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

Provision of General Medical Services (GMS) to the patients of Dr Semple's Medical Practice, Comber Health Centre, following the resignation of Dr Semple (Single handed GP) on 31st October 2018.

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)**

To ensure that the patients of Dr Semples practice in Comber Health Centre will have access to GMS services following the resignation of Dr Semple with effect from the 31st October 2018.

Meetings with Dr Semple and Dr Fitzpatrick.
HSCB met with all the neighbouring GP practices in Comber from 1/8-7/8 to inform them of Dr Semple resignation and the potential issue that may arise and advice on how to deal with same.
Patients were kept informed via letters issued in August 2018 and September 2018. In addition Patient Posters where provided to be displayed in the practice. Patients were advised to phone the HSCB if they had any concerns regarding Dr Semple's resignation.
BSO colleagues in ITS & FPS have been made aware and kept up to date regarding developments.
Local Medical Committee (LMC) were involved from the outset and throughout this process. (LMCs are local representative committees of NHS GPs and

represent their interests in their localities to the NHS health authorities).
Patient Client Council have been notified.
HSCB also liaised with the South Eastern Trust regarding premises.
The HSCB have had a number of meetings with the new contractor in an attempt to make the transfer of patients to the new practice as seamless as possible.

To be achieved by securing a new contractor to provide GMS services.

Key Constraints are:

- Will the HSCB be able to secure a new contractor
- The short period of time (3 Months)The number of patients affected 2600 approx.
- Shortage of GP regionally, made more difficult by the fact this is a singled handed contract.GP's are opting to work fewer sessions in general practice.
- Concerns voiced by remaining GP in Comber. Local GP's have noted that they are already working to capacity and they would not have the ability to register vast numbers of dispersed/reallocated patients.
- Lack of engagement by leaving GP with practice staff and other practices within the local area.

A new GP has been secured and will take up post with effect from the 1st November 2018. The new contractor will provide General Medical Service GMS from Comber Health centre which are the same premises. Patients will not have to do anything. The new contractor will write to patients shortly to give advice about services delivered by the practice.

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

HSC Service Users
Business Service Organisation Staff

- Patients of Dr Semple's practice in Comber Health Centre
- Neighbouring GP Practices
- Employees of Dr Semple's practice
- Trust employed staff working in Dr Semple's practice
- Acute hospitals in Trust Community Clinics

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

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

GMS Contract – Investing in General Practice (February 2003) provides that when a singlehanded GP resigns, the commissioner has an obligation to ensure the provision of primary medical services to that former GP's patients. This may include entering into a contract with existing or new providers.

Dr C Fitzpatrick & Dr Semple were in partnership working from Comber Health Centre. Dr Fitzpatrick resigned from the practice partnership with effect from 28/6/18 therefore making the remaining GP Dr Semple a single handed contractor. Thus Under the guidance of the GMS contract only requiring a single handed contractor to give the HSCB 3 months' notice. With effect from 28/07/18 Dr Semple provided notice to terminate her GMS contract with effect from 31/10/18 the HSCB (Health & Social Care Board) accepted the resignation.

HSCB immediately advertised the contract widely. The closing date for expressions of interest was Friday 24th August, with shortlisting set for week commencing 27th August.

Two applications were received with one being received by the Integrated care office after the close down.
Both applications were accessed based on criteria set by the HSCB and one application was successful.

A new contractor has been secured with effect from 1st November 2018. The new contractor will be providing GMS service from Comber Health Centre which is the same premises as the out-going GP.

(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.

https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland

Source: Patient registration information held by the BSO as at April 2018

Source: information not held by the practice, the following statistics are taken from the 2011 Census Ward: Ballymagee

https://www.carersuk.org/northernireland/policy/policy-library/state-of-caring-in-northern-ireland-2017-2

http://www.ninis2.nisra.gov.uk/public/SearchResults.aspx?sk=dependent;children

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	(Source: Patient registration information held by the BSO as at April 2018) Male = 1320 Females – 1336The 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%

<table>
<tr><td></td><td>The number who have sought treatment seems likely to continue 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.</td></tr>
<tr><td>Age</td><td>(Source: Patient registration information held by the BSO as at April 2018)

Number of Male Patients by age 1 April 2018

<table>
<tr><th>0-4</th><th>5-15</th><th>16-44</th><th>45-64</th><th>65-74</th><th>75-84</th><th>85+</th><th>Total</th></tr>
<tr><td>59</td><td>173</td><td>482</td><td>434</td><td>115</td><td>48</td><td>9</td><td>1320</td></tr>
</table>

Number of Female Patients by age 1 April 2018

<table>
<tr><th>0-4</th><th>5-15</th><th>16-44</th><th>45-64</th><th>65-74</th><th>75-84</th><th>85+</th><th>Total</th></tr>
<tr><td>49</td><td>179</td><td>455</td><td>428</td><td>130</td><td>59</td><td>39</td><td>1336</td></tr>
</table>
</td></tr>
</table>

Religion	Source: information not held by the practice, the following statistics are taken from the 2011 Census Ward: Ballymagee Catholic 9.31% Protestant 54.42% Other Christian 11.27% Other Religion 0.81% No Religion 19.52% Not Stated 4.64%
Political Opinion	
Marital Status	Source: information not held by the practice, the following statistics are taken from the 2011 Census Ward: Ballymagee Single 26.29% Married 58.35% Same sex civil partnership 0% Separated 2.72% Divorced 6.71% Widowed 5.90%
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 2017** Annual survey (UK wide, including NI) • 24% of respondents given up work to care • 26% reduced working hours to care Available at https://www.carersuk.org/northernireland/policy/policy-library/state-of-caring-in-northern-ireland-2017-2 **Northern Ireland Life and Times (2015)** ○ 17% respondents were carers: 21% of women and 13% of 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) HSCT breakdown by male/ female; age; long-term health problem or disability; economic activity / employment status; highest level of qualification; ethnic group; family type; age of dependent children' number of children with long-term health problem or disability; Urban/ rural SOA of residence. Available here http://www.ninis2.nisra.gov.uk/public/SearchResults.aspx?sk=dependent;children; **NI Lone parent families** = 115,959, with 123,745 dependent children in family (Census 2011). **Gender disparity**: Of the 115, 959 lone parents, 16, 691 are males and 99,268 are female. (Census 2011)
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 of Dexterity Difficulty – **11.44% (207, 163)**

	• A learning, intellectual, social or behavioural difficulty. **2.22% (40, 201)** • An emotional, psychological - **5.83% (105, 573)** • or mental health condition • 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) **Northern Ireland Life and Times 2016:** "Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?" Yes 24%; No 76%; Don't know 0%. Breakdown by age, gender and religion available at http://www.ark.ac.uk/nilt/2016/Background/ANYHCOND.html **Health Survey NI (2017)** • 42% longstanding illness (30% limiting and 12% non-limiting illness) • Males: limiting longstanding illness 27%; 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 15% among young adults aged 25 -34 years to 61% among those who are 75 plus years. (Health Survey NI 2016/17) https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland
Ethnicity	Source: information not held by the practice, the following statistics are taken from the 2011 Census Ward: Ballymagee White 98.88% Chinese 0.19% Irish Traveller 0.00% Indian 0.38% Pakistani 0.02% Bangladeshi 0.08% Other Asian 0.00% Black Carribean 0.00% Black African 0.00% Black Other 0.00% Ethnic Mixed 0.35% Ethnic Other 0.05%
Sexual Orientation	In 2016, estimates from the Annual Population Survey (APS) showed 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: ○ 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. (Available at https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016#main-points) 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	*Needs and Experiences*
Gender	Dr Semple is a single-handed female GP. The new contractor's practice has both male & female GPs so patients can have a choice. Transgender people having to disclose their gender identity to a new set of health care staff may experience particular challenges if they are in the process of transitioning. Both practices ware situated in Comber Health centre with shared staff.
Age	There are no implications as patients will have more choice of services, staff (male & female gp's) and both practices are based in Comber Health Centre. However it is recognised that in the case of the introduction of any new healthcare staff this may be challenging.
Religion	
Political Opinion	
Marital Status	
Dependent Status	The HSCB does not envisage any implications as the new contractor is based in the same health centre as the outgoing contractor.
Disability	The HSCB does not envisage any implications as the new contractor is based in the same health centre as the outgoing contractor; however it is recognised that in the case of the introduction of any new healthcare staff this may be challenging.
Ethnicity	People from ethnic minorities may experience particular linguistic and cultural barriers in accessing services.
Sexual Orientation	Lesbian, Gary and Bisexual people may have to disclose their sexual orientation to a new set of healthcare staff this may be challenging.

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.

The range of difference in households presenting can be significant - young people, elderly people, simple and complex cases, disability, linguistic and cultural barriers, religious and sectarian considerations, sexual orientation, gender including transgender etc.

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?***
The new GP will provide 9 sessions over 5days per week with a mixed economy of male & female GPs. Patients attending will be able to avail of a widerrange of new enhanced services that were previously not provided at Dr Semple's practice. This include the additional service childhood vaccinations and Immunisations . All patients of Dr Semple's practice will transfer to the new contractor. Dr Semple & the new contractor will have a number of handover sessions in which they discussed patients with very complex needs as well as palliative care patients. All patients involved in the transfer were given the opportunity to raise any concerns and request to be allocated	The HSCB has asked all patients that are transferring, to remain in the practice for a short period for stability of the new practice. After this short period patient may if they wish to do so register with another GP of their choice.

to a different practice if they wished	

2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	***Impact***	***Suggestions***
Religion	No further impact	None
Political Opinion	No further impact	None
Ethnicity	No further impact	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	

Please give reasons for your decisions.

HSCB was able to secure agreement from a neighbouring practice to transfer all of Dr Semples under a new GMS contract. This means that by the 1st November 2018 no patient was left without immediate access to GP services.

(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			

** 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
None	None	None

Approved Lead Officer: Dr Margaret O'Brien

Position: Assistant Director of Integrated Care

Policy/Decision Screened by: Linda McIlroy, Linda Doherty

Signed:
Date: 8/10/18

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