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 Gynae 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 Gynaecology pathway which will safely manage a range of routine gynaecological conditions (Coil fitting, Long Acting Reversible Contraceptives) in a primary care setting thus reducing the requirement to refer to secondary care by:

1. Allowing a greater number of patients with common gynaecological
   Cervical Dysplasia
   Menstrual Disorders
   Pelvic Floor Prolapse
   Pelvic Pain
   Polycystic Ovarian Syndrome
   Uterine Fibroids
   Urinary Incontinence
   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)**

The proposed service model will allow a greater number of patients with common gynaecological conditions to be managed within the primary care setting. This management will encompass assessment and treatment by the patient's own GP who will have access to the support of a GP with enhanced skills in the field of gynaecology.

The support offered will include telephone advice and mentorship, face to face assessment of the patients within their local primary care setting and access to long acting contraception including the provision of coil fitting within primary care that is local to the patient.

Many women are referred to secondary care gynaecology services with conditions / problems that can be managed in primary care.

There will be three initial areas of focus for this model, namely the management of women under 45 with heavy menstrual bleeding, the management of women in the peri-menopausal state and the provision of long acting contraception including coil fitting.

Analysis of referral data within the Belfast Local CommissioningGroup has shown 9692 referrals in the last year. There is wide variation in referral rates (lowest 1.6/100 to highest 81.5/100) reflecting multiple factors impacting on primary care services throughout the city.

If all practices were referring at or below the NI average rate (22.1/1000) this would see a reduction in referrals of approximately 900 representing approx. 10% of the total referrals.

It is proposed that the introduction of the above model will reduce referrals by 10%.

Patient journey

When a patient presents with a set of gynaecological symptoms they will see their own GP who will make an assessment. The GP will then have 5 options.

1. Manage the patient's symptoms and review as appropriate;
2. Seek telephone advice from a GP with enhanced gynaecological skills who is involved in peer review and mentorship of a cluster of local

practices;
3. Ask the GP with enhanced gynaecological skills to see the patient within their own primary care setting;
4. Refer to the primary care coil clinic which is run by the GP with enhanced gynaecological skills;
5. Refer directly to secondary care.

Step 5 is the only step where a referral is made outside primary care for specialist advice.

Steps 2-4 inc are initially aimed at managing those patients who present with bleeding problems under 45y, menopausal symptoms and those patients requiring coil fitting or sub dermal implant fitting.

The focus of the clinics within GP practices will be to see and treat women with primary care gynae conditions as well as provide support and mentorship to the practice team through the use of case discussion / review, follow up.

Volumes of patients

With a proposed reduction in approximately 900 referrals it would be anticipated that these patients will be seen within the primary care setting.

10 GPs with enhanced skills providing support to 8 or 9 neighbouring practices (cluster), in the form of coil fitting clinics locally and practice based clinics to see and manage patients who present with the primary care conditions described previously. As well as face to face consultations within practices these GPs will have time to provide availability for telephone advice to GP's within their hub on a regular basis.

- **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.

- 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

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.

The Gynaecology 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 Gynaecology 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 growing at 20% per annum or even faster. Few younger people

<table>
<tr><td></td><td>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>
<tr><td>Widowed or Surviving partner from SSCP</td><td>6.78 %</td></tr>
</table></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)

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

<table><tr><th>Type of long – term condition</th><th>Percentage of population with condition %</th></tr><tr><td>Deafness or partial hearing loss</td><td>5.14%</td></tr><tr><td>Blindness or partial sight loss</td><td>1.7%</td></tr><tr><td>Communication Difficulty</td><td>1.65%</td></tr><tr><td>Mobility of Dexterity Difficulty</td><td>11.44%</td></tr><tr><td>A learning, intellectual, social or behavioural difficulty.</td><td>2.22%</td></tr><tr><td>An emotional, psychological or mental health condition</td><td>5.83%</td></tr><tr><td>Long – term pain or discomfort.</td><td>10.10%</td></tr><tr><td>Shortness of breath or difficulty breathing</td><td>8.72%</td></tr><tr><td>Frequent confusion or memory loss</td><td>1.97%</td></tr><tr><td>A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy.</td><td>6.55%</td></tr><tr><td>Other condition</td><td>5.22%</td></tr><tr><td>No Condition</td><td>68.57%</td></tr></table>(Census 2011)

In Northern Ireland people experience the lowest disability free life expectancy (Age NI, 2010).</td></tr>
<tr><td>Ethnicity</td><td>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.</td></tr>
</table>

	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	Consider issues for transgender people. Transgender men who have not undergone gender reassignment surgery may present to their GP with any number of gynaecological issues. Intimate examinations may be painful for transgender men as long-term testosterone treatment causes vaginal atrophy. medical professionals carrying out these examinations may consider the

	use of small speculums or a proctoscope and topical lubricant. Transgender women who have undergone gender reassignment surgery have no biological female genital anatomy, yet may still present to their GP with gynaecological issues. Transgender women who have undergone gender reassignment surgery may present with vaginal discharge, dyspareunia, a short vagina, voiding difficulties or a lack of lubrication. https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/tog.12521 The gynae pathway may benefit transgender men and women as they will feel more comfortable being seen in their local GP practice by a doctor who knows their history and preferred names/pronouns etc.
Age	It is recognised that women over the age of 45 may also experience bleeding problems. The original pathway was developed inline with NICE guidance and local practice within secondary care. Subsequently NICE has removed the cut off age within its HMB guidance, however local consultant practice would still involve investigation of women over the age of 45 (and in some cases 40) prior to treating their HMB.
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	There is no data to suggest that the needs and experiences of service users differ on the basis of dependent status
Disability	The Gynae 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.

	The support offered includes telephone advice, mentorship and or face to face assessment of patients within their local primary care setting.
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.

n/a

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. Currently the service is not refusing referrals for women above this cut off but assessing and/or treating and referring on for USS / Pipette biopsy where appropriate.	n/a

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

Please give reasons for your decisions

The Gynaecology 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: Roger B. Kennedy

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