



Department of
Health

An Roinn Sláinte

Mánnystrie O Poustie

www.health-ni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

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Guidance on completion of the template can be found on the Equality Commission website at [S75 screening template 2010 \(web access checked 230920\) .docx](#)

Part 1. Policy scoping

1.1 Information about the policy

Name of the policy:

Reshaping Stroke Care: Saving Lives, Reducing Disability – Stroke Action Plan.

Is this an existing, revised or a new policy?

The Department consulted on a range of commitments and proposals to improve stroke services in NI. Following a public consultation which ran from 26th March to 30th August 2019, the Department has confirmed the need to enhance existing stroke services through improvements to prevention, community-based support and the establishment of Hyperacute Stroke Care. The Department has carefully considered the issues raised during the consultation. Responses have informed the development of a Stroke Action Plan which sets out next steps and revised timescales for driving improvements in relation to the commitments outlined in Reshaping Stroke Care along with additional analysis to determine a preferred option for Hyperacute Stroke Care in Northern Ireland.

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

Stroke is a major health issue in Northern Ireland with around 3,000 people being admitted to hospital each year and 39,000 stroke survivors living in our communities. It is important that every opportunity is taken to secure excellent care for people after a stroke and give them the best possible chance of a good recovery. Opportunities exist across the entire pathway for improving stroke care and much is currently being done to raise awareness of stroke, prevent more strokes, invest in rehabilitation and review the long-term support for those with stroke.

The Department consulted on 7 commitments to improve stroke care:

Commitment 1: We will identify a regional model for Transient Ischemic Attack (TIA / Mini Stroke) assessment by March 2020 and implement that model by 2022 to deliver a 7 day service of specialist assessment within 24 hours of symptoms.

Commitment 2: By 2022 we will remove the variance in delivering thrombolysis to ensure that patients across NI have timely access to the treatment.

Commitment 3: We will continue to invest in the growth of thrombectomy, increasing hours of operation to Monday – Friday 8am-8pm service by December 2019, and moving to 24/7 service by 2022.

Commitment 4: We will reshape stroke services by 2022 to establish dedicated Hyper Acute and Acute Stroke Units underpinned by regional service standards to deliver improved outcomes for stroke patients.

Commitment 5: The recently published Stroke Association document ‘Struggling to recover’ makes six recommendations to improve services. Alongside the reshaping of hospital services, we are committed to driving improvement in rehabilitation and long-term support and will use the Stroke Association’s analysis and recommendations as a blueprint to drive that improvement.

Commitment 6: The HSC will undertake a workforce review to identify the staffing and skill mix required to deliver effective stroke services.

Commitment 7: We will extend the partnership with the charity AANI to enable the Helicopter Emergency Medical Service (HEMS) to provide a secondary response to incidents including strokes by 2022 to improve access to services, particularly from rural areas.

In respect of Commitment 4, six potential options were identified for the provision of specialist emergency stroke care in Hyper Acute Stroke Unit (HASU) sites:

- **Option A:** under this option, 5 HASUs would be located at the following sites: Altnagelvin Area Hospital, Antrim Area Hospital, Craigavon Area Hospital, Royal Victoria Hospital and South West Acute Hospital. Acute Stroke Units (ASUs) would be co-located.
- **Option B:** under this option 4 HASUs would be located at the following sites: Altnagelvin Area Hospital, Antrim Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital. Acute stroke units to be co-located, with consideration of a fifth ASU at the Ulster hospital.
- **Option C:** under this option, 4 HASUs would be located at Altnagelvin Area Hospital, Craigavon Area Hospital, Royal Victoria Hospital and South West Acute Hospital. ASUs to be co-located, with consideration of a fifth ASU at the Ulster Hospital.
- **Option D:** under this option, 4 HASUs would be located at the following sites: Altnagelvin Area Hospital, Antrim Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital with services removed from Antrim Area Hospital over time.
- **Option E:** under this option, 4 HASUs would be located at the following sites: Altnagelvin Area Hospital, Craigavon Area Hospital, Royal Victoria

Hospital and South West Acute Hospital, with services removed from the South West Acute Hospital over time.

- **Option F:** under this option, 3 HASUs would be located at the following sites: Altnagelvin Area Hospital, Craigavon Area Hospital and Royal Victoria Hospital, with additional ASUs located at the Ulster Hospital and Antrim Area Hospital.

Following analysis of the responses to the consultation and the wider evidence base, the Department has developed a policy paper and Action Plan setting out the next steps for the implementation of reform. These are outlined below:

Priority 1: Prevention - Action: We will identify a regional model to ensure 7 day access to specialist TIA assessment within 24 hours of symptoms to be implemented by Summer 2023.

Priority 2: Thrombolysis – Action: By Summer 2023, we will ensure that all patients who would benefit from thrombolysis within guidelines will receive it.

Priority 3: Thrombectomy - Action: By December 2022, we will expand the use of Artificial Intelligence software to assist in the interpretation of scans and the targeting of treatment including thrombectomy and thrombolysis. We will also move over time to a 24/7 thrombectomy service by the end of 2024

Priority 4: Rehabilitation and Long Term Support – Action: We will identify gaps in support for stroke survivors and take forward a programme of work to ensure that stroke survivors have access to the right support at the right time for as long as they need it.

Priority 5: Hyperacute Stroke Care – Action: We will commence further external analysis by Autumn 2022 to identify and evaluate options for the establishment of Hyperacute Stroke Care, with a preferred option identified by Summer 2023.

Priority 6: Stroke Workforce – Action: We will commence a targeted workforce review in Summer 2022, building on the programme of work outlined in the Action Plan to develop a Workforce Plan by Summer 2023.

Commitment 7 in Reshaping Stroke Care is not being taken forward at this point in light of concerns raised during the consultation.

In respect of Hyperacute Stroke Care, the issue of travel time, particularly for those section 75 groups most affected by stroke, was a major issue. In

response to the concerns raised, the Department will not proceed with the establishment of Hyper Acute Stroke Units on the basis of the options outlined in Reshaping Stroke Care. Instead, as outlined in the Department's Stroke Action Plan, additional analysis will be undertaken to determine a preferred option for Hyperacute Stroke Care in Northern Ireland. The analysis will consider a range of additional factors including changes in demographics which were not included in the analysis underpinning Reshaping Stroke care. The outcome will be subject to additional equality screening when a preferred option for reconfiguration of hospital services has been identified.

Are there any Section 75 categories which might be expected to benefit from the intended policy? If so, explain how.

The total population in Northern Ireland, including people in the Section 75 categories, are expected to benefit from the actions outlined in the Department's Stroke Action Plan due to the envisaged significant improved outcomes compared with the ways in which services are currently provided in hospitals and the community. Populations in urban and rural areas would be expected to experience improvements in stroke clinical outcomes.

Who initiated or wrote the policy?

The Department of Health (DoH), building on the work of the Health and Social Care Board and Public Health Agency.

Who owns and who implements the policy?

DoH will own the policy; it is intended that the existing Stroke Network will lead on driving improvements in relation to commitments 1, 2, 3 and 5, with the Department leading on commitments 4 and 6.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision?

Yes, financial.

Additional funding will be required to drive improvements in stroke services in line with the actions set out in the Department's Stroke Action Plan.

1.3 Main stakeholders affected

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

Staff

Service users

Other public sector organisations

Voluntary / community / trade unions

Other - family members, friends and carers of stroke survivors and stroke patients.

1.4 Other policies with a bearing on this policy

- HSC Transformation Agenda - DOH
- Budget Allocations - DOF

1.5 Available evidence

What evidence/information (both qualitative and quantitative¹) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

Religious belief evidence / information:

There is no qualitative or quantitative evidence available in relation to the religious beliefs of those individuals who are affected by stroke (stroke survivors, potential stroke patients and family, friends or carers of stroke survivors/patients).

It is envisaged that developing stroke services as set out in the Department's Action Plan will improve outcomes for all groups compared with existing services.

Political Opinion evidence / information:

There is no qualitative or quantitative evidence available in relation to the political opinion of those individuals who are affected by stroke.

It is envisaged that developing stroke services as set out in the Department's Action Plan will improve outcomes for all groups compared with existing services.

Racial Group evidence / information:

Specific Northern Ireland Data is not available relating to the ethnicity of stroke survivors.

Since the 2001 Census, there has been a marked change in Northern Ireland's ethnic diversity. On Census Day 2011, 1.8% (32,400) of the resident population belonged to minority ethnic groups, more than double the proportion in 2001 (0.8%). The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3% of the population.

¹ * 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).

The risk of stroke is significantly worse for some racial groups with Black people at 1.5 to 2.5 times and South Asian people at 1.5 times greater risk of having a stroke than White people. In contrast people in the Chinese ethnic group have lower risk of stroke than White people. Data from the stroke register in London shows that while stroke incidence has decreased by 40% for White people in the past years, it has not decreased for Black people.²

It is envisaged that developing stroke services as set out in the Department's Action Plan will improve outcomes for all groups compared with existing services.

Age evidence / information:

Age is the single most important risk factor for stroke. The risk of having a stroke doubles every decade after the age of 55.

By the age of 75, 1 in 5 women and 1 in 6 men will have had a stroke. 1 in 4 (26%) of strokes in the UK occur in people under 65 years old. It is thought there are around 400 childhood strokes a year in the UK.³

Population

The latest NISRA 2020 interim based population projections for Northern Ireland 2022-2045 reported:-

- The NI population will increase from 1.896 million people in mid-2020 to 1.939 million by mid-2045.
- The population of people age 65 and over is projected to increase significantly from 319,900 to 481,500, (50.5%) over the next 25 years.

By mid-2045, almost 1 in 4 people in Northern Ireland are projected to be aged 65 and over.

The risk of stroke is known to increase with advancing age and this is demonstrated in the data collected from hospital admissions in Northern Ireland. In Northern Ireland, in 2020/21 28% of stroke admissions were patients aged 64 or under and 72% aged 65 or over.

² [Ethnic disparities in the major causes of mortality and their risk factors – a rapid review - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/reviews/ethnic-disparities-in-the-major-causes-of-mortality-and-their-risk-factors-a-rapid-review)

³ [State of the Nation Stroke statistics - January 2016](https://www.gov.uk/government/statistics/state-of-the-nation-stroke-statistics-january-2016)

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services. As part of the further analysis set out in the Department's Stroke Action Plan, the identification and evaluation of options for the establishment of Hyperacute Stroke Care will take into account increasing demand arising from demographic change.

Marital Status evidence / information:

There is no qualitative or quantitative evidence available in relation to the marital status of those affected by stroke. However it is acknowledged that access to family support by service users may differ by marital status in terms of family support. Some stroke survivors in these circumstances may be anxious as to how they will manage if they are discharged from hospital within a short period of time.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Sexual Orientation evidence / information:

Accurate figures are not available on the sexual orientation of the general population, neither is this information available for stroke survivors and potential stroke patients 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. It is however estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual.

There is nothing to suggest that the LGBT+ population would be more susceptible to stroke.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Men & Women generally evidence / information:

No data is available for potential stroke patients, however it is presumed that statistics are likely to be similar to known stroke patients.

Data collected from hospital admissions in Northern Ireland for 2020/21 reveal that stroke prevalence is evenly distributed among males and females with 47% female and 53% male stroke patients.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Disability evidence / information:

Data is presented for the population of existing stroke patients collected in the UK by the Stroke National Sentinel Audit and from Northern Ireland population census.

Disability Before Stroke

Recent 2020/21 data indicates that stroke patients have a higher level of pre-existing physical disability than that of the general population. This could indicate that those living with a physical disability may be at higher risk of stroke.

Level of Disability Before Stroke	% of all new stroke patients
Independent before stroke	51.7
Mild moderate physical disability	28.5
Moderate to severe Disability	19.8

It is also known that people with certain long-term conditions, including heart disease and diabetes, are at a higher risk of stroke.

Disability Following Stroke

Data from the National Stroke Audit report shows that approximately 10% of stroke patients are discharged to a care home, with approximately 65% of these being sent to a home for the first time.

The State of the Nation report by the Stroke Association indicates a range of difficulties experienced by people following a stroke⁴. These include limb weakness, vision problems, facial weakness, slurred speech, bowel and bladder control, swallowing, problems with memory and thinking and pain and fatigue.

Northern Ireland

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. Strabane and Belfast (both 24%) had the highest proportions of residents with a long-term health problem or disability.

Disability	Count	Percent %
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

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Dependants evidence / information:

Data on the caring responsibilities of stroke survivors is not routinely collected.

Given their older age profile, it is reasonable to assume that fewer of them will have dependents than in the general population as a whole. Nevertheless, it is recognised that some older people will themselves be carers, as Age UK data (2013) underlines: in the UK nearly 50,000 people aged over 85 provide unpaid care to a partner, family member or other person.

In turn, younger stroke survivors will be more likely to have caring responsibilities, including for children and/or older dependents.

⁴ [State of the Nation Stroke statistics - January 2016](#)

Carers:

Data is not collected specifically in respect of the carers of stroke patients in Northern Ireland.

Census data is available in respect of caring responsibilities of the NI population. 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. Twelve per cent of the population (213,980) provided such unpaid care, around a quarter (26%) of whom did so for 50 or more hours a week, a total of 56,000 people. The table below shows the provision of unpaid care in Northern Ireland.

Care provided	2011 Census	
	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

Sources: NISRA (2012) Table KS301 – Health and unpaid care (2011 numbers)

NI Assembly research⁵ indicates that:

- On Census Day 2011, 214,000 people were providing some form of unpaid care;
- 57% of unpaid carers were providing care for between 1- 19 hours per week, 17% between 20 and 49 hours and 26% 50 or more hours per week.

There has been a policy drive in recent years towards supporting carers in their caring role. The Department is currently consulting on proposals to strengthen support for carers⁶.

⁵ [Carers in Northern Ireland: Some key statistics - Research Matters \(assemblyresearchmatters.org\)](http://assemblyresearchmatters.org)

⁶ [doh-rasc-consultation-document.pdf \(health-ni.gov.uk\)](http://doh-rasc-consultation-document.pdf)

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

1.6 Needs, experiences and priorities

Taking into account the information referred to above, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision?

Specify details of the needs, experiences and priorities for each of the Section 75 categories below:

Religious belief

At this stage, there is no evidence that stroke survivors, stroke patients or family, friends and carers of those affected by stroke who are of different religions will have any different needs, experiences, priorities or issues in relation to the reforms outlined.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Political Opinion

At this stage, there is no evidence that stroke survivors, stroke patients or family, friends and carers of those affected by stroke who have different political opinions will have any different needs, experiences, priorities or issues in relation to the reforms outlined.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Racial Group

Some Minority Ethnic individuals will not be fluent in English. The number of requests received by the Northern Ireland Health and Social Care Interpreting Service has risen from 63,868 in 2011/12 to 132,434 in 2019/20 showing the increasing demand on services responding to a greater diversity in the

population. A report for 2020/21 is available but shows a marked drop in requests due to the impact of Covid-19 which is not reflective of normal circumstances. Responses to the Transforming Your Care Vision to Action consultation noted how important it was to have foreign-language interpreters available.

The risk of stroke is significantly worse for some racial groups with Black people at 1.5 to 2.5 times and South Asian people at 1.5 times greater risk of having a stroke than White people. In contrast people in the Chinese ethnic group have lower risk of stroke than White people. Data from the stroke register in London shows that while stroke incidence has decreased by 40% for White people in the past years, it has not decreased for Black people.⁷

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Age

The data suggests that the very old – a sizeable group of potential stroke service users – are likely to have no or reduced family networks and support they can draw on. Likewise, it shows that many will have a pre-existing disability: sensory loss and dementia being particularly prevalent within this age group. In addition, it is important to note that some individuals will have caring responsibilities. The consultation responses reflected this position and the perceived impact on older people by any change in services

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Marital status

Access to family support by service users may differ by marital status. Stroke survivors who are single may have less family support to draw on compared with those who are married. Some stroke survivors in these circumstances may be anxious as to how they will manage and how appropriate support can be put in place on short notice if they are discharged from hospital within a short period of time.

⁷ [Ethnic disparities in the major causes of mortality and their risk factors – a rapid review - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/reviews/ethnic-disparities-in-the-major-causes-of-mortality-and-their-risk-factors)

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Sexual orientation

Research suggests that older LGBT+ people are more socially isolated and have fewer family and community networks they can draw on for support.

It also indicates that the need to 'come out' to care staff, in particular when they have a partner, can cause anxieties. A patient journey that involves a number of moves in location or care teams thus may impact on people who are lesbian, gay or bisexual differentially from heterosexual stroke survivors.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services

Men and Women Generally

There are no indications that stroke survivors or potential stroke patients will have particular needs in relation to the options based on their gender.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Disability

Service users with disabilities may have particular needs in relation to the way stroke services are organised, including:

- information and communication support needs (people with sensory impairments and those with a learning disability);
- specific transport needs (people with mobility impairments); and
- specific needs relating to the continuity of care, minimising the number of moves and changes in both the location and teams providing care (people

with dementia). The consultation responses reflected this position and the perceived impact on stroke patients by any change in services.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Dependants

Younger stroke survivors will be more likely to have caring responsibilities, including for children and/or older dependents.

Carers

Some groups of carers will have particular needs and issues in relation to reconfigured services:

- Age – Younger and older carers tend to have less access to a car and rely more heavily on public transport than other age groups. The location of stroke services thus has particular implications for their ability to visit the person they care for. As so-called 'sandwich carers', those in middle age groups at times carry caring responsibilities for both children and elderly relatives. Longer travel times will negatively impact on their ability to juggle both sets of responsibilities.
- Ethnicity – Minority Ethnic carers often have less access to support from family and community networks. As support is sometimes highly localised they may be less able to draw on these networks if stroke services are located further away. Likewise, caring for their relative at home in general and a quicker discharge might pose greater challenges for them as they seek to prepare for the person returning home. Some individuals will face language barriers unless information and communication draws on interpreters and translations.
- Disability – In a similar way to Minority Ethnic carers, some carers who themselves have a disability may face additional challenges in relation to care at home and an earlier discharge. Likewise, they are likely to have particular needs in relation to transport and location, similar to those outlined above under 'age'. Those with sensory impairments or a learning disability will have needs for information to be provided in an appropriate format and for communication to draw on appropriate support.

- Sexual Orientation – For same-sex carers, a change in care setting and staff providing care to their partner is often associated with concerns about having to ‘come out’ to a new group of staff yet again and about how their partner will be treated. Similar concerns are reflected by the Transgender community and their families/ carers.

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

Details of the likely policy impacts on Religious belief: It is envisaged that developing stroke services as set out in the Department’s Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? None

Details of the likely policy impacts on Political Opinion: It is envisaged that developing stroke services as set out in the Department’s Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? None

Details of the likely policy impacts on Racial Group: It is envisaged that developing stroke services as set out in the Department’s Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? Minor - Positive

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates.

Details of the likely policy impacts on Age: It is envisaged that developing stroke services as set out in the Department’s Stroke Action Plan will

improve outcomes for all groups compared with existing services.

What is the level of impact? Minor - Positive

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates.

For younger people affected by stroke, the actions may produce specific benefits if repercussions for their working lives are reduced.

Details of the likely policy impacts on Marital Status: It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? None

Details of the likely policy impacts on Sexual Orientation: It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? None

Details of the likely policy impacts on Men and Women: It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? None

Details of the likely policy impacts on Disability: It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? Minor – Positive

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates.

Details of the likely policy impacts on Dependants: It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

What is the level of impact? Minor – Positive

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates.

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories? Yes/ No

Detail opportunities of how this policy could promote equality of opportunity for people within each of the Section 75 Categories below:

Religious Belief - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Political Opinion - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Racial Group – Yes.

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates thus enhancing their opportunities and quality of life.

Some Minority Ethnic groups may, in particular, benefit from improved outcomes.

Age - Yes.

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates thus enhancing their opportunities and quality of life.

Older age groups are likely to benefit from improved outcomes.

Marital Status - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Sexual Orientation - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Men and Women generally - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Disability - Yes

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates thus enhancing their opportunities and quality of life.

Those with a disability are likely to benefit from improved outcomes.

Dependants – Yes

The actions are intended to benefit stroke survivors and stroke patients by improving the level of recovery and quality of care received.

Stroke survivors and stroke patients should benefit from improved outcomes and survival rates thus enhancing their opportunities and quality of life.

This group are likely to benefit from improved outcomes.

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?

Details of the likely policy impacts on Religious belief:

None

Details of the likely policy impacts on Political Opinion:

None

Details of the likely policy impacts on Racial Group:

None

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

Detail opportunities of how this policy could better promote good relations for people within each of the Section 75 Categories below:

Religious Belief - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Political Opinion - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

Racial Group - No.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

2.5 Additional considerations

Multiple identity

Generally speaking, people can fall into more than one Section 75 category. **Taking this into consideration, are there any potential impacts of the policy/decision on people with multiple identities?**

No.

Provide details of data on the impact of the policy on people with multiple identities. Specify relevant Section 75 categories concerned.

It is envisaged that developing stroke services as set out in the Department's Stroke Action Plan will improve outcomes for all groups compared with existing services.

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.

It is recognised that the current configuration of stroke services in NI is resulting in poorer outcomes for stroke patients. The consultation proposed a programme of reform to address shortfalls in the current service. Actions in respect of commitments 1, 2, 3, 4, 5 and 6 have been set out in the Department's Stroke Action Plan. The Department does not intend to proceed with Commitment 7 in the context of concerns raised in the consultation.

In respect of commitment 4, responses to the consultation identified a range of concerns regarding the potential loss of local hospital-based services and the impact on outcomes of additional travel time if services are consolidated onto a smaller number of sites. In light of this, as outlined in the Department's Stroke Action Plan, further analysis will be undertaken to determine a preferred option for Hyperacute Stroke Care in Northern Ireland. The analysis will consider a range of additional factors including changes in demographics which were not included in the analysis underpinning Reshaping Stroke care. The outcome of will be subject to additional equality screening when a preferred option for reconfiguration of hospital services has been identified.

Part 3. Screening decision

3.1 Would you summarise the impact of the policy as; No Impact/ Minor Impact/ Major Impact?

Minor impact (positive)

3.2 Do you consider that this policy/ decision needs to be subjected to a full equality impact assessment (EQIA)?

No – Screened out

3.3 Please explain your reason.

Following analysis of the responses to the consultation and the wider evidence base, the Department has committed to implementing Commitments 1, 2, 3, 5 and 6 which will see the enhancement of existing service provision in those areas covered by the commitments. Actions in respect of each are set out in the Department's Stroke Action Plan. Commitment 7 is not being taken forward at this point in light of concerns raised during the consultation.

In respect of Hyperacute Stroke Care (Commitment 4 in Reshaping Stroke Care), the issue of travel time, particularly for those section 75 groups most affected by stroke, was a major issue. In response to the concerns raised, the Department's does not intend to proceed to establish Hyper Acute Stroke Units on the basis of the options set out in Reshaping Stroke Care. Instead, as set out in the Department's Stroke Action Plan further analysis will be undertaken to identify and evaluate a broad range of options which will lead to the identification of a preferred option for Hyperacute Stroke Care in Northern Ireland. The analysis will consider a range of additional factors including changes in demographics which were not included in the analysis underpinning Reshaping Stroke care. The outcome will be subject to additional equality screening when a preferred option for reconfiguration of hospital services has been identified.

3.4 Mitigation

When the public authority concludes that the likely impact is 'minor' and an equality impact assessment is not to be conducted, the public authority may consider mitigation to lessen the severity of any equality impact, or the

introduction of an alternative policy to better promote equality of opportunity or good relations.

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

Yes.

If so, give the reasons to support your decision, together with the proposed changes/amendments or alternative policy.

Following analysis of the responses to the consultation and the wider evidence base, the Department has committed to implementing Commitments 1, 2, 3, 5 and 6 which will see the enhancement of existing service provision in those areas covered by the commitments. Actions in respect of each are set out in the Department's Stroke Action Plan. Commitment 7 is not being taken forward at this point in light of concerns raised during the consultation.

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3.5 Timetabling and prioritising

Factors to be considered in timetabling and prioritising policies for equality impact assessment.

N/A EQIA not required.

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?

Target dates have been set out in the Stroke Action Plan as follows:

- Prevention – Implementation of a regional model to deliver a 7 day access to specialist TIA assessment within 24 hours of symptoms by Summer 2023.
- Thrombolysis – Ensure that all patients who would benefit from thrombolysis within guidelines will receive it by Summer 2023.
- Thrombectomy - By December 2022, we will expand the use of Artificial Intelligence software to assist in the interpretation of scans and the targeting of treatment including thrombectomy and thrombolysis. We will also move over time to a 24/7 thrombectomy service by the end of 2024.
- Rehabilitation and Long Term Support – We will identify gaps in support for stroke survivors and take forward a programme of work to ensure that stroke survivors have access to the right support at the right time for as long as they need it.
- Hyperacute Stroke Care - We will commence further external analysis by Autumn 2022 to identify and evaluate options for the establishment of Hyperacute Stroke Care, with a preferred option identified by Summer 2023.
- Stroke Workforce – Commence a workforce review in Summer 2022, developing a workforce plan by Summer 2023.

The Department will monitor improvements in Stroke Services regularly against the targets above through the information provided by Sentinel Stroke National Audit Programme (SSNAP) audits.

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

Data on performance in relation to stroke care is recorded as part of the national SSNAP audit. The department will keep this position under review.

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?

All people in the Section 75 categories might be expected to benefit from the actions identified in the Stroke Action Plan due to the envisaged improvement in stroke service provision and this would include people with disabilities.

As the reforms will have a primarily positive impact on stroke survivors and stroke patients including those with an existing disability to those individuals who acquire a disability as a result of a stroke, this group may experience better outcomes resulting in more positive attitudes and opportunities to participate in public life.

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. Changes have been made following comments received during the consultation.

Part 6. Human Rights

6.1 Does the policy / decision affects anyone's Human Rights?

Details of the likely policy impacts on Article 2 – Right to life:

Positive

Details of the likely policy impacts on Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment:

Neutral

Details of the likely policy impacts on Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour:

Neutral

Details of the likely policy impacts on Article 5 – Right to liberty & security of person:

Neutral

Details of the likely policy impacts on Article 6 – Right to a fair & public trial within a reasonable time:

Neutral

Details of the likely policy impacts on Article 7 – Right to freedom from retrospective criminal law & no punishment without law:

Neutral

Details of the likely policy impacts on Article 8 – Right to respect for private & family life, home and correspondence:

Neutral

Details of the likely policy impacts on Article 9 – Right to freedom of thought, conscience & religion:

Neutral

Details of the likely policy impacts on Article 10 – Right to freedom of expression:

Neutral

Details of the likely policy impacts on Article 11 – Right to freedom of assembly & association:

Neutral

Details of the likely policy impacts on Article 12 – Right to marry & found a family:

Neutral

Details of the likely policy impacts on Article 14 – Prohibition of discrimination in the enjoyment of the convention rights:

Neutral

Details of the likely policy impacts on 1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property:

Neutral

Details of the likely policy impacts on 1st protocol Article 2 – Right of access to education:

Neutral

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).*

N/A – identified positive impact on Article 2.

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.

N/A

Part 7 - Approval and authorisation

Screened by:	Position/Job Title	Date
Karen McAllister	Staff Officer	16/06/2022
Approved by:		
Dean Looney	G7	17/06/2022
Copied to EHRU:		17/06/2022