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

Integrated Elective Access Protocol 3.0

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)**

Background

The Department of Health, Social Services and Public Safety (now the Department of Health) developed and issued the Integrated Elective Access Protocol (IEAP) in August 2006, which was subsequently updated in April 2008. The IEAP protocol describes the processes for booking and scheduling patients and outlines good practice in the effective management of outpatient, diagnostic, inpatient/day case and Allied Health Professional (AHPs) waiting lists.

The five Health and Social Care Trusts (the Trusts) adherence to the protocol has made a significant contribution to improved quality outcomes for patients and ensured that a consistent approach was taken across and within all Trusts.

The HSCB, on behalf of the DOH, was asked to undertake a review of the current IEAP and draft a revised IEAP to reflect changes to clinical practice and the patient pathway since the IEAP was first issued and to ensure that patients are being booked and scheduled in a consistent way across the N. Ireland (N.I.).

A working group chaired by the Health and Social Care Board (HSCB) and consisting of senior managers from the Trusts, Integrated Care and the Public Health Authority (PHA) was established to review and update the current

Integrated Elective Access Protocol (IEAP).

The updated document reflects the changes in clinical practice including the use of the Clinical Communication Gateway (CCG), the Northern Ireland Electronic Care Record (NIECR), and other changes in clinical practice have helped modernise and streamline patient pathways such as E-triage, virtual clinics, and telephone reviews.

The document also formalises previous Departmental guidance on the processes for managing non attendance (Did Not Attend) and patient cancellations for hospital appointments (Could Not Attend) and patients who refuse a reasonable offer of treatment.

For the purposes of this document the terms **elective** and **elective care pathway** are used to describe elective outpatient, diagnostic, inpatient/day case and Allied Health Professional (AHPs) services.

Aim of Proposal

To adopt and implement the revised Integrated Elective Access Protocol (IEAP) which updates the previous IEAP (2008) in outlining the procedures and protocols to be followed for appointment booking and waiting list management of patients on the elective care pathway.

The overall aim of the protocol is to ensure that patients are treated in a timely, effective and fair manner from elective referral to first definitive treatment or discharge.

IEAP will be applicable across the five Trusts. All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions will be required to use this protocol.

The IEAP will require the DOH to sign off before the protocol can be formally implemented.

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

The current IEAP is a regional document issued by the Department of Health, Social Services and Public Safety (DHSSPS) in 2008.
It is not anticipated that patients/service users will be directly impacted by the adoption of the revised and updated protocol. It is anticipated that the only change they will notice is the improvement in the quality of service, including improved patient involvement and engagement in accessing elective appointments.

The needs of certain patient groups are highlighted in scheduling elective new and review appointments that best suit their needs.

The protocol has built in clinical discretion and flexible review arrangements in cases where patients refuse a reasonable offer or cancel or do not attend appointments which would otherwise mean being taken off waiting lists or have their waiting times reset.

It is anticipated that staff will be positively impacted by the adoption of the protocol as this recognises the importance of the service that they are already delivering. It is anticipated that the only change they will notice to the service they provide is the improvement in the quality of service.

The key stakeholders are the service users of elective care services and all staff who are involved in the administrative processes for patients on an elective care pathway, e.g.

- General Practitioners (GPs),
- Trust booking, appointments, administration and secretarial staff,
- Trust clinical staff e.g. medical, nursing, AHP staff,
- Trust operational managers,
- Trust information staff.

Other stakeholders are:

- The Department of Health,
- Health and Social Care Board,
- Public Health Authority,
- Trusts,
- Patient's representatives.

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

Integrated Elective Access Protocol 1.0 – DHSSPS, August 2006.

Integrated Elective Access Protocol 2.0 – DHSSPS, April 2008.
Mental Health Services, Integrated Elective Access Protocol Addendum - DHSSPS 2010.

System Technical guidance documents (various) – HSCB.
https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx

Regional Information Standards Board (ISB) Standards and Guidance; Acute Activity definitions. – HSCB, August 2019.
https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx

AHP Services Data Definitions Guidance - PHA June 2015.
https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015

The rationale for updating IEAP arises from the need to be in line with overall strategic direction outlined in *Quality 2020 - a ten year strategy to protect and improve quality in health and social care in Northern (2011)*, the strategy to protect and improve quality in health and social care in Northern Ireland.

The Bengoa report, *Systems, Not Structures - Changing Health and Social Care'. Department of Health (2016),* followed by the publication of the Department of Health's, paper, *Health and Wellbeing 2026 – Delivering Together* makes clear that there needs to be a move in Northern Ireland towards 'a new model of person-centred care focussed on prevention, early intervention, supporting independence and wellbeing'.

(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.

IEAP guidance has been in place since 2006 and was revised in 2008.

On-going engagement with Trust senior managers, patient access managers, primary care and AHP leads throughout the redrafting of the IEAP ensured that those directly involved in appointment booking and waiting list management of patients on the elective care pathway were able to shape the protocol to ensure best service for patients.

Trust staff and stakeholders were widely involved in drafting and commenting on the draft protocol with the final draft being agreed by Trust Directors of Performance on 3 August 2020.

Other information sources included:

- Census data (2011)
- NISRA mid-year population estimates (published June 2019)
- Northern Ireland Life and Times (2018)
- Health Survey (NI) 2017/18

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.

<table>
<tr><th>Category</th><th>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?</th></tr>
<tr><td></td><td>At present, the data available does not allow us to analyse the patient base against the section 75 equality categories. In developing our information systems in the future, it may be possible to give more definitive responses against the section 75 groups.

The IEAP applies to all patients on the elective care pathway.</td></tr>
<tr><td>Gender</td><td>Formal data on the number of female patients and female staff and female part time staff is not available.

General population - the population of Northern Ireland on Census Day 2011 was 1,810,900 of which there were 887,300 (49%) Males and 923,500 (51%) Females.

The N.I. Health and Social Care Workforce Census (March 2019) reported that 79% of staff were female and 56% (by headcount) worked full time.</td></tr>
<tr><td>Age</td><td>The population of Northern Ireland as per the 2017 Mid-Year Estimates was made up as shown below:

<table>
<tr><th></th><th>BHSCT</th><th>NHSCT</th><th>SEHSCT</th><th>SHSCT</th><th>WHSCT</th><th>N.I.</th><th>N.I.</th></tr>
<tr><td>Total</td><td>355,593</td><td>474,773</td><td>358,708</td><td>380,312</td><td>301,448</td><td>1,870,834</td><td>100%</td></tr>
<tr><td>0 - 17</td><td>76,422</td><td>108,667</td><td>81,120</td><td>96,945</td><td>73,249</td><td>436,403</td><td>23%</td></tr>
<tr><td>18 - 64</td><td>224,765</td><td>284,664</td><td>212,096</td><td>228,150</td><td>181,781</td><td>1,131,456</td><td>61%</td></tr>
<tr><td>65 +</td><td>54,406</td><td>81,442</td><td>65,492</td><td>55,217</td><td>46,418</td><td>302,975</td><td>16%</td></tr>
<tr><td>% 0 - 17</td><td>21%</td><td>23%</td><td>23%</td><td>25%</td><td>24%</td><td>23%</td><td></td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Religion</td><td>The religious background of the population of Northern Ireland on Census Day 2011 was made up as shown below:

42% Protestant and other Christian background
41% Catholic
17% other religions, no religion or religion not stated

<table>
<tr><th>Religion</th><th>% Census, 2011</th></tr>
<tr><td>Roman Catholic</td><td>45%</td></tr>
<tr><td>Protestant and other Christian background</td><td>36%</td></tr>
<tr><td>None</td><td>11%</td></tr>
<tr><td>Unknown</td><td>8%</td></tr>
<tr><td>Total</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Political Opinion</td><td>The first preference votes per party in NI Assembly Elections 2017:
<table>
<tr><th></th><th>First Preference Votes</th><th>Vote Share %</th></tr>
<tr><td>Total</td><td>803,315</td><td>100%</td></tr>
<tr><td>DUP</td><td>225,413</td><td>28.1%</td></tr>
<tr><td>Sinn Fein</td><td>224,245</td><td>27.9%</td></tr>
<tr><td>UUP</td><td>103,314</td><td>12.9%</td></tr>
<tr><td>SDLP</td><td>95,958</td><td>11.9%</td></tr>
<tr><td>Alliance</td><td>72,717</td><td>9.1%</td></tr>
<tr><td>Other</td><td>81,668</td><td>10.3%</td></tr>
</table>

(NI Assembly; Election Report, Northern Ireland Assembly Election, 2017)

Northern Ireland Life and Times, 2018;
In response to the question “Generally speaking , do you consider yourself a unionist, nationalist or neither?” the response was;

50% considered themselves as Neither,
26% considered themselves Unionist,</td></tr>
</table>

<table>
<tr><td></td><td>21% considered themselves Nationalist
1% considered themselves as Other and
2% didn’t know</td></tr>
<tr><td>Marital Status</td><td>The marital status of the population of Northern Ireland on Census Day 2011 was made up as shown below:

<table><tr><th>Status</th><th>N.I. %</th></tr><tr><td>Married</td><td>47.6%</td></tr><tr><td>Single (never married)</td><td>36.1%</td></tr><tr><td>Separated</td><td>4.0%</td></tr><tr><td>Divorced</td><td>5.5%</td></tr><tr><td>Same sex civil partnership (SSCP)</td><td>0.1%</td></tr><tr><td>Widowed or surviving partner from SSCP</td><td>6.8%</td></tr><tr><td>Total</td><td>100%</td></tr></table></td></tr>
<tr><td>Dependent Status</td><td>In Northern Ireland there are approximately 92,000 lone parents with 150,000 children.

25% of all children are from one parent families, separated or divorced.

There are approximately 207,000 carers in Northern Ireland with 2% of 0-17 year olds being carers (2011 Census).
5% of those in the16-24.age-group had caring responsibilities (Health Survey Northern Ireland 2017/18)</td></tr>
<tr><td>Disability</td><td>The term disability covers a wide range and combination of conditions. Multiple needs are evident across sensory, physical and learning disability groups.

Action on Hearing Loss estimate that 1 in every 6 people in Northern Ireland have some form of hearing loss.</td></tr>
</table>

	A breakdown of the long term health problems reported in the 2011 census reported 5% of the population as having deafness or partial hearing loss. Other conditions included: • 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 behavioral 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)** The Health Survey Northern Ireland 2017/18 shows that 43% longstanding illness (32% limiting and 11% non-limiting illness). Females were more likely to report a long-standing limiting illness: • Males: limiting longstanding illness 29%; non-limiting longstanding illness 11% • Females: limiting longstanding illness 34%; non-limiting longstanding illness 11% Special Educational Needs (DENI) 2017/18 latest data identified more than 79,000 pupils in schools have some form of special educational needs; this is 23.0% of the entire school population. Of this, more than 17,800, or 5.2% of pupils, have a statement of special educational needs. The number of pupils with special educational needs has been steadily rising, with more than 2,800 pupils with any needs and 800 additional pupils with statements compared to last year

Ethnicity	In the general population the 2011 Census indicated that 1.8% of the usual resident population belonged to minority ethnic groups, this figure has more than doubled since 2001 (0.8%).

Ethnic Origin	% Census, 2011
White	97.5%
Chinese	0.3%
Irish Traveller	0.1%
Roma Traveller	
Indian	0.4%
Pakistani	0.1%
Bangladeshi	0.1%
Black Caribbean	0.0%
Black African	0.1%
Black Other	0.1%
Mixed Ethnic Group	0.8%
Other Ethnic Group	0.5%
Not Stated	
Total	100.0%

It needs to be borne in mind that under the ethnic group label of 'white', those of a nationality other than British, Irish and Northern Irish are included. This includes, for instance, migrants from other European countries.

The most recent data (Apr 2019) from the Department of Education shows the most recent figures for the numbers of children from ethnic minority groups enrolled in all funded pre-school, nursery, primary, post-primary, special schools and EOTAS Centres in Northern Ireland in 2017/18.

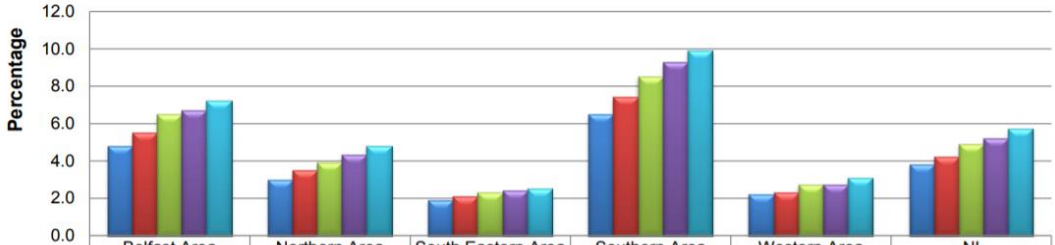
There are more than 14,400 pupils in schools in Northern Ireland recorded as "non-white", and this represents 4.2% of the school population.
This is an increase of more than 4,400 pupils and 1.1 percentage points compared to five years prior.

The growth in diversity in the school system may be explained by

increased levels of migration among school age children over the last number of years.

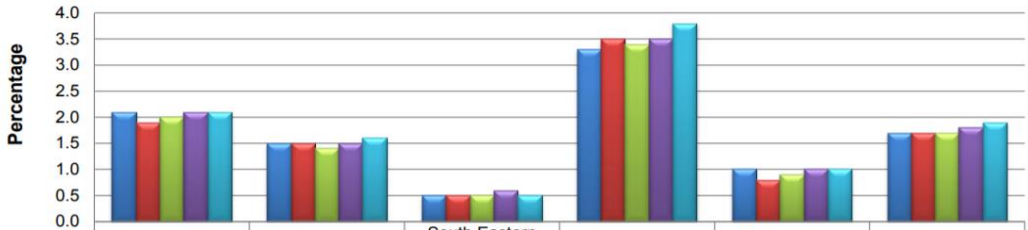
There is also a rise year-on-year in the number of pupils whose first language is not English. In 2017/18, there are approximately 90 first languages spoken by pupils, with Polish and Lithuanian being the most common behind English.

Primary School Pupils (Year 1-7) with English as Additional Language (Newcomers) by Area



	Belfast Area	Northern Area	South Eastern Area	Southern Area	Western Area	NI
2012/13	4.8	3.0	1.9	6.5	2.2	3.8
2013/14	5.5	3.5	2.1	7.4	2.3	4.2
2014/15	6.5	3.9	2.3	8.5	2.7	4.9
2015/16	6.7	4.3	2.4	9.3	2.7	5.2
2016/17	7.2	4.8	2.5	9.9	3.1	5.7

Post-Primary School Pupils with English as Additional Language (Newcomers) by Area



	Belfast Area	Northern Area	South Eastern Area	Southern Area	Western Area	NI
2012/13	2.1	1.5	0.5	3.3	1.0	1.7
2013/14	1.9	1.5	0.5	3.5	0.8	1.7
2014/15	2.0	1.4	0.5	3.4	0.9	1.7
2015/16	2.1	1.5	0.6	3.5	1.0	1.8
2016/17	2.1	1.6	0.5	3.8	1.0	1.9

Precise information on the numbers of adults from minority ethnic backgrounds is limited. To inform discussions a useful source of information is the NI Health and Social Services Interpreting Service. Statistics from the HSC Interpreting Service showed a significant rise in requests for interpreters from 63,868 requests in 2011/12 to 114382 in 2018/19

	Currently the service provides interpreters in approximately 40 languages. Northern Ireland HSC Interpreting Service Report: 1 April 2018 - 31 March 2019 This has implications for those who are from ethnic minorities or those from different racial backgrounds as they represent a greater proportion of the population since the 2011 census. Consequently assumptions have to be made in relation to an increase in the numbers with dual needs of disability and ethnicity.
Sexual Orientation	There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 7% and 10% of the population would identify as lesbian, gay or bisexual.

Top 20 languages	Requests 2018/19
Polish	30,948
Arabic	16,690
Lithuanian	16,512
Romanian	12,789
Portuguese	8,361
Bulgarian	7,557
Tetum	6,604
Slovak	6,152
Chinese - Mandarin	5,120
Chinese - Cantonese	3,388
Hungarian	3,222
Russian	2,632
Latvian	2,100
Somali	1,861
Czech	965
Spanish	839
Farsi	731
Bengali	612
Chinese - Hakka	581
Urdu	419
	128,083

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	Using census population data as a proxy indicator of patients that the protocol may impact on shows that there is a slightly higher proportion of females than males affected by this protocol. There is no evidence that current IEAP, which applies to all patients equally, has had or the updated and revised version will have an adverse impact with regard to gender. Staff are predominately female. Staff will require training accompanying the adoption of the updated and revised IEAP. Trusts provide training programmes for staff which include all aspects of the current IEAP with training cascaded to and by each clinical, managerial or administrative tier within Trusts. No specific considerations re female and part time staff were raised during the drafting of the protocol. This would indicate that the adoption of the protocol will have no negative impact on female or male staff. Research shows that transgender people report poorer experiences of health care, and are more likely to report negative experiences associated with transphobia, which may impact on whether they engage with the service or not. There is no specific evidence that gender of service users was a factor in access to elective services or transgendered people were affected by a differential impact in relation to the current IEAP.
Age	Using census population data as a proxy indicator of the ages of those patients that the protocol may impact on shows that the majority of those affected may be 0-16 and 55 plus years old. There are some groups e.g. children, those with sensory or learning disabilities or mental health issues where the patient is reliant on others (carers and proxies) to take the required actions outlined in the protocol, e.g. in accepting and making appointments, getting to appointments and making the service

	aware if they cannot attend appointments. Staff age should have no impact on their adoption of the revised protocol which is replacing the current one.
Religion	The majority of patients affected by the protocol will be either Protestant or Roman Catholic. It is recognised that patients from one religious community may find it more difficult accessing services (e.g. if they are sited in area regarded as belonging to the 'opposite' community. There is no evidence that current IEAP, which applies to all patients equally, has had an adverse impact in terms of religion. Religion should have no impact on their adoption of the revised protocol which is replacing the current one. Trusts have policies committed to promoting good relations for patients and staff in terms of religion, race and political opinion.
Political Opinion	Another recognised issue germane to the access of services is in terms of political opinion where the perceived or real association of the political affiliation of the location of the service. There is no evidence that current IEAP, which applies to all patients equally, has had an adverse impact in terms of political opinion. Political opinion should have no impact on their adoption of the revised protocol which is replacing the current one. Trusts have policies committed to promoting good relations for patients and staff in terms of religion, race and political opinion.
Marital Status	Using census population data as a proxy indicator the majority of patients and staff affected by the protocol will be married. There is no evidence that the current IEAP has had an adverse impact in terms of marital status and should have no impact on their adoption of the revised protocol.
Dependent Status	There are some groups e.g. children, those with sensory or learning disabilities or mental health issues where the patient is reliant on others (carers and proxies) to take the required actions outlined in the protocol, e.g. in accepting and making

	appointments, getting to appointments and making the service aware if they cannot attend appointments. Those with dependents can also have particular needs as regards access and cost of services. For example, those who have additional caring responsibilities may be restricted in the times the can access the service.
Disability	Disability can have a differential impact for patients and carers in carrying out day to day activities such as accessing services while transport and access to buildings can pose key barriers in accessing face to face interventions. In some circumstances the patient may need additional help or is reliant on others (carers and proxies) to take the required actions outlined in the protocol, e.g. in accepting and making appointments, getting to appointments and making the service aware if they cannot attend appointments. Patients who have certain mental health conditions (e.g. anxiety) or learning disabilities may be more likely to DNA/ CNA, which may place them at a disadvantage. People with sensory and learning disabilities have a need for written information in accessible formats and appropriate communication methods and support. Staff with a disability who require training once new IEAP is adopted will be provided with training that meets their needs.
Ethnicity	The difficulties experienced by minority ethnic and migrant groups when accessing public services is acknowledged. Most difficulties center on language and cultural barriers and potential racism. Minority ethnic and migrant groups may have a need for written information in different languages and require interpreting services when accessing services. Trusts provide a wide range of interpreting and translation services. Trusts have policies committed to promoting good relations for patients and staff in terms of religion, race and political opinion.

Sexual Orientation	Lesbian, Gay, and Bisexual people can face negative responses on the grounds of their sexuality in society and from institutions. Research has demonstrated that LGBT people report poorer experiences when accessing health and social care, are likely to delay access to healthcare based on previous negative experiences and fear of negative attitudes of health workers specifically in relation to their sexual orientation, and have poorer health outcomes than their heterosexual peers. There is no evidence that current IEAP, which applies to all patients equally, has had an adverse impact in terms of sexual orientation and should have no impact on their adoption of the revised protocol.

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.

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?***
Age: Specific aims included in IEAP are to "allow patients to maximise their right to patient choice in the care and treatment that they need" and "increase the number of patients with a booked outpatient or in-patient / day case appointment" IEAP promotes partial booking (the process whereby a patient has an opportunity to agree the date and time of their appointment that is convenient for them with the Trust) and virtual appointments (where the patient is contacted remotely, e.g. by telephone, and is not required to physically attend a clinic). The protocol has safeguards built in throughout, e.g. in situations where patient cannot accept a "reasonable offer" or DNA's CAN's an appointment with due to unforeseen or exceptional circumstances. IEAP highlights the Trusts responsibility to ensure that children and adults at risk who DNA or CNA their elective appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established. **Religion**: HSC venues are considered neutral and accessible and not a	The continued promotion of partial booking and direct access processes will result in an improvement in the quality of the services provided. The requirement to monitor and report on the services performance against IEAP will highlights areas of good practice and areas for improvement which hold the service to account and result in an improvement in the quality of the services provided This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally.

barrier to patients attending due to religion. The IEAP applies to all elective care pathways across five Trusts which provides for patient choice. **Political**: HSC venues are considered neutral and/or accessible and not a barrier to patients attending due to political opinion. The IEAP applies to all elective care pathways across five Trusts which provides for patient choice. **Dependent Status**: The IEAP recognises that additional steps may be required for in booking processes for children, adults at risk, those with physical/learning difficulties. An underpinning principle is that patients who are considered at risk for whatever reason have their needs identified and prioritised at the point of referral and appropriate arrangements made and that Trusts must have mechanisms in place to identify such cases. The IEAP promotes flexibility of appointments and communication to suit the individual needs and preferences of the patient/carer who may have dependents. This includes allowing proxies to act on behalf of patients in expressing their choices e.g. of appointments through partial booking or virtual appointments, The protocol has safeguards built in throughout, e.g. in situations where patient cannot accept a “reasonable offer” or DNA’s or CNA’s an	

appointment with due to unforeseen or exceptional circumstances. An underpinning principle of IEAP is that “Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established”. **Disability**: The IEAP recognises that additional steps may be required for in booking processes for children, adults at risk, those with physical/learning difficulties. An underpinning principle is that patients who are considered at risk for whatever reason have their needs identified and prioritised at the point of referral and appropriate arrangements made and that Trusts must have mechanisms in place to identify such cases. The IEAP promotes flexibility of appointments and communication to suit the individual needs and preferences of the patient/carer who may have dependents. This includes allowing proxies to act on behalf of patients in expressing their choices e.g. of appointments through partial booking or virtual appointments. The protocol has safeguards built in throughout, e.g. in situations where patient cannot accept a “reasonable offer” or DNA’s CAN’s an appointment with due to unforeseen or exceptional	

circumstances. An underpinning principle of IEAP is that “Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established”. **Ethnicity**: HSC venues are considered neutral and/or accessible and not a barrier to patients attending due to ethnicity. The IEAP recognises that additional steps may be required for in booking processes for those who require assistance with language and that their needs identified and prioritised at the point of referral and appropriate arrangements made and that Trusts must have mechanisms in place to identify such cases. An underpinning principle of IEAP is that “Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient’s pathway” . The needs of minority ethnic groups/individuals is given due consideration in the elective pathway, particularly ensuring that any language barriers are overcome to insure inclusion. HSC staff training includes Equality	

awareness training in order to raise awareness of the specific issues faced by minority ethnic groups accessing healthcare. **Sexual Orientation**: HSC venues are considered neutral and/or accessible and not a barrier to patients attending due to sexual orientation. The IEAP applies to all elective care pathways across five Trusts which provides for patient choice. HSC staff training includes Equality awareness training in order to raise awareness of the specific issues faced by LGB individuals accessing healthcare.	

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	
Political Opinion	N/A	
Ethnicity	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 protocol has been developed to replace the current protocol in defining the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of bookings, including cancer pathways and waiting list management.

The purpose of this protocol is to outline the approved processes for managing patients on the elective care pathway from referral through to discharge to allow consistent and fair care and treatment for all patients to ensure that all patients are treated in a timely and effective manner. IEAP requires that Patients are treated on the basis of their clinical urgency with urgent patients seen and treated first and patients with the same clinical need treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

The adoption of IEAP will have positive outcomes for all section 75 groups in that it aims to update current practice and/or achieve best practice based on current evidence.

There is no adverse impact on equality or human rights for patients or staff and so the screening outcome is ‘screened out’.

(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?*

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?*
The IEAP helps patients with a disability to access elective services. This is turn enables them to engage more readily with their non-disabled peers and participate in everyday life, thereby breaking down stereotypes associated with having a disability. All Trust staff receive mandatory Equality Awareness training.	

(5) CONSIDERATION OF HUMAN RIGHTS

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

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

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

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

List the Article Number	Positive impact or potential interference?	How?	Does this raise any legal issues?* Yes/No

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

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

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights
At present, the data available does not allow us to analyse the patient base which accesses elective care against the section 75 equality categories. In developing our information systems in the future, it may be possible to give more definitive responses against the section 75 groups.	.	

Approved Lead Officer: Linus Mc Laughlin, Performance Manager, Performance Management and Service Improvement Directorate, Health and Social Care Board.

Position: Chair (The Integrated Elective Access Protocol Review Group).

Policy/Decision Screened by: **The Integrated Elective Access Protocol Review Group**.

Signed: 

Date: 11 September 2020

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