Health and Social Care Board

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

Health and Social Care Board

Equality, Good Relations and Human Rights
SCREENING TEMPLATE

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Investment Proposal Template (IPT): Unscheduled Care in Hospital (Patient Flow)

- Control Room Support
- Phase 2 7/7 working
- Outpatient Parenteral Antibiotic Therapy (OPAT)

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**

Control room

Establishing a Control room and appointing staff to deliver its functions 7 days a week, 365 days a year to maintain timely patient flow and minimise delays in the patient journey from admission to timely discharge, and reduce the impact of delays associated with weekends and holiday periods. The control room is a new development with newly appointed staff specifically resourced to ensure all patient and service information is shared and acted upon. The staff appointed to the control room will be invoved in regular scheduled meetings and clear escalation plans with mitigating actions for addressing pressures. They will liaise with acute and community colleagues in their own Trust and others including the NI ambulance Service and primary care.

Phase two 7/7 working

Building on the 2014 paper "Improving Patient Flow in HSC Services" phase 1 of 7/7 working, embedded key staff in Emergency Departments and short stay wards 7 days a week to support the immediate assessment, treatment and onward referral / follow up / early implementation and liaison with appropriate links to community service liaison teams.

Phase 2 of 7/7 working is to ensure effective arrangements are in place to build on 7 day

working for Social Workers, Physiotherapists and Occupational Therapists embedded in key base wards to support patient flow. Essential to this will be the development of sustainable rotas, with effective decision making and skill mix.

Outpatient Parenteral Antibiotic Therapy (OPAT)

Inpatient administration of parenteral (intravenous) antibiotics can require significant nursing time to prepare and administer, and as a consequence compete for nursing time available with other elements of direct patient care and patient flow. Some medically stable patients are cared for in acute hospitals so that they can receive antibiotic therapy, which often could be discontinued, switched to an oral regime or delivered in their home or a community setting by an OPAT service. Inappropriate treatment with antibiotics (the wrong antibiotic, the wrong dose or wrong duration) is the major factor underlying increasing antimicrobial resistance. The Department of Health has committed to reducing inappropriate antibiotic use by 50% by 2021 (known as one of the 'O'Neill Ambitions; HSS(MD) 6/2017). The key objective of an OPAT service is to safely and effectively manage patients on Intravenous antibiotics as outpatients, ensuring that their treatment is optimised, appropriately delivered and supervised, and that risks are minimised. This development will involve appointing new additional nursing and pharmacy staff to assess patient medication and manage appropriate prescribing.

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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

Control Room

New staff, inpatients, current staff across hospital and community services, Ambulance, primary care, voluntarysupport organisations and relatives/carers.

Phase 2 7/7 day working

New and current staff, particularly AHPs and Social Workers, Patients, carers , hospital and community staff.
OPATs

Nursing and pharmacy staff. Patients and carers.

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

- **what are they?**

During 2018/19 all Trusts were engaged in a programme of support of “100% Challenge” to identify areas for focus to improve patient flow through Emergency Departments, with a particular emphasis on the 4 hour ED standard. Lessons learned from this programme have led to operational changes in the day to day management of hospital sites to facilitate patient flow.

The evidence supporting multi professional input across 7 days is growing and recommended in various documents including NHS England Seven Day Services Clinical Standards NHS Seven Day Services Clinical Standards and NHS Improvement: AHPs supporting patient flow AHP Supporting Patient Flow.

The AHP Strategy - [2012 – 2017] ‘Improving Health and Well-being through Positive Partnerships’ sets out a high level road map for the development of the AHP workforce and to support the commissioning and delivery of AHP practices to enhance the health and social well-being of the population in Northern Ireland. The development of 7 day AHP services is relevant to all four 4 key strategic themes:

- Promoting Person-centred Practice and Care
- Delivering Safe and Effective Practice and Care
- Maximising Resources for Success
- Supporting and Developing the AHP Workforce

It was in Everyone Counts: Planning for Patients 2013/14 that the aspiration for a 7-day NHS was formalised by NHS England. This led to the creation of the Seven Days a Week Forum, led by Professor Sir Bruce Keogh, with a remit to give all NHS commissioners the 'evidence, insight and tools they need to move the NHS towards routine services being available 7 days a week'. In its evidence base report, the Forum emphasised the importance of multidisciplinary working in the care of patients with complex clinical presentations: "Where early medical or surgical assessment is supported with input from care professions including nursing, physiotherapy, occupational therapy, speech and language therapy, pharmacy and social care, a management plan can be implemented that addresses all of the patient’s care needs up to and including preparation for their discharge."

In November 2014 the Regulation and Quality Improvement Authority (RQIA) published their report “Review of Discharge Arrangements from Acute Hospitals” (www.rqia.org.uk).

Outpatient Parenteral Antibiotic Therapy (OPAT).

Start Smart – Then Focus is a key guidance document for clinicians to improve the appropriateness of antibiotic prescribing. It acknowledges that antibiotics are generally started before a patient's full clinical picture is known. However, by 48-72 hours, when additional information is available, including microbiology, radiographic and clinical information, it is important for clinicians to re-evaluate why the therapy was initiated in the first place and to gather evidence on whether there should be changes to the therapy. The five 'antimicrobial prescribing decision' options are Stop, Switch, Change, Continue and OPAT:

(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

NISRA data June 2020

(Northern Ireland Life and Times, 2018)

Engagement and consultation with current providers and staff in HSC Trusts, Integrated Care Partnerships and Local Commissioning Groups

Health & Wellbeing 2026: Delivering Together (health-ni.gov.uk)

Review of HSC Commissioning Arrangements - Final report | Department of Health (health-ni.gov.uk)

Rebuilding HSC Services

Programme for Government (PfG)

Making Life Better(health=ni.gov.uk)

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

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	At 30 June 2020, Northern Ireland's population was estimated to

	be 1.90 million people. Just over half of the population (50.7 per cent) were female, with 961,400 females compared to 934,200 males (49.3 per cent). Men represent a higher proportion of unscheduled admissions NI-population-needs-assessment-report.pdf (health-ni.gov.uk) p62 than their proportion of the population. It may be that that men seek medical advice from GPs and tus intervention etc later than women. As a result, their condition may worsen in the community before they present in acute care. Women , however, have a longer life expectancy than men. Transgender and non-binary people may also present at ED with advanced conditions as they may have delayed or avoided contact with HSC professionals due to negative experiences of accessing care and support in the past.
Age	There are 4 times more unscheduled hospital care admissions and attendances for the over 65 age groups. Hospital Statistics: Emergency Care 2019/20 (health-ni.gov.uk) NI-population-needs-assessment-report.pdf (health-ni.gov.uk) p62 Respiratory conditions such as COPD for example are more prevalent in older people. It is estimated that there are 308,197 over the age of 65 years of age in Northern Ireland. Mid-year population estimates published by NISRA in 2019 show that 15% of the population are over 65 years of age: 65 – 74 yrs = 169,725 (9.0%) 75 – 89 yrs = 125,334 (6.6%) 90+ yrs = 13,138 (0.7%) NISRA estimated the proportion of people aged 65 years and over

<table>
<tr><td></td><td>is projected to increase by 65.1 percent to 491,700 people from mi 2016 –mid 2041 with the result that almost one in 4 people (24.5 percent) will be in this category.
https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/2016-based%20Population%20Projections%20-%20statistical%20bulletin.pdf

Population of over 65 per Trust area is detailed below;

<table><tr><td>NHSCT</td><td>SHSCT</td><td>SEHSCT</td><td>WHSCT</td><td>BHSCT</td></tr><tr><td>86,014

17%</td><td>58,703

15.1%</td><td>69,683

19.1%</td><td>49,709,

16.3%</td><td>55,840

15.5%</td></tr></table></td></tr>
<tr><td>Religion</td><td>Religion or Religion brought up in

• 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)

There is no specific data in relation to religion and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users.</td></tr>
<tr><td>Political Opinion</td><td>A recent survey of the NI population, published in 2018, explored political opinion. People were asked “Generally speaking, do you consider yourself as a unionist, a nationalist or neither?” Of those that responded to the survey, 26% generally considered themselves to be Unionist; 21% said they were Nationalist; 50% said neither Unionist nor Nationalist; and 1% said “Other”. 2% said they didn’t know (Northern Ireland Life and Times, 2018).

There is no specific data in relation to political opinion and older people but there is no reason to assume that the profile of actual</td></tr>
</table>

	service users would be different from that of 65+ year olds as potential service users.
Marital Status	**Northern Ireland Life and Times (2018)** Single (never married) 32% Married and living with husband/wife 51% A civil partner in a legally-registered civil partnership 0% Married and separated from husband/wife 3% Divorced 6% Widowed 7% **Civil partnerships** Annual Reports of the Registrar General for NI show that Between 2005 to 2018 inclusive, there have been 1298 civil partnerships registered in NI. Of these, 539 have been male civil partnerships, and 571 have been female civil partnerships. There is no specific data in relation to marital status and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users.
Dependent Status	• 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) CarersNI • 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 (• Any one of us has a 6.6% chance of becoming a carer in any year • 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 State of Caring 2019** Annual survey (UK wide, including NI) 1) 2 in 5 carers (39%) responding reported being in paid work. 2) 38% of all carers reported that they had given up work to care. 3) 18% had reduced their working hours. 4) 1 in 6 carers (17%) said that they work the same hours but their job is negatively affected by caring, for example because of tiredness, lateness, and stress. 5) 12% of carers said they have had to take a less qualified job or have turned down a promotion to fit around their caring responsibilities. 6) Just over 1 in 10 carers (11%) said they had retired early to care. 7) Only 4% of respondents of all ages said that caring has had no impact on their capacity to work. 8) Only one quarter (25%) of carers who aren't yet retired and had an assessment in the last year felt that their need to combine paid work and caring was sufficiently considered in their carer's assessment. 9) Carers who are not yet retired were also asked about their future plans and 53% said they are not able to save for their retirement. 10) Some carers are saving or have saved less for their retirement with 17% saying they did this because their working hours were reduced. Carers may also be overrepresented amongst those admitted to unscheduled care due to their help-seeking behaviour (i.e. delaying accessing care early/at the appropriate time because they tend to put their own health needs second to those they care for.
Disability	• 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) 43% longstanding illness (30% limiting and 12% non-limiting illness) • Males: limiting longstanding illness 28%; non-limiting longstanding illness 12% • Females: limiting longstanding illness 33%; non-limiting longstanding illness 12% • Prevalence of disability increases with age. Limiting longstanding illness increases from 18% among young adults aged 25 -34 years to 52% among those who are 75 plus years. It can be assumed that people with a disability are overrepresented amongst those admitted to unscheduled care in comparison to the general population.
Ethnicity	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) The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care. These include: - Language difficulties; - Lack of awareness and lack of appropriate information on the services available; - The need for a permanent address in order to register with a General Practitioner; - Fears about entitlement to health care; - Difficulty in coming to grips with a health care system that is different to what exists in their country of origin; - The failure of some services to meet migrants' cultural or religious needs; - Institutional racism and the negative attitudes of some health care staff; and - Immigration restrictions. There is no specific NI data available in respect of ethnicity and older people. However, the majority of the NI black and minority ethnic population are of working age and therefore it can be reasonable to assume that those of ethnic minority of 65+ make up a smaller share of the 15% of the general population. On the other hand, they may be more likely to access unscheduled care due to the barriers to accessing care early/at the appropriate time outlined above.
Sexual Orientation	The Annual Population Survey , 2016 (APS) estimates that: • 93.4% of the UK population identified as heterosexual or straight and 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of: o 1.2% identifying as gay or lesbian

	○ 0.8% identifying as bisexual • A further 0.5% of the population identified themselves as "Other", which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories. A further 4.1% refused, or did not know how to identify themselves. • The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%). • More males (2.3%) than females (1.6%) identified themselves as LGB in 2016. • The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%. • Sexual identity is one part of the umbrella concept of "sexual orientation". Sexual identity does not necessarily reflect sexual attraction or sexual behaviour – these are separate concepts that Office for National Statistics (ONS) currently does not measure. There is no specific NI data available in respect of sexual orientation and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users. Lesbian, gay and bisexual people could be overrepresented amongst those admitted to unscheduled care due to their help-seeking behaviour (ie. delaying accessing care early/at the appropriate time because of negative experiences with the HSC before or fear of these

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	Both Male and Female service users and staff will benefit from the service proposals. Transgender people may have particular concerns about being cared for in a hospital setting (for example, based on negative experiences in the past). Gender specific care, with due consideration towards those in the transgender community will be provided as far as reasonably possible, if requested.
Age	The needs of older people are met throughout unscheduled care services with accompanying developments such as Hospital at Home, ambulatory care and frail elderly services. There is ongoing consideration given to the needs of this age group.
Religion	There is no evidence of differential impact on the grounds of religion
Political Opinion	There is no evidence of differential impact on the grounds of political opinion.
Marital Status	Marital status of service users will be respected, including same sex families / carers
Dependent Status	Those over 65 years old are most likely to care for grand-children. Some adults also have adult dependents. Caring responsibilities will be considered as part of any personalised care.
Disability	A proportion of service users may have complex physical, mental or sensory life limiting disabilities including hearing loss or visual impairment. Prevalence of long term conditions such as stroke, diabetes and COPD is much higher within this older age groups of service users and as such services should be tailored to meet the needs of these users. Prevalence of long term conditions/disabilities such as physical, mental, sensory or life limiting difficulties are all associated with the older population and as such services should be tailored to meet the specific needs of these service users (including, for example access to sign language interpreting in the hospital setting).
Ethnicity	It is recognised that people from ethnic minorities can experience difficulties accessing public services based on language barriers as well as lack of familiarity with the services

	that are available. Those requiring assistance to access services will be given the necessary support. (including provision of interpreting or translation services.)
Sexual Orientation	Sexual orientation of the users will not determine service accessibility or delivery. Service providers will be respectful of same sex families. Some people in a same sex relationship may have particular concerns about being cared for in a hospital setting (for example, based on negative experiences in the past).

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.

Access to this service is applicable to all users.

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?***
Services will be accessible by all who require intervention or treatment and the needs of all service users were considered in the development and implementation of the service.	Access to services and service delivery will be monitored as part of the service agreement and any potential impacts will be addressed as part of the ongoing equality monitoring

The service will be tailored and personalized to the service user, taking account of their different needs based on any section 75 characteristic. Some section 75 groups may be uneasy with strangers even though they are HSC staff coming into their homes particularly those who live on their own, elderly, or belong to the LGB community or identify as transgender or non-binary.	process. Trusts are required to monitor the impact on some section 75 users going forward. Staff training and awareness

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	NONE	
Political Opinion	NONE	
Ethnicity	NONE	

(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.

This policy, while intended to benefit all users of unscheduled care services, is likely to produce particular benefits for people with a disability, older people, and possibly those from a minority ethnic group or, as they are more likely to be overrepresented amongst them .

(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?***
As part of the implementation and development of this investment , the Trust is required to consider the needs of those people with disabilities.	Future developments should seek to engage people with disabilities at the early stage of development so that concerns and opinions may be gauged.

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?***
N/A	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	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.	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 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
2	Positive impact	Access to unscheduled care services will be more timely and will better address patient's needs. This has potential to improve patient outcomes.	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.

HSC Trusts will be encouraged to continue to deliver relevant human rights based training for front line staff – which covers Article 2 Rights.

(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
The LCG and the Trusts will regularly monitor the effect of the services. The scheme will be implemented and managed by a service manager and will be subject to Post Project Evaluation to ensure that any negative impacts can be highlighted and resolved. Data is not currently available for the following equality groupings; -Age -Gender -Disability -Ethnicity The Trusts are required to collect this information for monitoring purposes.		

Approved Lead Officer: Mr Iain Deboys

Position:	Assistant Director of Commissioning
Policy/Decision Screened by:	Bernie Mooty
Signed:	
Date:	27/01/2022

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