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

Extension of the Hospital at Home scheme -Regional

1.2 Description of policy or decision

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

In June 2021 the Rebuilding Management Board approved a region-wide service model for Hospital at Homewhich would replace existing Acute Care at Home/Enhanced Care at Home services and extend them to all geographical areas. Existing Acute Care at Home and Enhanced Care at Home programmes in each Trust are expected to migrate to the Hospital at Home model.
Hospital at Home provides intensive hospital level care for acute conditions that would normally require an acute hospital bed, in a patient's home for a short episode, through multi-disciplinary healthcare teams.

Objectives for the service include:

- extending the reach of the Hospital at Home scheme to find more patients who could benefit, including supporting care homes to manage acutely ill patients and case-find within hospital EDs and working more closely on referral practice with GPs and NIAS.
- ensuring the threshold for acceptance of referrals to equivalent to an acute hospital admission
- an average length of stay of between 4 and 5 days.

Benefits to patient from receiving Hospital at Home;
-Avoids unnecessary admission to hospital and associated disbenefits such as deconditioning which can lead to loss of independence and increased risk of falls

- Patients are treated as though admitted to hospital, but managed within their own home
-The reduced stress of being in familiar surroundings and the removal of travelling costs
-Helps patients to be as safe and independent as possible at home.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

Service uses and Carers ,Acute and Community Staff, Non Governmental organisations

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

- **what are they?**

Health and Wellbeing 2026: Delivering Together
It will also support the implementation of No More Silos Key Action 7: Acute Care at Home as well as supporting Regional Anticipatory Care Planning and Enhanced Clinical Care Framework for the Care Home sector by providing immediate acute support in the patient's home, including care homes, to avoid the need for transfer to hospital where clinically appropriate.

- **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.

Census 2011

NISRA data June 2020

(Northern Ireland Life and Times, 2018-2020)

Engagement and consultation with current providers and staff in HSC Trusts, Integrated Care Partnerships and Local Commissioning Groups

Health & Wellbeing 2026: Delivering Together (health-ni.gov.uk)

Review of HSC Commissioning Arrangements - Final report | Department of Health (health-ni.gov.uk)

Rebuilding HSC Services

Programme for Government (PfG)

Making Life Better(health=ni.gov.uk)

http://healthallianceni.com/health-social-wellbeing/bme-groups/

2.2 Quantitative Data

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

The service will be provided to all service users aged over 65 who would otherwise, based on clinical judgement, be referred to an Emergency Department. Service users are likely to be more frail, more likely to have a carer and more likely to live with disability. More women than men survive to older ages and may therefore make more use of the service. Frailty is

more common in more deprived areas and for this reason may be associated with an imbalance in the way it impacts on some groups such as those in ethnic minorities who are more likely to live in more deprived areas.

<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>Gender</td><td>At 30 June 2020, Northern Ireland’s population was estimated to be 1.90 million people. Just over half of the population (50.7 per cent) were female, with 961,400 females compared to 934,200 males (49.3 per cent).

As at June 2020, Northern Ireland’s population for females for the over 65 group was 173,798 and 146,151 for males.(NISRA.gov.uk)

There is no quantitative data on the equality profile of the actual users but more women than men survive to older ages and may therefore make more use of the service.</td></tr>
<tr><td>Age</td><td>The potential service users for the Hospital at Home scheme is the older population. It is estimated that there are 319,949 over the age of 65 years of age in Northern Ireland. In the year mid 2019 to 2020, the population aged 65 and over increased by 1.7 percent (from 314,700 to 319,900). Mid-year population estimates published by NISRA in 2019 show that 15% of the population are over 65 years of age:65-74 (172,755)
-75-89 (133,267)
-90 + years (13,927)

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

Population of over 65 per Trust area is detailed below;

<table>
<tr><td>NHSCT</td><td>SHSCT</td><td>SEHSCT</td><td>WHSCT</td><td>BHSCT</td></tr>
<tr><td>86,014</td><td>58,703</td><td>69,683</td><td>49,709</td><td>55,840</td></tr>
</table>
</td></tr>
<tr><td>Religion</td><td>Religion or Religion brought up in

• 45.14% (817, 424) of the population were either Catholic or brought up as Catholic.</td></tr>
</table>

<table>
<tr><td></td><td>

48.36% (875, 733) stated that they were Protestant or brought up as Protestant.
0.92% (16, 660) of the population belonged to or had been brought up in other religions and Philosophies.
5.59% (101, 227) neither belonged to, nor had been brought up in a religion.

(Census 2011)

According to NISRA 2020, 20 percent of Protestants and other Christians were aged 65 and over compared with 11 percent Catholic, 11 percent belong to other religions and 8.7 percent no religion/or religion not stated.

No specific data in relation to religion and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users
</td></tr>
<tr><td>Political Opinion</td><td>
A recent survey of the NI population, published in 2018, explored political opinion. People were asked “Generally speaking, do you consider yourself as a unionist, a nationalist or neither?” Of those that responded to the survey, 26% generally considered themselves to be Unionist; 21% said they were Nationalist; 50% said neither Unionist nor Nationalist; and 1% said “Other”. 2% said they didn’t know (Northern Ireland Life and Times, 2018).

According to (Northern Ireland Life and Times, 2020) the over 65s group political attitudes are shown below;

<table>
<tr><th></th><th>65+%</th></tr>
<tr><td>Democratic Unionist Party (DUP)</td><td>17</td></tr>
<tr><td>Sinn Féin</td><td>4</td></tr>
<tr><td>Ulster Unionist Party (UUP)</td><td>21</td></tr>
<tr><td>Social Democratic and Labour Party (SDLP)</td><td>14</td></tr>
<tr><td>Alliance Party</td><td>29</td></tr>
<tr><td>Green Party</td><td>3</td></tr>
<tr><td>Other party</td><td>3</td></tr>
<tr><td>None of these</td><td>4</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>Other answer</td><td>2</td></tr>
<tr><td>Don't know</td><td>4</td></tr>
</table>

No specific data in relation to political opinion and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users.</td></tr>
<tr><td>Marital Status</td><td>Northern Ireland Life and Times (2018)
Single (never married) 32%
Married and living with husband/wife 51%
A civil partner in a legally-registered civil partnership 0%
Married and separated from husband/wife 3%
Divorced 6%
Widowed 7%

Civil partnerships
Annual Reports of the Registrar General for NI show that Between 2005 to 2018 inclusive, there have been 1298 civil partnerships registered in NI. Of these, 539 have been male civil partnerships, and 571 have been female civil partnerships.

According the NI Life and Times Survey - 2020 :(ark.ac.uk) the marital status for the over 65 group is shown in the table below;

<table>
<tr><td>Marital Status</td><td>Over 65</td></tr>
<tr><td>Single</td><td>15%</td></tr>
<tr><td>Married/Cohabiting</td><td>48%</td></tr>
<tr><td>Divorced/separated/Widowed</td><td>37%</td></tr>
</table>
(NLIT 2020)

No specific data in relation to marital status and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users.</td></tr>
<tr><td>Dependent Status</td><td>

11.81% (213, 863) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill – health/disabilities or problems related to old age.

</td></tr>
</table>

- 3.11% (56, 318) provided 50 hours care or more.
- 33.86% (238, 129) of households contained dependent children.
- 40.29% (283, 350) contained a least one person with a long – term health problem or a disability.

(Census 2011)

CarersNI

- 1 in every 8 adults is a carer
- 2% of 0-17 year olds are carers, based on the 2011 Census
- There are approximately 220,000 carers in Northern Ireland (
- Any one of us has a 6.6% chance of becoming a carer in any year
- One quarter of all carers provide over 50 hours of care per week
- People providing high levels of care are twice as likely to be permanently sick or disabled than the average person
- 64% of carers are women; 36% are men.

CarersNI State of Caring 2019 Annual survey (UK wide, including NI)

1) 2 in 5 carers (39%) responding reported being in paid work.
2) 38% of all carers reported that they had given up work to care.
3) 18% had reduced their working hours.
4) 1 in 6 carers (17%) said that they work the same hours but their job is negatively affected by caring, for example because of tiredness, lateness, and stress.
5) 12% of carers said they have had to take a less qualified job or have turned down a promotion to fit around their caring responsibilities.
6) Just over 1 in 10 carers (11%) said they had retired early to care.
7) Only 4% of respondents of all ages said that caring has had no impact on their capacity to work.
8) Only one quarter (25%) of carers who aren't yet retired and had an assessment in the last year felt that their need to combine paid work and caring was sufficiently considered in their carer's assessment.
9) Carers who are not yet retired were also asked about their

	future plans and 53% said they are not able to save for their retirement. 10) Some carers are saving or have saved less for their retirement with 17% saying they did this because their working hours were reduced. According to the NI Life and Times Survey - 2020: Background (ark.ac.uk) the over 65 people group were asked if anyone living with them who is sick, handicapped or elderly whom they look after or give special help to (for example, a sick, disabled or elderly relative, wife, husband, child, friend) 15% of over 65 said yes and 85% said no. 8% of the over 65 group are receiving social care (NILT 2010).
Disability	• 20.69% (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities. • 68.57% (1, 241709) of residents did not have long – term health condition. • Deafness or partial hearing loss – **5.14% (93, 078)** • Blindness or partial sight loss – **1.7% (30, 785)** • Communication Difficulty – **1.65% (29, 879)** • Mobility or Dexterity Difficulty – **11.44% (207, 163)** • A learning, intellectual, social or behavioural difficulty - **2.22% (40, 201)** • An emotional, psychological or mental health condition - **5.83% (105, 573)** • Long – term pain or discomfort – **10.10% (182, 897)** • Shortness of breath or difficulty breathing – **8.72% (157, 907)** • Frequent confusion or memory loss – **1.97% (35, 674)** • A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy. – **6.55% (118, 612)** • Other condition – **5.22% (94, 527)** • No Condition – **68.57% (1, 241, 709)** (Census 2011) 43% longstanding illness (30% limiting and 12% non-limiting illness) • Males: limiting longstanding illness 28%; non-limiting longstanding illness 12% • Females: limiting longstanding illness 33%; non-limiting longstanding illness 12%

	• Prevalence of disability increases with age. Limiting longstanding illness increases from 18% among young adults aged 25 -34 years to 52% among those who are 75 plus years. According to NI Life and Times Survey - 2020: Background (ark.ac.uk) 44% of the over 65 group in NI indicated that they had a disability compared to 55% who said they did not. 75% of the over 65 group indicated that their condition or disability had a substantial adverse effect on their ability to carry out normal day-to-day activities. (NILT-2020)
Ethnicity	1.8% (32,596) of the usual resident population belonged to minority ethnic groups: **White –** 98.21% (1, 778, 449) **Chinese** – 0.35% (6, 338) **Irish Traveller** – 0.07% (1, 268) **Indian –** 0.34% (6, 157) **Pakistani –** 0.06% (1, 087) **Bangladeshi** – 0.03% (543) **Other Asian** – 0.28% (5, 070) **Black Caribbean** – 0.02% (362) **Black African** – 0.13% (2354) **Black Other** – 0.05% (905) **Mixed** – 0.33% (5976) **Other** – 0.13% (2354) (Census, 2011) No specific NI data available in respect of ethnicity and older people. However, the majority of the NI black and minority ethnic population are of working age and therefore it can be reasonable to assume that those of ethnic minority of 65+ make up a smaller share of the 15%. NI Life and Times Survey - 2020: Attitudes to Minority Ethnic People (ark.ac.uk) showed that for over 65 group ;

	<table><tr><th></th><th>65+</th></tr><tr><td>White</td><td>98</td></tr><tr><td>Chinese</td><td>0</td></tr><tr><td>Indian</td><td>0</td></tr><tr><td>Other Asian</td><td>0</td></tr><tr><td>Black African</td><td>0</td></tr><tr><td>Black Other</td><td>0</td></tr><tr><td>Mixed ethnic group</td><td>0</td></tr><tr><td>Other ethnic group</td><td>1</td></tr></table>

Sexual Orientation	In 2016, estimates from the Annual Population Survey (APS) showed that:
	
	• 93.4% of the UK population identified as heterosexual or straight and 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:
	  ○ 1.2% identifying as gay or lesbian
	  ○ 0.8% identifying as bisexual
	• A further 0.5% of the population identified themselves as "Other", which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories. A further 4.1% refused, or did not know how to identify themselves.
	• The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).
	• More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.
	• The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.
	• Sexual identity is one part of the umbrella concept of "sexual orientation". Sexual identity does not necessarily reflect sexual attraction or sexual behaviour – these are separate concepts that Office for National Statistics (ONS) currently does not measure.
	
	No specific NI data available in respect of sexual orientation and older people but there is no reason to assume that the profile of actual service users would be different from that of 65+ year olds as potential service users.

	The 2011 Census did not collect data on the sexual orientation but according to the Moving towards a Sexual Orientation strategy for NI (ark.ac.uk) 0.4 percent of the 65 years group and older identified themselves as gay, lesbian or bisexual.

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	***Needs and Experiences***
Gender	Both Male and Female service users will benefit from the service proposals. Transgender people may have particular concerns about being cared for in a hospital setting (for example, based on negative experiences in the past) and thus draw particular benefits from Hospital at Home care. Gender specific care providers, with due consideration towards those in the transgender community will be provided as far as reasonably possible, if requested.
Age	This proposal focuses on the “Elderly” population, those aged 65+, this elderly population equates to over 16% of the NI Population. Each service user will receive a personal, tailored service that meets their individual needs. This will therefore have a positive impact on those aged 65 years or older.
Religion	There is no evidence of differential impact on the grounds of religion
Political Opinion	There is no evidence of differential impact on the grounds of political opinion.
Marital Status	Marital status of service users will be respected, including same sex families / carers
Dependent Status	Those over 65 years old are most likely to care for grand children. Some adults also have adult dependents. Caring responsibilities will be considered as part of any personalized care.
Disability	The service users may have complex physical, mental or sensory life limiting disabilities including hearing loss or visual impairment. Prevalence of long term conditions such as stroke, diabetes and COPD is much higher within this age group of service users and as such services should be tailored to meet the needs of these users. Prevalence of long term conditions/disabilities such as physical, mental, sensory or life limiting difficulties are all associated with the older population and as such services should be tailored to meet the specific needs of these service users (including, for example access to sign language interpreting in the home setting). Some people with a disability (such as dementia, a learning disability or with autism) may have particular concerns or experience significant stress about being cared for in an unfamiliar hospital setting and thus draw particular benefits from Hospital at Home care.

Ethnicity	The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care. These include: - Language difficulties; - Lack of awareness and lack of appropriate information on the services available; - The need for a permanent address in order to register with a General Practitioner; - Fears about entitlement to health care; - Difficulty in coming to grips with a health care system that is different to what exists in their country of origin; - The failure of some services to meet migrants' cultural or religious needs; - Institutional racism and the negative attitudes of some health care staff; and - Immigration restrictions. It is recognised that people from ethnic minorities can experience difficulties accessing public services based on language barriers as well as lack of familiarity with the services that are available. Ethnicity of the users will not determine service accessibility or delivery so has no impact on service development. Those requiring assistance to access services will be given the necessary support. (including provision of interpreting or translation services.)
Sexual Orientation	Sexual orientation of the users will not determine service accessibility or delivery. Service providers will be respectful of same sex families. Some people in a same sex relationship may have particular concerns about being cared for in a hospital setting (for example, based on negative experiences in the past) and thus draw particular benefits from Hospital at Home care.

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.

The service will increase the access of this service for all applicable service users.

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

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Services will be accessible by all who require intervention or treatment and intensive stakeholder engagement was completed to ensure that the needs of all service users were considered in the development and implementation of the service The service will be tailored and personalized to the service user and carer(s), taking account of their different needs based on any section 75 characteristic. Some section 75 groups may be uneasy with strangers even though they are HSC staff coming into their homes particularly those who live on their own, elderly, or belong to the LGBT community.	Access to services and service delivery will be monitored as part of the service agreement and any potential impacts will be addressed as part of the ongoing equality monitoring process. Trusts will be required to identify any barriers experienced by ethnic minorities in accessing the service. Staff training and awareness Trusts will be required to monitor the impact on some section 75 users going forward.

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	NONE	
Political Opinion	NONE	
Ethnicity	NONE	

(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 policy will have a positive impact for those over the age of 65 years of age. The service is personalized and tailored to the individual service user and takes account of their needs.

(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?***
It gives all service users regardless of disability benefit from increased independence through regular HSC home support and self management.	Regular needs analysis and monitoring effectiveness of the service The Regional Unscheduled Care Service User and Carer Reference Group ensured that service users were involved in the development of this policy and will have the opportunity to participate in the monitoring and review of the service in future.

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

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
By promoting independence and self management.	Staff training and awareness

(5) CONSIDERATION OF HUMAN RIGHTS

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

ARTICLE	Yes/No
Article 2 – Right to life	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.	Yes
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
8	Positive impact	Service providers will be providing care in patients/users 'home' and therefore will be conscious and respectful of service users right to privacy and family life.	No

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

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

HSC Trusts will be encouraged to continue to deliver relevant human rights based training for front line staff – which covers Article 8 Rights.

(6) MONITORING

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

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

Approved Lead Officer:	Mr Iain Deboys
Position:	Assistant Director of Commissioning
Policy/Decision Screened by:	Bernie Mooty
Signed:	
Date:	17 November 2021

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

Please forward completed template to:
Equality.Unit@hscni.net

Template produced November 2011
If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Equality Unit:

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