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

Quality Standards for Paediatric Audiology Services.

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

Currently, Northern Ireland (NI) is the only part of the UK that has yet to introduce quality standards for Paediatric Audiology. Audiology Quality Standards for adult services were introduced in 2013.

Aim of Proposal

To adopt and implement quality standards for paediatric audiology services in NI.

This will ensure that paediatric audiology services are fit for purpose based on the minimum acceptable standards of care that children, young people and their families can expect to receive on their journey through the service.
The adoption and ongoing assessment against the standards will be part of a framework for measurable, continuous improvement of services that informs stakeholders of areas of good practice and areas in need of development.

The Department of Health (DOH), Health and Social care Board (HSCB), HSC Trusts and the National Deaf Children's Society (NDCS) worked with the

Regional Audiology Forum, stakeholders and user representatives to develop an agreed set of quality standards for paediatric audiology services in NI and a scoring tool to provide for regular measurement and assessment of services against these standards. This included engaging with the full range of service users, their carers and the staff working with them.

Experience from the introduction of Adult Audiology Quality Standards has indicated that:

1. this has been a key in driving improvement within the service across with a sustained increase in performance since 2012 (41% to 77%) and an average increase in performance of 6% per annum since 2015 ,
2. implementing good practice standards should incur minimal costs. The quality scoring tool and evaluation template to carry out a baseline assessment of the service were developed in-house and are free to use although there will be an opportunity cost of the time taken by professional staff to carry out the baseline exercise and subsequent quality assessments and peer review. The outcome of the future assessments of the standards will assist in determining the cost implications of meeting these standards.

These standards will be applicable across the five HSC Trusts. There is no single pathway for paediatric audiology services across the Trusts, however, the standards will apply no matter what pathway children with suspected hearing difficulties are on.

The Quality Standards for Paediatric Audiology Services will require the Health Minister to sign off before they can be formally implemented. There is currently no NI Assembly executive in place to sign off draft standards.

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

It is not anticipated that patients/service users will be directly impacted by the adoption of the quality standards. It is anticipated that the only change they will notice is the improvement in the quality of service, including user involvement and engagement.

It is anticipated that staff will be positively impacted by the adoption of the quality standards as this recognises the importance of the service that they are already

delivering. The baseline exercise assessment (2019) shows an average performance level of 78% across all the 8 standards.

It is anticipated that staff will be positively impacted by the ongoing assessment of the standards once adopted as this will provide a quality measurement of their service which will formally acknowledge good performance in the service they deliver and also identify areas for improvement.

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 HSC paediatric audiology services (i.e. children from birth to 18 years old with suspected hearing loss and their parents/carers of children impacted) and Audiology staff.

Other stakeholders are:

- The Department of Health,
- Health and Social Care Board,
- Trusts,
- The Regional Audiology Forum,
- Clinical users
- Other HSC services with audiology input, e.g. ENT, Autism and Speech and Language services,
- Newborn Hearing Screening Programme (NHSP),
- The Auditory Implant Centre,
- Volunteers,
- The British Academy of Audiology (BAA),
- Public Health Authority (PHA),
- Children & Young People's Services Education Authority.
- Charites including the National Deaf Children's Society (NDCS), the British Deaf Association (BDA) and Action on Hearing Loss (AHL).

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

The rationale for adopting Paediatric Audiology Standards arises from the 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 priorities within the Executive's draft Programme for Government 2016-2021 framework which have a direct and/or indirect impact on the lives of children and young people also provide context for this strategy. Of particular note is the

outcome: ‘We give our children and young people the best start in life’.

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’.

- **what are they?**

- Adult Audiology Quality Standards (2013)
- Adult Audiology Workforce Plan (April 2017)
- Assessment of Adult Audiology Quality Standards (2018)
- Action on Hear Loss; Northern Ireland Audiology Services Patient Survey (2018)
- Quality Standards for Paediatric Audiology (Scotland), (2016)
- England, Improving Quality in Physiological Services,
- Wales; Quality Standards for Children’s Audiology (2016)
- Baseline Exercise re draft Paediatric Audiology Quality Standards (2019)

- **who owns them?**

Northern Ireland Audiology Services adopted the Adult Audiology Quality Standards in 2013, with the most recent assessment being completed in April 2018.

(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.

Draft paediatric audiology quality standards standards have been prepared, and a 10,000 More Voices survey on children and parent/guardian experiences of paediatric audiology services commissioned.

The need for stakeholder engagement, including through the user/patient experience surveys is acknowledged by the service and included in the draft standards.

On-going engagement with heads of audiology, senior audiologists and clinicians who provide paediatric audiology services throughout the development of the referral guidelines ensured that those providing audiology services were able to shape the guidelines to ensure best service for patients.(July 2018 to March 2019).

Trust staff and stakeholders were widely involved in drafting and commenting on the draft standards with the first draft being formally shared on 2nd October 2018 at a workshop facilitated by HSCB, Action on Hearing Loss, the National Deaf Children's Society, PHA and British Academy of Audiology (BAA) with representatives from HSCB, HSC Trust clinicians and management, DOH, and voluntary sector staff.

19th October 2018 – the British Academy of Audiology (BAA) Study day with Trust staff to gather views and to inform the development of the standards.

October 2018 – the National Deaf Children's Society (NDCS) facilitated parents and service user's involvement through a focus group in commenting on the draft standards in parallel with the service engagement process.

26th February 2019, New Born Screening Workshop - shared draft standards with health professionals involved in newborn hearing screening pathway.

20th March 2019 - British Deaf Association (Northern Ireland) Audiology Seminar - shared draft standards with health professionals involved in the care pathway of deaf children and young people and their families.

The Regional Audiology Forum continued to engage with a range of professionals, stakeholders and service users during October 2018 to March 2019 with the draft standards being shared widely for comment and feedback with NDCS, the British Deaf Association (BDA), Action on Hearing Loss (AHL), the British Academy of Audiology (BAA), Public Health Authority (PHA), Newborn Hearing Screening Programme (NHSP) and the Auditory Implant Centre and Children & Young People's Services Education Authority.
This allowed us to take on board any feedback from these groups and amend the guidelines accordingly.

The collection and analysis of waiting list data for paediatric audiology services to inform patient waiting times for these services on an ongoing basis.

Action on Hearing Loss was commissioned by HSCB to conduct a survey exploring service users' attitudes and experience of the adult audiology service in Northern Ireland. The survey focused on satisfaction with the service provided; including methods of communication, accessibility and location of facilities, and signposting to other services. Results were broken down by age, gender, ethnicity and HSC Trust area.

Northern Ireland Audiology Services/HSCB, working through the Regional Audiology Forum, carried out a baseline exercise on current paediatric services to test that the draft paediatric standards were fit for purpose as a framework for measurable, continuous improvement of services which was completed in March 2019.

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
- Department of Education statistics and others

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 which attends the audiology service 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.</td></tr>
<tr><td>Gender</td><td>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.

Formal data on the number of female and female part time audiology staff is not available, however during consultation a survey of Trusts found that 90% of staff were part time.

General population/ parent/ carers of Children and Young People;

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 population of Northern Ireland as per the 2017 Mid-Year Estimates was made up as shown below:

<table>
<tr><th></th><th>Age</th><th>N.I.</th><th>N.I. %</th></tr>
<tr><td>Male</td><td>0 - 17</td><td>223,887</td><td>51%</td></tr>
<tr><td>Female</td><td>0 - 17</td><td>212,516</td><td>49%</td></tr>
<tr><td>Total</td><td>0 - 17</td><td>436,403</td><td>100%</td></tr>
</table>
</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:</td></tr>
</table>

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

The standards will apply to children from birth to 18 years old with suspected hearing loss.

Religion

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

Religion	% Census, 2011
Roman Catholic	45%
Protestant and other Christian background	36%
None	11%
Unknown	8%
Total	100%

Political Opinion

The first preference votes per party in NI Assembly Elections 2017:

	First Preference Votes	Vote Share %
Total	803,315	100%
DUP	225,413	28.1%
Sinn Fein	224,245	27.9%
UUP	103,314	12.9%
SDLP	95,958	11.9%
Alliance	72,717	9.1%
Other	81,668	10.3%

(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,
21% considered themselves Nationalist
1% considered themselves as Other and
2% didn’t know

Marital Status

The marital status of the population of Northern Ireland on Census Day 2011 was made up as shown below:

Status	N.I. %
Married	47.6%
Single (never married)	36.1%
Separated	4.0%
Divorced	5.5%
Same sex civil partnership (SSCP)	0.1%
Widowed or surviving partner from SSCP	6.8%
Total	100%

Dependent Status	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)
Disability	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. 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)**

<table>
<tr><td></td><td>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</td></tr>
<tr><td>Ethnicity</td><td>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%).

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

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.

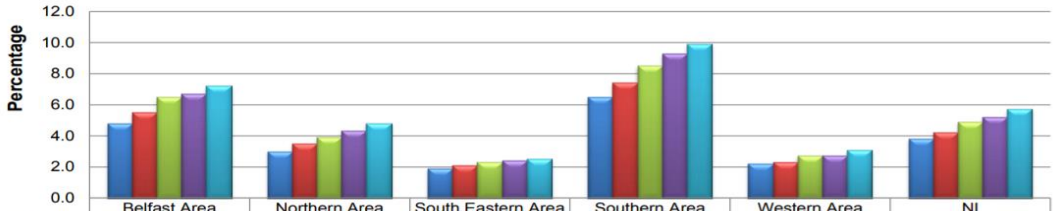
The most recent data (Apr 2019) from the Department of Education shows the most recent figures for the numbers of children from ethnic minority groups enrolled in all funded pre-school, nursery, primary, post-primary, special schools and EOTAS Centres in Northern Ireland in 2017/18.

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.

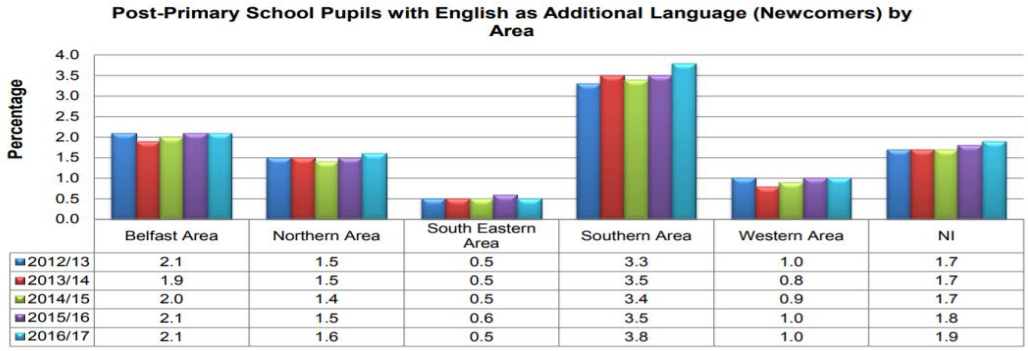
The growth in diversity in the school system may be explained by increased levels of migration among school age children over the last number of years.

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



	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.

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

	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.

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	Staff are predominately female with a significant number of them working part time. Whilst staff will not require any training accompanying the adoption of the standards, the high proportion of part time female staff could have an impact on accessing any training resulting from the findings of the ongoing assessment of the standards. The Paediatric Audiology Quality Standards Baseline Exercise 2018/19 reported a score of 90% against staff training and 90% against Continuing Professional Development (CPD) under the Skills and Expertise quality standard. Additionally, no specific considerations re female and part time staff were raised during the drafting of the standards or the baseline assessment exercise. This would indicate that the adoption of the standards 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 audiology services or transgendered people were affected by a differential impact in relation to the standards being adopted.
Age	The standards are based on the child and family's journey through paediatric audiology services and are applicable to children and young people of all ages from birth through to 18 years old. This includes specific pathways for newborns, infants, children and young people based on the principle of early intervention and intervention. This also includes receiving audiological assessment appropriate to their age and stage of development. Staff age should have no impact on their adoption of the policy.
Religion	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. The Northern Ireland Audiology Services (Adults) Patient Survey 2018, whilst it did not specifically ask about religion, reported that 95% of respondents found the location of audiology services convenient, with no adverse comments re religious association.
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. The Northern Ireland Audiology Services (Adults) Patient Survey 2018, whilst it did not specifically ask about political association, reported that 95% of respondents found the location of audiology services convenient, with no adverse comments re political association.
Marital Status	Audiology staff and service users have highlighted the pressures families and carers of a child or young person with hearing difficulties face and the need to support them in accessing services to meet their and their children's needs and to improve outcomes. However, there was no clear assessment in surveys, focus groups or the baseline exercise that marital status was a factor in accessing paediatric audiology services.
Dependent Status	Those with dependents can 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 parents 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. People with sensory and learning disabilities have a need for written information in accessible formats and appropriate communication methods and support.
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.
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.

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?***
Gender: HSC requires mandatory e-learning for Trust staff which specifically addresses transgender issues ('Making a Difference'). Age: The adoption of paediatric audiology standards will promote services for newborns, infants, children and young people by having specific quality measures that are assessed on a routine basis, in line with adult services.	The adoption of the standards will promote the services involvement with users through local user groups and increase the frequency of the user/patient experience surveys which will help highlight service issues for all users. The monitoring and reporting on the services performance against the standards (including to local users and those organisations working on behalf

Religion: HSC venues are considered neutral and accessible and not a barrier to patients attending due to religion. Additionally, the Audiology Workforce Plan 2017 identified 22 sites that deliver audiology services 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. Additionally, the Audiology Workforce Plan 2017 identified 22 sites that deliver audiology services across five Trusts which provides for patient choice. Dependent status: The standards promote and monitor flexibility of appointments and communication to suit the individual needs and preferences of the parent/carer who may have dependents. The standards also promote and monitor ease of access to physical locations where audiology services are delivered and the fitness of the accommodation the need for such areas to be family and child friendly. Disability: The standards promote and monitor flexibility of appointments and the fitness of communication to suit the individual needs and preferences of the parent/carer and child or young person. The standards also promote and monitor ease of access to physical locations where audiology services are delivered and the need for such areas to be family and child friendly. Ethnicity: HSC venues are considered neutral and/or accessible and not a barrier to patients attending due to ethnicity. The needs of minority ethnic	of the people who are deaf or have hearing loss) 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.

groups/individuals is given due consideration when delivering the service, particularly ensuring that any language barriers are overcome to insure inclusion. The need to target BME groups in an attempt to increase uptake from this Section 75 group, is acknowledged by the service and included in the draft standards. Sexual Orientation: HSC venues are considered neutral and/or accessible and not a barrier to patients attending due to sexual orientation. 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.

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

The adoption and ongoing assessment of the standards will provide formal evidence in respect of the quality of service received by users and highlight areas for service improvement.

There is no adverse impact on equality or human rights for staff or service users 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?*
The National Deaf Children's Society (NDCS), the British Deaf Association (BDA) and Action on Hearing Loss (AHL) were involved in the development of the standards providing input from disabled people. The standards will survey service user views, including the views of children/young people where possible, at least every **2** years, with the outcomes to be made widely available. The standards require each Trust's Audiology service to actively promote and participate with local users through local user groups.	The standards require that they be quality assessed, and reported on, on a regular basis. The results of the assessment will be widely shared, including with user groups, and used to identify areas of improvement at a local and regional level.

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 paediatric audiology service helps to address hearing loss in children and young people. 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.	

(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 attends the audiology service 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.	Local user groups and surveys improve disabled peoples' access to public life in that they will have a continued input into the service and allow for engagement and advocacy to drive improvement in hearing services. The regular monitoring of the standards ensures that Trusts are held accountable for delivery of such close working with users and stakeholders.	

Approved Lead Officer: Linus Mc Laughlin,
Performance Manager, PMSI, HSCB

Position: Chair (Regional Audiology Forum)

Policy/Decision Screened by: **The Regional Audiology Forum**;

Siobhan Sawey: Lead Paediatric Audiologist, Specialist Hospitals and Woman's Health Directorate, Belfast Health and Social Care Trust.

Roberta Campbell; Audiology Services Manager (interim), Surgical and Clinical Directorate, Northern Health and Social Care Trust.

Barbara Gregg: Audiology/ENT Services Manager, Woman & Acute Child Health Directorate, South Eastern Health and Social Care Trust.

Avril Watson: Audiology Services Manager, Acute Directorate (Cancer & Clinical division, Diagnostics), Southern Health and Social Care Trust.

Karyn McMulkin: Audiology Services Manager, Acute Directorate, Western Health and Social Care Trust.

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

The National Deaf Children's Society;

Helen Ferguson: Policy and Campaigns Officer NI, The National Deaf Children's Society

Signed:

Date: 12 November 2019

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

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:

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