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

Belfast Musculoskeletal/Pain Pathway

1.2 Description of policy or decision

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

This Investment Proposal Template provides detail on the Musculoskeletal(MSK)/Pain pathway which will safely manage a range of routine MSK conditions in a primary care setting thus reducing the requirement to refer to secondary care by:

1. Allowing a greater number of patients with common musculoskeletal conditions to be managed within primary care setting thus improving patient experience.

2. Improving capacity within primary care and investigation services by providing an alternative service. Patients being seen in a timely fashion by a primary care clinician in their own practice or a neighbouring practice and follow up within primary care as appropriate.

3. Improving the skill base in the Belfast area and will enhance the quality of referrals to secondary care.

- **how will this be achieved? (key elements)**

We propose to operate a ‘choose and book system’ so that the referring GP can give the patient an appointment for the Integrated Care Partnerships clinics

whilst they are reviewing them in primary care, reducing the amount of administration required.

Protocols will be developed and disseminated to local GP clinicians to identify the types of conditions which would be suitable for the ICP clinics.

12 shoulder clinics per month for the Belfast GP Federation. This would be staffed by one GP and physiotherapist with access to injection therapies and direct access radiology (xray, ultrasound and MRI).

There would then be access to ongoing group physiotherapy sessions. Please see attached protocol for managing shoulder complaints in primary care.

6 hand clinics per month for the Belfast GP Federation. This would be staffed by one GP with access to injection therapies, splints and direct access radiology. Please see attached protocols for managing hand conditions in primary care – carpal tunnel syndrome protocol.

6 foot clinics per month for the Belfast GP Federation. This would be staffed with one GP and podiatrist with access to injection therapies, direct access radiology and insoles. Please see attached protocol for managing foot conditions in primary care.

After patients are reviewed at the clinics, digital dictation will be utilized to send a clinic letter back to the referring clinician/GP practice.

This enhanced clinical service will be supported by an educational component:

1. 2 sessions/year to the local GP Federation monthly meetings
2. 8 sessions/year to ‘upskill’ local GPs in common MSK issues, using the Arthritis Research UK educational programme (which is supported by RCGP)
3. 1 session per week to train NIMDTA GP trainees in common musculoskeletal conditions and management

Dissemination of a primary care fibromyalgia protocol to allow better management of this common condition. This would be supported by dissemination of the Pain Toolkit to GP practices, to facilitate self-management of this condition within the community.

GPs providing the clinic will be trained to a level appropriate for the treatment they are providing. The project is aimed at conditions appropriate for management in primary care so specific specialist/GP specialist training is not required.

Whilst the overall clinical responsibility of the patient resides with the registered GP, the ICP GP will be clinically responsible for the episode of care provided. The ICP GP will be professionally and legally responsible, and accountable, for all aspects of their own work including management of patients in their care, in accordance with the GMC codes of ethics and rules of professional conduct.

An appropriate clinical room for the clinic will be organized through the Belfast GP Federation.

The project will be audited using agreed quality outcome measures

Significant adverse events will be recorded, reported where serious and discussed with all relevant staff.

Complaints will initially be handled at practice level and clinicians involved in care of the patient will respond to any complaint relating to the care they have provided.

All clinical personnel involved in patient care will inform their defence organisation of the care they are providing so that appropriate levels of indemnity cover are in place.

The project will provide care in the primary care environment before referral for specialist opinion is clinically appropriate. Care pathways will be developed to provide guidance to clinicians

- **what are the key constraints? (for example financial, legislative or other)**

1. Pressures in General Practice and competing priorities impacting on GP resources
2. Buy in from GP Federations; support required from GP Federations to rollout service. Through engagement with the Federation Support Unit, GP Federation leaders have been informed and engaged in the process of Elective Care Reform.
3. Demand versus capacity; there is a risk that there may be a temporary increase in demand.

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

Those primarily affected are:
Patients who are using the GP services
GPs and their staff
Health and Social Care Board
Belfast Health and Social Care Trust

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

- **what are they?**

In response to the publication of the *Elective Care Plan*, the Health & Social Care Board established the scheduled care programme board. This programme team is multi-disciplinary and includes staff from both the Health & Social Care Board and the Public Health Agency.

- **who owns them?**

The scheduled care programme board is currently chaired by the Interim Director of Performance, Lisa McWilliams.

(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

2.2 Quantitative Data

- NI Census data (2011)
- NISRA Mid-year population estimates. Available at: **https://www.nisra.gov.uk/publications/2017-mid-year-population-estimates-northern-ireland**
- McBride, R.S. (2011): Healthcare Issues for Transgender People Living in Northern Ireland. Belfast
- Monitoring Gender non-conformity (GIRES, 2014) Available at http://www.gires.org.uk/wp-content/uploads/2014/09/Monitoring-Gender-Nonconformity.pdf
- NI data from Carer's UK, available at http://www.carersuk.org/northernireland/news-ni/facts-and-figuresAvailable at https://www.carersuk.org/northernireland/policy/policy-library/state-of-caring-in-northern-ireland-2017-2

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.

The MSK/Pain pathway which will safely manage a range of routine dermatological conditions in a primary care setting thus reducing the requirement to refer to secondary care.

The MSK/Pain pathway will be made available to the full patient population including all Section 75 groups. Implementation of the pathway will improve access to services for all patients.

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 proportion of females in 2011 is 51.00% (923, 540). The male population is 49.00% (887, 323) in 2011. Mid-year population estimate (2016; published June 2017) The size of the resident population in Northern Ireland at 30 June 2016 is estimated to be 1.862 million people. Just over half (50.9 per cent) of the population were female, with 946,900 females compared to 915,200 males. Available at https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland **Transgender** Research suggests for the Northern Ireland population as a whole: • 140-160 individuals are affiliated with transgender groups • 120 individuals have presented with Gender Identity Disphoria • There are more trans women than trans men living in Northern Ireland. (McBride, Ruari Santiago (2011): Healthcare Issues for Transgender People Living in Northern Ireland. Institute for Conflict Research.)**The Gender Identity Research and Education Society (GIRES)** estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014): • gender variant to some degree 1% • have sought some medical care 0.025% • having already undergone transition 0.015% The number who have sought treatment seems likely to continue

<table>
<tr><td></td><td>growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among youngsters is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men).
Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2016) N=1,862,100:
18,621 people who do not identify with gender assigned to them at birth
466 likely to have sought medical care
279 likely to have undergone transition
This is a service that is open to all Belfast GP Federation practices.</td></tr>
<tr><td>Age</td><td>According to NISRA's 2017 mid-year population estimates the breakdown of the Northern Ireland population was as follows:
under 18 – 23.3% 18-40 – 28.5% 40-65 – 31.9% 65+ - 16.1%</td></tr>
<tr><td>Religion</td><td>2.2% of population from a Catholic background
52.9% of population from Protestant and other Christian background
4.9% of population from other religions, no religion or religion not stated
(2011 Census data)</td></tr>
<tr><td>Political Opinion</td><td>Most recently published data from the Northern Ireland Life and Times Survey (2016) on political opinion shows that:
Unionist 29%; Nationalist 24%; Neither 46%; Other/ don't know 2%.</td></tr>
<tr><td>Marital Status</td><td><table><tr><td>Married</td><td>47.56%</td></tr><tr><td>Single never married</td><td>36.14%</td></tr><tr><td>Separated</td><td>3.98%</td></tr><tr><td>Divorced</td><td>5.45%</td></tr><tr><td>Same Sex Civil Partnership</td><td>0.09%</td></tr></table></td></tr>
</table>

	<table><tr><td>Widowed or Surviving partner from SSCP</td><td>6.78 %</td></tr></table>(2011 Census)
Dependent Status	Information from CarersNI suggests that: • 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. **Health Survey NI (2016/17)** • 13% have caring responsibilities • Approx 70% receive no monetary reward for giving this care • 48% received help from other family members, but 38% received no support from others **Parents with dependent children (Census 2011)** Responsibility for dependent children: 238,094 households (33.9% of all NI households) **NI Lone parent families** = 115,959, with 123,745 dependent children in family (Census 2011). Of the 115, 959 lone parents, 16, 691 are males and 99,268 are female. (Census 2011)
Disability	It is estimated that in Northern Ireland, 42% have longstanding illness (30% limiting and 12% non-limiting illness) Health Survey NI (2017). Prevalence of longstanding limiting illness increases with age: approximately 8% among young adults aged 16 to 34 years,

compared to 60% among those who are aged 65 years and over. (Census 2011)

The table below indicates prevalence of different long term conditions using information gathered in the last census (although these may have changed over time):

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%
A learning, intellectual, social or behavioural difficulty.	2.22%
An 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%
No Condition	68.57%

(Census 2011)

In Northern Ireland people experience the lowest disability free life expectancy (Age NI, 2010).

Ethnicity

- Traveller population in N Ireland is estimated at 3905 (All-Ireland Traveller's Health Survey, 2010)
- Non-White ethnic groups (Asian, Black, Mixed, Other) estimated at: 31113.
- The number of births to mothers outside the UK and Ireland have increased over the past decade with 2347 births in 2008 compared with 661 in 2001 (9% of all registered births)

(2011 Census data)

	Northern Ireland Pooled Household Survey (NIPHS) tables, published 2017. Data are presented as 'Ethnicity White' and 'All Other Ethnicities' due to small cell sizes. **2013/14:** Ethnicity White 98.2% (1,399,000); All other Ethnicities 1.6% (23,000) (No response not included) **2014/15:** Ethnicity White 98.2% (1,409,000); All other Ethnicities 1.8% (26,000) **Language** The five most popularly requested languages in HSC settings (as reported by the HSC Translation Service) in 2017-2018 were: 1. Polish (30,292 requests); 2. Lithuanian (15,763 requests); 3. Arabic (11,360 requests); 4. Romanian (9908 requests) and 5. Portuguese (8524 requests).
Sexual Orientation	Between 2005 and 2017, there were 1202 recorded Civil Partnerships regionally. However, this is not indicative of the LGB 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.

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	***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	Women are more likely than men to develop musculoskeletal disorders
Age	Older people are more likely to develop musculoskeletal conditions

	such as arthritis than younger people. As older people are more likely to have sensory disabilities such as hearing or sight difficulties we will use larger fonts in written communication and ensure an appropriate environment to facilitate communication with those with hearing disability.
Religion	There is no data to suggest that the needs and experiences of service users differ on the basis of religion
Political Opinion	There is no data to suggest that the needs and experiences of service users differ on the basis of political opinion
Marital Status	There is no data to suggest that the needs and experiences of service users differ on the basis of marital status
Dependent Status	The MSK/pain Pathway will have a positive impact on people who have dependents as they will be able to travel to their local practice for treatment for themselves or their dependent.
Disability	MSK conditions are associated with a large number of co-morbidities including diabetes, depression and obesity. The MSK/Pain Pathway will have a positive impact on people with a range of disabilities as they will be seen in their local practice by familiar practitioners. This will ease difficulties in transport for people with physical disability and also ease anxieties in attending an unfamiliar location or doctor for those with learning disabilities or mental health problems.
Ethnicity	There is no data to suggest that the needs and experiences of service users differ on the basis of ethnicity
Sexual Orientation	There is no data to suggest that the needs and experiences of service users differ on the basis of sexual orientation

2.4 Multiple Identities

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

Older people with sensory disabilities.

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?***
It is recognised that individuals who have communication difficulties due to a disability may have additional communication needs. Provision will be made to have a sign language interpreter available if required. Information can be translated into different languages for those whose first language is not English should this be required.	Consider providing information in larger fonts for older people with visual 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	N/A	N/A

Political Opinion	N/A	N/A
Ethnicity	N/A	N/A

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

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

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

Please tick:

Major impact	
Minor impact	X
No further impact	

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

Please tick:

Yes	
No	X

The MSK/Pain pathway will be made available to the full patient population including all Section 75 groups. Implementation of the pathway will improve access to services for all patients.

No major adverse impacts were identified from the data and evidence available.

(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?*
N/A	N/A

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	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 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
N/A	N/A	N/A	N/A

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

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

N/A

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights

Approved Lead Officer: Roger Kennedy

Position: ________________

Policy/Decision Screened by:

Signed:

Date: ________________

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