Public Health Agency

Equality and Human Rights
Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a pro-forma to document consideration of each question.

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?

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

Implementation of the Faecal Immunochemical Test (FIT) as replacement test for the faecal occult blood (FOB) test in the Northern Ireland Bowel Cancer Screening Programme

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

Colorectal (bowel) cancer is the second most common cause of cancer death in Northern Ireland. Each year almost 1,200 people are diagnosed with the disease and approximately 425 die from it. However, it is well recognized that when bowel cancer is detected at a very early stage there is a 90% chance of successful treatment.

The Northern Ireland Bowel Cancer Screening Programme (BSCP) was launched in April 2010 with the aim of reducing mortality from bowel cancer by detecting cancers early in their progression so that they can be treated more effectively. The existing programme uses a card-based guaiac faecal occult blood test (gFOBT). At present, a test kit is posted to eligible individuals, completed at home and returned to a laboratory by post, where the bowel motion sample is checked for the presence of blood.

A qualitative faecal immunochemical test is currently used in Northern Ireland as a second line screening test for those who have an equivocal result from gFOBT (7.3% of all gFOBt kits returned).

The presence of hidden blood in the stools is an indicator that further investigations are required as the participant may be at risk of bowel cancer. Those participants who have a positive screening result are offered a colonoscopy procedure to visualise the bowel.

The Bowel Screening Programme in NI primarily operates to the same standards and guidance as the NHS Bowel Screening Programme. In August 2018, it was agreed that in the future bowel cancer screening in England will start at the age of 50. PHE and the NHS are looking at how this can be achieved. The Northern Ireland Screening Committee and the PHA are also looking at this.

In January 2016, the UK National Screening Committee (UK NSC) recommended that quantitative faecal immunochemical testing (FIT) should be adopted by the Bowel Cancer Screening Programme as the primary screening test for bowel cancer.

Evidence suggests screening using FIT will be a more effective way of detecting cancerous and pre-cancerous lesions in the bowel.

Key reasons supporting the UK NSC recommendation include the following:

- FIT is easier to use and can be measured more reliably using a machine rather than the human eye
- FIT is sensitive to a much smaller amount of blood than gFOBt and therefore can detect cancers more reliably and at an earlier stage
- the increased sensitivity enables FIT to detect more pre-cancer lesions (advanced adenomas)
- FIT requires a single faecal sample and is more acceptable to invited subjects which markedly increases participation rates
- FIT is a cost effective alternative to gFOBt

Trials of FIT for screening have shown a big impact on uptake, with a 7% increase overall[1]. It increased uptake in groups with low participation rates, such as men, ethnic minority populations, and people in more deprived areas.

Data from the first year of screening with FIT in Scotland[2] show that overall uptake of FIT was 63.9% compared with 56.4% for FOBT. Increases were seen in both sexes, and across age range and deprivation.

Key Stages of FIT implementation (note that these stages may run in parallel or out of the sequence noted below):

1) Set up an implementation group to begin planning for the introduction of FIT testing

2) Initiate the project, agreeing the PID, Terms of Reference, timeframe with all key stakeholders

3) Consultation period if required

4) Project management processes including Equality Impact Assessment, Rural Needs

[1] Moss S, et al. Increased uptake and improved outcomes of bowel cancer screening with a faecal immunochemical test: results from a pilot study within the national screening programme in England. Gut 2016

[2] Clark et al. Transition to quantitative faecal immunochemical testing from guaiac faecal occult blood testing in a fully rolled-out population-based national bowel screening programme. Gut 2020

Impact Assessment and Data Privacy Impact Assessment

5) Development of IT module for BSIMS (Bowel Screening Information Management System) to support FIT – training requirements identified for SSPs/Call/Recall/Support Officer

6) Agreement on test kit packaging and draft specification for tendering process.

7) Agreement on lab equipment, middleware and mailing services - draft specification for tendering of same

8) Agreement on FIT risk threshold and subsequent remodelling of colonoscopy services

9) Assessment of financial implications and final costs

10) Review of all literature to reflect new test kit

11) Implementation

12) 1,3 and 6 month review

As part of this work a communications plan has been developed.

The main restraints identified within FIT implementation are :

- Securing funding to support the implementation and additional activity costs
- The successful introduction of a new IT module within current system BSIMS
- Capacity at Trust level to be able to manage the expected increased demand on colonoscopy, radiology and pathology services
- Agreement on an appropriate FIT risk threshold
- Departure from existing contract for procurement of test kits
- Ensuring a seamless move from FOB to FIT
- Securing participant engagement in developing updated literature and resources
- Significant system testing will need to be carried out to ensure all elements of the IT system specific to FIT are working correctly.
- Potential impact from the COVID-19 pandemic

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 other

General Population/Service Users:
All individuals resident in Northern Ireland, registered with a Northern Ireland GP and aged between 60 and 74.

Department of Health

HSCB, PHA, BSO, HSC Trusts

PHA Screening Team - Responsibility for commissioning, coordinating and quality assurance of Bowel Cancer Screening Programme

BSO – Functions:
1) Call – Recall function of Bowel Cancer Screening Programme;
2) Helpline for participants;
3)ITS support;
4) Data Integration function

HSCB – Commissioning and Digital Health functions

HSC Specialist Screening Practitioners and Screening Colonoscopy teams in Trusts

NHSCT laboratory – processes all bowel cancer screening samples in NI
General Practitioners

Carers

Cancer / Bowel Cancer Charity and interest groups

Alpha Labs (Manufacturer of test)

RNB (Mailing provider of kits)

Royal Mail (Mail provider for NI)

Companies involved in IT aspects of screening:

- NHS Wales Informatics Services (NWIS) – IT supplier for programme – Bowel Screening Information Management System (BSIMS)
- Data Innovations (provide middleware, software to validate automated results from new test process)

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

- **what are they?**
- **who owns them?**

NATIONAL

- NHS Bowel Cancer Screening Programme. BCS Standards and Performance Objectives. (Updated August 2018). Public Health England.

- National Screening Committee approval

LOCAL

- Priorities for Action 2010/11

- Transforming your Care – A review of health and social care in Northern Ireland. December 2011, DHSSPS.

- Health and Wellbeing 2026 – Delivering Together. October 2016, Department of Health.

- Working Principles of the Expert Panel for Remodelling of Health and Social Care in Northern Ireland (Bengoa Principles). March 2016, Department of Health.

- Implementation of the NIBCSP in 2010

- Making Life Better – the bowel cancer screening programme is one of the key screening programmes in Northern Ireland aimed at the early detection of disease. http://www.publichealth.hscni.net/making-life-better

- Cancer Services Framework – Standard 17 of the DHSSPS Cancer Services Framework calls for all eligible people to be invited for bowel screening within the recommended timescales. http://www.cancerni.net/content/cancer-service-framework

- NI Screening Committee introduction of bowel screening programme in April 2010, and extension of age range to 60-74 in April 2014.

- The National Screening committee recommended that the faecal immunochemical Test (FIT) should replace the current first test used in the NHS Bowel Cancer Screening Programme in November 2015. Replacing the current Faecal Occult Blood (FOB) test with FIT provides the opportunity to detect and prevent more cancers and is easier to use.

- The Northern Ireland Screening Committee (NISC) formally endorsed the Faecal Immunochemical Test (FIT) as the primary screening test for bowel cancer, in line with the recommendation of the UK National Screening Committee. In June 2019, based on the NISC endorsement, the Department of Health directed the PHA, in cooperation with BSO and HSCB to implement FIT testing.

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

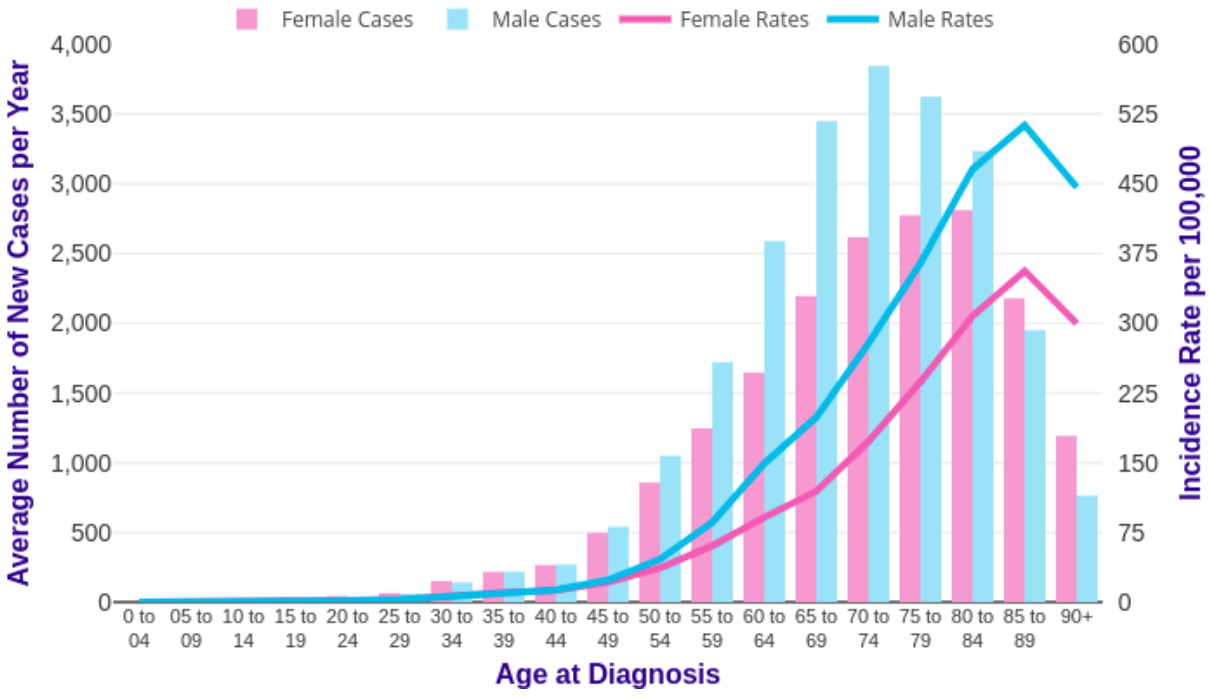
2.1 Data gathering

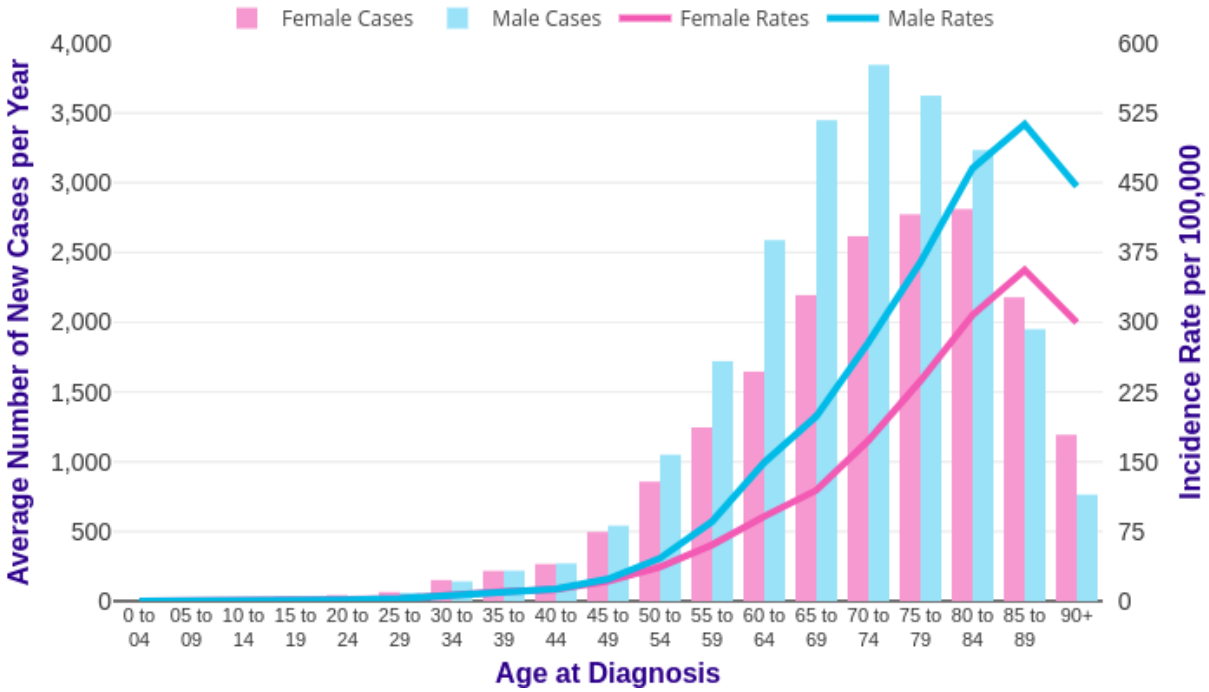
What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

- Northern Ireland Statistics and Research Agency (NISRA) census figure from 2011.
- Equality Screening Document from 2010 on implementation of the Northern Ireland Bowel Screening Programme
- Focus Groups in Northern Ireland to identify barriers to participation in BCSP (paper published in BMJ)
- Desk top research on studies in other UK nations
- Discussions with colleagues involved with the programme, eg consultant lead and programme manager
- Cancer Research UK data
- Cancer Research UK Reducing Inequalities in Bowel Cancer Screening, January 2019
- PHA Promoting Informed Choice: Programme of work across all screening programmes aiming to improve informed choice within screening populations
- PHA Literature Review of Evidence around Interventions aimed at Promoting Informed Choice and Screening Uptake. March 2019
- Draft PHA annual bowel cancer screening report 2017-18
- Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD)

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 issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?*
Gender	The NISRA 2018 mid-year population estimates by gender for the 60-74 age group are: Females: 139,758 Males: 132,744 Cancer Research UK report that Bowel Cancer is the 3rd most common cancer amongst women. There were 18,600 new cases diagnosed in 2015-17, which was 44% of all new cases. It is also reported as the 3rd most common cancer among men with 23,500 new cases in the same time period (55.5% of all cases).  There is no evidence to suggest that FIT implementation in bowel cancer screening will disproportionately impact negatively on the basis of gender. However, previous research in other countries has identified that introducing this test has improved bowel screening uptake rates, particularly among men. The reasons behind this are unclear but may include a simpler test and more acceptance of the test.

Age	All northern Ireland residents aged between 60 and 74, who are registered with a GP, are eligible to participate in the programme. According to the NI Census in 2011 the population of Northern Ireland was 1,810,863, with a mean age of 37.59 years. The number of individuals in the age range (60-74) was 13.25% (approx. 239,939 people). The 2018 midyear population estimates for NI (NISRA) show that the population aged 65 and over increased by 1.7% to 308,200 people between mid 2017 and mid 2018.  Data from Cancer Research UK, see graph, demonstrates that the incidence of Bowel cancer in the UK population increases from age 50. Incidence rates for bowel cancer in the UK are highest in people aged 85 to 89 (2015-2017). This suggests that older age groups are likely to benefit in particular from the introduction of the new test by virtue of making up the greater share of those diagnosed with bowel cancer, in particular men in the 70 to 74 age group. Northern Ireland Bowel Cancer Screening Programme screening uptake by age group, 2017-18 (Source: PHA Annual Bowel Cancer Screening Report 2017-18)

Age Group	Screening Uptake (at 6 months)
60-64	49.9%
65-69	56.2%
69-74	57.3%
NI (60-74)	53.7%

Local data suggests that there is some variation in participation of bowel screening on the basis of age groups within the eligible population.

<table>
<tr>
<td>Religion</td>
<td>
Screening Population

The religious make-up of the population of Northern Ireland, according to the 2011 census is as follows:

40.8% Protestant, 41.6% Catholic, 10.1% no religion, 0.8% other, 6.8% not stated.

There is currently no data routinely available to assess the community background of those diagnosed with Bowel Cancer or those participating in the Bowel Cancer Screening Programme.

The implementation of FIT testing should not have any adverse effect on any religious faith.
</td>
</tr>
<tr>
<td>Political Opinion</td>
<td>
Screening Population

First preference votes per party in NI Assembly Elections 2011:
• DUP 198,436
• Sinn Fein 178,222
• UUP 87,531
• SDLP 94, 286
• Alliance 50,875
• Other 52,384

The 2018 Northern Ireland Life and Times Survey asked ‘Generally speaking, do you think of yourself as a unionist, a nationalist or neither?’

<table>
<tr><th></th><th>Males (%)</th><th>Females (%)</th></tr>
<tr><td>Unionist</td><td>31</td><td>23</td></tr>
<tr><td>Nationalist</td><td>22</td><td>20</td></tr>
<tr><td>Neither</td><td>45</td><td>55</td></tr>
<tr><td>Other</td><td>1</td><td>1</td></tr>
<tr><td>Don’t Know</td><td>1</td><td>2</td></tr>
</table>

There is currently no information available in respect of incidence of bowel cancer, nor of participation in the programme in terms of political opinion.

The implementation of FIT testing should not have any adverse effect on individuals with a particular political opinion.
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</table>

<table>
<tr>
<td>Marital Status</td>
<td>
Screening Population

Data from the 2011 NI census for marital and civil partnership status in age group 25-74 is as follows;

<table>
<tr><th>Marital Status</th><th>Males</th><th>Females</th></tr>
<tr><td>Single</td><td>154,215</td><td>127,916</td></tr>
<tr><td>Married</td><td>312,281</td><td>317,364</td></tr>
<tr><td>Registered same-sex civil partnership</td><td>616</td><td>487</td></tr>
<tr><td>Separated</td><td>21,974</td><td>33,223</td></tr>
<tr><td>Divorced</td><td>31,793</td><td>43,696</td></tr>
<tr><td>Widowed</td><td>10,701</td><td>31,520</td></tr>
</table>

The 2011 Census showed:
• 47.6% (680,840) of those aged 16 and over were married
• 36.1% (517,359) were single
• 0.1% (1,288) were registered in same-sex civil partnerships
• 9.4% (134,994) were either divorced, separated or formerly in a same-sex partnership
• 6.8% (97,058) were either widowed or a surviving partner

Data is not routinely recorded on the martial status of people eligible for bowel cancer screening or of those who are diagnosed with Bowel Cancer. There is no basis for assuming that any of these categories would be higher/lower in the screening population in comparison to the population as a whole.

The implementation of FIT testing is not expected to impact on individuals on the basis of marital status.
</td>
</tr>
<tr>
<td>Dependent Status</td>
<td>
Screening Population

The 2011 Census showed that 34% of households in Northern Ireland contained dependent children.
It also highlighted that 12% per cent of the population (213,980) provided unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health/disabilities, or problems related to old age. Around a quarter (26%) of those did so for 50 or more hours a week, a total of 56,000 people.

Given the age profile of the people being invited to participate in BCSP, it may be reasonable to assume that fewer of them will have dependents than in the general population as a whole.

Nevertheless, it is recognised that some older people will themselves be carers, as Age UK data (2013) underlines: in the UK nearly 50,000 people aged over 85 provide unpaid care to a partner, family member or other person. In 2012, the Carers Trust estimated that around 49,000 carers in Northern Ireland were over the age of 60.
</td>
</tr>
</table>

	For all population screening programmes, uptake rates are often reported to be lower in among people with caring responsibilities. There is no data available in NI in relation to screening rates by participant's caring responsibilities. It is also recognised that some of the older people in the eligible group may be "cared for". It is not anticipated that FIT implementation would have any adverse effects for individuals with dependents or caring responsibilities. The simplified test process may reduce some of the barriers experienced by individuals with caring responsibilities. It is not anticipated that FIT implementation would have any adverse effects, in comparison to the existing testing process, for individuals who require care or assistance. The reduced number of tests required with FIT may improve the option for participation for individuals with caring needs. As part of the communications plan for FIT implementation we will include considerations for carers to raise awareness of the new test, so that they can assist eligible individuals to participate in bowel screening.
Disability	**Screening Population** It is estimated that between 17 – 21% of the NI population report having a disability. Twenty-one percent of the ordinarily resident population at the 2011 Census had a long term health problem or disability which limited their day to day activities. It was reported that 31.04% of households in Northern Ireland (with no dependant children) have someone with a long term health condition or disability. A large study conducted in England found that women with a disability (23% of 473,185 participants) were less likely to take part in breast and bowel cancer screening programmes compared to women with no disabilities.[3] Difficulties with self-care or vision were had the greatest reduction in screening participation. Public Health England (PHE) report that from 2015-2016, 75% of people with learning disabilities eligible for bowel cancer screening took the test compared to 83% of eligible people without identified learning disabilities.[4] The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) found issues with engagement in the bowel screening programme.[5]

[3] Floud S et al. Disability and participation in breast and bowel cancer screening in England: a large prospective study. Br J Cancer. 2017 Nov 21; 117(11): 1711–1714. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5729433/

[4] https://www.gov.uk/government/publications/cancer-screening-and-people-with-learning-disabilities/cancer-screening-making-reasonable-adjustments

[5] Available at http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

The following table shows the percentage of people in Northern Ireland population by type of long term condition or disability, based on the Census data.

Type of long – term condition	Percentage of population with condition %
Deafness or partial hearing loss	5.14
Blindness or partial sight loss	1.7
Communication Difficulty	1.65
Mobility of Dexterity Difficulty	11.44
Learning, intellectual, social or behavioural difficulty.	2.22
Emotional, psychological or mental health condition	5.83
Long – term pain or discomfort	10.10
Shortness of breath or difficulty breathing	8.72
Frequent confusion or memory loss	1.97
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy).	6.55
Other condition	5.22

There is no information in respect of disability in the GP registrations database that is used for call/recall.

For all population screening programmes, uptake rates are often reported to be lower in individuals living with a disability. There is no data available in NI in relation to screening rates and disability status of participants.

The information is not readily available on the distribution of disability in the age range of the screening programme. It can be reasonably assumed that the incidence of long term illness and disability increases with age and this may present barriers to participation in screening programmes.

It is not anticipated that FIT implementation would have any adverse effects on individuals with a disability. The simplified test procedure (single sample required) may optimise opportunities for individuals with a disability to participate in the programme.

Within the Bowel Screening Programme, invited individuals can provide information about any disabilities which may impact on their participation in the programme, to enable tailored communication methods to be used.

Ethnicity	Screening Population The 2011 Census showed that 1.8 per cent (32,400) of the usually resident population of Northern Ireland belonged to minority ethnic groups. The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3% of the population. Irish Travellers comprised 0.1% of the population. Cancer Research UK report that Bowel Cancer is more common in White people than in Asian or Black people. Within UK research, South Asian ethnicity has been associated with significantly lower bowel screening uptake (32.8% compared with 61.3% for non-Asian ethnicity, $p<0.001$), with rates noted to be particularly low for the Muslim subgroup.[6] For all population screening programmes, uptake rates are often reported to be lower in BAME groups compared with Caucasian groups. There is no data available in NI in relation to screening rates by ethnicity. The PHA continues to work on Promoting Informed Choice, a programme of work aiming to improve education and awareness of screening programmes among vulnerable population groups, to facilitate informed choice in relation to screening. It is not anticipated that FIT implementation would have any adverse effects for any specified ethnicity.
Sexual Orientation	It is estimated that 5-7% of the population are from the gay and lesbian or bisexual community. A study by the Office of National Statistics found that in NI: • 93.5% of the population (over 16) considered themselves to be heterosexual / straight • 0.8 considered themselves to be gay / lesbian • 0.2 considered themselves to be bisexual • 0.4 other • 4.5 responded don't know or refused to answer • 0.5 no response The HSC Equality team advise that voluntary sector organisations have argued that these figures significantly underestimate the size of the group. It is not anticipated that FIT implementation would adversely affect any identified sexual orientation.

[6] Szczepura A, Price C, Gumber A. Breast and bowel cancer screening uptake patterns over 15 years for UK south Asian ethnic minority populations, corrected for differences in socio-demographic characteristics. BMC Public Health 2008;8:346.

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	n/a
Age	There is an assumed increase in disabilities as people age. A simpler, single step test may be easier for people to use.
Religion	n/a
Political Opinion	n/a
Marital Status	n/a
Dependent Status	n/a
Disability	People with Visual disabilities, dexterity problems or learning disability may have difficulty in completing the test. The new test poses fewer barriers and therefore some people with a disability will be able to participate in bowel cancer screening who could not do so under the old test regime. People with learning disabilities and with sensory loss may have particular communication and information needs. The programme will continue to work on leaflets and instruction leaflets tailored to these needs. Updated Patient Information leaflets developed across the UK (which PHA contributed to) have less text and more graphics to attempt to address all literacy levels. Within the Bowel Screening Programme, invited individuals can provide information about any disabilities which may impact on their participation in the programme, to enable tailored communication methods to be used.
Ethnicity	Participants from ethnic minorities may have particular communication and information needs, as English may not be their first language.
Sexual Orientation	PHE report that there is no evidence on LGBT people's uptake of bowel cancer screening. An American study published in 2012 found no disparities in uptake of bowel cancer screening between heterosexual, bisexual and lesbian women.[7] In a NI study LGBTQ+ male respondents were three times more likely to have participated in bowel screening than females.[8]

[7] Austin et al. An Examination of Sexual Orientation Group Patterns in Mammographic and Colorectal Screening in a Cohort of U.S. Women. Cancer Causes Control. Author manuscript; available in PMC 2014 Mar 19. Published in final edited form as: Cancer Causes Control. 2013 Mar; 24(3): 539–547. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3959888/

[8] O'Doherty J. The Health of Ageing LGB&T People in Northern Ireland. Belfast: The Rainbow Project, 2013 (Unpublished). Report available from The Rainbow Project, Belfast.

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.

None over and above those identified in sections 2.2 and 2.3.

2.5 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?***
Existing literature for the Bowel Cancer Screening Programme, in respect to the new type test (FIT), is to be updated with attention is given to information needs of people with sensory and learning disabilities Education and Promoting informed Choice information sessions to include carers, men in areas of social deprivation and ethnic minorities. The programme provides translations of information sheets and instruction leaflets on the current test. These are being changed to account for the new test. Patient information leaflets are prepared in a range of translated languages, based on local need (Screening team working with Communications Publications team to identify local translation needs in Northern Ireland) The new patient information infographic on how to complete the test was developed through a project group based in Wales. This project included Personal and Public Involvement aspects, and the infographic contains mostly pictorial elements. It was therefore agreed that an easy-read version was not required in addition to this.	Translation of information into different languages. Keep under review any alternative test methods to offer people with disabilities. Enhancement of materials and training included in service for “Addressing Inequalities in Cancer Screening Through Promoting Informed Choice The programme will continue to monitor information available in terms of social deprivation and demographics to better promote equality of opportunity. Development of an information resource for carers through links with Bowel Cancer UK. Equality monitoring data is not currently provided within the demographic data that feeds into the bowel screening information system. It is anticipated that there will be significant changes to screening IT systems in coming years (in relation to the development of Encompass), and we will endeavour to incorporate equality monitoring mechanisms into these IT systems. Patient experience surveys are undertaken every few years; we plan to incorporate questions on disability and ethnicity into the

	next survey. We have consulted with colleagues in other screening areas and note work recently undertaken in relation to defining a care pathway for breast cancer and individuals with a disability. We hope to progress a similar action in relation to bowel screening in the near future. We will also continue to work with colleagues in relation to other developments to improve screening participation among individuals with sensory impairments and physical disabilities. We will continue to engage with primary care doctors and encourage them as to possible actions which may improve screening uptake among patient groups who are less likely to engage with bowel screening (such as men, individuals from lower socioeconomic group, BAME groups, learning disabilities, physical disabilities and sensory impairments).

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	No changes required. The aim of this decision is to ensure that the eligible population benefits from a safe and sustainable screening service, with outcomes in keeping with national guidance.	
Political Opinion		
Ethnicity		

(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

Please give reasons for your decisions.

The overall impact on all individuals is a positive one. Where inequalities have been identified previously, work is ongoing to address these through communication and education. This is especially the case in terms of addressing the disparity in uptake between males and females.

The needs of some people with a disability will still not be met by this test. Cooperation with other programmes and research bodies are continuously looking for alternative methods of testing as appropriate, particularly for people with sensory and physical disabilities.

There is no additional negative impact on anyone by changing the test from gFOBt to FIT.

Some positive impacts are anticipated such as improving accessibility and acceptability of the test, which may result in improved screening uptake among several identified groups.

(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?***
The simplified test procedure may enable individuals with a disability to participate in bowel cancer screening, either through completing the test on their own or for those who require assistance to complete the test.	Ongoing work within the Promoting Informed Choice programme involving people with disabilities to promote informed choice in relation to cancer screening. Consideration of an information leaflet for carers in the future (currently it is thought that patient information leaflets provide relevant important information for both patients and carers but this will be considered).

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?***
The new simplified test procedure enables people with disabilities to participate in bowel cancer screening.	Ongoing work within the Promoting Informed Choice programme involving people with disabilities to promote informed choice in relation to cancer screening.

(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	Yes
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.	Yes
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
Article 2: Right to Life	No	FIT implementation impacts positively on this right, as bowel cancer screening aims to identify pre-cancerous lesions or bowel cancer at an early stage, when survival outcomes are much better.	No
Article 8 – Right to respect for private & family life, home and correspondence	No	FIT implementation impacts positively on this right, as individuals who may have previously required assistance to complete the test process may be able to complete this themselves, or reduce the involvement of others (as the test process is simplified) Some individuals may require assistance to complete the test. Within updated information leaflets it is noted that carers should only help someone in relation to this if an individual wants assistance, and have agreed to this,	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.

No additional actions other than those noted in Section 5.2 (updated information leaflet).

(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
BSIMS receives demographic information from NHAIS. This currently does not include equality monitoring data. However, it is anticipated that there will be significant changes to the IT system in the future, with the development of Encompass. We will endeavour to ensure that equality monitoring data is included within this, so that it is possible to monitor screening uptake within these identified vulnerable groups in relation to health inequalities. Individuals can provide information to BSIMS to enable tailored communication methods are used where necessary. The PHA will attempt to review this information to monitor what types of communication methods are used, and the demand for these communication methods. We will incorporate some specific questions in relation to equality monitoring into the next patient experience surveys within the bowel cancer screening programme.	Individuals can provide information to BSIMS to enable tailored communication methods are used where necessary. The PHA will attempt to review this information to monitor what types of communication methods are used, and the demand for these communication methods. Ongoing links with the Promoting Informed Choice Programme to help monitor any identified challenges within bowel screening (or other population screening programmes) for individuals with a disability. We will incorporate some specific questions in relation to disability into the next patient experience surveys within the bowel cancer screening programme.	Data on bowel screening uptake rates, and survival data for bowel cancer will provide data to monitor the impact on the right to life.

Approved Lead Officer:	Dr Tracy Owen
Position:	Consultant in Public Health Medicine
Date:	09/11/20
Policy/Decision Screened by:	Nicola Kelly/Christine McKee
Business Unit and contact details	02895362882

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 updated January 2015

Any request for this document in another format or language will be considered. Please contact us (see contact details provided above).