23. Members of the Armed Forces benefit from the introduction in 2015 of the ability for a member of the Armed Forces to register with a GP practice whose patient list is open will enable service personnel to seek healthcare at the same practice for a period of up to two years where authorised by the Defence Medical Service. This is a positive impact for women as it allows pregnant women to obtain NHS primary medical services nearer to their home. The provision also reduces health inequalities by allowing service personnel suffering from a long term condition to access NHS primary medical services closer to their home.

24. The consolidated regulations make provision for the contractor to remove patients from its list under specific circumstances and with adequate warning. The contractor may not remove a patient from their list on the basis of the patient's race, religion, gender, gender reassignment, marriage or civil partnership, pregnancy or maternity, social class, age, sexual orientation, appearance, disability or medical condition. Any potential removal of a patient from the list as per the regulations will therefore not disadvantage any patient or patient group as the circumstances for removal are specific and regulated by NHS England. This ensures equal access to services for all patients and limits the circumstances in which patients may be removed from a practice's list.

<u>Disability</u>

25. Evidence shows that around 7% of children are disabled, as are 16% of working age adults and 42% of adults over state pension age in Great Britain.[3]

26. There is evidence[4] to show that continuity of care is beneficial for patients and we therefore believe that the introduction of a named, accountable GP for all patients will lead to an improvement in the quality of care provided for people with disabilities. In addition, expanding the scope of online access to medical records should help people with disabilities and long-term conditions to monitor their care.

27. GPs who do not provide out-of-hours care are required to monitor the quality of care given to their patients outside of surgery hours. This will improve the quality of care provided for all patients, including those with disabilities and long-term conditions.

28. Contractors are obliged within the consolidated regulations to provide premises that are suitable for delivering their services and will be sufficient to meet the reasonable needs of the contractor's patients. This will benefit all patients but particularly those who are disabled or caring for those whose mobility is limited or impaired. .

29. It is a requirement for the contractor to provide a low cost or free telephone line for which to patients to contact the surgery. The removal of premium rate numbers to make appointments and enquiries will benefit all patients but particularly those who may be on lower incomes, such as older patients and those receiving disability benefits, as well as those on low salaries, working reduced hours due to caring responsibilities and those who are unemployed. GPs must also provide medical certificates free of charge under certain circumstances, which should help people with disabilities and long-term conditions access benefits that could improve their health and quality of life.

30. Patient Participation Groups are a core contractual requirement. Previously they were an enhanced service in which practices could choose to participate. The contract requires PPGs to be as representative as possible of all the practice's patients. The requirement for Patient Participation Groups allows the contractor to obtain the views of patients about the services they deliver and to review these comments with a view to agreeing with the Group any improvements to the services provided. This should benefit all patients, including those with disabilities and long term conditions.

<u>Sex</u>

31. Men and women share many health risks. Yet there are some marked differences between men and women that impact upon morbidity, mortality and health outcomes. Domain One of the NHS Outcomes Framework shows that life expectancy has been steadily increasing for males

[3] Family Resources Survey 2013/14 - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437481/family-resources-survey-2013-14.pdf

[4] http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Continuity-of-Care.ashx

and females since 1990 and, although female advantage persists, the gap between males and females has narrowed over time.[5]

32. The consolidated regulations require practices to assign a named, accountable GP to each registered patient. The accountable GP will take lead responsibility to for the coordination of all appropriate services required under the contract. As this benefits all of the prescribed groups, it is likely to be of neutral benefit to patients based on gender alone.

33. The contractual requirement for all GP practices to have a Patient Participation Group and to make reasonable efforts for it to be representative of the practice population has the potential to have a positive effect in reducing gender inequalities. The GP Patient Survey will enable us to monitor any differences between the sexes that might arise in relation to GP services.

34. The consolidated regulations also provide for contraceptive services outlining that contractors who provide these services give advice about all methods of contraception available, referrals to sexual health specialists, unbiased referrals to doctors with no conscientious objection to termination of unwanted pregnancies and the prescribing of contraceptive substances and appliances. These provisions allow for women to have greater control over when they become pregnant and allows for non-judgemental support and treatment should they choose a termination of pregnancy. This will benefit women on the whole, and no other patient group will be negatively affected by this regulation.

Race

35. Evidence shows that some long term conditions are more prevalent and have more severe consequences for some ethnic groups.[6] Therefore, introducing coordinated care under the contract as provided by the named GP might be expected to support these ethnic minority groups. It will not have a negative impact on any of the other protected characteristics.

36. In addition, the contractual requirement for all GP practices to have a Patient Participation Group and to make reasonable efforts for it to be representative of the practice population has the potential to have a positive effect on the care provided to patients from ethnic minorities. In addition, some ethnic minorities – notably those of Pakistani heritage[7] – are more likely to use out of hours services and should benefit for the increased monitoring of out of hours services.

Age

37. We know that the numbers of people aged 75 and over is increasing; it is predicted that the proportion of people in that age group will rise from 8% of the population in 2011 up to 11% of

[5] NHS Outcomes Framework Equality Analysis: https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

[6] Long-term ill health, poverty and ethnicity; Sarah Salway, Lucinda Platt, Punita Chowbey, Kaveri Harriss and Elizabeth Bayliss; 29th April 2007 – http://www.jrf.org.uk/publications/long-term-ill-health-poverty-and-ethnicity

[7] GP Patient Survey www.gp-patient.co.uk

the population in 2026.[8] We also know that this group access primary and secondary healthcare more regularly – people aged 75 and over account for 29% of emergency admissions, 44% of unplanned bed days and 17% of GP consultations[9]. Almost half of all hospital Accident and Emergency Department attendances for this group result in admission into hospital, compared to 16% for younger patients.[10]

38. GP Patient Survey results suggest that older people are less likely to prefer the use of online services when booking GP appointments. The Equality Assessments produced for the Information Strategy and both '*No Decision About Me Without Me*' and '*Equality and Excellence*' consider accessing information to make choices and how when can ensure that those without access to online data are not excluded from making choices about their healthcare.

39. The contractor must provide a low cost or free telephone line for patients to contact the surgery. The removal of premium rate numbers to make appointments and enquiries will benefit all patients but particularly those who may be on lower incomes, such as older patients. Younger patients are also more likely to have lower incomes due to low salaries and high housing costs. Parents of young children may also earn lower wages due to caring responsibilities and those who are otherwise of retirement age may find their income reduced to provide care for elderly relatives. It is important to remember that 'age' does not just include older patients as each age group comes with its unique health challenges.

40. A high proportion of carers are aged between 45 and 64 and should benefit from the introduction of a named, accountable GP for all patients. The accountable GP will take lead responsibility for the coordination of all appropriate services required under the contract. Patients over 40 are offered an NHS Health Check, which is designed for the early diagnosis of and prevention of conditions like cardiovascular disease and kidney problems. Preventing these conditions is not only necessary for the patient's health and wellbeing but it is essential they look after themselves as well if they are providing care for another patient.[11]

41. The consolidated regulations include the provision of child health care surveillance services that benefit children and the health and wellbeing of their care-givers. The contractor can opt out of these services, which monitor the development of children under five. Where contractors opt out of these services, NHS England must ensure that the services are available to the

[8] ONS, http://www.ons.gov.uk/ons/rel/ctu/annual-abstract-of-statistics/quarter-3-2011/chap-15-population.xls

[9] http://www.hscic.gov.uk/searchcatalogue?productid=13264&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22&sort=Relevance&size=10&page=1#top

[10] Hospital Episodes Statistics – Admitted Patient Care: 2012/13 – http://www.hscic.gov.uk/searchcatalogue?productid=13264&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22&sort+Relevance&size=10&page=1#top

[11] http://www.nhs.uk/Conditions/nhs-health-check/Pages/the-evidence-for-NHS-Health-Check.aspx

contractor's patients. This provision is likely to have a neutral effect on the other patient groups.

42. Under these consolidated regulations, emphasis is being placed on the early identification of newly registered patients over the age of 16 who are drinking alcohol at increasing or higher risk levels with a view to seeking to reduce the alcohol related risks to that patient. Any patient identified as being at risk of elevated alcohol consumption should be offered appropriate advice and lifestyle counselling and any other factors that relate to the levels of drinking that may require additional treatment, such as mental health issues, can be identified and treated. Patients identified as dependent drinkers will be offered a referral to specialised services that are considered to be clinically appropriate. This provision will therefore benefit all patients over the age of 16, irrespective of categorisation in any other patient group, and will help identify and reduce physical and mental health issues associated with high levels of alcohol consumption. This will have a benefit for all patients irrespective of any of the protective characteristics who consume unhealthy amounts of alcohol but will have a neutral effect on patients who either abstain from alcohol or consume up to the Public Health England guidelines.

Gender reassignment (including transgender)

43. The National Lesbian, Gay, Bisexual and Transgender partnership have highlighted the importance of data security surrounding issues of sexual orientation and gender reassignment. These issues were considered as part of the Equality Analysis and how these concerns could be mitigated was set out in the Information Strategy published in 2012[12].

44. There is no current evidence to suggest that the regulations have a negative impact on the grounds of gender reassignment (including transgender). The contractual requirement for a named, accountable GP, with the resulting greater continuity of care, aims to improve the quality of care received by these patients.

45. As GP practices should have a Patient Participation Group that is reflective of their patient population, patients who are transgender or who are undergoing gender reassignment are represented in the practice.

Sexual orientation

46. The Government estimates that between 5% and 7% of the UK population are lesbian, gay or bisexual. We do not anticipate the consolidated regulations will have any adverse impact on these groups.

47. Concerns about confidentiality relating to personal data are considered in the Equality Assessment accompanying the Information Strategy and the strategy is clear that appropriate safeguards must be put in place. The consolidated regulations stipulate that GPs must record

12 http://webarchive.nationalarchives.gov.uk/20130802094648/http://informationstrategy.dh.gov.uk/personal-information/

patient information using secure access or coded information storage and filing and the 'GP2GP' system must be used to share information between practices. The GP2GP system benefits all patients because it provides safeguards to personal and confidential information, whilst allowing patients' records to be shared between healthcare professionals to provide the continuity of care.

Religion or belief

48. The GP Patient Survey suggests that some ethnic groups are more likely to access out-of-hours services than others. For example, data from the latest GP Patient Survey published in July 2015 shows that 23% of Pakistani patients and 21% of Bangladeshi patients contacted out-of-hours services for themselves or another compared to 14% of patients overall.

49. The GP Patient Survey published in July 2015 also shows that 62% of Jewish respondents had seen a GP within the three months preceding them completing the survey, along with 61% Muslims and 60% of Sikhs, all of which are above the national average of 55% of patients seeing a GP in the three months preceding them completing the survey. In contrast, 49% of Buddhists had seen a GP in the same time period and the number of patients recording as Jewish is lower than the number of patients who identify as Buddhists.

50. The consolidated regulations should have no negative impact on patients who have specific religions or beliefs because the NHS Constitution directs that patients should, wherever practicable, be consulted about their care.

Pregnancy and maternity

51. We believe that the requirement to provide a named accountable GP will have a positive effect on women who are pregnant or receiving maternity care.

52. The inclusion in these consolidated regulations of the requirement of contractors who offer maternity medical services to offer maternity services throughout the antenatal period and then throughout the postnatal period, and also for women whose pregnancy has not reached full gestation through miscarriage or abortion will improve the healthcare of women and their babies. . The provision will have a neutral impact on patients who are not accessing services for pregnancy and maternity purposes.

53. The contractual requirement for GP practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels will help reduce the level of harm done by excessive alcohol consumption. This should have an overall positive impact on all groups, but should be particularly helpful for those women who are pregnant and drinking at potentially harmful levels and continue to offering healthcare to patients. All patients consuming an unhealthy amount of alcohol will benefit from this regulation, but patients who consume no or less alcohol will not be adversely affected.

54. Female members of the armed forces will also be able to benefit from the ability to register with GP practice near to where they live when they are pregnant or receiving maternity care. Other patients will not be adversely affected.

Carers

55. Carers play an important role in caring for vulnerable older people and those with complex needs. By improving the way primary care operates, we expect to improve the experience and outcomes for carers.

56. The 2011 Census figures for England, Wales and Northern Ireland show an increase in the number of carers since the last Census in 2001, from 5.22 million to 6 million, an increase of 629,000 people who are providing care in only ten years.

57. Inequalities exist within the demographics of carers. Women are more likely to be carers than men, with 1 in 4 women between the ages of 50 and 64 being carers, and they are more likely to report poor health than men when caring for someone whilst they are working full-time[13]

58. GP Practices may also accept patients from outside of its practice boundaries unless it is not clinically appropriate or practicable to have them on that list. This will allow more patient choice, with the caveat that some services such as home appointments will not apply. This will benefit patients who spend long periods away from their permanent address for work or other reasons, including caring responsibilities. Carers will also benefit from the ability to register at practices with open lists as a temporary patient for up to three months. This will assist those with live-in caring responsibilities to care for family members during illness and treatment, and during the end of life period, as well as maintaining their access to primary healthcare, which is important for their own mental and physical health and wellbeing. Although the contractor can still refuse, this regulation will be of benefit to all patient groups and particularly those with caring responsibilities and refusal cannot be without good cause.

Summary of Analysis

59. Based on the above analysis, we believe that the consolidated regulations as a whole have a positive or neutral impact on each of the groups with protected characteristics. It is our intention that primary care will be more patient centred and GPs will provide increasingly proactive care. We believe that the consolidated regulations will have an overall positive impact on all groups. We do not expect any particular group to be disadvantaged as a result of these regulations.

60. The regulations aim to reduce health inequalities by ensuring that all patients have access to the same core primary medical services, as a minimum, regardless of where they live in England and regardless of whether they fall into the protected characteristics set out in the Equality Act 2010.

What is the overall impact?

[13] ONS – 2011 Census – unpaid care snapshot: http://www.ons.gov.uk/ons/guide-method/census/2011/carers-week/index.html

61. Consolidating the regulations with subsequent amendments will mean that general practitioners are clearer about the services that they must provide and patients are clearer about the services that they can expect to receive.

Addressing the impact on inequalities

62. This assessment has determined that there will be no negative impacts on equalities. An action plan to ensure that this remains the case is outlined below.

Action planning for improvement

63. We will continue to monitor data collected through the GP Patient Survey, the NHS Outcomes Framework and the Quality and Outcomes Framework. This will enable us to identify any areas of concern and act to mitigate this.

64. Monitoring the performance of GMS contracts and PMS agreements is the responsibility of NHS England.

65. The consolidated regulations will be monitored through a variety of data sets; the GP Patient Survey will remain an important source of information in terms of informing policy makers on the experiences of patients and provides valuable information about the quality of out-of-hours services and overall satisfaction with GP services.