Equality and Human Rights Screening Template: The development of a new Acute Hospital Inspection Programme

The Regulation and Quality Improvement Authority 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 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
SCREENING TEMPLATE

See Guidance Notes for further information on the ‘why’ ‘what’ ‘when’, and ‘who’ in relation screening, for background information on the relevant legislation and for help in answering the questions on this template (follow the links).

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

The development of a new Acute Hospital Inspection Programme (HIP)

1.2 Description of policy or decision

The Regulation and Quality Improvement Authority (RQIA) is Northern Ireland’s independent health and social care regulator. RQIA was established in 2005, under the provisions of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003.

RQIA’s principal objective is to provide independent assurance about the safety, quality and availability of health and social care services in Northern Ireland. RQIA seeks to encourage continuous improvements in services and to safeguard the rights of service users.

The Minister for Health, Social Services and Public Safety has tasked RQIA to carry out a series of inspections in acute hospitals across Northern Ireland. This rolling programme of unannounced spot check inspections, will examine the quality of services in acute hospitals in Northern Ireland from 2015-16 onwards. This project has been commissioned from the RQIA by the DHSSPS. In a letter dated 14th April 2014, the Chief Medical Officer formally asked RQIA to put in place appropriate arrangements to deliver a rolling programme of unannounced spot check inspection inspections of the quality of services in acute hospitals in Northern Ireland.

The development of a new Acute Hospital Inspection Programme is a project is to develop, design and pilot an agreed hospital inspection process and associated procedures which will conclude with the delivery of a fully tested process to deliver the programme of unannounced inspection. This will be a rolling programme of acute hospital inspections to provide assurance to the public that care provided in hospitals across Northern Ireland is

- safe,
- effective, and
- compassionate.

We consider that the assessment of each of these core indicators applies across the
hospital inspection programme regardless of the hospital/area/ward subject to inspection.

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

The proposed key deliverables for the project to establish the new programme of unannounced spot check inspection are to:

- Develop, pilot and implement a hospital inspection process, and associated procedures, in accordance with legislation, standards and relevant guidance
- Identify and agree access to relevant sources of information which could inform the content and delivery of the programme of inspections
- Develop a comprehensive training package to ensure that RQIA inspection staff, peer reviewers and lay assessors are suitably trained to carry out the inspections
- Develop a database to coordinate the programme of inspections
- Establish a forward work plan for the programme of inspections over the period 2015-18
- Ensure that relevant stakeholders, including the public, are kept informed about the development of the programme

**How will this be achieved? (key elements)**

To achieve the objectives, RQIA will engage with stakeholders across the HSC to ensure that the design and the content of the programme is underpinned by a sound evidence base. Using the information received during the scoping period, a proposed Hospital Inspection Programme will be developed. It is proposed that the programme will comprise of:

- An agreed list of core components which will be inspected in each inspection
- An agreed list of additional themes from which a number will be selected for specific inspections. The selection will be influenced by consideration of available information which may indicate that an inspection in a specific area is required
- The number of inspections and the number clinical areas inspected will be based on available resources

The frequency of inspections has been determined taking into account the entire RQIA IPHT inspection programme.

Once the development of the Hospital Inspection Programme (HIP) is completed, RQIA will again engage with stakeholders, informing them of the proposed HIP.

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

Possible constraints may include:

- Stakeholder participation and engagement with the inspection programme
- Resources in relation to staff capacity and funding to allow for the design and
piloting of the inspection programme
- Possible additional resource requirements in enable the delivery of the inspection programme to include staffing, administration and training
- Delivery of a comprehensive training programme for the Inspection Team & Peer Reviewers
- Inability to recruit or utilise appropriate Inspection Team & Peer Reviewer manpower to allow for the sustainability of the delivery of the inspection programme

### 1.3 Main stakeholders affected (internal and external)

The development of the HIP will affect the following stakeholders in terms of giving them the opportunity to input into the process.

- NI Assembly
- DHSSPS
- RQIA Board
- RQIA Executive Management Team (EMT)
- RQIA Project Board
- RQIA Project Organisational Team (POT)
- RQIA Staff
- HSC Board
- Public Health Agency
- Business Services Organisation
- HSC Trusts
- NI Safety Forum
- Patient Client Council
- Human Rights Commission

However the main stakeholders that need to be considered in relation to Equality Screening are:

- Actual and potential Service Users and their carers/advocates
- General Public

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

The decision making process for developing the development of a new Acute Hospital Inspection Programme (HIP), is linked to objectives contained within RQIAs corporate strategy.

**What are they?:** RQIAs Corporate Strategy 2015-18

**Who owns them?:** RQIA

The decision making process is also subject to the legislation that RQIA must work
within.

What are they?: The Health and Personal Social Services (Quality, Improvement Regulation) (Northern Ireland) Order 2003.
Who owns them?: DHSSPS

(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.

The majority of the information obtained during the data gathering for equality screening was identified from information available from the 2011 Census, published by the Northern Ireland Statistics and Research Agency. For groups that had limited or no information in the 2011 Census data, additional research was undertaken to identify appropriate information. The information sourced is identified in Section 2.2.

The views of colleagues involved in the development process are being considered. In addition, the views of the Project Board were sought to inform this equality screening.

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 main stakeholders that need to be considered in relation to Equality Screening are:

- Actual and potential service users and their carers/ advocates
- General Public

<table>
<thead>
<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>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Based on the 2011 Census data, the population of Northern Ireland was 1,810,860. The data shows there were more females (51%) than males (49%).</td>
</tr>
</tbody>
</table>


The Director of Public Health Annual Report 2013\(^1\) states that, ‘The largest contributor to the gap in life expectancy between genders was the higher mortality rate among men for coronary heart disease (1.3 years). Suicide and accidents (including transport accidents) each contributed 0.5 years to the gap, while cancer (other than breast and prostate cancer) contributed 1.2 years. Breast cancer in women subtracted 0.5 years from the gender gap; however, this was largely offset by prostate cancer in men, which added 0.4 years to the gap.

Recent research evidence highlighted that women generally have better health-related behaviours than men with regard to dietary habits, alcohol consumption and smoking. However, sub-groups within the population vary significantly between males and females. Challenges for women’s health include cardiovascular diseases, cancer and osteoporosis.

In contrast, men are characterised by their shorter lifespan and the fact that they do not use the health services, health improvement programmes or screening programmes as much as women’.

No reliable information is available on the number of transgender people living in Northern Ireland. In the UK, it is estimated the number of transgender people ranges from about 1 in 100 to as many as 1 in 20.

Following a comprehensive estimate for transgender status, Reed et al. (2009) have estimated that the number of people who have presented with Gender Identity Dysphoria in Northern Ireland is 8 per 100,000 (0.008%) of the population (aged 16 and over)\(^2\). This would represent approximately 120 people in Northern Ireland.

However, more recent work by McBride and Hansson (2011)\(^3\) suggests that there are between 140 and 160 individual affiliated with the three main trans support groups in Northern Ireland: The Butterfly Club, The Purple Group and the Oyster Group.

There are 80 to 100 transgender people known to, or who are accessing, support services within Northern Ireland. However, it is widely known that transgender people remain invisible and the numbers are estimated to be much higher. Older people who identify

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Like all other people, transgender people will need treatment for a full range of health conditions over the course of their lives.

### Age

Based on the 2011 Census data, the age distribution of the population of Northern Ireland was as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Population</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 0-9</td>
<td>235,669</td>
<td>13.0%</td>
</tr>
<tr>
<td>Aged 10-19</td>
<td>245,275</td>
<td>13.5%</td>
</tr>
<tr>
<td>Aged 20-40</td>
<td>492,211</td>
<td>27.2%</td>
</tr>
<tr>
<td>Aged 40-64</td>
<td>573,988</td>
<td>31.7%</td>
</tr>
<tr>
<td>Aged 65-75</td>
<td>145,597</td>
<td>8.0%</td>
</tr>
<tr>
<td>Aged 75 and over</td>
<td>118,120</td>
<td>6.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,810,860</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

In 2012 there were estimated to be 1,823,600 people living here. 20% (357,000) are under 15 years old and 15% (273,000) are aged 65 and over. Life expectancy at birth for men is 77.5 years and 82.0 for women.

Age is one of the most important characteristics of health. We know that older people are more likely to use acute hospital services than other age groups. Given that the number of people of current pensionable age in Northern Ireland is projected to increase by around 40% by 2023, it is important to have in place a range of comprehensive programmes to ensure fair, high quality, integrated Health and Social Care (HSC) services for older people.

The Director of Public Health Annual Report 2013 states that, ‘In older age, the focus is more on maintenance of functions and reduction of the gap between life expectancy and healthy life expectancy. The fall in fertility rates and the significant improvement in life expectancy have inevitably resulted in an older population overall in Northern Ireland. As illness is more common in later life, it follows that the incidence of illness and disability will also increase. Based on the 2011 Census, the proportion of the population who

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assess their general health as ‘bad’ or ‘very bad’ increases with age, from less than 1% among those aged 0–9 years to 10% among those in their 50s and 17% among those aged 85 and over. In a similar way, the proportion of the population who have at least one long-term condition increases'.

Some of this increased use of services by older people is due to increasing likelihood of health conditions with ageing. However, there is also evidence that older people are more likely to experience an emergency hospital admission for a potentially avoidable condition\(^7\).

When looking at age equality, we also need to consider issues for children and younger people using hospital services.

Previously common diseases which resulted in the deaths of children are now rare. Better health outcomes for children and young people, which could be one reason why young people aged 0-19 accounted for 26.5% of the population (Census 2011).

Findings from Child Health Reviews show that child mortality from all causes has declined in all age groups and UK countries between 1980 and 2010 by 50% to 70%. Injury is the most common cause of death accounting for 31% to 48% of deaths in children aged 1-18 in the UK. England had consistently lower rates of injury deaths than the other UK countries. This disparity has widened since 1980 for children aged 10 to 18 years. It is estimated that 52 fewer deaths would occur each year among children aged 10 to 18 years if all UK countries had the same mortality rate due to injury as England for children in this age group. There has been no decline in injury deaths due to intentional injuries (deaths due to self-harm, assault or undetermined intent) in 10 to 18 year olds in any UK country since 1980.\(^8\)

In Our Children and Young People – Our Pledge: A Ten Year Strategy For Children And Young People In Northern Ireland 2006 – 2016. The Minister for Children and Young People in Northern Ireland pledged to deliver on a shared vision for all children and young people over the next ten years. Success will be measured by improved outcomes in key areas of our children and young people’s lives including health\(^9\).

RQIA did identify some specific needs in relation to involvement in the HIP for some patients within this Section 75 group. In response we will take these into account when developing the

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\(^7\) http://www.cqc.org.uk/content/state-care-201213
\(^8\) http://www.rcpch.ac.uk/system/files/protected/page/CHR-UK%20MODULE%20B%20REVISED%20v2%2015112013.pdf

\(^9\) http://www.ofmdfmni.gov.uk/ten-year-strategy.pdf
Religion

Based on the 2011 Census data, the religious background of the population of Northern Ireland was as follows:

<table>
<thead>
<tr>
<th>Religion</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>40.76%</td>
</tr>
<tr>
<td>Protestant (including Presbyterian, Church of Ireland, Methodist)</td>
<td>35.8%</td>
</tr>
<tr>
<td>Other Christian Religions</td>
<td>5.76%</td>
</tr>
<tr>
<td>Other Religions</td>
<td>0.82%</td>
</tr>
<tr>
<td>No Religion</td>
<td>10.11%</td>
</tr>
<tr>
<td>No Stated Religion</td>
<td>6.75%</td>
</tr>
</tbody>
</table>

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.

Political Opinion

Accurate figures for the political opinions of all people in Northern Ireland are unavailable, so the identified figures are estimates based on research from opinions expressed at recent elections.

In 2011, 1,380,058 people were eligible to vote in the Northern Ireland Assembly elections. Research carried out by the Northern Ireland Assembly Research and Information Service\(^\text{10}\), identified that 661,734 first preference votes were counted (spoiled votes were not included in this figure). Approximately 48% of the eligible population of Northern Ireland voted. An approximate breakdown of the figures are as follows:

<table>
<thead>
<tr>
<th>Political Opinion</th>
<th>Vote</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unionism</td>
<td>303,940</td>
<td>22.1%</td>
</tr>
<tr>
<td>Nationalism</td>
<td>272,508</td>
<td>19.7%</td>
</tr>
<tr>
<td>Other political opinion</td>
<td>85,286</td>
<td>6.1%</td>
</tr>
<tr>
<td>Did not vote</td>
<td>718,324</td>
<td>52.1%</td>
</tr>
<tr>
<td>Total</td>
<td>1,380,058</td>
<td>100%</td>
</tr>
</tbody>
</table>

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.

Marital Status

Based on the 2011 Census data, the marital status of the population of Northern Ireland was as follows:

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>36.14%</td>
</tr>
</tbody>
</table>

\(^{10}\) Northern Ireland Assembly, Research and Information Service – May 2011 -
<table>
<thead>
<tr>
<th>Dependent Status</th>
<th>Based on the 2011 Census data, the following information on dependent status was determined for the population of Northern Ireland.</th>
</tr>
</thead>
<tbody>
<tr>
<td></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>
<tr>
<td></td>
<td>• 3.11% (56,318) provided 50 hours care or more.</td>
</tr>
<tr>
<td></td>
<td>• 33.86% (238,129) of households contained dependent children.</td>
</tr>
<tr>
<td></td>
<td>• 40.29% (283,350) contained a least one person with a long-term health problem or a disability.</td>
</tr>
</tbody>
</table>

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.

The number of carers, including younger carers, in the UK is increasing as the population ages and disabled people with serious illnesses live longer and are more likely to live at home. Carers also use hospital services, which might be directly as a result of ill health caused by their caring responsibilities. Based on the most recent information from Carers Northern Ireland, the following facts relate to carers:

• 1 in every 8 adults is a carer
• There are approximately 207,000 carers in Northern Ireland
• Any one of us has a 6.6% chance of becoming a carer in any year
• Carers save the Northern Ireland economy over £4.4 billion a year; more than the annual NHS spending in Northern Ireland.
• The main carers' benefit is worth just £55.55 for a minimum of 35 hours - £7.94 per day.

<table>
<thead>
<tr>
<th>(never married or never registered a same-sex civil partnership)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>47.56%</td>
</tr>
<tr>
<td>In a registered same-sex civil partnership</td>
<td>0.09%</td>
</tr>
<tr>
<td>Separated (but still legally married or still legally in a same-sex civil partnership)</td>
<td>3.98%</td>
</tr>
<tr>
<td>Divorced or formerly in a same-sex civil partnership which is now legally dissolved</td>
<td>5.45%</td>
</tr>
<tr>
<td>Widowed or surviving partner from a same-sex civil partnership</td>
<td>6.78%</td>
</tr>
</tbody>
</table>

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.
The Director of Public Health Annual Report 2013 states that, ‘Carers are a socially and demographically diverse group and, as the demand for care is projected to grow, people are increasingly likely to become informal providers of care at some point in their lives. The importance of unpaid care was reflected by its inclusion as an item in both the 2001 Census and 2011 Census. Valuing care, a report published in 2011, estimated that carers save the Northern Ireland economy over £4.4 billion a year.

In the 2011 Census, approximately one in eight people living in household in Northern Ireland (12%) provided unpaid care to family members, friends, neighbours or others. The provision of unpaid care was related to age, increasing from under 1% among children aged 5–9 to a peak of 23% among those aged 50–54, and thereafter declining to 6.7% among those aged 85 years and over. The number of people providing unpaid care in Northern Ireland has increased from 185,000 to 214,000 between 2001 and 2011.

Current evidence suggests that caring is more commonly undertaken by women and is more intensive in deprived areas.

Disability

Based on the 2011 Census data, the following information on disability was determined for the population of Northern Ireland.

- 374,668 people (20.69% of the population) regarded themselves as having a disability or long-term health problem/disability, which has an impact on their day to day activities.
- 1,241,709 people (68.57% of the population) did not regard themselves as having a long-term health condition/disability.

People have been identified with one or more of the following conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Population</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deafness or partial hearing loss</td>
<td>93,078</td>
<td>5.14%</td>
</tr>
<tr>
<td>Blindness or partial sight loss</td>
<td>30,785</td>
<td>1.7%</td>
</tr>
<tr>
<td>Communication Difficulty</td>
<td>29,879</td>
<td>1.65%</td>
</tr>
<tr>
<td>Mobility of Dexterity Difficulty</td>
<td>207,163</td>
<td>11.44%</td>
</tr>
<tr>
<td>A learning, intellectual, social or behavioural difficulty</td>
<td>40,201</td>
<td>2.22%</td>
</tr>
<tr>
<td>An emotional, psychological or mental health condition</td>
<td>105,573</td>
<td>5.83%</td>
</tr>
<tr>
<td>Long-term pain or discomfort</td>
<td>182,897</td>
<td>10.10%</td>
</tr>
<tr>
<td>Shortness of breath or difficulty breathing</td>
<td>157,907</td>
<td>8.72%</td>
</tr>
</tbody>
</table>

Frequent confusion or memory loss  | 35,674 | 1.97%
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy) | 118,612 | 6.55%
Other condition | 94,527 | 5.22%
No Condition | 1,241,709 | 68.57%

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.

In 2007, the Northern Ireland Statistics and Research Agency (NISRA) reported that nearly one in five people (18%) in households in Northern Ireland are limited in their daily activities for reasons associated with disability.

Disabled people make up a significant percentage of the population and we expect that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not yet available to confirm this.

RQIA did identify some specific needs in relation to involvement in the HIP for some patients within this Section 75 group. In response we will take these into account when developing the scope and content of the inspection methodology and the inspection process itself.

### Ethnicity

Based on the 2011 Census data, there are 32,400 people from minority ethnic groups living in Northern Ireland (Census 2011).

The ethnic breakdown of the population of Northern Ireland was as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>98.21%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.35%</td>
</tr>
<tr>
<td>Indian</td>
<td>0.34%</td>
</tr>
<tr>
<td>Irish Traveller</td>
<td>0.07%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.06%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.03%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>0.28%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>0.02%</td>
</tr>
<tr>
<td>Black African</td>
<td>0.13%</td>
</tr>
<tr>
<td>Other Black ethnicity</td>
<td>0.05%</td>
</tr>
<tr>
<td>Mixed ethnicity</td>
<td>0.33%</td>
</tr>
<tr>
<td>Other ethnicity</td>
<td>0.13%</td>
</tr>
</tbody>
</table>

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.
Ethnicity reflects social differences between people and communities which may change over time. People may want to identify themselves with more than one ethnic group, which is why a new ethnic category ‘Mix’ was introduced in the 2011 Census. Ethnic groups are non-homogenous, reflecting a highly diverse range of cultures and languages.

The Director of Public Health Annual Report 2013\(^{12}\) states that, ‘Between 2001 and 2009, it is estimated that around 110,000 migrants came to Northern Ireland. Previous immigrants to Northern Ireland tended to be from China and India, but more recently, eastern European migrants increased in number. During the tenure of the Worker Registration Scheme, figures showed relatively high numbers of migrants to Northern Ireland from A8 countries (eight eastern European countries that joined the European Union in 2004), compared with the UK as a whole. More than half of those migrants were from Poland, which continues to be the largest national minority group in Northern Ireland.

Since 2009, migration figures in Northern Ireland have started to stabilise and most recent figures indicate a slight decrease. NISRA figures show a total of 12,900 people came to live in Northern Ireland from outside the UK in the period from mid-2011 to mid-2012, with migrants from outside the UK and Republic of Ireland making up approximately 4.5% of the overall population. Only 2% of the overall population – about 36,000 people – are migrants from outside the European Union.

The 2011 Census found that English was not the main language for 3.1% (54,500) of Northern Ireland residents aged three years and over. The most prevalent main language other than English was Polish (17,700 people). Other main languages spoken included: Lithuanian (6,300 people), Irish (4,200), Portuguese (2,300), Slovak (2,300), Chinese (2,200), Tagalog/Filipino (1,900), Latvian (1,300), Russian (1,200), Malayalam (1,200) and Hungarian (1,000).\(^{12}\)

RQIA did identify some specific needs in relation to involvement in the HIP for some patients within this Section 75 group. In response we will take these into account when developing the scope and content of the inspection methodology and the inspection process itself.

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Accurate figures for the sexual orientation of people in Northern Ireland are unavailable, as this information was not included in the 2011 Census.</th>
</tr>
</thead>
</table>

There are no robust data on the number of lesbians, gay men and bisexuals in Northern Ireland. However, research in the UK estimates that around 5–7% of the population are lesbian, gay, or bisexual (LGB). This equates to about 65,000–90,000 of the Northern Ireland population.\(^{13}\)

We tried to identify any research that had been undertaken that could identify figures; however, no specific research has undertaken. All research in this area is specifically targeted at sexually orientated groups, rather than research trying to identify the prevalence of sexually orientated groups. Therefore the figures obtained from available research are not representative of the population of Northern Ireland. In one piece of research, Breitenbach (2004)\(^{14}\) also comments that a major difficulty encountered by research on sexual orientation is that of quantifying and describing the relevant population.

Whilst there are no accurate statistics on sexual orientation in the population as a whole, it is estimated that between 5-10% of people would identify as lesbian, gay or bisexual.

The HSCB does not hold any further regional information/data on patients using acute hospital services within this section 75 grouping.

### 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.**

RQIA have identified 2 distinct areas in the scope of this screening:

1. The content of the inspection, including what is included within the inspection process, for example, to assess how the hospital takes into account the identified needs of specific section 75 groups.
2. The process of inspection, including how RQIA engages with service users to inform the inspection

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<table>
<thead>
<tr>
<th>Category</th>
<th>Needs and Experiences</th>
</tr>
</thead>
</table>
| Gender   | The Director of Public health Annual Report 2013\(^{15}\) states that, ‘Compared to their heterosexual peers, LGB&T people are:  
  - two and a half times more likely to live alone;  
  - twice as likely to be single;  
  - four and a half times more likely to have no children to call on in times of need.  

**In relation to the content of the inspection:** The HIP will give consideration to how the hospital is meeting the needs of people within different gender groups including transgender.  

**In relation to the process of inspection:** There were no different needs, experiences or priorities identified between the different gender groups. |
| Age      | We know that older people can have a poorer experience when using acute hospital services, for example:  
  - Malnutrition Age concern’s report “Later life in the United Kingdom”\(^{16}\)  
  - Breaches of dignity and privacy: CQC Dignity and nutrition national report.\(^{17}\)  
  - Older people with other equality characteristics can face multiple disadvantage. For example, Stonewall highlighted particular equality issues for older lesbian, gay and bisexual people in its report LGB in Later Life (2011)\(^{18}\).  

When looking at age equality, we also need to consider issues for children and younger people using hospital services.  

**In Our Children and Young People – Our Pledge: A Ten Year Strategy For Children And Young People In Northern Ireland 2006 – 2016.** The Minister for Children and Young People in Northern Ireland pledged to deliver on a shared vision for all children and young people over the next ten years. Success will be measured by improved outcomes in key areas of our children and young people’s lives including health.\(^{19}\).  

**In in relation to engagement in the Acute Hospital Inspection** |

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\(^{19}\) [http://www.ofmdfmni.gov.uk/ten-year-strategy.pdf](http://www.ofmdfmni.gov.uk/ten-year-strategy.pdf)
Programme (HIP), in comparison to the general population, RQIA identified two specific age groups that may have particular needs to facilitate their engagement. These were younger people and older people defined as follows:

- Younger people - children aged 19 and under (26.5% of the population)
- Older people - adults aged 65 and over (14.5% of the population)

The Healthcare Commission (predecessor of the Care Quality Commission) produced a report in 2007\(^\text{20}\) ‘Improving services for children in hospital’. This report states that ‘Children should be active participants in decisions about their treatment and, where possible, they should be able to exercise choices. They have a basic need for play, which can also help them understand their treatment and speed up recovery. Also children, more than most other groups of patients, need to be kept safe. Many children had a poorer experience of hospital than they should because of a lack of training of staff in and highly variable access to staff who specialise in play.

Within the younger peoples group, we felt that infants and young children (up to the age of 10 years) would be unlikely to engage with the Acute Hospital Inspection Programme (HIP). While young people aged 11 to 19 would have more of an understanding of health and social care, they may still be less likely to engage with the Acute Hospital Inspection Programme (HIP). However, to ensure their views are captured RQIA will encourage and facilitate their engagement by providing information in an easy to understand format and by ensuring the inspection team have suitable skills to facilitate the engagement with children.

Within the older peoples group, it is likely that they could have more experience of using health and social care services and may be more willing to engage with the Acute Hospital Inspection Programme (HIP).

We identified that they may have specific needs in relation to their involvement, as a result of their age. We acknowledged they may have difficulties in relation to their ability to engage, for reasons such as ill-health or dementia.

In relation to the content of the inspection: The HIP will give

consideration to how the hospital is meeting the needs of people within specific age status groups.

In relation to the process of inspection: RQIA did identify some specific needs in relation to involvement in the HIP for some patients within this Section 75 group. Methods to ensure suitable engagement will be considered as the development of the HIP progresses. Details of the steps taken to address the equality issues of older people are outlined in Section 2.5. We will make the necessary adjustments to facilitate people’s involvement, when their needs are identified.

### Religion

We do know that there are many ways in which religious practices and beliefs have the potential to affect health and to have an impact on whether health services are appropriate for different religious and belief groups.

The Director of Public Health Annual Report 2013\(^1\) states that, ‘There are a diverse range of religious beliefs in Northern Ireland. It is likely that these beliefs have a role in and impact on people’s health. Current evidence suggests religious beliefs may have both positive and negative impacts on health and morbidity. Religious involvements may increase physical, mental and social wellbeing. On the other hand, discrimination based on religion and beliefs can contribute to poor health’.

There are many ways in which religious practices and beliefs have the potential to both affect health and the appropriateness of health services:

- Diet choice, and preparation of the food.
- Observance of fasting times.
- Orthodox Jews observance of the Sabbath.
- Ethics around Blood transfusion.
- Views on termination of pregnancy and contraception.
- Circumcision for religious reasons and views about the link between Female Genital Mutilation and religious requirements.
- Views on end of life care, withdrawal of treatment and resuscitation.
- Provision of Chaplaincy and prayer facilities.
- Ablution facilities where appropriate to the religious background of the patient.

In relation to the content of the inspection: The HIP will give

consideration to how the hospital is meeting the needs of people within different religious groups.

In relation to the process of inspection: There were no different needs, experiences or priorities identified between the different religious groups.

<table>
<thead>
<tr>
<th>Political Opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>In relation to the content of the inspection: There were no different needs, experiences or priorities identified between the different political opinion groups.</td>
</tr>
<tr>
<td>In relation to the process of inspection: There were no different needs, experiences or priorities identified between the different political opinion groups.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>In relation to the content of the inspection: There were no different needs, experiences or priorities identified between the different marital status groups.</td>
</tr>
<tr>
<td>In relation to the process of inspection: There were no different needs, experiences or priorities identified between the different marital status groups.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers are put under significant constraints through the physical and emotional demands of caring. The evidence also suggests the physical and mental health of those providing high levels of care is worse than that of non-carers’.</td>
</tr>
<tr>
<td>Recent research carried out by the Care Quality Commission[^22] suggests that:</td>
</tr>
<tr>
<td>- Overall experience of carers which can have an effect upon their health.</td>
</tr>
<tr>
<td>- Carers can experience stress; for example, if the person they care for is discharged from hospital too early, or not admitted soon enough when they need to be.</td>
</tr>
<tr>
<td>- Not have time to eat properly,</td>
</tr>
<tr>
<td>- Become exhausted,</td>
</tr>
<tr>
<td>- Experience physical injury through lifting for example.</td>
</tr>
<tr>
<td>- Experience emotional effects from not being consulted adequately about what is happening to the person for whom they care.</td>
</tr>
<tr>
<td>In specific relation to young carers:</td>
</tr>
<tr>
<td>- Only small numbers of young carers are currently being</td>
</tr>
</tbody>
</table>

identified or assessed for support.

- Young carers are 1.5 times more likely than their peers to be from Black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language.
- Can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere.
- More girls than boys act as carers.

Generally it is recognised that all carers have a need to be involved in decisions around discharge of the person they care for.

**In relation to the content of the inspection:** The HIP will give consideration to how the hospital is meeting the needs of people within this group.

**In relation to the process of inspection:** There were no different needs, experiences or priorities identified between the different dependent status groups.

<table>
<thead>
<tr>
<th>Disability</th>
</tr>
</thead>
</table>
| The Director of Public Health Annual Report 2013 states that, ‘The population of disabled people is heterogeneous, not only in terms of impairments but also demographically, socially and economically. Good quality information on people in Northern Ireland with a disability is limited, especially in terms of their multiple identities and their experiences across a range of social and economic contexts.

There is evidence that people with serious mental health problems are at high risk of coronary heart disease and stroke before the age of 55. Similarly, people with learning difficulties are at high risk of respiratory disease, malnutrition and obesity.

Cervical and breast screening uptake rates are lower among people with learning disabilities. There is also evidence that suggests people with disabilities are more likely to be living in poverty.

In addition, people with mental health problems and learning disabilities are more likely to experience social stigma and discrimination, which put them at greater disadvantage’.

Recent research carried out by the Care Quality Commission suggests that:

- People with a learning disability have higher levels of health

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25 http://www.cqc.org.uk/
needs than most of the population and can have a poorer experience when using acute hospital services. Death by Indifference, 74 Deaths and Counting, (Mencap 2012)\textsuperscript{26} described what had happened since Death by Indifference (2007)\textsuperscript{27}, which raised the issue of deaths of people with learning disabilities whilst in the care of the NHS.

- The Confidential Inquiry into Premature deaths of People with Learning Disabilities, (CIPOLD) was set up. Their investigation and report revealed deficiencies by the NHS and social care in treatment and care.
- People who have dementia also fall within the definition of disabled people under the Equality Act. Despite some improvements, people with dementia continue to have poorer outcomes in hospital compared to those without dementia. State of Care report (2012-13)\textsuperscript{28}.
- Disabled people with other equality characteristics can face multiple disadvantages. For example some ethnic groups have a higher proportion of the population who are disabled.

A HealthCare Commission Report in 2008: Not Just a Matter of Time - A review of urgent and emergency care services in England\textsuperscript{29}, reports that the provision of facilities for disabled patients by A&E departments and urgent care centres was variable. Although all patients they engaged with to inform the study stated that facilities were accessible by wheelchair users and 82\% reported that signs in the unit were suitable for people with visual impairments, they found that:

- Only 54\% had undertaken an audit of facilities for disabled people, that had actually involved disabled people.
- In 49\% of units, less than half of the staff had received training on disability awareness.
- Only 54\% of units had a hearing loop in place (and of these, a third did not test their system regularly).
- Only 41\% of units produced information for patients in ‘easy read’ formats suitable for people with learning disabilities.
- 23\% of A&E departments and urgent care centres did not have tools to help them assess the needs of people who find it difficult to communicate (for example, people with learning disabilities).

The report stated that ‘Although the number of people we spoke to

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{26} https://www.mencap.org.uk/news/article/74-deaths-and-counting
\item \textsuperscript{27} http://www.nmc.org.uk/globalassets/siteDocuments/Safeguarding/England/1/Death-by-Indifference.pdf
\item \textsuperscript{28} http://www.cqc.org.uk/content/state-care-201213
\item \textsuperscript{29} http://image.guardian.co.uk/sys-files/Society/documents/2008/09/26/emergencyreview.pdf
\end{itemize}
\end{footnotesize}
was relatively small, it is a concern that people with disabilities reported many poor experiences.’

In relation to the content of the inspection: The HIP will give consideration to how the hospital is meeting the needs of people within specific disability status groups.

In relation to the process of inspection: RQIA did identify some specific communication needs in relation to involvement in the HIP for some patients within this Section 75 group, including those with visual, hearing and speech and language difficulties. In response to the identified needs of these groups, methods to ensure suitable engagement will be considered as the development of the HIP progresses. Details of the steps taken to address the equality issues of older people are outlined in Section 2.5. We will make the necessary adjustments to facilitate people’s involvement, when their needs are identified.

Ethnicity

The Director of Public Health Annual Report 2013 states that, ‘In the last few decades, the Northern Ireland population has become more ethnically diverse. It is clear that net inward migration during the last decade has supplemented existing minority ethnic communities and changed the ethnic mix of many places, both urban and rural. Ethnic minorities, however, have persistent barriers to healthy living, such as language, relatively lower socioeconomic class, inferior working and living conditions, lack of cultural awareness, and lack of understanding of HSC systems.

Ethnic groups within the Northern Ireland population bring different opportunities as well as challenges.

These include:

- issues around health protection (e.g. hepatitis B, hepatitis C, HIV);
- vulnerability to non-communicable diseases;
- experience of health care (immunisation, prevention, screening, treatment);
- cultural beliefs about health/illness;
- acceptability of treatments’.

Migration also has significant implications for all areas of health practice. Patterns of disease, health needs and the type of health services required are different for migrant populations.

There is evidence that mental and social health problems are an issue for many migrants. In general, the physical health of migrants is likely to be similar to the local population of the same age, but there are some differences, e.g. the smoking levels among Polish migrants in other countries were found to be higher than the local population.

English is the main language in Northern Ireland and a lack of English language skills can therefore prevent or obstruct participation in society at the most basic level.

Access to and knowledge of the health systems among migrant populations is reported to be limited, with language as a recurring barrier.

Little or no knowledge of English is considered the most significant barrier to accessing HSC, as well as service delivery. This can lead to an over-reliance on friends, family and minority ethnic support organisations to provide information on services.

Current evidence suggests that people who are not fluent in English:

- have less access to healthcare;
- receive fewer preventive measures;
- may have poor experience of service.

On the other hand, competency in English:

- is linked to quality of life improvements;
- enables people to secure employment;
- contributes to inclusion, integration and active citizenship.

Many people whose first language is not English are migrants, asylum seekers, refugees or from ethnic minorities, so it is plausible that some of the health issues faced by non-English speakers are similar to those groups. Communication barriers within HSC:

- prolong appointments;
- take up more staff time;
- increase the risk of misdiagnosis, misunderstanding and non-consent to examination, treatment or care’.

**In relation to the content of the inspection:** The HIP will give consideration to how the hospital is meeting the needs of people from different ethnic groups.

In relation to the process of inspection: RQIA did identify some specific needs in relation to involvement in the HIP for some patients within this Section 75 group. RQIA have
identified that specific communication needs in relation to involvement in the HIP may arise for people whose first language is not English. It was identified that some people may require interpreting or translation services to ensure they are able to engage with the inspection process.

In response to the identified needs of these groups, methods to ensure suitable engagement will be considered as the development of the HIP progresses. Details of the steps taken to address the equality issues of older people are outlined in Section 2.5.

Sexual Orientation

The Director of Public health Annual Report 2013\(^{31}\) states that, ‘Although the acronym LGB is used as an umbrella term and the health needs of this community are often grouped together, each of these groups represents a distinct population with its own health concerns.

The availability of general health information on LGB people is patchy. However, recent research concluded that:

- LGB people are at significantly higher risk of mental disorders, suicidal thoughts, substance misuse and deliberate self-harm. Local evidence from Northern Ireland shows that 82% of LGB people
- experienced harassment and 55% have experienced homophobic violence.
- LGB people’s experience of healthcare suggests there are numerous barriers, including homophobia and heterosexism; misunderstandings and lack of knowledge; lack of appropriate protocols; poor adherence to confidentiality and an absence of LGB-friendly resources.

Local research evidence also suggests substance misuse and risky sexual behaviours are more prevalent among the LGB population. Individuals of alternate sexual orientation are over-represented among patients with sexually transmitted infections, including syphilis and HIV’.

Breitenbach (2004)\(^{32}\) also recognised that lesbian, gay, bisexual, and transgender (LGBT) people experience various forms of discrimination and harassment because of their sexual orientation and/or their gender. Though experience of discrimination may be common, not all experiences are the same, and reflect the different


life experiences of different groups, including personal, family and social life, patterns of health, treatment at work, and treatment by providers of public services. Furthermore, LGBT communities are not necessarily a cohesive group, and may not all see themselves as having a common identity or being part of a community of interest, and there may even be tensions between different groups.

Recent research carried out by the Care Quality Commission\(^3^3\) suggests that:

- There are issues with hospital and community healthcare staff understanding next of kin issues for LGB people.
- The home background of LGB people may differ from heterosexual people in that older LGB people are more likely to be single and more likely to live on their own than heterosexual people. They are also much less likely to have children or regularly see family members, so it is possible that there will not be anybody at home to care for the person after discharge.
- LGB people and their families and carers should have access to high quality end of life care that takes account of their needs and preferences, regardless of their individual circumstances\(^3^4\).

In relation to the content of the inspection: The HIP will give consideration to how the hospital is meeting the needs of people from specific sexual orientation groups.

In relation to the process of inspection: There were no different needs, experiences or priorities identified between the different political opinion groups.

\(^3^3\) [http://www.cqc.org.uk/](http://www.cqc.org.uk/)

\(^3^4\) [http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/EndofLifeCare-LGBTRouteToSuccess.pdf](http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/EndofLifeCare-LGBTRouteToSuccess.pdf)
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.

NONE

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?

<table>
<thead>
<tr>
<th>In developing the policy or decision what did you do or change to address the equality issues you identified?</th>
<th>What do you intend to do in future to address the equality issues you identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues identified in this screening process have been considered by the Project Team and in response the following actions have been undertaken:</td>
<td>The inspection process is scheduled to formally start in September 2015.</td>
</tr>
<tr>
<td>In relation to the content of the inspection: In relation specifically to the development of the new Acute Hospital Inspection Programme (HIP) RQIA will ensure that the content of the inspection programme will ensure that RQIA give consideration to how the hospital is meeting the needs of people from specific Section 75 groups including:</td>
<td>During the inspection process the inspection team will give consideration to assessing how acute hospitals are meeting the needs of people from specific Section 75 groups in the delivery of services. This will be given due consideration when the opportunity to do so arises; this may be via patient questionnaire, staff focus groups and/or via observations of practice undertaken, completion of the core inspection tool and associated supporting tools.</td>
</tr>
<tr>
<td>- Gender</td>
<td>During an inspection RQIA will provide clear information and support for all patients/service users and their carers/advocates to encourage participation in the inspection process and to support those who become involved.</td>
</tr>
<tr>
<td>- Age</td>
<td></td>
</tr>
<tr>
<td>- Religion</td>
<td></td>
</tr>
<tr>
<td>- Dependent Status</td>
<td></td>
</tr>
<tr>
<td>- Disability</td>
<td></td>
</tr>
<tr>
<td>- Ethnicity</td>
<td></td>
</tr>
<tr>
<td>- Sexual Orientation</td>
<td></td>
</tr>
</tbody>
</table>
This inspection will include assessment of the following:

- That all patients are active participants in decisions about their treatment, ensuring they have control over their own health care and the promotion of independence.
- That care is person centred, that every patient is treated as an individual and with compassion.
- That patients and carers experience effective communication that is sensitive to individual needs and preferences; this will include communication to staff that identifies an individual's communication needs.
- In specific relation to children the inspection will consider their basic need for play and access to staff who specialise in play.
- That all patients feel safe, secure and supported; this will include consideration of environmental safety and specific safeguarding needs.
- That all patients are treated with dignity and respect; this will include consideration of the suitability of the area/ward environment.

The inspection process will include the use of a core inspection tool with key criteria included to specifically assess the needs of all patients including those within the Section 75 groups identified above. This will include consideration of barriers which may result in a lack of understanding of HSC systems.

While the inspection process is underpinned by the core inspection tool it is augmented by a number of other supporting investigatory methods including:

- Observational of the quality of staff/patient interaction
- Inspection of Nursing and Medical care records
- Examination of staff training
- Availability of policy and procedural

Where possible during an inspection we will make reasonable adjustments to facilitate involvement, when individual needs are identified. This may include access to translation, interpreting services, material in accessible formats, age appropriate engagement etc.

RQIA are currently establishing links with the Royal College of Paediatrics and Child Health and are exploring the possibility of using representatives from their youth advisory panel as part of our HIP inspection team, when we are focusing on services within the Royal Belfast Hospital for Sick Children. However, it is not anticipated that there will be an inspection to RBHSC in the first year of the programme.

The inspection process will be delivered by a group of HSC professionals drawn from across the HSC including:

- Nurse
- Clinicians
- Allied Health Professionals
- Pharmacists
- Social Workers
- Paramedics
- Service Managers

Given the nature of the professions involved in the inspection process RQIA are satisfied that each inspection team will include the skills appropriate to the areas being inspected. However if any additional training needs are identified throughout the lifespan of the programme, these will be addressed.

During the inspection process, any specific Section 75 issues which emerge will be raised with the Organisation immediately and during the feedback process. Where specific issues need to be addressed these will be identified as part of the preliminary findings within 14 days and the draft report including a Quality Improvement Plan (QIP). The type of follow up will be dependent upon the
RQIA do recognise that there are many different reasons why some groups of people have difficulty engaging with HSC services. It may be because they are socially excluded, there are communication barriers, including visual, hearing and speech and language difficulties, or they are stigmatised in some way by society. RQIA will seek to engage with a wide range of people during the inspection process and we have taken the following steps to facilitate engagement, these are outlined below:

The patient questionnaire has been designed to take into account the needs of all people including those from these specific section 75 groups:

- Gender
- Age
- Religion
- Dependent Status
- Disability
- Ethnicity
- Sexual Orientation

In relation to the completion of questionnaire we did identify some specific communication needs in relation to involvement in the HIP that may arise for Section 75 groups particularly:

- Age
- Disability
- Ethnicity

It has been agreed that advocates, acting on behalf of people within the older and younger age groups, those with a learning disability and those from different ethnic backgrounds, can represent their interests when required.

To assist in the completion of patient questionnaires we will:
➢ develop an easy to understand questionnaire
➢ use a ‘visual’ rating scale
➢ communicate in a manner appropriate to
the individual
➢ offer assistance in completing the
questionnaire during the course of the
review
➢ provide pens and prepaid envelopes to
encourage patients to complete and
return questionnaires.

Furthermore RQIA will ensure that all RQIA
staff involved in the inspection process will
have undergone HSC Discovering Diversity
training.

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)

<table>
<thead>
<tr>
<th>Group</th>
<th>Impact</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td>None Identified</td>
<td></td>
</tr>
<tr>
<td>Political Opinion</td>
<td>None Identified</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>None Identified</td>
<td></td>
</tr>
</tbody>
</table>

(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:

<table>
<thead>
<tr>
<th>Impact Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Major impact</td>
<td>X</td>
</tr>
<tr>
<td>Minor impact</td>
<td></td>
</tr>
<tr>
<td>No further impact</td>
<td></td>
</tr>
</tbody>
</table>

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

Please tick:

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>X</td>
</tr>
</tbody>
</table>

Please give reasons for your decisions.

Mitigation has been put in place to address any issues for the section 75 groups identified through the screening process – see section 2.5. It is not thought that undertaking an EQIA will further identify opportunities to promote equality of opportunity.

(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?

<table>
<thead>
<tr>
<th>How does the policy or decision currently encourage disabled people to participate in public life?</th>
<th>What else could you do to encourage disabled people to participate in public life?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement with service users including disabled service users presents opportunities for disabled people to participate in the inspection process, which informs recommendations for service improvement.</td>
<td>None identified</td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>How does the policy or decision currently promote positive attitudes towards disabled people?</th>
<th>What else could you do to promote positive attitudes towards disabled people?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None identified</td>
<td></td>
</tr>
</tbody>
</table>

(5) CONSIDERATION OF HUMAN RIGHTS

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

<table>
<thead>
<tr>
<th>ARTICLE</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 2 – Right to life</td>
<td>YES</td>
</tr>
<tr>
<td>Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment</td>
<td>YES</td>
</tr>
<tr>
<td>Article 4 – Right to freedom from slavery, servitude &amp; forced or compulsory labour</td>
<td>No</td>
</tr>
<tr>
<td>Article 5 – Right to liberty &amp; security of person</td>
<td>YES</td>
</tr>
<tr>
<td>Article 6 – Right to a fair &amp; public trial within a reasonable time</td>
<td>No</td>
</tr>
<tr>
<td>Article 7 – Right to freedom from retrospective criminal law &amp; no punishment without law</td>
<td>No</td>
</tr>
<tr>
<td>Article 8 – Right to respect for private &amp; family life, home and correspondence.</td>
<td>YES</td>
</tr>
<tr>
<td>Article 9 – Right to freedom of thought, conscience &amp; religion</td>
<td>No</td>
</tr>
<tr>
<td>Article 10 – Right to freedom of expression</td>
<td>No</td>
</tr>
<tr>
<td>Article 11 – Right to freedom of assembly &amp; association</td>
<td>No</td>
</tr>
<tr>
<td>Article 12 – Right to marry &amp; found a family</td>
<td>No</td>
</tr>
<tr>
<td>Article 14 – Prohibition of discrimination in the enjoyment of the convention rights</td>
<td>No</td>
</tr>
<tr>
<td>1st protocol Article 1 – Right to a peaceful enjoyment of possessions &amp; protection of property</td>
<td>No</td>
</tr>
</tbody>
</table>
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 interfere with any of these rights? If so, what is the interference and who does it impact upon?

<table>
<thead>
<tr>
<th>List the Article Number</th>
<th>Interfered with? Yes/No</th>
<th>What is the interference and who does it impact upon?</th>
<th>Is it legal?* Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>While the development of the Hospital Inspection programme will not interfere with anyone’s Human Rights, it is envisaged the inspection process and associated tools will be designed to take account of The Human Rights Act 1998 particularly Articles 2, 3, 5 and 8.</td>
<td>Once developed the implementation of the inspection programme will assess Trusts recognition and compliance with Human Rights particularly in respect to Articles 2, 3, 5 &amp; 8</td>
<td>The inspection process will assess issues in relation to staff, patients and carers.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* 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.

Any specific Human Rights issues which emerge during the inspection programme will be raised with the Organisation immediately and during the feedback process. Where specific
issues need to be addressed these will be identified as part of the preliminary findings within 14 days and the draft report including a Quality Improvement Plan (QIP). The type of follow up will be dependent upon the severity of the issues identified at the inspection and subsequent action taken by the organisation.

(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?)

<table>
<thead>
<tr>
<th>Equality &amp; Good Relations</th>
<th>Disability Duties</th>
<th>Human Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will monitor any feedback from people in relation to equality or good relations.</td>
<td>We will monitor any feedback from people with disabilities, in relation to their involvement in the decision making process.</td>
<td>We will monitor any feedback from people in relation to human rights issues.</td>
</tr>
</tbody>
</table>

Approved Lead Officer: Dr David Stewart

Position: Director of Reviews and Medical Director

Date: 8 May 2015

Policy/Decision Screened by: Helen Hamilton

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