CWHHE Central London. West London. Hammersmith & Fulham. Hounslow. Ealing. Clinical Commissioning Groups

Equality and Health Inequalities Analysis: Standard Toolkit for CWHHE CCGs

Briefing and associated templates based on NHS England Standard Requirements

Contents

1 Equality and Health Inequalities Analysis

1.1 Introduction

These analysis templates have been developed to help you think through the implications of your work on equality and addressing health inequalities. They aim to help you take the right steps to make sure that the policy, commissioning and/or procedure you are developing has the best chance of reducing health inequalities and advancing equality of opportunity, whilst capturing the evidence that you have done so. This will support the CCG in meeting its separate legal duties on equality and health inequalities. Section 1 contains the equality analysis and Section 2 contains the health inequalities analysis.

Please note that all Equalities templates must be reviewed and signed off by the assistant director of Equalities.

1.2 Legal Duties

CCGs have two separate duties on equality and on health inequalities. Whilst the purpose of both duties is to ensure that informed and conscious consideration is given by decision makers to assess needs in respect of the equality and inequality duties, it is important to appreciate that they are two distinct duties. This document is therefore divided into two parts: section 1 contains the equality analysis template and section 2 contains the health inequalities analysis template.

1.3 Public Sector Equality Duty

The public sector equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

If you have any queries, please contact Dipen Rajyaguru, assistant director for equalities & patient experience, by emailing d.rajyaguru@nhs.net.

1.4 Health Inequalities Duties

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and ensure that services are provided in an integrated way. These duties had legal effect from April 1st 2013.

The duties require that CCGs properly and seriously take into account inequalities when making decisions or exercising functions, and have evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

What is meant by "…have regard to…" in the duties?

- Lawyers advise that "having regard to the need to reduce" means health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors.

- Part of having due regard includes accurate record keeping of how the need to reduce health inequalities have been taken into account.

1.5 The Analysis Templates

Neither the public sector equality duty nor the health inequalities duties specify how CCGs should analyse the effect of their existing and new policies and practices on equality or on health inequalities. These templates are designed to help CCG staff members to assess the impact of policy and decision-making on equality and on addressing health inequalities and to keep records of doing so. **There are and will be overlaps between the two templates and the evidence gathered for each.**

The process of using the templates and working through the questions is as important as the outcome. The process is an opportunity to evaluate your evidence base for each question and involve stakeholders who can be involved in the discussion. If the evidence is not readily available or gaps are found, a proactive approach may be needed. Finally, record keeping should take place as a matter of course.

Section 2: Equality Analysis
Please complete the template by following the instructions in each box.

Section 3: Health Inequalities Analysis
Please complete the template by applying each question to your work, referring to the best available evidence. We strongly advise that you use and work though the supporting questions in **Annex A**.

If you have any queries, please contact Dipen Rajyaguru, assistant director for equalities & patient experience, d.rajyaguru@nhs.net.

2 Equality Analysis

Title: GP at hand

What are the intended outcomes of this work? Include outline of objectives and function aims

This equality & health inequalities impact assessment has been completed following discussion at (and at the request of) the Hammersmith and Fulham CCG Primary Care Commissioning Committee. The CWHHE Collaborative, the working partnership between Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups has provided guidelines and templates to assist in this process.

GP at hand has also committed to using the EDS2 process and the four to further demonstrate 'Due regard' to equality. The main purpose of the EDS is defined *"to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED)."*

We believe that GP at hand will be the first general practice in the country to go through this process.

The aim of this EHIA is:

- To better understand the impact on the nine protected characteristic groups of offering GP services to GP at hand members
- Examine barriers to access to GP services for these groups
- Examine benefits of the GP at hand model for these groups
- To review and identify any further impacts to people from three defined groups giving due regard to the 11 communities identified including carers and those who may be socially or economically disadvantaged (including refugees) with a specific focus on:
    - People who have chosen to register for the non-digital (traditional) GP service
    - People who have chosen to register for the GP at hand service
    - People who *may* choose to register for GP at hand in the future

It is important to undertake this analysis from the user's perspective, to focus on the various impacts as the patient may experience them. With this in mind, GP at hand are also proposing additional focus groups and an EDS workshop in August. Any gaps in evidence will also be addressed via ongoing engagement.

About GP at hand (https://gpathand.nhs.uk)

From a patient perspective, GP at hand is a 'digital-first' service. Patients register with the service and download the Babylon app to their smartphone. Once they have registered, GP at hand becomes the patient's NHS primary care provider.

When a patient requires a GP consultation they book an appointment using the app or via the Babylon website. At the appointment time, the GP at hand doctor calls the patient and a video consultation takes place, via the app, using the smartphone camera. Patients can also opt for a voice-only call if they prefer.

The doctor discusses the patient's symptoms as they might during a regular GP consultation. The doctor may ask the patient to show them some things on camera. The appointment is recorded and can be played back by the patient at a later date.

Following the online consultation, if a patient requires a face-to-face consultation they can attend a practice, in person, for review by a GP or other appropriate clinician. This may be necessary if, for example, a physical examination by a GP at hand clinician is required. The service prescribes by sending prescriptions to the pharmacy of the patient's choice. It can also refer to secondary and community care services.

In addition, the service offers an online symptom checker, which asks patients questions to analyse their condition and give useful medical information and accurate triage advice on what to do next.

GP at hand is not offered in addition to a patient's existing NHS GP practice. If a patient registers with GP at hand, they will need to de-register their current NHS GP practice and transfer their care to the GP at hand service as an out-of-area patient.

During the initial phases of rollout, NHS England's Clinical Review Team have recommended that people in the following circumstances should seek advice before registering:

- Persons under the age of 16.
- Women who are or may be pregnant. (If you are pregnant, NHS England advises that you register with a GP practice close to where you live).
- Adults with a safeguarding need.
- People living with complex mental health conditions.
- People with complex physical, psychological and social needs.
- People living with dementia.
- Older people with conditions related to frailty.
- People requiring end-of-life care.
- Parents of children who are on the 'child at risk' protection register.
- People with learning difficulties.
- People with drug dependence.

It is important that people make an informed choice about whether this is the right service for them. GP at hand offers its service to everyone regardless of age or any other characteristic, acting in line with NHS England's out of area GP choice policy.

GP at hand operates from the following clinic locations in London, should patients require a face-to-face consultation:

- South Westminster Centre for Health, St Georges House, 82 Vincent Square, Westminster, London SW1P 2PF
- 21 Newby Place, E14 0EY
- 154 Drummond St, Kings Cross, NW1 3HP
- 139 Lillie Rd, SW6 7SX
- 292 Munster Road, SW6 6BQ

As set out on our website, GP at hand is a GP practice located in Hammersmith and Fulham CCG. GP at hand hold a standard GMS contract to provide NHS primary care services to patients. Patients can see a GP in person at any one of the five locations in London (two in Hammersmith and Fulham; one in Victoria, Euston and Poplar) or digitally via the Babylon smartphone app.

Individuals can register for:

- The GP at hand service, where patients can have an online consultation and see a GP in person at any of the locations. Registration is digital, via the website or the app. This has been available since June 2017.
- The non-digital (traditional) service, where patients can see a GP in person at any of two locations in Hammersmith and Fulham. Registration is in person at the practice. This has been available for many years.

Any individual living or working within 40 minutes public transport of any of the five physical locations can register for the GP at hand service.

Per the out of area patient choice policy, there is no obligation for GP at hand to provide home visits to patients living outside the practice area. The practice area is defined as approximately the southern half of Hammersmith and Fulham CCG.

Patients will need to live within a certain proximity to GP at hand's surgeries in order to register. They can also register if they work in London zones 1-3.

Please outline which Equality Delivery System (EDS2) goals/outcomes this work relates to? See EDS2 goals and outcomes

This work relates to EDS2 goals/outcomes

EDS2 mapping will be integrated into the work that GP at hand undertake on an ongoing basis, with regular reviews built in. Our view is that using the EDS2 process and the four goals demonstrates our commitment to showing 'due regard' to equality.

The main purpose of the EDS is defined *"to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED)."* We believe GP at hand will be the first practice in the country to do this.

Evidence

What evidence have you considered? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other equality analyses. If there are gaps in evidence, state what you will do to mitigate them in the evidence-based decision-making section on page 9 of this template.

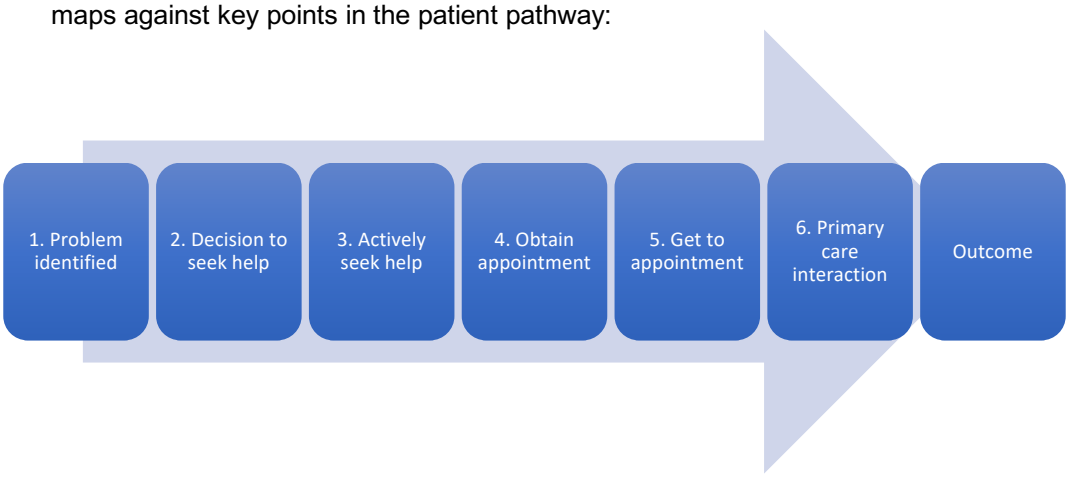
Annual equality reports from across the five CCGs:

- Hammersmith & Fulham (2017) – population 183,000
- Hounslow
- Ealing
- West London
- Central London

- 3-borough joint strategic needs assessment
- CAMHS report – RBKC & Westminster
- New patient experience portal to be launched by CWHHE Collaborative in 2018
- Engagement with partners and representatives from the GP at hand service (practice manager, director at Babylon, clinical lead at Babylon)
- National GP access research
- Proposed focus group and EDS2 workshop (dates TBC).

Rapid review: a high-level equalities matrix was completed in June 2018 as a starting point for this more detailed review and updated in July 2018. We would expect to update this matrix as part of ongoing EDS2 delivery work.

- The high-level equalities matrix (below) compares equalities of access to traditional GP practices with GP at hand (using previous literature reviews and looking at inequalities of access to GP practices in England as a baseline to offer a draft initial comparison). The matrix maps against key points in the patient pathway:



Summary matrix

H/M/L indicates the level of need for traditional GP services to make reasonable adjustments and address known barriers

- High (H) – There is likely to be a high level of need for traditional GP services to make reasonable adjustments and address any known barriers to ensure those who share this protected characteristic have a neutral or positive experience when accessing their services.
- Medium (M) – There is likely to be a medium level of need for traditional GP services to make reasonable adjustments and address any known barriers to ensure those who share this protected characteristic have a neutral or positive experience when accessing their services.
- Low (L) – There is likely to be a low level of need for traditional GP services to make reasonable adjustments and address any known barriers to ensure those who share this protected characteristic have a neutral or positive experience when accessing their services.

Colour coding highlights the positive or adverse impact of GP at hand relative to traditional GP services

- White – no identified difference between GP at hand and traditional GP services (see pregnancy and maternity as example)
- Green – much more likely to address most barriers than traditional GP services (it is possible that GP at hand addresses all barriers but further work will be carried out to check via desk research and continued local engagement)
- Light green – more likely to address most barriers than traditional GP services (to be tested further via engagement with staff, service users and other stakeholders)
- Red – adverse impact (where GP at hand might create more barriers than are removed relative to traditional GP services)

The high-level equalities matrix (below) compares equalities of access to traditional GP practices with GP at hand (using previous literature reviews and looking at inequalities of access to GP practices in England as a baseline to offer a draft initial comparison). The colours in the last rows show the potential improvements in access when using GP at hand in comparison with a traditional practice.

Patient pathway	Age	Religion or belief	Disability	Sex	Sexual orientation	Gender reassignment	Pregnancy and maternity	Marriage and civil partnership	Race	Carers	Socio-economic disadvantage
1.Identification of health problem	H	M	H	M	L	M	M	L	M	M	H
2. Decision to seek help	H	M	M	L	M	M	M	L	H	M	H
3. Actively seek help	M	L	M	M	M	M	M	L	H	M	H
4. Obtain appointment	M	L	H	L	L	L	L	L	H	M	M
5. Get to appointment	H	M	H	L	L	L	M	L	H	H	H
6. Primary care interaction	M	M	H	L	H	H	L	M	H	H	H

Disability Consider and detail disability-related evidence. This can include attitudinal, physical and social barriers as well as mental health/learning disabilities.

Selected relevant key facts from evidence	Analysis in relation to GP at hand
Since 2016, the number of disabled adults who had used the internet in the last three months increased by 5% to 9 million in 2017. **Across all age groups, the proportion of adults who were recent internet users was lower for those that were disabled, compared with those that were not.**	For a specific group of people with a disability (those without smartphone or internet access) this access route may be unsuitable due to low adoption of technology
Often carers of disabled people use the internet to access services.	Carers may benefit from use of GP at hand as this will allow them to consult a primary care practitioner whilst continuing with their care responsibilities
Physical access/transport is a barrier to healthcare for disabled people. **Patients with mental health conditions that mean that leaving their home is a challenge can use the service for initial consultations.**	GP at hand offers a route to GP care without the need for a person to travel for an initial conversation. However, for those with complex needs and those who have a requirement for multiple follow-ups in person, the service may be less suitable.
Those with some visual or hearing impairment may have difficulties when understanding information given during a GP appointment. **Visually impaired people can experience barriers to accessing primary care in cases where staff do not have the necessary skills to communicate.**	The online nature of the service may add to communication barriers for those who have impairments to their vision and hearing. However, the facility offered by GP at hand, to re-watch appointments offers an opportunity for patients to remind themselves or better understand information. GP at hand may explore the use of BSL or interpreting services for online consultations. The accessible information standard offers an opportunity for further improvements.
Deaf people would like to be able to communicate with primary care professionals using written or text communications.	GP at hand offers the ability to write to/message a GP in addition to the online consultation, offering alternative modes of access for deaf people.
Learning difficulties	We currently have 23 patients registered with us with learning difficulties. The Babylon app that supports GP at hand is designed to be accessible to all patients, and the language used is simple and easy to understand. Recorded consultations can be played back by the patient at any time, allowing information to be absorbed in a manageable way as required. All our patient notes are written in easy-to-understand language.

FEEDBACK FROM CLINICAL REVIEW

The service may be unsuitable for:

- Patients with hearing or sight problems, or other physical disabilities that would limit utilisation of digital technology
- Patients who are likely to need to be physically seen more often – for example, with frequent asthma or COPD exacerbations, or require regular practice nurse visits (for example, for wound dressing or B12 injections)
- Patients with reduced mobility when a physical consultation is required (although this may be mitigated by the GP at hand visiting service)
- Under the 'Choice of GP practice' policy, the practice is not obliged to provide patients who live outside the practice area with home visits or services out of hours.

With reference to prescribing and pharmacy services:

- Patients with poor adherence to their therapy due to either physical or mental disabilities will be assessed to receive their medication by multi-compartment aids. This is then discussed with patient's pharmacy and carers if any. These prescriptions are authorised on 12 weekly cycles. Patients are assessed and monitored every three months before further scripts are re-authorised by the pharmacist.

JOINT STRATEGIC NEEDS ASSESSMENTS

- In **Ealing**, the proportion of people stating they had a limiting long-term health problem or disability decreased from 15.1% in 2001 to 14.2% in 2011. It must be noted, however, that the data is only broadly comparable and therefore the change may partially be attributed to changes in the census question. Approximately 8% of those with a limiting long-term health problem or disability were within the working age group of 16-64 years, with 3.3% saying they had their activities limited a lot. About two thirds (61.4%) of the non-disabled population was of working age. Levels of disability, both mild and severe, were slightly higher amongst the white ethnic category as compared to others.
- Additionally, and as with older people, **transport** is often a barrier to health care for disabled people and an estimated 75% of adults with an impairment experience barriers using transport.[1]

ACCESS & USE OF TECHNOLOGY

- People with a disability are three times more likely to have never used the internet. In 2014, four million people with a disability had never been online.
- There is a strong correlation between low levels of digital skills and low levels of health literacy.[2]
- Some people who are deaf have raised concerns about the ease of getting an interpreter through their GP and explained how difficulties around communication can lead to

[1] Office of Disability Issues (2011): 'ODI Life Opportunities Survey Wave One Results'.
[2] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/health-literacy-report.aspx

confusion over managing their conditions, for example taking medication or managing diabetes.[3]

- More than three quarters (85%) of deafblind people don't get information about their healthcare appointments or follow-up correspondence in a format that they can access. Most reported that they needed to rely on someone else to read their letters for them so that they could know what was contained in them.[4]

- 19% of people with disability or limiting long-term illness also reported having experienced bullying, abuse, discrimination or exclusion from health services.[5]

EXPERIENCE OF AND SATISFACTION WITH SERVICES

- One in two (56%) **deafblind people** have left a GP appointment having not understood what had been discussed. Many reported needing to rely on a friend or family member to answer their questions or provide support and the lack of independence that this brought.[6]

- Some individuals with learning disabilities reported concern about the ability of primary care staff to communicate with them and understand their needs. One suggestion was that learning disability groups might be involved in delivering training events to help staff gain new skills and knowledge. Familiarity of environments, continuity of care (specifically with seeing the same clinicians on an ongoing basis) was also of particular concern.[7]

- Some feedback[8] about the visual quality of an online call suggested that the image was too dark, and the GP was too close or far away from screen to be seen. This affects the experience for some with audio-visual impairment.

DATA ON EXISTING PATIENTS USING THE SERVICE

- 153 patients with **serious mental illness** registered at practice (86 of whom are registered to use the digital service). SMI relating to anxiety, depression, personality disorder and/or psychosis with similar prevalence to other local practices. One patient has been re-registered at a practice nearer home after conversation with community mental health team.[9]

- The service offers choice to patients as they can choose a video consultation or a traditional face-to-face consultation with a GP at one of the practice sites. However, for housebound patients, it is only possible to receive a home visit from the GP at hand service GPs if they are in the catchment of the Dr Jefferies practice. For those living

[3] http://www.healthwatch.co.uk/resource/primary-care-review-local-healthwatch-reports Healthwatch England - March 2015
[4] Equal Access to Healthcare Report: The importance of accessible healthcare services for people who are deafblind
[5] Count me in too – experiences of deaf and disabled LGBT people (2009) University of Brighton
[6] Equal Access to Healthcare Report: The importance of accessible healthcare services for people who are deafblind
[7] The Gender and Access to Health Services Study
[8] Comment online under an article on Pulse (2017)
[9] GP at Hand Clinical Assurance meeting 1st February 2018: Summary notes of meeting http://www.hammersmithfulhamccg.nhs.uk/media/123449/PCCC-Item-7A-Appendix-A-GP-at-Hand-Clinical-Assurance-Meeting-1st-Feb-v02.pdf

outside of this catchment, all potential patients who are housebound (due to agoraphobia, limited mobility etc) are advised to choose an alternative route of care. It is, however, left to the individual patient's discretion.

Gender reassignment (including transgender) Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment.

Selected relevant key facts from evidence	Analysis in relation to GP at hand
GP at hand anecdotally offers a good level of service for trans-people.	GP at hand offers a suitable alternative to those unhappy with their existing GP provision.
Individuals may have a greater need for privacy.	GP at hand offers the confidentiality sought by trans people for initial consultations and a 'safe-space' for healthcare.

Individuals who identify as transgender have rights under the NHS Constitution, which describes the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the service. These rights cover access, quality of care and environment, access to treatments, medicines and screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS, and complaints and redress. In practice, this means that NHS services should be provided in a non-discriminatory way and there should be no absolute absence or refusal of service.

DEMOGRAPHICS

- It has been estimated that there are 20 transgender people per 100,000 population.

EXISTING USER FEEDBACK

The service recently received the following feedback from an advocate for the trans community:

> *"We're hearing initial reports that your GP at hand service is knowledgeable and experienced with trans issues and following the relevant medical guidelines correctly with respect to bridging prescriptions (a rarity for a GP service)."*

ACCESS TO SERVICES

- Although there is a lack of evidence, the little that is available indicates that trans people experience health inequalities (e.g. Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care April 2012 National Centre for Transgender Equality), including sexual health inequalities, which may include higher rates of STIs, and difficulties accessing services and relevant information.

- Some individuals who have undergone gender reassignment may have a greater need for privacy.[10] The first appointment of the day may be preferred if waiting areas are less occupied, offering the most discretion.[11]

- Individuals who have undergone gender reassignment may have a greater need for privacy when accessing primary care than other sections of the population.[12]

[10] NHS England EHIA on improving access to general practice (January 2017)
[11] EHRC (2010): 'Provision of goods, facilities and services to trans people: guidance for public authorities in meeting your equality duties and human rights obligations', p.24
[12] NHS England EHIA on improving access to general practice (draft Dec 2016)

Marriage and civil partnership Consider and detail evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

Civil partners must be treated the same as married couples on a wide range of legal matters.

If two people of the same sex are civil partners, they have the same rights as a married couple. A civil partnership also gives the right to be your partner's nearest relative. This means that they can make certain decisions about healthcare, such as making an application for their partner to be admitted for assessment. If a couple is not in a civil partnership or marriage, the ethical approach of many healthcare teams is to ask patients who they would like as their point of contact (rather than using the term 'next of kin'). This is so that their wishes are recognised by the healthcare team.

Our evidence search produced no relevant evidence to suggest any concerns in respect of people with this protected characteristic.

Pregnancy and maternity Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

NHSE currently deem out-of-area registrations to be inappropriate for those who are pregnant or seeking to become pregnant. The clinical review stated that it was important for this group to have a close relationship with their healthcare provider and the patient pathways for this group require ongoing face-to-face consultation and review.

"It is advised that women who are pregnant are registered with a local GP. However, women who are pregnant are still able to exercise their choice and **can** register with the GP at hand service. All of their midwifery care, pre-natal checks happen at their local clinic or a hospital of their choice as usual."

Race Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish Travellers, nationalities, cultures, and language barriers.

Selected relevant key facts from evidence	Analysis in relation to GP at hand
Those from BAME groups who experienced barriers due to language said that they preferred an interpreter. However, some were happy with online solutions if they made communication easier.	GP at hand has the potential to respond to this need.
Recently arrived migrants experience barriers to accessing GP services due to stigma, lack of understanding of how services work and a lack of community networks.	GP at hand widens access for migrant groups – especially those who have recently arrived. GP at hand offers interpreting services.
Language concordance/doctor patient communication is important for those from BAME groups, especially those who do not speak English well or very well.	GP at hand through the Babylon app uses language which is easy to understand.
South Asian – lowest satisfaction with process of making an appointment, high proportion unable to make an appointment (GP patient survey 2015).	GP at hand can target the promotion of service to these groups to drive up patient experience and satisfaction regionally.
Uptake of GP registration by recent entrants to the UK has been low.[13]	GP at hand is in discussion with the NHS to increase take-up amongst the unregistered population.

DEMOGRAPHIC INFORMATION

In 2011 one third (32%) of the population were from black, Asian and minority ethnic (BAME) groups, up from 22% in 2001. Hammersmith & Fulham has a small Asian population but a similar black population to the London average and larger than the average proportions from the 'mixed' and 'Arab' categories. (H&F annual equality report, 2017)

In 2011, Ealing was the 3rd most diverse borough in England & Wales. According to the National Census, compared to the rest of England & Wales, the ethnic composition of Ealing included the:

- Largest Polish population (21,507)
- Highest number of Afghans (6,789)
- Highest number of Serbians (441)
- 2nd highest number of Japanese residents (2,798)
- 2nd highest number of Iranians (2,981)
- 3rd highest Somali population (2,835), with a further 535 Somali landers
- 4th highest number of Arabs (10,076)

[13] Stagg HR, Jones J, Bickler G, et al. 'Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study'. BMJ Open 2012;2:e001453.

- Between 2015 and 2045 the white population in Ealing is expected to grow by 10%. For all other ethnicities the projected rise in numbers is steeper over this time period: Asian/Asian British by 37%, black/black British by 16%, residents of mixed ethnic heritage by 27%, Chinese by 40% and population of other ethnic origin by 43%.

- The total traveller population in **Ealing** is estimated to be in excess of 2,000 individuals at certain times of the year. Currently, traveller groups resorting to, or residing in, the borough are largely from the following traditional communities: 1. Travellers of Irish heritage, 2. East European Roma, 3. English, European and international circus and fairground Travellers. Traveller Irish communities are the largest group in the **Ealing area**.

- Since the break-up of political systems in Eastern Europe, some Roma families have travelled to Ealing. They now constitute the second largest Gypsy Traveller group in the borough. Their first language is Roma, and their second language is generally that of their point of departure, e.g. Polish, Czech, Slovak, Albanian, Romanian or any of the languages of the former Yugoslavia.

- **Hounslow** is one of the most diverse populations in London. In the 2011 census, the three most common ethnicities were white British, Indian and Pakistani. Hounslow has a number of new communities including Afghan, Bulgarian, and Nepalese communities.

- In the 2011 Census, 49% of borough residents were from black and minority ethnic backgrounds; in 2016, it was estimated at 51% and it is projected to rise further.

- Around 38% of the population of **Westminster** and 29% of the population of **Kensington and** Chelsea are from black, Asian and ethnic minority groups.

- In 2011, more than one in three in the Bangladeshi and Pakistani groups lived in a deprived neighbourhood, which is considerably more than any other ethnic group (CoDE, 2013)

- *"All ethnic minority groups in England are more likely to live in deprived neighbourhoods than the white British majority"* ESRC The Centre for Dynamics of Ethnicity 2013

ACCESS AND EXPERIENCE

An NAO report focusing on access to GP services in England (2015) shared that:

- BAME groups tend to prefer same-day appointments and to see a GP over other practice staff
- In the GPPS 2015-16, 63% of Asian/Asian British patients reported a good experience of making an appointment. The lowest level of satisfaction of all ethnic groups.
- It is generally understood that deprived areas have a lower ratio of GPs and nurses to patients making it more difficult to obtain appointments.[14] This has a disproportional impact on **South Asian populations** as they tend to live in deprived areas.
- In 2014-15, 11% of white patients and 19% of Asian patients reported that they were unable to obtain an appointment. If patients cannot access a GP, they are more likely

[14] NAO Study 2015

to suffer poorer health outcomes, or use other more expensive NHS services like A&E departments.

GP preference is deemed more important to many than opening hours, and many have shared their comfortableness with seeing a nurse if the GP is not available.[15] However, Roma Gypsy and some other BAME groups will go to A&E if preferred GP is unavailable.

Whether patients can access the same professional each time they need or want is described as continuity of care

- 62% of white patients received continuity of care, compared to only 47% of black and Asian patients
- 65% of all patients were happy to see a nurse if the GP was unavailable
- 83% wanted to consult a GP specifically (GP patient survey 2015)

South Asian and Chinese patients report lower ratings of physician communication than white British patients in primary care settings.[16]

Communication is a key driver of overall satisfaction with primary care and in either enabling the development of trusting, empathetic interpersonal relationships and collaborative decision-making.[17] Among UK-born individuals identifying as **Bangladeshi, Pakistani, or Indian**, a respective 30%, 23% and 14% report not speaking English well or at all.

Doctor patient communication is a key driver of overall satisfaction with primary care and has been shown to influence healthcare access, health outcomes and patient satisfaction. Doctor–patient communication is key in either enabling or preventing the development of trusting, empathetic interpersonal relationships, the exchange of information and collaborative decision-making.[18]

The largest dissatisfaction is currently reported by older female Pakistanis and Bangladeshi responders, and younger responders who describe themselves as 'any other white'. In the GPPS, under the questions relating to doctor patient communication, namely:

- Enough time
- Listening to you
- Explaining tests and treatment
- Involving you in decisions about your care, and
- Treating you with care and concern

The main barriers or reasons for poor satisfaction were cited as poor language proficiency; lack of acculturation, and provider-side discrimination (stereotyping and bias).[19]

[15] Cowling, T., Harris, M. & Majeed, A. (2016) 'Extended opening hours and patient experience of general practice in England: Multi Level regression analysis of a national patient survey' BMJ Qual Saf
[16] Lyratzopoulos G, Elliott M, Barbiere JM, et al. (2012) 'Understanding ethnic and other socio-demographic differences in patient experience of primary care: evidence from the English general practice patient survey' BMJ Qual Saf
[17] Brodie K, Abel, G. & Burt, J. (2016) 'Language spoken at home and the association between ethnicity and doctor-patient communication in primary care: Analysis of survey data for South Asian and White patients' BMJ Open
[18] Brodie K, Abel, G. & Burt, J. (2016) 'Language spoken at home and the association between ethnicity and doctor-patient communication in primary care: Analysis of survey data for South Asian and white patients' BMJ Open
[19] Butt.J., et al (2016) 'Variations in GP-patient communication by ethnicity, age and gender: Evidence from a national primary care patient survey' British Journal of General Practice

Patient Experience GPPS survey results 2015-16
Trust & confidence in GP:

- White British – 66%
- Chinese – 44%
- Bangladeshi – 52%
- Pakistani – 52%

Only 63% of Asian/Asian British patients reported a good experience of making an appointment. The lowest level of satisfaction of all ethnic groups (GP Patient Survey 2015-16). GP practices across England have different processes for booking appointments. In 2014-15, the variation of those who could not book appointments was 0-52%. This needs to be reduced.

NATIONAL EXPERIENCES FROM ENGAGEMENT WITH HEALTHWATCH ENGLAND:

Pakistani women in Walthamstow reported the following barriers or poor experience when attempting to obtain an appointment:

- Short time frame to book appointments in mornings
- Queues at practices
- Long wait for routine appointments.[20]

Black, Asian and minority ethnic participants of a focus group in Islington share the following reasons for not preferring phone or email appointments:

- Hearing difficulties
- Concerns about how interpreting would be offered
- Feeling that a face-to-face appointment allowed the GP to check the patient more thoroughly
- Some mentioned not having a computer for email contact
- Some of the people we spoke to had been assigned a 'named' GP, but said that in practice this was not working because their named GP was often very busy and it was difficult to see them. Roma Gypsy and some other BAME groups will go to A&E if their preferred GP is unavailable[21]

WIDER EVIDENCE

A recent study in the UK found strong evidence to conclude that South Asian and Chinese patients report lower ratings of physician communication than white British patients in primary care settings.[22] Around half of the difference in scores was explained by the concentration of South Asian and Chinese patients in low-scoring primary care practices.

- Perception of discrimination or the deterioration of trust due to historic social or health system discrimination can impact a patient's comfortableness during a consultation.[23]
- Cultural competency of services must increase and therefore should be a key objective for service commissioners and delivery.[24]

Some ***recently arrived migrants*** will be encountering a primary care service for the first time in their lives and do not have an established community base to support them.[25] Their experiences

and expectations of healthcare are likely to differ from established ethnic minority patients who are familiar with primary care and more likely to be confident in speaking English. ***Established migrants*** may also have easier access to a practice where their language is spoken or where they can consult with a doctor from a similar ethnic background.[26]

Research seeking the perspectives of ***migrants (especially asylum seekers***) indicates that they may find it difficult to understand the system in which the general practitioner (GP) acts as gatekeeper to other services, with many feeling that their concerns had not been taken seriously by the GP.[27] [28]

While they discussed service-related and system-related barriers (access to interpreting services, awareness of eligibility for primary care services), a provider-related barrier also emerged in some participants' perception of recent migrants as an unacceptable burden on health services.[29]

Many **Roma** have negative experiences of using health services in their countries of origin, and this contributes to distrust of health professionals. They may also be unaware of their right to access certain health services.[30]

Roma patients may have a limited understanding of which services are available and correct methods for obtaining referrals to specialist services. They may also be unaware of their right to access certain health services.[31]

Roma patients – even those who speak English – will often need interpreters to help explain health-related information.[32] Some gypsy traveller groups face uncertainties around seeking support from strangers, particularly over the phone. Face-to-face interventions are much more reliable as trusting relationships can be built. Within the majority of gypsy traveller families, there

[20] Perspectives in Primary Care – Part 2 (2016) Healthwatch England
[21] Black and minority ethnic groups accessing services in Islington (2016) Diverse Communities Health Voice. Healthwatch Islington
[22] Lyratzopoulos G, Elliott M, Barbiere JM, et al. (2012) 'Understanding ethnic and other socio-demographic differences in patient experience of primary care: evidence from the English general practice patient survey' BMJ Qual Saf
[23] Ahmed. F. (2015) 'Does availability of a South Asian language in practices improve reports of doctor-patient communication from South Asian patients? Cross-sectional analysis of a national patients survey in English general practices' BMC Family Practice
[24] Wilkinson, E & Randhawa, G (2016) 'An examination of concordance and cultural competency in diabetes care pathway: South Asians living in the UK' Institute of Health Research.
[25] Phillimore J. 'Delivering maternity services in an era of superdiversity: the challenges of novelty and newness' Ethn Racial Stud 2015;38:568–82.
[26] Ahmed F, Abel GA, Lloyd CE, et al. 'Does the availability of a South Asian language in practices improve reports of doctor–patient communication from South Asian patients? Cross sectional analysis of a national patient survey in English general practices' BMC FamPract 2015;16:55.
[27] Bhatia R, Wallace P. 'Experiences of refugees and asylum seekers in general practice: a qualitative study' BMC Fam Pract 2007;8:48.
[28] O'Donnell CA, Higgins M, Chauhan R, et al. 'Asylum seekers' expectations of and trust in general practice: a qualitative study' Br J Gen Pract 2008;58:e1–11
[29] Lindenmeyer A, Redwood S, Griffith L, et al. (2016) 'Experiences of primary care professionals providing healthcare to recently arrived migrants: a qualitative study' BMJ Open
[30] Roma Support Group – Leaflet for health professionals (2016) Roma Support Group
[31] Roma Support Group – Leaflet for health professionals (2016) Roma Support Group
[32] Roma Support Group – Leaflet for health professionals (2016) Roma Support Group

is a strong gender divide making it inappropriate for men or women to discuss health issues with strangers or with members of the opposite sex.[33]

People wanted better information and a choice in methods of communication. Although there was an agreement that having an interpreter in the room was best, many of the participants said that they would be happy with online solutions, if they would make communication easier.[34]

FEEDBACK FROM CLINICAL REVIEW (2017)

Service may be less appropriate for: Patients not confident to consult in English, although translation services may result in better written e-consultation support for people who do not have English as a first language and who would otherwise have to rely on friends or family to translate for them, or require traditional GP services to access interpreting services.

Religion or belief Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

Selected relevant key facts from evidence	Analysis in relation to GP at hand
Some faith groups restrict how women (and sometimes children) interact with health providers (e.g. some women are not able to see a GP without permission from their husbands or other male in the household, or without male accompanying them)	Online consultation allows for this to happen from own home.
Various timings for religious activities (e.g. prayer times)	Offers more choice for appointments at times that do not conflict with religious/faith commitments

DEMOGRAPHICS

According to the 2011 Census, nearly half (44%) of Ealing residents regard themselves as Christian. This represents a decrease of 7% compared to the 2001 Census. The proportion of most major religions remained similar between 2001 and 2011, with the exception of Islam (6% increase to 16%).

Sex Consider and detail evidence on men and women. This could include access to services and employment.

Selected relevant key facts from evidence	Analysis in relation to GP at hand
Young men are underusing local primary care services leading to late presentation (substance misuse, sexual health and mental health).	Younger cohorts of patients choosing to utilise/register with GP at hand creates opportunities to do crisis prevention work with this age group
Some women and men prefer to see a GP of the same gender.	Increased scope for accessing the same gender GP because GP at hand has a large pool of GPs available enabling the service to meet patient

[33] Fair Access for all Gypsies and Travellers in Sussex: GP Services and barriers to primary care (2010) Friends, Families & Travellers

[34] http://www.healthwatch.co.uk/resource/primary-care-review-local-healthwatch-reports Healthwatch England - March 2015

	need (http://www.cqc.org.uk/content/nigels-surgery-78-same-gender-doctors)
Parents and carers of young children often find it hard to see a GP due to high demand of appointments before and after school/nursery.	Parents, guardians and carers of young children are able to obtain appointment that fits around other commitments and save on travel time.
Differences in health needs among young women (e.g. common mental illness/eating disorders) and young men (problematic substance misuse)	Babylon app product development includes targeting health messages to specific patient cohorts.
Nearly twice as many men as women visit their GP less than once a year.[35]	In-app notifications (currently being built) can remind men about importance of health checks and also promote key messages focused around local priorities specific to men (CVD health checks, bowel cancer, prostate cancer prevention etc)
Research suggests that women attempt self-treatment more often and are more likely to consult a lay person for support	GP at hand service enables those who attempt self-treatment more often to instead seek convenient medical advice and support from a GP or nurse, in addition to being able to use the AI symptom checker chatbot

In their policy briefing paper for National Men's Health Week in 2009, the Men's Health Forum reported:

"*In Great Britain, men visit their GP 20% less frequently than women. The difference in usage is most marked for the 16-44 age group – women of this age are more than twice as likely to use services as men. Women have higher consultation rates for a wide range of illnesses, so the gender differences cannot be explained simply by their need for contraceptive and pregnancy care."*

Men, especially young men, are much less likely than women to have regular dental check-ups or to use community pharmacies as a source of advice and information about health. Just 10% of NHS community contraception service users are male.

NHS smoking cessation programmes are less well used by men than women and the same is true of NHS and commercial weight management services, health trainers and of disease-specific helplines run by third sector organisations. Male uptake was markedly lower than female uptake in the pilot programmes for the NHS bowel cancer screening programme.

DIFFERENTIAL USE OF GP & PRIMARY CARE SERVICES

Lack of familiarity with the health system may be a factor [for ***men's underuse*** of primary care]. ***Women*** are much more likely to use health services routinely – for contraception, cervical cancer screening (after the age of 25), pregnancy, childbirth and for their children's health. When they are ill, they are more likely to know how to access services, and which services to use, and to feel more comfortable with a healthcare professional.[36]

Research suggests that there are differences between women and men in where they seek help and why they delay. Differences between women and men in the reason for delay include

[35] Source: ONS 2005
[36] Men's Health Forum 2015

women's belief that they are less likely than men to be having a heart attack, and that women often attribute their symptoms to a less threatening cause. Women are also more likely to say they wanted to avoid troubling other people, and they attempt self-treatment more often and are also more likely to consult a lay person (Walsh et al., 2004)[37]

Men's unwillingness to seek help is reinforced by a number of practical barriers, including the demands of long working hours and problems with accessing primary care services near the workplace. Anecdotal evidence suggests that some men are deterred by a perception that GP and pharmacy services are aimed mainly at women and children and feel like 'feminised' spaces **(Men's Health Forum and DOH, 2008).**

Research completed by the Men's Health Forum (in relating to their MAN MOT chat to GP service) concluded that:

- Men experience barriers that inhibit their use of conventional GP services.
- Men will use online health information and advice services such as Man MOT.
- Young men may be the age group most likely to use online health information and advice services.
- Men living in areas of deprivation will use online health information and advice services.
- Men generally prefer to access online services via mobile platforms.
- Online health information and advice services are likely to receive a disproportionate demand from men about sexual health, urological and mental health issues.
- Online health information and advice services may be most effectively delivered on a national basis.
- Developing a sustainable free-to-use online health information and advice service is challenging.

Older men often do not feel that services run specifically for their age group are appropriate for their needs except perhaps as a last resort.

"Differences in gender can be seen in young adults. Young women are three times as likely to have a common mental disorder and ten times as likely to have an eating disorder as young men. Young men are more likely to have problematic substance misuse and less likely to be seen in services in their expected numbers." – Young Adults JSNA 2017

Men and boys from Gypsy traveller groups often access healthcare advice and appointments with the support of their wives, mothers and daughters.[38]

EXPERIENCE AND PATIENT FEEDBACK
Some mothers of young children have shared their wish for easier to access services, praising their local walk-in centres and welcoming the idea of Skype appointments.[39]

Sexual orientation Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

[37] The Gender and Access to Health Services Study (2008) University of Bristol
[38] Fair Access for all Gypsies and Travellers in Sussex: GP Services and barriers to primary care (2010) Friends, Families & Travellers
[39] http://www.healthwatch.co.uk/resource/primary-care-review-local-healthwatch-reports Healthwatch England - March 2015

Selected relevant key facts from evidence	Analysis in relation to GP at hand
Gaps in equality monitoring data across the catchment area (stated in annual equality reports and JSNA).	GP at hand registration could include more robust equality monitoring data collection allowing for better analysis of service users, and targeting of health messaging in future.
Experience of discrimination is a barrier to accessing GP services.	All GP at hand staff have mandatory equality and diversity training. There are also staff LGBT networks. Additional work can be done on fostering good relations to ensure promotional materials and images in the app reflect full diversity of service users.

DEMOGRAPHICS

- 3.3 million lesbian, gay and bisexual people live in England – Stonewall
- 1.7% of adults in the UK identify themselves as lesbian, gay or bisexual. 2.5% in London. 3.3% of 16-24-year-olds identify as gay, lesbian or bisexual – annual population survey 2015
- In **Westminster (Central London)** there are estimated to be over 10,000 lesbian, gay, bisexual or transgender (LGBT) people.

EXPERIENCE OF DISCRIMINATION

Historic social or health system discrimination can impact a patient's comfortableness during a consultation. For example, those who identify as lesbian, gay or bisexual were about one and a half times more likely to report unfavourable experiences especially relevant to primary care intervention.[40]

In England and Wales, under the Equality Act 2010, it is unlawful to treat people unfairly because of their sexual orientation. This means that service providers have a duty to ensure that their services and their staff do not discriminate against people on the grounds of their sexual orientation.

Black and Asian LGB people may face double discrimination, being at risk of negative perceptions and treatment on the basis of both their sexuality and their visible ethnicity. LGB people whose minority ethnicity is less visible (for example, **Eastern European** people) are less likely to experience some forms of racial discrimination.[41]

People with a **disability/long-term health impairment** reported having experienced bullying, abuse, discrimination or exclusion in employment (21%); and from health services (19%) and they felt more uncomfortable using services because of their gender/sexual identity than other LGBT people.[42]

Experience when accessing healthcare in 2012[43]	Gay and bisexual men	Lesbian and bisexual women

[40] Elliott, et al (2015) 'Sexual minorities in England have poorer health and worse healthcare experiences: a national survey' University of Cambridge

[41] Hunt, R. and Fish, J. (2008) 'Prescription for Change: Lesbian and bisexual women's health check' Stonewall

[42] 'Count me in too – experiences of deaf and disabled LGBT people' (2009) University of Brighton

[43] Experiences of Healthcare Briefing (2012) Stonewall UK

GP or healthcare professional assumed that they were heterosexual	16%	39%
No opportunity to discuss their sexual orientation	15%	23%
Came out to their GP or healthcare professional and they were either ignored or the healthcare professional continued to assume they were heterosexual	3%	9%
Patients were asked inappropriate questions by their GP or healthcare professional after coming out to them	3%	6%
Healthcare professional had provided them with the opportunity to come out	9%	7%
Healthcare professional acknowledged they were gay, lesbian or bisexual after they had come out to them	28%	26%
Patients were told their partner was welcome to be present during a consultation	12%	12%
Healthcare professionals had specifically given them information relevant to their sexual orientation	26%	11%
GP surgery displayed a non-discrimination policy that included sexual orientation	21%	9%
GP surgery has a clear policy on confidentiality	40%	24%
None or few GP or healthcare professionals know they are gay, lesbian or bisexual	34%	49%

Experience of discrimination from both public services and society can cause some groups and individuals to avoid actively seeking help, especially if this is coupled with a lack of support network. For example, 7% of **lesbian, gay and bisexual people** expect to be treated worse than heterosexual people by their GP increasing to one in eight (12%) **gay young people** aged 18 to 24[44]**.**

Safety can be a real concern for LGBT users of social care[45] and there is anxiety about other service users or staff passing on information that may lead to hostile behaviour

- 36% of LGBT people have been subject to verbal abuse.
- 44% of gay men have been physically attacked.

Hate crimes of this sort have a serious effect on people's behaviour too with many changing how they interact with public services. **Black and Asian lesbian, gay and bisexual** people may face double discrimination, being at risk of negative perceptions and treatment on the basis of both their sexuality and their visible ethnicity.[46] Feelings of discomfort and fears of judgement can often deter **trans patients** from accessing health care.

[44] 'Gay in Britain – Lesbian, gay and bisexual peoples experiences and Expectations of discrimination' (2011) Stonewall
[45] 'Count me in too – Experiences of deaf and disabled LGBT people' (2009) University of Brighton
[46] Hunt, R. and Fish, J. (2008) 'Prescription for Change: Lesbian and bisexual women's health check' Stonewall

MONITORING DATA

There is a current lack of equality monitoring data, especially for the LGBT community across the 5 borough catchment and London generally. Local CCGs rely heavily on the JSNA data but there is not a specific JSNA for equalities or each of the protected characteristics yet. Research by Stonewall has recommended that patients should be asked about sexual orientation as part of patient records (to give individuals the opportunity to share their sexual orientation and thus receive more appropriate services)[47]

EXPERIENCE

LGBTQ young people experience several inequalities when accessing and using public services, including:

Facing barriers to accessing health care – many young people feel that health care professionals treated LGBTQ people differently which has prevented them from visiting regularly. Specific services for transgender young people are particularly oversubscribed **(Count me in too, University of Brighton 2009)**

Carers Consider and detail evidence on part-time working, shift-patterns, general caring responsibilities.

Selected relevant key facts from evidence	Analysis in relation to GP at hand
There are a large number of carers in the service catchment area. The Care Act places duty on the public sector.	There is current development work happening within the online app to help identify carers and share information to support carers and signpost to their local groups and services.

DEMOGRAPHICS

There are around 4.8 million carers in England providing care to sick or disabled relatives or friends, or the elderly – Carers UK[48]

ACCESS

Some patients have competing priorities such as carers, parents and guardians. Others have additional access needs such as disabled people who depend on carers' support for mobility, those who need to book professional interpretation services or an advocate (learning disability, deaf and other disabled people plus those who have low English proficiency and depend upon professional interpretation services). It seems probable that people with significant caring responsibilities (a majority of whom are women) may experience problems of access to general practice services

Some members of traveller stakeholder groups have reported difficulty in accessing GP services at convenient times when juggling the conflicting demands of family life. This led some to use out-of-hours GP as their default primary care service, rather than waiting for an appointment with their GP practice.[49]

[47] Report on health and social care perceptions & experiences of lesbian, gay and bisexual people in later life. http://www.healthylives.stonewall.org.uk/lgb-health/older-people/

[48] Carers UK (2014): 'Facts about Carers'

[49] Fair Access for all Gypsies and Travellers in Sussex: GP Services and barriers to primary care (2010) Friends, Families & Travellers

People with significant caring responsibilities (a majority of whom are women) may experience problems difficulty finding a convenient appointment.[50]

Carers from refugee and new migrant carers may not have English as a first language and may require information in appropriate formats, assistance to identify and culturally sensitive support.

Other identified groups Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status (migrants, asylum seekers).

Selected relevant key facts from evidence	Analysis in relation to GP at hand
GP at hand catchment has high number of homeless or rough sleepers.	Specific gains in terms of access from smartphone and without stable home address.
Certain groups like care leavers, students have transient home address.	Online consultation allows for patient to be anywhere in the country and still have remote consultation.
High cohort of young people in catchment and also choosing to utilise the GP at hand service.	Targeted questions and information for young people (in tune with addressing local health priorities for this age group) able to be included in app (in development) and GP interactions.
People with complex needs are advised to seek advice before registering with the service.	GP at hand service is clear about registration/deregistration and informs patients in accessible and easy to understand ways (patient feedback has been included in this process).
The most socio-economically deprived areas have the lowest ratios of GPs and nurses to the population.	GP at hand, unlike physical-first practices, is not reliant on all GPs working in the same areas as their patients live.
Care and management of patient records.	GP at hand is a single practice and the patient records will be on a single practice system (SystmOne). The practice service is subject to all the information governance, data protection and information security rules applicable to any NHS practice.
43% of the English working age population do not understand health information they are given and this rises to 61% when numeracy is involved.[51]	Babylon app includes the functionality for patients to play back their appointment to help foster understanding.
Confusion about entitlements and the need for ID are an ongoing issue in UK primary care. Although an NHS guideline states that the lack of ID should not be a barrier to registering,[52] vulnerable migrants and	GP at hand registration allows this cohort to register online.

[50] 'The Gender and Access to Health Services Study' (2008) Department of Health, Men's Health Forum. University of Bristol

[51] https://hee.nhs.uk/sites/default/files/documents/MECC%20Case%20Study%204%20Synopsis%20-%20Incorporating%20Health%20Literacy%20approaches%20into%20Making%20Every%20Contact%20Count.pdf

[52] NHS England. Patient Registration Standard Operating Principles for Primary Medical Care (General Practice). Leeds: Primary Care Commissioning, 2015.

homeless people are still being refused registration in primary care.	

FEEDBACK FROM CLINCAL REVIEW

GPs from NHS England (London) medical directorate, North West London sustainability and transformation partnership, an independent GP and the heads of primary care for NHS England (NWL) and Hammersmith & Fulham CCG met members of the practice to review the clinical model, governance processes and patient safety aspects of the services in August 2017. The review noted that:

- The service can adequately manage patients who develop complex needs requiring effective coordination with local services near to their home having registered with the service. Whilst we recognise the support given to patients to register elsewhere if their needs cannot be effectively met by the service, it is very important that people registering with the service are made more aware of any limitations of the service from the outset.

- An adequate process is in place for safe prescription request handling for patients who have visited their local hospital and been provided with an outpatient prescription to be handed over to their GP. These prescriptions often require a rapid turnaround for patients.

DEMOGRAPHICS

- 28% of the households in Ealing suffered multiple deprivation i.e. in two or more dimensions. This is higher than in Outer London (25%) and London (26%). It makes Ealing the 18th highest ranked borough nationally in terms of households with multiple deprivation (where 1st is the most deprived borough).
- There are approximately 3,450 rough sleepers across the boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster.
- Westminster (Central London) has the highest number of rough sleepers of anywhere in the country with over 2,570 people being identified in 2014/15 (St. Mungo's Broadway, 2015/16). Westminster has the highest recorded population of rough sleepers of any local authority in the country. This population has higher rates of physical and mental health problems compared to the general population (St. Mungo's Broadway, 2015/16), and are at higher risk of complicating alcohol and or drug dependency (JSNA 2013). Rough sleepers attend accident and emergency approximately seven times more often than the general population, and are also generally subject to emergency admission and prolonged hospital stays more often (ibid.).
- The most deprived areas in England have a lower ratio of GPs and nurses to patients making it more difficult to obtain appointments.[53]
- Patients who experience the most difficulty in getting to see a GP tend to live in the most deprived areas (GP Patient Survey 2014). [54]
- In **Hounslow,** 42% of households have no car
- 6% (1,400) of 11,147 new patients of GP at hand live outside of London (20/01/2018)[55]

[53] NAO Study 2015

[54] See: http://www.rcgp.org.uk/news/2014/june/millions-facing-postcode-lottery-over-gp-appointments.aspx

[55] BMJ Article: Babylon App increases CCG costs 20th January 2018 https://www.bmj.com/bmj/section-pdf/959161?path=/bmj/360/8137/This_Week.full.pdf

- It is estimated that there are about 80,000 sex workers in the UK (with up to 20,000 of them migrants).[56]

- 'Due to lack of knowledge of primary health services, **ex-offenders** on release from prison are part of the large proportion of people using the NHS's urgent healthcare services'.[57]

- The homeless, offenders, the Gypsy and Traveller community and people in some rural communities experience health inequalities. These people are at an additional disadvantage because of the lack of internet access or broadband.

- There is a strong correlation between low levels of digital skills and low levels of health literacy.[58]

- In 2016, of the 11% of households with no internet access, 21% relayed that this was due to lack of skills, further barriers included the equipment costs being too high, and access costs being too high (9%).

YOUNG PEOPLE:

Key issues around young people, in particular those who fall into the 'inclusion health groups', which are important to be mindful of – and for GP at hand service to integrate in their service response to the 18-25 age group:

SUBSTANCE MISUSE – The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues. However, adult services cater predominately to crack and opiate users. Vulnerabilities increase likelihood of young people using drugs and alcohol. Care leavers and victims of domestic abuse, sexual assault and/or sexual exploitation are disproportionately likely to be seen in services, as are people with lower socio-economic status.

Currently, there is a relatively low number of referrals into services through GPs. As substance misuse is relatively common in young adults, although not necessarily identified as problematic, it is important that GPs are comfortable proactively discussing substance and alcohol misuse with young people. Many young adults are not aware that they have an issue until they reach a crisis. GPs must be aware of new trends in substance misuse, such as the emergence of new psychoactive substances. Members of the Westminster Youth Council confirmed many of the points made above, including that cannabis use had become normalised, with many young people believing it was not really illegal and daily expenditure on cannabis of over £20 was common, funded through dealing. The young people consulted as part of this project were not aware of substance misuse services but supported the principle of young adults being treated in appropriate settings.

[56] See: http://www.rcgp.org.uk/news/2013/december/~/media/Files/Policy/A-Z-policy/RCGP-Social-Inclusion-Commissioning-Guide.ashx
[57] See: http://www.medeconomics.co.uk/article/1001873/gp-access-reaches-ex-offenders
[58] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/health-literacy-report.aspx

SEXUAL HEALTH - There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of unplanned pregnancy than the general young adult population.

GANGS and MENTAL HEALTH Research from John Moores University on males aged 18 to 34 years found that those who were gang members had significantly higher levels of mental illness than both men in the general population and non-gang affiliated violent men. Using standardised screening tools, 86% of gang members were identified as having antisocial personality disorder, 67% alcohol dependence, 59% anxiety disorder, 58% drug dependence, 34% suicide attempt, 25% psychosis and 20% depression (Centre for Public Health, 2015).

GP REGISTRATION

Homeless people are 40 times more likely to not be registered with a GP practice than other sections of the general population.[59]

Uptake of GP registration by recent entrants to the UK has been low;[60] less than a third (32.5%) of new entrants to England who are eligible for tuberculosis screening at ports register with a GP.[61]

The biggest barrier to GP registration is the inability to provide paperwork: 39% of registration refusals (out of 849 attempts) were due to lack of ID; 36% to lack of proof of address; and 13% to immigration status[62]. This presents a barrier for **individuals sleeping rough, living in a hostel or other temporary accommodation** where they are unlikely to have utility or bank statement registered to their name. **Asylum seekers and undocumented migrants** are also at risk. These include children, pregnant women, victims of torture, trafficking, domestic and sexual violence.

Engagement and involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

In the development of this EHIA, a range of primary and secondary evidence has been examined to support the analysis. We are also planning future engagement and involvement with additional groups.

Primary evidence includes experiences shared:

- Initial focus groups
- Online comments – in-app reviews
- Facebook Reviews
- Feedback from GP at hand service users

Secondary evidence has been gathered via:

[59] Crisis (2002): 'Critical Condition: Vulnerable Single Homeless People and Access to GPs' See: http://www.crisis.org.uk/data/files/publications/GP_policybrief%5B1%5D.pdf

[60] Stagg HR, Jones J, Bickler G, et al. 'Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study' BMJ Open 2012;2:e001453.

[61] Stagg HR, Jones J, Bickler G, *et al (2012)* 'Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study' *BMJ Open*

[62] 'Registration Refused: A study on access to GP registration in England' (2015) Doctors of the World/Medicins Du Monde

- CCG Annual equality reports
- Healthwatch England (National report of experiences of people's access to primary care services in England, 2015)
- Young People's JSNA
- Local JSNAs

Local groups that are cited in secondary evidence relevant to this EHIA and the GP at hand service include (not limited to):

- Learning Disability Steering group (Hammersmith & Fulham or 3-borough (RBKC, Westminster)
- Westminster Youth Council
- West London LGBT Forum

Potential groups for additional engagement:

Westminster and Kensington & Chelsea:
For 2016/2017 our grants covered the following demographics: children, carers, people with mental health conditions, people with learning disabilities and dementia. A particular highlight has been the creation of a model for accessible PPGs for people with learning disabilities run by the organisation "The Advocacy Project". The 2016/17 projects include the following areas:

Abundance Arts: Wow wellbeing intergenerational community arts and wellbeing project
The project is a unique weekly intergenerational wellbeing project, responding to the needs of vulnerable local people using arts as a tool to engage participants creatively with the wider community, helping to build healthier, stronger, more active communities from the grass roots.
Central London Youth Development Trust: Men's Health Improvement & Empowerment
The project is aimed at BME men, focusing on older men from the Bangladeshi community leaving in the Queen's Park and Paddington area, who are not fluent English speakers.
Dalgarno Trust: VIP Project (Very Important People)
The project aims to support people experiencing social isolation or at risk of isolation/loneliness e.g. carers and care-users, people with different disabilities, people with low-level mental health issues, people from the most disadvantaged and hard to reach groups.
Equal People Mencap: Healthy Living Project
The project will be open to people with learning disabilities, autism, complex needs, mental health needs or physical disabilities and will aim to engage those who may be isolated and need additional support to learn and develop skills and confidence, and to increase knowledge and awareness of healthy living options and opportunities whether through catering or relaxation and exercise.
French African Welfare Association: African Men Health Initiative
The programme is intended to improve the health of African men registered with GPs in the West London CCG area by offering them health related education, and other skills which they might find useful or enjoyable.
Hear Women/GarGar Foundation: Know Your Health
The project is primarily aimed at BME families, especially women, from the African and Arabic Communities who live in North Kensington and North Westminster, specifically 11 around Golborne, Westbourne, Harrow Road, and Queens Park.
MSH Health & Wellbeing Community Interest Company: MSH@Home Companionship Programme
The programme is aimed at people who are at risk of social isolation and loneliness, specifically LGBT residents living in the Queens Park, Paddington and Earls Court areas, in particular those also living with long-term HIV/AIDs.
Woman's Trust: Self-Development Domestic Violence Workshops
This project is aimed at women in the WLCCG area, aged 16+ who experience domestic violence, current or historic regardless of ethnicity.
Youth Projects International: Linking African Young People to Services
The project will address mental health issues with young people from BME communities; it will look at what is mental health, enable young people understand it and be able to seek help early.

We have also secured funding to ensure that we film the successful impact of some of our small grants. These videos will then be used for promotion of services, raising awareness of PPE across WLCCG and also to promote the next round of grants programmes for Sept 2017-2018.

BME Health Forum across Westminster, Kensington and Chelsea, and Hammersmith & Fulham.

How have you engaged stakeholders in testing the service development and proposals?

- In-app ratings provide real-time feedback (200 ratings in May 2018)
- Facebook reviews
- UX testing via hundreds of individuals prior to main product launches
- Comments and feedback mechanisms (online, email, website, etc)
- GP patient survey

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Of 200 in app ratings made in May 2018, 176 were for the full 5 stars (positive) with many praising the approach of the consultant GP and swiftness/accessibility of the service. This is a small fraction of the total of sample of 21,015 5-star ratings (88% of all the GP at hand ratings received for digital appointments as of 11/7/18)

Facebook reviews of GP at Hand: https://en-gb.facebook.com/GPathand/

The service recently received the following feedback from an advocate for the trans community:

"We're hearing initial reports that your GP at hand service are knowledgeable and experienced with trans issues, and following the relevant medical guidelines (Royal College of Psychiatrists cr181 and the GMC guidance here https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare#mental-health-and-bridging-prescriptions) correctly with respect to bridging prescriptions (a rarity for a GP service)."

Summary of analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts. If so, state whether adverse or positive and for which groups and/or individuals.

Overall the GP at hand service **advances** equality of access to GP services for some groups, especially in the areas of obtaining an appointment and getting to an appointment. Some gains have also been made within primary care interaction.

Despite the improvements that the service offers over traditional general practice, there remain some equalities risks that we are aware of and are taking action to mitigate against (as detailed in the equalities matrix) specifically related to those sharing the following protected characteristics:

- Age (both **old and young age groups**, ensuring good participation and representation from **men)**
- Disability (including **people with multiple long-term conditions, learning disabilities and mental health conditions**
- Race (**Asian – particularly Pakistani and Bengali communities, Black and minority ethnic communities, and new migrants**, **non-English speakers** and **Gypsies and Travellers**)
- Religion and belief (particularly **minority faith groups** to understand prevalent health beliefs)
- Carers including **young and older carers**, and **parents of disabled children**
- Social deprivation (especially **those living in areas of high economic deprivation**)

How you will mitigate any negative impacts?
We have made a recommendation 'long list' through the EHIA process and will prioritise areas for action on the basis of this.

How you will include certain protected groups in services or expand their participation in public life?
We will continue to strengthen PPG and engagement.

Now consider and detail below how GP at hand will eliminate discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

GP at hand will continue to do this through staff training, surveys, handling complaints, existing equalities policies etc and a commitment to the EDS2 process.

Advance equality of opportunity

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

See high level equalities matrix.

In relation to patient experience, positive feedback has been received from:

- young people
- disabled people (mobility, mental health conditions which may make it difficult to leave the house)
- people with long-term conditions
- people who identify as transgender.

Promote good relations between groups

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

We have identified opportunities to foster and promote good relations via the way we advertise services and the channels we use (e.g. student papers - https://thetab.com/author/babylon)

Evidence-based decision-making

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to eliminate discrimination issues, partnership working with stakeholders and data gaps that need to be addressed through further consultation or research.

An equalities action plan is currently under discussion. This will integrate actions relating to the EDS2 summary report. The action plan is being developed based on our recommendation 'long list' through the EHIA process and we will prioritise areas for action on the basis of this.

In addition, and as part of the commitment to the EDS, we will continue to engage with:

- Relevant local Healthwatch and recommended groups within the catchment area of GP at hand
- PPG group for the practice: plans are being developed to further strengthen the Patient Participation Group, with more digital interaction, in an effort to increase the membership, level of involvement and inclusion/representation (including by groups sharing protected characteristics).

How will you share the findings of the equality analysis? This can include corporate governance, other directorates, partner organisations and the public.

To support transparency of decision-making, it is important that the findings of the equality analysis are shared with key stakeholders. These will be presented in a number of ways to take account of different stakeholder groups:

- Shared with the equalities lead and specific commissioners for assurance purposes
- Shared with participants at the EDS workshop

3 Health Inequalities Analysis

Evidence

1. What evidence have you considered to determine what local and national health inequalities exist in relation to your work? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other equality analyses. If there are gaps in evidence, state what you will do to mitigate them in the evidence-based decision-making section on the last page of this template.

We are committed to working in partnership with all organisations across the catchment area to address health **inequalities**.

The chart below shows the protected characteristics and national health and wellbeing issues to consider alongside local health inequalities. This chart is included in all five CWHHE annual equality reports:

Age (Older adults)	Diagnoses and management of Long Term Conditions including dementia. Social isolation; falls (65 years+); flu vaccination (65 years+); excess weight (35 years +); preventable sight loss (AMD). Reliance on carers, the Community Voluntary Sector and adult safeguarding and supported accommodation.
Disability	Excess weight; LD and smoking; LD and screening uptake. Increase in safeguarding enquiries and social care assessments. Supported accommodation needs.
Gender reassignment	A small number of residents identify themselves as transgender, international evidence suggests a vulnerable population with mental health needs and a higher risk of cardiovascular disease.[1]
Marriage and civil partnership	National evidence suggests marriage or civil partnership is a protective factor against risk taking behaviours[2], and long term conditions including mental health. However These are only where the relationship is a supportive one. Poor relationships affect the adults concerned and any children that they care for[3].
Pregnancy and maternity	Giving children the best start in life, tackling low birth weight, and maternal mental wellbeing. Appropriate contraception services, and reduction in terminations.
Race	Vegetable consumption; Excess weight; Diabetes and Coronary Heart Disease[4], TB. Asylum seeker and travellers needs. Hat crime, Sexually Transmitted Diseases[5].
Religion or belief	International reports that some religious groups are correlated with higher prevalence of Cardiovascular disease and diabetes, however they have not factored in the relationship between religion and ethnicity[6]. There is some national evidence that suggests a link between smoking and religious group.
Sex	Females: MusculoSkeletal related injuries, Violence Women and Girls, employment, FGM, Cervical screening, respiratory mortality. Males: School attainment, Cardiovascular disease mortality; Mental Health, Emergency readmission to hospital
Sexual orientation	National evidence for LGBT people suggests higher rates of HIV, smoking drug and alcohol use, and an observed reluctance to engage with primary care[6].

Dhejne,C., Boman,M.,Johansson,A.,Langstrom,N.andLanden,M.(2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PloS ONE,6,(2).
Murphy M. Family living arrangements and health. In: Office for National Statistics. (Ed.) Focus on families. Hampshire: Palgrave Macmillan; 2007
Mooney A, Oliver C, Smith M. Impact of family breakdown on children's well-being: evidence review. London: Department for Children, Schools and Families (RB113); 2009
British Heart Foundation (2010) Ethnic Differences in Cardiovascular Disease. Available from http://www.bhf.org.uk/publications/view-publication.aspx?ps=1001549. (Internet 2014).
Aspinall, PJ. (2014). (Centre for Health Services Studies, University of Kent). Hidden Needs. Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and ex Worker; Inclusion Health 2014.
The Scottish Government . Scotland. Equally Well: Report of the Ministerial Task Force on Health Inequalities (2008) Available from http://www.scotland.gov.uk/Publications/2008/06/25104032/4 and www.phoutcomes.info
Williams,H.Varney,J.,Taylor,J.,Fish,J.,Durr,P., and Elan-Cane ( ) The Lesbian, Gay, Bisexual and Trans.Public Health Outcomes Framework Companion Document. UK: Department of Health and Public Health England.

Jan – Feb 2018: **key areas of business** led by the chief officer in the CWHHE clinical commissioning groups. CWHHE comprises NHS Central London, NHS West London, NHS Hammersmith & Fulham, NHS Hounslow, and NHS Ealing CCGs. The report is a standard report across the five CCGs.

With a focus on these key areas of business, GP at hand has identified the following areas which will have the most impact on health inequalities across the boroughs.

Delivery Area 1 – Improving Health and Wellbeing
Rollout of the national Making Every Contact Count programme (MECC).

The MECC training has been extended for a further six months to enable further roll across NW London. Making Every Contact Count supports clinical and non-clinical staff in their day-to-day interactions with the wider NW London public. This is to encourage behavioural changes that have a positive effect on the health and wellbeing of individuals, communities and populations. Training has taken place in Central London, West London, Hammersmith & Fulham, Brent, Harrow and Hounslow. The team is working with the maternity transformation team to develop tailored antenatal MECC training specific for staff caring for pregnant women. The aim of this is to promote healthier lifestyles, for pregnant women and their children.

Physical activity – a local push on encouraging people to engage in physical activity is taking place through 2018/19 (links to better care for self-care, diabetes, project 1,4).

Delivery Area 2 – Better care for people with long term conditions:
Diabetes The diabetes transformation programme is delivering to 4 key projects. £2.3 million funding has been awarded by NHS England to prime the programme, recognising that the benefits will be realised over a longer timescale. A full business case has been developed that is being considered by the CCGs. This is being incorporated into 2018/19 QIPP programmes and is made up of:

- Project 1 – Increasing uptake of structured education so people with diabetes understand and can manage their condition
- Project 2 – Reducing unwarranted variation in the 3 treatment targets of HbA1c, blood pressure and cholesterol
- Project 3 – Reducing amputations by improving access to the multi-disciplinary diabetes foot team
- Project 4 – Implementing 'Healthier You: the NHS Diabetes Prevention Programme' (Type 2 diabetes)

Digital Self Care
All eight CCGs have agreed to implement the myCOPD digital tool in 2018/19, which helps to enable patients to self-manage their condition. A total of 4,852 licences have been secured through NHS England Innovation in Technology Tariff (enough to cater for 20% of those recorded as having COPD).

Evaluation of the diabetes digital apps showed average weight change for participating patients of 3 to 4kg and an average hbA1c reduction of 6-8 mmol/mol. These are significant positive changes in managing a person's diabetes. In addition, focus group feedback from trial participants was positive.

The Patient Activation Measurement (PAM) assessment tool helps to assess someone's ability to self-care. PAM activity for quarter three totals 8,578 across NW London, bringing the total assessments to more than 15,000. The January PAM report for CWHHE CCGs showed strong activity for Hounslow (550) and West London (240). NHS England PAM plans for 18-19 have now been submitted for NW London (58,000 target).

The GP at hand service will support the local priorities to address health inequalities with three areas being examples: Making Every Contact Count, encouraging physical activity, better care for people with long-term conditions (diabetes education and prevention) and promoting digital self-care tools.

Impact

2. What is the potential impact of your work on health inequalities? Can you demonstrate through evidence-based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

Please see detailed evidence set out in this document.

3. How can you make sure that your work has the best chance of reducing health inequalities?

Promotion of the service

- Following this EHIA, GP at hand will review its approach to ensure that it responds to the needs and preferences of groups where the opportunity to further reduce inequalities has been identified as greatest.
- The use of social media and online advertising can proactively target forums and groups where those from protected characteristics groups communicate and gather information.

Partnership with other healthcare providers

- Engagement with acute trusts to foster partnerships which promote GP at Hand as an alternative to emergency care services for those who access them inappropriately.

Partnership with commissioners

- GP at hand will continue to foster a collaborative approach with commissioners to explore how the service can support achievement of local equality objectives and action plans (including addressing local health inequalities).

Monitor and Evaluation

4. How will you monitor and evaluate the effect of your work on health inequalities?

Through the EDS2 process.

At present, the GP at hand service gathers data and monitors in several ways, including:

- When patients register with the service, they are required to complete the GMS1 form, which gives the service basic demographics
- Asking users of the service for their feedback on their experience
    - of the chatbot
    - of digital consultations
    - of physical consultations

As part of these processes, GP at hand will undertake data analysis at key points in the year to provide a snapshot of the changing mix of patients accessing the service. This will be mapped against local demographics.

In addition, service feedback will be reviewed to identify any trends with regard to equality concerns.

As also described above, plans are being developed to further strengthen the Patient Participation Group, with more digital interaction, in an effort to increase the membership, level of involvement and inclusion/representation (including by groups sharing protected characteristics).

EDS2 mapping will be integrated into the work that GP at hand undertake on an ongoing basis, with regular reviews built in. Our view is that using the EDS2 process and the four goals demonstrates our commitment to showing 'due regard' to equality and by extension address health inequalities.

The main purpose of the EDS is defined *"to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED)."* We believe GP at hand will be the first practice in the country to do this.

For your records

Name of person(s) who carried out these analyses:

Verve Communications Ltd

Name of sponsor director: Paul Bate (on behalf of GP at hand Partnership)

Date analyses were completed: 11 July 2018

Review date: 11 July 2019