HSC Health and Social Care Board

Equality, Good Relations and Human Rights SCREENING

The Health and Social Care Board is required to consider the likely equality implications of any policies or decisions. In particular it is asked to consider:

1) What is the likely impact on equality of opportunity for those affected by this policy, for each of the section 75 equality categories? (minor, major or none)

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

3) To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor, major or none)

4) Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

For information (evidence, data, research etc) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website: http://www.hscbusiness.hscni.net/services/1798.htm

Health and Social
Care Board

Equality, Good Relations and Human Rights
SCREENING TEMPLATE

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Northern Ireland Local Enhanced Service (NILES): Proactive GP care for nursing and residential homes

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**

Covid-19 has highlighted the need for clear care pathways and anticipatory care planning for care home residents with clear communication across the health and social care system.

This NILES will combine elements of a number of current enhanced services to include Medical care planning NILES, Key information summaries and a number of proactive care home local enhanced services. This will allow a regional NILES incorporating the core elements of these services for care home patients. Patients who are suitable for medical care planning but not resident in a care home will be reviewed under the new anticipatory care planning NILES. All care home residents will have anticipatory care plans completed through this service.

HSC Trusts are planning to develop trust multidisciplinary support teams (TST) who will go into care homes and be available to support GPs in accessing appropriate services for their patients.

The aims of this NILES

1. To identify care home resident wishes to allow planning of future care.
2. To proactively review new care home residents medical needs as soon as possible after arrival in the home.

3. To proactively review care home residents ongoing medical needs on a regular basis.
4. To develop or update an individual medical care plan to improve the patient's quality of life, aid decision making when managing deterioration in health and identify and address any palliative care needs.
5. To use Key Information summaries to improve communication of patient wishes from primary to secondary care.
6. To use local services and Trust Multidisciplinary Support teams (TST) as available to help manage care home residents' health needs within the care home setting when possible. With the aim of avoiding hospital admission unless necessary.
7. When hospital admission is required to use local pathways as alternatives to ED when possible.
8. To improve team working and communication within the care home, community, primary care and HSC Trust services.
9. To allow standardisation of organisational aspects of providing primary care services for care home patients (to include GP registration processes, home visits, repeat medications, care planning and communication across interfaces between primary and secondary care)

- **how will this be achieved? (key elements)**

This NILES is offered to all GP Practices across Northern Ireland. As NILES's are voluntary GP practices choose whether or not to contract for each NILES and to provide it to their patients.

This NILES will fund:

1. <u>Proactive GP Care</u>

The GP practice to provide a weekly review to all nursing and residential homes it has patients residing in. Arrangements for the review (day or time) should be agreed with the home at sign up to the service. The review should be completed by a GP working regularly within the GP practice, this could include an ST3 GP trainee as part of their training.

A list of patients requiring review should be compiled in advance by the care home. A review should be done to address any concerns on request of staff, the patient or the patient's relative. All new patients registering permanently or temporarily to a care home should also have a review at the next proactive weekly review. This should include any patients who are discharged back to the home following a hospital admission. This LES does not negate the responsibility for appropriate planning for patient care prior to admission to a care home. Prior to transfer to a nursing or residential home plans for GP registration should be considered and a management plan should be in place. On discharge from hospital a 28 day supply of medication should be supplied with all relevant medical details and any follow up investigations or onward referral to other services in place. This will aid the GP in their medical review which for the purposes of the LES should include establishing current medical conditions, a review of medication and updating of the patients medical records.

If no patients require a GP review from the care home on a particular week this should be communicated to the practice. The care home and practice should agree at commencement of the service how this will be communicated. Patients identified for review should be assessed either remotely or face to face depending on clinical need.

Patients who are acutely unwell between the planned weekly review will still be assessed by the GP under normal GMS contract arrangements.

Patients who have medical needs beyond usual GMS requirements (eg those in intermediate care beds), will continue to have their medical care through established HSC trust arrangements and will not be included in the reviews for the purposes of this NILES.

As the HSC trusts develop their Trust Multidisciplinary Support Teams (TSTs) GPs can give direction to them as required to assist the GP in managing patient care. As acute care at home teams are developed with community geriatrician leads, GPs providing this NILES will be able to discuss and refer patients accordingly through this pathway. GPs using the NILES are expected to become familiar with available pathways as they are developed and to work with the Trust Multidisciplinary Support Teams to provide best care for patients.

Medical Care Planning and Key Information Summary (KIS)

All new permanently registered patients should have a medical care plan completed within 4 weeks of admission to the care home.

All other permanently registered patients in the care home should have a medical care plan completed or reviewed on an annual basis.

All registered nursing/residential home patients should have a care plan completed or reviewed before year end. Exceptions will be granted for patients who are resident for less than 4 weeks eg have been discharged or died before GP able to complete care plan, or any new residents in the last 4 weeks of the contracting year.

The medical care plan should be used to complete the KIS template and should be uploaded to NIECR subject to patient consent/patient best wishes.

Medical Care plans can be completed during the planned weekly review. Ideally medical care plans will be completed face to face. However, given the current situation with Covid-19 in some circumstances it may not be appropriate for GPs to attend patients face to face. GPs can use their clinical judgment to decide when it is more appropriate to provide the service via telephone or video call. This should ensure practices can continue to provide this NILES as a priority even in the event of further Covid-19 pressures.

When completing the Medical Care Plan the following should be completed:

- **Identify and record existing record of patient wishes or Advance Care Plan Summary or formal advance decision to refuse treatment**
  NOTE: Advance care plan summaries or other records of patient wishes are non-legal documents which should influence patient care. Advance decision to refuse treatment is a legal document completed by the patient. These are less frequently used but do have legal standing.
  https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/

  Identify if the patient has a "Record of my Wishes" such as the one provided in "Your Life and Your Choices, plan ahead" booklet or an Advance Care Plan Summary.

  If so these should form the basis of discussions and completing the Medical Care Plan.

  If they do not have a record of their wishes the patient should be offered the option of completing an Advance Care Planning Summary if they wish to do so (it is not a requirement). Time and support should be offered to complete a record of my wishes or Advance Care Planning Summary. The Advance Care Planning Summary can be completed by a healthcare professional who knows the patient, such as care home nurse, heart failure or respiratory nurse or palliative care key worker before the holistic review or by the GP during the holistic review.

- **Medicines review**
  Medicines review should be carried out either shortly before or during the holistic review. Practice pharmacists or GPs can complete the medicines review.

- **Face to face (or remote consultation) structured holistic review by GP and completion of medical care plan**

a. This should be completed annually for all patients identified.
b. Check Medicines review has been completed and advance care plan has been offered.
c. The medical care plan should be developed after face to face (or remote consultation) review of the patient and input from other professionals involved with the patient's care and relatives
d. **For some (but not all) patients** it may be appropriate to consider a Do Not Attempt CPR (DNACPR) decision. A copy of the plan should be left with the patient/carers/nursing home.
e. A copy of the plan should be included in the patient records.
f. The medical care plan should be used to complete a Key Information Summary (KIS) and (if consented/best interests) uploaded to ECR.
g. The Special notes box on the KIS should be used to record the existence **and location** of any advance care planning summary or advance directive to refuse treatment or DNACPR decision (eg in patients hand held records, with nursing home manager)

- **Completing and Uploading KIS**
  Details included within specification for information about completing the KIS template and a patient information leaflet. The KIS template should be completed based on the medical care plan. If required practices can request training in KIS completion and upload by emailing: KISinformation@hscni.net

  Patients with capacity should be asked for their consent to upload KIS to ECR. KIS should be uploaded with consent or if not uploaded a note of dissent should be recorded.

  GPs may make a best interests decision to upload KIS to ECR for patients who do not have capacity to make that decision themselves.

Team working and communication

Practices participating in the NILES should participate in 2 meetings throughout the year with representatives from GP practices and the nursing and residential homes. The homes and practices should determine how this is best delivered. It may be more convenient to arrange a single meeting for groups of care homes or groups of practices to avoid duplication of work, or for a practice with the majority of patients within a care home to meet with that particular care home and then feedback to other practices participating in the NILES with patients resident in the home. Only practices who participate in a meeting can claim payment.

Once the meeting is arranged the practice may wish to invite other attendees for example; the Trust Multidisciplinary Support team (TST), consultant geriatrician and palliative care team.

The meetings can be arranged remotely as required. They should last a minimum of 1 hour. These meetings can be used as opportunity for;

- Review of any relevant governance issues within the care home
- Review of any GP organisational issues such as prescribing arrangements, GP registration.
- HSC Trusts to present any new development of pathways, or reiterate current pathways. Opportunity for discussion about any difficulties accessing these pathways or ways of improving them.
- Update from consultant geriatrician/ Trust Multidisciplinary Support team (TST) as appropriate.
- The attending GP will be expected to disseminate a written summary from the meetings back to their GP practice and any other GP practices they have agreed to represent.

- **what are the key constraints? (for example financial, legislative or other)**

1. The potential pressures that a second wave of Covid-19 could place on primary care and General Practice
2. Pressures in General Practice and competing priorities impacting on GP resources
3. Demand versus capacity; there is a risk that there may be a temporary increase in demand.

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

Those primarily affected are:
GPs and their staff
Patients
Care homes
Health and Social Care Trust Multidisciplinary support teams
Health and Social Care Board

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

- **what are they?**

Department of Health consent forms for examination, treatment and care. Advance refusal to refuse treatment is a legal document completed by the patient. These are less frequently used but do have legal standing.

- **who owns them?**

Department of Health

(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.

Statistics from the Medical Care planning NILES for patients with chronic conditions 2019/2020, Key Information Summary NILES 2019/2020, and Enhanced Care at Home LES's.

NI Census data (2011)

NISRA 2019 Mid-year population estimates available at:
https://www.nisra.gov.uk/publications/2019-mid-year-population-estimates-northern-ireland

RQIA Residential homes & beds trend report 2008 to 2018

2.2 Quantitative Data

Data from the 2019/2020 Medical Care planning for patients with chronic conditions LES shows that 284 GP practices across Northern Ireland contracted for this LES providing 9,146 new medical care plans, and 19,095 annual reviews including updating individual Medical Care Plans.

The 2019/2020 KIS was made available to all EMIS practices. At January 2020 93% of EMIS practices contracted to provide the LES. The number of KIS assessments completed was 7,106. This included 4,030 assessments for dementia patients which exceeded the set target by over 30%. The number of patients not on the dementia registers but deemed suitable and with a KIS completed was 2,621.

The 2019/2020 Enhanced care at Home LES available to GP practices in the South Eastern LCG area confirms that over 80% of practices contracted to provide this service to their patients.

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.

This NILES is available to the full patient population of Northern Ireland including all Section 75 groups.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	Mid-year population estimate 2019 (published 11 June 2020) shows that the resident population in Northern Ireland at 11 June 2020 is estimated to be 1.893 million people. Just over half (50.7 per cent) of the population were female - 961,000, compared to 933,000 males (49.3%). Available at https://www.nisra.gov.uk/publications/2019-mid-year-population-estimates-northern-ireland The proportion of females in 2011 was 51% (923, 540). The male population was 49% (887, 323) in 2011. Transgender Research suggests for the Northern Ireland population as a whole: • 140-160 individuals are affiliated with transgender groups • 120 individuals have presented with Gender Identity Dysphoria • There are more trans women than trans men living in Northern Ireland. (McBride, Ruari Santiago (2011): Healthcare Issues for Transgender People Living in Northern Ireland. Institute for Conflict Research.) **The Gender Identity Research and Education Society (GIRES)** estimate the number of gender nonconforming employees and service users, based on the information that 7 GIRES assembled for the Home Office (2011) and subsequently updated (2014): • gender variant to some degree 1% • have sought some medical care 0.025% • having already undergone transition 0.015% The numbers who have sought treatment seems likely to continue

	growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among youngsters is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men). Applying GIRES figures to NI population (using NISRA 2019 mid-year population estimates) N=1,893,700: • 18,937 people who do not identify with gender assigned to them at birth • 474 likely to have sought medical care • 284 likely to have undergone transition
Age	According to NISRA's 2019 mid-year population estimates the people aged 65 or over = 314,700 (16.6%). The RQIA Residential homes & beds trend report 2008 to 2018 informs us that the total population of Northern Ireland increased from 1,779,152 to 1,870,834 in 2017, representing a growth of approximately 4%. However, during this same ten year period, the population of persons aged 65 years or older jumped from 247,500 to 302,975 (an increase of 22%). • The percentage of persons 65 years or older as a proportion of the total population has increased from 14% to 16%. • Over the same time period, the number of nursing beds has increased by 10% • The percentage increase in nursing beds was less than half of the increase in the population aged 65 years or over. (Northern Ireland Statistical Research Agency) The Report goes on to state that in October 2018, there were 5,200 residential beds and 10,800 nursing care beds available in Northern Ireland
Religion	The 2011 Census data shows that: •42.2% of population from a Catholic background • 52.9% of population from Protestant and other Christian background

	• 4.9% of population from other religions, no religion or religion not stated
Political Opinion	The most recently published data from the Northern Ireland Life and Times Survey (2016) on political opinion shows that: Unionist 29% Nationalist 24% Neither 46% Other/ don't know 2%.
Marital Status	Data from the 2011 Census informs us that: Married 47.56% Single never married 36.14% Separated 3.98% Divorced 5.45% Same Sex Civil Partnership 0.09% Widowed or Surviving partner from SSCP 6.78 %
Dependent Status	Information from CarersNI suggests that: • 1 in every 8 adults is a carer • 2% of 0-17 year olds are carers, based on the 2011 Census • There are approximately 220,000 carers in Northern Ireland • Any one of us has a 6.6% chance of becoming a carer in any year • One quarter of all carers provide over 50 hours of care per week • People providing high levels of care are twice as likely to be permanently sick or disabled than the average person • 64% of carers are women; 36% are men. **Health Survey NI (2016/17)** • 13% have caring responsibilities • Approx 70% receive no monetary reward for giving this care • 48% received help from other family members, but 38% received no support from others **Parents with dependent children (Census 2011)** Responsibility for dependent children: 238,094 households (33.9% of all NI households) **NI Lone parent families** = 115,959, with 123,745 dependent children in family (Census 2011). Of the 115, 959 lone parents, 16, 9 691 are males and 99,268 are female. (Census 2011)

Disability

The Alzheimer's Society (http://www.alzheimers.org.uk) informs us (as at 2013) that 80% of people living in care homes have a form of dementia or severe memory problems.

It is estimated that in Northern Ireland, 42% have longstanding illness (30% limiting and 12% non-limiting illness) Health Survey NI (2017).

Prevalence of longstanding limiting illness increases with age: approximately 8% among young adults aged 16 to 34 years, compared to 60% among those who are aged 65 years and over. (Census 2011)

The table below indicates prevalence of different long term conditions using information gathered in the last census (although these may have changed over time):

Type of long – term condition	Percentage of population with condition %
Deafness or partial hearing loss	5.14%
Blindness or partial sight loss	1.7%
Communication Difficulty	1.65%
Mobility of Dexterity Difficulty	11.44%
A learning, intellectual, social or behavioural difficulty	2.22%
An emotional, psychological or mental health condition	5.83%
Long – term pain or discomfort	10.10%
Shortness of breath or difficulty breathing	8.72%
Frequent confusion or memory loss	1.97%
A chronic illness (such as cancer, HIV, diabetes, heart disease or	6.55%

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<tr><td>epilepsy</td><td></td></tr>
<tr><td>Other condition</td><td>5.22%</td></tr>
<tr><td>No Condition</td><td>68.57%</td></tr>
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(Census 2011)

In Northern Ireland people experience the lowest disability free life expectancy (Age NI, 2010).
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<td>Ethnicity</td>
<td>•Traveller population in N Ireland is estimated at 3905 (All-Ireland Traveller’s Health Survey, 2010)
• Non-White ethnic groups (Asian, Black, Mixed, Other) estimated at: 31113.
• The number of births to mothers outside the UK and Ireland have increased over the past decade with 2347 births in 2008 compared with 661 in 2001 (9% of all registered births)
(2011 Census data)

Northern Ireland Pooled Household Survey (NIPHS) tables, published 2017. Data are presented as ‘Ethnicity White’ and ‘All Other Ethnicities’ due to small cell sizes.
2013/14: Ethnicity White 98.2% (1,399,000); All other Ethnicities 1.6% (23,000) (No response not included)
2014/15: Ethnicity White 98.2% (1,409,000); All other Ethnicities 1.8% (26,000)

Language
The five most popularly requested languages in HSC settings (as reported by the HSC Translation Service) in 2017-2018 were:
1. Polish (30,292 requests);
2. Lithuanian (15,763 requests);
3. Arabic (11,360 requests);
4. Romanian (9,908 requests) and
5. Portuguese (8,524 requests)</td>
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<td>Sexual Orientation</td>
<td>Between 2005 and 2017, there were 1202 recorded Civil Partnerships regionally. However, this is not indicative of the LGB population.
There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 5% and 10% of the</td>
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	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	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	There is no data to suggest that the needs and experiences of service users differ on the basis of gender
Age	This service will impact older patients. Patients residing in care homes are in general are aged 65 years old and over.
Religion	There is no data to suggest that the needs and experiences of service users differ on the basis of religion
Political Opinion	There is no data to suggest that the needs and experiences of service users differ on the basis of political opinion
Marital Status	There is no data to suggest that the needs and experiences of service users differ on the basis of marital status
Dependent Status	There is no data to suggest that the needs and experiences of service users differ on the basis of dependent status
Disability	This service will impact those who have disabilities. For example, a large majority of people living in care homes have a form of dementia or severe memory problems. People with certain disabilities such as dementia, hearing loss or learning disabilities can have communication difficulties and may need information presented in an alternative format. It is recognised that some patients with dementia or certain learning disabilities may lack capacity to give consent for assessment and may need the help of a relative, partner, friend, carer or advocate.
Ethnicity	Issues relating to accessible information for people whose first language is not English are considered in our Accessible Formats Policy .

Sexual Orientation	There is no data to suggest that the needs and experiences of service users differ on the basis of sexual orientation

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.

Elderly patients with dementia or severe memory problems.

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?***
Disability Issues relating to accessible information for people with disabilities are considered in our Accessible Formats Policy The HSCB Accessible Formats Policy outlines how those developing information should consider alternative formats, and how information and publications can be requested in alternative formats. HSCB will provide alternative formats on request to meet the needs of	Doctors and Nurses working for the service, in line with GMC guidance on consent, work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. Ways in which to maximise the individuals ability to make decisions for themselves will be facilitated (taking account of confidentiality issues) such as: bringing a relative, partner, friend, carer or advocate to consultations, or

people with a disability who may need information in an accessible format. **Ethnicity** Issues relating to accessible information for people whose first language is not English are considered in our Accessible Formats Policy As part of HSCNI, HSCB can access the regional contract for translation and interpreting.	having written or audio information about their condition or the proposed investigation or treatment; speaking to those close to the patient and to other healthcare staff about the best ways of communicating with the patient. A patient is only treated as lacking the ability to make their decisions, i.e. capacity, once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.

2.6 Good Relations

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

Group	***Impact***	***Suggestions***
Religion	N/A	N/A
Political Opinion	N/A	N/A
Ethnicity	N/A	N/A

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	X
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	X

This NILES will be made available to the full patient population including all Section 75 groups. Implementation of the service will identify care home residents wishes to allow planning of future care, proactively review new care home residents medical needs as soon as possible after arrival in the home, develop or update an individual anticipatory care plan to improve the patient's quality of life, aid decision making when managing deterioration in health and identify and address any palliative care needs.

No major adverse impacts were identified from the data and evidence available.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	***What else could you do to encourage disabled people to participate in public life?***
N/A	N/A

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
N/A	N/A

(5) CONSIDERATION OF HUMAN RIGHTS

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

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

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

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

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

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

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

N/A

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights

Approved Lead Officer: Dr Rachel Edwards

Position: GP Medical Adviser

R Edwards.

Policy/Decision Screened by: John Scates

Signed:

John Scates

Date: 30 November 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:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 95363961 (for Text Relay prefix with 18001); fax: 028 9023 2304