Health and Social Care Board

# Equality, Good Relations and Human Rights SCREENING

The Health and Social Care Board is required to consider the likely equality implications of any policies or decisions. In particular it is asked to consider:

1) What is the likely impact on equality of opportunity for those affected by this policy, for each of the section 75 equality categories? (minor, major or none)

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

3) To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor, major or none)

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

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

**For information (evidence, data, research etc) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website**:
http://www.hscbusiness.hscni.net/services/1798.htm

Health and Social Care Board

# Equality, Good Relations and Human Rights
# SCREENING TEMPLATE

## (1) INFORMATION ABOUT THE POLICY OR DECISION

### 1.1 Title of policy or decision

Updated formula for Mental Health Programme of Care to be incorporated into the Regional Capitation Formula

### 1.2 Description of policy or decision

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

The capitation formula is produced by the Capitation Formula Review Group (CFRG) and is used to determine each Local Commissioning Group (LCG) share of available resources based on its population size, age/gender mix and the additional need profile of the population.

The current formula is based on a programme of care (PoC) approach. There are 9 PoCs, each with an associated formula, most comprising of 3 elements:

- Relevant population – the client group on which the PoC is based
- Age/ Gender weighting – compensation for the differing need for health and social care based on the age/gender structure of a population
- Additional needs weighting – differential needs for services, likely to be due to socio-economic factors e.g. depreciation. The relevant factors are chosen for each PoC.

The PoC formulae are consolidated to produce fair shares at LCG level. Two cost adjustments are then made to compensate LCGs for differing costs of provision of service to their populations – rurality (additional cost of delivering services in rural areas) and economies of scale (differing infrastructures).

The resulting formula establishes the fair share of available resources that each LCG should receive based on their relative, not absolute, need.

A decision was taken by the Capitation Formula Review Group (CFRG) to carry out a full review of the Mental Health formula and carry out any necessary update.

The Mental Health PoC formula considers all Personal social and Community and Personal Social Services where the primary reason for the service is due to Mental illness, as well as activity relating to a hospital inpatient episode where the Consultant is a specialist in one of the following areas:

- Mental Illness
- Child & Adolescent psychiatry
- Forensic psychiatry
- Psychotherapy

The current formula uses information taken from the 1991 population census. The utilisation data dates back to 1997/98 and was provided by Trusts in the former Eastern, Northern and Western Board areas, none was available from the Southern area.

Whilst the focus of the review is the Mental Health formula, consideration must be taken that this is only one element of the capitation formula used in the allocation of resources across localities.

- **how will this be achieved? (key elements)**

### Summary Methodology

Hospital, Community & Personal Social Services Mental Health activity data was collected across Northern Ireland at patient level and a cost attached (assume use of service reflects need).

This costed data is then mapped across Northern Ireland at Super Output Area (SOA) level. There are 890 SOAs across Northern Ireland; each SOA has approximately the same number of people (2,000).

The statistical model marries up the costed activity data with population characteristics and choses those which best explain the observed variation at SOA.

A number of statistical modelling approaches were trialled and a two stage additive modelling approach was chosen and the models developed.

Stage 1 – develop a standardised dependent variable (based upon the ratio of the observed and expected level of need. Where the expected level is determined for the SOA population based on a national level age cost curve)

Stage 2 – Computation of additional needs variable for each SOA (developed using the dependent variable from stage 1 as the regress and in statistical modelling)

- **What are the main constraints?**

The main constraints to achieving the objective of are:

- The availability of accurate and timely activity data has been the main limiting factor in this exercise. As the securing of activity data has been difficult, this exercise has taken longer than expected. These extensive data collection exercises are the main factor which limits and slows the development of the allocation formulae.

## 1.3 Main stakeholders affected (internal and external)

Local Commissioning Groups

HSC Trusts

Current and future service users who will benefit from new resources being better targeted to areas of higher needs.

## (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.**

A detailed data collection exercise was carried out across the Health & Social Care Trusts covering 2012/13 activity. Hospital, Community & Personal Social Services activity data was gathered, where available, at patient level. A cost was applied to the activity data and then mapped to Super Output areas across NI reflecting the level of spend on Mental Health attributable to that area.

A meeting was set up with the Bamford Mental Health and Learning Disability Service Team to have user involvement early in the process. Aidan Murray, Assistant Director of Mental Health and Learning Disability and Adrian Walsh, Head Accountant, HSCB, were co-opted onto a Capitation Formula Technical group to provide oversight guidance of the formula development.

The Bamford group suggested a list of potential variables explaining the need for Mental Health services and a model option was developed on this basis.

The final preferred model option was shared with service users from the Bamford group who approved of both the methodology in the formula and the resultant needs variables.

Collaborative peer review of model development took place with University of Manchester

Population estimates and potential needs variable data were collected from the 2011 census in order to develop the models.

Equality Commission NI, 2006

http://www.carersuk.org/northernireland/news-ni/facts-and-figures

http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health.htm - Health Survey NI 2012-13

Electoral Office NI, 2011

Northern Ireland Statistics and Research Agency (NISRA) 2007

## 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.**

This new model will be used to allocate resources to the entire Northern Ireland population. Thus the affected group is equal to that of the current census (Census 2011).

<table>
<tr><th>Category</th><th>What is the makeup of the affected group? ( %) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</th></tr>
<tr><td>Gender</td><td>The population of Northern Ireland on Census Day 2011 was 1,810,900 of which there were 887,300 (49%) Males and 923,500 (51%) Females.<br><br>The new age cost curve for this model shows that there is slightly less service use in the female population compared to the males. However this in line with the expectations of the professionals on the technical working group who input to the model development.<br><br>Compared to the old Mental Health model where males had an average age gender index 1.4% above the average, the age gender index for males is now 9.2% above the Northern average. This change is mirrored in the average female index. The formula therefore skews more resources to the male population.<br><br>This change is in line with observed research and the expectations of the Mental Health professionals involved in the development of this model.<br><br>The Deloitte method for the investigation of unmet need or lower uptake in each of the SOA geographies was carried out; this did not identify areas for concern.</td></tr>
<tr><td>Age</td><td>The population of Northern Ireland on Census Day 2011 was made up as shown in Table 1 below.<br><br>Table 1 Age Breakdown of 2011 Census population<br><br>
<table>
<tr><td>Children (under 16)</td><td>379,300</td><td>21%</td></tr>
<tr><td>Working age (16-64)</td><td>1,043,600</td><td>65%</td></tr>
<tr><td>65-84</td><td>233,997</td><td>13%</td></tr>
</table>
</td></tr>
</table>

| | | | |
|---|---|---|---|
| | 85+ | 31,765 | 1.7% |

**Religion**

The population of Northern Ireland on Census Day 2011 was made up as shown overleaf

**Table 2 Census of population by religion**

| Proportion | Religious Background |
|---|---|
| 41.6% | Catholic background |
| 40.8% | Protestant and other Christian background |
| 17.6% | other religions, no religion or religion not stated |

**Political Opinion**

Population data

First preference votes per party in NI Assembly Elections 2011:

| | |
|---|---|
| DUP | 198, 436 |
| Sinn Fein | 178,222 |
| UUP | 87,531 |
| SDLP | 94,286 |
| Alliance | 50,875 |
| Other | 52,384 |

(Electoral Office NI, 2011)

**Marital Status**

Population data

| | |
|---|---|
| Married | 47.56% |
| Single never married | 36.14% |
| Separated | 3.98% |
| Divorced | 5.45% |
| Same Sex Civil Partnership | 0.09% |
| Widowed or Surviving partner from SSCP | 6.78 % |

<table>
<tr><td></td><td>(2011 Census)</td></tr>
<tr><td>Dependent Status</td><td><u>Population data</u><br><br>In Northern Ireland there are approximately 92,000 lone parents with 150,000 children. 25% of all children are from one parent families, separated or divorced.<br><br>Based on information from Carers Northern Ireland, the following facts relate to carers:<br><br>• 1 in every 8 adults is a carer<br>• There are approximately 214,000 carers in Northern Ireland<br>• Any one person has a 6.6% chance of becoming a carer in any year<br>• One quarter of all carers (26%) provide over 50 hours of care per week<br>• People providing high levels of care are twice as likely to be permanently sick or disabled than the average person<br>• Approximately 30,000 people in Northern Ireland care for more than one person<br>• 64% of carers are women; 36% are men<br><br>(http://www.carersuk.org/northernireland/news-ni/facts-and-figures)<br><br>Almost a quarter of those in the 45-54 age-group (23%) had caring responsibilities compared with 7% of those aged 16-24.<br><br>Three-quarters of those aged 75 and over (74%) cared for someone for more than 20 hours per week compared with a quarter of those aged 16-24 (24%).<br><br><u>http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health.htm</u> - <u>Health Survey NI 2012-13(MS Word 1.1MB)</u></td></tr>
<tr><td>Disability</td><td>A breakdown of the long term health problems reported in the 2011 census is included below.<br><table><tr><th></th><th>All usual residents</th><th>Proportion of Population</th></tr><tr><td>All usual residents</td><td>1,810,863</td><td>100%</td></tr><tr><td>Deafness or partial hearing loss</td><td>93,091</td><td>5%</td></tr><tr><td>Blindness or partial sight loss</td><td>30,862</td><td>2%</td></tr><tr><td>Communication difficulty</td><td>29,871</td><td>2%</td></tr><tr><td>A mobility or dexterity difficulty</td><td>207,173</td><td>11%</td></tr></table></td></tr>
</table>

| | | | |
|---|---|---|---|
| A learning, intellectual, social or behavioural difficulty | **40,177** | **2%** |
| An emotional, psychological or Mental Health condition | **105,528** | **6%** |
| Long-term pain or discomfort | **182,820** | **10%** |
| Shortness of breath or difficulty breathing | **157,890** | **9%** |
| Frequent periods of confusion or memory loss | **35,616** | **2%** |
| A chronic illness | **118,554** | **7%** |
| Other condition | **94,617** | **5%** |
| No condition | **1,241,785** | **69%** |

Taken from census table DC3101NI: TYPE OF LONG-TERM CONDITION BY AGE BY SEX

**Ethnicity**

<u>Population data</u>

This formula is applied to the entire population, the ethnic construction of which is shown below. No variables specific to ethnic groups were identified in the preferred option.

- Traveller population in N Ireland is estimated at 1301
- Non-White ethnic groups (Asian, Black, Mixed, Other) estimated at: 31113.
- The number of births to mothers outside the UK and Ireland have increased over the past decade with 2347 births in 2008 compared with 661 in 2001 (9% of all registered births)

(2011 Census data)

Statistics from the HSC Interpreting Service showed a significant rise in requests for interpreters from 1,850 in 2004-2005 to 63,868 requests in 2011-2012 as indicated

| | | | |
|---|---|---|---|
| Polish | **21780** | Hungarian | **1453** |
| Lithuanian | **12485** | Arabic | **796** |
| Portuguese | **6357** | Chinese - Hakka | **430** |
| Chinese - Mandarin | **4188** | Bulgarian | **412** |
| Slovak | **3075** | Czech | **305** |
| Chinese - Cantonese | **2817** | Somali | **301** |
| Russian | **2382** | Bengali | **205** |
| Tetum | **2328** | Spanish | **121** |
| Latvian | **2001** | Punjabi | **104** |
| Romanian | **1564** | Farsi | **99** |

**Sexual Orientation**

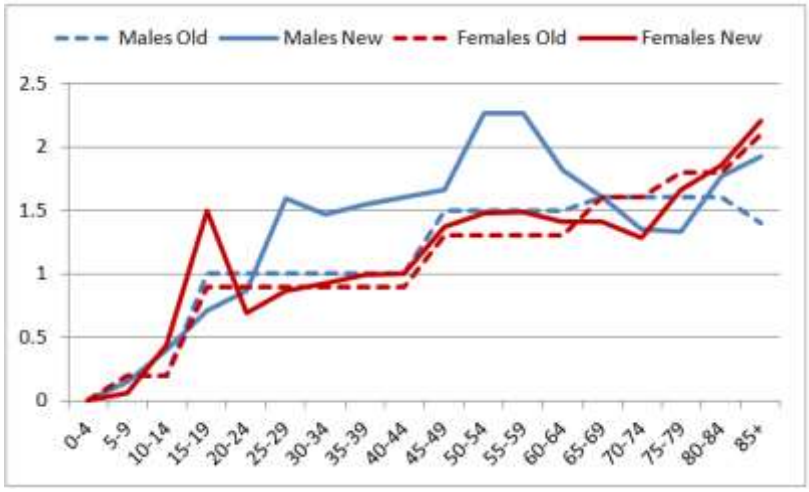
Between 2006 and 2012, there were 715 recorded Civil Partnerships. However, this is not indicative of the LGB population. There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 5% and 10% of the population would identify as lesbian, gay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

| | |
|---|---|
| | |

## 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.**

This model determines the needs for Mental Health services, at SOA across Northern Ireland via statistical modelling. Thus the aim is specifically to update the measure of Mental Health service need to current levels.

| *Category* | *Needs and Experiences* |
|---|---|
| Gender | Generally, males appear to need more resources given by the age gender adjustment where their age gender index was 1.016. With the formula revision this is increased to 1.094. With no change in the needs elements, the combined index has increased similarly from 1.014 to 1.092. |
| Age | The elderly are needier because of their age (1.652) but do not tend to live in areas with higher additional needs (0.965). The revision has tempered this effect with the age effect reduced (1.384) while the needs index increased slightly (0.999) resulting in the combined index reducing from 1.595 to 1.383.<br><br>The new age cost curve shown below highlights that the new trend of observed service use is significantly higher in middle age men compared to the old model. Thus this new model is skewing more resources to this group. Additionally there is also an additional new peak in the 15-19 year old females which was not observed in previous modelling exercises. This too was also expected.<br><br>  <br>**Figure 1 Comparison of the old and new age cost curves** |

<table>
<tr><td></td><td></td></tr>
<tr><td>Religion</td><td>In the 5th review formula the average age-need index for Catholics was 4.4% above the NI average (1.044) while the age-need index for Protestants was 6.5% below the NI average at 0.935. With the move to the new formula this gap is reduced to Catholic being equal to the average 1.0 and Protestants only 1.5% below the average at 0.985.<br><br>Compared to the old model, when the age-needs assessment is carried out considering the religious breakdown of the areas, the average combined age needs index of the areas is closer to average for the Protestant and Catholic areas with the Catholic age needs index reduced from 1.06 to 1.01 and to Protestant index increased from 0.95 to 0.99. For the other religions, which only account for 17.6%, the index has increased from 0.96 to 1.09.</td></tr>
<tr><td>Marital Status</td><td>Divorced/widowed/separated people tended to be older (1.173) and live in areas with greater need (1.059). The formula revision reduces this effect changing the overall index from 1.242 to 1.194.<br><br>When the age needs index for marital status is considered there appears to be a small redistribution of accessed needs in the old model:<br>Old Model<br><table><tr><th>Single (never married)</th><th>Married</th><th>Divorced/Widowed/Separated</th></tr><tr><td>0.920</td><td>0.964</td><td>1.242</td></tr></table><br>While the new model has the indices below<br><table><tr><th>Single (never married)</th><th>Married</th><th>Divorced/Widowed/Separated</th></tr><tr><td>0.908</td><td>0.982</td><td>1.194</td></tr></table>This swing is from the other categories into married though this is still below the average.</td></tr>
<tr><td>Dependent Status</td><td>Those without dependent children have greater index when age and additional need is combined; age-need index 1.050, but this appears to be because they are a little older with an age index of 1.053 and additional need index 0.997. When the formula is revised this difference is reduced slightly and results in a combined age needs index of 1.038</td></tr>
<tr><td>Disability</td><td>This formula is specifically concerned with Mental Health needs and as such people with this type of disability will benefit from the improved distribution of resources.<br>Considering specifically those with limiting long-term illness (LLTI) under the old formula they were given a higher age index (1.375) than those without an LLTI and lived in areas with greater need (additional need index 1.059). This resulted in an age need index of 1.456. With the revision, this has been slightly reduced to a combined age need index of 1.407 due to a small reduction in the age to needs element</td></tr>
</table>

| | |
|---|---|
| Ethnicity | Black and minority ethnic people tend to be younger (0.832) and live in areas with more need (1.057). The age effect is larger than the needs effect. The formula revision slightly improves this position with the overall combined index increasing from 0.880 to 0.956 |
| Sexual Orientation | There are no accurate robust statistics on sexual orientation at SOA level or by age and gender which would enable analysis of this aspect. |
| Political Opinion | There are no accurate robust statistics on political opinion at SOA level or by age and gender which would enable analysis of this aspect. |

## 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.**

| |
|---|
| This formula will positively redistribute available funds to SOAs with residents with higher needs for Mental Health services. |

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

| ***In developing the policy or decision what did you do or change to address the equality issues you identified?*** | ***What do you intend to do in future to address the equality issues you identified?*** |
|---|---|
| (NA) | (NA) |

| | |
|---|---|
| | |

## 2.6 Good Relations

**What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)**

| ***Group*** | ***Impact*** | ***Suggestions*** |
|---|---|---|
| Religion | n/a | n/a |
| Political Opinion | n/a | n/a |
| Ethnicity | n/a | n/a |

## (3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

**How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)**

**Please tick:**

| | |
|---|---|
| Major impact | |
| Minor impact | |
| No further impact | ✔ |

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

**Please tick:**

| | |
|---|---|
| Yes | |
| No | ✔ |

Please give reasons for your decisions.

There could be a redistribution of Mental Health care fair shares from areas previously seen as more needy, to areas currently identified as needy. These revisions are however in line with the Mental Health services utilisation data collected and are thus evidence based. However as the formula is applied at Local Commissioning Group level this impact will be reduced. The impact is further reduced when the Mental Health formula is incorporated into the full CFRG formula.

Thus, it is felt that any impact as a result of the updated identified needs will be relatively small at SOA level and also justified due to the evidence based approach taken in developing this new model.

## (4) CONSIDERATION OF DISABILITY DUTIES

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

| *How does the policy or decision currently encourage disabled people to participate in public life?* | *What else could you do to encourage disabled people to participate in public life?* |
|---|---|
| Engagement has taken place with the Bamford group in the HSCB. This group includes service professionals and users/carers. The group proposed needs variables which could explain the utilisation of mental health services and a model was developed on this basis for consideration.<br><br>The final model option chosen was shared with the group who agreed with the findings | The results of the consultation can be shared with the group. |

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

| *How does the policy or decision currently promote positive attitudes towards disabled people?* | *What else could you do to promote positive attitudes towards disabled people?* |
|---|---|
| n/a | n/a |

## (5) CONSIDERATION OF HUMAN RIGHTS

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

| ARTICLE | Yes/No |
|---|---|
| Article 2 – Right to life | No |
| Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment | No |
| Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour | No |
| Article 5 – Right to liberty & security of person | No |
| Article 6 – Right to a fair & public trial within a reasonable time | No |
| Article 7 – Right to freedom from retrospective criminal law & no punishment without law | No |
| Article 8 – Right to respect for private & family life, home and correspondence. | No |
| Article 9 – Right to freedom of thought, conscience & religion | No |
| Article 10 – Right to freedom of expression | No |
| Article 11 – Right to freedom of assembly & association | No |
| Article 12 – Right to marry & found a family | No |
| Article 14 – Prohibition of discrimination in the enjoyment of the convention rights | No |
| 1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property | No |
| 1st protocol Article 2 – Right of access to education | No |

*If you have answered no to all of the above please move on to **Question 6** on monitoring*

**5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?**

| List the Article Number | Interfered with? Yes/No | What is the interference and who does it impact upon? | Does this raise any legal issues?* Yes/No |
|---|---|---|---|
| n/a | | | |

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

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

| |
|---|
| |

## (6) MONITORING

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

| Equality & Good Relations | Disability Duties | Human Rights |
|---|---|---|
| No impact | No impact | No impact |

Approved Lead Officer: _____

Position: _____

_____

Policy/Decision Screened by:

Signed:
Date: _____

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

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

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

2 Franklin Street; Belfast;
BT2 8DQ;

email: Equality.Unit@hscni.net;

phone: 028 90535531 (for Text Relay prefix with 18001);
fax: 028 9023 2304