



Department
of Health

GP contract changes 2014/15

Equality Analysis

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Contents

- Introduction.....4
- Equality analysis7
- Aims and objectives7
- Evidence10
- Protected Characteristics.....13
 - Disability.....13
 - Sex.....14
 - Race.....16
 - Age17
 - Gender reassignment (including transgender).....18
 - Sexual orientation19
 - Religion or belief.....19
 - Pregnancy and maternity20
 - Carers21
- Engagement and involvement22
- Summary of Analysis.....24
- What is the overall impact?25
- Addressing the impact on equalities25
- Action planning for improvement.....25
- For the record26

Introduction

1. NHS Primary Medical Services are provided by around 36,000 general practitioners (GPs) in England working in around 8,000 GP practices. These practices directly employ around 2,300 practice nurses and 8,000 care assistantsⁱ - in total there are over 300 million patient consultations a year. GP practices act as both the gateway to and coordinator of patient access throughout their care journey. They are usually the first point of contact for a patient seeking treatment or advice about their health.
2. GP practices hold contracts with NHS England to undertake this work for the NHS. There are three contracting routes for GP practices. These are General Medical Services (GMS) contracts, Personal Medical Services (PMS) agreements and Alternative Provider Medical Services (APMS) contracts.
3. Approximately half of general practice is currently provided under GMS contracts, which are negotiated nationally. PMS agreements reflect the terms agreed as part of the national negotiations for the GMS contract, but will also include local variation. A small proportion of practices hold an APMS contract. Regulations and Directions set out what should be included in these contracts:
 - The National Health Service (General Medical Services Contracts) Amendment Regulations 2014;
 - The National Health Service (Personal Medical Agreements) Amendment Regulations 2014;
 - The National Health Service (Alternative Provider Medical Services) Amendment Directions 2014.
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.
5. The governing regulations and directions sit alongside two further sets of directions that respectively make provision in respect of the enhanced services that GP practices may provide and the financial package:
 - The Primary Medical Services (Directed Enhanced Services) Directions 2014;

- The General Medical Services Statement of Financial Entitlements Amendment Directions 2014.
6. An agreement was reached with the General Practitioners Committee (GPC) of the BMA on changes to the GMS contract for 2014/15. These changes support our and NHS England's strategic objectives for primary care, including providing more proactive care for people with more complex health needs, empowering patients and the public, giving parity of esteem to physical and mental health, promoting more consistently high standards of quality, and reducing inequalities.
 7. This Equality Analysis builds on the Equality Analyses and Equality Impact Assessments prepared for the different policy areas that are brought together within the amending regulations and directions. It will consider the potential impact on the 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
 - Carers 'by association' with some of the protected characteristics e.g. disability and age
 8. 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.
 9. 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 existing Public Sector Equality Duty (PSED) to which all public bodies are subject.

10. 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;
- foster good relations between people who share a protected characteristic and people who do not share it.

11. The Department of Health's Equality Objectives Action Planⁱⁱ 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 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.

Equality analysis

Aims and objectives

We know that GPs want to provide the best care for their patients, treating them as people, not a series of symptoms or diseases. All patients are different and need a personal approach to their consultation. So we have removed some of the targets which can be a barrier to such an approach.

For these reasons, through next year's contract we have agreed that:

- Every person aged 75 and over will be assigned a named accountable GP, who will coordinate their care.
- To free up space for GPs to provide more personalised care, the Quality and Outcomes Framework will be reduced by more than a third.
- GPs will implement the Friends and Family test, and also will be able to offer registration to patients outside traditional boundaries.
- Practices will be required to monitor the quality of services provided to their patients out of hours.
- To improve record sharing and to improve patient access, GP practices will introduce a range of new IT systems.
- We will take a step towards fairer funding, by starting to phase out seniority payments and making a commitment to reviewing the funding formula so that it better reflects deprivation.
- Through a new enhanced service GPs will be encouraged to reduce emergency hospital admissions for their most vulnerable patients. This will be done through improving practice availability, providing proactive case management, improving discharge processes and internally reviewing unplanned admissions.

The contract changes aim to give GPs the flexibility to use their clinical judgement in treating patients and to provide more personalised and proactive care. However, we recognise the need for practices to deliver high quality services for patients – and, alongside commissioners, the CQC will play a key role in driving up standards through effective inspection and ratings of both health and social care providers.

By providing coordinated and proactive care we hope to better enable patients to manage their illness and limit the occurrence of avoidable hospital admissions, which are often inefficient and distressing for patients.

The amending regulations sit alongside two sets of directions, which set out the financial package for GP services and the enhanced services that GPs can provide. Together, the regulations and directions make a series of changes aimed at providing proactive, personalised and joined-up care to those with the most complex needs.

The amending regulations will introduce:

- **The ability for patients to register with a practice in whose practice area they do not reside** – from 1 October 2014, new arrangements will allow patients to register with a GP in whose practice area they do not live, subject to the agreement of that GP, while relieving the GP practice of its contractual obligations to provide home visits. In these circumstances, NHS England is responsible for ensuring that patients registering with a GP practice away from their home area have access to primary medical services when away from the practice area.
- **The requirement for a named accountable GP for those patients aged 75 and over** – as part of the commitment to more personalised care for more patients with long term conditions, all patients aged 75 and over will have a named accountable GP. This GP will take lead responsibility for care provided under the contract and for working with other health and social care professionals involved in the care and treatment of the patient.
- **A requirement to monitor the quality of services provided to patients out of hours** – there will be a new contractual requirement for practices who have opted out of providing out-of-hours services to their patients to monitor the quality of those services provided to their patients and to report any concerns to NHS England (or as directed by NHS England to the delegated commissioner). The amending regulations also introduce a process for dealing with information requests from out-of-hours providers.
- **A requirement to include summary information in the Summary Care Record** – the amending regulations provide for the automated upload of a summary of patient information to be made to the summary care record which may then be accessed by the patient.
- **A requirement to use the GP2GP IT facility to allow the safe and effective transfer of patient records** – from 1 April 2014, contractors are required to use the GP2GP facility to allow the safe and effective transferral of patient records to another provider of primary medical services, in circumstances where a patient registers with a different GP practice.

- **A requirement to use the NHS number in all clinical correspondence** – when writing to other health care providers about the care and treatment provided to a patient, GP practices are required to include the NHS number where known as the primary identifier of a patient.
- **The introduction of patient online services** – a requirement to promote and offer patients the facility to book appointments online, order repeat prescriptions online and to view and print a list of those drugs, medicines or appliances that they have on repeat prescription.

The two sets of directions will introduce:

- **A new enhanced service** – to encourage a holistic view in the care of those with the most complex needs, incentivising action that prevents unnecessary and avoidable admissions to hospital. Under this enhanced service GP practices will have to carry out the following activities:
 - *Improve practice availability* – provide same day telephone consultations for vulnerable patients with urgent enquires; provide timely telephone access for other clinicians and health and care services to support decisions relating to hospital transfers or admissions.
 - *Provide proactive case management* – carry out regular risk profiling to identify the two per cent of the adult practice population who will benefit from proactive case management and enrol them onto the new programme of proactive care; provide identified patients with a named accountable GP, a care coordinator and a personalised, holistic care plan; ensure patient reviews are held regularly, as clinically necessary.
 - *Review and improve discharge process* – provide timely follow up by an appropriate professional in the practice team when an identified patient is discharged from hospital, to ensure coordination and delivery of care; review emergency admissions and Accident and Emergency department (A&E) attendances from care and nursing homes; share information with the CCG to help inform commissioning decisions.
 - *Internally review unplanned admissions* – regularly review all unplanned admissions/readmissions to identify factors which may have avoided admission; undertake a monthly practice review of vulnerable patients to prevent unplanned admissions.
 - *Monitor* – complete agreed reporting for use by NHS England area teams and CCGs; participate, if required on an exceptional basis, in peer reviews.
- **Reform of the Quality and Outcomes Framework (QOF)** – the number of QOF

indicators will be reduced by a third, cutting down bureaucracy and freeing up time for GP practices to provide more personalised care for those with the most complex needs. The reduction is not aimed at reducing appropriate clinical workload, but enabling GPs to use their professional judgement to provide appropriate, proactive and holistic care.

- The money released from the discontinued indicators will be added into the global sum and fairly shared between practices, or invested into enhanced services.
- Retirements take account of NICE's views on the relative priority of current QOF indicators, and have been agreed by senior clinicians in NHS England. Indicators are being retired where they are either duplicating other work, are of low clinical value are unnecessarily prescriptive or are already embedded in clinical practice.
- NHS England is currently developing procedures for continued data analysis and reporting for the retired indicators.
- NHS England is committed to using this information to promote quality improvement in the care patients receive, monitoring any impact on health inequalities and services. The final decision on frequency of extraction and reporting is yet to be decided.
- **Fairer funding through phasing out seniority pay** – the seniority pay scheme was designed to reward experience, with GP partners receiving seniority pay after 7 years at £600 per year reaching a maximum of £13,900 after 47 years' reckonable service. Average seniority pay is £6,000.
 - The scheme will be closed to new entrants from April 2014 and stopped entirely from April 2020, in line with government objectives on progression pay.
 - Funding released through phasing out seniority payments will be reinvested into the global sum and fairly distributed between practices.

Evidence

This Equalities Analysis brings together Equality Analyses 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.

In addition, the Department ran an extensive engagement programme over the summer of 2013, to consider how to improve out of hospital care for older people and those with complex needs. This included a series of discussions with stakeholders

from the health and care community, voluntary and private sectors, and patient and carer representatives. The discussions ranged from small meetings to four round table discussions and two national events; we encouraged organisations to hold discussions with their members to inform their own response and supplied an engagement presentation to enable this. We also ran an extensive online engagement over 12 weeks including receiving responses via the Mandate refresh consultation.

Information strategy

The amending regulations will increase the online services that GP practices are required to provide for patients. Patients should be able to order repeat prescriptions online, to view appointments online as well as certain information which is contained in their Summary Care Record. In addition, provision is made for the electronic transfer of patient records between GP practices and for the automated upload of summary information to the Summary Care Record. These commitments take forward the vision, ambitions and next steps set out the Government's published information strategy for health and care in England: *'The power of information: giving people control of the health and care information they need'*. The associated Equality Analysis is available here:

www.gov.uk/government/publications/giving-people-control-of-the-health-and-care-information-they-need

Choice

The contract will enable GP practices to register patients from outside their traditional practice areas. This will mean that patients can register with the GP practice of their choice, regardless of where they live (subject to the agreement of that GP practice). The policy to extend patient choice was consulted on and equality assessed in 2010 and further considered in *No Decision About Me, Without Me*. Both respective Equality Impact Assessment and Equality Analysis are available here:

webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_cons_um_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_113490.pdf

www.gov.uk/government/uploads/system/uploads/attachment_data/file/216982/Equality-Analysis-no-decision-about-me-without-me.pdf

The Mandate to NHS England

The Mandate sets out the Government's priorities for the NHS by setting objectives for NHS England. The objectives in the Mandate are central to NHS England's accountability relationship with the Department, underpinning both the Secretary of State for Health's responsibility for the health service as a whole and their responsibilities for driving improvements in the NHS through the commissioning system. The content of the Mandate was refreshed for April 2014.

Therefore NHS England's objectives are reflected in the contract. The initial Equality Analysis and the Equality Analysis for the Mandate refresh are available here:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/213134/Full-EA-Mandate-v11.pdf

www.gov.uk/government/uploads/system/uploads/attachment_data/file/256409/ordinating_impact_equality_statement_mandate.pdf

GP Patient Survey

This Equality Analysis 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. The survey results can be found here:

<http://www.gp-patient.co.uk/>

The Care Bill

The contract changes support the vision and ambition of the Care Bill. As part of the new enhanced service, carers' needs and interests will be considered and identified, where appropriate, in personalised care plans. Recognising carers as active partners in patients' care, GPs will need to understand the contribution carers are able and willing to make to patients' care, as well as the support the carers themselves need to remain healthy and continue caring. This commitment extends the vision laid out in the

Care Bill to ensure carers receive the support they need to remain healthy and deliver effective care.

The Equality Analysis for the Care and Support Legal Reform (part one of the Care Bill) can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/275519/Care_and_Support_Legal_Reform.pdf

Protected Characteristics

Disability

Evidence shows that the prevalence of disability increases with age. Around 6% of children are disabled, compared to 16% of working age adults and 45% of adults over state pension age in Great Britainⁱⁱⁱ.

We expect GPs to provide more personalised and proactive care for those aged 75 or over. We would expect this to benefit people with a disability, who fall within that cohort. The benefits will include improved care planning, preventative risk stratification and greater integration between services.

The contract will reduce the number of indicators in the Quality and Outcomes Framework (QOF) by a third, enabling GPs to make decisions about the most appropriate care for the patient they are treating based on their clinical judgement. If a particular test or treatment is necessary, patients will still receive it.

The changes to QOF indicators are not expected to have an adverse impact on any group, including those with disabilities: many aspects of the retired indicators are now embedded as good clinical practice. In addition, NHS England is developing procedures for continued data monitoring for the retired indicators. They are committed to using this information to promote quality improvement in the care patients receive and to monitor any impact of the retirements on health inequalities and services.

The reduction in QOF indicators has enabled investment in the new enhanced service aimed at reducing unnecessary emergency admissions. Under this enhanced service, practices will identify two per cent of their adult practice population with the most complex needs and who would benefit from proactive case management. Those who most need it will therefore receive the benefits associated with more personalised, proactive and coordinated care. Given that those individuals with a disability are more likely to have complex health needs, it is probable that they will disproportionately benefit from the new service, positively redressing inequality and providing the support necessary.

The most recent GP Patient survey results show that 6% of respondents had tried to contact their out-of-hours services in the 6 months preceding the survey for their own use. However, for people that described themselves as permanently sick or disabled, 14% stated they had contacted their out-of-hours services for their own use within the 6 months preceding the survey. The amending regulations set requirements for GPs to monitor the quality of services offered by out-of-hours providers to their registered patients, and we would expect this to have a clear benefit for people who have more regular contact with that service.

The Equality Analysis considering choice of GP practice highlighted that people with disabilities are more likely to want to register with a practice that is well-placed to help coordinate care with other agencies and health and care professionals. Therefore the changes to the contract that enable patients to register with a GP practice of their choice, regardless of where they live, could be beneficial for this group (particularly for those that move house and wish to stay with their current GP). There is evidence to show that continuity of care is beneficial to patients.^{iv}

To ensure disabled people can access the information they need, the Equality Analysis prepared for the Information Strategy makes clear that NHS and local government will be encouraged to offer support to people who need help in accessing and understanding information, so that no part of society is unfairly disadvantaged. It also states highlights the role of HealthWatch, stating that HealthWatch will have a signposting function and should connect to and involve local groups and organisations who work with and are part of communities of interest, geography, demographic and characteristic. This will mean that, locally, people can have access in different ways to the information they need.

The phasing out of seniority pay is expected to have no discernible impact for those with disabilities.

Sex

Men and women share many health risks. Yet there are some marked differences between them which impact upon morbidity, mortality and health outcomes. Domain One of the NHS Outcomes Framework shows that life expectancy has been steadily rising for males and females since 1990 and, although female advantage persists, the gap between males and females has narrowed over time.^v

The amending regulations require practices to assign a named accountable GP to each registered patient aged 75 and over, a requirement not based on sex. However,

we expect there to be a greater number of women with a named accountable GP, as there are approximately a third more women between the ages of 75 and 90.^{vi}

Similarly, the reduction of QOF indicators is not expected to have a negative impact on any group. The change does not represent a removal of funding from services, but rather a change in how funding is distributed to ensure fairness in the system. The developments aim to deliver improvements to health services, and any effect on the quality of health care will be closely monitored.

Some conditions are more prevalent in the different sexes, and therefore QOF reductions may have a slightly greater impact on these groups. However, NHS England is developing procedures for continued data monitoring for the retired indicators. This information will be used to promote quality improvement in care and monitor any impact of the retirements on health inequalities and services.

Additionally, the new enhanced service will present an opportunity to treat those most at need regardless of personal characteristics, such as gender. For those groups where some diseases are more prevalent, it is likely that they will benefit from this proactive and personalised service.

The GP Patient Survey demonstrates that up until the age of 75 women go to their GP more regularly than men. The Mandate set an objective for NHS England to make every contact count. This objective should help to reduce inequalities caused by men's reluctance to access GP services and advance equality. In addition, the drive to improve information and advice available to all should help raise awareness and encourage more men to seek advice earlier.

The GP Patient Survey also shows that women access out-of-hours services more regularly than men: 7% of female respondents had contacted their out-of-hours service for their own use in the 6 months preceding the survey, compared to 5% of male respondents. The same is also true for female respondents contacting out-of-hours services on behalf of others, wherein 9% of female respondents compared to 7% of male respondents had contacted their out-of-hours service. However satisfaction rates for both males and females were broadly similar – 66% of male respondents and 69% of female respondents stating their overall experience of out-of-hours care was either fairly good or very good. Increased monitoring of the quality of out of hours services will ensure a better service for all users of out-of-hours care.

The Equality Analyses prepared on the choice of GP practice and the Information Strategy highlight some issues relating to gender. However we do not envisage an adverse impact on the grounds of gender as a result of changes introduced by the

amending regulations. The GP Patient Survey will enable us to monitor the differences between the sexes that might arise in relation to GP services.

The phasing out of seniority pay is not expected to impact negatively on the grounds of sex. It has been shown that despite women making up 47% of the GP workforce, only 34% of recipients of seniority pay are female.^{vii} By phasing it out, gender parity within the clinical profession may improve.

Race

Evidence shows that some long term conditions are more prevalent and have more severe consequences for some ethnic minority groups.^{viii} Therefore, where these patients are aged 75 or over, they will benefit from the more proactive care planning provided by the named accountable GP.

The changes to QOF indicators are not expected to impact negatively on this group. These changes aim at ensuring overall improvements are delivered to health services and more time is spent with those most at need,

The new enhanced service will bring the benefits associated with greater care coordination and more personalised, proactive services to those with the most complex needs, regardless of personal characteristics such as race. Given that some long term conditions are more prevalent in some ethnic minority groups, it may be the case that they benefit disproportionately more from the enhanced service than other groups. However, this would only represent a fair distribution of additional services to those who most need them.

The GP Patient Survey data suggests that some ethnic minority groups utilise out-of-hours services more often than the national average. For example, 9% of respondents from Arabic backgrounds and 10% from Bangladeshi backgrounds reported that they had tried to access out-of-hours services in the 6 months preceding the survey: this is compared to 6% of all respondents. There is some variation in the overall satisfaction with the out-of-hours services with 54% of Chinese respondents reporting that they were very or fairly satisfied with the service and 69% of English, Welsh or Scottish respondents stating that they were very or fairly satisfied with the out-of-hours service. We believe that increased monitoring of out-of-hours services will improve the quality of those services, which will be beneficial to all patients irrespective of race.

The Equality Analyses produced for the Information Strategy and both No Decision About Me Without Me and Equality and Excellence consider attitudes to choice and

accessing information to make choices.

The retirement of seniority pay is not expected to impact negatively on this group.

Age

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 the population in 2026.^{ix} 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. Almost half of all Accident and Emergency Department attendances for this group result in admission to hospital, compared to 16% for younger patients.^{iv, x}

We believe that those aged 75 and over will see significant benefits of having a named accountable GP. There is evidence that person centred, coordinated care for older people is particularly beneficial^{xi} and has been associated with a reduction in the number of emergency admissions for this age group.

Focusing on people aged 75 and over represents an opportunity to consider how out of hospital care can be delivered in a more person centred way, with integration between health and social care becoming the norm. This will provide valuable experience that can be drawn upon to improve these services for all parts of the population.

We recognise that there are risks that younger patients with complex conditions will be disadvantaged by not having access to a named accountable GP under the requirements set out in the amending regulations. To mitigate this, the directions setting out the enhanced services' requirements will instigate a new enhanced service requiring GPs to offer patients with the most complex conditions a named accountable GP. Given that older people have been shown to use their GP services more frequently than others, one may anticipate that they will gain a disproportionate benefit according to their disproportionate need.^{xii} However, the new enhanced service states that along with identifying the two per cent of patients aged 18 and over with complex needs, practices should also identify any children with complex health and care needs who require proactive case management. As such, this enhanced service will seek to redress any potential imbalance in care for those young people who most need support. We are also considering how we can apply the principles of more personalised care to other groups.

The changes to QOF indicators are not expected to impact negatively on this group. These changes will ensure that overall improvements are delivered to health services

and more time is spent with those most in need, regardless of personal characteristics. Given that older people have been shown to use their GP services more frequently than others, there is a probability that they will benefit from these changes. Similarly, as some conditions are more prevalent with age, the enhanced service and the additional care it offers will mitigate any impact older people feel from the retirement of some QOF indicators.

GP Patient Survey results suggest that older people are less likely to prefer the use of online services when booking GP appointments. The Equality Analyses 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 we can ensure that those without access to online data are not excluded from making choices about their healthcare.

The phasing out of seniority pay is not expected to impact negatively on this group.

Gender reassignment (including transgender)

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.

The Equality Analysis prepared for the Mandate and choice of GP practice identify issues concerning choice of services: responses to the consultation on the Mandate suggested that the transgender community find it very hard to access their preferred services. However, it was not clear whether this extended to choice of GP practice and there is no current evidence to suggest that these changes will have an impact either positively or negatively, on the grounds of gender reassignment (including transgender).

The phasing out of seniority pay and retirement of some QOF indicators are expected to have no discernible impact relating to gender reassignment. The new methods of funding allocation should free up time for GPs to focus their care on those who need it the most, regardless of gender identification.

Similarly, the new enhanced service will encourage GPs to help their patients with the most complex needs avoid unnecessary admissions to hospital. This focus is unlikely to have any negative impact on those individuals who are transgender or undergoing gender reassignment.

Sexual orientation

The Government estimates that between 5% and 7% of the UK population are lesbian, gay or bisexual. The Equality Analysis considering choice found a lack of evidence about whether LGBT people face discrimination in being offered choices of their healthcare or exercising those choices, and this was echoed by the Equality Analysis prepared for the Mandate. Therefore we do not anticipate changes on choice will have any adverse impact, and are likely to improve care for these groups.

Concerns about confidentiality relating to personal data are considered in the Equality Analysis accompanying the Information Strategy and the strategy is clear that appropriate safeguards must be put in place.

The changes to QOF indicators are expected to have no discernible impact on the grounds of sexual orientation; GPs will be able to focus care on those with the greatest need, irrespective of sexual orientation.

Similarly, the new enhanced service will encourage GPs to provide proactive, personalised care to those patients with the most complex needs. Patients benefiting from this enhanced service will be selected purely on the basis of complexity of need; as such, we do not believe this focus will have any disproportionate benefits or drawbacks on the grounds of sexual orientation.

The phasing out of seniority pay is not expected to have an impact on the grounds of sexual orientation.

Religion or belief

The GP Patient Survey suggests that 66% of Jewish respondents had seen their GP in the 3 months preceding being surveyed, whilst only 49% of Buddhist respondents had, compared to an overall average of 54%. Of these Jewish respondents who had seen their GP in the past 3 months, 84% rated their overall experience as fairly or very good, compared to 87% of Buddhists; this is reasonably in line with the overall average of 84%, indicating that satisfaction with services is relatively uniform.

All patients aged 75 and over will be assigned a named accountable GP; therefore, we do not expect this to have a disproportionate effect on the grounds of religion or belief.

The phasing out of seniority pay is expected to have no discernible impact relating to religious belief, and neither will the changes to the Quality Outcomes Framework or the creation of the new enhanced service. All these changes are designed to improve GP

services for all who use them; for this reason, it is possible that the groups outlined above that use GP services most frequently will observe the benefits more than others.

In terms of out-of-hours services, 11% of Muslim respondents stated they had tried to contact their out-of-hours services in the 6 months preceding responding, compared to 5% of Christians, compared with an overall average of 6%. We believe that increased monitoring of out-of-hours services will improve the quality of those services, which will be beneficial to all patients irrespective of religion or belief.

In terms of data sharing, the Information Strategy considers issues that may affect specific groups and is clear that appropriate safeguards must be put in place to ensure data is not shared inappropriately.

Pregnancy and maternity

We do not believe that the requirement to provide a named accountable GP will have either a negative or positive affect on women who are pregnant or receiving maternity care as it is focused on those aged 75 and over. GPs will also continue to be responsible for providing good clinical care irrespective of whether their patients fall within this group.

There is very little evidence regarding pregnancy and maternity and choice of GP practice. We would expect choice of GP practice to be beneficial for women wishing to remain with or register with a particular practice for their ante and post natal care, especially if it is not their local practice.

It is not expected that there will be any adverse effects on this group as a result of QOF reduction. Additionally, NHS England is developing procedures for continued data monitoring for the retired QOF indicators (the final decision on frequency of extraction and reporting is yet to be determined). This information will be used to promote quality improvement in case and to monitor any impact on health inequalities and services.

In addition, NHS England is developing procedures for continued data monitoring for the retired indicators. They are committed to using this information to promote quality improvement in the care patients receive and to monitor any impact of the retirements on health inequalities and services.

The phasing out of seniority pay is anticipated to have no discernible impact relating to pregnancy and maternity.

Carers

Carers play an important role in caring for older people who are in vulnerable circumstances and those with complex needs. By improving the way primary care operates, we expect to improve the experience and outcomes for carers, ensuring they receive the support they need to remain healthy and deliver effective care.

Throughout the engagement exercise that we held during the summer of 2013, we heard the opinions and views of both individual carers and organisations representing carers. This made clear the integral role of carers in the lives of older people and people with complex needs.

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 10 years.

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 working full-time.^{xiii} People providing high levels of care are twice as likely to be permanently sick or disabled, and some ethnic minorities are far more likely to be carers than other ethnic groups. Bangladeshi and Pakistani men and women, for example, are three times more likely to provide care compared with their white British counterparts.^{xiv}

Through the engagement process we heard that a lack of continuity of care complicates the role of the carer. They were supportive of the proposed changes and suggested further services that might be delivered through the accountable GP. The accountable GP will be responsible for taking the lead in improving the continuity of care by overseeing care planning and integration between health and social care services. We would also hope that the proactive and personalised care provided by the accountable GP will help to reduce avoidable unplanned admissions to hospital. Therefore, we foresee the introduction of a named accountable GP as beneficial to carers.

As part of the new enhanced service, carers' needs and interests will be considered and identified, where appropriate, in personalised care plans. Recognising carers as active partners in patients' care, GPs will need to understand the contribution carers are able and willing to make to patients' care, as well as the support the carers themselves need to remain healthy and continue caring.

Additional monitoring of the quality of out-of-hours services, as provided by GPs through the amending regulations, will also be beneficial to this group, not only for the health of the carer, but also the person for whom they are providing care.

It is possible that a broader choice of GP practices would have a positive effect, allowing carers to register with a practice that is either near their home, or near the home of the person they are caring for (if that is different).

The phasing out of seniority pay is expected to have no discernible impact in relation to carers.

As made clear in the Care and Support Legal Reform equality analysis, the Care Bill for the first time enshrines rights of carers in legislation. This year's contract changes look to support these rights and ensure that carers are recognised as active partners in patient care.

Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)? Yes

The Department ran an extensive engagement programme over the summer of 2013, to consider how to improve out of hospital care for older people and those with complex needs. This included a series of discussions with stakeholders from the health and care community, voluntary and private sectors, and patient and carer representatives. The discussions ranged from small meetings to four round table discussions and two national events; we encouraged organisations to hold discussions with their members to inform their own response and supplied an engagement presentation to enable this. We also ran an extensive online engagement over 12 weeks including receiving responses via the Mandate refresh consultation.

The amending regulations also bring together a number of policy areas, which have been subject to public consultation and engagement:

Information Strategy

<https://www.gov.uk/government/publications/an-information-revolution-summary-of-responses-to-the-consultation>

Choice

The policy to extend patient choice was consulted on and equality assessed in 2010 and further considered in *No Decision About Me, Without Me*. Both EAs and consultations are available here:

webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_113490.pdf
www.gov.uk/government/uploads/system/uploads/attachment_data/file/216982/Equality-Analysis-no-decision-about-me-without-me.pdf

The Mandate to NHS England

The consultation on the Mandate refresh and Equality Assessments are available here:

<https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>

The consultation and Equality Assessment for the first Mandate are available here:

<http://webarchive.nationalarchives.gov.uk/20130922140506/https://www.gov.uk/government/publications/the-nhs-mandate>

The Care Bill

The policy to reform care and support was consulted on and equality assessed; the Equality Analyses and consultation on reforming what and how people pay for their care and support can be found here:

<https://www.gov.uk/government/publications/the-government-published-a-series-of-impact-assessments-alongside-the-care-bill>

<https://www.gov.uk/government/consultations/caring-for-our-future-implementing-funding-reform>

The Better Care Fund

The Better Care Fund will provide £3.8 billion to local services to give elderly and vulnerable people an improved health and social care system. Local areas will complete bids for how they will use their portion of the fund to join up health and care services around the needs of patients. Further information and guidance for the local areas can be found here:

<https://www.gov.uk/government/publications/better-care-fund>

The Mandate to Health Education England (HEE)

The HEE mandate provides details of the strategic objectives in the areas of workforce planning, health education and training and development. It aligns with the mandate for NHS England and the government's response to the Francis report. The mandate for April 2013 to March 2015 can be found here:

<https://www.gov.uk/government/publications/health-education-england-mandate>

Summary of Analysis

We believe that the contract changes will have a positive impact on all groups and will work to reduce inequalities with respect to the benefits people can obtain from the health service. It is our intention that primary care will be more patient centred and GPs will provide increasingly proactive care. In addition, patients will have more choice of GP practice and will be able to access their records more easily and will be able to book appointments and order repeat prescriptions quickly. Pay will be fairer, fitting with the Government's wider policy on public sector pay and meaning that additional funding now follows the patient, no longer perpetuating 'box ticking' exercises and freeing up GPs' time to provide more proactive care.

We believe that these contract changes will make improvements to the services that GPs provide. The GP Patient Survey identifies that particular groups use some services more frequently than others. However we expect these changes to improve GP services for all groups. We also do not believe that these changes will entail a negative impact on those who do not use GP services frequently.

The improvements to monitoring out-of-hours services will have widespread benefits. We expect that any disproportionate benefits will be a result of certain demographics utilising out-of-hours services more frequently than others. We do not expect any disproportionately negative effects.

The regulations include specific changes for people aged 75 and over as older people tend to use services more frequently we believe it will have a positive impact for this group. However the expected impact is to improve care for all groups.

We have identified concerns about data sharing and access from specific groups. The Equality Analysis for the Information Strategy addresses these concerns. The strategy

states that appropriate safeguards should be in place and the NHS and local government will be encouraged to offer support to people who need help in accessing and understanding information.

Retiring some indicators from the Quality and Outcomes Framework has enabled the introduction of a new enhanced service that seeks to avoid unnecessary hospital admissions, providing personalised, proactive and joined-up care to those who need it most. The policy is in nature designed to increase care and support for those who most require it, based on health need and irrespective of personal characteristics. The plan will therefore reduce inequalities between the people of England with respect to the benefits they can obtain from the health service

What is the overall impact?

We believe that the contract changes will have an overall positive impact on all groups. Considering the evidence and engagement responses as cited in this document, we would not expect any particular group to experience a rise in inequalities as a result of these changes.

Addressing the impact on equalities

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

Action planning for improvement

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.

Please give an outline of your next steps based on the challenges and opportunities you have identified.

The changes made to the contract 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.

The new enhanced service will be monitored for effectiveness. The overarching indicator of success will be a reduction in the number of unplanned emergency admissions.

Changes to QOF indicators will continue to be monitored. NHS England is currently determining the most appropriate way of ensuring that no negative effects emerge from their retirement.

For the record

Name of person who carried out this assessment:

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Paul Thompson

Rachel Wilkinson

Date assessment completed:

24 March 2014

Name of responsible Director/Director General:

Gareth Arthur

Date assessment was signed:

24 March 2014

References

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- ⁱⁱⁱ Family Resources Survey 2010/11 - <https://www.gov.uk/government/publications/family-resources-survey-201011>
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- ^v NHS Outcomes Framework Equality Analysis: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131722.pdf
- ^{vi} ONS Population Estimates for UK – 2011: <http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2011-and-mid-2012/sty---uk-population-estimates.html>
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- ^{xiii} ONS - 2011 Census - unpaid care snapshot: <http://www.ons.gov.uk/ons/guide-method/census/2011/carers-week/index.html>
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