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

Reform of Northern Ireland Certification of Visual Impairment (CVI) processes

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)**

The aim of this piece of work was to improve the processes and systems for the certification of visual impairment in Northern Ireland.

A review of annual CVI data by RNIB in 2013 indicated that the rates of certification per 100,000 population in England, Wales and Northern Ireland were as follows:

England	45 per 100,000 pop.
Wales	48 per 100,000 pop. (unofficial)
Northern Ireland	21 per 100,000 pop.

These figures suggested that patients in Northern Ireland were less likely to be certified and it was considered important to understand the reasons for this and how practice might be consistently improved.

This was achieved through the workings of a small subgroup which had the authority to make decisions on behalf of RNIB, Ophthalmic Services, Sensory Support and the Department of Health.

There were no constraints.

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

- Main patient group – primarily aged 65+ (see section 2.2) with no other section 9 differences from the general population demographic.
- Ophthalmic Services delivered in all 5 HSC Trusts via two provider Trusts, BHSCT and WHSCT.
  HSC Northern Ireland Workforce by Trust, September 2018 - Headcount (HC) and Whole Time Equivalent (WTE)
  Belfast HSC Trust - HC 20,386 WTE 17,856.4
  Northern HSC Trust - HC 10,940 WTE 9,211.5
  South Eastern HSC Trust - HC 9,621 WTE 8,310.4
  Southern HSC Trust - HC 10,311 WTE 8,799.8
  Western HSC Trust - HC 10,212 WTE 9,054.4
  Trusts Total - HC 62,734 WTE 54,461.4
- RNIB Eyecare Liaison Officer (ECLO) Service – accessible to 100% of patients in NI. There are 8 ECLOs. 2 FTE's within the Western Trust and 5 (4 FTE and 1 0.9 FTE) in Belfast Trust. There is 1 FTE peripatetic providing support across both Western and Belfast Trust areas.
- HSC Trust Sensory Support teams – 9 teams regionally – will contact 100% of patients.

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

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

This piece of work was derived from the Northern Ireland Eyecare Strategy – published Department of Health October 2012 and overseen by the Project Board of the Developing Eyecare Partnerships (DEP) Project which was established to implement that strategy.

(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.

- Analysis of annual CVI returns in NI
- Review of annual CVI data from England and Wales
- Census 2011
- Northern Ireland Pooled Household Survey (NIPHS) tables, published 2017
- Northern Ireland Life and Times Survey, 2016
- NI Health Survey (published 2018)
- NISRA mid-year population estimates

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	**Patients**: Of the 589 validated forms from 2018, 312 were female, 276 male (1 unspecified). **Workforce:** The UK-wide gender breakdown from the 2018 Royal College of Ophthalmologists census shows that 69% of the consultant workforce are male and 31% female.
Age	**Patients**: Of the 589 validated forms from 2018 the average age of those certified was 62.4 years (Median 75 years). The average age of those certified according to certification category was 67.6(SSI) and 52.5(SI) years (Median values 77(SSI) and 67(SI) years). **Workforce**: the 2018 Royal College of Ophthalmologists Census outlines that there is are 35.89 Whole Time Equivalent consultant ophthalmologists in NI. At a UK wide level, the census shows that

	25% of all consultants are aged between 55 and 64 i.e. nearing probable retirement age. Only 2% of all consultants are aged 65 or over. 13% of all consultants are aged less than 39 years. NISRA estimated and projected population by age, mid-2016 to mid-2041 show that in 2016, 20.8% of the NI Population were aged 0-15 years, and this is projected to decrease 18.2% in 2041. The proportion of adults aged 16-64 in 2016 was 63.2% of the whole population, set to decrease to 57.2 by 2041. However, the proportion of people aged 65 years and over is projected to rise from 16.0% in 2016 to 24.5% in 2041, overtaking the numbers of children.
Religion	There is no data collected on the religious breakdown of current service users. However population data suggests that shows that of the population in NI: • 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)
Political Opinion	Data on the political opinion of service users is not routinely collected. Data from the Northern Ireland Life and Times Survey (2016) show that the general political opinion of the Northern Ireland population is: Unionist 29%; Nationalist 24%; Neither 46%; Other/ don't know 2%.
Marital Status	Currently, no information is collected on the marital status of service users. However, the last Northern Ireland Census found that • 47.56% (680, 840) of those aged 16 or over were married • 36.14% (517, 359) were single • 0.09% (1288) were registered in same-sex civil partnerships • 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership • 6.78% (97, 058) were either widowed or a surviving partner. Given that the age profile of service users is older, it can be assumed that a larger proportion of these will be either widowed,

	or a surviving partner of a marriage/ partnership than the general population.
Dependent Status	There is no data collected on the dependent status of current service users Data from the NI Health Survey (2018) show that 17% respondents were carers: 21% of women and 13% of men. Census data (2011) shows that 238,094 households (33.9% of all NI households) have responsibility for dependent children.
Disability	Of the 589 validated forms from 2018, 377 were Severely Sight Impaired (SSI/Blind) Certifications (64%) and 201 Sight Impaired (SI/Partially Sighted) Certifications (35%) (11 were unspecified). Although all of those using the service have sight impairments, they may also have additional disabilities. Census data shows that: 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. These include: • 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) Given the age profile of the service user group, and that the likelihood of having a disability increases with age, those engaged with the services are more likely to have additional disabilities compared to the general population.
Ethnicity	The most recently published population-based data (Northern

	Ireland Pooled Household Survey (NIPHS) tables; published 2017) suggests that in 2014/15 the ethnic breakdown in Northern Ireland was: Ethnicity White 98.2% (1,409,000); All other Ethnicities 1.8% (26,000)
Sexual Orientation	Although there are no accurate population statistics on sexual orientation, 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	***Needs and Experiences***
Gender	None
Age	Older people might find it more difficult to engage with the services, particularly given the additional vulnerability of visual impairment.
Religion	None
Political Opinion	None
Marital Status	People with a spouse may be more likely, due to encouragement, to take up the offer of Sensory Support services.
Dependent Status	People with the support of grown up children may be more likely, due to encouragement, to take up the offer of Sensory Support services.
Disability	Patients with additional issues such as deafness, learning disability, dementia, mobility issues may find it more difficult to engage with the services. It has also been recognised that patients with dexterity difficulty need additional support for administration of certain eye medications.
Ethnicity	Potential language issues could be a barrier to access.
Sexual Orientation	None.

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.

As referenced above, service users who have both a visual impairment AND:

- are older
- have additional disabilities, such as a hearing impairment or a learning disability
- are from ethnic minorities

may find it more difficult to engage with the services.

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?***
All reference to "registration" or a "blind register" have been removed as there is no legislative basis for such references in Northern Ireland (no register exists) to reduce fear among older people, disabled people, ethnic minorities and other vulnerable groups and to consequently reduce barriers to services. There is quick (within 2 weeks of certification) proactive contact from Sensory Support rather than reactive. This will have particular benefits for people who are older, people who do not have the support of dependents and people who do not have the support of a spouse. In order to alert Sensory support staff of the additional needs faced by certain groups of patients, the new CVI forms ask: • Age • Gender • Ethnicity • Does the patient live alone?	There will be an annual review meeting to analyse the data collected in the CVI returns and other relevant audits, and to identify any gaps in provision or potential barriers to access.

• Does the patient also have a hearing impairment? • Does the patient have poor physical mobility? • Does the patient have a learning disability? • Please indicate if the patient has diabetes In relation to disability – an ID card is offered to all people certified with a sight impairment and a special ID card to people who have both a sight and a hearing impairment. With regard to dexterity difficulties, a chart showing medication aids was developed for prescribers through the wider DEP Project as it is was recognised that people with dexterity difficulties need additional support when self-administering eye drops and other medications. In relation to ethnicity - interpreting and translation services are available if required.	

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		

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.

All equality issues have been mitigated against as far as possible.

(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?***
Part of the reform involved the development of an ID card for people with visual impairment so that they can clearly identify themselves, in a discreet manner, when accessing facilities such as leisure centres, theatres, airports, restaurants etc. and ensure that staff are aware that additional support might be needed. Patients with disabilities have been involved from the outset in the development and design of ID cards. Those with visual impairments have also have provided positive feedback on these cards.	Continue to raise awareness among people with sight impairment of the ways in which other people with sight impairment are engaging in public life.

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?***
Production of the ID card mentioned in 4.1 raises awareness of visual impairment and its use in reducing barriers to participation in public life promoted positive attitudes towards people with a sight impairment.	Continue to raise awareness of the prevalence of sight impairment, which may be invisible to others, and develop better public understanding of the needs of people with sight impairment.

(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

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

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

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights
• Age • Gender • Disability – diabetes, learning disability, physical mobility, hearing impairment • Dependent – whether patient lives alone • Ethnicity	Access to sensory support is triggered by completing this process correctly and data will be kept on this. Data will be recorded on number of ID cards issued.	N/A

Approved Lead Officer:	Máire Gallagher
Position:	Ophthalmic Services Project Manager Health and Social Care Board
Policy/Decision Screened by:	Máire Gallagher
Signed:	
Date:	29th March 2019

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.

Template produced November 2011