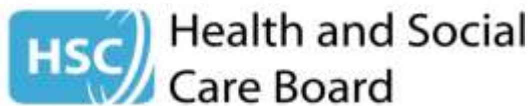


Equality, Good Relations and Human Rights SCREENING

The Health and Social Care Board is required to consider the likely equality implications of any policies or decisions. In particular it is asked to consider:

1) What is the likely impact on equality of opportunity for those affected by this policy, for each of the section 75 equality categories? (minor, major or none)

2) Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

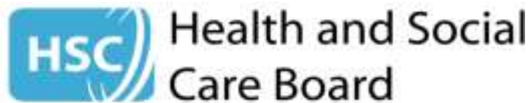
3) To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor, major or none)

4) Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

For information (evidence, data, research etc) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website:
http://www.hscbusiness.hscni.net/services/1798.htm



Equality, Good Relations and Human Rights
<u>SCREENING TEMPLATE</u>

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

The Northern Ireland Regional Point-of-Care Testing (POCT) Policy

1.2 Description of policy or decision

Introduction

In January 2019, the NI Pathology Network Board agreed that all HSC Organisations will adopt and implement new regional policies and procedures approved by the Network Board. This decision is in line with the Department of Health (DoH) policy on Pathology Transformation and approved by all HSC Trust Chief Executives.

The policy set out in this document also represents the strategic direction of travel for Pathology Services as a whole across Northern Ireland. A programme of regionalisation is currently underway, with numerous regional policies which may require equality screening. As part of this programme, the POCT Specialty Forum (which is a formal group of subject matter experts established by the NI Pathology Network) has identified the need for a regional POCT policy.

The policy has been drawn up and reviewed in light of the statutory obligations contained within Section 75 of the Northern Ireland Act (1998). In line with the statutory duty of equality, this policy has been screened against particular criteria. If at any stage of the life of the policy there are any issues within the policy which are perceived by any party as creating adverse impacts on any of the groups under Section 75, that party should bring these to the attention of the NI Pathology Network.

Purpose of this Policy
The purpose of the Policy is to ensure that POCT is effectively managed across all HSC Organisations so as to maximize the clinical benefit of POCT in patient care and to limit the risks to patients and staff associated with its use.

Objectives / Elements of this Policy
It will ensure that POCT systems in all HSC Organisations are managed in accordance with national/international best practice guidelines and accreditation standards, in particular ISO 15189:2012 (Medical Laboratories - Requirements for quality and competence)[2] and ISO 22870:2016 (Point-of-Care Testing [POCT] – Requirements for quality and competence).

Scope of Policy
This policy applies to all HSC staff undertaking or having responsibility for POCT and to all Departments and Services in which POCT is undertaken. This policy refers exclusively to POCT undertaken in a hospital or community using equipment procured by HSC Organisations and undertaken by HSC staff. Patient self-testing falls out with the scope of this policy.

What is Point-of-Care Testing (POCT)
Point-of-Care Testing (POCT) is any test performed for a patient by a healthcare professional outside the conventional laboratory setting. Other terms commonly used to describe POCT include:

- near patient testing (NPT)
- bedside testing
- extra-laboratory testing
- disseminated / decentralised laboratory testing

Over the years there has been a continual rise in the use of POCT due to the drive to improve patient pathways and as a result of technological advances.

POCT may be performed in a variety of locations such as acute units in secondary care and, increasingly, in the community and primary care. POCT must be performed by staff whose training and competence has been established and recorded. The reason for this is to protect the patient, and ensure the quality of the service is appropriate to the clinical setting. This is applicable to all providers of POCT services.

As stated above, POCT can be carried out in a wide variety of settings. The following list is not exhaustive but serves to illustrate the variety of locations.

Secondary care (in hospital)

- A&E departments

- ambulance service
- cardiac units
- coagulation clinics
- dental clinics and hospitals
- diabetic clinics
- hospital wards
- intensive treatment units
- liver units
- neonatal units
- occupational health departments
- operating theatres
- out-patient departments
- renal units

Primary care (in the community)
- co-located commercial sites
- community clinics
- community pharmacies
- GP surgeries
- health centres
- independent sector
- industrial medical centres
- mobile units
- polyclinics – diagnostic centres
- sexual health clinics/GUM clinics
- dental surgeries
- residential settings

Before deciding whether to implement POCT it is essential to:
- establish a clinical need
- consider the benefit to patients of introducing POCT

In many cases improving the patient pathway and experience could be major considerations when introducing POCT. As regards clinical need, this should be based on establishing that the perceived need is valid. POCT must deliver an equivalent level of quality and clinical effectiveness as the alternative. Users should also keep under review the continuing clinical need for POCT.

Main health conditions/applications where POCT is used:
POCT can be performed for a patient by a healthcare professional outside the conventional laboratory setting for any health condition/application if deemed appropriate do to so, for example:
- Monitoring glucose and ketone levels in diabetics

- Testing urine for pregnancy
- Testing urine for protein, glucose, blood, leucocytes to screen for illness.
- Monitoring INR in those on warfarin
- Monitoring blood gas results in those with respiratory conditions (COPD, respiratory infection) or metabolic conditions (DKA) or investigation those acutely unwell

Some benefits of POCT for the Organisation and Staff

- Reduced number of clinic visits
- Earlier discharge from hospital
- Fewer unnecessary hospital admissions
- Optimised drug treatment
- More appropriate use of drugs
- Reduced use of blood products
- Reduced use of staff, equipment and space

Potential advantages for the Organisation and Staff

- Improved turnaround time – mainly by shortening the pre- and post-analytical steps.
- Potential for better monitoring of certain conditions and where frequent testing is desirable.
- Smaller sample and reagent volumes – POCT methods may be less clinically invasive.
- Advantageous in remote areas where access to a laboratory is limited.
- POCT may offer an easier to access service e.g. for the elderly.
- Economic – although POCT is generally more expensive than laboratory testing, it may offer wider economic benefits with a reduced number of clinic visits, reduced length of stay in hospital and fewer hospital admissions.
- Greater patient involvement in their own care.
- Improved patient experience.
- Availability outside normal laboratory core hours.
- Opportunity for ward staff to develop additional skills and experience

Potential disadvantages for the Organisation and Staff

- Poor quality of analysis.
- Poor record keeping.
- Lack of result interpretation.
- Unnecessary duplication of equipment.
- Failure to detect erroneous results.
- The availability of an array of tests may tempt users to perform unnecessary or inappropriate testing.

Benefits and disadvantages for the Patient

Benefits

- Improved patient experience
- Quicker turnaround of results
- Reduce unnecessary anxiety / stress
- Reduced number of clinic visits
- Earlier discharge from hospital
- Fewer unnecessary hospital admissions

Disadvantages

- Poor quality of analysis which may result in repeat tests required or laboratory analysis and longer wait times for results. E.g. potassium may be due to haemolysed sample and falsely raised.
- False positive or false negative result e.g. pregnancy testing
- Result may not be on the patient electronic record if test not connected or patient identifier not used.

1.3 Main stakeholders affected (internal and external)

Patients

A POCT test can be performed on all patients and within all age ranges. As highlighted above there are various advantages and disadvantages for patients when considering a POCT test.

Staff of POCT

Users (i.e. doctors, nurses, pathology staff) of POCT should have a sound understanding of the relevant analytical principles, and of issues such as quality assurance (QA), interpretation of test results, limitations to use and liability issues. It is therefore important that users of POCT should have access to clear guidance on these and other issues relating to the management of POCT. This new regional policy will play a pivotal role in the management of POCT across Northern Ireland.

1.4 Other policies or decisions with a bearing on this policy or decision

All Trusts must develop, implement and enforce a policy for the control of POCT. The following list is not exhaustive but serves to illustrate the variety of other relevant guidance etc.

- MHRA - Management and Use of IVD Point of Care Test Devices
- British Standard EN ISO 15189:2012 (Medical Laboratories - Requirements for quality and competence)
- British Standard ISO 22870:2016 (Point-of-Care Testing [POCT] –

Requirements for quality and competence)

- Department of Health Advisory Committee on Dangerous Pathogens (2003) Infection at work controlling the risk
- Department of Health, London, Health Services Advisory Committee (2003) Safe working and the prevention of infection in clinical laboratories and similar facilities
- Health and Safety Executive, Control of Substances Hazardous to Health (COSHH) 2002
- The Health and Safety at Work Act (1987)

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

- An extensive pre-consultation exercise was undertaken with key stakeholders from the POCT Specialty Forum (See Appendix 1).
- HSC Workforce Census
- HSC staff equality data
- Census 2011
- Further sources of data are referenced in 2.2 below.

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Category	***What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	Bearing in mind that in principle POCT can be performed for a patient for any health condition/application, in relation to some of the main examples outlined above (1.2), differential gender profiles of patients impacted can reasonably be assumed for the following: • Monitoring glucose and ketone levels in diabetics. • Testing urine for pregnancy - vast majority female (with potentially some transgender male patients). • Monitoring INR in those on warfarin. • Monitoring blood gas results in those with respiratory conditions (COPD, respiratory infection) or metabolic conditions (DKA) or investigation those acutely unwell. **Gender information from NI HSC Workforce Census 2015** • 74% of all HSC staff were female • 54% of HSC staff (by headcount) work full-time

	https://www.dhsspsni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-census-march-2015 **Gender information from Pathology Services Section 75 Data** • 64% are female • 73% work full time In comparison to the HSC as a whole, Pathology services have fewer female workers and fewer part time staff. Data on the number of female part time workers was unavailable.
Age	Bearing in mind that in principle POCT can be performed for a patient for any health condition/application, in relation to some of the main examples outlined above (1.2.), differential age profiles of patients impacted can reasonably be assumed for the following: • Monitoring glucose and ketone levels in diabetics. • Testing urine for pregnancy. • Monitoring INR in those on warfarin. • Monitoring blood gas results in those with respiratory. conditions (COPD, respiratory infection) or metabolic conditions (DKA) or investigation those acutely unwell. **Age information from NI HSC Workforce Census 2015** • 39% of all HSC Staff were under the age of 40 • 29% were aged between 40 and 49 • 32% were aged 50 and over **https://www.dhsspsni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-census-march-2015** **Age information from Pathology Services Section 75 Data** • 5% were under the age of 25 • 28% were under the age of 35 • 67% were aged 50 and over In comparison to the HSC as a whole, Pathology services have a higher proportion of workers aged 50 and over.
Religion	**Religion information from 2011 census** • 36% were Protestant • 41% were Roman Catholic • 23% were other or unknown

	Religion information from Pathology Services Section 75 Data • 44% were Protestant • 39% were Roman Catholic • 17% were other or unknown Pathology services are generally reflective of 2011 census data.
Political Opinion	**Political Opinion information from Pathology Services Section 75 Data** • 10% were Broadly Unionist • 7% were Broadly Nationalists • 83% were other or unknown There is no census data available to draw a comparison.
Marital Status	**Marital Status information from 2011 census** • 47.6% of those aged 16 and over were married • 36.1% were single • 0.1% were registered in same-sex civil partnerships • 9.4% were either divorced, separated of formerly in a same-sex relationship • 6.8% were either widowed or a surviving partner https://www.nisra.gov.uk/demography/default.asp11.htm **Marital Status information from Pathology Services Section 75 Data** • 53% were married • 35% were single • 12% were other or unknown Pathology services are reflective of 2011 census data
Dependent Status	**Dependent Status information from 2011 census and CarersNI** • 11.81% (213, 863) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill – health/disabilities or problems related to old age. • 3.11% (56, 318) provided 50 hours care or more. • 33.86% (238, 129) of households contained dependent children. • 40.29% (283, 350) contained a least one person with a long

	– term health problem or a disability. (Census 2011) • 1 in every 8 adults is a carer • 2% of 0-17 year olds are carers, based on the 2011 Census • There are approximately 220,000 carers in Northern Ireland (• One quarter of all carers provide over 50 hours of care per week • People providing high levels of care are twice as likely to be permanently sick or disabled than the average person • 64% of carers are women; 36% are men. • (CarersNI) **Dependent Status information from Pathology Services Section 75 Data** • 25% reported Yes • 24% reported No • 51% were unknown It is important to note that the available figures are not explanatory of the nature of the dependent (i.e. parent or carer)
Disability	**Disability information from 2011 census** • 20.69% (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities. • 68.57% (1, 241709) of residents did not have long – term health condition. • Deafness or partial hearing loss – 5.14% (93, 078) • Blindness or partial sight loss – 1.7% (30, 785) • Communication Difficulty – 1.65% (29, 879) • Mobility or Dexterity Difficulty – 11.44% (207, 163) • A learning, intellectual, social or behavioural difficulty - 2.22% (40, 201) • An emotional, psychological or mental health condition - 5.83% (105, 573) • Long – term pain or discomfort – 10.10% (182, 897) • Shortness of breath or difficulty breathing – 8.72% (157, 907) • Frequent confusion or memory loss – 1.97% (35, 674) • A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy. – 6.55% (118, 612)

	• Other condition – 5.22% (94, 527) • No Condition – 68.57% (1, 241, 709) • (Census 2011) It can reasonably be assumed that the share of patients with a disability is significantly higher amongst those receiving POCT than in the general population. **Disability information from Pathology Services Section 75 Data** • 3% reported Yes • 62% reported No • 35% were unknown It is important to note that the prevalence of disability amongst HSC workforce may be under reported.
Ethnicity	Bearing in mind that in principle POCT can be performed for a patient for any health condition/application, in relation to some of the main examples outlined above (1.2.), differential ethnic profiles of patients impacted can reasonably be assumed for the following: • Monitoring glucose and ketone levels in diabetics. • Testing urine for pregnancy • Monitoring INR in those on warfarin • Monitoring blood gas results in those with respiratory conditions (COPD, respiratory infection) or metabolic conditions (DKA) or investigation those acutely unwell **Ethnicity information from 2011 census** • 1.8% of the NI population belonged to a monitory ethnic group. **Ethnicity information from Pathology Services Section 75 Data** • 75% were White • 2% were other which included minority ethnic groups • 23% were unknown Pathology services are reflective of 2011 census data
Sexual Orientation	Accurate figures are not readily available but it is estimated that 5-7% of the population are from the gay and lesbian or bisexual community.

	Sexual Orientation information from Pathology Services Section 75 Data
	Sexual Orientation information from Pathology Services Section 75 Data • 46% reported being attracted to the opposite sex • 2% reported other • 52% were unknown

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	***Needs and Experiences***
Gender	**Patients** There is no qualitative data to indicate there would be any impact.
Age	**Patients** POCT may have benefits for certain age ranges e.g. children and elderly as it may mean less waiting times and hospital appointments.
Religion	**Patients** There is no qualitative data to indicate particular needs on the basis of religion.
Political Opinion	**Patients** There is no qualitative data to indicate particular needs on the basis of political opinion.
Marital Status	**Patients** There is no qualitative data to indicate particular needs on the basis of marital status.
Dependent Status	**Patients** There is no qualitative data to indicate particular needs on the basis of dependent status.
Disability	**Patients** POCT may have benefits for certain disabilities e.g. Chronic illness or learning disability as it may mean less waiting times and hospital appointments.
Ethnicity	**Patients** There is no qualitative data to indicate there would be any impact.
Sexual Orientation	**Patients** There is no qualitative data to indicate particular needs on the basis of sexual orientation.

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

The issues of multiple identities are important. In relation to this policy the Health & Social Care Board (HSCB) will ensure that equality categories are not considered in isolation.

2.5 Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Based on the issues identified in 2.2. and 2.3, the POCT Specialty Forum did not need to change or address any issues that would indicate there would be any impact on patients or staff due to this regional policy.	The POCT Specialty Forum is committed to the promotion of equality of opportunity for staff and patients. In future and if deemed to do so, relevant groups will be engaged when monitoring and reviewing this policy. If at any stage of the life of the policy there are any issues within the policy which are perceived by any party as creating adverse impacts on any of the groups under Section 75, that party should bring these to the attention of the NI Pathology Network.

2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	*Impact*	*Suggestions*
Religion	n/a	n/a
Political Opinion	n/a	n/a
Ethnicity	n/a	n/a

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	x
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	x

The information provided in section 2.1 to 2.5 above sets out potential equality implications for relevant Section 75 groups. The information also outlines the actions the POCT Specialty Forum has taken or plans to take to mitigate against any of the potential implications associated with the policy.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	*What else could you do to encourage disabled people to participate in public life?*
There are no additional measures considered relevant in the context of the policy over and above the considerations set out in relation to the Section 75 group on 2.2 & 2.3 above.	The POCT Specialty Forum is committed to the promotion of equality of opportunity for disabled people. In future and if deemed to do so, relevant groups will be engaged when monitoring and reviewing this policy.

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	*What else could you do to promote positive attitudes towards disabled people?*
There are no additional measures considered relevant in the context of the policy over and above the considerations set out in relation to the Section 75 group on 2.2 & 2.3 above.	N/A

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Are Human Rights relevant? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	There is no evidence to indicate there would be any impact
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	There may be impact following the outcomes from incidents.
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	There is no evidence to indicate there would be any impact
Article 5 – Right to liberty & security of person	There is no evidence to indicate there would be any impact
Article 6 – Right to a fair & public trial within a reasonable time	There is no evidence to indicate there would be any impact
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	There is no evidence to indicate there would be any impact
Article 8 – Right to respect for private & family life, home and correspondence.	There is no evidence to indicate there would be any impact
Article 9 – Right to freedom of thought, conscience & religion	There is no evidence to indicate there would be any impact
Article 10 – Right to freedom of expression	There is no evidence to indicate there would be any impact
Article 11 – Right to freedom of assembly & association	There is no evidence to indicate there would be any impact
Article 12 – Right to marry & found a family	There is no evidence to indicate there would be any impact
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	There is no evidence to indicate there would be any impact
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	There is no evidence to indicate there would be any

	impact
1st protocol Article 2 – Right of access to education	There is no evidence to indicate there would be any impact

If you have answered no to all of the above please move onto to move on to ***Question 6*** *on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision have a potential positive impact or does it potentially interfere with anyone's Human Rights?

List the Article Number	Positive impact or potential interference?	How?	Does this raise any legal issues?* Yes/No
Article 3	Positive impact	Patients receive quicker access to pathology services which may result in improved patient pathways in terms of diagnosis and treatment.	No

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

N/A

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights?

Equality & Good Relations	Disability Duties	Human Rights
POCT SF will consider collecting relevant data in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights). For example, patient experience in relation to gender, age and disability.	N/A	N/A

Approved Lead Officer: Dr Derek McKillop

Position: NI Pathology Network POCT Specialty Forum Chair & Consultant Clinical Scientist, SEHSCT

Policy/Decision Screened by: Ronan Strain, Senior Project Manager NI Pathology Network

Signed: *Derek McKillop / Ronan Strain*
Date: 04.05.2021

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality

Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

Please forward completed template to:
Equality.Unit@hscni.net

Template produced November 2011
If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 95363961 (for Text Relay prefix with 18001); fax: 028 9023 2304

Appendix 1 – POCT Specialty Forum stakeholders

Name	HSC Trust
Derek McKillop (Chair)	South Eastern HSC Trust
Ciara Strain	Southern HSC Trust
Elinor Hanna	Northern HSC Trust
Emma Reilly	Belfast HSC Trust
Gareth McKeeman	Belfast HSC Trust
Gerard Duffy	Northern HSC Trust
Jeremy Neely	Belfast HSC Trust
Kathy Ryan	Western HSC Trust
Mark Lynch	Western HSC Trust
Marnie Dodd	South Eastern HSC Trust

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