Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

Part 1 – Policy scoping

Part 2 – Screening questions

Part 3 – Screening decision

Part 4 – Monitoring

Part 5 – Disability Duties

Part 6 – Human Rights

Part 7 – Approval and Authorisation

Guidance notes are available to assist with completing this template. For further help please contact the Equality and Human Rights Unit ext 20539.

Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

Service Framework for Respiratory Health and Wellbeing

1.1.2 Is this an existing, revised or a new policy / decision?

Revised policy

1.1.3 What is it trying to achieve? (intended aims/outcomes)

The aim of Service Frameworks is to set out the standards of care that patients, clients, their carers and wider family can expect to receive in order to help people to:

- prevent disease or harm;
- manage their own health and wellbeing, including understanding how lifestyle affects health and wellbeing including the causes of ill health and its effective management;
- be aware of what types of treatment and care are available within health and social care; and
- be clear about the standards of treatment and care they can expect to receive.

The aim of this framework is to improve the health and wellbeing of the population of Northern Ireland, reduce inequalities and improve the quality of health and social care in relation to respiratory disease, recognising that achievement of this aim goes beyond traditional HSC boundaries and is strongly influenced by population/individual attitudes and behaviours, and the contribution of other sectors.

The Service Framework for Respiratory Health and Wellbeing sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation and palliative care of individuals/communities who currently have or are at greater risk of developing respiratory disease. Recognising that several diseases can co-exist, share common risk factors and can adversely impact on prognosis, this service framework includes consideration of:

Standards for specific conditions:

- Chronic Obstructive Pulmonary Disease (COPD)
- Oxygen Therapy in COPD
- Asthma in Adults
- Asthma in Children and Young People
- Community Acquired Pneumonia (CAP) in Adults
- Community Acquired Pneumonia (CAP) in Children and Young People
- Obstructive Sleep Apnoea / Hypopnoea Syndrome (OSAHS) in Adults
- Obstructive Sleep Apnoea Syndrome (OSAS) in Children and Young People
- Long Term Ventilation in Adults
- Long Term Ventilation in Children and Young People
- Cystic Fibrosis
- Bronchiectasis
- Interstitial Lung Disease (ILD)

Service Frameworks have a 3 year lifecycle. The Service Framework for Respiratory Health and Wellbeing was originally published in November 2009. This revised Service Framework updates and replaces the original.

1.1.4 If there are any Section 75 categories which might be expected to benefit from the intended policy, please explain how.

1.1.5 Who initiated or wrote the policy?

Initiated by DHSSPS as part of the Service Framework programme. The fundamental review of this Framework has been conducted by the Regional Respiratory Forum, supported by the Long Term Conditions Service Team

1.1.6 Who owns and who implements the policy?

The policy is owned by DHSSPS and is implemented by the HSC Trusts. Monitoring will be undertaken by the HSC Board / PHA.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision? If yes, are they

Financial	X	Please explain: While many of the standards do not require additional resources to implement, for others there may be additional costs. The ability to deliver all of the standards may be affected by the currently challenging financial position.
Legislative		
Other		

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon?

Staff	X
Service users	X
Other public sector organisations	X
Voluntary/community/trade unions	X
Other, please specify	

1.4 Other policies with a bearing on this policy / decision. If any:

Policy	Owner(s) of the policy
Transforming Your Care (In Development) In addition, as appropriate further policies are listed in the Framework Document under the evidence sections	DHSSPS

of each standards.	

1.5 Available evidence

What evidence/information (both qualitative and quantitative*) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

Section 75 category	Details of evidence/information
Religious belief	The religious breakdown recorded in the 2011 Census indicates that:- Catholic 738,033 Presbyterian Church in Ireland 345,101 Church of Ireland 248,821 Methodist Church in Ireland 54,253 Other Christian (including Christian related) 104,380 Other religions 14,859 No religion 183,164 Not stated 122,252 **TOTAL 1,810,863** (NISRA website, Table DC2118NI)
Political opinion	There is limited data available, however, data on the first preference votes per party in NI Assembly Elections 2011, from the Electoral Commission can be used as proxy information: DUP – 198,436 Sinn Fein – 178,222 UUP – 87,531 SDLP – 94,286 Alliance – 50,875

<table>
<tr><td></td><td>Other – 52,384

(Electoral Office NI, 2011)</td></tr>
<tr><td>Racial group</td><td>The 2011 census indicates the following breakdown of ethnic groups:-

<table>
<tr><td>White</td><td></td></tr>
<tr><td>White</td><td>1,778,449</td></tr>
<tr><td>Irish Traveller</td><td>1,301</td></tr>
<tr><td>Asian</td><td></td></tr>
<tr><td>Chinese</td><td>6,303</td></tr>
<tr><td>Indian</td><td>6,198</td></tr>
<tr><td>Pakistani</td><td>1,091</td></tr>
<tr><td>Bangladeshi</td><td>540</td></tr>
<tr><td>Other Asian</td><td>4,998</td></tr>
<tr><td>Black</td><td></td></tr>
<tr><td>Caribbean</td><td>372</td></tr>
<tr><td>African</td><td>2,345</td></tr>
<tr><td>Other</td><td>899</td></tr>
<tr><td>Mixed</td><td>6,014</td></tr>
<tr><td>Other</td><td>2,353</td></tr>
<tr><td>TOTAL</td><td>1,810,863</td></tr>
</table>

NISRA website Table DC2101NI

According to the All Ireland Traveller Health Study (AITHS), the Traveller population in Northern Ireland is estimated at 3905, with 1562 families. The age profile of this community is markedly different from that of the general population with 70% of Travellers aged 30 or under, and only 1% aged 65 and over. This reflects in part a higher birth rate, higher mortality rates and inward migration rates.

The number of requests received by the NI HSC Interpreting Service has risen from 10,257 in 2005/6 to 63,868 in 2011/12.

The upward trend has continued and in the last quarter of 2012/13 20,408 requests were received.</td></tr>
</table>

NIHSCIS Languages 1 January - 31 March 2013

Polish	7087
Lithuanian	3743
Portuguese	1941
Chinese - Mandarin	1170
Slovak	1053
Tetum	875
Russian	798
Chinese - Cantonese	753
Hungarian	595
Latvian	554
Romanian	478
Arabic	399
Somali	231
Czech	175
Bulgarian	146
Chinese - Hakka	86
Bengali	76
Spanish	54
Italian	43
Urdu	24
Farsi	16
Punjabi	16
French	14
German	13
Thai	11
Hindi	9
Japanese	8
Malayalam	8
Slovenian	6
Albanian	5
Tagalog	4
Nepali	4
Pashto Central	3
Ukranian	3
Pashto Southern	2
Estonian	2
Korean	1
Turkish	1
Serbian	1
Total	**20408**

	Figures from NIHSCIS.
Age	NISRA's 2013 mid-year population estimates are shown in the table below:- **Age Group** **Persons** 0-4 126,700 5-9 118,200 10-14 113,200 15-19 123,000 20-24 122,200 25-29 124,500 30-34 122,800 35-39 115,800 40-44 127,900 45-49 133,400 50-54 123,400 55-59 105,900 60-64 93,600 65-69 87,300 70-74 68,000 75-79 52,700 80-84 37,900 85-89 21,900 90+ 11,300 **All Ages** **1,829,700** http://www.nisra.gov.uk/demography/default.asp17.htm Population projections indicate that the most significant change in age structure will occur in the older age bands. The median age of the Northern Ireland population has increased from 28 to 37 years over the last three decades. This is mainly due to the ageing of the population. It is projected that by 2027 the older population will be larger than the number of children. People over 60 in Northern Ireland make up 19% of the population and the number of older people is increasing

rapidly.

The number of people aged 65 plus continues to rise after 2023. By 2041 it is estimated that 42% of the population will be over 50 years, 25% will be pensionable age and 14% over 75 years.

According to the 2010/11 Health Survey Northern Ireland (HSNI) the proportion of respondents reporting their health as not good increased with age (3% of 16-24 year olds, compared with 25% aged 75 or over). Similarly the proportion of respondents indicating they have a long standing illness increased with age from 14% of 16-24 year olds to 70% in the age group of 75 and over. There are differences across the genders as women live longer than men.

Prevalence of a number of conditions covered by this Framework increases with age.

Marital status

The marital status by age recorded in the 2011 Census for those aged 16 and over is shown in the table below.

NISRA table DC1103NI

	Males	Females	Total
Single (never married or never registered a same-sex civil partnership)	273,076	244,317	517,393
Married	341,430	339,401	680,831
In a registered same-sex civil partnership	681	562	1,243
Separated (but still legally married or still legally in a same-sex civil partnership)	22,818	34,093	56,911

Divorced or formerly in a same-sex civil partnership which is now legally dissolved	32,839	45,235	78,074
Widowed or surviving partner from a same-sex civil partnership	22,087	75,001	97,088
TOTAL	**692,931**	**738,609**	**1,431,540**

Sexual orientation

Accurate figures are not readily available but it is estimated that 5-7% of the population are from the gay, lesbian, bisexual or 'trans' (transsexual, transgendered, and transvestites) (LGBT) community. (Equality Commission website)

Gender (Men and women generally)

NISRA's 2013 mid-year population estimates are shown in the table below:-

Age Group	Males	Females	Persons
0-4	64,700	62,000	126,700
5-9	60,800	57,500	118,200
10-14	58,100	55,100	113,200
15-19	63,100	59,900	123,000
20-24	61,900	60,300	122,200
25-29	61,400	63,100	124,500
30-34	59,600	63,100	122,800
35-39	56,400	59,400	115,800
40-44	62,500	65,400	127,900
45-49	65,500	67,900	133,400
50-54	61,000	62,400	123,400
55-59	52,800	53,100	105,900
60-64	46,400	47,300	93,600
65-69	42,000	45,300	87,300
70-74	31,900	36,100	68,000
75-79	23,400	29,200	52,700

80-84	15,100	22,800	37,900
85-89	7,500	14,400	21,900
90+	3,000	8,300	11,300
All Ages	**897,100**	**932,600**	**1,829,700**

http://www.nisra.gov.uk/demography/default.asp17.htm

In addition, as women generally live longer than men it is more likely that that they will need care for a longer period of time.

Accurate figures on the number of transgender persons are not currently available. It is estimated that the number of people who have presented with gender dysphoria in Northern Ireland is 8 per 100,000 (aged 16 and over). In Northern Ireland, it is recognised that there is a higher proportion of male to female transitions.

McBride, Ruari-Santiago (2011): Healthcare issues for Healthcare Issues for Transgender People Living in Northern Ireland. Belfast indicated that 120 individuals presented with gender dysphoria.

Transgender groups in Northern Ireland suggest that they are in touch with 140-160 individuals with gender dysphoria It is recognised however, that current figures may be an underestimate.

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. Female life expectancy has consistently been higher than that for males however this gender gap has declined in recent years.

In addition, the influence of social conditions and lifestyle behaviours is evident when comparing life expectancy for men and women across geographical areas – males living in the 10% least deprived areas in NI could expect on average to live almost 12 years longer than those living in the 10% most deprived areas. For females, the gap is more than 8 years.

Men and women are prone to different types of diseases at different ages, and there are different prevalences of health behaviours. For example:

- Smoking prevalence – 27% males, 23% females
- Around a quarter of males (27%) drank above weekly limits compared with 16% of females
- A similar proportion of males and females were obese, however males were more likely to be overweight than females (44% and 30%)
- Males are more likely than females to meet the recommended level of physical activity (44% and 35%)
- Young males in deprived areas are particularly vulnerable, as are marginalised groups such as those who are unemployed, or people with mental illness and addiction problems.
- Men are 3 times more likely to die of a heart attack and twice as likely to die from lung cancer.

In addition, evidence suggests that men have higher levels of risk behaviour but are less likely to attend their GP or leave it late to attend. The impact of leaving attendance at GPs too late is that men are more likely to attend Accident and Emergency Services (Evidence collated for Audit of Inequalities 2010).

Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey
http://www.csu.nisra.gov.uk/survey.asp29.htm

COPD is more prevalent in men than women, although the prevalence among woman is increasing. Idiopathic Pulmonary Fibrosis is more prevalent in women than men.

Disability (with or without)

The prevalence of Long Term conditions recorded in the 2011 Census is shown in the table below.

	Male	Female	Total
Deafness or partial hearing loss	50,901	42,190	93,091

Blindness or partial sight loss	14,273	16,589	30,862
Communication difficulty	17,482	12,389	29,871
A mobility or dexterity difficulty	88,175	118,998	207,173
A learning, intellectual, social or behavioural difficulty	26,536	13,641	40,177
An emotional, psychological or mental health condition	43,708	61,820	105,528
Long-term pain or discomfort	76,791	106,029	182,820
Shortness of breath or difficulty breathing	74,684	83,206	157,890
Frequent periods of confusion or memory loss	15,721	19,895	35,616
A chronic illness	63,790	54,764	118,554
Other condition	42,955	51,662	94,617
No condition	614,050	627,735	1,241,785
All usual residents	**887,323**	**923,540**	**1,810,863**

NISRA Table DC3101NI

McConkey *et al* (2006) predict that the population of adult persons in NI with a learning disability will increase by 20.5% by 2021 (N=10,050). This compares to an estimated increase of 16.2% in England. The percentage of persons aged over 50 years in 2021 will increase to 35.7% in Northern Ireland (up from 26.8% in 2002).
The Northern Ireland Survey of Activity Limitation and Disability 2006/7 provides information on disability and other Equality categories.

The prevalence of disability amongst adults varies significantly with age, ranging from a low of 5% amongst young adults aged 16-25 to 60% amongst those aged 75 and above. Indeed, amongst the very elderly, aged 85 and above, the prevalence of disability increases to almost 67%.

For both males and females the prevalence of disability increases with age. The prevalence of disability is particularly high for females aged 75 and above (at 62%). Figures 7 and 8 show that it is only amongst the youngest adults, aged 16 to 25, that male prevalence rates (at 6%) are higher than the equivalent for females (4%).

Dependants (with or without)	Based on information from Carers Northern Ireland, the following facts relate to carers: • 1 in every 8 adults is a carer • There are approximately 207,000 carers in Northern Ireland • One quarter of all carers provide over 50 hours of care per week • People providing high levels of care are twice as likely to be permanently sick or disabled than the average person • Approximately 30,000 people in Northern Ireland care for more for than one person • 64% of carers are women; 36% are men (June 2011) Carers often neglect their own physical and mental wellbeing and are • Twice as likely to be sick or permanently disabled • More likely to experience high levels of psychological distress, including anxiety, depression and loss of confidence and self esteem than non-carers. Women are more likely to be informal carers than men. Also, it is recognised that persons with dependents can find it more difficult to access in hours unscheduled care and have difficulties regarding the flexibility of appointment times in order to access health care services *Carer experience:* Carers indicate that they are often viewed by staff as additional competitors for scarce resources rather than as equal partners in the care of the person. They sense staff ambivalence rather than the prospect of collaboration. Trust training programmes include development sessions on this for staff, yet day-to-day practice still lags behind the aspirations of partnership. (HSCB Audit of Inequalities 2010)

	Short breaks - Respite care: There is little consistency in targeting carers in need of respite – a Trust may have several sets of criteria. Better methods of assessing the strain and stress of caring as experienced by carers are required (HSCB Audit of Inequalities 2010).

* Qualitative data – refers to the experiences of individuals related in their own terms, and based on their own experiences and attitudes. Qualitative data is often used to complement quantitative data to determine why policies are successful or unsuccessful and the reasons for this.

Quantitative data - refers to numbers (that is, quantities), typically derived from either a population in general or samples of that population. This information is often analysed either using descriptive statistics (which summarise patterns), or inferential statistics (which are used to infer from a sample about the wider population).

1.6 Needs, experiences and priorities

Taking into account the information recorded in 1.1 to 1.5, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision? Specify details for each of the Section 75 categories

Section 75 category	Details of needs/experiences/priorities
Religious belief	No evidence has been found that different religions will have any different needs, experiences, priorities or issues in relation to the framework.
Political opinion	No evidence has been found that people of different political opinions will have any different needs, experiences, priorities or issues in relation to the framework.
Racial group	No evidence has been found that people of different race will have any different needs, experiences, priorities or issues in relation to the framework.
Age	The incidence of Community Acquired Pneumonia varies markedly with age, occurring most frequently in the elderly and very young. It is twice as common in children under five as in older children. The incidence of bronchiectasis and Idiopathic Pulmonary Fibrosis increases with age The highest incidence of sarcoidosis is in the 25-35 age group.
Marital status	No evidence has been found that people of different marital status will have any different needs, experiences, priorities or issues in relation to the framework.
Sexual orientation	No evidence has been found that people of different sexual orientation will have any different needs, experiences, priorities or issues in relation to the framework.

Gender (Men and women generally)	Obstructive Sleep Apnoea Hypopnoea Syndrome is more common in men. COPD is more prevalent in men than women, although the prevalence among woman is increasing. Idiopathic Pulmonary Fibrosis is more prevalent in women.
Disability (with or without)	No evidence has been found that people with a disability will have any different needs, experiences, priorities or issues in relation to the framework.
Dependants (with or without)	No evidence has been found that people with or without dependants will have any different needs, experiences, priorities or issues in relation to the framework.

Part 2. Screening questions

2.1 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/none)		
Section 75 category	Details of policy impact	Level of impact? minor/major/none
Religious belief		None
Political opinion		None
Racial group		None
Age		None
Marital status		None
Sexual orientation		None
Gender (Men and women generally)	The standards will aim to ensure that health and social services are equitable (does not vary in quality because of personal characteristics such as gender).	Minor
Disability (with or without)		None

Dependants (with or without)		None

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories?		
Section 75 category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		No
Political opinion		No
Racial group		No
Age		No
Marital status		No
Sexual orientation		No
Gender (Men and women generally)	Yes, see 2.1 above	
Disability (with or without)	Yes. Consideration of those who present with co-existing conditions which would impact on the patient's ability to avail of some of the services	

	outlined in this framework, for example accessible information, acknowledgement of how respiratory conditions can affect communication skills and the consequences of impaired communication on a patient's ability to participate in important decision making processes particularly in end of life circumstances	
Dependants (with or without)		No

2.3 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group? (minor/major/none)		
Good relations category	Details of policy impact	Level of impact minor/major/none
Religious belief	Changes to planning and delivery of services could have an impact on 'hard to reach groups'. For instance co-construction of services with service users of different religious belief or cultural practices, at the right stages in their care pathway can make a real difference. This could be in access to diagnostics, pulmonary rehabilitation services, health information, adherence and compliance programmes, or support for families and carers.	Minor
Political		None

opinion		
Racial group	The standards relating to communication and involvement will mean service users of different racial groups should feel more confident in the service they receive despite any language barriers etc.	Minor

2.4 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?		
Good relations category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		No, this is a framework aimed at all people, regardless of religious beliefs.
Political opinion		No, this is a framework aimed at all people, regardless of political opinion.
Racial group		No, this is a framework aimed at all people, regardless of race.

2.5 Additional considerations

Multiple identity

Provide details of data on the impact of the policy on people with multiple identities (e.g. minority ethnic people with a disability, women with a disability, young protestant men, young lesbian, gay or bisexual persons). Specify relevant Section 75 categories concerned.

Respiratory disease can affect anyone, so there are numerous multiple identities upon which the Framework will impact. However, as the aim of the standards is to ensure that health and social care services are equitable and person centred, the impact on these groups will be positive.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

Part 3. Screening decision

3.1 How would you summarise the impact of the policy / decision?

No impact	X	
Minor impact		Consider mitigation (3.4 – 3.5)
Major impact		

3.2 Do you consider that this policy / decision needs to be subjected to a full Equality Impact Assessment (EQIA)?

Yes - screened in	
No - screened out	X

3.3 Please explain your reason for making your decision at 3.2.

The Service Framework for Respiratory Health and Wellbeing aims to improve the health and wellbeing of the population of Northern Ireland, reduce inequalities and improve the HSC quality of care in relation to cardiovascular disease. As such implementation of the Framework will have a positive impact on all Section 75 groups.

Mitigation

If you have concluded at 3.1 and 3.2 that the likely impact is '**minor**' and an equality impact assessment is not to be conducted, you must consider mitigation (or scope for further mitigation if some is already included as per 2.6) to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

3.4 Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations?

Yes	☐
No	☐

3.5 If you responded "**Yes**", please give the **reasons** to support your decision, together with the proposed changes/amendments or alternative policy.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

Monitoring of the Service Framework for Respiratory Health and Wellbeing will be undertaken by the HCB Board and PHA. These HSC organisations will develop plans for its implementation and monitoring. The development of these plans will include the collection of data and achievement of targets.

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

See above.

Please note: - For the purposes of the annual progress report to the Equality Commission you may later be asked about the monitoring you have done in relation to this policy and whether that has identified any Equality issues.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

No

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

No

Part 6. Human Rights

6.1 Please complete the table below to indicate whether the policy / decision affects anyone's Human Rights?

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT = human right interfered with or restricted	NEUTRAL IMPACT
Article 2 – Right to life			X
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment			X
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			X
Article 5 – Right to liberty & security of person			X
Article 6 – Right to a fair & public trial within a reasonable time			X
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			X
Article 8 – Right to respect for private & family life, home and correspondence.			X
Article 9 – Right to freedom of thought, conscience & religion			X
Article 10 – Right to freedom of expression			X
Article 11 – Right to freedom of assembly & association			X
Article 12 – Right to marry & found a family			X
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights			X

1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property			X
1st protocol Article 2 – Right of access to education			X

6.2 If you have identified a likely negative impact who is affected and how?

At this stage we would recommend that you consult with your line manager to determine whether to seek legal advice and to refer to Human Rights Guidance to consider:

- *whether there is a law which allows you to interfere with or restrict rights*
- *whether this interference or restriction is necessary and proportionate*
- *what action would be required to reduce the level of interference or restriction in order to comply with the Human Rights Act (1998).*

6.3 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/decision.

Part 7 - Approval and authorisation

	Name	Grade	Date
Screened completed by	John Maguire	SO	15/04/2015
Approved by[1]	David Best	G7	17/04/2015
Forwarded to E&HR Unit[2]			

Notes:

[1] The Screening Template should be approved by a senior manager responsible for the policy this would normally be at least Grade 7.

[2] When the Equality and Human Rights Unit receive a copy of the final screening it will be placed on the Department's website and will be accessible to the public from that point on. In addition, consultees who elect to receive it, will be issued with a quarterly listing all screenings completed during each three month period.