Equality and Human Rights Screening Template

The BSO is required to address the 4 questions below in relation to all its policies.

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/none)

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

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/none)

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

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

For advice and support on screening contact:
Equality Unit, Business Services Organisation
2 Franklin Street, Belfast BT2 8DQ

Tel: 028 9536 3961
email: Equality.Unit@hscni.net

SCREENING TEMPLATE

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.

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision paper

Digital Identify Programme

1.2 Description of policy or decision

The Health and Social Care of Northern Ireland (HSCNI) Business Services Organisation (BSO) are in the process of developing the Digital Identity Service (DIS) for the replacement of the current regional HCN (Health Care Number Index) and NHAIS (National Health Authority Information Index) applications with one system which will provide a unique digital identity and registration management for all users of HSC services.
HSCNI Business Services Organisations (BSO) manage The Health Care Number Index (HCNI) database which allocates the HSCNI unique patient identifier to all HSCNI Service Users, this combined with NHAIS which has live links to the HCN index and GP systems will be used to form the structure of the new DIS.
Key constraints will be completing the project within the timescale given and the potential use and source of extra dataset items such as telephone number, email address, transgender, ethnicity and disability. The more information collected for each service user will assist the matching function of DIS in securing a unique identity. This new system will bring benefits of improved clinical care, risk and inequality reduction, with the capability to support wider organisational change taking place within HSCNI.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

Staff at HCN and FPS and also the general public

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

The prime objective is to replace the two end of life systems (HCN Index and NHAIS). The current Service is a mixture of systems, people and processes which have been developed over 13 years.

- This project will deliver a new Digital Identity Service for HSCNI which will utilize a Master Data Management (MDM) solution to replace and transform the two key systems and integrate the supporting services which have been developed as service improvements in the interim period since its initial implementation. This will consolidate and simplify how patient identity and patient information is managed and shared throughout the HSCNI services.
- FPS (NHAIS) and DQT (HCN) current business process rely on this information to make a more informed decision on duplication; the more information they collect will aid their response. Therefore it is key we gain the appropriate measures to ensure equality of full data collection. The DIS programme will provide functional training of new system, but trust end users should still follow there mandatory Information Governance training on data collection

Draft NI Programme for Government 2016-21
“Transforming Your Care”, a review of Health and Social Care in NI (DoH, 2011)
‘Quality 2020’, a 10-year strategy to Protect and Improve Quality in Health and Social Care in NI (DoH, 2011)
‘Making Life Better’: a whole system strategic framework for public health 2013-2023 (DoH, 2016)
Health and Wellbeing 2026: ‘Delivering Together’ (DoH, 2016)
BSO Service Offerings and Service Level Agreements

(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.

Census 2011

Equality Commission NI, 2006

http://www.carersuk.org/northernireland/news-ni/facts-and-figures

McBride, R.S. (2014) "Grasping the nettle: the experiences of gender variant

children and young people living in Northern Ireland" Institute for Conflict

Research, Belfast

GIRES. The Number of Gender Variant People in the UK - Update 2011. Available at

http://www.gires.org.uk/prevalence.php)

http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health.htm -

Health Survey NI 2012-13

Electoral Office NI, 2011

Northern Ireland Statistics and Research Agency (NISRA) 2007

Workforce Data (HRPTS)

BSO Customer Satisfaction Surveys 2017-19. Northern Ireland Health and

Social Care Workforce Census March 2021.

Annual Population Survey

https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016#main-points)

Health Alliance. Available http://healthallianceni.com/health-social-wellbeing/bme-groups/

National Institute for Health and Care Excellence (NICE). (2017) ***Health and social care directorate - Quality standards and indicators: Briefing paper*****. (Available at**: https://tinyurl.com/y33hhr42.)

DIS will engage with the wider stakeholders through a range of groups within the trust demographics improvement group, this aims at developing a HSC core demographic dataset across HSC DIG – The key

purpose of the Regional Demographic Improvement Group is to identify a regional approach to the management and sharing of Patient Client Demographic data. The group will advise the Digital Identity Service on the requirements for the regional HSC demographic dataset that meets the needs of all sectors of the HSCNI and enhances the HSCNI's ability to achieve true interoperability between our clinical and information systems as close to real time as is possible.
The group will advise and support the Information Standards Group and Digital Identity Service Programme on:

*** The development of a HSC Core Demographic Dataset across the HSC;**
*** The development of robust data quality management function covering all HSC information systems;**
*** The development of regional Demographic Data Quality and Standards to manage the electronic sharing of information and systems interoperability.**

These items in the future will include extra items such as patient telephone number, email address, gender to be known as (a classification of the gender in person self-declared or inferred by observation for those to declare their person stated gender), Ethnicity (subjective to the person based on common cultural tradition geographical origin descent language and religion) Disability(based on the equality act and access to services)

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. Also give consideration to multiple identities.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	**Population**: Mid-year population estimate (2018; published June 2019): The size of the resident population in Northern Ireland at 30 June 2018 is estimated to be 1.88 million people. Just over half (50.8 per cent) of the population were female, with 955,400 females compared to 926,200 males (49.2 per cent). With regards to the numbers of transgender individuals, The Gender Identity Research and Education Society (GIRES)

	assembled estimates for the Home Office (2011) and subsequently updated (2014):estimate the number of gender nonconforming employees and service users, based on the information that GIRES • gender variant to some degree 1% • have sought some medical care 0.025% • having already undergone transition 0.015% Applying GIRES estimates to NI population (using NISRA mid-year population estimates for June 2019) N=1,881,600 (approx.) suggests that: • 18,816 people who do not identify with gender assigned to them at birth • 470 likely to have sought medical care • 282 likely to have undergone transition. **Staff** (includes aggregated data for all 6 HSC Organisations (includes NI Ambulance Service and Business Services Organisation): The most recent HSC Census shows that a substantial majority (78% or 56,476) of HSC employees were female and 57% of females worked full-time.
Age	**Population** Mid-year population estimates published by NISRA show that: 0-19 yrs (inclusive) = 485,064 (25.7% of all NI population) 20 – 34 yrs = 364,623 (19.3%) 35 – 49 yrs = 366,967 (19.5%) 50 - 64 yrs = 356,790 (19.0%) 65 – 74 yrs = 169,725 (9.0%) 75 – 89 yrs = 125,334 (6.6%) 90+ yrs = 13,138 (0.7%) **Staff** (includes aggregated data for all 6 HSC Organisations

	(includes NI Ambulance Service and Business Services Organisation): Forty-two per cent of all HSC staff were under the age of 40; 25% were between 40 and 49, and 33% were over 50.
Religion	**Population** The last census shows the NI population Religion or Religion brought up in was: • 45.14% (817, 424) of the population were either Catholic or **brought up** as Catholic. • 48.36% (875, 733) stated that they were Protestant or **brought up** as Protestant. • 0.92% (16, 660) of the population belonged to or had been **brought up** in other religions and Philosophies. • 5.59% (101, 227) neither belonged to, nor had been brought up in a religion. (Census 2011) **Staff** (includes aggregated data for all 6 HSC Organisations (includes NI Ambulance Service and Business Services Organisation): Protestant **40.4** Roman Catholic **46.4** Neither **13.2**
Political Opinion	**Population** Recent information from the Northern Ireland Life and Times survey explored political opinion amongst the sample. People were asked “Generally speaking, do you consider yourself as a unionist, a nationalist or neither?” **(**Northern Ireland Life and Times, 2019) Unionist 33% Nationalist 23% Neither 39% Other 2% Don't know 3%. **Staff** Broadly Unionist **9.0**

	Broadly Nationalist **7.6** Other **8.4** Do Not Wish To Answer/Not Known **75.0**
Marital Status	**Population** Census data shows that of the Northern Ireland population • 47.56% (680, 840) of those aged 16 or over were married • 36.14% (517, 359) were single • 0.09% (1288) were registered in same-sex civil partnerships • 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership • 6.78% (97, 058) were either widowed or a surviving partner (Census 2011) **Staff** Single **30.2** Married **59.7** Not Known **10.1**
Dependent Status	**Population** The last census showed that 34% of households (238,094) in Northern Ireland had dependent children. Official statistics published in 2020 as part of the Northern Ireland Health Survey 2018/19 show that 14% of respondents were carers (i.e. looking after someone who was elderly or disabled): 17% of women and 10% of men. **Staff** Caring for a Child/Children / Dependant **24.4** Older Person / Person With a Disability None **20.0** Not Known **55.6**
Disability	**Population** The last census shows that 20.69% of the NI population (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities. • 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) **Staff** Yes **2.2** No **64.0** Not Known **33.8**
Ethnicity	**Population** The last published census showed that 1.8% (32,596) of the usual resident population belonged to minority ethnic groups: **White –** 98.21% (1, 778, 449) **Chinese** – 0.35% (6, 338) **Irish Traveller** – 0.07% (1, 268) **Indian –** 0.34% (6, 157) **Pakistani –** 0.06% (1, 087) **Bangladeshi** – 0.03% (543) **Other Asian** – 0.28% (5, 070) **Black Caribbean** – 0.02% (362) **Black African** – 0.13% (2354) **Black Other** – 0.05% (905) **Mixed** – 0.33% (5976) **Other** – 0.13% (2354) (Census, 2011) However, it is recognised that migration patterns have changed substantially since the last census. Statistics from the HSC Interpreting Service showed a large rise in requests for interpreters from 1,850 in 2004-2005 to 132434 requests in 2019-2020. The most popularly requested language translations in 2019-2020 are listed below: Top 20 Language Requests

	1. Polish 30231 2. Arabic 20392 3. Lithuanian 15503 4. Romanian 13059 5. Portuguese 8312 6. Bulgarian 7881 7. Tetum 6623 8. Slovak 5696 9. Mandarin 4794 10. Cantonese 3170 11. Hungarian 3003 12. Russian 2978 13. Latvian 2104 14. Somali 2101 15. Czech 996 16. Farsi 964 17. Bengali 827 18. Spanish 728 19. Hakka 531 20. Urdu 381 **Staff** Bangladeshi **0.01** Black African **0.11** Black Caribbean **0.01** Black Other **0.02** Chinese **0.14** Filipino **0.53** Indian **0.86** Irish Traveller **0.02** Mixed Ethnic **0.14** Pakistani **0.12** Other **0.14** White **70.18** Not Known **27.72**
Sexual Orientation	**Population** There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual. In 2016, estimates from the Annual Population Survey (APS) showed that approximately 7% of the UK population did **not**

	identify as heterosexual or “straight” **Staff** Opposite Sex **44.9** Same Sex **1.0** Same and Opposite Sex **0.1** Do Not Wish To Answer/Not Known **54.0**

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. Also give consideration to multiple identities (such as single parents for example).

Category	***Needs and Experiences***
Gender	Research has shown that many transgender and non-binary people experience barriers to accessing healthcare, including discrimination and a lack of understanding of their needs with regards to services. Research also demonstrates that transgender people are often subject to harassment and abuse, which can make them reticent about declaring their gender identity. It is also acknowledged that the HSC administrative systems to record patient gender identity are lacking, with current HSC systems unable to record gender identity accurately. This can have a negative impact on treatment and care if transgender individuals are not treated appropriately, for example being called for sex-specific screening programmes such as cervical cancer screening, breast screening. Incorrect or incomplete information or records can also have an impact on other HSC services, such as blood markers for certain diseases. Research has also demonstrated that unaltered records can lead to potentially embarrassing situations in healthcare settings and

	lead inappropriate pronouns and/or names to be used in official correspondence. The inability to change medical records was a significant cause of frustration amongst trans individuals. It was seen to lead to breaches of confidentiality that effectively 'outed' the individual to all members of staff who viewed their records. It could also cause inappropriate pronouns and names to be shown in public reception areas and waiting rooms.
Age	No specific needs identified
Religion	No specific needs identified
Political Opinion	No specific needs identified
Marital Status	No specific needs identified
Dependent Status	No specific needs identified
Disability	It is recognised that people can develop disabilities as they age, and individuals can have more than one disability. There is also evidence of patients with disabilities being treated inappropriately by HSC professionals, for example instances of people with sight or hearing issues not being provided with the reasonable adjustments in the form of an interpreter or information provided in braille/ audio with regards to appointments and treatment pathways. Those with learning disabilities may also need information in an easy-read format.
Ethnicity	Currently, HSC administration systems do not capture ethnicity and language spoken. This is important because where patients do not speak English, both the HSC professional and patient may require the services of a translator in order to provide safe and effective services to patients. According to the Health Alliance, many minority ethnic communities have close social networks and strong cultural beliefs and practices, which can promote health and social wellbeing. However, the National Institute for Health and Care Excellence (NICE) has demonstrated that some black, Asian and other minority ethnic groups face major health inequalities, and multiple health issues and risk factors for ill health are more prevalent in minority ethnic communities, and highlight a need for more local data collection and monitoring of ethnicity and race categories across health and social care and other sectors, to provide more accurate data to inform targeted action to address

	health inequalities.
Sexual Orientation	No specific needs identified

2.4 Making Changes

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?***
Gender: In order to encourage service users to provide information, informed consent will be sought, with a clear rationale provided as to what will be done with the information and who will have access to this. Ethnicity: In order to allow HSC professionals to provide a better service to ethnic minority individuals, a second field will be added to the dataset looking at the main language spoken by the individual. This will allow healthcare staff to ensure that translation services are available for appointments, and that written information is translated appropriately. Disability: Fields will be added to the Digital Identity service in order to capture what disabilities an individual experiences, and any reasonable adjustments they may need (e.g. sign language interpreter/ braille/ easy read etc. This will support healthcare providers to ensure disabled patients' needs are met with regards to	Ensure all of the population is represented by incorporating the extra datasets such as ethnicity, disability and gender to be known as. Equality issues will be addressed through the DIG. Groups will be organised to represent each trust where the outcome will be develop regional data quality and standards to manage electronic sharing of information. Equality issues raised were concerning the consent and collection of extra data, how can DIS justify the purpose of collecting this information and some may feel this is discriminatory.

healthcare. These fields can be updated in recognition that patients can develop new disabilities over time.	

2.5 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	
Political Opinion	N/A	
Ethnicity	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	X
No	

Please give reasons for your decisions.

DIS will have a minor impact as the data will be used to identify potential duplicate records and the merging of HSCNI patients with similar names gender and often DOB. The matching function should minimise the impact of assigning the incorrect record with the assistance of extra datasets to help further identify a patient. As DIS will act as a processor of information it will rely on a data feed from primary and secondary care therefore it is the consent of the public to disclose this information, this will ensure that services are fair and accessible to everyone and can help address health and social care trends in the population.

(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?***
Not Applicable.	Not Applicable.

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?***
Not Applicable.	Not Applicable.

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

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

*If you have answered no to all of the above please 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 interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/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.

(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

Approved Lead Officer: _____

Position: _____

Contact Details _____

Date: _____

Policy/Decision Screened by: _____

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

Any request for the document in another format or language will be considered. Please contact the Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; Email: Equality.Unit@hscni.net
Phone: 028 9536 3961