HSC Health and Social Care Board

Draft Equality Impact Assessment

On

Regional Communication Support Services Review

DATE: 06/01/2016 V10

Consultation Announcement

This document is being presented for public consultation. It reports the outcome of an Equality Impact Assessment (EQIA) by the HSCB on the regional communication support services review.

A copy of the full report is also available on the organisation's website at: www.hscboard.hscni.net Consultation on the EQIA will end on 5 September 2016. It is intended that other consultation methods will be used to seek views and it may be that you will receive further communication from us in due course.

We hope that you will find time to comment on this document.

Contact

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Accessibility statement

Any request for the document in another format or language will be considered.

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1. Executive Summary

The Organisation

The Health and Social Care Board (HSCB), together with its Local Commissioning Groups (LCGs) is accountable to the Minister for Health, Social Services and Public Safety and translates the Minister's vision for health and social care into a range of services that deliver high quality and safe outcomes for users, good value for the taxpayer and compliance with statutory obligations.

A key role of the HSCB with the Public Health Agency (PHA) is effective engagement with providers, Patient Client Council (PCC), local government, Service Users, local communities, other public sector bodies and the voluntary and community sectors.

Regional Communication Support Services Review

The Review of Communication Support Services Review recommends that regional communication support services require changes to ensure an accessible, efficient, affordable and sustainable service model is available going forward. Demand has increased over the past five years and so have costs.

In order to deliver the service more effectively, efficiently and consistently, one key recommendation is presented in the Review report:

> **Develop and procure a Regional Standardised model of service provision which will offer consistency, standardisation and accessibility of service delivery;**

The Report outlines five options;

1. The HSC Trusts and HSCB continue to contract with 2 provider organisations and freelance interpreters to deliver the service.

2. The HSCB devolves to the BHSCT and SEHSCT and thus enables all 5 Trusts to procure their own service providers i.e. individual contracts within all five Trusts.
3. The communication support service would be procured by HSC Trusts themselves, hosted by one Trust on a consortium basis, and commissioned and contracted with a single provider who would provide a regional service across all 5 Trusts.
4. The regional communication support service would be commissioned by the HSCB through a contracted provider.
5. The regional communication support service would be provided on a shared service basis by the HSC Business Services Organisation, managed independently of the HSC provider organisations.

Preferred Option

Based on the options appraisal, the preferred option for the regional communication support service is Option 5; a regional shared/managed service provided by the HSC Business Services Organisation.

Data Collection

Data was gathered for, namely:

- The general population, with a targeted focus on people with a disability, specifically those that are deaf or have partial hearing; and
- From the Association of Sign Language Interpreters (ASLI); and
- From the Delegated Statutory Functions; and
- From the Northern Ireland Statistics and Research Agency (NISRA).

In preparing the draft EQIA, the findings from a range of data and research sources were taken into account. Data was considered for older people and men and women generally. There was not sufficient data to understand impacts on the grounds of political opinion, religion or ethnicity. These will be explored further during the consultation phase.

Statistical information was available from Northern Ireland Statistical Research Agency (including Census information from 2011) and Delegated Statutory Functions Returns.

Targeted engagement was also undertaken with relevant stakeholders in the form of a regional workshop. Presentations were provided by a range of organisations (Association of Sign Language Interpreters, British Deaf Association and Sign Language Interpreting Service). A Task and Finish Group was formed to take the Review forward.

Due to the nature of the review, it was agreed upfront to carry out an Equality Impact Assessment, to provide the opportunity to explore any equality issues in more depth. This report is primarily concerned with the impact of the review, and particularly the preferred option in the review, on people with a Disability, older people, men and women generally, people from minority ethnic backgrounds as well as political opinions and religion.

The needs of the wider general population, outside of the aforementioned groups were also taken into account.

Key Findings

This section reflects a summary of key findings for the main groups we are looking at.

The analysis of the data gathered in the course of this draft report suggests that there is sufficient evidence on the effects of the reports recommendation on a number of groups, to undertake an equality impact assessment at this time.

Gender

The data would suggest that there may be gender difference issues with more men experiencing deafness or partial hearing loss during adulthood up until aged 80 than women when the prevalence swings in the opposite direction and may need to be reflected in the gender make-up of communication support staff. Gender make-up of the Interpreting workforce is significant with regard to intimate care issues e.g. gynaecological matters.

Whilst the number of available interpreters overall is small, there is significantly more female than male interpreters available.

Age

Of the total people with deafness or partial hearing loss (93,091), 55,504 (59.6%) are aged 65+ and 35,164 (37.8%) are aged 18 to 64. The data would suggest that there may be age difference issues with more men experiencing deafness or partial hearing loss during adulthood up until aged 80 when than women when the difference swings in the opposite direction. From the NISRA material reproduced in table 19 it can be seen that the incidence of deafness or partial hearing loss increases significantly from the age of 40 onwards. Additionally there is a significant step rise in prevalence from the age of 65 onwards.

The delivery of a consistent, professional service, as a result of the review's recommendation will deliver positive outcomes for those older people that are more likely to utilise the interpreting service.

Religion & Political Opinion

While no data has been identified to suggest differential impacts of Communication Support Services on the grounds of political opinion or religion, it would appear prudent to note the Survey Report produced by Parks and Parks in 2012 that suggests most Irish Sign Language users would identify themselves as Irish and therefore political opinion is influenced. The corollary of this would be that British Sign Language users may identify themselves as British and therefore political opinion is influenced. Caution needs to be applied to these broad assumptions.

Service provision must take into account the requirements of both British Sign Language and Irish Sign Language users. Attention must also be paid to the demographic spread of British Sign Language and Irish Sign Language users. This will be explored further during the consultation phase of this EQIA.

Ethnicity

No data has been identified to suggest differential impacts of Communication Support Services on the grounds of ethnicity. Due to the lack of available data, this will be explored further during the consultation phase of the EQIA.

Disability

It is important that Communication Support is available to people who are deaf or hard of hearing everyone, and this is particularly important for those people with co-morbidities or multi-disabilities.

Of the total people with deafness or partial hearing loss (93,091), 55,504 (59.6%) are aged 65+ and 35,164 (37.8%) are aged 18 to 64. Given this demographic information the health and social care needs of people who are deaf or partial hearing loss will be diverse and multi-faceted, therefore, interpreters should be competent to work in the area of health and social care across the sectors of health and social care provision i.e. Primary, Social Care/SW and Acute Care.

The delivery of a consistent, professional service, as a result of the review’s recommendation will deliver positive outcomes for those people with a disability, that are more likely to utilise the interpreting service.

A revised Regional Communication Support service will involve a significant cultural shift in how the HSCB and Health and Social Care Trusts currently ensure accessible health & social care. This transformation will involve a partnership approach between individuals, professionals and across all sectors to provide a broader understanding of what Communication Support is and how to avail of it. This will require consideration of how we communicate and engage with staff and the public. Moreover, staff training and monitoring the implementation will be essential to ensuring Communication Support is a success.

The scope of the Equality Impact Assessment therefore is on the equality outcomes and impacts, with a particular focus on potential impacts and particular needs for people within a number of the Section 75 categories namely; age, disability, ethnicity, gender, ethnicity, political opinion and religion.

Proposed Actions

Gender	Action
A limited number of interpreters means it may be difficult to provide gender specific interpreter on request.	Outside of normal booking procedures, a gender specific interpreter will be considered if required to meet a patient's needs, on request. The Commissioning Body and the Business Services Organisation will endeavour to meet the need for interpreters in HSC, identifying and encouraging a gender balance as appropriate The gender of service users will be monitored Service users request for a gender specific interpreter will be monitored alongside the HSC service it has been requested for.

Religion/Political Opinion	Action
Due to limited availability of data, unsure of any likely impacts (particularly around the border areas of NI) – association of each language with one of the two main religions/political opinions is assumed	Issues of Irish Sign Language/British Sign Language service use preference will be explored on the grounds of political opinion/religion, with a view to ensuring that provision levels for each language can meet

	demand Monitoring of use of British Sign Language and Irish Sign Language will be undertaken
Ethnicity	**Action**
There is no known information available at present as to the current usage of communication support services across the region for people from minority ethnic backgrounds.	A regional communication support service will be able to better monitor usage and identify the demographic usage of the service. Any underrepresentation can subsequently be addressed. A regional advisory group be established which would have relevant stakeholders.

Monitoring

The governance arrangements for the regional communication support service are set within the context of the overall Transforming Your Care Programme governance arrangements.

It is proposed that the regional shared/managed service provided by the HSC Business Services Organisation would work closely with the Trusts to ensure consistency of data gathering and monitoring, including Section 75 data.

It is further proposed that, as for the existing Regional Language and Interpreting Service, a regional advisory group be established which would:

- Be chaired by the provider organisation (HSC Business Services Organisation), with accountability to the commissioner;
- Include Public Health Agency representation to advise on public health considerations for deaf people;
- Include a representative of the Regional Interpreting Service;
- Include Trust representation through the Equality Leads and other staff such as Sensory Rehabilitation, Audiology, Emergency Departments, Regional Emergency Social Work Service;
- Include representation from Integrated Care Directorate regarding General Medical Practice needs in and out of hours provision;
- Include Independent Contractor representation;
- Include Service User representatives, including British Sign Language and Irish Sign Language Service users, British Deaf Association, Action on Hearing Loss, SENSE;
- Include representatives from the Deaf community;

- Include a Risk and Governance representative to account for the legal and governance requirements of the health and social care family towards deaf people.

2. Background

Organisational Background

In 2005, the NI Review of Public Administration (RPA) concluded that major reform was required in the administrative structures of health and social services. In addition an Independent Review of Health and Social care Services in NI conducted by Professor John Appleby the same year highlighted the need for reform and modernisation of the management of these services.

As a first phase of the RPA reforms in health and social care, five integrated Health and Social Care (HSC) Trusts were established in April 2007 to operate alongside the existing Northern Ireland Ambulance Services HSC Trust.

Following public consultation, the Minister of Health, Social Services and Public Safety announced details of the second phase of health and social care reform in Northern Ireland. Central to this was the establishment from 1st April 2009 of a new Health and Social Care Board (HSCB), including 5 Local Commissioning Groups coterminous with the Trusts, the Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

The HSCB, together with its Local Commissioning Groups (LCGs) is accountable to the Minister for Health, Social Services and Public Safety and translates the Minister’s vision for health and social care into a range of services that deliver high quality and safe outcomes for users, good value for the taxpayer and compliance with statutory obligations.

A key role of the HSCB with the Public Health Agency (PHA) is effective engagement with providers, Patient Client Council (PCC), local government, Service Users, local communities, other public sector bodies and the voluntary and community sectors.

In short, the HSCBs key functions include:

- In line with Ministerial objectives, ensuring effective commissioning to secure the provision of health and social services and other related interventions that address the needs of people from pre-conception to death;
- The efficient, effective and appropriate use of delegated funding of some £4bn per annum to meet agreed objectives in line with Ministerial objectives and Department policy in order to maximise access to quality and safe services and reduce unnecessary bureaucracy;
- Implementing a comprehensive framework for performance management and service improvement that will monitor HSC performance against relevant objectives, targets and standards and provide appropriate assurance to the Department and the Minister about their achievement;
- Establishing arrangements at a regional and local level that ensures close strategic and operational partnership with key stakeholders both within the HSC and wider public sector in meeting the objectives of the Board and proactively engages and informs local communities and the voluntary and community sectors on the work of the Board;
- Establishing a close working relationship at a regional and local level with the PHA minimising unnecessary duplication and ensuring a seamless approach to the improvement of the health and social wellbeing of all the people of NI reflected in the development of an integrated annual commissioning plan for approval by the Minister;
- Facilitating and supporting Local Commissioning Groups in their role of achieving effective locality based commissioning, managing their performance, and holding them to account so that

they can exercise their devolved authority within an effective framework of regional priorities and standards;

- Within the parameters of the Department's overarching Framework Document, working with other key stakeholders such as the Department, Public Health Agency, Trusts and Regulation & Quality Improvement Authority (RQIA) to ensure clarity of responsibility and appropriate provision for the safety of services, the management of critical incidents and service failings and the protection of the public;

- Ensuring that regional priorities – for example programmes for improving cancer services – are integrated into local plans while promoting real delegation to a local level within that framework; and

- Overseeing the agreed publication of performance information.

Equality Impact Assessments

Schedule 9 of the Northern Ireland Act 1998 provides for a comprehensive consideration by public authorities of the need to promote equality of opportunity, giving effect to Section 75 of the Act, between:

- people of different religious belief, political opinion, racial group, age, marital status or sexual orientation;

- men and women generally;

- people with a disability and people without one; and

- people with dependants and people without dependants.

These are called 'Section 75 Groups' because the relevant law is Section 75 of the Northern Ireland Act 1998. In addition, without affecting the above duty, public authorities must have regard to the desirability of promoting good relations between people of different religious beliefs, political opinions and racial groups.

Equality Schemes must be prepared, which among other things must set out arrangements for assessing the likely impact on the promotion of equality of opportunity of the policies adopted or proposed.

Where equality impacts are likely to be major, a public authority needs to undertake an Equality Impact Assessment (EQIA). This is “a thorough and systematic analysis of a policy, whether the policy is written or unwritten, formal or informal, and irrespective of the scope of the policy or the size of the public authority.”

As part of the assessment consideration must be given of anything that could reduce any adverse impact on equality of opportunity of the policies proposed. Thinking through what opportunities exist to better promote equality must also be a part of the assessment. Consideration to alternative policies that might better promote equality of opportunity must also be given.

The policy subjected to an Equality Impact Assessment

The purpose of the Regional Communication Support Services Review was to review the arrangements for providing interpreting services across all Trusts to ensure a consistent approach to interpreting provision and to explore the potential for greater use of technology (RQIA:2011:pg15).

The catalyst for the Regional Communication Support Services Review is to be found in the Regulation Quality Improvement Authority’s (RQIA) Review of Sensory Support Service in Northern Ireland (2011), which recommended the following:

“A major issue identified during the review was access to sign language interpreting services, mainly due to the limited availability of qualified interpreters. While this area was identified as under-funded across all trusts, most trusts tried to address the issue through the re-allocation of resources and by representing this gap as an unmet need to the HSCB. However, little progress had been made to improve the availability of sign language interpreting services, in line with other foreign language interpreting services. The HSCB informed the review team that it wanted

to review the arrangements for providing interpreting services across all trusts to ensure consistent approach to interpreting service and to explore the potential for greater use of technology". (Page 15, Standard 1 Human Rights and Equality). "Review of Sensory Support Service in Northern Ireland Overview Report", September 2011.

This Review of Communication Support Services Report recommends that regional communication support services require changes to ensure an accessible, efficient, affordable and sustainable service model is available into the future. As the Report states, demand has increased over the past five years and so have costs.

The aim of the Review was to scope and review communication support service provision for health and social care in NI with a view to providing details about current service provision and future requirements to support an accessible, equitable and efficient service for people with hearing loss.

For the purposes of this review 'communication support', is defined as Sign Language interpreters, electronic or manual note takers, speech to text reporting and Lip to Speech-Deaf Blind Manual.

A number of objectives were set out as follows:

1. To undertake a regional communication support services scoping exercise;
2. To analyse provider contract information returns with a view to profiling need, uptake of service and cost regionally;
3. To stocktake current communication support service standards with a view to developing a regional minimum standard for future commissioning and delivery of services;
4. To explore a range of options to meet the needs of people with hearing loss;
5. To engage with service users in relation to the range of options identified;
6. To carry out value for money appraisal on each option;
7. To present the preferred option(s) analysis to the relevant Commissioners.

How will this be achieved? (Key elements)

The key elements within the scope of the Review are:

- Review current British Sign Language/Irish Sign Language service;
- Review of current demand and supply;
- Identify options for new service delivery model and carry out an option appraisal on each.

There is four phases to the review.

Phase 1: Project Set Up	Phase 2: Scoping
Key tasks included: • Establishing a Task and Finish Group; • Develop Terms of Reference; • Develop Review Methodology; • Agree scoping exercise and templates for gathering necessary data.	Key tasks included: • Mapping current provision – including demand and capacity data; • Understanding financial envelope and costs of service – including baseline funding and actual costs; • Map current service models across Trusts; • Identify unmet need; • Review Best Practice outside NI – collecting data from service in Republic of Ireland • Identify Key Issue(s)/Groups - identify initial issues and targeting stakeholders for engagement.

Phase 3: Engagement	Phase 4: Future Model
Key tasks included: • Engagement Workshop with all stakeholders – conducted a workshop which included representatives from service users, services and other stakeholders involved in commissioning, delivery, monitoring and users of the existing interpreting services across NI; • Targeted individual engagements – this included focused meetings with service users forum groups, service providers, Association of Sign Language Interpreters (ASLI) and individual representatives from each of the above groupings; • Workshop Report - involved writing a document about the content and outcome of the Engagement Workshops held on 25th September 2013.	Key Tasks Included: • Identify lists of options for service model; • Engagement Process; • Options Appraisal; • Targeted Consultation Process (3 months); • Preferred option agreed and presented to Commissioner; • Equality Good Relations and Human Rights Screening; • Develop specification for new service model; • Agreed Model Initiated.

The findings of the Review have identified a range of issues which support and confirm the need for change including: accessibility, value for money, sustainability, standardisation and modernisation.

Accessibility

Service Users and Sensory Support staff have expressed concern about the booking time required and availability of communication support, for planned appointments, emergency attendance at acute settings, out of hours services and for non-health and social care appointments, most notably, onward referrals from a HSC professional to, for example, non-HSC specific leisure centres, social activities. This review **is focused only on health and social care related access**. Section 5.1 details the current access criteria to services and clearly there are anomalies across the region.

It has been noted that service users also make requests for a particular interpreter to support them when attending particular medical or other confidential appointments; however, the service user, could reside in the East of the province and make a request for an interpreter who lives West of the province, which incurs a much higher fee to cover mileage and travel time.

It has also been noted that in some instances family members are used as interpreters which poses challenges on the level/accuracy of interpretation and raises issues around confidentiality and governance. While is done mostly without remuneration being sought, in at least one Trust area some service users insist on using family that are registered interpreters and that the interpreters get paid for this. This practice has largely been stopped.

At present there are only two known Electronic Note Takers in Northern Ireland. There is also no known remote communication support service in operation from any of the contracted providers at present. Trust staff and service users also noted that whilst the Out of Hours communication support service is available, it is infrequently utilised and queried whether there was a need or an awareness-raising requirement.

Value for money

The financial information (See Section 5.2, Table 9) demonstrates that the current service model has cost in excess of budget consistently over the last 5 years as noted, and has risen year on year across Trusts.
It has highlighted that the current model of delivery is not meeting the growing demand. The total variance between budgets and actual costs is currently approximately £155,640.

There is an assumption that demand will continue to rise and this been incorporated into the financial planning assumption from the review.

There is some known inefficiency across the Region due to cancelled appointments which has a financial consequence for commissioners and is wasteful of a scarce resource. Table 12 below shows the number of charged cancellations for the last 2 financial years.

Table 1

	2013/14		**2014/15**	
Trust	**Number of bookings cancelled**	**Cost**	**Number of bookings cancelled**	**Cost**
BHSCT & SEHSCT	73	£7339	54	£5193
NHSCT	29	£2151	19	£1499
SHSCT	42	£5546	37	£4763
WHSCT	0	£0	3	£479
Totals	144	£15,036	113	£11,634

Source: Monitoring returns

This ‘wastage’ shows an improving picture but the issue still needs on-going work to reduce this as much as is possible; it will not be possible to reduce to zero due to unavoidable late cancellations such as service user illness.

Sustainability

To ensure future sustainability, remodelling of the current service is required to identify more efficient and cost effective ways to deliver the service, for example, through the use of remote interpreting provision where possible and appropriate.

Table 2 Service Activity over 5 year period

Trust	2010-11	2011-12	2012-13	2013-14	2014-15	Total
BHSCT	485	461	502	549	646	**2643**
SEHSCT	556	540	730	817	623	**3266**
NHSCT	765	845	874	798	720	**4002**
SHSCT	236	214	305	495	531	**1781**
WHSCT	436	449	594	691	823	**2993**
Total	**2478**	**2509**	**3005**	**3350**	**3343**	**14685**

Source: Monitoring returns

There has been variance from across the region (See Table 2 & 3) regarding growth and reduction in the number of bookings made/ taken from within each trust area. NHSCT has seen a reduction in the number of bookings taken (by over 150) in 2014-15 compared to 2012-13. The NHSCT provides interpreting for “Health and well-being appointments including hospital, social care and GP…. but does not allow provision for opticians, dental appointments, solicitors, employer meetings and schools.”(This review does not include provision for non-health & social care services). Bookings from within the SEHSCT have decreased by 194 in 2014-15 from the previous year without any restriction in access being imposed.

Table 3 Variance Increase over 5 year period

Trust	2010-11	2011-12	2012-13	2013-14	2014-15	Variance Increase
BHSCT	Baseline Year	-4.9%	8.9%	9.4%	17.7%	33.2%
SEHSCT		-2.9%	51.9%	11.9%	-23.7%	12.1%
NHSCT		10.5%	3.4%	-8.7%	-9.8%	-5.9%
SHSCT		-9.3%	42.5%	62.3%	7.3%	125%
WHSCT		3%	32.3%	16.3%	19.1%	88.8%

Future demand

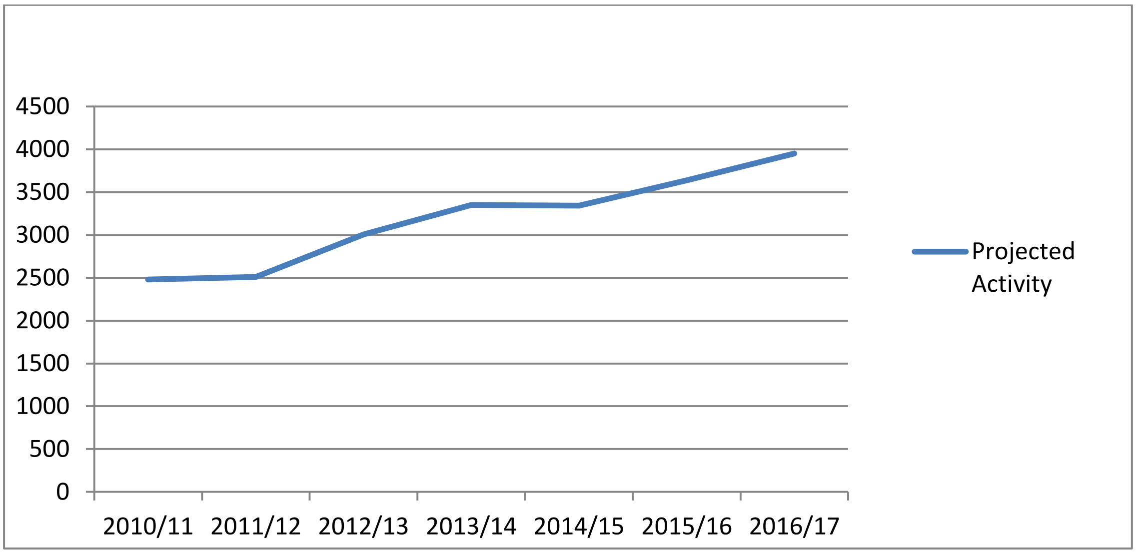
It is also important to anticipate and project future demand. Based on the data contained within this report, it is estimated that a possible 8.7% increase in activity for the next 2 financial years can be anticipated (See Table 4 below).

Table 4

Year	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
	2478	2509	3005	3350	3343	3635	3951
% increase	**Baseline Year**	0%	20%	10%	0%	8.7%	8.7%

By March 2017 it is estimated that the cost of the current service model will be in the region of £455k, with an approximate budget of £240k if no additionality other than small uplifts, is secured.

Table 5 **Projected Activity**



Standardisation

The current communication support model in place across Northern Ireland is brokered through two organisations and through use of freelance interpreters. The cost of service, length of each assignment, travel time, eligibility criteria, booking processes, access to service etc. all vary from Trust to Trust.

The British Deaf Association (BDA) in its presentation at the Regional Workshop in September 2013 made a number of recommendations in this regard for a future model, which have been borne in mind in the Options Appraisal below. Additionally, the learning from Sign Language Interpreting Service (SLIS) and the implicit recommendations emanating from their presentation along with the recommendations made by Association of Sign Language Interpreters (ASLI) also at the September Workshop have also been given careful consideration.

Options Appraisal for future provision

This section explores the list of options that were considered during the Review. In line with the rationale for change, and key to meeting the long-term sustainability of the service, key criteria were agreed against which to weight the options. The criteria seek to ensure standardisation, accessibility, experience and value for money.

The options are:

Option One – No Change

The HSC Trusts and HSCB would continue to contract with 2 provider organisations and freelance interpreters to deliver the service, therefore cost, eligibility criteria, booking processes all remain inconsistent and varied across Northern Ireland causing difficulties with standardisation, accessibility, user experience, value for money, and equity.

It will **not** address the current overspend apparent in 3 of the 5 Trusts due to increased demand.

Option Two – Trust Devolved Model

The HSCB would devolve responsibility to the BHSCT and SEHSCT and thus all 5 Trusts would be able to procure their own service providers i.e. individual contracts within all five Trusts. Accessibility may potentially be improved at a local level, however, there will be little regional standardisation, and may indeed be fragmented from Trust to Trust in the absence of a regional approach (see section 5.1 for current service provision and access). Efficiency will be negatively impacted on due to 5 separate models with separate reporting, monitoring arrangements and running costs/overheads not reduced.

It will **not** address the current overspend apparent in 3 of the 5 Trusts due to increased demand.

Option Three – Trust Model Through Single Provider

The communication support service would be commissioned/procured by HSC Trusts themselves, hosted possibly by one Trust on a consortium basis, and commissioned and contracted with a single provider which would provide a regional service across all 5 Trusts. This option could offer consistency and standardisation of approach but it does not address the issue of a central booking system for all requests unless one is put in place to achieve standardisation.

The reporting and monitoring arrangements may need to be tailored to meet the needs of each of the 5 Trusts, especially if regional criteria for access are not agreed and, therefore, might not offer value for money. This option would require the host Trust to oversee the booking arrangements and put administrative arrangements in place. It would also require each Trust to have identified Lead Officers to monitor the service and to follow up on issues pertinent to the respective Trust, e.g. cancelled chargeable bookings. This option does not naturally sit with any one Trust in terms of core business; it does seem consistent with a recommendation within the Physical and Sensory Disability Strategy regarding sharing resources.

It will **not** address the current overspend apparent in 3 of the 5 Trusts due to increased demand.

Option Four – Regional HSCB Commissioned Model

The regional communication support service would be commissioned/ procured by the HSCB through a contracted provider. This option would be very similar to Option 3; it could offer consistency of approach as there would be regional access criteria and, therefore, the need for Trust specific variance is nullified. This option would require the HSCB to oversee the booking arrangements and put administrative arrangements in place. It would also require each Trust to have identified Lead Officers to monitor the service and to follow up on issues pertinent to the respective Trust, e.g. cancelled chargeable bookings. This option would not set a precedent for HSCB as it holds a number of regionally procured contracts for services provided by the voluntary sector.

It will **not** address the current overspend apparent in 3 of the 5 Trusts due to increased demand.

Option Five– Regional Shared Service

The regional communication support service would be provided on a shared service basis by the HSC Business Services Organisation (BSO), managed independently of the HSC provider organisations. This option provides a consistent business model and approach, delivered by an organisation with a track record in shared services. The Business Services Organisation has the knowledge, expertise and resources gained from the recent profiling of the Regional Language Interpreting services to meet the communication support needs of deaf service users regionally. It could meet the requirements and demands of a quality service specification, based on sound business principles and practices. This option would also be the closest to the RQIA recommendation of 2011, and offers the best option to address the issues flagged by the stakeholder workshop (see section 6.2). This option would also, at face value, appear to meet the expectations of the Association of Sign Language Interpreters and British Deaf Association recommendations and match the service in place in Republic of Ireland.

It will **not** address the current overspend apparent in 3 of the 5 Trusts due to increased demand but offers the best value for money proposal.

Preferred Option

Based on the options appraisal, the preferred option for the regional communication support service is Option 5; a regional shared/managed service provided by the HSC Business Services Organisation (BSO). This means that the service would be managed independently of the Health and Social Care provider organisations. In favour of this option is that the Regional Language Interpreting Service could also include Interpreting services for deaf people who require access to health or social care services and fits with the aim and strategic objectives of the BSO. The BSO would be in a good position regionally across Trusts, other Health and Social Care organisations and independent contractors to set strategic direction and proactively manage the service.

Screening and Scope of the Equality Impact Assessment

A full equality impact assessment is necessary for the following reasons: the proposal being significant in terms of strategic importance, there are potential equality impacts that are unknown, that further assessment offers a valuable way to explore evidence and the proposal is significant in terms of its expenditure. This assessment will determine if the preferred option of introducing a Regional Shared Service for interpreting services as outlined above has any potential equality impacts.

Initial engagement and RQIA recommendations have concluded that considerable reform needs to be introduced to address the issues of availability, under funding across some of the Trusts and lack of consistency across the Region. A standard and consistent service will offer people a quality and equal service regardless of where they live.

The scope of the Equality Impact Assessment therefore is on the equality outcomes and impacts, with a particular focus on potential impacts and particular needs for people within a number of the Section 75 categories namely; age, disability, ethnicity, gender, ethnicity, political opinion and religion.

3. Data Collection

In line with the Equality Commission (NI) Guide to the Statutory Duties and EQIA Guidelines, data was drawn from a number of sources to help us prepare this draft EQIA.

Data was gathered for a range of communities, namely:

- the general population, with a targeted focus on people with a disability, specifically the deaf and hard of hearing community;
- the Association of sign language interpreters, as they represent the views of the interpreters who are in daily contact with British Sign Language and Irish Sign Language service users;

- the British Deaf Association (BDA), as they are user led organisation and held focus groups in order to contribute to the workshop;
- the Delegated Statutory Functions Annual Reports, as these represent the number of deaf and hard of hearing people who are in contact with statutory social services.

In preparing the draft EQIA, the findings from a range of data and research sources were taken into account. Data was considered for older people and men and women generally. There was not sufficient data to understand impacts on the grounds of political opinion, religion or ethnicity. These will be explored further during the consultation phase. Statistical information was available from Northern Ireland Statistical Research Agency (including Census information from 2011) and Delegated Statutory Functions Returns.

Targeted engagement was also undertaken with relevant stakeholders in the form of a regional workshop. Presentations were provided by a range of organisations (Association of Sign Language Interpreters, British Deaf Association and Sign Language Interpreting Service). A Task and Finish Group was formed to take the Review forward.

Disability

Service Users from across the region, British Deaf Association who attended and presented at the Stakeholder Engagement Workshop. Sign Language Interpreting Service /Deaf Village Ireland who also presented at the workshop, SENSE – Deafblind charity were also in attendance at the workshop, and Trusts Sensory Rehabilitation services who assesses need and provide services to people who are deaf or hard of hearing.

Interpreters

Association of Sign Language Interpreters and Sign Language Interpreters Service attended and presented at the Stakeholder Engagement Workshop. During the twelve week consultation period for this draft EQIA, the HSCB will undertake targeted engagement with a range of groups, service users and carers and providers and Interpreters. We will also engage with wider Section 75 Groups and individuals as appropriate as well as the Equality Commission for Northern Ireland to produce the final equality impact assessment.

Key findings

This section outlines our key findings across the nine equality groups outlined in Section 75(1) of the Northern Ireland Act. This analysis has been produced following a desktop review of available local, national and international literature and engagement with service providers and users. As far as the availability of data allows, across the nine equality categories each section looks at profile, impacts and needs which have been identified.

Gender

The population of Northern Ireland on Census Day 2011 was 1,810,863. Of the population there were 93,091 persons who recorded deafness or partial hearing loss which equates to 5.14%.

Table 6: Gender breakdown of residents in Northern Ireland recorded against those who are deaf or having partial hearing loss

Gender	General Population	Number	Percentage
Males	887,300	50,901	2.81%
Females	923,500	42,190	2.33%

(Source: NISRA 2011)

Accurate figures on the number of transgender people are not currently available. McBride (2011) ‘Healthcare Issues for Transgender People Living in Northern Ireland’ estimates that the number of people who say they are transgender in Northern Ireland is 8 per 100,000 (120) people (aged 16 and over). There is a higher proportion of male to female transitions.

Negative attitudes are displayed towards transgender people, according to the 2011 Equality Awareness Survey by the Equality Commission. This found that 35% of respondents would mind (a little or a lot) having a transgender person as a work colleague, while 40% would mind having one as a neighbour and 53% would mind having one as an in-law.

Negative attitudes were stronger among people over 65 years old. They were more likely to mind having a transgender person as a work colleague (52%), as a neighbour (54%), or in a relationship with a close relative (69%) compared with the younger age groups aged 16–29 years old (29%, 33% and 46%, respectively) or 30 to 44 years old (28%, 34% and 48%, respectively).

According to Action on Hearing Loss information, a higher proportion of men than women will develop hearing loss over the age of 40. This is possibly because more men have been exposed to high levels of industrial noise compared to women. Among the over 80 years of age population, more women than men have hearing loss, which is due to women living longer than men on average, not because women are more likely to become deaf. (Source: Action on Hearing Loss Information July 2011). This would suggest that there may gender difference issues and may need to be reflected in the gender make-up of communication support staff.

Currently there are 23 trained interpreters across Northern Ireland, of which 20 (87%) are female and 3 (13%) are male. The limited number of interpreters means that it may be difficult to provide a gender specific interpreter on request, should this be required.

Age

Table 7: Age breakdown of residents in Northern Ireland recorded as deaf or having partial hearing loss

Age Range	General Population	Number	Percentage of population
0-16 years	379,300	2423	0.13%
17-64 years	1,043,600	35164	1.94%
65 and above	265,762	55504	3.07%

(Source: NISRA 2011)

The population of Northern Ireland is ageing. Between the 2001 and 2011 census reports the median age increased from 34 years to 37 years.

According to NISRA, the population aged 85 and over has increased by 38% between 2002 and 2012. Within Northern Ireland this population is projected to grow from the 31,800 at the 2011 census to 100,000 by 2041.

In March 2013 Age UK launched a twenty page fact sheet highlighting those over 85 whom they labelled as the ‘oldest old’. Some key points to note from this briefing were:

- Almost three quarters (74.8%) of the ‘oldest old’ live on their own
- Dementia affects one in six aged over 80 and one in three aged over 95
- In the UK nearly 50,000 people aged 85 and over, provide unpaid care to a partner, family member or other person
- 90% of those aged 85 and over are estimated to spend an average of 80% of time in their home
- 30% of those aged over 80 have limited access to services such as shops and GPs and 25% are cut off from friends and family

- About 40% of the 'oldest old' have a 'severe disability'
- The Newcastle 85+ study found hearing impairment in 59.6% and visual impairment in 37.2% of the study.

With an ageing population the number of people with deafness or partial hearing loss will increase and so will the demand on communication support services. More and more people will require support and assistance to be able to access Health and Social Care services across the region without the need to rely on carers/family and friends. More older people are likely to be affected by social isolation and there is a strong link between hearing loss and dementia. According to one study, people with mild hearing loss are two times as likely to develop dementia, and this increases to three times for those with moderate hearing loss. (Source: Lin et al 2011).

This data would suggest that there may be age difference issues with more men experiencing deafness or partial hearing loss during adulthood up until aged 80 when than women when the difference swings in the opposite direction.

The proposed recommendation within the review will deliver a consistent and professional service which will provide positive outcomes for older service users. There is therefore a positive impact for older people.

Marital Status

Table 8: Martial Status of Northern Ireland residents aged 16+ years, Census 2011

Marital Status	Count	Percentage
Married	680,831	47.6
Single	517,393	36.1
Same-sex Civil Partnership	1,243	0.1
Separated	56,911	4.0

Divorced	78,074	5.5
Widowed or Surviving Partner	97,088	6.8

(Source: NISRA 2011 Table KS103)

Table 3 shows that at the time of the 2011 Census the majority of the residents aged over 16 (47.6%) were married compared to 36.1% who declared themselves as single.

There is no evidence of a differential impact of the proposals on the grounds of marital status.

Religion

Total population – 1,810,863
Table 9: Religious make up of Northern Ireland

Religion/Religion brought up in	Count	Percentage
Protestant/Other Christian	875,717	48.4
Roman Catholic	817,385	45.1
Other Religions	6,569	0.9
None	101,169	5.6

(Source: NISRA 2011, Table KS212)

The vast majority of the population (93.5%) declared themselves as either Catholic or Protestant. Less than 1% of the population were of another religion and 5.6% declared no religion.

Service provision must take into account the requirements of both British Sign Language and Irish Sign Language users. Attention must also be paid to the demographic spread of British Sign Language and Irish Sign Language users.

During the scoping it was unclear whether or not there would be any likely impacts on service users who use the different sign languages i.e. Irish Sign Language or British Sign Language given the assumption that there is a perceived association of each language with one of the two main religions.

It is therefore considered appropriate to explore this issue further during the consultation phase of the EQIA to better understand likely impacts.

Ethnicity

All usual residents 1,810,863

Table 10: Ethnic makeup of Northern Ireland in 2011

Ethnic Group	Count	Percentage
White	1,778,449	98.2
Chinese	6,303	0.4
Indian	6,198	0.3
Irish Traveller	1,301	0.1
Pakistani	1,091	0.1
Bangladeshi	540	0
Other Asian	4,998	0.3
Black Caribbean	372	0
Black African	2345	0.1
Black Other	387	0.1
Mixed	3319	0.3
Other	1290	0.1

(Source: NISRA 2011, Table KS201)

Irish Travellers comprised 0.1% of the population. Since 2001, the minority ethnic count rose from 14,300 to 32,400. Increases were recorded for all groups with the exception of Irish Travellers, whose number fell from 1,700 in 2001 to 1,300 in 2011. Belfast (3.6%), Castlereagh (2.9%), Dungannon (2.5%) and Craigavon (2.1%) had the highest proportions of residents from minority ethnic groups.

Residents born outside Northern Ireland in March 2011 accounted for 11% (202,000) of the population, compared with 9% (151,000) in April 2001. This change resulted largely from inward migration by people born in the 12 countries that have joined the European Union since 2004 (EU 12). These accounted for 2% (35,700) of Northern Ireland residents on Census Day 2011, compared with 0.1% in 2001.

The rest of the population born outside Northern Ireland consisted of 4.6% born in Great Britain, 2.1% born in the Republic of Ireland, 0.5% born in countries that were EU members before 2004, and 2% born elsewhere.

Table 11: Breakdown of country of birth for the population of Northern Ireland

Country of birth	Count	Percentage
Northern Ireland	1,608,853	88.8
Outside Northern Ireland	202,000	11.2
England	64,717	3.6
Scotland	15,455	0.9
Wales	2,552	0.1
Republic of Ireland	37,833	2.1
EU before 2004	9,703	0.5
EU 12	35,704	2.0
Other	36,046	2.0

(Source: NISRA (2012) Table KS204)

The number of requests received by the Northern Ireland Health and Social Care Interpreting Service has risen from 18,151 in 2006 to 95,894 in 2014, showing the increasing demand on services responding greater diversity in the population. Responses to the Transforming Your Care Vision to Action consultation noted how important it was to have foreign-language interpreters available.

According to the “All-Ireland Traveller Health Study” (AITHS), the Traveller population in Northern Ireland is estimated at 3,905, with 1,562 families. The age profile of this community is markedly different from that of the general population. Some 70% of Travellers are aged 30 or under, and only 1% are aged 65 and over. This partly reflects a higher birth rate, a higher death rate and inward migration.

National research suggests there are differences within black and minority ethnic (BME) groups generally when compared with the white population. Ill health often starts at an earlier age in BME groups than among white people. There are variations from one health condition to another; for example, BME groups have higher rates of cardiovascular disease than white people but lower rates of many cancers. Diabetes is more common in BME groups and high blood pressure is more common in Asian groups.

Evidence suggests a lack of knowledge among BME groups about social care services. There is a particular lack of knowledge about services for those with dementia and their Carers.

People from BME groups face particular difficulties in accessing services, making complaints and getting mistakes corrected. The Health Professions Council’s ‘Scoping Report on Existing Research on Complaints Mechanisms’ says this can partly be explained by a relative lack of knowledge about how services work. People from BME groups may also be more likely to fear the consequences of complaining or asserting themselves.

Currently there is no robust information on ethnic minorities accessing communication services. It is therefore considered appropriate to explore this issue further during the consultation phase of the EQIA to better understand likely impacts.

Political Opinion

The Electoral Commission's data on the first-preference votes per party in the Northern Ireland Assembly Elections 2011 provides the political preferences for the whole of Northern Ireland.

Table 12: First preference votes per party in Northern Ireland Assembly Elections 2011

Political Party	Votes
Democratic Unionist Party	198,436
Sinn Fein	178,222
Social Democratic and Labour Party	94,286
Ulster Unionist Party	87,531
Alliance	52,384
Other	52,284

(Source: Electoral Office NI, 2011)

Service provision must take into account the requirements of both British Sign Language and Irish Sign Language users. Attention must also be paid to the demographic spread of British Sign Language and Irish Sign Language users.

While no data has been identified to suggest differential impacts of Communication Support Services on the grounds of political opinion, it would appear prudent to note the Survey Report produced by Parks and Parks in 2012 that suggests most Irish Sign Language users would identify themselves as Irish and therefore political opinion is influenced. The corollary of this would be that British Sign Language users may identify themselves as British and therefore political opinion is influenced. Caution needs to be applied to these broad assumptions.

During the scoping it was unclear whether or not there would be any likely impacts on service users who use the different sign languages i.e. Irish Sign Language or British Sign Language given the assumption that there is a perceived association of each language with one of the two main political opinions. It is therefore considered appropriate to explore this issue further during the consultation phase of the EQIA to better understand likely impacts.

Dependants (Carers)

In the 2011 Census, respondents were asked whether they provided any unpaid help or support to family members, friends, neighbours, or others because of long-term physical or mental ill-health/disabilities, or problems related to old age. 12% of the population (231,980) provided such unpaid care, 26% (56,000) of those did so for more than 50 hours a week.

Table 13: Provision of unpaid care in Northern Ireland

Care Provided	Count	Percentage
Provides no unpaid care	1,596,883	88.2
Provides 1-19 hours unpaid care per week	122,301	6.8
Provides 20-49 hours unpaid care per week	35,369	2.0
Provides 50+ hours unpaid care per week	56,310	3.1
Total	1,810,863	100

(Source: NISRA 2011, Table KS301)

As referenced above, in Table 13 and supporting narrative, particular attention should be paid to older carers who may have hearing loss or who are deaf.

There is however no evidence to suggest differential impacts as a result of the review's recommendations, on the grounds of dependant status.

Sexual Orientation

Accurate figures are not available on the sexual orientation of the general population, and estimates vary considerably. The Northern Ireland Statistics and Research Agency (NISRA), along with other UK census offices, concluded that the census was not suitable for obtaining such information. The 2011 Census does provide some information, based on same-sex civil partnerships.

Research by HM Treasury shows that from 5%–7% of the UK population say they are gay, lesbian or bisexual.

The 2010 Northern Ireland Life and Times survey (1,205 adults) reported the figure as only 1%. The Office for National Statistics 2010 report (450,000 respondents) found that in Northern Ireland 92.5% said they were heterosexual and 0.9% of respondents said they were LGB, although 0.4% reported as 'other' and 6.2% said they didn't know or refused to respond.

Between 2006 and 2012, there were 715 recorded Civil Partnerships regionally. However, this is not indicative of the LGB population. There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual.

No data has been identified to suggest differential impacts of Communication Support Services on the grounds of sexual orientation.

Disability

Census figures show that in 2011 just over one in five of the resident population (21%) had a long-term health problem or disability that limited their day-to-day activities, similar to the proportion in 2001 (20%). Strabane and Belfast (both 24%) had the highest proportions of residents with a long-term health problem or disability.

Table 14: Long-term health problem or disability of Northern Ireland Population

Disability	Count	Percentage %
Long-term health problem or disability: day-to-day activities limited a lot	215,232	11.9
Long-term health problem or disability: day-to-day activities limited a little	159,414	8.8
Long-term health problem or disability: day-to-day activities not limited	1,436,217	79.3

(Source: NISRA (2012) Table KS301 – Health and unpaid care)

According to a NISRA survey carried out in 2006; some 37% of households include at least one person with a disability and 20% of these include more than one disabled person.

For both men and women, the rate of disability increases with age. Women on average live longer than men therefore disability tends to be more common among women. The rate is particularly high for women aged 75 and above (at 62%). It is only among the youngest adults aged 16 to 25 that the rate for men (at 6%) is higher than for women (4%)

(Northern Ireland Survey of Activity Limitation and Disability (2006/07).

Some 32% of the 1,860 people receiving direct payments from their local Health and Social Care Trust have a physical or sensory disability (January 2011).

In Northern Ireland there are about 16,500 people with a learning disability. McConkey et al (2006) predict this will increase by 20.5% by 2021. Any change to older people's services must take account of the needs of older people with learning disabilities as well as other forms of disability. (McConkey et al, 'Accessibility of healthcare information for people with a learning disability. A Review and Discussion Paper' (2006)

Table 15: Percentage of People in Northern Ireland population by type of long term condition or disability

Type of long – term condition	**Percentage of population with condition %**
Deafness or partial hearing loss	5.14
Blindness or partial sight loss	1.7
Communication Difficulty	1.65
Mobility of Dexterity Difficulty	11.44
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

No Condition	68.57

(Source: NISRA 2011)

Table 16: Children with a Disability known to Social Services, by major disability, NI - As at March 2012

Major Disability	0-4		5 - 11		12-15		16+		Total	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Physical (Ex. Sensory)	63	52	110	90	69	71	50	40	292	253
Sensory	51	41	87	66	31	39	32	18	201	164
Learning	201	105	593	300	483	218	300	148	1577	771
Chronic illness	8	8	8	8	3	0	0	0	19	16
Other (undefined)	21	8	88	17	56	20	26	10	191	55
TOTAL (With Disability)	344	214	886	481	642	348	408	216	2280	1259

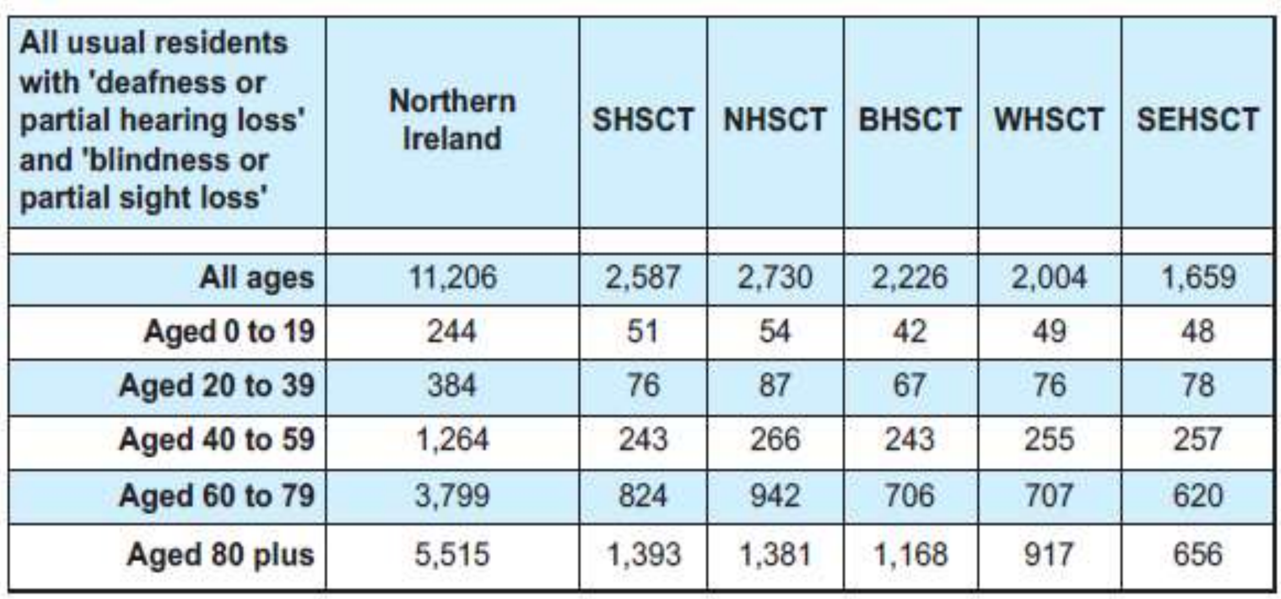
Table 17: Children with a Disability known to Social Services, by major disability type, age and gender, NI – As at March 2013

Major Disability	0-4		5 - 11		12-15		16+		Total	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Physical (Ex. Sensory)	64	54	135	75	73	54	57	36	329	219
Sensory	37	25	81	55	21	31	19	8	158	119
Learning	170	101	518	274	402	211	268	110	1358	696
Chronic illness	13	9	6	4	1	5	2	1	22	19
Autism	37	3	198	53	180	26	97	22	512	104

Other (undefined)	137	115	185	121	94	86	37	50	453	372
Total (With Disability)	458	307	1123	582	771	413	480	227	2832	1529

- Based on information obtained from SOSCARE, there are 4,361 children registered with a disability in NI at March 2013 (children on caseload of Children's Disability Teams)
- Of the 4,361 children with a disability, 2,832 were males (65%) and 1,529 were females (35%)
- Most children had a Learning Disability (47%), followed by the 'other' category which includes Chronic Illness
- Most children with a disability were aged 5-11 (39%), followed by 27% aged 12-15 years

Table 18: All usual residents with deafness or partial hearing loss and blindness or partial sight loss in NI and by HSC Trust



All usual residents with 'deafness or partial hearing loss' and 'blindness or partial sight loss'	Northern Ireland	SHSCT	NHSCT	BHSCT	WHSCT	SEHSCT
All ages	11,206	2,587	2,730	2,226	2,004	1,659
Aged 0 to 19	244	51	54	42	49	48
Aged 20 to 39	384	76	87	67	76	78
Aged 40 to 59	1,264	243	266	243	255	257
Aged 60 to 79	3,799	824	942	706	707	620
Aged 80 plus	5,515	1,393	1,381	1,168	917	656

Within the population there are a number of people who have dual sensory loss, also known as Deafblind, and the above table gives the breakdown by age and Trust area.

The majority of the 244 figure quoted above will be in some form of education therefore other government departments will be responsible for interpreting services within education.

The service, therefore, must be sensitive to the needs of those with dual sensory loss.

Table 19: Long Term Condition

The information below is abstracted from the 2011 Census and details the long term condition by age and sex.

	All usual residents	Aged 0 to 4	Aged 5 to 7	Aged 8 to 9	Aged 10 to 14	Aged 15	Aged 16 to 17	Aged 18 to 19	Aged 20 to 24	Aged 25 to 29
All usual residents	**1,810,863**	**124,382**	**67,662**	**43,625**	**119,034**	**24,620**	**51,440**	**50,181**	**126,013**	**124,099**
Deafness or partial hearing loss	**93,091**	501	447	253	775	128	319	360	1,069	1,265
Blindness or partial sight loss	**30,862**	261	278	158	471	99	214	227	638	602
Communication difficulty	**29,871**	1,564	1,500	894	2,079	335	696	666	1,464	1,178
A mobility or dexterity difficulty	**207,173**	1,121	910	633	1,766	343	767	821	2,656	3,233
A learning, intellectual, social or behavioural difficulty	**40,177**	1,663	2,690	2,300	6,640	1,170	2,223	1,951	3,489	2,363
An emotional, psychological or mental health condition	**105,528**	226	267	190	878	257	699	1,149	4,613	6,172
Long-term pain or discomfort	**182,820**	333	262	192	694	203	488	620	2,462	3,683
Shortness of breath or difficulty breathing	**157,890**	4,452	4,622	3,160	9,359	1,826	3,587	3,202	7,248	6,403
Frequent periods of confusion or memory loss	**35,616**	57	64	66	191	53	101	146	481	558
A chronic illness	**118,554**	635	495	349	1,289	299	678	704	1,977	2,234
Other condition	**94,617**	2,237	1,603	1,125	3,252	651	1,325	1,215	3,112	3,279
No condition	**1,241,785**	115,163	58,458	37,051	99,439	20,673	43,448	42,282	105,675	103,048
Males	**887,323**	**63,526**	**34,803**	**22,306**	**61,032**	**12,725**	**26,284**	**25,592**	**63,913**	**60,795**
Deafness or partial hearing loss	**50,901**	291	256	130	420	61	181	184	572	710
Blindness or partial sight loss	**14,273**	142	156	81	270	54	125	134	335	337
Communication difficulty	**17,482**	1,120	1,095	619	1,501	251	495	451	944	773
A mobility or dexterity difficulty	**88,175**	616	557	358	1,036	189	403	423	1,346	1,619
A learning, intellectual, social or behavioural difficulty	**26,536**	1,176	1,980	1,682	4,824	864	1,589	1,341	2,231	1,525
An emotional, psychological or mental health condition	**43,708**	133	181	138	576	138	344	509	1,894	2,457
Long-term pain or discomfort	**76,791**	167	144	109	354	88	222	263	1,115	1,662
Shortness of breath or difficulty breathing	**74,684**	2,702	2,783	1,876	5,466	1,029	1,964	1,641	3,480	2,973
Frequent periods of confusion or memory loss	**15,721**	26	40	43	126	29	59	86	308	357
A chronic illness	**63,790**	356	291	196	656	155	345	367	969	1,113
Other condition	**42,955**	1,203	915	683	1,851	341	699	615	1,513	1,475
No condition	**614,050**	58,016	29,016	18,181	49,094	10,403	21,779	21,401	53,813	50,884
Females	**923,540**	**60,856**	**32,859**	**21,319**	**58,002**	**11,895**	**25,156**	**24,589**	**62,100**	**63,304**
Deafness or partial hearing loss	**42,190**	210	191	123	355	67	138	176	497	555
Blindness or partial sight loss	**16,589**	119	122	77	201	45	89	93	303	265
Communication difficulty	**12,389**	444	405	275	578	84	201	215	520	405
A mobility or dexterity difficulty	**118,998**	505	353	275	730	154	364	398	1,310	1,614
A learning, intellectual, social or behavioural difficulty	**13,641**	487	710	618	1,816	306	634	610	1,258	838
An emotional, psychological or mental health condition	**61,820**	93	86	52	302	119	355	640	2,719	3,715
Long-term pain or discomfort	**106,029**	166	118	83	340	115	266	357	1,347	2,021
Shortness of breath or difficulty breathing	**83,206**	1,750	1,839	1,284	3,893	797	1,623	1,561	3,768	3,430
Frequent periods of confusion or memory loss	**19,895**	31	24	23	65	24	42	60	173	201
A chronic illness	**54,764**	279	204	153	633	144	333	337	1,008	1,121
Other condition	**51,662**	1,034	688	442	1,401	310	626	600	1,599	1,804
No condition	**627,735**	57,147	29,442	18,870	50,345	10,270	21,669	20,881	51,862	52,164

	Aged 30 to 34	Aged 35 to 39	Aged 40 to 44	Aged 45 to 49	Aged 50 to 54	Aged 55 to 59	Aged 60 to 64	Aged 65 to 69	Aged 70 to 74	Aged 75 to 79	Aged 80 to 84	Aged 85 to 89	Aged 90 and over
All usual residents	**119,839**	**122,260**	**131,848**	**131,645**	**116,933**	**99,272**	**94,290**	**82,121**	**63,479**	**50,358**	**36,366**	**21,165**	**10,231**
Deafness or partial hearing loss	1,467	1,985	3,252	4,920	5,886	6,422	8,538	10,109	10,392	11,013	10,729	8,173	5,088
Blindness or partial sight loss	636	862	1,103	1,509	1,658	1,776	2,107	2,413	2,630	3,297	3,873	3,510	2,540
Communication difficulty	1,150	1,407	1,614	1,867	1,718	1,511	1,455	1,323	1,308	1,589	1,781	1,617	1,155
A mobility or dexterity difficulty	4,219	6,563	10,376	13,649	16,677	18,478	22,349	23,010	21,152	20,195	18,149	12,755	7,351
A learning, intellectual, social or behavioural difficulty	2,005	1,938	2,123	2,186	1,858	1,437	1,194	856	654	492	438	310	197
An emotional, psychological or mental health condition	7,470	9,818	12,351	13,804	12,895	10,883	8,821	5,657	3,242	2,353	1,847	1,234	702
Long-term pain or discomfort	5,034	7,800	12,031	15,625	18,338	19,437	21,744	20,750	16,989	14,432	11,331	6,894	3,478
Shortness of breath or difficulty breathing	6,232	7,042	8,424	9,627	10,410	10,764	12,897	13,315	11,710	10,011	7,526	4,255	1,818
Frequent periods of confusion or memory loss	745	1,207	1,800	2,315	2,614	2,482	2,459	2,489	2,609	3,635	4,475	4,219	2,850
A chronic illness	2,464	3,415	4,899	7,083	9,153	11,088	14,328	15,907	14,243	12,385	8,645	4,507	1,777
Other condition	4,020	5,230	6,994	8,444	8,815	8,618	8,927	7,817	6,019	4,999	3,673	2,210	1,052
No condition	96,550	93,170	94,565	87,894	71,024	53,508	43,590	32,865	21,095	12,872	6,422	2,388	605
Males	**58,210**	**60,160**	**64,530**	**64,967**	**57,860**	**49,802**	**46,180**	**39,603**	**29,473**	**21,918**	**14,033**	**6,985**	**2,626**
Deafness or partial hearing loss	787	1,132	1,986	3,211	3,861	4,221	5,345	6,345	6,112	5,819	4,879	3,034	1,364
Blindness or partial sight loss	378	527	626	898	983	1,059	1,201	1,230	1,239	1,392	1,394	1,149	563
Communication difficulty	720	866	1,016	1,126	1,002	913	899	793	708	738	700	530	222
A mobility or dexterity difficulty	1,977	3,092	4,792	6,240	7,552	8,507	10,355	10,485	9,098	7,934	6,257	3,668	1,671
A learning, intellectual, social or behavioural difficulty	1,268	1,221	1,362	1,382	1,124	887	726	471	351	224	169	95	44
An emotional, psychological or mental health condition	2,848	3,789	4,892	5,704	5,531	4,791	4,181	2,500	1,322	799	574	286	121
Long-term pain or discomfort	2,207	3,595	5,371	6,963	8,273	8,981	9,934	9,062	6,854	5,309	3,549	1,841	728
Shortness of breath or difficulty breathing	2,933	3,253	3,741	4,187	4,616	4,965	6,025	6,301	5,373	4,348	3,013	1,470	545
Frequent periods of confusion or memory loss	460	683	1,026	1,200	1,416	1,347	1,316	1,293	1,192	1,453	1,560	1,173	528
A chronic illness	1,177	1,749	2,536	3,826	5,112	6,518	8,379	9,264	7,907	6,462	4,051	1,826	535
Other condition	1,720	2,377	3,111	3,841	4,010	4,090	4,222	3,563	2,574	1,993	1,253	641	265
No condition	47,494	46,502	46,913	43,881	35,340	26,745	20,675	15,157	9,407	5,610	2,583	909	247
Females	**61,629**	**62,100**	**67,318**	**66,678**	**59,073**	**49,470**	**48,110**	**42,518**	**34,006**	**28,440**	**22,333**	**14,180**	**7,605**
Deafness or partial hearing loss	680	853	1,266	1,709	2,025	2,201	3,193	3,764	4,280	5,194	5,850	5,139	3,724
Blindness or partial sight loss	258	335	477	611	675	717	906	1,183	1,391	1,905	2,479	2,361	1,977
Communication difficulty	430	541	598	741	716	598	556	530	600	851	1,081	1,087	933
A mobility or dexterity difficulty	2,242	3,471	5,584	7,409	9,125	9,971	11,994	12,525	12,054	12,261	11,892	9,087	5,680
A learning, intellectual, social or behavioural difficulty	737	717	761	804	734	550	468	385	303	268	269	215	153
An emotional, psychological or mental health condition	4,622	6,029	7,459	8,100	7,364	6,092	4,640	3,157	1,920	1,554	1,273	948	581
Long-term pain or discomfort	2,827	4,205	6,660	8,662	10,065	10,456	11,810	11,688	10,135	9,123	7,782	5,053	2,750
Shortness of breath or difficulty breathing	3,299	3,789	4,683	5,440	5,794	5,799	6,872	7,014	6,337	5,663	4,513	2,785	1,273
Frequent periods of confusion or memory loss	285	524	774	1,115	1,198	1,135	1,143	1,196	1,417	2,182	2,915	3,046	2,322
A chronic illness	1,287	1,666	2,363	3,257	4,041	4,570	5,949	6,643	6,336	5,923	4,594	2,681	1,242
Other condition	2,300	2,853	3,883	4,603	4,805	4,528	4,705	4,254	3,445	3,006	2,420	1,569	787
No condition	49,056	46,668	47,652	44,013	35,684	26,763	22,915	17,708	11,688	7,262	3,839	1,479	358

Of the total people with deafness or partial hearing loss (93,091), 55,504 (59.6%) are aged 65+ and 35,164 (37.8%) are aged 18 to 64. Given this demographic information the health and social care needs of people who are deaf or partial hearing loss will be diverse and multi-faceted, therefore, interpreters should be competent to work in the area of health and social care across the sectors of health and social care provision i.e. Primary, Social Care/SW and Acute Care.

People in Northern Ireland with Deafness or partial hearing loss	93,091
People in Northern Ireland with Communication Difficulties	29,871

(Source: NISRA 2011)

The proposed recommendation within the review will deliver a consistent and professional service which will provide positive outcomes for service users with a disability. There is therefore a positive impact for people with a disability.

4. Good Relations

Service provision must take into account the requirements of both British Sign Language and Irish Sign Language users. Attention must also be paid to the demographic spread of British Sign Language and Irish Sign Language users.

During the scoping it was unclear whether or not there would be any likely impacts on service users who use the different sign languages i.e. Irish Sign Language or British Sign Language given the assumption that there is a perceived association of each language with one of the two main religions and political opinions.

It is therefore considered appropriate to explore this issue further during the consultation phase of the EQIA to better understand likely impacts in terms of both equality and good relations.

5. Disability Duties

Through the development of the Communication Support Services Review we have consistently considered our obligations under the Disability Discrimination Act 1995, Disability Discrimination Order 2006 and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). We have engaged with organisations representing disabled people and disabled people directly through the review and drafting of the draft Equality Impact Assessment. We will undertake targeted engagement with disabled people and representative organisations during the 12 week formal consultation phase to produce the final EQIA and inform the outcome of the review.

<u>United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)</u>

The development of the Communication Support Services Review contributes to meeting the HSCB's obligations under the UNCRPD, namely:

Article 9 Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;

b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures:

a) To develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;

c) To provide training for stakeholders on accessibility issues facing persons with disabilities;

e) To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;

Article 21 Freedom of expression and opinion, and access to information

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

(a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost

Article 22 Respect for Privacy

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

Article 25 Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(*d*) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.

Article 26 Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(*b*) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Article 31 Statistics and Data Collection

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:

a) Comply with legally established safeguards, including legation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;

b) Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.

3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

Disability Discrimination Order 2006

The implementation and out workings of Communication Support Services Review can contribute to the two duties of the HSCB of the Disability Discrimination Order 2006.

1. Encouraging disabled people to participate in public life

Detailed engagement with disabled people and charities has already been undertaken. The preferred option is seeking to enhance the ability of disabled people to get involved in public life by providing interpreters across HSC generally.

2. Promoting positive attitudes towards disabled people

The HSCB acknowledges the importance of promoting positive attitudes towards disabled people.

To that end, the HSCB will continue to work alongside Trust Equality and Personal and Public Involvement leads, Carers, Service Users and disabled people to promote positive attitudes towards disabled people through GP guidelines for accessible GP services, placement scheme within HSCB for persons with a disability and service user involvement at all stages of the implementation of Physical and Sensory Disability Plan.

Accessible Communications Activities

The HSCB has produced an Accessible Communications Policy and all documents must comply with the guidelines herein.

A multiagency working party has been created to develop and implement a web based portal which would store all relevant accessible communications guidance and initiatives. This portal is intended to be accessible to relevant partners and staff of this initiative i.e. HSCB, BSO, PHA, Trusts and Voluntaries.

A ‘Level 1’ E-Learning awareness raising programme for hearing and sight loss has been developed in partnership with Voluntary and Statutory partners and funded by the HSCB; and is in the process of implementation.

HSCB has participated in and funded the Trusts ‘Making Communications Accessible Guide 2015’. This will be made available electronically and in hard copy.

HSCB has funded and procured a regional advocacy service for people who are deaf from British Deaf Association.

6. Human Rights

The relevant articles under the Human Rights Act are Article 6 – Right to a fair trial, Article 8 – Right to respect for private & family life, home and correspondence and Article 10 – Freedom of Expression.

By having a fully accessible Communication Support Service, service users will be empowered to understand their rights to services including eligibility criteria, charging policies, appeals processes which is an enhancement and protection of Article 6 rights.

A key objective of this review is to procure a regional service which is fully accessible and enables service users of all ages to access Health and Social Care services. This would negate the need for service users to rely on other family members and friends to interpret for them especially in regard to sensitive and complex matters thus protecting the right to private life.

As stated above service users will be empowered to communicate accurately and effectively with professionals across the Health and Social Care service which ensures freedom of expression.

Throughout the design, conduct and write up of the review, consideration was given to equality and human rights.

HSCB entered into a piece of collaborative work with the Northern Ireland Human Rights Commission to develop a customised training package for staff regarding commissioning and to develop a Human Rights Screening Tool for commissioning. This has been delivered to a pilot group of staff within the RSIG and the screening tool has been utilised as part of this EQIA.

7. Conclusions

Summary and Assessment of Key Findings

Based on all the available material and data collected and reviewed in this draft EQIA the key conclusion is that the Deaf Community in Northern Ireland has been subject to Trust variability as regards what access they can have to communication support and that regionalising this into a new consistent and efficient service is the best way to address this and offer a consistent, professional standardised of service.

The proposed service would offer both Irish Sign Language and British Sign Language equitably which would overcome any perceived inequality based on perceived religious and political affiliation.

The intention of exploring and utilising remote interpreting will be one element of the new service to address value for money, access and equity and may address access issues for older people and also for carers who are older.

There was no evidence of any differential impact for three of the Section 75 groups, namely marital status, dependant status and sexual orientation.

There was evidence of positive impacts for two of the Section 75 groups, namely age, specifically older people, and disability, through provision of a consistent, professional service.

There was evidence of a potential differential impact on the grounds of gender. More females than males use the service and whilst there are more female interpreters than males, the small number of interpreters generally across NI may make it difficult to offer a gender specific interpreter should this be required. The EQIA proposes a range of actions to mitigate this and it will be explored further during the consultation.

Finally, for three of the Section 75 groups, namely, religion, political opinion and ethnicity, there is not enough data or knowledge at this stage to know if there are differential impacts. Obtaining this information will form part of the consultation phase.

Proposed Action

A revised Regional Communication Support service will involve a significant cultural shift in how the HSCB and Health and Social Care Trusts currently ensure accessible health & social care. This transformation will involve a partnership approach between individuals, professionals and across all sectors to provide a broader understanding of what Communication Support is and how to avail of it. This will require consideration of how we communicate and engage with staff and the public. Moreover, staff training and monitoring the implementation will be essential to ensuring Communication Support is a success.

Proposed Actions

Gender	Action
A limited number of interpreters means it may be difficult to provide gender specific interpreter on request.	Outside of normal booking procedures, a gender specific interpreter will be considered if required to meet a patient's needs, on request. The Commissioning Body and the Business Services Organisation will endeavour to meet the need for interpreters in HSC, identifying and encouraging a gender balance as appropriate The gender of service users will be monitored

	Service users request for a gender specific interpreter will be monitored alongside the HSC service it has been requested for.

Religion/Political Opinion	**Action**
Due to limited availability of data, unsure of any likely impacts (particularly around the border areas of NI) – association of each language with one of the two main religions/political opinions is assumed	Issues of Irish Sign Language /British Sign Language service use preference will be explored on the grounds of political opinion/religion, with a view to ensuring that provision levels for each language can meet demand Monitoring of use of Irish Sign Language and British Sign Language will be undertaken
Ethnicity	**Action**
There is no known information available at present as to the current usage of communication support services across the region for people from minority ethnic backgrounds.	A regional communication support service will be able to better monitor usage and identify the demographic usage of the service. Any underrepresentation can subsequently be addressed. A regional advisory group be established which would have relevant stakeholders.

Proposed Monitoring

Monitoring

The governance arrangements for the regional communication support service are set within the context of the overall Transforming Your Care Programme governance arrangements.

It is proposed that the regional shared/managed service provided by the HSC Business Services Organisation would work closely with the Trusts to ensure consistency of data gathering and monitoring, including Section 75 data.

They will be tasked with implementing and monitoring the agreed actions following the closure of the EQIA.

It is further proposed that, as for the existing Regional Language and Interpreting Service, a regional advisory group be established which would:

- Be chaired by the provider organisation (HSC Business Services Organisation), with accountability to the Commissioner;
- Include Public Health Agency representation to advise on public health considerations for deaf people;
- Include a representative of the Regional Interpreting Service;
- Include Trust representation through the Equality Leads and other staff such as Sensory Rehabilitation, Audiology, Emergency Departments, Regional Emergency Social Work Service;
- Include representation from Integrated Care Directorate regarding General Medical Practice needs in and out of hours provision;
- Include Independent Contractor representation;

- Include Service User representatives, including Irish Sign Language and British Sign Language Service users, British Deaf Association, Action on Hearing Loss, SENSE;

- Include representatives from the Deaf community;

- Include a Risk and Governance representative to account for the legal and governance requirements of the health and social care family towards deaf people.

Appendix 1 – The Steps of an EQIA

What is an Equality Impact Assessment? (EQIA)

An EQIA is “a thorough and systematic analysis of a policy, whether the policy is written or unwritten, formal or informal, and irrespective of the scope of the policy or the size of the public authority.”

The Steps of an EQIA

What is it we are actually looking at? (‘Aims of Policy’)

The first part of an EQIA involves thoroughly understanding the policy to be assessed; what context it is set in; who is responsible for what; what links there are with other organisations or individuals in implementing the policy etc.

How can we tell what is happening on the ground? (‘Consideration of Data’)

This involves reviewing what data is available in-house or elsewhere and identifying what data needs to be newly collected. ‘Data’ means statistics and the views, experiences and suggestions of those affected by the policy. ‘Collecting new data’ means going out and doing a survey and also talking to people who are affected by a policy or those who are involved in implementing the policy, for example in delivering a service.

So are there any problems for any of the groups? (‘Assessment of Impacts’)

All relevant data that has been identified (whether collected from available sources or newly gathered) is brought together and analysed. Conclusions are drawn as to the impact of the policy on the nine groups.

What can be done to make things fairer? (‘Consideration of Measures’)

Now the findings are related back to action: proposals are what can be done to address any inequalities/ unfairness that the analysis of the data has revealed.

Are we getting the right picture and are we thinking of doing the right thing? (‘Formal Consultation’)

The findings and the proposed actions are brought back to the public at this stage, usually on the basis of a draft report. Now it's time to find out what people think about the analysis and proposals!

With what people have told us – what are we going to do? ('Decision by Public Authority')

After the wider public has had a chance to comment on the analysis and proposals it's time for the organisation to take final decisions and commit themselves to action points.

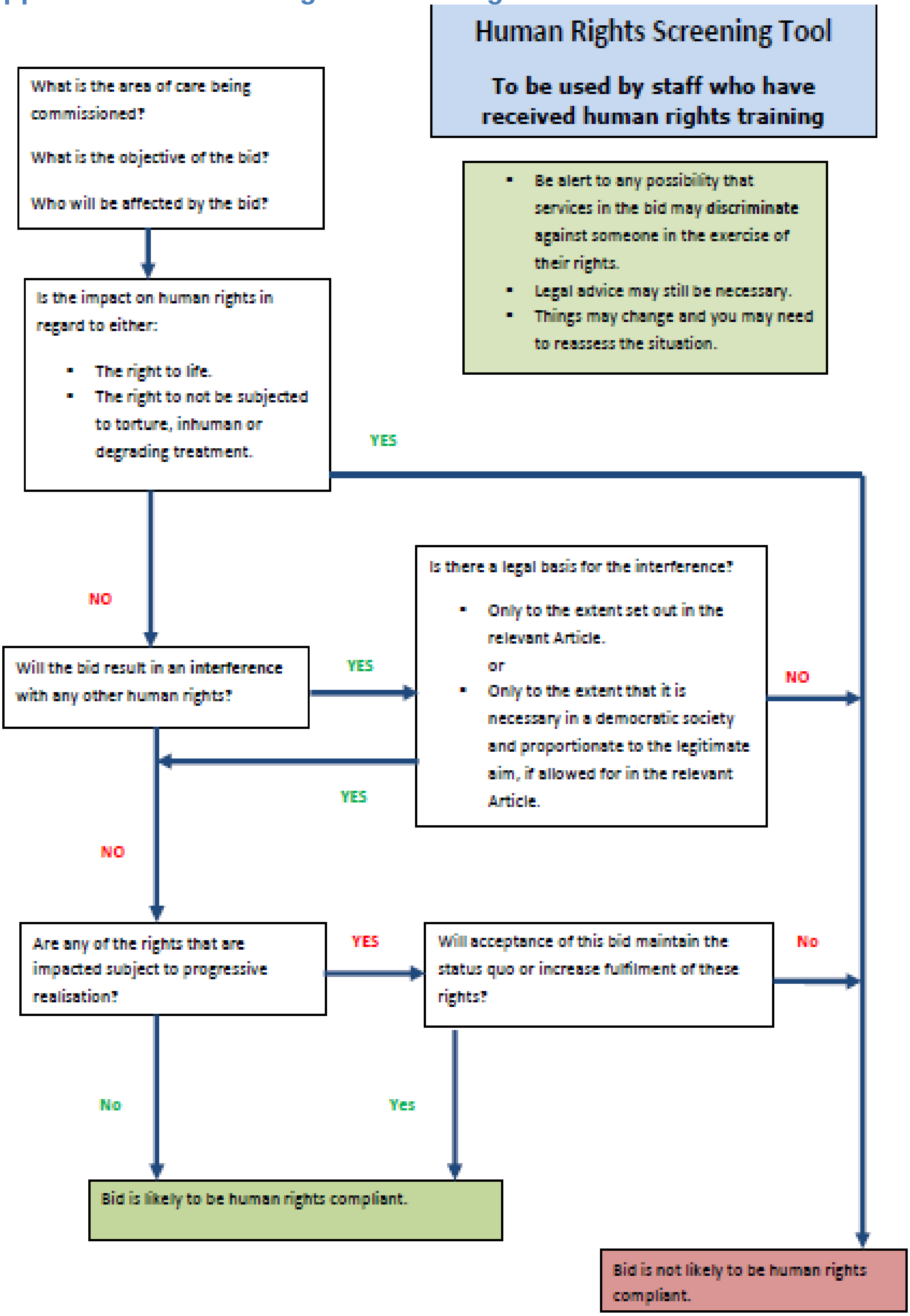
This is what we have found out and this is what we will do ('Publication of Results of EQIA')

These decisions and commitments are published in a final report alongside the findings from the analysis of collected data and the comments raised by the wider public during formal consultation.

Keeping a close eye on what is happening ('Monitoring of Adverse Impacts')

An EQIA is not a one off. It's important to keep a close eye on what difference the changes to the policy actually make.

Appendix 2 – Human Rights Screening Tool



Human Rights Screening Tool

To be used by staff who have received human rights training

- Be alert to any possibility that services in the bid may discriminate against someone in the exercise of their rights.
- Legal advice may still be necessary.
- Things may change and you may need to reassess the situation.

What is the area of care being commissioned?

What is the objective of the bid?

Who will be affected by the bid?

Is the impact on human rights in regard to either:

- The right to life.
- The right to not be subjected to torture, inhuman or degrading treatment.

Will the bid result in an interference with any other human rights?

Is there a legal basis for the interference?

- Only to the extent set out in the relevant Article.

or

- Only to the extent that it is necessary in a democratic society and proportionate to the legitimate aim, if allowed for in the relevant Article.

Are any of the rights that are impacted subject to progressive realisation?

Will acceptance of this bid maintain the status quo or increase fulfilment of these rights?

Bid is likely to be human rights compliant.

Bid is not likely to be human rights compliant.

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All Ireland Traveller Health Survey: https://www.ucd.ie/t4cms/AITHS_SUMMARY.pdf

Electoral Commission Data: http://www.electoralcommission.org.uk/__data/assets/pdf_file/0012/141222/NIA-election-report-final-web-no-embargo.pdf

NI Life and Times Survey: http://www.ark.ac.uk/nilt/2010/