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Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

Part 1 – Policy scoping

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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

Policy proposals for the statutory Duty of Candour and Being Open Framework

Is this an existing, revised or a new policy?

This is a new policy.

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

The policy objective is to implement recommendations 1, 2, 3, 4, and 6 from the report of the Inquiry into Hyponatraemia-related deaths, undertaken by Sir John O'Hara and published in January 2018.

Implementation of these recommendations would introduce a statutory requirement for every healthcare organisation and everyone working for them to be open and honest in all their dealings with patients and the public. Criminal liability would attach to breach of this duty, and obstruction of another in the performance of this duty. The introduction of these duties would be accompanied by unequivocal guidance issued by the DOH regarding what is expected to ensure compliance, accompanied by appropriate training, as well as support and protection for those who properly fulfil their duty.

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

The intended policy is expected to benefit patients/service users/carers/families (or their duly authorised representatives), as well as staff and organisations providing health and social care services, by providing a clear framework for openness and candour in these settings. It is therefore expected to benefit all Section 75 categories.

Who initiated or wrote the policy?

The policy was initiated by recommendations from the Inquiry into Hyponatraemia-related Deaths, which reported in January 2018. The policy has been drafted by Workstream 1 of the Hyponatraemia Implementation

Programme, which was established by the Department of Health in June 2018 to implement the recommendations arising from the review.

Who owns and who implements the policy?

The Department of Health owns the policy, and will have overall responsibility for implementation.

1.2 Implementation factors

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

Financial & Legislative

Once policy proposals are finalised following public consultation, a business case will be required in order to evaluate the financial impact of implementation. Implementation of the proposals relating to the statutory duty of candour will also require primary, and potentially secondary, legislation subject to approval by the NI Assembly and the Executive.

1.3 Main stakeholders affected

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

Staff

Service users/carers/families

Other public sector organisations

Voluntary/community/trade unions

1.4 Other policies with a bearing on this policy

Policy	Owner(s) of the policy
Procedure for the Reporting and Follow up of Serious Adverse Incidents	Health and Social Care Board
Guidance in relation to the HSC Complaints Procedure	Department of Health
'Being Open' Policy – saying sorry when things go wrong	Regional Working Group on Adverse Incidents & Department of Health
Personal and Public Involvement policy	Department of Health
Whistleblowing Procedures	HSC Trusts, and other health and social care organisations
Mental Capacity (NI) Act 2016	Department of Health
Patient Consent Policy	Department of Health
Shared Decision Making Framework	Department of Health

1.5 Available evidence

What evidence/information (both qualitative and quantitative[1]) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

As part of the policy development process, the Duty of Candour workstream, along with its Being Subgroup, has:

- Commissioned and considered research papers to assist discussions, primarily to better understand the approach to candour in other jurisdictions, and to identify the legal issues that will impact upon this policy area. The key analysis and background papers considered by the workstream can be accessed here;

- Published these research papers for consideration by wider stakeholders, and issued call for further evidence from these stakeholders in order to assist the development of policy options. The submissions received to this call for evidence can be accessed here;

- Held a series of involvement and engagement events workshops with key stakeholders in order to consider the potential implications of the statutory duties of candour for the health and social care system. The feedback from all events has been analysed and a summarised document has been developed for and consideration by the Workstream when drafting the policy proposals. The summary document and the raw data upon which it is based, can be accessed here; and

- Commissioned a public survey to gain insight into service user and patient experience of openness, honesty and involvement when interacting with the Health and Social Care System. The survey ran for 4 days, from 22- 25 January 2021 and had 2,295 responses.

[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 purpose of each of these initiatives was to help the workstream further understand the potential impact of the duty of candour policy that it is seeking to develop.

In addition to the evidence and qualitative data outlined above, the following sources of quantitative evidence/information have been considered as part of this screening exercise:

- Information from the 2011 Census in Northern Ireland, published by the Northern Ireland Statistics and Research Agency (NISRA);
- The HSC Staff Survey 2019, published by NISRA;
- Statistics for sexual identity in the UK by sex, region and age group, sourced from the Annual Population Survey published by the Office for National Statistics; and
- The Northern Ireland Health and Social Care Workforce Census, published by the Department of Health's Information Analysis Directorate in March 2020

Evidence/Information by Section 75 Category

Religious belief:

It is not possible to get a specific breakdown of the religious belief held by service users, or for all health and social care staff.
However, we do know the breakdown across the adult population as per the 2011 Census[2]. The population of Northern Ireland at the time of the 2011 census was 1,810,863, with religious belief broken down as follows:

- Catholic – 40.8%
- Protestant – 41.6%
- Other – 0.8%
- Unknown – 16.9%

In 2019, NISRA conducted the HSC Staff Survey[3], which did collect some demographic data from respondents. It is important to caveat this data by noting that, of the 77,781 staff employed at the time of the survey, only 19,094 completed a response. Of those who responded, community background religion was broken down as follows:

- Protestant Community – 42%

[2] https://www.nisra.gov.uk/statistics/census/2011-census
[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/2019-HSC-Staff-Survey-Regional-Benchmark-Report.PDF

- Roman Catholic Community – 45%
- Neither Protestant nor Roman Catholic community – 13%

In addition, religious belief was broken down as follows:

- Christian – 77%
- None – 18%
- Other religion – 5%

Political Opinion:

It is not possible to get a specific breakdown of the political opinion held by service users, or health and social care staff.

Racial Group:

It is not possible to get a specific breakdown of the racial group that service users, or all health and social care staff, relate to.

However, we do know the breakdown across the adult population as per the 2011 census[4]: The population of Northern Ireland at the time of the 2011 census was 1,810,863, and 1.8% (32,596) of the usual resident population belonged to minority ethnic groups. The overall population breakdown was as follows:

- White – 98.21% (1,778,449)
- Chinese – 0.35% (6,338)
- Irish Traveller – 0.07% (1,268)
- Indian – 0.34% (6,157)
- Pakistani – 0.06% (1,087)
- Bangladeshi – 0.03% (543)
- Other Asian – 0.28% (5,070)
- Black Caribbean – 0.02% (362)
- Black African – 0.13% (2354)
- Black Other – 0.05% (905)
- Mixed – 0.33% (5976)
- Other – 0.13% (2354)

[4] https://www.nisra.gov.uk/statistics/census/2011-census

In 2019, NISRA conducted the HSC Staff Survey[5] , which did collect some demographic data from respondents but no specific data on racial group was collected. Similarly, in 2020 the Department of Health's Information Analysis Directorate published the Northern Ireland Health and Social Care Workforce Census, but it did not contain data in relation to racial group.

Age:

It is not possible to get a specific breakdown of the age group that service users, or all health and social care staff, relate to.

However, we do know the breakdown across the adult population as per the 2011 census[6]: The population of Northern Ireland at the time of the 2011 census was 1,810,863, and age breakdown was as follows:

Children

- 0-4 – 6.78% (124,400)
- 5-9 – 6.15% (111,300)
- 10-14 – 6.57% (119,000)
- Young people 15-19 – 6.97% (126,200)
- Total under 19 – 26.56% (480,900)

Older People[7]

- People over 60 in NI now make up 19% of the population (Census 2011).
- The number of people aged over 85 years makes up 1.73% of the population (Census 2011).

Overall NI Age Profile

- 0-15 – 20.95% (379,378)
- 16-19 – 5.61% (101,589)
- 20-24 – 6.96% (126,036)
- 25-29 – 6.85% (124,044)
- 30-44 – 20.65% (373,943)
- 45-59 – 19.21% (347,867)

[5] https://www.health-ni.gov.uk/sites/default/files/publications/health/2019-HSC-Staff-Survey-Regional-Benchmark-Report.PDF
[6] https://www.nisra.gov.uk/statistics/census/2011-census
[7] https://www.nisra.gov.uk/statistics/population/estimates-population-aged-85-and-over

- 60-74 – 5.21% (94,346)
- 65-74 – 8.04% (145,593)
- 75-84 – 4.79% (86,740)
- 85-89 – 1.17% (21,187)
- 90 and over – 1.17% (10,141)

In 2019, NISRA conducted the HSC Staff Survey[8], which did collect some demographic data from respondents. It is important to caveat this data by noting that, of the 77,781 staff employed at the time of the survey, only 19,094 completed a response. Of those who responded, the age breakdown was as follows:

- 16 to 30 – 10%
- 31 to 40 – 23%
- 41 to 50 – 29%
- 51 to 65 – 36%
- 66+ - 2%

In March 2020, the Department of Health's Information Analysis Directorate published the Northern Ireland Health and Social Care Workforce Census[9]. This is the twentieth publication in a series of annual reports analysing the make-up of the Health and Social Care (HSC) workforce in Northern Ireland.

The age breakdown of the HSC workforce was as follows:

- Under 40 – 41%;
- 40 to 49 26%; and
- Over 50 – 33%.

Marital Status:

It is not possible to get a specific breakdown of the marital status that service users, or all health and social care staff, relate to.

However, we do know the breakdown across the adult population as per the 2011 census[10]: The population of Northern Ireland at the time of the 2011 census was 1,810,863, and breakdown of marital status was as follows:

[8] https://www.health-ni.gov.uk/sites/default/files/publications/health/2019-HSC-Staff-Survey-Regional-Benchmark-Report.PDF
[9] https://www.health-ni.gov.uk/sites/default/files/publications/health/hscwc-march-20.pdf
[10] https://www.nisra.gov.uk/statistics/census/2011-census

- 47.56% (680,840) - aged 16 or over were married;
- 36.14% (517,359) - single never married;
- 0.09% (1288) - registered in a same-sex civil partnership;
- 9.43% (134,994) - either divorced, separated or formally in a same-sex civil partnership;
- 6.78% (97,058) - either widowed or a surviving partner.

In 2019, NISRA conducted the HSC Staff Survey[11], which did collect some demographic data from respondents. It is important to caveat this data by noting that, of the 77,781 staff employed at the time of the survey, only 19,094 completed a response. Of those who responded, the breakdown of marital status was as follows:

- Single – 21%;
- Married/civil partnership – 69%; and
- Other – 10%.

Sexual Orientation:

It is not possible to get a specific breakdown of the sexual orientation that service users, or all health and social care staff, relate to.

The Office for National Statistics publishes statistics for sexual identity in the UK by sex, region and age group, sourced from the Annual Population Survey[12]. In 2018[13], the figures for Northern Ireland were as follows:

- Heterosexual or straight – 97%;
- Gay or lesbian – 0.8%;
- Bisexual – 0.4%;
- Other – 0.4%;
- Don't know or refuse to respond – 1.5%

In 2019, NISRA conducted the HSC Staff Survey[14], which did collect some demographic data from respondents. It is important to caveat this data by noting that, of the 77,781 staff employed at the time of the survey, only 19,094 completed a response. Of those who responded, the breakdown of sexual orientation was as follows:

[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/2019-HSC-Staff-Survey-Regional-Benchmark-Report.PDF
[12] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality
[13] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualidentityuk
[14] https://www.health-ni.gov.uk/sites/default/files/publications/health/2019-HSC-Staff-Survey-Regional-Benchmark-Report.PDF

- The opposite sex – 97%;
- The same sex – 3%; and
- Of the same and opposite sex – 1%.

Men & Women generally:

It is not possible to get a specific breakdown of the gender that service users, or all health and social care staff, relate to.

However, we do know the breakdown across the adult population as per the 2011 census[15]: The population of Northern Ireland at the time of the 2011 census was 1,810,863, and breakdown of gender was as follows:

- 49% Male; and
- 51% Female.

In March 2020, the Department of Health's Information Analysis Directorate published the Northern Ireland Health and Social Care Workforce Census[16]. This is the twentieth publication in a series of annual reports analysing the make-up of the Health and Social Care (HSC) workforce in Northern Ireland.

The gender breakdown of the HSC workforce was as follows:

- 79% (54,043) were female; and
- 21% (14,723 were male.

Disability:

The NI Census 2011 contains statistics in relation to long-term health problems or disabilities, and include the following percentage breakdown of all usual residents whose day-to-day activities are:

- Limited a lot – 11.89%;
- Limited a little – 8.80%; and
- Not limited – 79.31%.

Dependants:

Based on the most recent information from Carers NI[17], taken from information within the NI Census 2011 and Valuing Carers (2011), the following facts relate to carers:

[15] https://www.nisra.gov.uk/statistics/census/2011-census
[16] https://www.health-ni.gov.uk/sites/default/files/publications/health/hscwc-march-20.pdf
[17] http://www.carersuk.org/northernireland/news-ni/facts-and-figures

- 1 in every 8 adults is a carer;
- There are 214,000 carers in Northern Ireland;
- Any one of us has a 6.6% chance of becoming a carer in any year;
- Carers save the Northern Ireland economy over £4.4 billion a year - more than the annual NHS spend in Northern Ireland;
- The main carers' benefit is worth just £61.35 for a minimum of 35 hours - £8.76 per day;
- Over a quarter of all carers (26%) 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 than one person;
- 64% of carers are women; 36% are men; and
- By 2037 the number of carers could have increased to 400,000.

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

In relation to these particular policy proposals, no different needs, experiences and priorities on the grounds of religious belief have been identified.

Political Opinion

In relation to these particular policy proposals, no different needs, experiences and priorities on the grounds of political opinion have been identified.

Racial Group

The development of the policy has recognised that it will have to be sensitive to cultural differences, including language, when developing guidance materials for staff, service users, and organisations, in order to ensure the needs of persons from all backgrounds are met.

Age

The ageing population in Northern Ireland, combined with growing incidence of dementia amongst this group, suggests that capacity to participate may be an issue for some individuals. The development of the policy has recognised the different needs of this group and specific supports to enable engagement with the candour and openness policies will be included. For example, the policy proposals for the statutory duty of candour include provisions which:

- Obligate organisations to provide support for service users and carers in the event of an incident involving serious harm or death; and
- guarantee the involvement of a “duly authorised representative” on behalf of a service user or patient if they are unable to act for themselves.

Marital status

In relation to these particular policy proposals, no different needs, experiences and priorities on the grounds of marital status have been identified.

Sexual orientation

In relation to these particular policy proposals, no different needs, experiences and priorities on the grounds of sexual orientation have been identified.

Men and Women Generally

In relation to these particular policy proposals, no different needs, experiences and priorities have been identified in respect of men and women generally.

Disability

The evidence considered by the workstream during the development of the policy has identified the need to include safeguards and supports which ensure the effective participation of patients or service users with a disability. For

example, the policy proposals for the statutory duty of candour include provisions which:

- Obligate organisations to provide support for service users and carers in the event of an incident involving serious harm or death; and
- guarantee the involvement of a “duly authorised representative” on behalf of a service user or patient if they are unable to act for themselves.

Dependants

The evidence considered by the workstream during the development of the policy has identified the need to include safeguards and supports which enable the participation of carers and families on behalf of dependents in appropriate circumstances. For example, the policy proposals for the statutory duty of candour include provisions which:

- users and carers in the event of an incident involving serious harm or death; and
- guarantee the involvement of a “duly authorised representative” on behalf of a service user or patient if they are unable to act for themselves.

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:

What is the level of impact? None

Details of the likely policy impacts on Political Opinion:

What is the level of impact? None

Details of the likely policy impacts on Racial Group:

What is the level of impact? Minor

No adverse impact on equality of opportunity but it has been identified, as noted above, that the policy must account for the need to be sensitive to cultural differences, including language, in order to ensure accessibility.

Details of the likely policy impacts on Age:

What is the level of impact? Minor

No adverse impact on equality of opportunity, but safeguards and supports have been included within the policy in order to ensure equality of opportunity for all individuals on the basis of age.

Details of the likely policy impacts on Marital Status:

What is the level of impact? None

Details of the likely policy impacts on Sexual Orientation:

What is the level of impact? None

Details of the likely policy impacts on Men and Women:

What is the level of impact? None

Details of the likely policy impacts on Disability:

What is the level of impact? Minor

No adverse impact on equality of opportunity, but safeguards and supports have been included within the policy in order to ensure equality of opportunity for persons with a disability.

Details of the likely policy impacts on Dependants:

What is the level of impact? Minor

No adverse impact on equality of opportunity, but safeguards and supports have been included within the policy in order to ensure equality of opportunity for persons with dependents and carers.

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. The available evidence does not suggest the potential for a differential impact on equality of opportunity for this Section 75 group.

Political Opinion –

No. The available evidence does not suggest the potential for a differential impact on equality of opportunity for this Section 75 group.

Racial Group –

Yes. As outlined above, the policy has been drafted to include safeguards and support to promote equality of opportunity for this Section 75 group.

Age –

Yes. As outlined above, the policy has been drafted to include safeguards and support to promote equality of opportunity for this Section 75 group.

Marital Status –

No. The available evidence does not suggest the potential for a differential impact on equality of opportunity for this Section 75 group.

Sexual Orientation –

No. The available evidence does not suggest the potential for a differential impact on equality of opportunity for this Section 75 group.

Men and Women generally –

No. The available evidence does not suggest the potential for a differential impact on equality of opportunity for this Section 75 group.

Disability –

Yes. As outlined above, the policy has been drafted to include safeguards and support to promote equality of opportunity for this Section 75 group.

Dependants –

Yes. As outlined above, the policy has been drafted to include safeguards and support to promote equality of opportunity for this Section 75 group.

2.2 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group?

Please provide details of the likely policy impact and determine the level of impact for each of the categories below i.e. either minor, major or none.

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

2.3 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. This policy does not differentiate between, or seek to promote good relations between, people of different religious belief.

Political Opinion –

No. This policy does not differentiate between, or seek to promote good relations between, people of different religious belief.

Racial Group –

No. This policy does not differentiate between, or seek to promote good relations between, people of different religious belief.

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?**
(*For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people).*

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

The impact will be experienced by all those accessing, and working for, health and social care services in Northern Ireland. Particular impacts on certain Section 75 categories have been acknowledged above, and safeguards introduced into the policy proposals as a consequence. Some individuals may fall into more than one of these categories, for example disabled older people, making the inclusion of these safeguards all the more important in order to mitigate against this impact.

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.

N/A

Part 3. Screening decision

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

Minor

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

No

3.3 Please explain your reason.

The decision is not to conduct an equality impact assessment on the draft policy proposals at this time. Some minor impact on Section 75 groups has been identified as part of the policy development and screening process, with safeguards and supports included within the proposals as a consequence.

However, this policy will be screened again once the consultation exercise has concluded and any amendments are made to the proposals, in order to identify and mitigate against any consequential differential equality impacts. In order to assist with this process, as part of the public consultation exercise a question has been included relating to the potential impact of the policy, and feedback will be requested from stakeholders regarding the equality impacts. The public consultation plan has also been drafted in order to create opportunities for the workstream to receive additional feedback on the impact of the policy.

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?

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

See above.

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?

The policy includes proposed statutory requirements for organisations subject to the legal duty of candour to monitor their adherence to the law and provide an annual report to the DoH and the Regulation and Quality Improvement Authority (RQIA) for consideration.

Separately, another recommendation from the IHRD report has recommended oversight of compliance with the statutory duties be undertaken by the RQIA, and proposals are being developed in order to implement this recommendation.

The Workstream has also sought feedback from stakeholders on the best method of monitoring the impact of the policy once implemented as part of the consultation exercise. Possible data sources may include patient experience data and staff feedback, for example. Feedback in this regard will inform the development of data sources and key measures in order to monitor the effect of the policy once implemented.

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?

As outlined above, the policy includes safeguards and protections to ensure that all individuals, including those with a disability, are able to effectively participate in the duty of candour process and experience openness from health and social care services.

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?

None have been identified at this early stage of policy development. We will be engaging further with key stakeholders, including service users and advocacy groups, during the formal public consultation on the draft policy. This aspect will be kept under review and amended as necessary.

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:

What is the impact? Positive

Article 2 (Right to life) requires states to protect people's lives by safeguarding against accidental deaths, and the introduction of statutory duty of candour is intended to improve reporting and investigation of these incidents to prevent reoccurrence.

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

What is the impact? Positive

Article 3 (prohibition of torture and cruel, inhuman and degrading treatment) provides that citizens should never be treated in ways that cause us serious physical or mental suffering. Again, the introduction of statutory duty of candour is intended to improve reporting and investigation of incidents involving serious harm to prevent reoccurrence.

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Positive

Article 10 (freedom of expression) provides the right for us to hold our own opinions, to express our views and ideas, and to share information with others. The introduction of a statutory duty of candour will provide statutory rights for patients and service users to participate in the investigation of safety incidents, and also protect members of staff who participate honestly and openly in these proceedings.

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

What is the impact? Neutral

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

N/A

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.

None

Part 7 - Approval and authorisation

Screened by:	**Position/Job Title**	**Date**
Alan Weir	Deputy Principal	First draft – 17/2/21 Second draft - 7/4/21
Approved by:		
Linda Greenlees	Grade 7	First draft – 18/2/21 Second draft - 7/4/21
Copied to EHRU:		First draft – 2/4/21 Second draft - 7/4/21