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 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

Stroke –Enhancement of Early Supported Discharge for WHSCT, and SHSCT.

1.2 Description of policy or decision

This proposal is for WHSCT and SHSCT to increase Community Stroke Team capacity to improve Early Supported Discharge which was established in 2018/19, funded through transformation. The investment will provide enhanced staffing support though an Early Supported Discharge service for stroke survivors. It will promote a patient centred approach to care through the delivery of a flexible and adaptive model of care delivered within the patient's home setting. The establishment of an ESD service in WHSCT and SHSCT has improved the equity of service provision. Four Trust areas (B, SE, S and WHSCT) can now offer ESD to stroke patients. There is a proposal to extend to NHSCT ESD subject to securing a funding source.

Early Supported Discharge reduces the patients' length of stay in hospital - improving direct access to and % of stay on a stroke unit – while continuing therapy in the home environment at the same intensity as hospital.

Stroke is the single largest cause of adult disability in the UK and the fourth largest cause of death. Two thirds of those who survive stroke have a life changing disability. Stroke is a major health issue in NI with around 2,900 people being admitted to hospital each year and 36,000 stroke survivors living in our communities.

It is important that every opportunity is taken to secure excellent care for people after a stroke and give them the best possible chance of a good recovery. The number of people in NI experiencing stroke each year is likely to increase in future because of a growing older population, with three out of four people who experience stroke being over the age of 65.

Around two thirds of stroke survivors will require some continued support or rehabilitation in the community after discharge from hospital. Up to 40% of stroke survivors may be suitable

for ‘Early Supported Discharge’ (ESD).

Early supported discharge forms part of the wider stroke pathway. It is aimed at enabling patients who are medically stable, have reached an appropriate level of physical and cognitive recovery and have adequate support in the community to continue rehabilitation in their own environment. ‘Early’ implies that patients can return home and receive rehabilitation sooner than would otherwise be possible, rather than being related to time since stroke onset.

Benefits of ESD to patients

- can reduce long term mortality and institutionalisation rates for up to 50% of stroke survivors.
- Improved patient outcomes result in stroke survivors being more likely to be independent and living at home after six months.

It is therefore recommended that WHSCT and SHSCT should continue the ESD service for stroke that is comprised of a multi-disciplinary team with stroke specialist skills. These investments will support enhancement to the existing service to improve patient flow through the acute stroke units , reducing length of stay by providing self-management and reducing dependency on acute stroke services over 48 weeks.

There are approximately 350 patients admitted with stroke to WHSCT hospitals each year, and approximately 500 patients admitted with stroke to SHSCT .Optimal outcome is achieved if the patient is admitted directly to a stroke unit within 4 hours and spends at least 90% of inpatient spell on a stroke unit as measured through the Stroke Sentinel National Audit Programme (SSNAP).

WHSCT and SHSCT performance for both measures is significantly behind its peers nationally and in NI. For WHSCT up to 40% (140 patients) could benefit from ESD and up to 40% (200 patients) for SHSCT could also benefit, reducing inpatient length of stay and increasing direct access to stroke unit within the Trust. therefore improving patient flow and benefitting all stroke patients

There will also be a benefit to staff through the implementation of ESD. Additional funding will enable the uplift to the Community Stroke Teams to put staff in place to provide additional nursing, AHP and rehabilitation assistants. Staff will also be given the opportunity to gain new skills.

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 users (stroke patients assessed as suitable for Early Supported Discharge arers and Hospital and Community Stroke Team Staff.

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

- **what are they?**

Early Supported Discharge is an important element of stroke service transformation and is of high strategic importance in line with the following:

- New Decade, New Approach (NI Executive, 2020)
- Reshaping Stroke Care – Saving Lives, Reducing Disability (DoH, 2019)
- Systems not Structures, Changing Health & Social Care (2016)
- Improving Stroke Services in Northern Ireland (DHSSPS, 2008)

(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
- NICHS stroke statistics
- National Stroke Strategy Department of Health 2007
- Healthcare for London Stroke rehabilitation guide: supporting London commissioners to commission quality services in 2010/11 November 2009
- Beech, R.; Rudd, A.; Tilling, K. Wolfe, C. (1999) Economic consequences of early supported discharge to community-based rehabilitation for stroke in an inner London teaching hospital. Stroke 30:729-735
- http://Healthalliance.com
- National Audit public report AprJul 2017

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.

Category	***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?***
Gender	Stroke prevalence varies according to gender. The prevalence of stroke is higher among men up to the age of approximately 80 years, after which it becomes higher in women. In 2019/20, **1,344 females** (47.6% of total admissions) and **1,477 males** (52.4%) were admitted to hospital for stroke.(NICHS stroke statistic) There was a 1.25% decrease in females compared to the year before, compared to 2% increase in number of males admitted the year before. (NICHS Stroke statistics).

	The estimated population of the **Western** Health and Social Care Trust (HSCT) at 30 June 2020 was **303,207**, of which **150,793 (49.7%)** were male and **152,414 (50.3%)** were female. The estimated population of the **Southern** Health and Social Care Trust (HSCT) at 30 June 2020 was **388,688**, of which **194,148 (49.9%)** were male and **194,540 (50.1%)** were female. NI HSC Workforce Census as at March 2021 reports that 78% of all HSC staff were female, and 57% (by headcount) worked full-time.
Age	Stroke affects all ages but most strokes occur amongst people who are older than normal retirement age with three out of four people who experience stroke being over the age of 65. The hospital admissions for stroke and TIA in 2019/20, 939 were under the age of 70 (33.3% of all admissions), compared to 981 in the previous year (35%).(NICHS) There are 303,207 in the WHSCT population and **49,709** people 65 years and older. The SHSCT is made up of 388,688 and **58,703** people 65 years and older. .
Religion	There are no accurate NI robust statistics of religion of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds of religion. **(Census 2011)** **WHSCT** **67.69%** belong to or were brought up in the Catholic religion and **29.75%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion; and **SHSCT** **56.69%** belong to or were brought up in the Catholic religion and **39.15%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion; (Census 2011).
Political Opinion	There are no accurate NI robust statistics on the political opinion of stroke patients which would enable analysis of this aspect. In relation to staff, there is no NMC Equality and Diversity data for this group and NI HSC Workforce Census for this is unavailable but there is no evidence of differential impact on the grounds of political opinion.

<table>
<tr><td></td><td>Census 2011 for NI population

Nationality

• British only – 39.89% (722, 353)
• Irish only – 25.26% (457, 424)
• Northern Irish only – 20.94% (379, 195)
• British and Northern Irish only – 6.17% (111, 730)
• Irish and Northern Irish only – 1.06% (19, 195)
• British, Irish and Northern Irish – 1.02% (1847)
• British and Irish only – 0.66% (11, 952)
• Other – 5.00% (90, 543)</td></tr>
<tr><td>Marital Status</td><td>There are no accurate NI robust statistics of marital status of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds marital status.

Census 2011 for NI population
• 47.56% (680, 840) of those aged 16 or over were married
• 36.14% (517, 359) were single
• 0.09% (1288) were registered in same-sex civil partnerships
• 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership
• 6.78% (97, 058) were either widowed or a surviving partner

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

Dependent Status	Data on the caring responsibilities of stroke survivors is not routinely collected. Given their age profile, it is reasonable to assume that fewer of them will have dependents than in the general population as a whole. Nevertheless, it is recognised that some older people will themselves be carers, as Age UL data (2013) underlines in the UK nearly 50,000 people aged 85 provide unpaid care to a partner, family member or other person. In turn, younger stroke survivors will be more likely to have caring responsibilities , including for children and/ or older dependents. (Census 2011) In the **WHSCT** area 11.04% of people in the WHSCT area stated that they provided unpaid care to family, friends, neighbours or others. In **SHSCT** area, 11.34% of people stated that they provided unpaid care to family, friends, neighbours or others. NI Data (Census 2011) • 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. • 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. **Carers NI 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.
Disability	Stroke is the single biggest cause of disability in adults in the UK (NICE, 2019). Stroke can have many different effects on someone, including problems with mobility, swallowing and continence. It can affect their vision and cause communication problems, fatigue and problems with memory and concentration. It can also have emotional effects, like depression and anxiety. It can also cause behaviour changes Data from the stroke sentinel National Audit public report indicates that stroke patients have a higher level of pre-existing physical disability than that of the general population. This could indicate that those living with a physical disability may be at higher risk of stroke. It is also known that people with certain long term conditions , including heart disease and diabetes , are at a higher risk of stroke. (Census 2011) **21.85%** of people had a long-term health problem or disability that limited their day-to-day activities in the **WHSCT** area; **In SHSCT, 19.64%** of people had a long-term health problem or disability that limited their day-to-day activities.(Census 2011) NI Data • 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). **Census 2011** It becomes clear, therefore, that a sizeable share of stroke survivors in NI will have pre-existing disabilities, physical disabilities as well as certain long term conditions such as diabetes and heart disease in particular. NI HSC Workforce Census for this is unavailable
Ethnicity	There are no accurate NI robust statistics of ethnicity of stroke patients or staff which would enable analysis of this aspect. National research suggests that there are differences within black and minority ethnic (BME) groups generally when compared with the white population. Ill health often starts at an earlier age in BME groups than among white people. There are variations from one health condition to another, for example, BME groups have higher rates of cardiovascular disease than white people but lower rates of cancer, Diabetes is more common in BME groups and high blood pressure is more common in Asian groups. NICE (2019) states that black people are almost twice as likely to have a stroke as white people. On average, people of black African, black Caribbean and South Asian descent in the UK have strokes earlier on in their lives.

(Census 2011)

In the WHSCT area **1.10%** where from an ethnic minority population and the remaining **98.90%** were white (including Irish Traveller).

In SHSCT **1.34%** were from an ethnic minority population and the remaining **98.66%** were white (including Irish Traveller)

NI Data – Census 2011

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)

-

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 ;

	65+
White	98
Chinese	0
Indian	0
Other Asian	0
Black African	0

	Black Other	0
	Mixed ethnic group	0
	Other ethnic group	1

Sexual Orientation	No specific data for WHSCT and SHSCT areas but unlikely to impact.
	
	NI Data (Census)
	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.
	
	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	Stroke prevalence varies according to gender. The prevalence of stroke is higher among men up to the age of approximately 80 years, after which it becomes higher in women. A majority of studies indicate that the case-fatality rate is higher in female than in male stroke patients; there is also some evidence, albeit relatively weak, indicating a better functional outcome in men (NICE, 2019). The needs of the people who identify as transgender or non-binary should be considered . Many are less likely to have a supportive family environment. 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 Early supported discharge as Service providers will be continuing therapy in the patient/users home environment .
Age	Most strokes occur amongst people who are older than normal retirement age. They are more likely to live alone than younger people, which means they tend to need more support if they return home to live after a stroke. They are also more likely than younger people to have other pre-existing health issues which may compound their needs when recovering from a stroke. However, there is still a substantial proportion of people who have had a stroke will be of working age, and will wish to return to work. This may affect the type of rehabilitation they require, and if they have acquired impairment from their stroke they may need to retrain to a different job, or have adaptations made to their working environment. If the partner of a stroke survivor is of working age this may affect their ability to take on additional caring responsibilities (CQC, 2019).
Religion	There is no evidence of specific needs on the grounds of religion.
Political Opinion	There is no evidence of specific needs on the grounds of Political Opinion..
Marital Status	There are no accurate NI robust statistics of marital status of stroke patients or staff which would enable analysis of this aspect but there is no evidence of differential impact on the grounds marital status. Stroke survivors who are single/widowed/divorced or separated and living alone may have less family support to draw on compared with those who are married or living with a partner.
Dependent Status	There are no accurate NI robust statistics of ethnicity of stroke patients or staff which would enable analysis of this aspect. However, research shows that there is a substantial burden to families of people who have had a stroke in terms of informal unpaid care (NICE, 2019).
Disability	Stroke is the single biggest cause of disability in adults in the UK (NICE, 2019). Stroke can have many different effects on someone, including problems with mobility, swallowing and continence. It can affect their vision and cause communication problems, fatigue and problems with memory and concentration. anxiety. It can also cause behaviour changes. 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.

	It can also have emotional effects, like depression and anxiety. It can also cause behaviour changes. 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. People who are disabled and then have a stroke are likely to have additional needs that need to be recognised in the care that they receive for the stroke.
Ethnicity	There are no accurate NI robust statistics of ethnicity of stroke patients or staff which would enable analysis of this aspect. 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 are less likely to be able to draw on family and community networks for support, They can also experience difficulties accessing public services based on language barriers as well as lack of familiarity with the services that are available. Cultural barriers may likewise play a role. Those service users who need assistance to access the services will be facilitated. Those requiring assistance to access services will be given the necessary support (including provision of interpreting or translation services).

Sexual Orientation	There are no accurate robust statistics on sexual orientation of stroke patients which would enable analysis of this aspect. Research suggests that older lesbian, gay and bisexual people are more socially isolated and have fewer family and community networks they can draw on for support. 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 Early supported discharge and continuing therapy in the patient/users home environment. Sexual orientation of the users will not determine service accessibility or delivery. Service providers will be respectful of same sex families.

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 proposal would ensure people with multiple identities are given the opportunity to return home and receive rehabilitation sooner.

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?***
Currently there is variation in access to ESD within and between Trusts and their performance.	ESD performance is currently raised at 4 monthly Trust service delivery meetings. This provides an opportunity to make Trusts aware of the need for improvement and to

	develop action plans to address gap from ESD Target The Network has plans for future investment to reduce variation across Trusts.
Services will be accessible by all who require intervention or treatment and Trusts will ensure that the needs of all service users were considered in the development and implementation of the service.	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.
The service will be tailored and personalized to the service user, taking account of their different needs based on any section 75 characteristic.	Trusts are required to monitor the impact on some section 75 users going forward.
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. Cultural barriers may likewise play a role.	Trusts will be required to identify any barriers experienced by ethnic minorities and disabilities in accessing the service.
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, belong to the LGB community, or who identify as transgender or non-binary.	Staff training and awareness

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

Please give reasons for your decisions.

This proposal would ensure people from WHSCT and SHSCT are given the opportunity to return home and receive rehabilitation sooner following a stroke.

(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?*
	A draft version of the Community Integrated Stroke Service and Long Term Care Service Specification was shared with Service Users. This Specification outlines the requirements of an ESD service. As the Specification is revised it will to be shared with service users. 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.

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?*
People who are disabled and then have a stroke are likely to have additional needs that need to be recognised in the care that they receive for the stroke. The most pervasive negative attitude is focusing on a person's disability rather than on an individual's abilities. Services will be tailored to each individual stroke survivor; providing therapeutic, emotional and psychological support, taking account of their different needs based on any section 75 characteristic, including disability. .	A draft version of the Community Integrated Stroke Service and Long Term Care Service Specification was shared with Service Users. This Specification outlines the requirements of an ESD service. As the Specification is revised it will to be shared with service users. 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.

(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	Yes
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
2	Positive	By promoting that a person living with the effects of a stroke can live a meaningful life with the condition	No
8	Positive	Service providers will be continuing therapy in the patient/users home environment at the same intensity as hospital and will therefore 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.

(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. 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. Monitoring information should be gathered in relation to the particular needs of people based on their gender identity and sexual orientation . This could be via engagement with relevant voluntary and community sector		

organisations.		

Approved Lead Officer: Mr Iain Deboys

Position: Assistant Director of Commissioning

Policy/Decision Screened by: Ms Bernie Mooty

Signed:
Date: 7 February 2022

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