NHS
Midlands and Lancashire
Commissioning Support Unit

Equality and Health Inequalities Impact and Risk Assessment (EHIIRA)

Stage 2 Template for Services, Policies & Functions

Title of Service / Policy / Function:

Medicare Unit Surgery – Relocation of Services

Please complete all sections of this EHIIRA template and refer to the EHIIRA Guidance document for more information.

For further support or to submit your completed Stage 2 EHIIRA document for approval, contact your Equality and Inclusion Business Partner directly or e-mail equality.inclusion@nhs.net

1. Assessment Overview

Name of organisation: Adlington Medical Centre

Assessment Lead Contact: Brian Hann

Responsible Director/Board Member for this assessment:

Insert here

Other contacts involved in undertaking this assessment:

Insert here

Start Date: **DD/MM/YYYY** **Completed Date:** **DD/MM/YYYY**

Who is impacted by this service / policy / decision?	Yes	No	Indirectly / Possibly
Patients / Service Users	☐	☐	☑
Carers or Family	☐	☐	☑
General Public	☐	☑	☐
Staff	☐	☑	☐
Partner Organisations	☐	☑	☐

Summary information of the service / policy / decision being assessed:

Closure of building and relocation of patient services from Medicare Unit Surgery Branch Surgery at 1 Croston Road to the Village Surgery Lostock Hall branch surgery (100 metres away) – closing the Medicare Premises (which is not fit for modern Primary Care Services – and has been limited opening since the Pandemic)

What are the aims and objectives of the service / policy / decision being assessed?

Following completion of refurbishment of the Village Surgery (Lostock Hall), one of two buildings we own in the same/immediate Geographical location (previously two practices serving the same population) we are now reinitiating the plan to close the unfit for purpose Victorian Building (Medicare Unit).

For context – both buildings are branch surgeries for Adlington Medical Centre (based 13.5km away) – and form part of the surgery group run by Dr Muttucumaru (also known as the Chorley and South Ribble Health Care Network PCN).

In full collaboration with the then CCG – our organisation aquired the contracts from two retiring GP contract holders in 2017 and 2018. The intended acquisition was to combine services in a potential new build practice on the nearby new housing development as part of the Preston New Deal).

Unfortunately – this plan did not come to fruition (with planning for the whole development stopped due to ground geology concerns).

Therefore – the two buildings were instead option appraised for suitability and assessed for refurbishment, with services then to be combined from one fit for purpose location.

Patients were made aware of this at contract change-over.

Medicare Unit Surgery is an 1830's semi detached – multi story building – with x2 flying freehold covenant restrictions. A sub optimal and inferior conversation of these premises in the 1980's provided two consultation rooms (both small and below current requirements for clinical rooms) – with a third space on the upper floors – inaccessible for disabled and infirm patients – and via narrow corridors.

The Village Surgery Location is a reasonably modern build (late 1990's) and provides all patient services from a ground floor level. There are 4 large consultation spaces and an upper flow which provides a large administration hub (over 12 desks) which provides centralised services for all 24000 patients in the group.

In 2018 – conversions were made to the upper flow to allow centralised functions, and in 2019 a major refurbishment for ground floor clinical spaces was carried out (including the creation of the 4th Clinical room). The net result is one additional clinical space that existed across the two buildings pre 2019.

Crucially – both building was assessed structurally and RAAC and Asbestos in 2018. Medicare Unit has significant structural issues, and the possible existence of Asbestos which would prevent basic renovation works.

At no time has there been a strategy to keep both buildings operational (this formed part of the CCG's own capital works assessment and strategy which we contributed to) – and therefore the works were carried out on Village Surgery.

The CQC were also informed of this plan in 2018.

The existence of both buildings allowed for capital works to be carried out at Village Surgery – with patients seen locally at Medicare Unit Surgery – and across the wider group.

Full closure of Medicare was then planned for early 2021. However, with the pandemic, these timelines were put on indefinite hold.

Following immediate COVID risk assessments made in March 2020 – Medicare Unit was closed for all patient services – along with other locations, and in tandem with CCG planning – we operated Village Surgery as a Viral Site (Hot Site).

With the post pandemic world in mind – some further renovations were carried out at Village Surgery in 2023 – and now we are completing the relocation of ALL services from Medicare now that these works have completed.

Patient have not accessed CORE GP services from Medicare for over three years – with the site used for specific clinics only – and as overflow for some specialised care.

Therefore the objective now is simply to close the redundant premises (saving the system Notional rent) and to continue with the now established care from the refurbished premises.

This will enable us to concentrate all services from the newly refurbished – expanded and fit for purpose premises.

[There will be no impact of any kind. We acquired both Medicare Unit Surgery and Village Surgery Lostock Hall buildings from the incumbent providers in 2017 and 2018. Medicare Unit was previously a separate contract held by Dr Wijethilleke and The Village Surgery Lostock Hall was also a separate contract held by Dr Mashayekhy. These contracts were transferred via NHSE to Dr Muttucumaru, and in 2020 we combined these and two other contracts (Croston Medical Centre and Eaves Lane Surgery) into Adlington Medical Centre. These separate practice buildings are effectively now branches – but are themselves part of a wider practice group including Buckshaw Village Surgery. Patients across our network travel between sites routinely.

At the time these contracts changed hands – we shared the plan with the then CCG of combining both practices into one fit for purpose location in 2020. The two building are 120 meters apart (door to door) – see below

They are separated by the free public car park that services both buildings.

With the full knowledge and support of the CCG Estates team – we carried out an options appraisal of the two sites – to decide which of the two buildings would offer Lostock Hall registered patients the service. We also considered a new build project – which ultimately did not come to fruition.

Medicare Unit Surgery is a Victorian semi-detached property which under the previous incumbent had received no modernisation or improvement since its acquisition. Similarly – Village Surgery Lostock Hall had not been improved since it had been built in the 1990's. Both buildings were not fit for purpose, but it was clearly easier to improve the more modern building (Village) when compared to the Medicare Building.

We commenced a thorough refurbishment and renovation of the Village Surgery in 2019, increasing Clinical Capacity by 100% and fully modernising the building in all aspects. We merged contracts in 2020 (March), and then the pandemic hit.

Medicare Unit Surgery was initially mothballed (alongside Eaves Lane and Buckshaw) We operated a Hot Site (at Village Surgery) a Cold Site at Croston, and a Routine Cancer site at Adlington. Within two weeks – we reopened Medicare to provide Baby Vaccinations and baby checks (as a cold safe site). Buckshaw became our Midwifery site.

This continued throughout the pandemic and through into 2022. Services have continued from Medicare on a reduced basis, predominately Nursing and AARS appointments up to current day. Our plans for relocating services had not changed – but with the take off in AARS and PCN activity – we had considered renovating the premises to a fit for purpose state to help with capacity for new emerging out of hospital services.

Most recently however – we have carried out a full building inspection (as part of MRACC) and there are considerable structural improvements needed to keep the building fit for purpose. The costs of renovating this Victorian building would far outstrip any financial payback – and we feel strongly that we should not expect NHSE or ICB handouts to fund our buildings. We have now renovated and three buildings at our expense and have a proven track record in doing so.

Therefore – we are now in the position to fully relocate.

The impacts – are almost negligible. Patients have since 2017 been seeing clinicians from other buildings – with Lostock Village patients seeing GP's exclusively from Village Surgery. There is no significant impact to patients with regards travel. At worst – there is an additional 100 meters to walk – but as outlined above most patients drive and park in the same car park. It is equal distance form spaces in that car park to either building.

The refurbishment of Lostock has – overall – provided more capacity than existed in 2019 across two buildings. Therefore – there is no reduction in Clinical Space. The Village surgery site is more modern, has no renovation need – and has also been altered on the first floor to allow for centralisation of admin staff – with enough space to house teams from the wider estate. Previously – prior to renovation and with both Medicare and Village Surgery accounted – there were 5 admin positions. There are now 14.

It is more accessible for patients (including for disabled) and is owned by Dr Muttucumaru and therefore will receive the investment it needs for the future.

Dr Muttucumaru spends a minimum of 20% of his sessions at the site – and there is a full compliment of Nursing and AARS support for the building.

We have already engaged with Peter Gilkes Estate Agents – to facilitate the process of planning permission change of use – as our intention is to sell the building as a multi purpose (residential and/or business premises).

When the CQC inspected in 2022 – we informed them of the plan to close Medicare in 2023/24 and they judged the service accordingly – understanding that we would not seek to renovate those premises. They agreed that the Village Surgery premises was the correct setting.

To summarise – there is no loss of any capacity – or appointments. Access has actually increased since 2019 Village Surgery Improvements. All appointments are centralised and Admin Functions (other than receptionist) is not on these premises. Receptionist will be redeployed (all staff work across all sites) Opening hours remain the same – and enhanced access is still available as now at Buckshaw Village Surgery.]

If this assessment relates to a review of a currently commissioned service or an existing policy, what are the main changes proposed and what are the reasons for the review?

The assessment relates to a branch surgery for Adlington Medical centre. As explained in the previous section – the change is the final closure of the redundant building (serving the same Patient Population) . There are no changes to service – as these are already provided from the second location.

What engagement work is planned (or has already been carried out)? How will you involve people from protected characteristics, vulnerable groups, and groups that experience health inequalities to ensure that their views inform this decision-making process?

Patients were already informed of the intention to merge buildings in 2017 and where aware of the refurbishment in Lostock Surgery – with subsequent opening days. This was completed at acquisition stage of both locations – with the chosen site (Village Surgery) then confirmed with patients in 2018.

A full exercise of patient engagement was completed – including ALL registered patients receiving a letter of intent at acquisition – and updates via both SMS, Website and then open days at the Village Surgery Site.

The Pandemic closure and then limited use of the building has therefore resulting in patients already assuming the Medicare building is no longer the practice site.

As outlined above – the entire reason for the Village Surgery site being chosen – was due to the (Medicare's) restricted access for some vulnerable groups (being on two floors without a lift). It has narrow corridors and small consultation rooms. Due to possible asbestos – there was also no scope (even if structurally there had been possibility for conversion and extension) for the short term introduction of sensory and visual equipment (such as check in screens/voice to speech prompts and display boards etc) – as drilling into the building fabric was restricted.

With regards Demographics.

Historically – there was one GP provider in Lostock Hall – and this was provided from Medicare Unit. Then in mid 20th Century – a second GP (related to the other) opened another practice (in a different Lostock Location – in a wealthier area). This then relocated to a very close (geographical) area to Medicare Unit. This remained the same for the later half of the 20th Century – before a third GP in the late 1990's also opened a practice.

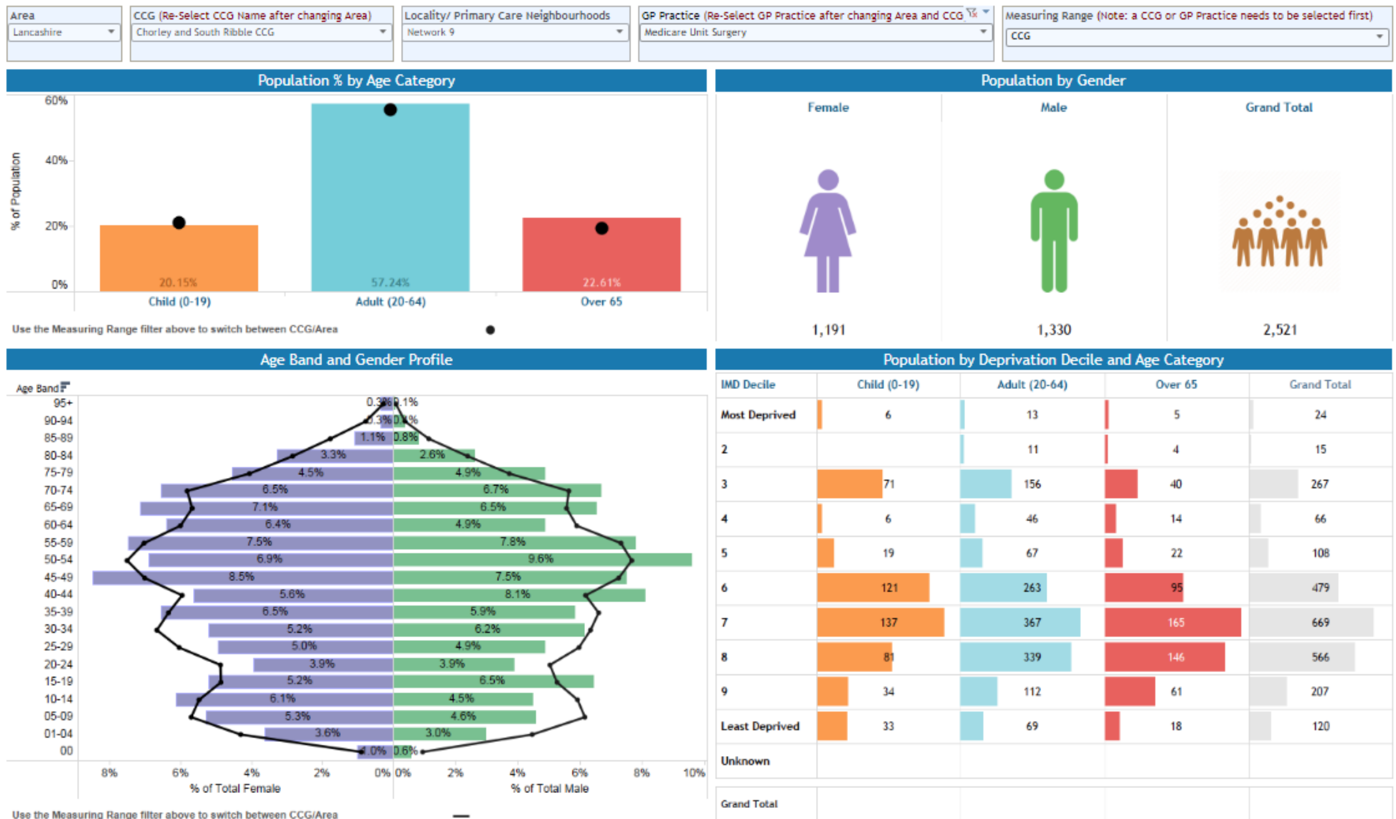
In reality – the population for Lostock Hall did not three buildings, but the historic nature of GP's and how they were privately funded meant that small 'surgeries' – serving named individuals was prevalent.

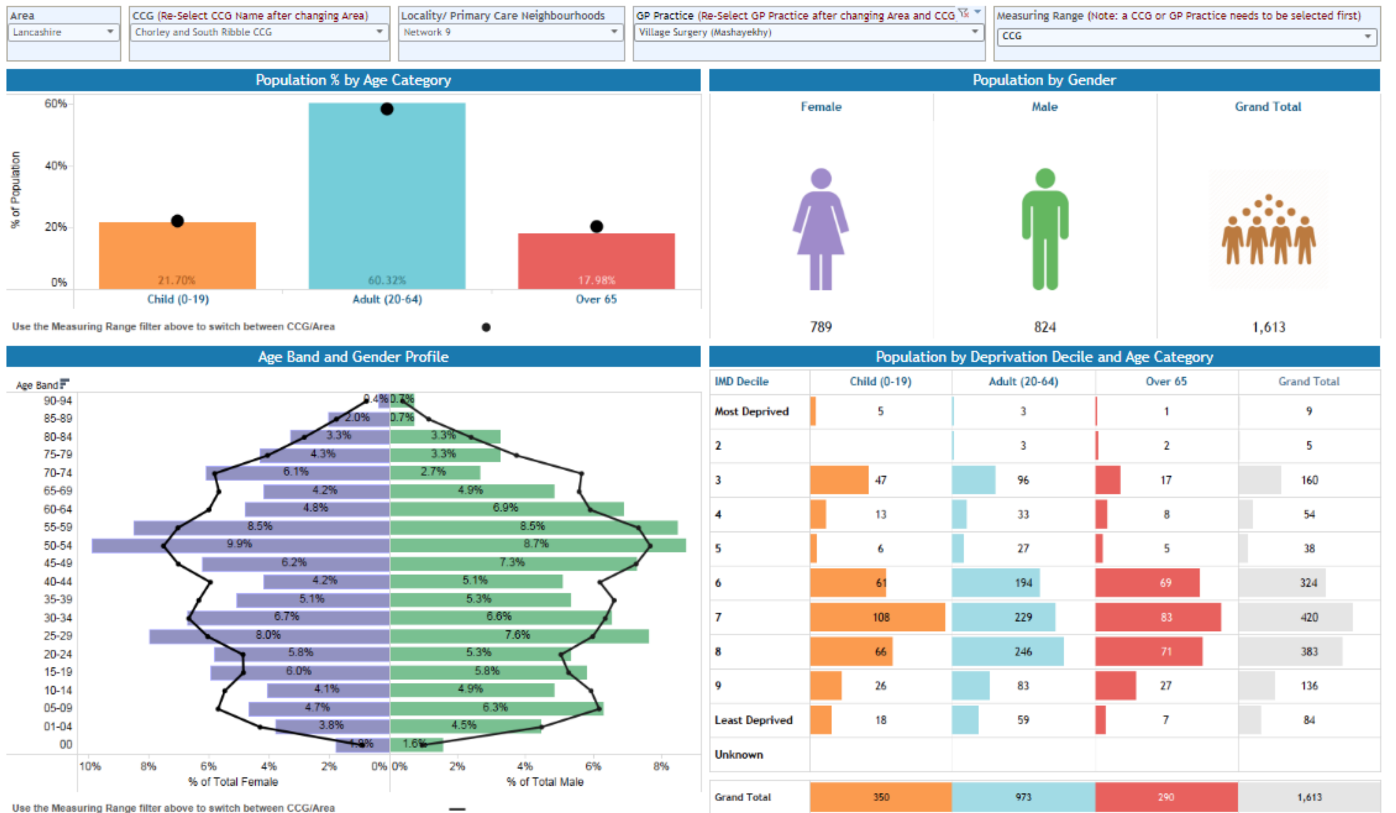
The demographic profile of patients accessing these practices has changed dramatically – with Lostock Hall being once a more affluent district of nearby Penwortham and Bamber Bridge – before the railways introduced more dense social housing – and heavy industry.

Today- Lostock Hall has significant pockets of social deprivation – and the once affluent district where Medicare Unit Surgery (Croston Road) is located – is now deemed deprived.
The Village Surgery location is literally 100 metres (door to door). Today – a separate surgery would not be agreed by commissioners – and indeed was questionable in its need back in the late 1990's.

It therefore serves the exact same demographic and patient population.

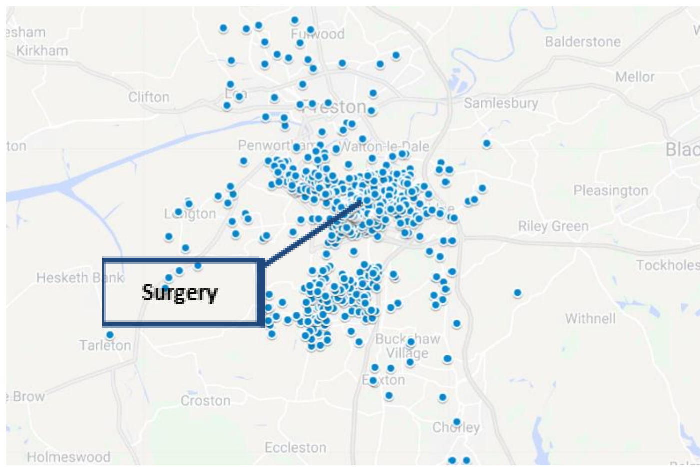
Due to the merging of contracts into Adlington Surgery – it is impossible now to identify 'Lostock Hall patient demographics specifically – as they form part of an 11,500 patient list.
However, prior to this merger – and in 2018 following acquisition it showed the following:

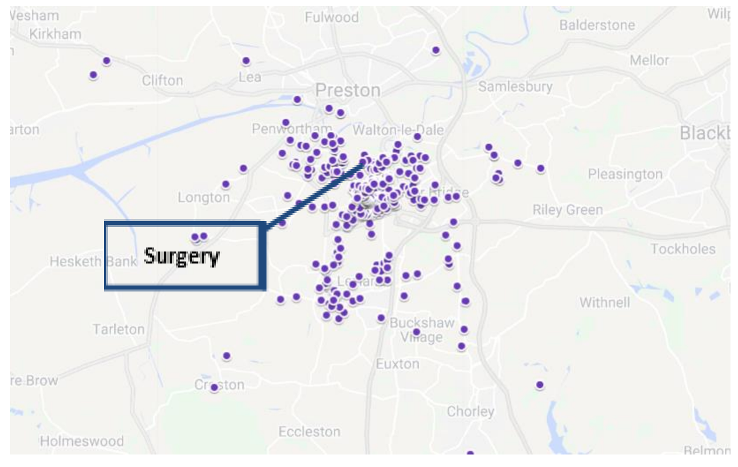




As can clearly be seen – the demographic profile is close to identical – and would obviously by the case considering the location of the two buildings.

A further view of postcodes registered shows the same spread (with Medicare having more patients clustered on the VILLAGE SURGERY location





Whilst it is now virtually impossible to specifically pick our patients who would have been historically REGISTERED at a Lostock Practice – we are able to use heat maps to understand Health Inequalities and Disease Prevalence.

The Branch Surgery (Village) and therefore by default Medicare which we will close – is situated in an area with higher levels of Obesity and co related illnesses (Hypertension and Diabetes). However, in comparison to ICB (and previous CCG) averages – these are not outliers.

The age demographic is similar to ICB averages – and therefore levels of age-related illness is none remarkable.

When the last view could be taken of the lists as separate – it showed only one key disease difference between the two – Depression. With Medicare having a then much higher rate of depression patients to the CCG average – and almost double the percentage as Village Surgery. See below

INDICATOR	REGISTER	PRACTICE LIST SI...	PREVALENCE
Asthma	130	2,595	5.01%
Atrial fibrillation	63	2,595	2.43%
Cancer	83	2,595	3.20%
Cardiovascular disease – primary prevention	8	1,612	0.50%
Chronic kidney disease	153	2,129	7.19%
Chronic obstructive pulmonary disease	59	2,595	2.27%
Dementia	12	2,595	0.46%
Depression	365	2,129	17.14%
Diabetes mellitus	150	2,153	6.97%
Epilepsy	18	2,129	0.85%
Heart failure	22	2,595	0.85%
Hypertension	395	2,595	15.22%
Learning Disability	13	2,595	0.50%
Mental health	14	2,595	0.54%
Obesity	272	2,129	12.78%
Osteoporosis: secondary prevention of fragilit...	10	1,142	0.88%
Palliative care	15	2,595	0.58%
Peripheral arterial disease	31	2,595	1.19%
Rheumatoid arthritis	19	2,187	0.87%
Secondary prevention of coronary heart disease	90	2,595	3.47%
Stroke and transient ischaemic attack	47	2,595	1.81%

INDICATOR	REGISTER	PRACTICE LIST SI...	PREVALENCE
Asthma	83	1,579	5.26%
Atrial fibrillation	37	1,579	2.34%
Cancer	50	1,579	3.17%
Cardiovascular disease – primary prevention	8	885	0.90%
Chronic kidney disease	62	1,287	4.82%
Chronic obstructive pulmonary disease	31	1,579	1.96%
Dementia	4	1,579	0.25%
Depression	110	1,287	8.55%
Diabetes mellitus	82	1,306	6.28%
Epilepsy	14	1,287	1.09%
Heart failure	11	1,579	0.70%
Hypertension	183	1,579	11.59%
Learning Disability	22	1,579	1.39%
Mental health	7	1,579	0.44%
Obesity	63	1,287	4.90%
Osteoporosis: secondary prevention of fragilit...	2	650	0.31%
Palliative care	5	1,579	0.32%
Peripheral arterial disease	16	1,579	1.01%
Rheumatoid arthritis	11	1,331	0.83%
Secondary prevention of coronary heart disease	57	1,579	3.61%
Stroke and transient ischaemic attack	40	1,579	2.53%

However, this was established to be specific to the previous (incumbent) outgoing GP's coding of records – and has subsequently since our business took ownership become below average levels for the area.

In summary there – there are no adverse impacts of any kind for Equality and Health impacts in this closure and 'relocation' – with the same population being served by the same provider in much improved facilities (facilities they already access care from) – which also offer improved access for those with disabilities – and finally with increased capacity for services through additional clinical capacity.

Is this proposal likely to affect health inequalities – either positively or negatively? YES ☑ / NO ☑

Please provide rationale for your answer below:

We have deliberately answered YES and NO to this. The rationale being:

YES – positively – as for all the reasoning explained above.

However – NO – as there is literally no impact to patients in accessing the service – as they are already doing so from the single site.

2. Evidence Section

What evidence have you considered to inform your decision-making within this assessment?

The more evidence you are able to provide in this section, the better informed your decision-making will be. Such evidence may include NICE guidance, clinical research, literature reviews, quality and performance data, workforce metrics, engagement findings, demographic data, community intelligence, health inequalities data (RightCare profiles, JSNA), etc.

We must reinforce that there is ZERO detrimental impact of any kind for service users. This EHIRA assessment process would clearly recognise that this is a very simple process of simply formally closing and already redundant space that has not been offering Core services for now 4 years.

The main impacts for patients were at the time of the contracts changing hands (2017/2018) when Medicare Unit was previously a separate contract held by Dr Wijethilleke and The Village Surgery Lostock Hall was also a separate contract held by Dr Mashayekhy. These contracts were transferred via NHSE to Dr Muttucumaru, and in 2020 we combined these and two other contracts (Croston Medical Centre and Eaves Lane Surgery) into Adlington Medical Centre. These separate practice buildings are effectively now branches – but are themselves part of a wider practice group including Buckshaw Village Surgery. Patients across our network travel between sites routinely.

There was recognition then of the destabilising impact for patient. However, there is a stark reality for commissioners and NHS England to recognise that sole GP practitioners running smaller practices do retire (and/or become ill/die). Both of the GP's in question retired from practice (although one has returned in another locality) and had our organisation not have taken the contracts over – then the patients would have had a far greater impact on their service.

A list dispersal to practices located elsewhere in the area would have resulted – as the CCG's own option's appraisal of premises would have not deemed Medicare fit for purpose (this was established in the ERIC WRIGHT work pre pandemic.

We are not aware of any NICE guidance/clinical research etc – that offers Commissioners (let alone providers) a blueprint for dealing with Health Inequalities when a GP (for whatever reason) leaves practice. Indeed – current commissioning of services locally from existing providers to competitive tender (APMS) would suggest that the ICB's own risk assessments do not highlight unacceptable levels of risk in changing providers.

This assessment (and the decisions arrived at – and actioned prior to these requirement) has focused entirely on the PREMISES and which one of the two current buildings offer the best option for patients now and into the future.

The two building are 100 meters apart (door to door) – see below

They are separated by the same free public car park that services both buildings. As previously outlined, and with the full knowledge and support of the CCG Estates team – we carried out an options appraisal of the two sites – to decide which of the two buildings would offer Lostock Hall registered patients the service. We also considered a new build project – which ultimately did not come to fruition.

Medicare Unit Surgery is a Victorian semi-detached property which under the previous incumbent had received no modernisation or improvement since its acquisition. Similarly – Village Surgery Lostock Hall had not been improved since it had been built in the 1990's. Both buildings were not fit for purpose, but it was clearly easier to improve the more modern building (Village) when compared to the Medicare Building. We commenced a thorough refurbishment and renovation of the Village Surgery in 2019, increasing Clinical Capacity by 100% and fully modernising the building in all aspects. We merged contracts in 2020 (March), and then the pandemic hit.

We have completed now three full refurbishments of premises – and have been instrumental in two new build premises – and have been fully informed by the Health Building Notes and ProCure23 (and predecessors) in designing spaces. More applicable to new builds – it does offer significant guidance for refurbishment properties – and is underpinned by research into the needs of all types of patients (with focus on protected characteristics).

Most recently we carried out a full building inspection (as part of MRACC) and these further identified significant structural improvements needed to keep the Medicare Unit building fit for purpose and indeed safe. The costs of renovating this Victorian building would far outstrip any financial payback – and the recent NHS England Estates assessment process has highlighted the need for this and similar buildings to have patient services relocated.

We are now therefore essentially formalising this process.

The options appraisal that was completed in 2018 used NHS Premises guidelines and was carried out in conjunction with the then CCG estates department (who were fully aware of the plan and encouraged it). Medicare Unit's contract was formally closed in 2020 with its merger into Adlington Medical Centre – with the premises becoming a branch. At this time – services were offered across 6 other locations and patients access care from all of them (including Buckshaw Village Surgery).

As Medicare is less than 100 metres door to door from Village Surgery – and uses the same Public Car Park for patient, there is no impact for distance. Therefore no impacts on vulnerable groups. The more modern – refurbished premises of Village Surgery has had over £75k of premises improvements made (late 2019 and through 2021) with disabled access considerations incorporated. All clinical services are on the ground floor – and using building regulations and NHS Guidelines for clinical space – consultation rooms are laid out to offer best practice clinical environments. The full building survey of Medicare has highlighted significant structural issues – and whilst there is no MAARC issues – there would be a requirement for significant changes (including demolishing an extension) to achieve a basic Primary Care establishment fit for 21st century provision. There are no impacts on Workforce and engagement has been without a single issue raised. Essentially – patients no longer view this building as a practice and are already accessing services elsewhere.

The impacts – if any are so marginal that they are almost irrelevant. Patients have since 2017 been seeing clinicians from other buildings – with Lostock Village patients seeing GP's exclusively from Village Surgery. There is no significant impact to patients with regards travel. As a worst case scenario – there is an additional 100 meters to walk (should a patient arrive on foot from the South), however as outlined above most patients drive and park in the same car park. It is equal distance from spaces in that car park to either building. The refurbishment of Lostock has – overall – provided more capacity than existed in 2019 across two buildings. Therefore – there is no reduction in Clinical Space. The Village surgery site is more modern, has no renovation need – and has also been altered on the first floor to allow for centralisation of admin staff – with enough space to house teams from the wider estate. Previously – prior to renovation and with both Medicare and Village Surgery accounted – there were 5 admin positions. There are now 14. It is more accessible for patients (including for disabled) and is owned by Dr Muttucumaru and therefore will receive the investment it needs for the future

At acquisition – we were very mindful of the impacts on continuity of care – and impacts on patients familiar with the outgoing GP's. To this end we held full patient engagement (drop in sessions) – invited patients to meet their new team – and crucially (due to our depth and size of clinical workforce) introduced a huge increase in patient services (not available to them prior).

In addition – our lead clinician Dr Muttucumaru spends a minimum of 20% of his sessions at the site alongside a team of other regular GP's, together with the full complement of Nursing and AARS support.

To summarise – there is no loss of any capacity – or appointments. Access has actually increased since 2019 Village Surgery Improvements. All appointments are centralised and Admin Functions (other than receptionist) is not on these premises. Receptionist will be redeployed (all staff work across all sites) Opening hours remain the same – and enhanced access is still available as now at Buckshaw Village Surgery.

There is no Impact on Equality or Health of any kind.

If this assessment relates to a policy / strategy, has an equality statement been added (or is it planned to be added) to the document? YES ☐ / NO ☐ / N/A ☑

If you have answered 'No', please explain why not:

Add narrative here

3. Impact Assessment

This section should record any identified and/or potential impacts on protected characteristic groups, groups experiencing health inequalities, and other groups at risk of experiencing poorer health outcomes. Both positive and negative impacts should be recorded for each of the groups defined below where applicable.

Think about any barriers to access, areas of inequity, and how different groups may be disproportionately impacted by this proposal. Conversely, think about how certain groups may benefit or see better health outcomes as a result of this proposal.

Protected Characteristics

Age Groups impacted may include young people, older people or working-age population.	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

Village Surgery shares for all intent and purpose the exact same geographical footprint as Medicare Unit. It is ground loor based (Medicare is across two floors without a lift)

All our other 5 locations are all fit for purpose for all these age groups and therefore this is a positive impact.

For Lostock based patients – there is negligible distance (100 metres) difference in distance should they walk to a site – from the south) – however, the vast majority of patients drive to surgery and the car park is shared between both buildings – with therefore a unquantifiable likelihood that distance to Village from parked car is at worst meters different – but could well be closer.

For older people – we cannot 100% guarantee that the distance is not greater (however 100 metres – with shared car park) could not be deemed a significant impact.

Finally – this is not a new situation – patients have already been accessing care from Village Surgery since 2018.

Disability Groups impacted may include people with physical / learning disabilities, long term conditions, or poor mental health	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

The other 5 locations are all fit for purpose for those with disabilities therefore this is a positive impact.

For Lostock based patients – the disabled bays in the car park are CLOSER to the Village Surgery entrance. All services are on the ground floor in all other buildings – Medicare is across two floors.

As outlined in the above sections – Village Surgery has been refurbished – and include modern General Practice patient support technology (such as hearing loops – text to speech call in – an check in). The waiting area is larger and there are additional 'safe spaces' for those with sensory needs.

Crucial to the understanding of the patient model. For those patients we identify with specific needs – or requiring reasonable adjustments – we offer care from 5 locations – and if any one building would not meet a patients need – they are seen either domiciliary or from another location which better suits their needs.

Finally – this is not a new situation – patients have already been accessing care from Village Surgery since 2018.

Sexual Orientation Groups impacted may include gay / bisexual men, lesbian / bisexual women, or heterosexual people	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There are no changes specific to this characteristic for patients under this move.

Gender Reassignment This includes people proposing to undergo, who are undergoing or have undergone gender reassignment.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There are no changes specific to this characteristic for patients under this move.

Sex (Gender) Groups impacted may include males or females – or specific gendered groups such as boys and girls.	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

The increased size of consultation rooms offers a more suitable space for chaperone processes. Medicare unit rooms are too small – and offer little dignity and making Chaperoning difficult at best.

Race Groups impacted may include different ethnicities, nationalities, national identities, and skin colours.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There are no changes specific to this characteristic for patients under this move.

Religion & Belief Groups impacted can include all recognised faith groups and those who do not follow any religion or belief system	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

The increased size of consultation rooms offers a more suitable space for those with religious beliefs who need to be examined. Medicare unit rooms are too small – and offer little dignity.

Pregnancy & Maternity Groups impacted may include pregnant women, people on maternity leave and those caring for a new-born / young child	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

The additional space in the other 5 buildings has enabled our organisation to offer Family Planning (previously unavailable. Baby vaccinations and checks benefit from larger space in clinical rooms. Investment in waiting rooms has improved waiting environment for families and children.

Crucial to the understanding of the patient model. For those patients we identify with specific needs – or requiring reasonable adjustments – we offer care from 5 locations – and if any one building would not meet a patients need – they are seen either domiciliary or from another location which better suits their needs.

Finally – this is not a new situation – patients have already been accessing care from Village Surgery since 2018.

Marriage & Civil Partnership This includes people within a formal legal partnership – same sex and opposite sex	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There are no changes specific to this characteristic for patients under this move.

Inclusion Health Groups

The services we commission should be available to all and as inclusive as possible. Your proposal should also consider any other population groups that are (or are at risk of being) socially excluded. This can include carers, people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers and many other socially excluded groups.

Think about which other inclusion health groups may be impacted by your proposal. Select from the drop-down list in each section below or manually state which other socially excluded groups you are considering. Select the table and click the blue '+' symbol in the bottom right of the table to add more sections if required.

For more information about inclusion health groups, please refer to our EHIIRA Guidance document.

Carers Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

All patients see positive benefit from improved premises – without any impact to their access

Crucial to the understanding of the patient model. For those patients we identify with specific needs – or requiring reasonable adjustments – we offer care from 5 locations – and if any one building would not meet a patients need – they are seen either domiciliary or from another location which better suits their needs.

Finally – this is not a new situation – patients have already been accessing care from Village Surgery since 2018.

Military Veterans and their families Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

All patients see positive benefit from improved premises – without any impact to their access

Crucial to the understanding of the patient model. For those patients we identify with specific needs – or requiring reasonable adjustments – we offer care from 5 locations – and if any one building would not meet a patients need – they are seen either domiciliary or from another location which better suits their needs.

Finally – this is not a new situation – patients have already been accessing care from Village Surgery since 2018.

Looked After Children & Young People Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

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Finally – this is not a new situation – patients have already been accessing care from Village Surgery since 2018.

Core20PLUS5

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the '**Core20PLUS**' – and identifies '**5**' areas of clinical focus requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMD)

PLUS refers to ICS-chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach.

The **5** areas of clinical focus are as follows:

1. **Maternity** - Ensuring continuity of care for 75% of women from ethnically diverse backgrounds and from the most deprived groups.
2. **Severe Mental Illness** - Ensuring annual health checks for 60% of those living with SMI (bringing this in line with success seen in learning disabilities)
3. **Chronic Respiratory Disease** - A clear focus on COPD driving up uptake of COVID, flu and pneumonia vaccines
4. **Early Cancer Diagnosis** - Ensuring that 75% of cases are diagnosed at Stage 1 or Stage 2 by 2028.
5. **Hypertension Case-finding** - Allow for interventions to optimise blood pressure and minimise risk of myocardial infarction and stroke.

More information about Core20PLUS5 can be found using the following link - https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Please record any identified or potential areas of impact – both positive and negative – for the target cohorts and any relevant clinical areas defined below and consider how your proposal may be able to contribute to making improvements in these priority areas.

Core20 - Deprivation The most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD).	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There are no changes specific to this characteristic for patients under this move. These patients are already seen at Village Surgery.

PLUS Any other locally determined population groups experiencing poor health outcomes – examples are listed above. **Please state which groups you are considering in your response.**	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There are no changes specific to this characteristic for patients under this move.

Choose one of the five areas of clinical focus Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

Maternity - Ensuring continuity of care for 75% of women from ethnically diverse backgrounds and from the most deprived groups.

Severe Mental Illness - Ensuring annual health checks for 60% of those living with SMI (bringing this in line with success seen in learning disabilities)

Chronic Respiratory Disease - A clear focus on COPD driving up uptake of COVID, flu and pneumonia vaccines

Early Cancer Diagnosis - Ensuring that 75% of cases are diagnosed at Stage 1 or Stage 2 by 2028.

Hypertension Case-finding - Allow for interventions to optimise blood pressure and minimise risk of myocardial infarction and stroke.

All patients will see positive benefit from improved premises – without any impact to their access

4. Compliance with Legal Duties

Has the organisation given due regard and consideration to the following areas?

Eliminating unlawful discrimination, harassment and victimisation YES ☑ / NO ☐

Unlawful discrimination takes place when people are treated 'less favourably' due to having a protected characteristic.

Advancing equality of opportunity between people who share a protected characteristic and those who do not. YES ☑ / NO ☐

This means making sure that people are treated fairly and given equal access to opportunities and resources.

Fostering good relations between people who share a protected characteristic and those who do not. YES ☑ / NO ☐

This mean creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference.

Are there any Human Rights concerns? YES ☐ / NO ☑

If you have answered '**Yes**', please seek advice from the Equality and Inclusion Team to discuss carrying out a specific Human Rights Assessment

Compliance with the NHS Standard Contract? YES ☑ / NO ☐

In relation to Service Condition SC13 which includes the NHS Accessible Information Standard

Please provide a supporting narrative to support your responses to the above questions: **This section must be completed**

We are already compliant with the above at Village Surgery – there are no impacts with the merger (which is already complete) and the building is simply ceasing services (which have been limited or stopped since 2020)

5. Equality Related Risk

If you have identified an area of actual or potential equality-related risk due to your proposal, please use the matrix below to work out the risk score and tick the corresponding box. If the area of risk gives a score of 9 or above, this should be escalated using the organisation's risk management procedures.

Risk score is calculated as the likelihood of risk multiplied by the level of consequence.

For more information about how to calculate a risk score, please refer to the EHIIRA Guidance document.

Likelihood of risk ➔ Level of consequence ➔	RARE = 1	UNLIKELY = 2	POSSIBLE = 3	LIKELY = 4	HIGH = 5
NEGLIGIBLE = 1	1 ☑	2 ☐	3 ☐	4 ☐	5 ☐
MINOR = 2	2 ☐	4 ☐	6 ☐	8 ☐	10 ☐
MODERATE = 3	3 ☐	6 ☐	9 ☐	12 ☐	15 ☐
MAJOR = 4	4 ☐	8 ☐	12 ☐	16 ☐	20 ☐
CATASTROPHIC = 5	5 ☐	10 ☐	15 ☐	20 ☐	25 ☐

Please provide a narrative to explain the risk score relating to your proposal:

There are no risks to any patients of any kind or any characteristic. The Medicare unit building is not fit for purpose (and was always earmarked for closer prior to the pandemic). During the Pandemic – the building was opened for one specific group (children) to eliminate infections risks from our Hot site. Following it has not reopened for core primary care services – due to the estate (5 other buildings) offering fit for purpose provision – with Lostock Hall patients able to access care 100 metres away – sharing the same car park.

6. Equality Action Plan

Please outline any actions or recommendations arising from this assessment of the proposal.

A target completion date is required for all actions and recommendations

Action Required	Lead Person	Target Date	Further Comments
All communications have already been made regarding Village Surgery – and patient are now operating from there – however a formal notification will go on the website once date of closure is confirmed.	Population Health Manager.	30/06/2024	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

7. Approval

All EHIIRAs should have governance oversight via formal committee. Please provide details of the arrangements for formal approval below.

Name of formal committee approving this assessment: Insert here

Date of committee meeting: DD/MM/YYYY

Name of person completing this assessment: Insert here

Below fields to be completed by E&I Team upon receiving assessment:

Date received by E&I Team for assurance check: 30/05/2024

Name of E&I Team member completing assurance check: Travis Peters

Date of completed assurance check: 31/05/2024

8. What Next?

1. **Regularly review the action plan and update the EHIIRA accordingly.**

2. **Save a finalised copy for your records and share via your governance pathways and with the E&I Team.**

3. **Follow any specialist advice or guidance from the E&I Team (if provided).**