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?

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 Portal - Screening Resources & Evidence**.**

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

Stroke – Thrombectomy – Increasing Nurse Capacity (Regional)

1.2 Description of policy or decision

This investment will increase stroke nurse capacity in all Trust areas. This will enable a stroke nurse accompany a patient on the blue light transfer to RVH for a thrombectomy procedure.

The accompanying nurse will be responsible for observations and monitoring of the patient during transfer. This nurse will rapidly handover the essential details, with comments on any changes, on arrival at RVH.

Stroke is the single largest cause of adult disability in the UK and the fourth largest cause of death. Two thirds of those who survive stroke have a life changing disability. Stroke is a major health issue in NI with around 2,900 people being admitted to hospital each year and 36,000 stroke survivors living in our communities.

It is important that every opportunity is taken to secure excellent care for people after a stroke and give them the best possible chance of a good recovery. The number of people in NI experiencing stroke each year is likely to increase in future because of a growing older population, with three out of four people who experience stroke being over the age of 65.

Patients who have a particular large clot may be suitable for an intervention to remove a clot called thrombectomy. Thrombectomy is a procedure which involves the insertion of a specially-designed clot removal device through a catheter into the blocked artery to remove the clot. This can be provided to some patients not suitable for thrombolysis and also to some patients after having received thrombolysis. Approximately 1 in 10 stroke patients would benefit from thrombectomy. For every 100 people receiving the procedure, 20 will subsequently be able to lead an independent life and 38 people will be less disabled after a stroke. This is approximately double what would be expected with normal treatment. The expansion of thrombectomy to date has increased numbers of patients across NI benefiting

from the procedure, reducing mortality and long term disability.

Thrombectomy is delivered in RVH Belfast from 8am – 5pm Monday to Sunday with patients directly admitted or via blue light transfer from one of the other 7 Lysing sites in NI.

Need:

Approximately 85% of Strokes are ischaemic (blockage) with up to 10% having a large vessel occlusion which could benefit from a mechanical thrombectomy procedure (extraction of clot) should a 24/7 service provision be in place. However, the Regional service currently operates Monday to Sunday, 8am – 5pm with 120 procedures commissioned.

Below is a table that shows that stroke incidence varies across Trusts. The BHSCT total numbers may include stroke admissions from other Trusts and is therefore not a true representation of their Locality population. Patients that are transferred from other hospitals will be included in the total discharges from BHSCT. In 2020/2021, there were approximately 96 thrombectomy referrals to BHSCT from other Trusts. The WHSCT have a younger population which could suggest why they have a lower prevalence of stroke.

Deaths and discharges per Trust 2016-2021

	Deaths and Discharges				
Trust	FY2016/2017	FY2017/2018	FY2018/2019	FY2019/2020	FY2020/2021
Belfast	829	772	905	996	925
Northern	688	702	799	732	724
South Eastern	468	525	468	488	522
Southern	542	536	570	669	606
Western	470	522	479	509	474
Total	2997	3057	3221	3394	3251

Below is a brief description of each of the proposals in the four Trust areas

NHSCT have approximately 540 ischaemic admissions each year- 22% of NI total. The equitable share of commissioned procedures could see the transfer of up to 28 patients from the Trust to RVH for thrombectomy each year. This investment will be used to increase nurse capacity in the NHSCT. This will enable a nurse to accompany a patient on each blue light transfer to RVH for a thrombectomy procedure. There were 12 patients transferred from

Antrim Hospital in 2020/21. With the band 6 nurse recruited it is predicted there will be 12 thrombectomy transfers during the hours of 8am – 5pm, Monday – Sunday based on last year's figures.

WHSCT have approximately 350 ischaemic admissions each year- 15% of NI total. The equitable share of commissioned procedures could see the transfer of up to 19 patients from the Trust to RVH for thrombectomy each year. Additional funding will be used to expand the Nursing wte within Ward 40 Stroke Unit in Altnagelvin Hospital. This will enable a band 6 nurse to accompany a patient on each blue light transfer to RVH for a thrombectomy procedure. There were 12 patients transferred from Altnagelvin in 2020/21. With the band 6 nurse recruited it is predicted there will be 12 thrombectomy transfers during the hours of 8am – 5pm, Monday – Sunday based on last year's figures. Funding only supports a nurse in Altnagelvin and not in SWAH, the HSCB made the decision on the location as there is a higher prevalence of stroke and thrombectomy referrals in the northern sector of WHSCT and there is a lower ratio of nurses in Alt than the SWAH. In 20/21 there were 218 stroke discharges from Alt and 157 SWAH (discharges are used as an approximation of admissions).

Staff to bed ration is shown in the table below.

Hospital		**Alt**	**SWAH**
Number of Stroke Beds		11	9
Band	**Profession**	**WTE**	**WTE**
BAND 6	Nursing	1.30	1.40
BAND 7	Nursing	0.44	0.50

SHSCT have approximately 470 ischaemic admissions per annum -19.7% of NI total. The equitable share of commissioned procedures could see the transfer of up to 24 patients from the Trust to RVH for a thrombectomy each year. This requires a stroke nurse to accompany the patient on each blue light transfer to the RVH and continue the medical monitoring, removing them from providing care on the ward.

SEHSCT have approximately 305 ischaemic admissions per annum - 13 % of NI total. The equitable share of commissioned procedures could see the transfer of up to 15 patients from the Trust to RVH for a thrombectomy each year. This requires a stroke nurse to accompany the patient and continue the medical monitoring, removing them from providing care on the ward. This investment will be used to increase nurse capacity in the SEHSCT. This will enable a nurse to accompany a patient on each blue light transfer to RVH for a thrombectomy procedure. There were 17 patients transferred from Ulster Hospital in 2020/21. With the band 6 nurse recruited it is predicted there will be 17 thrombectomy transfers during the hours of 8am – 5pm, Monday – Sunday based on last year's figures.

BHSCT – a separate equality screening will be completed for the BHSCT IPT as they provide the mechanical thrombectomy service for NI and their proposal is about sustaining the thrombectomy service Monday – Sunday, 8am – 5pm.

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

Service users and Hospital Staff.

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

- **what are they?**

The transformation of Stroke Services (including the expansion of the stroke thrombectomy service) is of high strategic importance in line with the following:

- New Decade, New Approach (NI Executive, 2020)
- Reshaping Stroke Care – Saving Lives, Reducing Disability (DoH, 2019)
- Systems not Structures, Changing Health & Social Care (2016)
- Improving Stroke Services in Northern Ireland (DHSSPS, 2008)

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

- Census 2011
- NISRA data June 2020
- NICHS stroke statistics
- The programme for Government (PFG) 2016-20216 framework,
- New Decade, New Approach (NI Executive, 2020)
- Reshaping Stroke Care – Saving Lives, Reducing Disability (DoH, 2019)
- Systems not Structures, Changing Health & Social Care (2016)
- Improving Stroke Services in Northern Ireland (DHSSPS, 2008)
- http://healthallianceni.com/health-social-wellbeing/bme-groups/

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Category	***What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	Stroke prevalence varies according to gender. The prevalence of stroke is higher among men up to the age of approximately 80 years, after which it becomes higher in women. A majority of studies indicate that the case-fatality rate is higher in female than in male stroke patients; there is also some evidence, albeit relatively weak, indicating a better functional outcome in men (NICE, 2019). NI HSC Workforce Census as at March 2021 reports that 78% of all HSC staff were female, and 57% (by headcount) worked full-time . At 30 June 2020, Northern Ireland's population was estimated to be 1.90 million people. Just over half of the population (50.7 per cent) were female, with 961,400 females compared to 934,200 males (49.3 per cent). In 2019/20, **1,344 females** (47.6% of total admissions) and **1,477 males**

<table>
<tr><td></td><td>(52.4%) were admitted to hospital for stroke.(NICHS stroke statistic)

There was a 1.25% decrease in females compared to the year before, compared to 2% increase in number of males admitted the year before. (NICHS Stroke statistics).

The estimated population of the Western Health and Social Care Trust (HSCT) at 30 June 2020 was 303,207, of which 150,793 (49.7%) were male and 152,414 (50.3%) were female.

The catchment area of the chosen location for the stroke nurse is Altnagelvin. It has a resident population of 63582 of these 31,451 were male (49.5%) and 32,131 female(50.5%).(Census 2011) It shows therefore that the gender profile of the Altnagelvin catchment area is broadly in line with that of the Trust population overall.

The estimated population of the Southern Health and Social Care Trust (HSCT) at 30 June 2020 was 388,688, of which 194,148 (49.9%) were male and 194,540 (50.1%) were female.

The estimated population of the Northern Health and Social Care Trust (HSCT) at 30 June 2020 was 480,194, of which 236,392 (49.2%) were male and 243,802 (50.8%) were female.

The estimated population of the South Eastern Health and Social Care Trust at 30 June was 364,191 of which of which 177,795 (48.8%) were male and 186,396 (51.2%) were female.</td></tr>
<tr><td>Age</td><td>Stroke can affect all ages but most strokes occur amongst people who are older than normal retirement age with three out of four people who experience stroke being over the age of 65.

. – The hospital admissions for stroke and TIA in 2019/20, 939 were under the age of 70 (33.3% of all admissions), compared to 981 in the previous year (35%).(NICHS)

Mid-year population estimates published by NISRA in 2019 show that:
65 – 74 yrs = 169,725 (9.0%)
75 – 89 yrs = 125,334 (6.6%)
90+ yrs = 13,138 (0.7%)

NISRA Estimated the proportion of people aged 65 years and over is projected to rise from 16.0% in 2016 to 24.5% in 2041.

Population of over 65 per Trust area is detailed below;

<table>
<tr><td>NHSCT</td><td>SHSCT</td><td>SEHSCT</td><td>WHSCT</td></tr>
<tr><td>86,014</td><td>58,703</td><td>69,683</td><td>49,709</td></tr>
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	(17.0%)	(15.1%)	(19.1%)	(16.3%)

In the catchment area Altnagelvin, the chosen location for the stroke nurse, 4592 were 65 years and over giving a percentage of 7.2%. (Census 2011) This suggests a younger age profile of the population than in the Trust area as a whole.

Religion	There are no accurate NI robust statistics of religion of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds of religion. **(Census 2011)** **WHSCT -67.69%** belong to or were brought up in the Catholic religion and **29.75%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion; In the catchment area of Altnagelvin, 33310 (54%) were brought up catholic and 22588 (36%)were brought up in a 'Protestant and Other Christian (including Christian related)' religion, 7,675 (12%)were brought up other or no religion; (Census 2011)suggesting a lower religious profile of those brought up catholic and higher profile of thise brought up in Protestant and other christian than the Trust overall. **SHSCT- 56.69%** belong to or were brought up in the Catholic religion and **39.15%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion; (Census 2011). **NHSCT- 33.61%** belong to or were brought up in the Catholic religion and **59.58%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion. **SEHSCT- 31.13%** belong to or were brought up in the Catholic religion and **59.79%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion.
Political Opinion	There are no accurate NI robust statistics on the political opinion of stroke patients which would enable analysis of this aspect. In relation to staff, there is no NMC Equality and Diversity data for this group and NI HSC Workforce Census for this is unavailable but there is no evidence of differential impact on the grounds of political opinion. A recent survey of the NI population, published in 2018, explored political opinion. People were asked “Generally speaking, do you consider yourself as a unionist**,** a nationalist or neither?” Of those that responded to the survey, 26% generally considered themselves to be Unionist; 21% said they were Nationalist; 50% said neither Unionist nor Nationalist; and 1% said “Other”.

	2% said they didn't know (Northern Ireland Life and Times, 2018).
Marital Status	There are no accurate NI robust statistics of marital status of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds marital status. • 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 (Census 2011) **Northern Ireland Life and Times (2018)** Single (never married) 32% Married and living with husband/wife 51% A civil partner in a legally-registered civil partnership 0% Married and separated from husband/wife 3% Divorced 6% Widowed 7% **Civil partnerships** Annual Reports of the Registrar General for NI show that Between 2005 to 2018 inclusive, there have been 1298 civil partnerships registered in NI. Of these, 539 have been male civil partnerships, and 571 have been female civil partnerships.
Dependent Status	Data on the caring responsibilities of stroke survivors is not routinely collected. Given their age profile, it is reasonable to assume that fewer of them will have dependents than in the general population as a whole. Nevertheless, it is recognised that some older people will themselves be carers, as Age UL data (2013) underlines:in the UK nearly 50,000 people aged 85 provide unpaid care to a partner, family member or other person. In turn, younger stroke survivors will be more likely to have caring responsibilities , including for children and/ or older dependents. (Census 2011) In the **WHSCT** area 11.04% of people in the WHSCT area stated that they provided unpaid care to family, friends, neighbours or others. In **SHSCT** area, 11.34% of people stated that they provided unpaid care to family, friends, neighbours or others. In **NHSCT** area, **11.55%** of people stated that they provided unpaid care to family, friends, neighbours or others. **In SHSCT area 12.82%** of people stated that they provided unpaid care to

	family, friends, neighbours or others. • 11.81% (213, 863) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill – health/disabilities or problems related to old age. • 3.11% (56, 318) provided 50 hours care or more. • 33.86% (238, 129) of households contained dependent children. • 40.29% (283, 350) contained a least one person with a long – term health problem or a disability. (Census 2011) CarersNI • 1 in every 8 adults is a carer • 2% of 0-17 year olds are carers, based on the 2011 Census • There are approximately 220,000 carers in Northern Ireland (• Any one of us has a 6.6% chance of becoming a carer in any year • One quarter of all carers provide over 50 hours of care per week • People providing high levels of care are twice as likely to be permanently sick or disabled than the average person • 64% of carers are women; 36% are men. **CarersNI State of Caring 2019** Annual survey (UK wide, including NI) 1) 2 in 5 carers (39%) responding reported being in paid work. 2) 38% of all carers reported that they had given up work to care. 3) 18% had reduced their working hours. 4) 1 in 6 carers (17%) said that they work the same hours but their job is negatively affected by caring, for example because of tiredness, lateness, and stress. 5) 12% of carers said they have had to take a less qualified job or have turned down a promotion to fit around their caring responsibilities. 6) Just over 1 in 10 carers (11%) said they had retired early to care. 7) Only 4% of respondents of all ages said that caring has had no impact on their capacity to work. 8) Only one quarter (25%) of carers who aren't yet retired and had an assessment in the last year felt that their need to combine paid work and caring was sufficiently considered in their carer's assessment. 9) Carers who are not yet retired were also asked about their future plans and 53% said they are not able to save for their retirement. 10) Some carers are saving or have saved less for their retirement with 17% saying they did this because their working hours were reduced.
Disability	Stroke is the single biggest cause of disability in adults in the UK (NICE, 2019). Stroke can have many different effects on someone, including problems with mobility, swallowing and continence. It can affect their vision and cause communication problems, fatigue and problems with memory and concentration. It can also have emotional effects, like depression and anxiety.

It can also cause behaviour changes.

Data from the stroke sentinel National Audit public report indicates that stroke patients have a higher level of pre-existing physical disability than that of the general population. This could indicate that those living with a physical disability may be at higher risk of stroke.

It is also known that people with certain long term conditions , including heart disease and diabetes , are at a higher risk of stroke.

(Census 2011)

21.85% of people had a long-term health problem or disability that limited their day-to-day activities in the **WHSCT** area;

Altnalgelvin on health suggesting that the incidence of disability in this area is in line with the Trust overall.

Health	
Very Good	**31275 49%**
Good	**19430 31%**
Fair	**9427 15%**
Bad	**2809 4%**
Very Bad	**641 1%**
Total	**63582**

In SHSCT, 19.64% of people had a long-term health problem or disability that limited their day-to-day activities.(Census 2011)

In NHSCT, 19.65% of people had a long-term health problem or disability that limited their day-to-day activities;

In SEHSCT, 19.82% of people had a long-term health problem or disability that limited their day-to-day activities;

NI Data

- 20.69% (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities.
- 68.57% (1, 241709) of residents did not have long – term health condition.
- Deafness or partial hearing loss – **5.14% (93, 078)**
- Blindness or partial sight loss – **1.7% (30, 785)**

	• Communication Difficulty – **1.65% (29, 879)** • Mobility or Dexterity Difficulty – **11.44% (207, 163)** • A learning, intellectual, social or behavioural difficulty - **2.22% (40, 201)** • An emotional, psychological or mental health condition - **5.83% (105, 573)** • Long – term pain or discomfort – **10.10% (182, 897)** • Shortness of breath or difficulty breathing – **8.72% (157, 907)** • Frequent confusion or memory loss – **1.97% (35, 674)** A chronic illness (such as cancer, HIV, diabetes, heart disease • or epilepsy. – **6.55% (118, 612)** • Other condition – **5.22% (94, 527)** • No Condition – **68.57% (1, 241, 709)** (Census 2011) 43% longstanding illness (30% limiting and 12% non-limiting illness) • Males: limiting longstanding illness 28%; non-limiting longstanding illness 12% • Females: limiting longstanding illness 33%; non-limiting longstanding illness 12% • Prevalence of disability increases with age. Limiting longstanding illness increases from 18% among young adults aged 25 -34 years to 52% among those who are 75 plus years. According to NI Life and Times Survey - 2020: Background (ark.ac.uk) 44% of the over 65 group in NI indicated that they had a disability compared to 55% who said they did not. 75% of the over 65 group indicated that their condition or disability had a substantial adverse effect on their ability to carry out normal day-to-day activities. (NILT-2020). **Census 2011** It becomes clear, therefore, that a sizeable share of stroke survivors in NI will have pre-existing disabilities, physical disabilities as well as certain long term conditions such as diabetes and heart disease in particular. NI HSC Workforce Census for this is unavailable
Ethnicity	National research suggests that there are differences within black and minority ethnic (BME) groups generally when compared with the white population, Ill health often starts at an earlier age in BME groups than among white people. There are variations from one health condition to another, for example, BME groups have higher rates of cardiovascular disease than white people but lower rates of cancer, Diabetes is more common in BME groups and high blood pressure is more common in Asian groups. NICE (2019) states that black people are almost twice as likely to have a stroke as white people. On average, people of black African, black Caribbean and South Asian descent in the UK have strokes earlier on in their lives.

In the WHSCT area **1.10%** were from an ethnic minority population and the remaining **98.90%** were white (including Irish Traveller).

In the catchment area of chosen location Altnagelvin the ethnic minority population is shown in the table below;

White	**62472**
Mixed Ethnicity	**176**
Indian	**449**
Pakistani	**21**
Bangladeshi	**13**
Chinese	**187**
Other Asian	**135**
Black African	**37**
Black Caribbean	**20**
Other Black/African/Caribbean	**11**
Other	**61**
Total	**63582**

This suggests that the ethnic minority share of the population in the Altnagelvin catchment area, though small overall, is somewhat higher than in the Trust area overall (1.75%).

In SHSCT **1.34%** were from an ethnic minority population and the remaining **98.66%** were white (including Irish Traveller)

In NHSCT, **1.30%** were from an ethnic minority population and the remaining **98.70%** were white (including Irish Traveller);

In SEHSCT **- 1.46%** were from an ethnic minority population and the remaining **98.54%** were white (including Irish Traveller);

<u>NI Data</u>

1.8% (32,596) of the usual resident population belonged to minority ethnic groups:

White – 98.21% (1, 778, 449)

	Chinese – 0.35% (6, 338) **Irish Traveller** – 0.07% (1, 268) **Indian –** 0.34% (6, 157) **Pakistani –** 0.06% (1, 087) **Bangladeshi** – 0.03% (543) **Other Asian** – 0.28% (5, 070) **Black Caribbean** – 0.02% (362) **Black African** – 0.13% (2354) **Black Other** – 0.05% (905) **Mixed** – 0.33% (5976) **Other** – 0.13% (2354) (Census, 2011) No specific NI data available in respect of ethnicity and older people. However, the majority of the NI black and minority ethnic population are of working age and therefore it can be reasonable to assume that those of ethnic minority of 65+ make up a smaller share of the 15%.

Sexual Orientation	NI Data (Census)
	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:
	  o 1.2% identifying as gay or lesbian
	  o 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.
	
	The 2011 Census did not collect data on the sexual orientation of older people but according to the Moving towards a Sexual Orientation strategy for NI (ark.ac.uk) 0.4 percent of the 65 years group and older identified themselves as gay, lesbian 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	Stroke prevalence varies according to gender. The prevalence of stroke is higher among men up to the age of approximately 80 years, after which it becomes higher in women. A majority of studies indicate that the case-fatality rate is higher in female than in male stroke patients; there is also some evidence, albeit relatively weak, indicating a better functional outcome in men (NICE, 2019).
Age	Most strokes occur amongst people who are older than normal retirement age. They are more likely to live alone than younger people, which means they tend to need more support if they return home to live after a stroke. They are also more likely than younger people to have other pre-existing health issues which may compound their needs when recovering from a stroke. However, there is still a substantial proportion of people who have had a stroke will be of working age, and will wish to return to work. This may affect the type of rehabilitation they require, and if they have acquired impairment from their stroke they may need to retrain to a different job, or have adaptations made to their working environment. If the partner of a stroke survivor is of working age this may affect their ability to take on additional caring responsibilities (CQC, 2019).
Religion	There are no accurate NI robust statistics of religion of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds of religion.
Political Opinion	There are no accurate NI robust statistics on the political opinion of stroke patients which would enable analysis of this aspect. In relation to staff, there is no NMC Equality and Diversity data for this group and NI HSC Workforce Census for this is unavailable but there is no evidence of differential impact on the grounds of political opinion.
Marital Status	There are no accurate NI robust statistics of marital status of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds marital status. Stroke survivors who are single may have less family support to draw on compared with those who are married.
Dependent Status	Research shows that there is a substantial burden to families of people who have had a stroke in terms of informal unpaid care (NICE, 2019).
Disability	.Stroke is the single biggest cause of disability in adults in the UK (NICE, 2019). Stroke can have many different effects on someone, including problems with mobility, swallowing and continence. It can affect their vision and cause communication problems, fatigue and problems with memory and concentration. It can also have emotional effects, like depression and anxiety. It can also cause behaviour changes. People who are disabled and then have a stroke are likely to have additional needs that need to be recognised in the care that they receive for the stroke. Prevalence of long term conditions/disabilities such as physical, mental, sensory or life limiting difficulties are all associated with the older population and as such services should be tailored to meet the specific needs of these service users.

Ethnicity	There are no accurate NI robust statistics of ethnicity of stroke patients or staff which would enable analysis of this aspect. The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care. These include: - Language difficulties; - Lack of awareness and lack of appropriate information on the services available; - The need for a permanent address in order to register with a General Practitioner; - Fears about entitlement to health care; - Difficulty in coming to grips with a health care system that is different to what exists in their country of origin; - The failure of some services to meet migrants' cultural or religious needs; - Institutional racism and the negative attitudes of some health care staff; and - Immigration restrictions. It is recognised that people from ethnic minorities can experience difficulties accessing public services based on language barriers as well as lack of familiarity with the services that are available. Cultural barriers may likewise play a role. Those service users who need assistance to access the services will be facilitated. Those requiring assistance to access services will be given the necessary support (including provision of interpreting or translation services).
Sexual Orientation	There are no accurate robust statistics on sexual orientation of stroke patients which would enable analysis of this aspect. Research suggests that older lesbian, gay and bisexual people are more socially isolated and have fewer family and community networks they can draw on for support. Some people in a same sex relationship may have particular concerns about being cared for in a hospital setting (for example, based on negative experiences in the past) and thus draw particular benefits from Early supported discharge and continuing therapy in the patient/users home environment. Sexual orientation of the users will not determine service accessibility or delivery. Service providers will be respectful of same sex families.

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.

This decision would support the timely safe transfer of people with multiple identities.

2.5 Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Services will be accessible by all who require intervention or treatment and Trust will ensure that the needs of all service users were considered in the development and implementation of the service.	Access to services and service delivery will be monitored as part of the service agreement and any potential impacts will be addressed as part of the ongoing equality monitoring process.
The service will be tailored and personalized to the service user, taking account of their different needs based on any section 75 characteristic.	Trusts are required to monitor the impact on some section 75 users going forward.
People from ethnic minorities can experience difficulties accessing public services based on language barriers as well as lack of familiarity with the services that are available. Cultural barriers may likewise play a role.	Trusts will be required to identify any barriers experienced by ethnic minorities in accessing the service.
Some section 75 groups may be uneasy with strangers even though they are HSC staff particularly those who live on their own, elderly, or belong to the LGBT community.	Staff training and awareness

2.6 Good Relations

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

Group	*Impact*	*Suggestions*
Religion	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.

This decision would support the timely safe transfer of all individuals to hospital to receive live saving or disability reducing treatment. The service will be available for all Trusts.

(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?*
In 2019 the DoH undertook a formal public Consultation with stroke survivors and carers which included a series of engagements and meetings into how best to improve stroke care for patients in Northern Ireland Service user representation is encouraged within the Network. Service users are invited to become a member of various Network groups or join the Readers Panel. As a member of a Network group service users, would attend meetings which gives them the opportunity to highlight issues which are important to patients and their families, propose and influence areas for change and contribute to policy development. The Readers panel will read information written by the Stroke Network for stroke services, patients or the public and feedback comments before it is published. This ensures that the information is clearly presented, easy to read and is helpful and informative.	Regular needs analysis and monitoring effectiveness of the service Access to services and service delivery will be monitored as part of the service agreement and any potential impacts will be addressed as part of the ongoing equality monitoring process. Trusts will be required to monitor the impact on some section 75 users going forward. The Network will continue to encourage Service Users participation. The Network will work with PCC and the voluntary sector to involve service users. The Network will ensure, service users are provided with support to undertake this role as confidently as possible. All information should be treated with confidence at all times. We will make sure we do our best to accommodate any special needs you have. Your involvement is entirely voluntary. You can tell us what you are willing, or not willing to do and how much time you can give us.

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?*
By promoting independence and self-management.	Staff training and awareness

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Are Human Rights relevant? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	Yes
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	no
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	no
Article 5 – Right to liberty & security of person	no
Article 6 – Right to a fair & public trial within a reasonable time	no
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	no
Article 8 – Right to respect for private & family life, home and correspondence.	no
Article 9 – Right to freedom of thought, conscience & religion	no
Article 10 – Right to freedom of expression	no
Article 11 – Right to freedom of assembly & association	no
Article 12 – Right to marry & found a family	no
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	no
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	no
1st protocol Article 2 – Right of access to education	no

If you have answered no to all of the above please move onto to move on to ***Question 6*** *on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision have a potential positive impact or does it potentially interfere with anyone's Human Rights?

List the Article Number	Positive impact or potential interference?	How?	Does this raise any legal issues?* Yes/No
2	Positive impact	This decision would have a positive impact as it supports the timely safe transfer of all individuals to hospital to receive lifesaving or disability reducing treatment.	No

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

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

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

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights
The LCG and the Trusts will regularly monitor the effect of the services. The scheme will be implemented and managed by a service manager and will be subject to Post Project Evaluation to ensure that any negative impacts can be highlighted and resolved. Minimum Datasets have been agreed with LCG and Integrated Care Partnerships to ensure that implementation and management of service can be monitored regularly. Data is not currently available for the following equality groupings; -Age -Gender -Disability -Ethnicity Trusts will be required to collect this information for monitoring purposes.		

Approved Lead Officer: Mr Iain Deboys

Position: Assistant Director of Commissioning

Policy/Decision Screened by: Ms Bernie Mooty

Signed:
Date: 20/12/2021

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:

Equality Unit/ BSO /James House/ 2-4 Cromac Avenue/ Belfast/ BT7 2JA Tel: 028 9536 3961