

# Equality and Human Rights Screening Template

The Business Services Organisation is required to address the 4 questions below in relation to all its policies.

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/none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

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/none)

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](#).**

# SCREENING TEMPLATE

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.

## (1) INFORMATION ABOUT THE POLICY OR DECISION

### 1.1 Title of policy or decision

**Policy for Service User and Carer Representative Involvement within the HSC Clinical Education Centre**

### 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 purpose is to outline a policy for service user involvement in HSC CEC design and delivery of education programmes for nurses, midwives and AHPs reflective of health and social care policy.

Service users as partners in designing and delivering professional development education can enrich programmes in many ways such as bringing the lived experience to the classroom as well as helping practitioners consider the impact of their practice on the service user. Additionally service users playing the role of the patient in the classroom can support clinically skills practice in a controlled environment and help the practitioner develop their person centred care approach.

This is in line with HSC Personal and Public Involvement (PPI) under the statutory duty for some HSC Organisations to involve and consult service users, carers and the public in the planning, development, implementation and evaluation of services. Co- production is part of the continuum of involvement. Although CEC is not subject to statutory duty in relation to PPI Involvement they are committed to working towards this as good practice. For further information please go to <http://engage.hscni.net/>

Service user engagement in design and delivery of professional development education programmes is encouraged, as appropriate, in as many courses as possible across a range of programmes of care. This engagement can be at different levels of involvement from a pre-recorded or face to face story telling of a patient's lived experience of a condition to design and delivery input to programmes such as Wheelchair Skills, STORM (suicide prevention and self-harm) or KUF (personality disorder knowledge and understanding). Service users are engaged on a voluntary basis only. Sourcing of the service user varies from programme to programme with some identified by HSC Trusts, and some by 3<sup>rd</sup> sector. Section 75 screening is considered in the selection process of service users.

### 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**

Clinical Education Centre Staff

External Education Providers both HSC (6 Trusts) and private sector.

3<sup>rd</sup> sector organisations- Community Voluntary Sector

Arm's length bodies such as PHA

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

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

#### **Regional Policies**

1. DOH April 2019 The Code of Practice on protecting the Confidentiality of Service User Information, <https://www.health-ni.gov.uk/sites/default/files/publications/health/user-info-code2019.pdf>
2. DOH- Adult Safeguarding Policy: Prevention and Protection in Partnership (DHSSPS 2015) - Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection <https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents>
3. DOH- Mental Capacity Act 2016. <https://www.health-ni.gov.uk/publications/mca-ni-2016-deprivation-liberty-safeguards-january-2020-easy-read-version>
4. DOH Coproduction Guide 2018 <https://www.health-ni.gov.uk/sites/default/files/publications/health/HSCB-Co-Production-Guide.pdf>

#### **BSO Policies**

1. Data Protection - [http://www.hscbusiness.hscni.net/pdf/20180524\\_Data\\_Protection\\_Policy.pdf](http://www.hscbusiness.hscni.net/pdf/20180524_Data_Protection_Policy.pdf)
2. Information Governance – [http://www.hscbusiness.hscni.net/pdf/20180524\\_Information\\_Governance\\_Policy.pdf](http://www.hscbusiness.hscni.net/pdf/20180524_Information_Governance_Policy.pdf)

3. Staff Code of Conduct-

<http://www.hscbusiness.hscni.net/pdf/Code%20of%20Conduct%20for%20HSC%20Employees.pdf>

**CEC Policies**

1. Communication Strategy

<T:\Shared Folder\CEC Policies & Procedures\CEC - Communications Strategy Nov 2018 v3.pdf>

2. Guidance on raising a concern

<T:\Shared Folder\CEC Policies & Procedures\CEC - Raising and Acting on Concerns - Guidance\CEC - Raising and acting on concerns for Nursing and Midwifery Oct 2019 version 2.pdf>

3. Reimbursement policy Link will be added when available (in draft form at time of writing this policy)

## (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.**

CEC continually gather programme data including programme contributor data, source of contributors, teaching methods and venues for teaching.

Stakeholders and colleagues are engaged in a number of ways:

- Stakeholder Engagement Events
- Service Level Agreement quarterly meetings/ AHP Clinical Forum engagement with HSC Trusts
- BSO Customer Survey (every two years)
- Participant programme evaluations
- Regional PPI Forum- PHA

Census 2011 data

Data from HRPTS relating to Section 75 breakdown of NHSCT, BHSCT, SHSCT, SEHSCT AND WHSCT, and BSO staff

2017/18 NI Health Survey

PPI and Engage forum guidance <http://engage.hscni.net/>

KUF Resources and standards: <https://kuftraining.org.uk/>

STORM training guidance: <https://stormskillstraining.com>

Elliott MN, Kanouse DE, Burkhart Q, et al. Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey Journal of General Internal Medicine. Published online September 4 2015)

PHA. Sexually Transmitted Infection in Northern Ireland 2019. Available at <https://www.publichealth.hscni.net/sites/default/files/2019-08/STI%20surveillance%20report%202019.pdf>

O'Hara (2013) Through Our Minds: Exploring the emotional health and well being of lesbian, gay, bisexual and transgender people in Northern Ireland. The Rainbow Project, Belfast.

Northern Ireland HSC Interpreting Service Report: 1 April 2019 - 31 March 2020

## 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. Also give consideration to multiple identities.**

Composition of HSC Workforce – table below includes aggregated data for NHSCT, BHSCT, SHSCT, SEHSCT AND WHSCT, and BSO.

Section 75 Group		Percentage
Gender	<p><b>HSC Workforce Profile</b>            Female            Male</p> <p><b>Population data</b>            Mid-year population estimate (2018; published June 2019)</p> <p>The size of the resident population in Northern Ireland at 30 June 2018 is estimated to be 1.88 million people. Just over half (50.8 per cent) of the population were female, with 955,400 females compared to 926,200 males (49.2 per cent).</p>	<p>79.9            20.1</p>
Religion	<p><b>HSC Workforce Profile</b>            Protestant            Roman Catholic            Neither</p> <p><b>Population data</b>            Religion or Religion brought up in</p> <ul style="list-style-type: none"> <li>45.14% (817, 424) of the population were either Catholic or <b>brought up</b> as Catholic.</li> </ul>	<p>40.4            46.4            13.2</p>

	<ul style="list-style-type: none"> <li>• 48.36% (875, 733) stated that they were Protestant or <b>brought up</b> as Protestant.</li> <li>• 0.92% (16, 660) of the population belonged to or had been <b>brought up</b> in other religions and Philosophies.</li> <li>• 5.59% (101, 227) neither belonged to, nor had been brought up in a religion.</li> </ul> <p>(Census 2011)</p>	
Political Opinion	<p><b>HSC Workforce Profile</b></p> <p>Broadly Unionist 9.0  Broadly Nationalist 7.6  Other 8.4  Do Not Wish To Answer/Not Known 75.0</p> <p><b>Population data</b>  Given the large volume of HSC missing data, population level information (using the Northern Ireland Life and Times survey, 2018) suggests the NI population are:</p> <p>Broadly Unionist  Broadly Nationalist 26%  Neither 21%  Other/ Don't know 50%  3%</p>	
Age	<p><b>HSC Workforce Profile</b></p> <p>16-24 4.1  25-34 23.3  35-44 24.8  45-54 27.2  55-64 18.0  65+ 2.6</p> <p><b>Population data</b>  Mid-year population estimates published by NISRA in 2019 show that:  0-19 yrs (inclusive) = 485,064 (25.7% of all</p>	

	<p>NI population)</p> <p>20 – 34 yrs = 364,623 (19.3%)</p> <p>35 – 49 yrs = 366,967 (19.5%)</p> <p>50 - 64 yrs = 356,790 (19.0%)</p> <p>65 – 74 yrs = 169,725 (9.0%)</p> <p>75 – 89 yrs = 125,334 (6.6%)</p> <p>90+ yrs = 13,138 (0.7%)</p>	
Marital Status	<p><b>HSC Workforce Profile</b></p> <p>Single Married Not Known</p> <p><b>Population data</b></p> <ul style="list-style-type: none"> <li>• 47.56% (680, 840) of those aged 16 or over were married</li> <li>• 36.14% (517, 359) were single</li> <li>• 0.09% (1288) were registered in same-sex civil partnerships</li> <li>• 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership</li> <li>• 6.78% (97, 058) were either widowed or a surviving partner</li> </ul> <p>(Census 2011)</p>	<p>30.2 59.7 10.1</p>
Dependent Status	<p><b>HSC Workforce Profile</b></p> <p>Caring for a Child/Children / Dependant Older Person / Person With a Disability None Not Known</p> <p><b>Population data</b></p> <p>Given the large volume of missing HSC staff data relating to dependent status, official statistics were also used. The Health Survey NI suggests that 13% of the Northern Ireland population have caring responsibilities. More females (14%) than males (10%) have caring responsibilities.</p>	<p>24.4 20.0 55.6</p>

	Census data suggests that 33.9% of all NI Households have dependent children. (Census 2011),	
Disability	<p><b>HSC Workforce Profile</b></p> <p>Yes 2.2 No 64.0 Not Known 33.8</p> <p><b>Population data</b></p> <p>Census (2011) data reveals that 20.69% of the NI population (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities. This includes:</p> <ul style="list-style-type: none"> <li>• Deafness or partial hearing loss <b>5.14% (93,078)</b></li> <li>• Blindness or partial sight loss <b>1.7% (30,785)</b></li> <li>• Communication Difficulty <b>1.65% (29,879)</b></li> <li>• Mobility or Dexterity Difficulty <b>11.44% (207,163)</b></li> <li>• A learning, intellectual, social or behavioural difficulty <b>2.22% (40,201)</b></li> <li>• An emotional, psychological or mental health condition <b>5.83% (105,573)</b></li> <li>• Long–term pain or discomfort <b>10.10% (182,897)</b></li> <li>• Shortness of breath or difficulty breathing <b>8.72% (157,907)</b></li> <li>• Frequent confusion or memory loss <b>1.97% (35,674)</b></li> <li>• A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy) <b>6.55% (118,612)</b></li> <li>• Other condition <b>5.22% (94,527)</b></li> <li>• No condition <b>68.57% (1, 241, 709)</b></li> </ul> <p>Findings from the 2017/18 Health Survey</p>	

	show that the prevalence of disability increases with age. Findings also show that females are more likely to have a limiting long-standing illness compared to males (34% compared to 29% respectively).	
Ethnicity	<p><b>HSC Workforce Profile</b></p> <p>Bangladeshi 0.01  Black African 0.11  Black Caribbean 0.01  Black Other 0.02  Chinese 0.14  Filipino 0.53  Indian 0.86  Irish Traveller 0.02  Mixed Ethnic 0.14  Pakistani 0.12  Other 0.14  White 70.18  Not Known 27.72</p> <p><b>Population data</b>  Statistics from the HSC Interpreting Service showed a large rise in requests for interpreters from 1,850 in 2004-2005 to 132434 requests in 2019-2020. The most popularly requested languages in 2018-19 are described below:</p> <p>Top 10 Languages requests include:</p> <ol style="list-style-type: none"> <li>1. Polish 30231</li> <li>2. Arabic 20392</li> <li>3. Lithuanian 15503</li> <li>4. Romanian 13059</li> <li>5. Portuguese 8312</li> <li>6. Bulgarian 7881</li> <li>7. Tetum 6623</li> <li>8. Slovak 5696</li> <li>9. Mandarin 4794</li> <li>10. Cantonese 3170</li> </ol>	

<p>Sexual Orientation towards:</p>	<p><b>HSC Workforce Profile</b></p> <p>Opposite Sex Same Sex Same and Opposite Sex Do Not Wish To Answer/Not Known</p> <p><b>Population data</b></p> <p>There are no accurate statistics on sexual orientation in the population as a whole, it is however estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual.</p> <p>A report published by the Rainbow Project (O’Hara, 2013), based on research conducted with more than 500 individuals reported common experiences of invisibility, homophobia/transphobia, and a range of violence from threats to physical violence, whether direct or indirect. As a result of their actual or perceived sexual orientation and/or gender identity:</p> <ul style="list-style-type: none"> <li>- 65.8% had been verbally assaulted at least once;</li> <li>- 43.3% had been threatened with physical violence at least once;</li> <li>- 33% had been threatened to be ‘outed’ at least once;</li> <li>- 34.7% had experienced discrimination in accessing goods, facilities or services at least once.</li> </ul>	<p>44.9 1.0 0.1 54.0</p>
------------------------------------	--	--------------------------------------

### 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. Also give consideration to multiple identities (such as single parents for example).**

<b>Category</b>	<b>Needs and Experiences</b>
Gender	<p>There are some courses where there may be service users/patients of higher prevalence in one gender group</p> <p>For example:</p> <ul style="list-style-type: none"> <li>- STORM (males more at risk of suicide/ females more at risk of self-harm)</li> <li>- Pelvic Floor Health (females only)</li> <li>- As females are more likely to have a limiting long-standing illness compared to males there is a possibility that service user engagement will be greater in this category.</li> <li>- Carer involvement in programmes- more female carers than males in caring roles</li> </ul>
Age	<p>As disability and disease prevalence increases with age it is likely that engagement will be greater with service users in the higher age categories</p>
Religion	<p>There are no issues regarding religion with service user/ carer engagement selection.</p>
Political Opinion	<p>There are no issues regarding political opinion when seeking service user/carers engagement.</p>
Marital Status	<p>There is no impact relating to marital status in service user/carers engagement in programmes.</p>
Dependent Status	<p>There may be an impact relating to dependent status particularly for carers to have the capacity to engage in programmes. Virtual and blended teaching methods, pre-recordings at a convenient time should minimise this.</p>
Disability	<p>Many of the service users/carers engaging as 'expert' patient or sharing their story will have a disability some of which may be obvious or some may be hidden. Environmental barriers should not cause a challenge for physical disability as CEC buildings DDA compliant. Other disabilities should be accommodated as far as possible by the programme facilitators and teaching methods such as video platforms should be adjusted to allow for sensory loss. Linkage to specialist support such as sign language</p>

	<p>and 3<sup>rd</sup> sector support should be organised if appropriate.</p> <p>It is recognised that user involvement in delivering certain programmes (e.g. STORM) may have more of an impact on those with mental health issues.</p>
Ethnicity	There is no impact relating to ethnicity in service user/carer engagement in programmes.
Sexual Orientation	There is no impact relating to sexual orientation in service user/carer engagement in programmes.

## 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.**

No impact noted.

## 2.5 Making Changes

**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?**

<i><b>In developing the policy or decision what did you do or change to address the equality issues you identified?</b></i>	<i><b>What do you intend to do in future to address the equality issues you identified?</b></i>
<p><b>Gender:</b> As appropriate a balance of gender will be sought but realising that prevalence as outlined may focus more strongly in a particular gender depending on programme content and impact of the condition being taught e.g. pelvic floor health for applicable</p>	

<p>for females only.</p> <p><b>Age:</b> All age sectors will be included in any requests for service user/ Carer involvement in programmes</p> <p><b>Dependents:</b> Virtual platforms will be offered to ease the burden on carers and facilitate engagement.</p> <p><b>Disability:</b> CEC sites are DDA compliant and most physical disabilities should not present a barrier to engagement. For sensory disability loop system is available and virtual platforms are being adapted to accommodate those with sensory loss. Service users or those attending programmes can avail of sign language interpreting if they are deaf or hard of hearing.</p> <p>Additionally contact details for services such as Lifeline can be made available to service users if deemed appropriate.</p>	
--	--

## 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)**

<b>Group</b>	<b>Impact</b>	<b>Suggestions</b>
Religion	No impact	

Political Opinion	No impact	
Ethnicity	No impact	

**(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 areas of the population have been considered when engaging service users/carers in programme design and delivery. Any equality impacts have been effectively mitigated against when developing the policy, and a full EQIA is not expected to highlight any further equality impacts.

#### (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?

<b><i>How does the policy or decision currently encourage disabled people to participate in public life?</i></b>	<b><i>What else could you do to encourage disabled people to participate in public life?</i></b>
<p>Example programmes with service user involvement are:</p> <ul style="list-style-type: none"> <li>- A wheelchair user teaching onto wheelchair programmes</li> <li>- Continence programme</li> <li>- Parkinson’s Disease programme</li> </ul> <p>The views of people with disabilities are actively sought and built into the design and implementation of these programmes.</p>	<p>We continually seek to involve service users in the development and delivery of CEC programmes.</p>

##### 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?

<b><i>How does the policy or decision currently promote positive attitudes towards disabled people?</i></b>	<b><i>What else could you do to promote positive attitudes towards disabled people?</i></b>
<p>Having those with disabilities (either visible or invisible) involved in active teaching and/or development of these programmes increases peoples’ awareness of those with disabilities and the contribution they make.</p>	



## (5) CONSIDERATION OF HUMAN RIGHTS

### 5.1 Does the policy or decision affect anyone's Human Rights? 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
1 <sup>st</sup> protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1 <sup>st</sup> protocol Article 2 – Right of access to education	No

*If you have answered no to all of the above please 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 interfere with any of these rights? If so, what is the interference and who does it impact upon?**

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise 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
When service users/ carers are sought to volunteer to participate in education programme design and deliver data regarding nature of role and consents are held centrally for ease of access.		

Approved Lead Officer: Fiona McCallion  
Position: AHP Education Manager  
Date: 18.1.21  
Policy/Decision Screened by: Fiona McCallion

**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](mailto:Equality.Unit@hscni.net)

For advice and support on screening contact:

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

Any request for the document in another format or language will be considered.  
Please contact:

Claire Smith, CEC Business Manager.