Equality and Human Rights Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

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)

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

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

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

SCREENING TEMPLATE

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

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Procurement of Community Garden Projects

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

Community Development and Health procurement

The range and variety of communities including profile of need, urban/rural, existence and level of available community and public sector assets, community relations context etc has meant that there are a wide range and variety of 'Community Development and Health' Contracts supported by PHA across the region.

Critically the PHA primary commissioning focus needs to be on the Making Life Better Strategic framework and to set commissioning themes leading to the submission and selection of best possible interventions addressing the improvement of health and wellbeing, particularly for those who are currently or who are at risk of experiencing poor health and wellbeing outcomes.

In particular there are four key streams that have been the subject of PHA investment since 2008/09 which also include legacy Investing for Health and Board commissioning from 2002. These are;

- Explicitly categorised community development and health support Contracts to organisations and communities –these are highly varied including for example; 3 Posts located with Local Area Partnerships within the Shankill, South and West Belfast; the Northern Community Network Contracts –resourcing 3 specific Networks whose remit is to provide CD and Health support to designated geographical locations. There are within this category a number of

Contracts that aim to build capacity building for BME, for example, Chinese Welfare Association and STEP.

- Commissioning of health and wellbeing improvement services from community based organisations known as Healthy Living Centres, primarily working in areas of high deprivation and concentrated in Western and Belfast localities;
- Commissioning of services which promote sustainable communities such as community gardens and allotments
- Testing new ways of working in local Neighbourhoods such as the Clare Project in Mount Vernon or Resurgam in Lisburn.

The current Community Gardens and allotments contracts have an annual value of in circa £373,346.

In addition to the legal requirement for PHA to openly award contracts, it is also an opportune time to review PHA investment and align it to the emerging Community Development Framework being produced by the Transformation Implementation Group (TIG) Community Development Work stream, which has been tasked to share the learning from effective community development practice and grow this practice over time in order to improve health and wellbeing to reduce inequalities to contribute to the overall HSC Transformation outlined in 'Health and wellbeing 2026: Delivering Together.'

Over the last few years there has been a growing body of evidence supporting the benefits of community growing, green spaces and outdoor education for physical and mental wellbeing. Horticultural and other tasks involved in community growing (such as regular exercise) alongside healthy eating patterns are some of the positive outcomes usually cited in this research. Studies have found that the mental health benefits of gardening are extensive. Not only can it reduce mental health problems like depression and anxiety, but it can also reduce stress and combat high blood pressure

The Public Health Agency currently supports a number of horticulture-type projects across the region with a total current investment of £373,346 (3 x pilot projects, 1 x tendered contract and 5 x rolled forward contracts. The projects supported range in type and include 3 x community nursery hubs (pilot projects Belfast South Eastern area), Green Gym projects through The Conservation Volunteers, and gardening projects through Ground work. (A list of the current investment can be found in Appendix 1).

Summary of what we plan to do

Based on the evidence gathered on the benefits of community gardening on health and wellbeing options were discussed for services to be tendered based on what produces best health and wellbeing outcomes currently. It was agreed that commissioning will involve 2 distinct programmes/models

within the overall community garden model.

Community Gardens Model 1 is a preventative model which uses an outreach approach to increasing physical activity, improving mental health and social wellbeing through horticulture and nature through short-term interventions, and using existing community resources. This model promotes therapeutic objectives, such as confidence-building and increasing self-esteem, knowledge and skills acquisition, whilst encouraging interaction and teamwork. In addition this model will also develop employability and life skills required for independent and sustainable living.

Community Gardens Model 2

Given the evidence gathered through the evaluation of the three pilot community nursery hubs (report to be attached to business case as appendix when finalised), it was also agreed that there is value in longer-term community garden projects which meet the needs of a range of individuals/groups and which will work towards becoming community nursery hubs at the end of 5 years. The evaluation report describes a community nursery hub as:

> *A green space which provides a focal point and facilities to foster greater local community activity to improve the quality of life in their areas through the natural environment and horticulture. A nursery hub should have adequate space and resources required to maintain their project and also to enhance the capacity of smaller community growing spaces. A nursery hub will use a partnership approach to develop strong links with other community, voluntary and statutory organisations in order to maximise opportunities for people to access the services. A nursery hub will provide opportunities for individuals and groups to maximise their potential, learn new skills, acquire knowledge, build confidence and increase self-esteem and will provide a more long-term service tailored to individual/group need.*

PROGRAMME 1 OBJECTIVES

- To improve mental health and wellbeing through the delivery of innovative interventions/programmes that promote positive mental health and wellbeing
- To contribute to the reduction of social isolation through
    - the delivery of programmes to be delivered to vulnerable groups/individuals in communities
    - provision of opportunities for community engagement
- promotion of activities that help to overcome the risks faced by and poor health outcomes of individuals who are lonely and socially isolated
- Address the determinants of poor health and reduce health inequalities by
    - Targeting the delivery of resources, programmes and/or services to individuals/groups within the top 20% most disadvantaged neighbourhoods.
    - Targeting the delivery of resources, programmes and/or services to vulnerable

groups/individuals in local communities
- To build sustainable resilient communities through
    - Capacity building within communities
    - Increasing community participation
    - Promotion of volunteering
- Encouraging partnership working

PROGRAMME 1 TARGETS

The specification for Take 5 service should include the following:

- 1 x facilitator with appropriate skills, qualifications and knowledge including community development experience to co-ordinate the project
- Number x sessions on community garden / horticulture to be delivered to number x participants (Participants to be recruited from a range of groups including disability, mental health, learning disability, older people, young people, unemployed, people from areas of multiple deprivation etc. **(Connect/Keep Learning)**
- Number x community groups to be supported to develop community gardens and allotments **(Connect/Keep Learning)**
- Encourage formal training and qualifications in horticulture to enhance employability **(Keep Learning)**
- Development of number x community gardens - a local green space which can be enjoyed by all service users alike and which connects people to nature and their environment**(Take Notice)**
- Hold a series of community gardening events to engage with new members based on health intelligence **(Connect)**
- Hold a series of taster sessions on community gardening to engage with new members based on health intelligence (**Connect)**
- Promote a range of community gardening volunteering opportunities and recruit number x volunteers per year **to include strong links with Volunteer Now(Give)**
- Encourage independence and sustainability of established groups
- Assess improvement in health and wellbeing by using an evidence-based assessment tool pre post programme such as Short Warwick Edinburgh Mental Wellbeing Scale.

AND

Given the evidence gathered through the evaluation of the three x pilot community nursery hubs, it was also agreed that there is also a place for longer-term community garden projects which meet the needs of a range of individuals/groups and which will work towards becoming best practice sites/community nursery hubs at the end of 5 years. The provider could either be selected on a regional basis for local

delivery in each locality or a provider selected for delivery within each locality.

PROGRAMME 2 OBJECTIVES

- Develop a community nursery hub as a model of best practice and to support the development of smaller community gardens within the local community by end March 2024.
- By 2024 have a minimum of 10 groups participating in the nursery hub per year, through regular involvement in gardening activities and participation in community garden / horticulture sessions
- To contribute to the reduction of social isolation through
    - provision of opportunities for community engagement
    - promotion of activities that help to overcome the risks faced by and poor health outcomes of individuals who are lonely and socially isolated
- Address the determinants of poor health and reduce health inequalities by targeting the delivery of resources, programmes and/or services to vulnerable groups/individuals in local communities.
- To build sustainable resilient communities through
    - Capacity building within communities
    - Increasing community participation
    - Promotion of volunteering
    - Encouraging partnership working

- To support healthier lifestyles by gathering evidence to support this eg through use of evidence-based tool such as SEWMBS.

The specification for Best Practice/Community Nursery Hub model service should include the following:

PROGRAMME 2

- Establish robust marketing/communications process and referral pathways to become involved in the community gardens project
- Establish robust induction process for accessing and being involved in the community gardens project
- Develop 3 x outreach demonstration sites per year
- Facilitate number x groups made up of service users with varying needs/abilities to develop skills and knowledge in developing and sustaining a community garden
- Offer a range of opportunities for individuals who are not able to work as part of a group, for a variety of reasons e.g. psychological issues, to develop skills and knowledge in developing and maintaining a community garden.
- Engage with local/neighbouring communities
- Host number x community gardening events on site
- Hold a summer scheme for children from local/neighbouring communities

- Provide appropriate training for number x volunteers to become lead volunteers aiming to have number x lead volunteers per year
- Provide a written programme of gardening activities
- Evaluation to be embedded from outset using an evidenced based tool such as SEWMBS to measure improvement in health and wellbeing.
- Sustainability to be embedded from the outset
- Deliver number x workshops on horticulture per year

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

The main groups that will be affected by the Procurement of Community Garden projects are as follows:

External

Externally the key stakeholders are:

- The wider community
- Groups and individuals including service users and carers covered by the 9 equality categories under section 75 equality legislation
- The Department of Health, Social Services and Public Safety
- HSC Trusts and Agencies
- Health and Social Care Professionals
- The Community sector
- The Voluntary Sector
- The independent Sector
- Other statutory organisations
- Universities
- Trade Unions

Internal

- Public Health Agency with an emphasis on commissioning priorities in terms of community development

- Health and Social Care Board with an emphasis on commissioning priorities in terms of community development

1.4 Other policies or decisions with a bearing on this policy or decision

Draft Programme for Government 2018-19

The draft Programme for Government contains 14 strategic outcomes which, taken together, set a clear direction of travel and enable continuous improvement on the essential components of societal wellbeing. They touch on every aspect of government, including the attainment of good health and education, economic success and confident and peaceful communities. The outcomes below are clearly illustrated by the work of community gardening projects

(i) We have a more equal society

People in different social circumstances experience markedly different outcomes in terms of preventable deaths, healthy life expectancy, and long term conditions. Health and wellbeing and health inequalities, are shaped by many factors that affect people's choices and the control they have over their lives. These include family, community, education, work and income, beliefs and traditions and physical and social environments such as housing and air quality. Support for local communities to adopt sustainable living practices such as the development of community gardens, can improve health and wellbeing, build social capital, and help to reduce health inequalities.

(ii) We enjoy long, healthy, active lives

Good physical and mental health brings social and economic benefits both at an individual and societal level. Although there has been a marked increase in our life expectancy in recent times, it is a fact that for many of us these additional years are not enjoyed in good health. For individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives, active collaboration is needed across government and with local government, the community and voluntary sector, private businesses and other organisations and delivery partners, to address the factors which impact on health and wellbeing. It is widely recognised that regular contact with plants, animals and the natural environment can improve our physical and mental wellbeing. For the large number of people in our society, who live with challenging physical or mental health problems, gardening and community food growing can be especially beneficial. Such activities can relieve the symptoms of serious illnesses, prevent the development of some conditions, and introduce people to a way of life that can help them to improve their wellbeing in the longer term.

(iii) We are an innovative, creative society, where people can fulfil their potential

For individuals and communities experiencing poverty and deprivation, outside intervention and support is essential. It is not possible to break free from poverty without confidence, capability and

necessary skills. However living under difficult conditions makes it difficult to acquire those attributes. We need to find innovative ways to break this cycle by giving people opportunities to fulfil their potential. Community gardens can provide fresh produce to areas where affordable, healthy food may be hard to come by, but it also creates a community asset for residents to be proud of. Gardens can foster social ties alongside the knowledge and pride that volunteers gain from working there and this, in turn, contributes to increasing community resilience.

(iv) We care for others and we help those in need

It is important that we support all citizens in our society to build self-confidence and capacity to live independent self-fulfilling lives and in particular, those who are vulnerable and ensure they have the means to help themselves and can live their lives free from fear, discrimination and exclusion. Northern Ireland's population is growing and we are living longer. We must consider the needs of an ageing population, promote positive attitudes to older people and tailor support to enable them to enjoy better health and active lifestyles. We also need to ensure that older people are able to feel safe and secure in their environments, and that they do not become economically or socially isolated. Community gardens are an excellent example of asset-based community development approach to tackling social isolation as they deliver a range of services that meet 3 key criteria 1) Being what local older people want, 2) Involving older people and 3) Being sustainable.

Making Life Better

A Whole System Strategic Framework for Public Health 2013-2023

Making Life Better 2012-2023 is the ten year public health strategic framework. The framework provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland. It builds on the Investing for Health strategy (2002-2012) and retains a focus on the broad range of social, economic and environmental factors which influence health and wellbeing. It brings together actions at government level and provides direction for implementation at regional and local level. The Making Life Better framework seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential to reduce inequalities in health. The following outcomes are clearly linked to health and wellbeing outcomes achieved through community garden type projects.

(i) Equipped Throughout Life

Community Gardening Projects encourage and engage people at any age in leisure activities which impact on both physical and mental health and wellbeing, as well as on such issues as creativity, social inclusion, and good relations. Participation in such interests offers lifelong enjoyment and fulfilment and is an essential part of healthy living. Volunteering also benefits individuals, communities

and wider society. It helps to connect and support people, and to progress issues or interests. It also helps individuals develop new skills, and utilises the resources of those with skills and expertise to promote the transfer of skills to others. Volunteering has the potential to build capacity, capability and self-esteem in the young, and also promote social inclusion and intergenerational activity.

As well as physical health it is clear that mental health is a major public health concern in Northern Ireland, necessitating a strong strategic drive to prevent mental illness (where possible) and promote positive mental health and wellbeing in the general population. This is a major outcome of community gardening projects.

(ii) Healthy Active Ageing

It is important for older people to be able to maintain active healthy lives. Community gardening projects encourage older people to maintain active independent lives, with access to opportunities to engage in social and educational activities. In addition they:

• advance health and wellbeing into older age;

• reduce inequalities experienced by older people;

• promote the inclusion and full involvement of older people in society and their local communities

(iii) Empowering communities

The communities and social networks to which people belong also have a significant impact on health and wellbeing. Support from families, friends and communities is associated with better health. Social capital – the links that connect people within communities - can promote resilience against difficulties and give people a feeling of control over their own lives. Community gardening projects provide a vehicle for building social capital and creating resilient communities, and they provide opportunities for engagement, particularly of vulnerable or hard to reach groups, and for creativity. They can also generate intergenerational and environmental benefits.

(iv) Making the most of the physical environment

Green spaces are vital in communities to encourage community cohesion and promote healthy lifestyles and can also renew civic pride in local communities. Physical environments can be designed to promote health and wellbeing through providing access to services and opportunities for social interaction. Numerous studies point to the physical and mental health benefits of access to green spaces and better air quality. Community gardening projects make the most of the physical environment in promoting healthy and active living. Health inequalities are halved in greener areas. For example, a recent study suggested that in the most deprived groups the number of mortalities are halved in areas with the greenest space. Improving green space use may promote social cohesion by allowing groups from different social backgrounds to interact, which in turn has health benefits, such as reducing stress and depression. Green or social prescribing is the referral of outdoor physical activity as well as, or instead of, clinical support and medication. Researchers have used terms such as ‘dose of nature’ to engage health practitioners and encourage use of exercise prescriptions. NICE has

recommended exercise referral schemes as an intervention only for sedentary or inactive patients that have existing health conditions or other factors that put them at increased risk of ill health. GP's prescribe activity to improve physical health and wellbeing.

Health and Wellbeing 2026 Delivering Together

Delivering Together, published by the Department of Health in 2016, sets out a vision for transforming health and social care services in response to the Expert Panel Report on Health and Social Services in Northern Ireland – Systems not Structures (the Bengoa report). It also builds on the reports of Sir Liam Donaldson and Transforming Your Care. Delivering Together is now the roadmap for the reform of health and social care. The goal is the transformation of the whole system of health and social care in order to underpin a more holistic model of person-centred care focussed on prevention of ill health, early intervention, and supporting independence and wellbeing. In other words, a shift towards health promotion and a population health model supporting people to keep well.

Delivering Together places clear emphasis on building capacity in communities in order to reduce health and wellbeing inequalities. It states that the HSC will become better at tapping into the innovative ideas and energies in communities themselves, and in the community and voluntary sectors. Community gardening projects epitomise innovation in tackling health inequalities as they allow groups from different social backgrounds to interact, which in turn has health benefits such as reduced stress, anxiety, and depression. These projects create the circumstances for people to stay healthy, well, safe and independent in the first place, which is a clear ambition of the Delivering Together report.

A Fitter Future for All – Framework for Preventing and Addressing Obesity in Northern Ireland 2012 – 2022

This Framework aims to "empower the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity related diseases and improve health and wellbeing, by creating an environment that supports and promotes a physically active lifestyle and a healthy diet". Obesity has been described as a "time-bomb", and it has the potential to severely affect the health and wellbeing of the population. It also impacts upon wider society through the increased cost of health care (including increased pressure on the system) and lost productivity.

In fact, overweight and obesity are now so common among the world's population that they are beginning to replace malnutrition and infectious diseases as the most significant contributors to ill health. Maintaining a healthy weight, eating a balanced diet and keeping physically active can improve

health and reduce the risk of diseases associated with being overweight, such as coronary heart disease, osteoporosis, type-two diabetes and certain cancers. The obesity-related conditions outlined above can reduce life expectancy, impact on mental health, undermine quality of life, and impose huge burdens on families, carers and health services. Investing resources in preventing and addressing obesity should provide value for money, and if levels of obesity continue to rise unabated, it is very likely that the related costs will grow significantly over the next few decades.

Within the 'obesogenic environment' specific reference is made to the impact and importance of the built environment. There is also an argument that there is a particular relationship between the built environment and health inequalities. In respect of obesity it has been argued that:

- Physical activity through the presence of green space not only reduces the risk of heart disease (by up to 50%), but also has a positive impact on stress, obesity and a general sense of wellbeing. It also cuts the risk of premature death (by 20-30%).
- Green spaces link directly to levels of physical activity. Children with more green space are less likely to be over-weight

Community gardens come in many shapes and forms but overall they share similar benefits. They provide opportunities to increase physical activity, improve food and nutrition knowledge, and increase consumption of fruit and vegetables. Participation in community gardens can therefore have a positive impact on both physical and emotional wellbeing (Armstrong 2000)

Expansion of Community Development Approaches (Transformation Implementation Group) May 2018

Community gardening projects provide opportunities to reduce health inequalities. They are an alternative to a health care setting and provide a range of health and wellbeing outcomes including positive physical, mental, and social wellbeing. The community development approaches used by the community gardening projects contribute to

- Improved individual capacity to make positive change
- Improved social and physical determinants
- Improved quality accessible services
- Fairer distribution of power, wealth and resources

Challenging unequal power relationships and promoting equality are central tenets of community

development, as defined by the National Occupational Standards. The key outcomes created by implementing community development values and principles have been identified as co-operation, organisation, confidence, inclusivity and influence. By developing individual confidence and co-operation, community development has the potential to enable people to make changes that support their health. More significantly, by enabling communities to address their own needs, community development has the potential to empower people to improve their local services, environment and life conditions. Most importantly, by transferring power to communities, and their constituent groups, community development addresses the inequitable distribution of power, a root cause of health inequalities.

Community Planning Processes

Community planning is about wider engagement with communities in the co-design and production of services, and engagement with those sectors that influence the determinants of health and wellbeing ie education, employment, urban planning and so forth. From a health perspective, it is about working with communities in order to co-create health and wellbeing.

Health and wellbeing is now firmly embedded as a theme of all the community plans drawn up for each of the eleven District Councils.

Other strategies and programmes contributing to community development

Enabling individuals, families, and communities to live healthy lives requires action across a wide range and variety of policy areas. This includes policies and programmes for:

- improving health and wellbeing outcomes, addressing harmful behaviour and promoting healthy behaviour
- addressing the complex inter-relationship between mental and physical health and wellbeing, and inequality and disadvantage;
- improving educational, social, cultural, environmental, and economic outcomes; and
- preventing violence and abuse.

CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

Qualitative Data

Demonstrating the need for the project

Supporting healthy lifestyles

The first results of The Health Survey Northern Ireland 2016/17 reports that 36% of respondents were overweight and 27% were obese (No increase on 2015/16, but general upward trend in obesity over the last decade as illustrated in Figure 1). Males are more overweight and obese (39% and 28% respectively) than females (34% and 25% respectively). There is a definite upward trend and therefore there is a need to provide opportunities for people to participate in physical activity that is both enjoyable and effective.

Epidemiological research shows that being obese can increase the risk of a range of health conditions including Type II Diabetes, some cancers and heart disease[1]. One element of the Obesity Prevention Strategy: A Fitter Future for All Framework focuses on encouraging participation in physical activity as one way to help tackle this modern lifestyle epidemic. Implementing community gardening initiatives will support the aim of the Framework by supporting participants to engage in physical activity through gardening tasks, as well as providing information and support to encourage people to make healthy choices, reducing the risk of becoming obese and overweight, and associated health conditions. Engagement in gardening can address the recommendation of encouraging participation in physical activity, as the gardening activity is recognised as a moderate-intensity physical activity that adults are advised to undertake 30 minutes or more of on five or more days of the week (NICE, 2006).

The 'Growing a Healthier Older Population' project in Wales, UK measured the impact of being a gardener on aspects of physical and psychological health and wellbeing, comparing gardeners on an allotment plot or at a community garden with people same age group who were on an allotment waiting list (Hawkins et al, 2013). In this study, 68% of gardener participants reported exercise frequencies that met physical activity recommendations, compared to on 25% of adults in the same age group in the Welsh population in general. Similarly Park et al (2008 concluded that healthy older gardeners in their study met their physical activity recommendation through gardening and that this

[1] A Fitter Future for All Outcomes Framework

may be a factor leading to better physical and mental health.

Mental health

Mental illness is a major public health issue in NI and is the single largest cause of ill health and disability. NI has higher levels of mental ill health than any other region in the UK and 1 in 5 adults here have a mental condition at any one time, which is a 25% higher overall prevalence of mental illness than England.[2]

In the 2015-16 NI Health Survey, one-fifth (19%) of respondents scored highly (greater or equal to 4) on the GHQ12 (General Health Questionnaire) (see Figure 3), suggesting they may have a mental health problem. This is more likely to be the case for women (21%) compared with 16% of men (see Figure 4). Respondents in the most deprived areas were also twice as likely to record a high GHQ12 score (27%), as those in the least deprived areas (13%) (see Figure 5). In the 2016/17 NI Health Survey 17% of respondents had a high GHQ12 score which could indicate a mental health problem. The proportion of females with a high GHQ12 score fell to 18% (from 21% in 2015/16) Males remained unchanged. 45% of those who had mental health concerns felt that their normal activities were affected (22% missed time at work/school/university). Nearly a third (30%) had concerns about their own mental health in the past year.

Gardens, as well as the activity of gardening, have been shown to have a positive impact on mental health and wellbeing, the result of both the physical activity and the use of the garden as a space for mental relaxation and stimulation. In 2013 the UK charity Mind published a report on the outcomes of their 130 ecotherapy projects across England (Mind, 2013). They described "ecotherapy as an intervention that improves mental and physical health and wellbeing by supporting people to be active outdoors; doing gardening, food growing or environmental work". Based on a number of external evaluations (Bragg et al. 2013, New Economics Foundation, 2013) of their projects they concluded ecotherapy services can help people to look after their mental wellbeing, support people who may be at risk of developing a mental health problem and help the recovery of people with existing mental health problems (Mind, 2013). Growing plants gives us a sense of responsibility in that you have to care for a living thing and help to nourish it and grow it, otherwise it will die. This responsibility is beneficial for people suffering with mental health issues as it gives them purpose and a sense of worth and it can improve self-esteem and confidence.[3] Gardening connects people with nature and the outdoors and this has a hugely beneficial impact on mental health. Concentrating on a physical task

[2] *Making Life Better*, DHSSPS, June 2014, page 18, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf

[3] https://www.capitalgardens.co.uk/blog/gardening-great-mental-health-wellbeing

can take our minds of stresses and worries of everyday life and therefore reduce anxiety.

Social Isolation

Social isolation has been defined as the complete or near-complete lack of contact with people and society for members of a social species, in this case, human beings. Loneliness has been defined as a subjective, unwelcome feeling of lack or loss of companionship.[4] One of the good news health stories of recent years is that we are living longer however with an ageing population comes certain challenges such as how to maintain independence and health. Within an ageing population, loneliness and social isolation are major issues facing our society, impacting significantly on wellbeing and quality of life, with discernible negative health effects.[5] There are many ways to tackle social isolation in older people but the key messages are to keep active, both physically and mentally. The NICOLA study explored current patterns of social engagement in Northern Ireland within three contexts: participation in groups; volunteering behaviours; and religious beliefs and practices. Participants in the NICOLA study were asked about their participation in different types of activities and organisations. Thirty-nine percent took part in activity groups (where people get together to do an activity or talk about things), 30% took part in a local group, whilst only 9% participated in a national group (such as political or environment groups or charities. The most popular activity groups related to sports/exercise (36%) or religious groups (31%). Only one in ten participated in groups for older people.[6] This data indicates that social isolation remains a significant problem for many older people in our society. The Active Ageing Strategy[7] supports the United Nations Principles for Older People of which there is a theme under Participation. The principles of participation are as follows:

- Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
- Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
- Older persons should be able to form movements or associations of older persons.

Community garden projects are underpinned by these principles of participation as they provide a place where older people can feel valued, increase social contact, social support, social cohesion, and learn new skills. In their study of Social and Therapeutic Horticulture, Sempik et al (2005) argue that

[4] Volunteering and Combating Social Isolation and Loneliness Volunteer Now June 2017
[5] Early key findings from a study of older people in Northern Ireland (The NICOLA Study)
[6] Early key findings from a study of older people in Northern Ireland (The NICOLA Study)
[7] Active Ageing Strategy 2016-2021 Northern Ireland Executive

community gardens enable social inclusion through providing meaningful activities for participants (production) in an environment that is deliberately structured to promote social interaction and maximise social opportunities.[8]

The Health Survey Northern Ireland 2016/17 data on loneliness indicates that almost half of the over 65's feel they lack companionship some of the time. This is evident also in over 65's when asked how often they feel isolated from others as just under half the population have responded that they feel isolated some of the time. It is clear that there is still more work to do in order to reduce social isolation, particularly in older people.

Loneliness

"Loneliness can be transient, a feeling that occurs from time to time, at a particular stage in life or associated with specific life events or chronic where a person feels lonely most or all of the time."[9]

There are a range of vulnerable groups who are at risk of loneliness including; Members of the Lesbian, Gay, Bisexual and Transgendered community; Individuals living with dementia or cognitive impairment; Individuals with a physical disability/mobility issues; individuals with an intellectual disability; Individuals who are caring for a family member or friend

A large majority of people who participate in community garden projects suffer from poor mental health, are older, or have disabilities. The majority of these people suffer loneliness and social isolation to some degree in their lives and community garden projects provide an outlet for them to connect to other people, to have something to look forward to every week, and to make friends with other people.

Early key findings from a study of older people in Northern Ireland – The Nicola Study – November 2017: Sharon Cruise, Frank Kee

The latest population figures published in October 2017 suggest that by 2041, almost one in four people will be aged 64 or over. Indeed, by mid-2028, it is estimated that the number of people in this age group will exceed the number of children for the first time. The statistics also suggest that by 2041, 4% of the population will be aged 85 years or over. Older people make a huge contribution to their families and wider society,for example, in paid work, by volunteering, and by providing childcare for their grandchildren. At the same time, large numbers of older people are suffering due to poorer health, poverty and lack of appropriate care. Too many are experiencing loneliness for a host of reasons, including loss of relationships and social networks, often features of the ageing journey.

Department for Health Caring for Carers Strategy, Recognising, Valuing and Supporting the

[8] Green Care: A Conceptual Framework Sempik et Al 2010

[9] Loneliness and ageing: Ireland, North and South Summary Report Institute of Public Health in Ireland 2016

Caring Role 2006

It is clear that carers enable many thousands of vulnerable people who need support, to continue to lead independent lives in their local communities. At the same time carers reduce the amount of input that health and social services and other agencies need to make. It is essential that we act positively to protect the interests of carers and to foster a climate where they can continue to care for as long as they wish and are able to do so, without jeopardising their own health and well-being, financial security, or reducing their expectations of a reasonable quality of life. We want to enable carers to make more choices for themselves and to have more control over their lives. We want services to recognise carers as individuals in their own right. So we are giving new support to carers.

The Bamford Review of Mental Health and Learning Disability (Northern Ireland)2006 (Human Rights and Equality of Opportunity October 2006)

Respect for human rights and promotion of equality of opportunity: these values underpin the Bamford Review of Mental Health and Learning Disability (Northern Ireland) This report is a key product of the Review and provides the ethical foundation on which
proposals for service reform and modernisation, including legislative reform, have been based. Much of the detail of how this rights-based vision can be achieved in practical terms is given in other reports from the Review and, in particular, the report on Promoting Social Inclusion.

Other sources of data

- https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland **NISRA Mid-year estimates**
- The Census 2011
- Northern Ireland Life and Times Survey 2016
- Annual Reports for the Registrar General
- Carers NI The State of Caring 2017
- The Health Survey Northern Ireland 2016/17
- Northern Ireland Pooled Household Survey (NIPHS) tables published 2017
- Annual Population Survey 2016

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND

EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Group	**Census 2011: total population in Northern Ireland is 1,810,900.** **Latest NISRA mid-year population estimates (2016; published in June 2017) that NI population is** 1,862,100 Available at https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland
Gender	The proportion of females in 2011 is 51.00% (923, 540). The male population is 49.00% (887, 323) in 2011. Mid-year population estimate (2016; published June 2017) The size of the resident population in Northern Ireland at 30 June 2016 is estimated to be 1.862 million people. Just over half (50.9 per cent) of the population were female, with 946,900 females compared to 915,200 males. Available at https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland

	Transgender Research suggests for the Northern Ireland population as a whole: • 140-160 individuals are affiliated with transgender groups • 120 individuals have presented with Gender Identity Disphoria • **There are more trans women than trans men living in Northern Ireland.** (McBride, Ruari Santiago (2011): Healthcare Issues for Transgender People Living in Northern Ireland. Institute for Conflict Research.) **The Gender Identity Research and Education Society (GIRES)** estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014): • gender variant to some degree 1% • have sought some medical care 0.025% • having already undergone transition 0.015% The number who have sought treatment seems likely to continue growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among youngsters is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men). Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2016) N=1,862,100: • 18,621 people who do not identify with gender assigned to them at birth • 466 likely to have sought medical care • 279 likely to have undergone transition.
Age	**Mid-year population estimates** published by NISRA in 2017 show that: 0-19 yrs (inclusive) = 483,978 (26.0% of all NI population)

	20 – 34 yrs = 366,619 (19.7%) 35 – 49 yrs = 370,263 (19.9%) 50 - 64 yrs = 343,522 (18.4%) 65 – 74 yrs = 166,059 (8.9%) 75 – 89 yrs = 118,965 (6.4%) 90+ yrs = 12,731 (0.7%) **Age projections** NISRA Estimated and projected population by age, mid-2016 to mid-2041 show that in 2016, 20.8% of the NI Population were aged 0-15 years, and this is projected to decrease 18.2% in 2041. The proportion of adults aged 16-64 in 2016 was 63.2% of the whole population, set to decrease to 57.2 by 2041. However, the proportion of people aged 65 years and over is projected to rise from 16.0% in 2016 to 24.5% in 2041, overtaking the numbers of children. https://www.nisra.gov.uk/publications/2016-based-population-projections-northern-ireland-statistical-bulletin-charts
Religion	Religion or Religion brought up in • 45.14% (817, 424) of the population were either Catholic or **brought up** as Catholic. • 48.36% (875, 733) stated that they were Protestant or **brought up** as Protestant. • 0.92% (16, 660) of the population belonged to or had been **brought up** in other religions and Philosophies. • 5.59% (101, 227) neither belonged to, nor had been brought up in a religion. (Census 2011) Currently identifying as: Catholic 40.76% (738, 108)

	Presbyterian Church in Ireland 19.06% (345, 150) Church of Ireland 13.74% (248, 813) Methodist Church in Ireland 3% (54, 326) Other Christian(including Christian related) 5.76% (104, 308) Other religions 0.82% (14, 849) No religion 10.11% (183, 078) Did not state religion 6.75% (122, 233) (Census 2011)
Political Opinion	**Nationality** • British only – 39.89% (722, 353) • Irish only – 25.26% (457, 424) • Northern Irish only – 20.94% (379, 195) • British and Northern Irish only – 6.17% (111, 730) • Irish and Northern Irish only – 1.06% (19, 195) • British, Irish and Northern Irish – 1.02% (1847) • British and Irish only – 0.66% (11, 952) • Other – 5.00% (90, 543) (Census 2011) **"Which of these political parties do you feel closest to?" (**Northern Ireland Life and Times, 2016) DUP/Democratic Unionist Party 17%

	Sinn Fein 14 % Ulster Unionist Party (UUP) 12% Social Democratic and Labour Party (SDLP) 12% Alliance Party 9% Other Party (WRITE IN) 3% None of these 23% Other answer (WRITE IN)/ Don't know 12%. Breakdown by males and females, religion and age can be found here: http://www.ark.ac.uk/nilt/2016/Political_Attitudes/POLPART2.html **"Generally speaking, do you consider yourself as a unionist, a nationalist or neither?" (**Northern Ireland Life and Times, 2016) Unionist 29%; Nationalist 24%; Neither 46%; Other/ don't know 2%. Breakdown by males and females, religion and age can be found here: http://www.ark.ac.uk/nilt/2016/Political_Attitudes/UNINATID.html
Marital Status	• 47.56% (680, 840) of those aged 16 or over were married • 36.14% (517, 359) were single • 0.09% (1288) were registered in same-sex civil partnerships • 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership • 6.78% (97, 058) were either widowed or a surviving partner (Census 2011) **Northern Ireland Life and Times (2016)** Single (never married) 33% Married and living with husband/wife 50%

	A civil partner in a legally-registered civil partnership 0% Married and separated from husband/wife 3% Divorced 6% Widowed 8% Results for males/ females; religion; age available here http://www.ark.ac.uk/nilt/2016/Background/RMARST.html **Civil partnerships** Annual Reports of the Registrar General for NI show that Between 2005 to 2016 inclusive, there have been 1110 civil partnerships registered in NI. Of these, 539 have been male civil partnerships, and 571 have been female civil partnerships. (Available at https://www.nisra.gov.uk/publications/registrar-general-annual-report-2016-civil-partnerships-and-dissolutions
Dependent Status	• 11.81% (213, 863) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill – health/disabilities or problems related to old age. • 3.11% (56, 318) provided 50 hours care or more. • 33.86% (238, 129) of households contained dependent children. • 40.29% (283, 350) contained a least one person with a long – term health problem or a disability. (Census 2011) Carers NI • 1 in every 8 adults is a carer • 2% of 0-17 year olds are carers, based on the 2011 Census • There are approximately 220,000 carers in Northern Ireland (• Any one of us has a 6.6% chance of becoming a carer in any year • 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

	• 64% of carers are women; 36% are men. **Carers NI State of Caring 2017** Annual survey (UK wide, including NI) • 24% of respondents given up work to care • 26% reduced working hours to care Available at https://www.carersuk.org/northernireland/policy/policy-library/state-of-caring-in-northern-ireland-2017-2 **Northern Ireland Life and Times (2015)** ○ 17% respondents were carers: 21% of women and 13% of men. **Health Survey NI (2016/17)** • 13% have caring responsibilities • Approx 70% receive no monetary reward for giving this care • 48% received help from other family members, but 38% received no support from others **Parents with dependent children (Census 2011)** Responsibility for dependent children: 238,094 households (33.9% of all NI households) **NI Lone parent families** = 115,959, with 123,745 dependent children in family (Census 2011). **Gender disparity**: Of the 115, 959 lone parents, 16, 691 are males and 99,268 are female. (Census 2011)
Disability	20.69% (374, 668) regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities. 68.57% (1, 241709) of residents did not have long – term health condition.

	○ Deafness or partial hearing loss – **5.14% (93, 078)** ○ Blindness or partial sight loss – **1.7% (30, 785)** ○ Communication Difficulty – **1.65% (29, 879)** ○ Mobility of Dexterity Difficulty – **11.44% (207, 163)** ○ A learning, intellectual, social or behavioural difficulty. **2.22% (40, 201)** ○ An emotional, psychological - **5.83% (105, 573)** ○ or mental health condition ○ Long – term pain or discomfort – **10.10% (182, 897)** ○ Shortness of breath or difficulty breathing – **8.72%** ○ **(157, 907)** ○ Frequent confusion or memory loss – **1.97% (35, 674)** ○ A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy. – **6.55% (118, 612)** ○ Other condition – **5.22% (94, 527)** ○ No Condition – **68.57% (1, 241, 709)** (Census 2011) **Northern Ireland Life and Times 2016:** "Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?" Yes 24%; No 76%; at http://www.ark.ac.uk/nilt/2016/Background/ANYHCOND.html **Health Survey NI (2017)** 42% longstanding illness (30% limiting and 12% non-limiting illness) https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland
Ethnicity	**1.8% (32,596) of the usual resident population belonged to minority ethnic groups:** **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) (Census, 2011) **Language (Spoken by those aged 3 and over);** **English – 96.86% (1, 681, 210)** **Polish – 1.02%(17, 704)** **Lithuanian – 0.36% (6, 249)** **Irish (Gaelic) – 0.24% (4, 166)** **Portuguese – 0.13% (2, 256)** **Slovak – 0.13% (2, 256)** **Chinese – 0.13% (2, 256)** **Tagalog/Filipino – 0.11% (1, 909)** **Latvian – 0.07% (1, 215)** **Russian – 0.07% (1, 215)**

	Hungarian – 0.06% (1, 041) **Other – 0.75% (13, 018)** (Census, 2011) **Northern Ireland Pooled Household Survey (NIPHS) tables, published 2017.** Data (2013/14 and 2014/15) from four NI Household Surveys (i.e. Labour Force Survey, Family Resources Survey; NI Health Survey, and Continuous Household Survey). Results presented for 11 Local Government Districts. Presented as 'Ethnicity White' and 'All Other Ethnicities' due to small cell sizes. Available here **https://www.nisra.gov.uk/publications/northern-ireland-pooled-household-survey-niphs-tables** **2013/14:** Ethnicity White 98.2% (1,399,000); All other Ethnicities 1.6% (23,000) (No response not included) **2014/15:** Ethnicity White 98.2% (1,409,000); All other Ethnicities 1.8% (26,000) • Between 2000 and 2014, an estimated 175,000 long-term international migrants came to Northern Ireland, while 143,000 left, leaving a net total of 32,000. Local government districts in the west and south-west of Northern Ireland saw the largest net inflow of new residents, in particular: Mid Ulster (9,800), Armagh, Banbridge and Craigavon (9,300) and Newry, Mourne and Down (6,000). • Poland continues to be the most popular country of origin for international migrants coming to live in Northern Ireland. During 2014 and 2015, however, migration from Romania rose substantially, albeit from a low baseline. • Around 1,000 members of the Roma community, mostly from Romania, are thought to be living in Northern Ireland, mainly in South Belfast. • International migration impacts upon the host community in a myriad number of ways, including maternity services, school enrolments, social housing, health and social care, and hate crime. • Births to mothers born outside the UK and Ireland now account for over 10 per cent of all births in Northern Ireland each year. In 2014, 18 per cent of all births in the Mid Ulster local government district were to non-UK and Ireland mothers, followed by Armagh, Banbridge and Craigavon (15%), Belfast (15%), Fermanagh and Omagh (14%) and Newry, Mourne and Down (14%). • Figures from the Regional Interpreting Service show that just under half a million

	requests (493,660) for interpreters were made between January 2004 and December 2014. Hate crime incidents and offences with a racial motive increased substantially between 2011 and 2014.

Sexual Orientation	In 2016, estimates from the Annual Population Survey (APS) showed that:
	• 93.4% of the UK population identified as heterosexual or straight and 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:
	  ○ 1.2% identifying as gay or lesbian
	  ○ 0.8% identifying as bisexual
	• A further 0.5% of the population identified themselves as "Other", which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories. A further 4.1% refused, or did not know how to identify themselves.
	• The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).
	• More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.
	• The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.
	(Available at https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016#main-points)

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	***Needs and Experiences***
Gender	It is important to recognise that when engaging with women, some women will be single parents and the method, timing and venue of any engagement process would need to be considered in light of this need. People who identify as transgender or non-binary experience social isolation, marginalisation and discrimination very often in everyday life. Consequently specific resources may need to be considered for capacity building. Historically

	there is a poor evidence base relating to gender identity issues therefore it is particularly important to include any good practice and to create a more robust evidence base for this particular grouping. This programme addresses all adults within the target population equally and on an individualised basis.
Age	This programme addresses older people within the target population equally and on an individualised basis. Effective engagement with older people involves actively listening and genuinely responding to what matters to them most. Engagement is not only about giving older people a voice, it is about ensuring that older people are valued and are respectfully included in the decisions that ultimately affect them
Religion	Cognisance will need to be given to choice of location and access routes for engagements and delivery of programmes.
Political Opinion	While there are no specific needs, or priorities in this area, cognisance will need to be given to the political sensitivities that may exist within the local areas.
Marital Status	Cognisance will be given to the needs of single parents as these may differ from couples. A flexible programme will be required to meet the needs of single parents.
Dependent Status	Cognisance will be taken into the needs of carers as time is a big factor affecting carers. Any programme aimed at carers needs to be cognisant of their needs.
Disability	People with disabilities may experience communication difficulties, they may have particular needs regarding both communication and information. For example with any tools and resources that are being developed these will have to be developed to be accessible and useable by people with visual impairment/learning disability etc. It is important that people with a disability are given the opportunity for their voices to be heard. All programmes will need to be accessible and useable for people with a disability. When engaging with people with physical disabilities and mobility issues location and access will need to be considered.
Ethnicity	People from ethnic minority communities may experience or are likely to have particular needs in relation to cultural and communication needs. They may

	experience language barriers and may have particular needs regarding accessible communication and information including the provision of translated information as well as interpreting services and sometimes rely on children and young people to interpret. Experience in working with families from ethnic minorities is that language and culture often act as a barrier to getting families to engage with services; in addition some groups e.g. Roma Community and Asylum Seekers do not engage as they tend to be suspicious of services which can be caused by a lack of understanding of the health and social care system within Northern Ireland. Some BME families live in cramped, poor conditions sometimes in unsafe areas. It has been reported that some BME families are indirectly limited in their choice of housing and are often allocated housing in certain areas or are excluded from others.
Sexual Orientation	People of same sex couples and people who are lesbian, gay or bisexual may have particular needs in terms of engagement. With the involvement of an advisory group, organisations may determine that there are particular issues on which the views of lesbian, gay and bisexual people should be actively sought. An advisory group can advise on any issues which may disproportionately impact on local gay people or on which they may have significant concerns. Information provided will be gender appropriate and accessible and take account of particular needs e.g. people who experience gender dysphoria or who are transgender. Incidence of mental health problems is disproportionately high among children and young people who identify as LGB. It is also important to link into Transgender organisations possibly to establish referral pathways and to seek their views.

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

The Community Development Procurement Group acknowledges the cross cutting needs of the equality groupings. It recognises the need to take into account geographical differences and issues facing people who live in areas of high deprivations.

The 20% of most deprived areas in Northern Ireland represent nearly 340,000 people. groups with the highest poverty risk are: Ethnic minorities and migrant workers; Travellers; young people, especially aged 16-18, lone parent families; families of ex-prisoners; people with low or no educational qualifications; long term unemployed; people living in disadvantaged communities; people living in border areas. (Northern Ireland Anti-Poverty Network)

Health inequalities are the unfair and avoidable differences in the health of people in our society. They are the result of imbalances of power, wealth and resources and are produced and shaped by factors such as quality of housing, educational attainment, employment opportunities, physical environment, access to services and level of social connections known as the social determinants. These imbalances mean that no one's health is as good as it could be in Northern Ireland. There is a social gradient in health – the lower a person's social position, the worse his or her health is likely to be. Those who live in areas of disadvantage are most likely to experience the worst health outcomes, with shorter life expectancy and more years with chronic illness and/or disability. Whilst we have seen improvements in the overall health of the population, the gap between the most affluent and least affluent persists and in some instances is widening. Poverty is a significant determinant of health and a challenge given that an estimated 23% of children in Northern Ireland are reported to live in poverty (Poverty in Northern Ireland, Joseph Rowntree 2018 https://www.jrf.org.uk/report/poverty-northern-ireland-2018)

In Northern Ireland many people die prematurely. In 2013-15 the life expectancy for men living in the most deprived areas was 74.1 years, seven years less than those in the least deprived areas (81.1 years). Inequalities are also evident in a range of groups such as young men, ethnic minorities, migrants, carers, lesbian, gay, bisexual and transgender people, people experiencing homelessness, and people with a disability. For example, male Traveller's life expectancy is 61.7 years – fifteen years less than the general population.

Focusing solely on the most disadvantaged groups will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal (across all society), but with recognition that people in areas of disadvantage may need more intense support, or support of a different kind.

Tackling inequality is a matter of fairness and social justice which requires action across the social determinants, between government departments and within communities across the whole of Northern Ireland. Improving health and reducing health inequalities requires co-ordinated action across government, health and social care, and a range of partners across community, voluntary and independent sectors.

The World Health Organisation (WHO) Commission on the Social Determinants of Health (CSDH) recommends three principles for tackling health inequalities. These have been adopted by the Work Stream to underpin its work:

1. Improve daily living conditions – the conditions in which people are born, grow, live and work.
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of these conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise awareness of those determinants.

Action on the social determinants of health must involve the whole of government, civil society, local communities and the business community. Policies and programmes need to embrace all the key sectors of society not only the health sector. Commitment to tackling health inequalities through action on the social determinants is nuanced and sometimes complex. People, communities and populations are affected by different determinants at different times and to varying degrees; for example, taking action to increase housing stock across a region may improve health outcomes for some, but not all. It is essential that we understand what approach works, for whom and in what context.

Margaret Whitehead (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465710/) outlines four broad categories where action to tackle social inequalities tends to be positioned:

1. Strengthening individuals
2. Strengthening communities
3. Improving materials and living conditions
4. Promoting health macro policies

2.5 Making Changes

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

In developing the policy or decision what did you do or change to address the equality issues you identified?	*What do you intend to do in future to address the equality issues you identified?*
• The providers will be requested to ensure they are flexible in delivering the programme and any identified barriers to delivery are addressed to ensure it is tailored to meet the needs of the children and parents, any equality issues should be identified and addressed. • All staff delivering the service to complete equality and diversity training, in line with their employer.	• The equality screen has identified equality issues to be taken into account when delivering the programme. • The tender specification and responses will consider work actions relating to particular needs of Section 75 groupings in relation to communication and engagement. • The tender specification and responses will consider training each provider with knowledge of the potential communication needs of particular Section 75 groupings e.g. information in different languages / possibility of a translation service. • The programme will seek the views and experiences of service users though monitoring of compliments and complaints and actively seek feedback as part of the evaluation process of the programme which could capture information from a range of section 75 or other groups. • The tender specification should include the requirement for diversity issues to be integrated into the content of the programme / the ability for the programme to be adjusted to address diversity issues.

2.6 Good Relations

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

Group	*Impact*	*Suggestions*
Religion	No impact identified at this time	All work will include cross-community work

Political Opinion	No impact identified at this time	All work will include cross-community work
Ethnicity	No impact identified at this time	All work will include cross-community work

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

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

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

Please tick:

Major impact	
Minor impact	✔
No further impact	

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

Please tick:

Yes	
No	✔

Please give reasons for your decisions.

It is recognised that the needs, experiences and priorities of groups within each Section 75 category may vary substantially and will be identified and addressed through the delivery of the programme and consideration will be given to the mitigating actions identified as likely. Measures will be taken to promote equality within this programme.

(4) CONSIDERATION OF DISABILITY DUTIES

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

How does the policy or decision currently encourage disabled people to participate in public life?	***What else could you do to encourage disabled people to participate in public life?***
	Disability Action and other organisations will be kept informed and will also be invited to represent their service users on sub groups and any engagement events

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

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
	Encourage positive attitudes to disabled people and challenge negative stereotyping. This programme will help to challenge staff and organisations to examine how to support and facilitate engagement and recognise the benefits of meaningful involvement. It could be requested that all staff delivering the programme have relevant training and awareness around working with people with disabilities.

(5) CONSIDERATION OF HUMAN RIGHTS

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

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

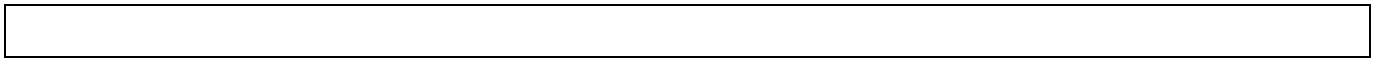
*If you have answered no to all of the above please move on to **Question 6** on monitoring*

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

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

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

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



(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights
The programme will collect data to monitor • Gender • Age • Ethnicity • Household composition • Religion • Dependent status • Disability to include type of disability – Physical, learning, sensory & ASD • Consideration will be given to seeking the views and experiences of service users through an evaluation. This type of evaluation could capture information from a range of section 75 or other groups • Qualitative information will be collated as part of the evaluation process by collating views from all S75 groupings. Compliments and complaints will be monitored.	• Staff delivering the programme must complete equality training in line with their employer.	

Approved Lead Officer:	
Position:	Health and Social Wellbeing Improvement Manager
Date:	15/01/19
Policy/Decision Screened by:	Nikki Girvan Senior Health Improvement Officer
Business Unit and contact details	Health Improvement Team Linum Chambers 02895361678 nikki.girvan@hscni.net

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

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

Template updated January 2015

Any request for this document in another format or language will be considered. Please contact us (see contact details provided above).