Public Health Agency

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

Implementation of the "Expansion of Community Development Approaches" Framework (Report to Transformation Implementation Group) Year 1 Recommendations 2018/2019

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)**

In October 2016, a ten-year approach to transforming health and social care was launched by the Department of Health, in a document entitled "Health and Wellbeing 2026: Delivering Together". This ambitious plan, the Health and Social Care Transformation Programme, was the response to a report produced by an expert panel, led by Professor Rafael Bengoa. The panel had been tasked with considering the best configuration of health and social care services in Northern Ireland. Delivering Together set out a long term roadmap, together with initial priorities, to make an ambitious start towards this reform of our health and social care system. Two key groups are now in place to provide strategic oversight to this work: the Transformation Advisory Board, which acts in an advisory capacity to oversee the direction of reform, and the Transformation Implementation Group (TIG) leads the design, development and implementation of the Transformation Programme. As part of the Delivering Together programme, various Work Streams were established. A Community Development Workstream (which produced the report) was set up in January 2017 to examine how best community development can contribute to the Transformation Process.

Aim

The Community Development Workstream is tasked to set a clear direction and expand community development approaches to reducing health inequalities in Northern Ireland. Its' remit was to assess current progress and make recommendations for how community development practice could be strengthened in the future.

Objectives

Moving forward, the Work Stream proposes a three phased approach across ten years:

 Phase 1 – (2017 – 2020): develop the framework presented on February 21, 2018, at a second symposium; establish a website portal to share tools, resources and materials; begin system mapping; identify and enable training and capacity building with academic and other providers; develop an on-line Academy with resources and training opportunities; refine outcomes framework.

 Phase 2 – (2020 – 2025): embed good practice; initiate systematic change; build on existing procurement and measurement systems.

 Phase 3 – (2025 – 2027): Capture the learning, facilitate positive practices and modules; validate an established community development register of approaches and their application; apply quality standards.

Key Elements of How this will be achieved

The implementation plan for the Community Development Framework has been created in detail for Year One: 2018 – 2019. The focus is on establishing a foundation infrastructure. The priorities are based on the consultation and research which the sector, are to embed the outcomes framework, build capacity and establish governance arrangements. This will enable more detailed plans for years 2019-2021 to be developed.

The stages and activities for Year One implementation include the following:

a) Produce the Community Development Framework, report back to the contributors who were consulted with regionally and at local council levels and align with parallel TIG work streams.
b) Where possible, align with other relevant process such as PHA's procurement of Community Development, review of Neighbourhood Renewal, relevant plans of the Department of Communities, the development of Healthy Places, and the Community Plans of local councils
c) Collate and share community development tools and resources and make available through a Community Development online "portal" which is fundamental to capacity building and skills, and the dissemination of good practice.
d) Develop a Capacity Building curriculum with providers and community organisations which is relevant, accessible and evidence based.
e) Map the overall system of Community Development activity in Northern Ireland to provide a baseline against which future progress and impact can be assessed
f) Secure resource and funding on a multi annual basis to rebuild community development practice and infrastructure in conjunction with other government departments
g) Design and implement an evaluation framework to measure and assess the impact of the Community Development Framework and create a Northern Ireland evidence base which will inform future development in 2019-2021.

Implementation Governance

The Department of Health's Transformation Implementation Group will be the accountable structure for the implementation of this framework. The PHA will establish a Community Development Framework Implementation Board to manage and co-ordinate the implementation process and this Board will report to the Department of Health Group. This will be made up of representation from the following organisations:

Community Development Framewrok Implementation Board

- Co-Chair (PHA and Community Voluntary Sector)
- Local Government
- Department for Communities

- HSCTs
- Member organisations eg NICVA, CDHN, CFNI
- Healthy Living Centre Alliance
- Volunteer Now

Two specific sub groups will then be established to oversee the evaluation framework, and the capacity building element of the framework.

Capacity Building Sub Group

The Capacity Building sub group will consist of representatives of the provider system, including communities of interest, academic and research. They will assist in developing and delivering the Community Development curriculum and populating the online Community Development Academy website.

Evaluation Framework Sub Group

The Evaluation Framework sub group will be responsible for developing NI evidence base of 'what works' and develop a health economic model. Representation for this group has not yet been agreed but will take cognisance of s75 groupings.

Reference Panel

A Reference Panel will be established to quality assure, co-ordinate, advise, target resources. It will also have a consultative role and will have representation from other departments eg DfC, DE, DEARA

Key Constraints

A few key constraints will need to be considered and addressed in the implementation of this framework:

A) Getting buy - in from all relevant stakeholders i.e statutory partners and community voluntary organisations. This can be achieved by regular communication flow, information processes, and consultations etc
B) Recruiting appropriate representation for work streams from community voluntary sector. This can be achieved by providing community voluntary sector with a clear brief as to what the role involves so they can make an informed decision about getting involved.
C) Timeframes – Transformation monies, subject to confirmation have to be spent by a certain timeframe therefore the expectation is that all projects will be complete by March 2020. This can be achieved by robust project management processes in place.

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 Implementation of the Community Development Framework 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 sunder 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

Health and Wellbeing 2026: Delivering Together

The mandating report for this Work Stream is Delivering Together, published by the Department of Health in 2016. Delivering Together 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. Community Development is one of a number of work streams that have been established to commence implementation of the Delivering Together Transformation Programme. In other cases, actions will be taken forward through

normal processes for policy development, planning and commissioning. The transformation programme is a key enabler of the draft Programme for Government outcome: Long, healthy and active lives for everyone.

Appendix 2 outlines the actions and commitments made under Delivering Together that are particularly relevant to the community development approach to addressing health inequalities and to the development of healthy resilient communities.

Programme for Government (PfG)

The Executive's highest level strategic document, the Programme for Government (PfG), was published in draft in October 2016. This PfG is different from any of its predecessors in that it is constructed around a framework of wellbeing outcomes, expressing the ambitions of the Executive for everyone in society.

There is a very substantial focus in the draft PfG on improving health, wellbeing and quality of life, particularly those who experience economic/social disadvantage and its attendant health inequalities. Health and wellbeing also featured very strongly in public consultation feedback on PfG.

It is proposed that the draft PfG will be taken forward on the basis of twelve high-level population outcomes with progress measured through some 50 indicators of success. A large number of these indicators are particularly relevant for community development approaches to health and social care, for example:

- Improved mental health
- Reduced health inequality, increased healthy life expectancy, and fewer preventable deaths
- Better health in pregnancy
- Improved child development
- Reduced educational inequality
- Improved support for adults with care needs
- Reduced crime
- More cultural participation
- Increased confidence and capability of people and communities
- Percentage of the population living in poverty.

The draft PfG has been developed using the Outcomes Based Accountability (OBA) approach whereby progress is measured through numerical indicators of success.

Delivery plans have been drawn up for each of the indicators and continue to be refined. These incorporate programmes relevant to health, such as Healthier Places Programme to work with local communities and develop more effective collaboration across Departments over time to meeting needs. There will also be opportunities to share learning from places where communities have been mobilised to address their own priorities for health and wellbeing and also an important opportunity to align Government Planning at local level.

Making Life Better

The cross-government Public Health Strategic Framework, Making Life Better, sets out an integrated inter-departmental approach to health improvement, the prevention of ill health, and the reduction of inequalities in health. Two of the themes in MLB – "Empowering communities" and "Creating the Conditions" are particularly relevant to community resilience building: they are designed to address the wider structural, economic, environmental, and social conditions impacting on local communities. These align with government strategies to develop the economy, tackle poverty, and improve community relations.

A Regional Project Board, led by the PHA, supports implementation at local level and will be informed by, and support, Local Partnerships of statutory, private sector, and community/voluntary bodies. The Partnerships will identify opportunities for partnership working based on local need and will drive services to support those most in need. These arrangements are currently under review.
A new approach will be introduced for wider regional implementation of MLB which will be driven by partners and based on the needs of communities. The aim is to bring about the broadest level of engagement and encourage co-production on issues impacting on health and health inequalities. This involves the establishment of a cross-sectoral MLB Regional Network to:

- encourage local and regional innovation and partnerships;
- share learning and expand good practice;
- and help build capacity and community empowerment.

The Regional Network and local partnerships will link into and align with local Community Planning arrangements.

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.

From Social Work to Sure Start, there is a very wide range of strategy and networks across government (and programmes delivered by other sectors) designed to address the issues

outlined above and which deliver action that resonates with the community development approach to reducing health inequalities. The task of expanding community development approaches within health and social care also requires action with other Government departments.

Where possible, actions identified within the strategic framework developed by this Work Stream, should be linked to associated actions being taken forward under other relevant strategies. This interconnection will ensure that the potential offered through community development is fully realised and will assist in the achievement of common outcomes

(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.

Qualitative Data

Consultation work

A series of local community engagement workshops were delivered during August – November 2017, in partnership with local government, and together with health and social care trusts, in order to share expertise, and explore critical success factors needed to nurture the growth of community development practice, as a means to tackling health inequalities and improve health and wellbeing.

Aim of workshops

The overall aim of the workshops was to engage with a wide range of key stakeholders and Community Development and Health and Wellbeing practitioners in order to inform the development of a Community Development Strategic Framework for the future.

Objectives

- Consider the policy context for community development
- Share experience of community development at a local level
- Examine outcomes and the rationale for the vital role that community development can play in reducing health inequalities and the link with the draft Programme for Government
- Consider critical success factors, enablers and barriers to creating effective community development outcomes in Northern Ireland.

Summary of Workshop Discussions

The 12 engagement workshops were promoted through a range of networks including the PHA, local Councils, Community Development and Health Network (CDHN) and Northern Ireland Council for Voluntary Action (NICVA). A total of 391 participants attended from across the community and voluntary sectors, Government Departments, statutory agencies, Health and Social Care Trusts and Councils.

2nd Symposium 21 February 2018

122 key stakeholders attended a second symposium, hosted by the CD Work Stream on Wednesday 21 February 2018. The purpose of the symposium was to report on the outputs

of the Community Development Work Stream and set out draft recommendations to TIG for the next 12 – 18 months period.

List of Community Voluntary Organisations who were consulted/attended engagement events

ABC Council
Action for Children NI
Northern Ireland Housing Executive
Action Hearing Loss
Age NI
Autism Group
Age North Down Ards
Age Sector Platform
Agewell Partnership
Alzheimers Society
Alzheimers Society
Ards Community Network
Armagh Traveller Support Group
Arthritis Care
Ballybeen Womens Centre
Ballynahinch Support Group
Barnardo's
Belfast Health Development Unit
Belfast Healthy Cities
Belfast MET
NEXUS
Big Lottery Fund
Bowel Cancer UK
Boys and Girls Clubs
Brain Injury Foundation
Bristish Red Cross
Cancer Focus
Causeway Coast Community Planning
Cedar Foundation
Community Evaluation Norther Ireland
Chinese Welfare Association
Circle of Friends
Citizens Advice Bureau
Clanrye Group
Claughmills Community Action Team
CLEAR Project
Cloverhill Supported Living
Coalisland Residents Community Forum
Commissioner for Older People Northern Ireland office
Communities NI
Compassionate Communities
Confederation of Community Groups Newry
Contact
Counselling All Nations Services
County Down Rural Community Network
Crossgar Pharmacy

Cruse Bereavement
Culmore Community Partnership
De Paul
Denett Interchange
Derg Valley Healthy Living Centre
Down Community Transport
Dunsford Arts and Craft Group
East Belfast Community Development Agency
East Belfast Community Development Agency
Extern
Federation of Small Business
Fermanagh Rural Community Network
First Housing
Foods Standards
Funding Officer, Big Lottery Fund
Garving Housing Dev Trust
Good Morning Antrim
Good Morning Ballymena
Good Morning Northwest
Goodmorning Ballycastle
Guide Dogs NI
APEX Housing
Harpurs Hill Children and Family Centre Ltd
Healthy Living Centre Alliance
Heart Healthy Living Centre
HURT (Drug Addiction Treatment Centre)
Improving Benefit Uptake, Department of Communities
Inspire Wellbeing
Kilcooley Womens Centre
Koram Centre
Lagan Valley Vineyard Church
Lighthouse Charity
Linking Generations Northern Ireland
Locality Manager, Drink Wise, Age Well Addition NI
Loughshore Care Partnership
Lower Ormeau Residents Action Group
Macmillan Cancer Support
MAP
Marie Curie
Melmont and East Bank Estates Community
Mens Shed
Migrant Centre NI
Mourne Heritage Trust
Neighbourhood Renewal Manager Colin Neighbourhood Partnership
Newlodge Duncaren CHP
NEXUS Sexual Abuse Counselling NI
NICHI Project
Northern Ireland Chest Heart and Stroke
Northern Ireland Confederation of Health and Social Care
North Antrim Community Network
NOW Group

Oak Healthy Living Centre
Outdoor Recreation NI
Parkinsons UK
Parenting NI
Peninsula Healthy Living Centre
Programme Manager, Sure Start
Project co-ordinator - Smile Sure Start
Project Manager, Creative Local Action Responses and Engagement CLARE
QUB - SBES- Kerry McIvor
Rainbow child and family centre
Resurgam Trust
Royal National Institute for the Blind
Rural Development Community Association
Shoulders Partnership
Sinn Fein
South Belfast Partnership
South Lough Neagh Regeneration Association
Southern Area Hospice
SPACE (Family Hub Partnership)
Drumgath Ladies Group/Rathfriland Regeneration
Sport Northern Ireland
St Vincent de Paul
South Tyrone Empowerment Programme
Stewartstown Road Health Centre
Strabane Health Improvement Project
Strabane PSNI
CAW/Nelson Drive Action Group
Strabane Sigersons GAA
Suicide Strategy Implementation Body
Supporting Communities
SureStart
The Conservation Volunteers
The Gender Trust
The Identity Trust
Triangle Housing Association
Verbal Arts Centre
Victims and Survivors of The Troubles
Vineyard Compassion
Volunteer Now
Windsor Womens Centre
Womens Aid Armagh Down
Womens Resource Development Agency

Research

Institute for Conflict Research – Grasping the Nettle: The Experiences of Gender Variant Children and Transgender Youth Living in Northern Ireland. Ruari-Santiago McBride February 2013

The report highlights the numerous challenges that young transgender people and their families face in multiple spheres of their lives because of the widespread ignorance, prejudice and discrimination that continues to exist towards transgender people in Northern Ireland. The

report argues that service providers and policy makers need to take a proactive approach in order to erode the cultural inertia that is marginalising young transgender people and preventing many of them from reaching their full potential.

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 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.

Northern Ireland Assembly 28 January 2014 Michael Potter – Review of Gender Issues in Northern Ireland

This paper briefly reviews the representation of women in positions of power in Northern Ireland and examines a selection of recent policy developments with regard to their impacts on women

Women are under-represented across all major positions of political, economic, social and judicial power. This demonstrates a gender-related systemic impediment to access to decision-making. Certain policy decisions, such as budget reductions, appear to differentially impact on women more than men.
Updates to the Gender Equality Strategy have not demonstrated significant change in the position of women in Northern Ireland over time. Certain remedies have been suggested for increasing women's representation or for making decision-making more gender-sensitive:

 Quotas are a fast-track method of increasing women's representation and have been used elsewhere for political office and company boards, but could equally be applied to public appointments and areas of employment

 Programmes for women to increase participation in management or non-traditional occupations, for example, have been used on a limited, time-bound or project-related basis, but could be mainstreamed

 Organisational change processes have been used to imbed more inclusive practices or ethos into workplaces and could equally be applied to other bodies, such as legislatures

 Childcare provision is more accessible and affordable in other contexts and a major potential contributor to women's participation

 Education and career advice and guidance can potentially give girls and boys a greater range of options, rather than gender-specific determination

A Gender Equality Strategy for Northern Ireland 2006-2016

The Gender Equality Strategy provides an overarching strategic policy framework within which departments, their agencies and other relevant statutory authorities will channel their existing actions and initiate new actions to achieve an agreed vision, guided by a set of principles and objectives aimed at tackling gender inequalities and promoting gender equality across government's major policy areas for the benefit of both women and men generally.

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 Gender Identity Research and Education Society (GIRES) 2014
- 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

2.2 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%; Don't know 0%. Breakdown by age, gender and religion available 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 lights 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.
Age	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 engagement/consultation with carers needs to be a a time and place to suit 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. Also the online portal 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	This programme addresses all people equally and on an individualised basis. People of same sex couples and people who are lesbian, gay or bisexual may have particular needs in terms of engagement.

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 Transformation Implementation 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

Community development processes tend to be categorised in a similar way (as evidenced in the Draft Outcomes Framework), which strengthens the case for community development as an effective approach to tackling inequality.

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?***
	<u>Collate and share tools and resources</u> • Any tools and resources that are collated should include tools specifically for people with a learning disability, people with visual impairment, people who identify as transgender or non-binary, ethnic minority groupings, people who identify as lesbian, gay or bisexual and other more marginalised groups. • Acknowledge the following groups when establishing the online portal and resources; people with a learning disability, people with visual

	impairment, people who identify as transgender or non-binary, ethnic minority groupings, people who identify as lesbian, gay or bisexual and other more marginalised groups. • The service specification will include accessibility standards • Ensure all case studies include examples from all S.75 groupings **Capacity Building** • Check who all providers are against S.75 groupings • Strengthen skills and knowledge of those involved regarding the various groupings. • Curriculum will be equality screened. **System Mapping** • Ensure that there are no gaps as regards the S.75 groupings when mapping all relevant stakeholders and how they incorporate CD Framework into their operations. **Evaluation and Evidence** • Ensure baseline data is collated for all equality groupings. • **Evaluation framework will be equality screened**

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

The scope of this screening relates to Year 1 Actions. Impacts are minor as mitigating actions have been identified as likely to address the listed equality issues.

(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 framework will help to challenge staff and organisations to examine how to support and facilitate engagement and recognise the benefits of meaningful involvement.

(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 TIG will collect quantitative data to monitor • Gender • Age • Ethnicity • Household composition • Religion • Dependent status • Disability to include type of disability – Physical, learning, sensory & ASD This information will be obtained throughout the following processes: • Collate and share tools and resources • Capacity building – • System Mapping • Resources and funding • Evaluation and Evidence . 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 attendance at mandatory equality training will be monitored. Staff attendance at any additional equality training will be monitored	

Approved Lead Officer: D McIntyre

Position: Health and Wellbeing Improvement Manager

Date: 10/10/18

Policy/Decision Screened by:	Nikki Girvan 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).