Appendix 2

Hillingdon Clinical Commissioning Group (HCCG)
EQUALITY IMPACT ANALYSIS (EIA)

Hillingdon Clinical Commissioning Group

1. An **Equality Impact Analysis (EIA)** must be completed for any change of service (commission, re-commission/redesign, de-commission) policy, strategy or other substantial set of decisions by Hillingdon Clinicial Commissioning Group (HCCG), here called the '**scheme**'. This is a legal requirement and the responsibility of the Governing Body. In Hillingdon the Public Participation, Involvement and Equality (PPIE) committee assures the Governing Body that the EIA is adequate to meet the standard of '**Due Regard**' as required in the Public Sector Equality Duty. Also see HCCG Corporate Risk Register, and Strategic (Commissioning) Intentions.
2. The EIA identifies where some **populations** of people who share certain characteristics (eg. their sex or their ethnicity), currently have disproportionately poor health as a group when compared with other social groups in the current situation (Section 2). It can be other disadvantages affecting health outcomes such as poorer utilisation or access than others. **Positive actions** based on evidence of inequality can be planned into schemes to 'level up' and make access to health more equitable for more equal health outcomes in future.
3. The EIA also identifies future risks relevant to the new scheme, where groups of people might face disadvantages in future in relation to the new scheme, for example around access or self-help (Section 3).
4. The EIA indicates high risk areas where there is a high likelihood of negative impact. **Mitigating actions** are required to reduce risk of negative risk.
5. **Positive** and/or **mitigating** actions are then reflected when developing service specifications and operational planning (Section 4).

-Text in red: Hints and suggestions to help complete the EIA and can be deleted.

-(N#): See Supporting Notes at the end of the document for more information.

SCHEME TITLE	**Adult Phlebotomy**			
SCHEME SRO	Tarvinder Kalsi Assistant Director Primary Care Hillingdon CCG			
SCHEME CRO	Dr Mayur Nanavati Hillingdon CCG			
EIA AUTHOR/S / Clinical input	Caroline Davidson Commissioning Manager Long Term Conditions			
APPROVED / REVIEWED AT COMMITTEES AND DATES	*as applicable*	Date reviewed	Date approved	Date next update/review due
	PPIE	19.02.2021	24.02.2021	
	QCSR			
	GB (N14)			
	Contract meetings			
PUBLISHED ONLINE	Is there any reason not to publish this EIA? : ~~Yes~~ / No If yes, explain Is there any reason not to publish appendices including data : ~~Yes~~ / No If yes, explain Date published online : (Once approved all EIAs should be published)			

SECTION 1: GENERAL INFORMATION	In response to Covid19 the walk in phlebotomy offer at THH reduced by 61% due to hospital appointment slots of 10 to 12 minutes with 5 or 6 patients bled an hour versus 12/ hour preCovid. Also the OP waiting area can only socially distance 40 patients (as opposed to 80 precovid) and patients are queuing up outside. In November when the CQC inspected Hillingdon Hospital it noted the high footfall in the OP department and the covid risk to patients. Due to the Phlebotomy clinics being in the main building and in the OP department the Trust has had to close these clinics. In November/ December additional phlebotomy capacity was quickly stood up to compensate for capacity issues at Hillingdon hospital site and then the subsequent closure of the clinics on the recommendation from CQC that footfall must be reduced at Hillingdon hospital outpatients. This was a temporary stop gap and has managed demand in the short term while practices have been focusing on essential services only. This has created a backlog in blood test requests which needs to be urgently worked down and along with a return to business as usual with GPs resuming routine referrals for phlebotomy this will mean a deficit in capacity. The interim service model is not financially sustainable so it is not feasible to expand recent arrangements.

Snapshot of Hillingdon CCG Equality Objectives 2020 -2024

HILLINGDON CCG EQUALITY OBJECTIVES 2020 - 2024 Approved Feb 2020		Tick relevant HCCG's Equality Objectives (EO), (N2)
EO1: HCCG's Governing Body will ensure HCCG's work is making progress towards eliminating discrimination, ensuring equal opportunity for all and fostering good relations by ensuring equality analysis and review processes are in place, drawing on sound evidence, and used effectively in HCCG decision-making e.g. Good quality Equality Impact Analysis (EIA) is used effectively throughout the organisation.	a) Establish and consolidate sound equality structures and processes in the Hillingdon Integrated Care Partnership. b) Maintaining due regard and progress, during transition to one CCG. c) Ensuring providers, as 'agents' of the CCG are complying with statutory Equality and Health Inequality duties. d) Maintain good equality practice within HCCG processes.	
EO2: HCCG Staff: To reduce health inequalities in Hillingdon and address possible and actual risks of health inequality, support staff to identify, design, commission and procure equitable services for all, including mitigating actions where there is a risk that commissioning or decommissioning services may have a negative impact on any equality population in Hillingdon.	Support staff to make best use of EIAs and Equality Objectives.	
Characteristic / Equality Population–based Positive Action		

EO3: Identify priority populations in Hillingdon facing unequal Health Outcomes and/or at risk of disadvantages where positive action can be taken to reduce the risk of disadvantage. - Improve appropriate use and effective access for the following disadvantaged groups - Others to be explored.	- Equitable access to Primary Care in Hillingdon (See Objective 4): - Parents and Carers of Disabled children, particularly children with learning difficulties (See Objective 5), - Cancer screening (See Objective 6)	
EO4: Primary Care Improve appropriate use and effective access for the following disadvantaged groups to **Primary Care** in Hillingdon: HCCG Members, staff and Governing body will identify populations at risk of or facing health inequality in Hillingdon because of poor or inappropriate access to Primary Care.	a) Population Health data b) Race: particularly people who have migrated to the UK who may be less familiar with the NHS, regarding access to right care, right place. c) Race and Disability: Language and access to interpreting (including BSL) in primary care. d) Race / Disability: access to support for self-care.	
EO5: Learning Disability (LD)/Autism Improving access to useful support for parents of children with Learning Disability (LD)/Autism		
EO6: Cancer Screening To increase uptake of cancer screening for patients with protected characteristics that are identified as having disproportionately low take up in Hillingdon.	Initial priorities: a) Race/identified minority ethnic groups, ethnic minority women; b) Disability – mental health; c) Disability – mental health and Sexual Orientation; d) Disability - Carers	

SECTION 2: **EXISTING UNEQUAL HEALTH OUTCOMES – *THE <u>CURRENT</u> SITUATION*** *(past and present)*	Phlebotomy is a generic service that is available to all patients for the purpose of taking blood samples for testing to support diagnosis and management of a wide range of illnesses and conditions including cancer and Long Term Conditions (LTCs) such as diabetes, respiratory and cardiovascular diseases. Across London most CCGs have a Local Incentive Scheme (LIS) for phlebotomy services provided in GP practices and in NWL Hillingdon is the only CCG that does not have a LIS for the provision of Phlebotomy by GPs. PreCovid approx. 187,000 patients per year attended walk in phlebotomy clinics at Hillingdon Hospital or MVH. 86% of bloods were taken in the THH and MVH walk-in 14% of activity is provided in 8 outreach clinics across the borough. This means that patients in the South of the borough have limited access to phlebotomy services without having to travel across the borough. The Hospital clinics are walk in which while favourable to many patients is also restricting for patients who work or have caring responsibilities or want to be able to plan their appointments to reduce uncertainty and risk around waiting times since often there are minimum 30 people waiting from 7.30am and often up to 120 people waiting 2 to 3 hours. This is creating risk of Covid19 infection for patients especially as Covid19 infection control processes has reduced phlebotomy capacity to 61% due to hospital appointment slots of 12 minutes verses 5 minutes with 4 or 5 patients bled an hour versus 12 per hour preCovid. Currently there is a requirement for patients to bring the pathology test form to the Phlebotomy appointment because the hospital does not have an administrator in the clinic and does not have access to ICE therefore if patients forget to take the pathology request form with them to the clinic the phlebotomist is unable to take the bloods. This may prove challenging for some patients. A PCN Service has access to EMIS and ICE should the patient forget their form. Also with greater use of telephone/ virtual consultations by GPs this means that the GP texts a pdf of the form the patient has to print out the form at home but not all patients have a printer, otherwise the form is either posted or left in reception for the patient to pick up causing delay. To illustrate how inequalities affect the demand for the service for blood tests to diagnose, monitor and manage disease and also the need to improve access to support earlier diagnosis, Long term conditions has been used as examples below. • Black and Minority Ethnic (BAME) groups account for 45% of the Hillingdon population and White ethnic groups account for 55%[1]. The population for each locality is evenly distributed across the localities but in Hayes and Harlington the population is more dense and the proportion of ethnic minorities is twice that of the other localities. Ethnicity is closely linked to health status, inequalities and poor health outcomes • Public Health data helps us to assess the future demand for the treatment of certain conditions which are more prevalent in specific population groups e.g. Type 2 Diabetes. Hospital admissions from Diabetes were highest from the South of the borough (Botwell, Townfield, West Drayton and Pinkwell wards) while Northwood and Northwood Hills had the lowest number of admissions[2]. • There will be a predicted 9% increase in the number of people aged over 65 between 2015 – 20203. The population in the South of the borough is younger with higher ethnicity while in the North it tends to be older and less ethnically diverse.

	•There are Inequalities in life expectancy due to circulatory, cancer and respiratory diseases. Circulatory diseases account for 31% of all deaths with the highest mortality rates from coronary heart disease in the South of the borough. Deaths from all cancers accounted for 29%[4]. The gap in male life expectancy between Eastcote and East Ruislip in the north of the Borough and Botwell in the south of the Borough is 8.55 years whilst premature deaths in males <65 are highest in the Heathrow Villages. • Hypertensive disease is the most prevalent condition recorded on GP registers at 13% (although expected prevalence is double), followed by obesity (9%) and diabetes (6%)[6]. Hillingdon has the highest levels of excess weight in London with 67% of the adult population are estimated to be overweight or obese[7]and this is linked to LTCs such as diabetes and heart disease. Also the prevalence of asthma is 92% higher in obese patients and 30% higher for patients who are overweight. •Rising numbers of people with a LTC and an aging population means that increasing numbers of people will find themselves responsible for the day to day care of a relative. In the 2011 census[3] 25,702 people identified themselves as carers (9.5% of the resident population). There is an even distribution of carers across the localities, however in the North of the borough carers tend to be aged 50+ and in the south of the borough carers are younger. Therefore many carers themselves may have LTCs. •30% of people with an LTC also have a related mental health problem specifically anxiety and depression[8]. • In addition around 40% of people with depression and anxiety also have a LTC. **References:** 1.Greater London Authority 2012 Round Final Ethnic Group projection figures (GLA EGRP 2012); 2.Joint Strategic Needs Analysis 2011; 3.Office for National Statistics 4.Office for National Statistics; 5.Greater London Authority; 6.Quality Outcomes Framework; 7.Public Health England. 8 Cimpean and Drake 2011.
HCCG Highlight relevance to equality groups defined in HCCG Equality Objectives	
EO4 Equitable Access to Primary Care	Access to the hospital Phlebotomy Service is inequitable because Mount Vernon Hospital is much less accessible for patients in the South of the borough. Attending a hospital increases patient risk of infection from Covid19. The PCN Phlebotomy Service reduces this risk and the service has bookable appointments which reduces the number of patients in the waiting rooms and ensures an orderly flow of patients whereas the hospital service is walk in with 50% less waiting room capacity and double the length of slots to provide time for infection control processes so it often means patients are queuing outside the building. However if practices / PCNs are confident to manage patient flows they may offer walk in if they wish where there is patient preference for it. The PCN service improves access for patients because they are based in GP practices and there is a site in each PCN across Hillingdon but especially improves access for patients in the south of the borough.
EO5 LD/Autism	There are 980 people on the QoF LD register (0.3%)
EO6 Cancer Screening	Blood tests are first line diagnostic for identifying possible cancer therefore access to Phlebotomy is key to cancer screening. The LTC cohort of patients using this service have an increased risk of developing cancer particularly COPD patients (of whom 90% are smokers) and patients with heart disease or diabetes who are obese. Hence managing patients conditions better through quicker access to phlebotomy clinics will reduce this risk. The Covid 19 pandemic has discouraged patients from seeking advice from their GP and caused the suspension of outpatient and

	elective services which has increased waiting times and delayed diagnosis. By ensuring patients have the diagnostics they need the service may support detection of cancer by enabling quicker diagnosis through increased capacity and availability for phlebotomy.

Equality Act 2010 Equality Populations by All Protected Characteristic	
Age	Hillingdon has a higher proportion of 5-19 and 50+ year olds, than 25-39 year olds The service is available for patients aged 14+, however there is a separate Paediatric Service provided by the Confederation in the Community. Blood tests are a key tool in the diagnosis of condition affecting people of all ages. Many long term conditions (LTCs) and drug therapies require regular monitoring and blood tests and since many LTCs are age related (eg. Heart Failure, COPD, hypertension, diabetes) and conditions such as arthritis treated with strong medications require regular monitoring of kidney/ liver function etc are mostly age related. This means that older patients are more likely to need access to Phlebotomy services. The primary care sites improve access for the elderly especially if they travel by public transport. It will reduce their risk of Covid 19 infection by having more local access and not attending hospital particularly as it is >60s who have highest risk of complications from Covid 19. Bookable appointments also reduces lengthy waiting times up to 2 hours experienced at the hospital walk in service. They also enable people of working age to take minimum time off work. People engaged in full time employment or education, or those with carer responsibilities may have difficulty accessing services during working hours. Extended hours is being considered. However it is possible to book phlebotomy appointments via the Extended access phlebotomy service provided by the Confederation in the hubs.
Disability	The 2011 Census identified that there were 37,850 people in Hillingdon who considered their day to day activities were limited by a disability or long term illness. 69% of these were aged 50+ and more at risk of developing LTCs and hence require phlebotomy services for regular monitoring via blood tests. People with mobility impairments can experience difficulty accessing services, depending on their means of travel and the severity of any underlying impairment. Anxiety, panic and depression is associated with restrictions on mobility (Cleland, Lee & Hall, 2007; Moore & Zebb, 1998; TenVergert et al., 1998; Weaver, Richmond & Narsavagel, 1997; Coventry & Gellatly 2008) and can affect motivation to attend appointments Bloods for housebound patients are managed by District Nurses or the Rapid response service. Many of the patients using the service will have a LTC that will need to be monitored by blood tests. of 30% of people with an LTC also have a related mental health problem specifically anxiety and depression[2]. In addition around 40% of people with depression and anxiety also have a LTC. There are 2628 people on the QoF MH register (0.8%) In 2018/19 approx 6,600 patients were referred/ self referred to Talking therapies. 1275 people had a LTC. *2011 Census showed that there are 25,702 carers in Hilliingdon.*

	0 - 24 2,450 *25 - 64 18,609* *65 + 4,643* Of those who live with parents or other relatives who are their main Carers 35% of these Carers are 65+ and 5% are 75+ and hence likely to have a condition that needs monitoring via blood tests. It is unclear how many carers need to access interpretation service's for themselves and for those they care for. A high proportion of carers will be working and may have difficulty accompanying the patient to appointments or accessing services themselves during working hours. Extended hours is being considered. However it is possible to book phlebotomy appointments via the Extended access phlebotomy service provided by the Confederation in the hubs. Eyesight deteriorates with age so visual impairment prevalence is increasing due to aging population. The RNIB suggest a figure of 1 in 500 as an estimated basis of people who would qualify to be registerable visually impaired. People with visual impairment are likely to have difficulty accessing services and not have appropriate information. Visually impaired people are at higher risk of depression which can affect motivation to attend appointments so easier access is important. localised PCN sites mean reduction in travel distance to less familiar locations, which may make access easier for people with visual impairments. Hearing deteriorates with age and a large cohort of patients requiring phlebotomy services are elderly. People with learning disabilities need a sufficient number of staff who are appropriately trained and confident in working with patients with learning disabilities in your service. Key issues for this cohort of patients include capacity for consent for the procedure, accessible information and heightened anxiety – even phobia – related to needles. Reasonable adjustments should include less invasive alternatives such as the possibility of a finger prick blood test as opposed to venepuncture or checking saliva levels rather than blood levels. the use of topical applications to numb the skin prior to needle insertion. Arranging pre appointment visits to the site to help the person be less sensitised to the procedure is another adjustments. The PCN sites will improve access for people with disability especially if they travel by public transport. It will reduce their risk of Covid 19 infection by having more local access and not attending hospital.
Gender Reassignment	Inequality when accessing services is a significant issue for trans people. Blood tests are an important part of the treatment plan for people undergoing transition and on a very regular basis afterwards for measurement of hormones and a host of other markers. Trans people encounter issues when using the NHS due to the negative attitudes and lack of knowledge or understanding from some healthcare professionals. Research carried out on the experiences of trans people accessing health services by Healthwatch (March 2020), found that key issues include communication and admin for example the wrong title is 'often used' on blood forms e.g. Mr and then the female name, causing distress. In addition, NHS numbers do not always match as they should and consequently, the results of the blood test are lost. National LGBT survey (2018), 21% of trans people who responded said their specific needs were ignored or not considered when they accessed, or tried to access, healthcare services in the 12 months preceding the survey. These on-going challenges have led to trans gender people not attending

	appointments as they should because they fear of discrimination and prejudice, which may be contributing to the inequalities in health in this population compared with the general population.
Marriage & Civil Partnership	The service is available to all patients regardless of their relationship status.
Pregnancy & Maternity	The PCN sites will improve access for pregnant patients who may require blood tests especially if they travel by public transport. It will reduce their risk of Cvid 19 infection by having more local access and not attending hospital particularly as pregnancy increases risk of complications from Covid 19.
Race	According to the Greater London Authority in 2017, 46.9% of Hillingdon population is from Black & Minority Ethnic groups (source: GLA 2015 Round Demographic Projections, 2016). 51.1% of people living Hayes and Harlington are from BME groups. 8,240 residents (16.8%) stated they cannot speak English well or at all. People from BME populations are at higher risk of developing some cancers and LTCs such as diabetes and heart disease. The service will improve access in the South of the borough where the biggest BME populations and those for whom English is not a first language, live. Hillingdon practices routinely offer interpretation services and so can access this for phlebotomy patients. People with LTCs require regular monitoring via blood tests and so these patients will benefit from improved access to phlebotomy.
Religion & Belief	The predominant religions in the borough at 2011 (Census data) are: Christian 134,813 49.2% Muslim 29,065 10.6% Hindu 22,033 8.0% Sikh 18,230 6.7% Buddhist 2,386 0.9% Jewish 1,753 0.6% No Religion 6,492 17% Other (Mormons, Jehova's Witness) 23,303 8.5% Also 8.5% of residents stating other (23,303) which includes Mormons and Jehova's witness who may have concerns regarding a blood sampling service.
Sex	No adverse impacts identified for this protected characteristic.
Sexual Orientation	There is an absence of reliable statistical data on sexual orientation The service is available to all patients regardless of their sexual orientation.

	Similar to transgender people, people who are LGBT are known to experience prejudice and discrimination in health services.
Other priority disadvantaged groups noted by NHS.	
Homeless, travellers and people with high mobility	Homeless people have disproportionately higher respiratory disease because 85% are smokers. 20% have asthma and 4.9% have COPD. These patients will benefit from improved access to Phlebotomy as their LTCs will require regular monitoring.
Ex-Service personnel	Ex-Service personnel may suffer PTSD and have poor mental health so may be prescribed strong medications that require regular monitoring of kidney/ liver function via blood tests. These patients will benefit from improved access to Phlebotomy.
Asylum-Seekers and Refugees (see also 'Race')	See above "race"
Obesity	In Hillingdon 62% of the adult population are overweight or obese8. Obesity increases risk of diabetes and heart disease. Also the prevalence of asthma is 92% higher in obese patients and 30% higher for patients who are overweight. These patients will benefit from improved access to Phlebotomy as their LTCs will require regular monitoring.

SECTION 3: **THE PROPOSED SCHEME** ***- RISK OF DIRECT OR INDIRECT DISCRIMINATION (in future)***	3. Give a brief description of the approach and design of different elements of the scheme, ie. what will be delivered and how. Briefly highlight any significant changes from previous relevant schemes. **Care pathway** 1. GP/healthcare professional (HCP) will ensure the patient does not fall within the exclusion criteria for the service (excluded patients will be advised of alternative provider locations.) 2. HCP will Complete the appropriate requisition/blood form {see comments in Trans gender section} 3. HCP will book a practice/ PCN appointment on EMIS (unless walk in is available). 4. Phlebotomists at all providers to have access to ICE and if possible EMIS to ensure digital transfer of patient information and tests requested. see comments in Trans gender section 5. Patient attends appointment Phlebotomist checks patient details and runs through covid check list questions then draws blood from patient as indicated by the referring HCP. see comments in Trans gender section and in Disability (LD section) 6. Advise the patient regarding the test result follow-up process. 7. Sample bottles are clearly and appropriately labelled - see comments in Trans gender section 8. Samples are sealed in appropriate bags and are stored in a safe and appropriate clinical environment prior to transportation to the Pathology Department, in accordance with the specimen handling section of Infection Prevention and Control Guidance for Primary Care 9. The phlebotomist logs details of patient contact on appropriate system using codes specified in section 9. 10. Collection of specimens and transport to secondary care pathology department 11. Results returned to patient's GP practice 12. Appointment waiting times should not exceed 7 days for routine bloods and 2 days for urgent bloods. Appointments should be flexible for patients with additional needs such as learning difficulties where best practice should be followed. 13. The premises should be easily accessible with provision for people with disabilities including waiting areas.

a) RISK OF DIRECT DISCRIMINATION Deliberately causing disadvantages to people with protected characteristics.	4. What level of **risk** is there that people will face <u>direct discrimination</u> at any point in connection with this scheme or change in policy? a) Does the scheme bring members of the public into direct contact with each other? Never ~~1~~ ~~2~~ ~~3~~ ~~4~~ ~~5~~ ~~Constantly~~ (Have you considered waiting rooms, self-help groups etc.) b) Is there individual discretion in decisions about access (eg. booking appointments) or care for individuals? Never ~~1~~ ~~2~~ ~~3~~ ~~4~~ 5 Constantly

	c) Are reasonable precautions taken in the scheme to reduce the risk / prepare a response if there are incidents of direct discrimination? (*Have you considered* warning notices, complaints processes, staff support and whistle blowing policies etc.) Yes 1 ~~2 3 4 5~~ No d) Summary of Risk of Direct Discrimination: Low 1 ~~2 3 4 5~~ High e) Is additional action required? No 1 ~~2 3 4 5~~ Yes

b) BACKGROUND RISK OF INDIRECT DISCRIMINATION Unintentionally causing disadvantages to people with protected characteristics.	5. In the table below, consider each equality population and each element designed into the scheme. a) Describe any risk that people in that population could be unintentionally, or unavoidably, disadvantaged in ways that might impact on their health and wellbeing. Give special attention to those identified in Section 2. as already having poorer health outcomes. Positive action, reasonable adjustments, accessible communications that are *already confirmed* as part of the design of the new scheme should be noted here. Likely positive impacts can also be noted, (though not scored). A risk of negative impact does not stop the scheme being approved. But where there is a high risk of negative impact for a certain equality population/s, mitigating actions should be considered (Section 4) to reduce either likelihood or the scale of the negative impact. There is no set checklist of issues to consider. You can consider how the following might affect people in different social groups: - awareness of referral routes, levels of GP registration, access issues, existing familiarity with NHS services and access, - physical mobility and transport, locations and venues, timings, - communication including use of online or digital tools, access to IT, skill in understanding and speaking in English, literacy, - potential to make best use of self-help/self-care, Also consider social factors, eg. how some social groups are constrained by caring roles, gendered relationships, social perceptions, stigma etc. b) Put a score in the columns. The score should be for the risk after taking *confirmed* positive actions and adjustments into account. What is the likelihood of people in that population being disadvantaged, from 1-5 where 5 is high. What could be the impact of people in that population being disadvantaged, from 1-5 where 5 is high. It may be useful to refer to guidance for the Corporate Risk Register on impact / scale of risk.

Population	**Description of risk**	Likelihood of -ve impact **1-5**	Scale of -ve impact **1-5**	Likelihood x Scale = Risk Score
HCCG Highlight relevance to equality groups defined in HCCG Equality Objectives				
EO4 Equitable Access to Primary Care	The Primary Care Service improves access for patients because they are based in GP practices but especially improves access for patients in the south of the borough.	1	1	1
EO5 LD/Autism				
EO6 Cancer Screening	Blood tests are first line diagnostic for identifying possible cancer therefore access to Phlebotomy is key to cancer screening. The service will enable quicker diagnosis by increasing capacity and availability for phlebotomy.	1	1	1
Equality Act 2010 Equality Populations by All Protected Characteristic				
Age	The service improves access for all patients aged 14+	1	1	1

	The primary care sites improve access for the elderly especially if they travel by public transport. Bookable appointments enable people of working age to take minimum time off work. Extended hours is being considered. However it is possible to book phlebotomy appointments via the Extended access phlebotomy service provided by the Confederation in the hubs. Contractual reporting requirement to monitor access to the service by people by age and undertake patient satisfaction audits.			
Disability	The primary care sites improve access to phlebotomy for people with disability as outlined in section 2 especially if they travel by public transport. Provide access and facilities for patients with disabilities, in accordance with the Disability Discrimination Act 1995 Red Flag on electronic records ensure appropriate signage and information materials Emphasis on good verbal communication Improve staff awareness of risk of depression and use of Patient Health Questionnaire PHQ4 which is embedded in EMIS. Inform all patients of the availability of IAPT and that they can self refer. Identify carers and offer a Carers assessment and provide information on IAPT. Appropriately targeted information Provide appointment booking by email Ensure sign language services are available at appointments and Monitor usage as part of KPI Ensure there are loops for deaf people in the hubs Contractual reporting requirement to monitor access to the service by people with disability and undertake patient satisfaction audits.	1	1	1
Gender Reassignment	Training for PCN site staff to raise their awareness around issues related to communication (use of correct pronouns and titles) and admin (checking that labels are correct) So as to avoid loss of samples	1	1	1

	or delay in processing samples) Staff should be encouraged to ask how an individual likes to be addressed so that the preferred name, pronoun or term is used in communications.			
Marriage & Civil Partnership	The Primary care sites improve access to phlebotomy for all patients regardless of their relationship status.	1	1	1
Pregnancy & Maternity	The Primary care sites will improve access for all pregnant patients who wont need to travel across the Borough to hospital.	1	1	1
Race	The service is available to all patients regardless of their race. The service will improve access in the South of the borough where the biggest BME populations live. Ensure that information and communications are delivered in other languages and that interpreting services are made available to all people who require them. Identify champion groups to promote smoking cessation and pulmonary rehab. Monitor usage of Language Line etc as part of KPI Contractual reporting requirement to monitor access to the service by people of different races and undertake patient satisfaction audits	*1*	*1*	*1*
Religion & Belief	The Primary care sites improve access to phlebotomy for all patients regardless of their religion or beliefs Services delivered in a private treatment room to be sensitive to the needs of specific groups eg. shaperones. Practices and hub staff to consider religious/faith/belief festival periods i.e. Ramadan (fasting)	1	1	1
Sex	The Primary care sites improve access to phlebotomy for all patients regardless of their sex. Target information and communications to women and male groups Contractual reporting requirement to monitor access to the service by these groups and undertake patient satisfaction audits.	1	1	1
Sexual Orientation	Training for staff on the sensitivities for LGBT issues. Target information and communications LBGT groups Contractual reporting requirement to monitor access to the service by these groups and undertake patient satisfaction audits.	1	1	1
Other priority disadvantaged groups noted by NHS.				

Homeless, travellers and people with high mobility	The Primary care sites improve access to phlebotomy for all homeless, travellers or high mobility patients regardless of their sexual orientation. In Hillingdon Homeless people are able to register with a gp practice. Target information and communications to homeless groups and hostels	1	1	1
Ex-Service personnel	The Primary care sites improve access to phlebotomy for all Ex-service personnel.	1	1	1
Asylum-Seekers and Refugees (see also 'Race')	see 'Race'	1	1	1

SECTION 4 : ACTIONS - POSITIVE and MITIGATING ACTIONS	**Positive action** is encouraged in law when there is evidence that extra effort is needed to help specific populations overcome disadvantages, ensure their participation and use and provide for any special needs to prevent further disadvantages in future. An EIA is a significant tool to justify positive action and ensure equitable services. The law also requires **reasonable adjustments** and **accessible communications** to support equal opportunities for disabled people.
Summary of Confirmed Positive Actions	6. Summarise the positive actions that have already been confirmed for this scheme (these may have also been noted in Section 3) Refer to section 3
Summary of further potential Positive Actions	7. What other positive actions are being considered to address existing health inequalities, if any? Refer to section 3
Summary of Mitigating Actions	8. Regarding the equality populations identified in Section 3 where the Risk Score is over 6, give a brief description of confirmed and proposed mitigating actions? **Mitigating actions** should be considered where certain equality populations have been identified who will be disadvantaged by a new scheme, whether that is by the whole scheme or just one element or design feature of the scheme.

Brief description of mitigating action	**Populations served by this mitigating action**	**Confirmed or Proposed?**
1.		
2.		
3.		
4.		
5.		To add rows, put cursor in last box and press tab

SECTION 5: EQUALITY DATA - MONITORING AND REVIEWING EQUALITY IMPACT / EVIDENCE	What equality data will be collected? - how, by whom, who, by when? (Eg. will this be a KPI?)	As NHS standard Contract KPIs and General Conditions.
	How will equality data and impact be reviewed with providers? (Eg. in contract meetings?)	In contract meetings
	How will HCCG internally review data on equality impact - how, by whom, and when? When will EIA be reviewed and updated? *Review dates should be included on the front page and added to Forward Planners*	Commissioner in Contract meetings In 12 months.

Appendix 2

SECTION 6: EQUALITY EVIDENCE used in this EIA	Please attach any data generated specifically for this scheme/EIA as appendices, including any internal reviews of equality data, PPI Engagement Logs (N15) etc. For all data, please give reference and date so others can draw from the same sources.

Source of Equality Data	**Equality Data / Document details** (/online address) (Note if attached)
HCCG Internal Equality Evidence	
Equality Evidence Review / HCCG Equality Objectives (2019)	yes / no
PPI/Patient Experience/ Engagement*/Complaints (Attach engagement/consultation report as appendix)	~~yes~~ / no - details
Local HCCG data: EMIS/BI/Other	~~yes~~ / no - details
Data from Provider/ Performance/KPI data	~~yes~~ / no - details

Other Hillingdon/North West London Equality Evidence	
LBH: JSNA / Census 2011	yes / ~~no~~ – details see section 2
Voluntary/Community	~~yes~~ / no - details
Other BHH / NWL	~~yes~~ / no - details

Other London/National Equality Evidence	
NHS England, DoH,	1. yes ~~/ no~~ – details Department of Health (2011) Ten Things You Need to Know about Long-term Conditions.
NICE eg. Equality Assessmt	~~yes~~ / no - details
EHRC	~~yes~~ / no - details
Non-profit Sector/ Academic eg. BHF, Kings Fund	~~yes~~ / no – details
Refrences	Greater London Authority 2012 Round Final Ethnic Group projection figures (GLA EGRP 2012); 2.Joint Strategic Needs Analysis 2011; 3.Office for National Statistics 4.Office for National Statistics; 5.Greater London Authority; 6.Quality Outcomes Framework; 7.Public Health England.Cimpean and Drake 2011. DiMatteo et al 2000. Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions. Sarah Deeny, Ruth Thorlby, Adam Steventon, 2018