Public Health Agency

Equality and Human Rights Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

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/none)

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

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/none)

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

For advice & support on screening contact:

Tel: 028 95363961
email: Equality.Unit@hscni.net

SCREENING TEMPLATE

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 .

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Decision to provide pregnant women with a folder to hold their Maternity Hand Held Record and associated documentation.

1.2 Description of policy or decision

Northern Ireland's regional Maternity Hand Held Record (MHHR) is based on an accumulation of evidence around best practice in maternity care. The purpose of the regional MHHR is to serve as a central repository for planning the delivery of care; and documenting communication with and interactions between members of the multi-disciplinary health care team, between the health care team and the woman to provide safe, person-centred care.

Structured maternity records should be used for antenatal care, and maternity services should have a system whereby women carry their own notes. When a standardised, national maternity record with an agreed minimum data set becomes available, this should be adopted.
[RCOG 2008]

The maternity hand-held record includes information based on NICE guidance for the woman as well as healthcare professionals. It is designed to be used by all professionals, including GPs, who see the woman during her pregnancy.

The woman should be asked if she wishes to carry these notes from booking through to completion of her maternity episode when the notes will be handed to the community midwife for secure return to the Health and Social Care Trust in which the birth took place.

The overall objectives of the MHHR are:
- to act as a tool of communication
- to facilitate co-ordination of care and continuity of care;
- to improve maternal, fetal and neonatal surveillance;
- to promote safe, effective, and evidence based maternity care;

- to provide appropriate and adequate information for informed choice;
- to avoid duplication of information;
- to empower women to be partners in their care, and;
- to promote a culture of excellence in record keeping.

All members of multi-disciplinary team who provide direct care to the woman and the baby should record in the MHHR. The MHHR is a multi-disciplinary record and replaces any clinical/midwifery notes previously used to record all aspects of maternity care.

Given the importance of the MHHR the folder was proposed to help women keep their documentation complete, secure and in good condition. The design of the folder provides women with succinct health information prompts on medication, exercise, healthy eating, smoking, substance misuse and wellbeing.
If a woman loses her maternity record, she is advised to contact her midwife or maternity unit as soon as possible.

1.3 Main stakeholders affected (internal and external)

The folder was developed to take into consideration the needs of the three main 'stakeholders' in maternity care: the woman, her baby, and her care providers.

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

- Transforming Your Care: A Review of Health and Social Care in Northern Ireland, HSC, 2011
- A Strategy for Maternity Care in Northern Ireland 2012-2018, DHSSPS, 2012
- Antenatal Care Quality Standard QS22, NICE, 2012
- Guideline for Admission to Midwife-Led Units in Northern Ireland, GAIN,2018

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved

stakeholders, views of colleagues, service users, staff side or other stakeholders.

• Feedback on the design of the folder was received from maternity collaborative members, (healthcare professionals working in maternity services). Draft designs were also circulated to a service user social media group for comment. The feedback received was included to inform the final design. • Northern Irelands Regional Maternity Hand Held Record: Operational Guidance. • Census 2011 • ONS Childbearing for women born in different years, England and Wales: 2017 • Bardsley, O. (2013) Single Parents: Seeing beyond the stigma. Available at https://www.theguardian.com/social-care-network/2013/feb/21/single-parents-beyond-the-stigma
• National Institute for Health and Care Excellence (NICE). (2017) Health and social care directorate - Quality standards and indicators: Briefing paper. (Available at: https://tinyurl.com/y33hhr42.)
•Northern Ireland Policing Board (NIPB). (2017). *Thematic Review of Policing Race Hate Crime.* Available at: https://www.nipolicingboard.org.uk/sites/nipb/files/media-files/race-hate-crime-thematic-review.PDF • O'Hara (2013) Through Our Minds: Exploring the emotional health and well being of lesbian, gay, bisexual and transgender people in Northern Ireland. Belfast: The Rainbow Project. • Elliott MN, Kanouse DE, Burkhart Q, et al. Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey Journal of General Internal Medicine. Published online September 4 2015

2.2 Quantitative Data

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

<table>
<tr><th>Category</th><th>What is the makeup of the affected group? (%) Are there any issues 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>Northern Ireland Population Statistics (Census 2011)
Male 49% Female 51%

The population of Northern Ireland in 2011 was 1,810,900

<table>
<tr><td>Age Group</td><td colspan="2">Females</td><td colspan="2">Males</td><td>All</td></tr>
<tr><td></td><td>N</td><td>%</td><td>N</td><td>%</td><td>N</td></tr>
<tr><td>16-44</td><td>366200</td><td>50.46</td><td>359500</td><td>49.54</td><td>725700</td></tr>
</table>
</td></tr>
<tr><td>Age</td><td>The target group for this piece of work is expectant mothers. A woman’s childbearing is assumed to start at age 15 years and end at the age of 45 years (ONS 2018).

Female Population by age, Census 2011

<table>
<tr><td>Age Group</td><td>N</td><td>%</td></tr>
<tr><td>15-19</td><td>61600</td><td>48.81</td></tr>
<tr><td>20-24</td><td>62100</td><td>49.29</td></tr>
<tr><td>25-29</td><td>63300</td><td>51.01</td></tr>
<tr><td>30-34</td><td>61600</td><td>51.42</td></tr>
<tr><td>35-39</td><td>62100</td><td>50.78</td></tr>
<tr><td>40-44</td><td>67300</td><td>51.06</td></tr>
</table>
</td></tr>
<tr><td>Religion</td><td>Population by religion, Census 2011</td></tr>
</table>

	N	%
Catholic	738033	40.8
Presbyterian Church in Ireland	345101	19.1
Church of Ireland	248821	13.7
Methodist Church in Ireland	54253	3.0
Other Christian (including Christian related)	104380	5.8
Other religions	14859	0.8
No religion	183164	10.1
Religion not stated	122252	6.8

Religion (Females aged 15-44), Census 2011

		Total	Catholic	Protestant and other Christian	Other religions	None
Aged 15-44	N	750300	323415	274485	7141	91925
	%		43.10	36.58	0.95	12.25

Political Opinion

National identity, Census 2011

	N	%
All usual residents	1,810,863	
British	722379	39.9
Irish	457482	25.3
Northern Irish	379267	20.9
British & Northern Irish	111748	6.2
Irish & Northern Irish	19132	1.1
British, Irish & Northern Irish	18406	1.0
British & Irish	11877	0.7
Other	90572	5.0

Marital Status

Marital status NI residents 16+ years, Census 2011

	N	%

	All usual residents	1,431,540	
	Single (never married or never registered a same-sex civil partnership)	517393	36.1
	Married	680831	47.6
	In a registered same-sex relationship	1243	0.1
	Separated (but still legally married or still legally in a same-sex civil partnership)	56911	4.0
	Divorced or formerly in a same-sex civil partnership which is now legally dissolved	78074	5.5
	Widowed or surviving partner from a same-sex civil partnership	97088	6.8

In 2018 there were 659 births to mothers under the age of 20 years. The majority (95.6%) of mothers under the age of 20 years were not married.

Dependent Status

In 2018 there were 659 births to mothers under the age of 20 years and 52 of these births were to mothers under the age of 17 years.5

Of the 692 births to mothers under 20 years, 31.4% were registered to fathers under 20 years, 39.3% to fathers aged 20-24 years, 5.8% to fathers 25-29 years and 1.2% to fathers over 30 years of age; 21.4% had no father registered.6

The rate of births to teenage mothers (<20 years) living in the 20% most deprived areas is around 3 times higher than in the 20% least deprived areas (17.2 vs 4.2 births per 1,000 population).7 There is also variation by Health and Social Care Trust.

A report on young people leaving care during the year ending 31 March 2018
found that 12% of care leavers aged 19 were parents (19 young women and 11 young men); Almost one in five (18%) of female care leavers aged 19 in 2017/18 became mothers on or before their 19th birthday.

During 2017, 1% of 15-19 year old females in the general population in Northern Ireland became mothers. Although these figures are not

<table>
<tr><td></td><td>directly comparable, it does indicate a higher prevalence of teenage mothers in the cohorts of care leavers.

Caring responsibilities
Census 2011 data reveals that the majority of carers are aged 35–64 years, with one third (33%) aged 35–49, and a further 31 per cent aged 50–64. However, there are also a significant number of young carers (those aged under 18). For example, 6,700 young people (aged 0–17) in Northern Ireland provide between 1 and 19 hours of unpaid care per week, while a further 960 provide 20–49 hours, and 820 care for 50 hours or more.</td></tr>
<tr><td>Disability</td><td>Figures show that one in five people in Northern Ireland has a long term health problem (20.7%). Data also shows that 10.1% of those aged 16-44 years had a long term health problem or disability.

Long-term health problem by age group, Census 2011
<table>
<tr><td></td><td></td><td colspan="2">long term health problem</td></tr>
<tr><td></td><td></td><td>N</td><td>%</td></tr>
<tr><td>All usual residents</td><td>1810863</td><td>374,646</td><td>20.7</td></tr>
<tr><td>All usual residents 16-44</td><td>725,680</td><td>73,303</td><td>10.1</td></tr>
<tr><td>Aged 16 to 44 males</td><td>359,484</td><td>36,069</td><td>10.0</td></tr>
<tr><td>Aged 16 to 44 female</td><td>366,196</td><td>37,234</td><td>10.2</td></tr>
</table></td></tr>
</table>

Type of long – term condition	**% 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%
Learning, intellectual, social or behavioural difficulty.	2.22%
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 epilepsy).	6.55%
Other condition	5.22%

Ethnicity

NI Population Statistics 16-44 years old (Census 2011)

	Female	Male	Total
White	357988	350450	708438
Irish traveller	262	252	514
Chinese	1738	1872	3610
Indian	1575	1898	3473
Pakistani	245	322	567
Bangladeshi	117	177	294
Other Asian	1713	1252	2965

Black Caribbean	99	151	250
Black African	624	836	1460
Black other	173	360	533
Mixed	1206	1066	2272
Other	447	848	1295

Statistics from the HSC Interpreting Service showed a large rise in requests for interpreters from 1,850 in 2004-2005 to 132434 requests in 2019-2020. The most popularly requested languages in 2019-20 are described below:

1. Polish 30231
2. Arabic 20392
3. Lithuanian 15503
4. Romanian 13059
5. Portuguese 8312
6. Bulgarian 7881
7. Tetum 6623
8. Slovak 5696
9. Mandarin 4794
10. Cantonese 3170

Births to mothers born outside the UK and Ireland now account for almost 11% of all births in Northern Ireland each year. This compares with 2.5 per cent 20 years ago.

Sexual Orientation

There is variation in estimates of the size of the LGB&T population in Northern
Ireland. Historically, estimates are as high as 5-7% (65-90,000) of the adult
Population of Northern Ireland (based on the UK government estimate of between 5-7% LGB&T people in the population for the purposes of costing the Civil Partnerships Act).

	Northern Ireland Continuous Household Survey 2017/18	Northern Ireland Life and Times Survey 2017

	Heterosexual/Straight	97.80%	97%
	Gay / Lesbian	0.60%	1%
	Bisexual	0.50%	1%
	Other	0.30%	1%
	Don't Know / Refusal	0.70%	

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	The folder is provided to pregnant women attending their booking or early antenatal care appointment. The design incorporates succinct health and wellbeing messages appropriate to this audience. Language is gender neutral unless this is likely to cause confusion.
Age	The target group for this piece of work is expectant mothers. A woman's childbearing is assumed to start at age 15 years and end at the age of 45 years (ONS 2018). There is no data that suggests that people of different ages will have additional needs in relation to the MHHR folder.
Religion	Health professionals providing antenatal care will respect the religious backgrounds of the women in their care. Pregnant women from minority religions may be less likely to fully engage with antenatal care providers due to the sensitivity of the issue for some cultures. Some women from different religions may prefer a health care professional of the same sex as themselves. Where possible the delivery of antenatal care will take into account cultural sensitivity for minority religions.

Political Opinion	There is no suggestion that those of different political opinions will have additional needs with regards to using the MHHR folder. Health professionals providing antenatal care will respect the political opinions of the women in their care. They will be unaware of political opinion unless the pregnant woman chooses to disclose this.
Marital Status	The percentage of married pregnant women is likely to differ between age groups. In 2018 there were 659 births to mothers under the age of 20 years. The majority (95.6%) of mothers under the age of 20 years were not married. Census information shows that the majority of single parents in Northern Ireland are female. It is recognised that unmarried mothers or women without a partner in Northern Ireland still face a stigma, and are often subject to negative stereotypes – particularly younger single mothers who may not have the support of a partner.
Dependent Status	In 2018 there were 659 births to mothers under the age of 20 years and 52 of these births were to mothers under the age of 17 years. Of the births to mothers under 20 years, 31.4% were registered to fathers under 20 years, 39.3% to fathers aged 20-24 years, 5.8% to fathers 25-29 years and 1.2% to fathers over 30 years of age; 21.4% had no father registered. The rate of births to teenage mothers (<20 years) living in the 20% most deprived areas is around 3 times higher than in the 20% least deprived areas (17.2 vs 4.2 births per 1,000 population).7 There is also variation by Health and Social Care Trust.
Disability	Antenatal care is provided to all pregnant women. This includes women a learning disability, those with a sensory disability and women with a physical disability.

	It is recognised that there may be occasions when a woman may choose not to hold her MHHR. Maternity staff may also consider that in some individual cases (e.g. for vulnerable women) it may be more appropriate to retain the MHHR within the maternity unit where she is booked for confinement or in the community clinic. It is also recognised that those with a learning disability may be unable to read all the information contained in the folder.
Ethnicity	Pregnant women from all ethnic backgrounds are offered antenatal care. Health professionals take into account cultural and religious differences and can access interpreter services. Some individuals from certain ethnic groups may have a preference for care givers of the same gender as themselves. It is recognised that knowledge of health services available may be poor, especially in recent migrants. The National Institute for Health and Care Excellence (NICE) has demonstrated that some black, Asian and other minority ethnic groups face major health inequalities, and multiple health issues and risk factors for ill health are more prevalent in minority ethnic communities.[1] Research published by the Northern Ireland Policing Board in 2017 conducted a *Thematic Review of Policing Race Hate Crime* (NIPB, 2017)[2] which highlighted significant increases in racially motivated crimes, reporting that a race hate incident is reported approximately every seven hours. Racist hate crimes are the second most common type of hate crime recorded by PSNI, with sectarian hate crime being the most common. It is recognised that women from the Travelling community may receive treatment within a different number of HSCT areas. It is also recognised that women from certain ethnic groups,

[1] National Institute for Health and Care Excellence (NICE). (2017) *Health and social care directorate - Quality standards and indicators: Briefing paper*. (Available at: https://tinyurl.com/y33hhr42.)

[2] Northern Ireland Policing Board (NIPB). (2017). *Thematic Review of Policing Race Hate Crime.* Available at: https://www.nipolicingboard.org.uk/sites/nipb/files/media-files/race-hate-crime-thematic-review.PDF

	particularly migrants or asylum seekers may present at maternity ward without attending a booking appointment, normally at around 12 weeks into pregnancy.
Sexual Orientation	It is recognised that not all women will choose to disclose their sexual orientation. Research published by the Rainbow Project found that more than 1 in 3 respondents had experienced discrimination in accessing goods, facilities or services, while almost 2 in 3 had been verbally assaulted at least once die to their perceived or actual sexual orientation. Other research published in 2015 using data from the English Practice Patient Survey, showed that sexual minorities were more likely to report poorer health and negative experiences when accessing healthcare.

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.

Antenatal care is provided to all pregnant women. This will include LGB&T people, Minority Ethnic young people, young mothers and fathers, etc. Some may have multiple identities.

2.5 Making Changes

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

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Gender	Equality issues will be reviewed and

The target group are pregnant women. In placing consumers at the centre of maternity services and facilitating shared decision making, women are being increasingly encouraged to participate in writing and holding their own maternity records. There may be exceptions when it is not appropriate to file professional notes while the MHHR is being hand held e.g. records made by social services or psychologists, or sensitive information that the woman herself does not wish to be included in the MHHR. Each HSCT must have procedures in place that ensure that should the exceptions mentioned above occur, relevant staff are alerted to the existence of other documentation and the location of such documents/information. **Disability** Service users include women who may have mental health issues, and/ or those who have a physical disability. It is recognised that there may be occasions when a woman may choose not to hold her MHHR. Maternity staff may also consider that in some individual cases (e.g. for vulnerable women) it may be more appropriate to retain the MHHR within the maternity unit where she is booked for confinement or in the community clinic. This should be discussed with the woman and noted on PAS. The clinician should check at each contact the woman is still content to carry the	addressed as appropriate.

MHHR. To promote confidentiality, enhance continuity of communication and care, and maintain the safety and integrity of the record, local procedures need to be developed to ensure her MHHR is available for all appointments and if the woman unexpectedly present herself to the maternity unit outside 'normal working hours'. Those providing women with antenatal care have relevant skills and training, and experience of targeting groups as listed. Key health messages are designed with low literacy in mind. All entries in the MHHR must be unambiguous, with no jargon, meaningless phrases, or irrelevant speculation The health and wellbeing messages on the folder are delivered in simple, short sentences, supported by appropriate graphics. When women are given the written information to keep in the folder the midwife provides a verbal explanation of what they are and their purpose. **Ethnicity** A MHHR should still be initiated for any pregnant woman who presents at a Maternity Unit within Northern Ireland even though she is not 'booked' for delivery in any unit in Northern Ireland. If the woman is remaining in the HSCT	

area she should be given a 'booking' antenatal appointment and asked to bring the MHHR with her to this appointment. If the woman is not staying within Northern Ireland the MHHR should be retained by the unit and the woman provided with a photocopy of relevant sections of her MHHR for her to show her new care provider(s) and her pregnancy episode closed on the Patient Administration System (PAS). Also, the MHHR can be translated into minority languages if needed. Given that ethnic minorities may face additional barriers in accessing health services, the imagery used in the folder is designed to be as inclusive as possible, including people of different races and ethnic groups. In addition to feedback from maternity collaborative members (who are healthcare professionals working in maternity services), draft designs were also circulated to a service user Facebook group for comment. **Sexual orientation** Antenatal care is inclusive, regardless of sexual orientation. Given that people who are gay, bisexual or lesbian are more likely to report negative experiences of health care, language used in the leaflets and publications in the MHHR folder is reflective of all types of families and service users in Northern Ireland. Imagery used in the folder is androgynous, designed to be as inclusive as possible. In addition to feedback from maternity collaborative	

members (who are healthcare professionals working in maternity services), draft designs were also circulated to a service user Facebook group for comment. **Marital Status/ Dependant status** It is recognised that unmarried mothers or women without a partner in Northern Ireland can still face a stigma and negative stereotypes. Given that people who are single parents (especially younger single parents) are more likely to be subject to stigma and negative attitudes than those in traditional two-parent families, language used in the leaflets and publications in the MHHR folder is reflective of all types of families in Northern Ireland. Imagery used in the folder is androgynous, designed to be as inclusive as possible. In addition to feedback from maternity collaborative members (who are healthcare professionals working in maternity services), draft designs were also circulated to a service user Facebook group for comment. The service should promote social inclusion, addressing issues around disadvantage, sexual orientation, gender identity, ethnicity, disability and rural / urban communities. Health care providers will have policies for staff on child protection and guidelines for staff around disclosure	

and other sensitive issues. Health professionals will display non-judgmental attitudes when discussing sensitive issues.	

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	Not applicable	
Political Opinion	Not applicable	
Ethnicity	Not applicable	

(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)		Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?	
Please tick		Please tick	
Major impact		Yes	
Minor impact	✓	No	✓
No further impact			

Please give reasons for your decisions.

It is felt that the equality issues have been identified within the equality screening template, and mitigation put in place to address these. It is not felt that a full EQIA would further identify any other issues or needs for Section 75 groups.

The PHA's role covers a wide range of issues across health improvement, health protection, service development and screening and has the aim of improving the health and wellbeing of all people in NI (covering all section 75 groups) as well as reducing health inequalities.

(4) CONSIDERATION OF DISABILITY DUTIES

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

How does the policy or decision currently encourage disabled people to participate in public life?	***What else could you do to encourage disabled people to participate in public life?***
The PHA as an organisation actively promotes the inclusion of disabled people in service planning, monitoring and evaluation such as through Personal and Public Involvement initiatives and advisory groups.	Encourage people to get involved in user groups etc. Always ensure that venues are completely accessible.

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

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
The PHA promotes positive	Encourage positive attitudes to

attitudes towards disabled people and values their views.	disabled people and challenge negative stereotyping through programmes and inclusive language. Challenging negative stereotypes/ myths which people may have in relation to disabled people.

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

Article		**Yes / No**
2	Right to life	No
3	Right to freedom from torture, inhuman or degrading treatment or punishment	No
4	Right to freedom from slavery, servitude & forced or compulsory labour	No
5	Right to liberty & security of person	No
6	Right to a fair & public trial within a reasonable time	No
7	Right to freedom from retrospective criminal law & no punishment without law	No
8	Right to respect for private & family life, home and correspondence.	No
9	Right to freedom of thought, conscience & religion	No
10	Right to freedom of expression	No
11	Right to freedom of assembly & association	No
12	Right to marry & found a family	No
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 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 interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference? Who does it impact upon?	Does this raise legal issues?*
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.

Methods and approaches developed will recognise the value of a human rights based approach.

(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
Health organisations and professionals delivering care will collect a range of data to fulfil their legal obligations and assist in the planning of services for the future.	Health organisations and professionals delivering care will collect a range of data to fulfil their legal obligations and assist in the planning of services for the future.	Health organisations and professionals delivering care will collect data on promoting a culture of respect for human rights.

Approved Lead Officer: Brian Mallaghan

Position: Project Support Officer

Date: 22 September 2021

Policy/Decision Screened by: Brian Mallaghan

Business Unit and contact details: Directorate of Nursing, PHA.

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 updated January 2015

Any request for this document in another format or language will be considered. Please contact us (see contact details provided above).