

## Equality, Good Relations and Human Rights SCREENING

The Health and Social Care Board is required to consider the likely equality implications of any policies or decisions. In particular it is asked to consider:

- 1) What is the likely impact on equality of opportunity for those affected by this policy, for each of the section 75 equality categories? (minor, major or none)
- 2) Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?
- 3) 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 or none)
- 4) Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

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.

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

**For information (evidence, data, research etc) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website:**

<http://www.hscbusiness.hscni.net/services/1798.htm>

## **Equality, Good Relations and Human Rights SCREENING TEMPLATE**

### **(1) INFORMATION ABOUT THE POLICY OR DECISION**

#### **1.1 Title of policy or decision**

*Advocacy Service for Deaf Adults*

#### **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)**

The *Advocacy Service for Deaf Adults* (hereafter the Service) is a contract procured by the Health & Social Care Board (HSCB).

#### **AIM**

The aim is to deliver an accessible, regional, independent, and person-centred Service that will provide:

- Advocacy for deaf adults in relation to accessing Health and Social Care, and
- Information and outreach support to deaf adults and their communities with regard to health improvement, health promotion, and well-being.

It is anticipated that the provision of this Service will:

- Improve the experiences and outcomes of deaf people accessing Health and Social Care,

## INFORMATION ABOUT THE POLICY OR DECISION

- Raise awareness and understanding of the issues which potentially impact on the lives of deaf adults and how to address these, and
- Enable other service providers and commissioners to design and/or make adjustments to services to better meet the needs of deaf people.

### HOW WILL THE AIM BE ACHIEVED?

It is intended that the Service will be delivered by suitably trained staff and advisors via email/other online facilities, face to face in regional offices and/or agreed locations, and/or through home visits, where necessary.

The supplier will be required to:

- Accept referrals from a number of sources: self-referrals; carers; Health and Social Care personnel; other statutory providers; and community and voluntary organisations.
- Provide personal advocacy support to deaf adults to overcome barriers in accessing Health and Social Care services.
- Provide information sessions on health improvement and promotion topics for the deaf community, ensuring that deaf people are offered the opportunity for inclusion in health promotion and wellbeing.
- Conduct outreach work with deaf clubs and deaf people, delivering partnership working with other organisations for deaf people and promoting the service.
- Organise community forums to facilitate discussions of issues affecting the deaf community and how these issues can best be addressed.
- Educate other service providers and commissioners on how to design and/or make adjustments to services to meet the needs of deaf people.
- Deliver deaf awareness and deaf equality training for staff who provide Health and Social Care services for the deaf community.

### KEY CONSTRAINTS

- **Cost:** The contract has an annual budget of £82K. This budget is based on the delivery of the service in previous years.
- **Procurement – process and timescales:** The current contract to deliver this Service expires on 31 March 2020. The current contract has run from the 1.4.15 – 31.3.18, with an additional two 12-month extensions to

31.3.20. Purchasing this Service is subject to public procurement rules and legislation. Accordingly, the HSCB must comply with strict timescales: the tender specification must be completed in August 2019, to allow for the correct advertisement period, assessment period and process, contract award, and potential Transfer of Undertakings (Protection of Employment) (also referred to as TUPE) actions, prior to commencement of the new contract on 1 April 2020.

- **Regional provision for service users and carers from all backgrounds and Programmes of Care:** The Service must be delivered on a regional basis across Northern Ireland.

As such, the tender specification and procurement process is required to include provisions that ensure equal access to the service:

- In both urban and rural areas – therefore, alongside this Equality Screening, a Rural Needs Assessment has been completed; and
- For people who come from all backgrounds – hence the need for this Equality Screening, to consider potential impacts on equality of access to the Service by people from all of the different Section 75 groups.

### **1.3 Main stakeholders affected (internal and external)**

- Actual and potential service users and their carers.
- Health and Social Care Trusts (HSCTs) – all five regional HSCTs make referrals into the current service and will continue to do so.
- Health and Social Care Board (HSCB) Social Care Directorate – this is the commissioning body.
- Department of Health – the funder, with responsibility for overarching policy and strategic direction.
- Disabled People User Lead Organisations (DPULO) and Community and Voluntary Sector Organisations – these bodies deliver services and support to people from across all Programmes of Care across Northern Ireland, and therefore interface with the current and any new Service provider to provide holistic and locally-accessible services and support to service users and carers.

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

Key programmes and policies with a bearing on this Service include:

- **Transforming Your Care (2011):** This historic Department of Health (DOH) strategy sets an overarching agenda for developing person centred services. (Available at: <https://tinyurl.com/k8beo4u>).
- **Health and Wellbeing 2026: Delivering Together (2016):** The current DOH strategy builds on *Transforming Your Care*, reinforced the value and centrality of the personalisation agenda. The responsibility for delivering on this strategy is shared across the Health and Social Care System. (Available at: <https://tinyurl.com/j5eut4m>.)

The Service should also align to the following key strategic frameworks and their broad principles and objectives:

- **Draft Programme for Government (2016)** – noting in particular: Outcome 4 (*We enjoy long, health, active lives*), Outcome 8 (*We care for others and we help those in need*), Outcome 9 (*We are a shared, welcoming and confident society that respects diversity*), Indicator 5 (*Satisfaction with health and social care*) and Indicator 42 (*Average life satisfaction score of people with disabilities*). These overarching outcomes and indicators will inform the development and delivery of the Service specification and monitoring arrangements. (Available at: <https://tinyurl.com/y4c53ln5>.)
- **Physical and Sensory Disability Strategy (2012-15/18)** – while the strategy has now closed, the principle that the services commissioned and provided by Health and Social Care organisations for people with disabilities should develop in such a way that they: “...support disabled people to become well informed and expert in their own needs and encourage the social inclusion of disabled people and work to address the stigma associated with disability” still applies. Conducting this Equality Screening, and thereby giving due regard to Disability Duties (see section 4 below), forms part of this consideration. (Available at: <https://tinyurl.com/y6439dhl>.)

## (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.**

#### **Primary research and statistical data:**

- **Current service-user data collated by the current Service provider,** reported to the Health & Social Care Board as part of the current contract monitoring arrangements.

#### **Consultation and engagement with the following stakeholders:**

- **The Health and Social Care Board staff that have managed the current contract:** This has involved collective reflection on the strengths and limitations of the current contract, and opportunities for improvement in the procurement of the new contract.
- **The staff and management team that deliver the current contract:** As above, this has involved collective reflection on the strengths and limitations of the current contract, and opportunities for improvement in the procurement of the new contract (at a meeting in August 2019). This has included reflection on engagement with service users and their feedback.
- **Sensory Team Leads from the five regional Health and Social Care Trusts:** As above, this has involved reflection on the strengths and limitations of the current contract, and opportunities for improvement in the procurement of the new contract (at a meeting in August 2019, and via questionnaire).

#### **Other published sources:**

- **Physical and Sensory Disability Strategy (2012-15/18):** This strategy includes a section on *Prevalence*, which has informed this Screening. (Available at: <https://tinyurl.com/y6439dhl>.)
- **Population-level data:** Northern Ireland Census (2011) and Northern Ireland Statistics and Research Agency (NISRA) statistics (available at:

<https://tinyurl.com/y2fl3nnz>), including the most recent mid-year population estimates (2017) (available at: <https://tinyurl.com/yxdzm398>).

- **Equality and Disability Action Plans Consultation Report (2018):** This report, produced by the Regulation and Quality Improvement Authority on behalf of the HSC family of organisations, outlines the findings of a public consultation on their new Equality and Disability Action Plans, including specifically recommendations and comments in relation to the needs of deaf people.
- **Data in relation to potentially ‘hard to reach’ or marginalised groups defined under Section 75 as follows:**
  - Belfast Health & Social Care Trust (BHSCT) & Aware Defeat Depression. (2014). *Ethnic Minorities: Mental Health Toolkit – A Guide for Practitioners*. Available at: <https://tinyurl.com/yy3qsjza>.
  - Carmel, T. C. & Erickson-Schroth, L. (2016). ‘Mental Health and the Transgender Population’, *Journal of Psychosocial Nursing & Mental Health Services*, 54 (12): 44–48.
  - Elliot, M. et al. (2015). Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey. *Journal of General Internal Medicine*, 30 (1): 9-16.
  - Gray, A.M., Horgan, G., & Leighton, A. (2013). ARK Policy Brief: *Moving towards a Sexual Orientation Strategy for Northern Ireland*. Available at: <https://tinyurl.com/yynqj55q>.
  - McBride, R. (2011). *Healthcare issues for transgender people living in Northern Ireland*. Belfast: Institute for Conflict Research. Available at: <https://tinyurl.com/yydozoru>.
  - Northern Ireland Health Survey (2017) Available at: <https://tinyurl.com/y5o3y3x5>.
  - O’Doherty, J. (2016). *OUTstanding in your field. Exploring the needs of LGB&T people in rural Northern Ireland*. Available at: <https://tinyurl.com/yxwb369c>.
  - Sneddon, H. (2018). *Mental Health and Wellbeing of Asylum Seekers and Refugees: Evidence Review and Scoping*. Belfast: Public Health Agency.

## 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.**

<b>Category</b>	<b><i>What is the makeup of the affected group? ( %) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</i></b>
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### **Note:**

The key Section 75 groups involved in accessing the *Advocacy Service for Deaf Adults* are people with a disability, specifically people who are deaf or hard of hearing, and their carers (or, people with dependants). This observation applies equally to the current Screening exercise.

In conducting this Screening exercise, however, the Health & Social Care Board (HSCB) has sought to conduct a comprehensive review of the potential impact for all Section 75 groups that may require access to the *Advocacy Service for Deaf Adults* (hereafter, the Service).

In doing so, it has been identified that, in the experience of professionals within the Health and Social Care (HSC) system and the current Service provider, while the profile of service users and carers accessing the Service has an inevitable emphasis on people with a disability, it also correlates broadly with the profile of the Northern Ireland population in terms of other identity categories – i.e. majority white, roughly 50% male/female.

It has also been identified, however, that Section 75 information is not currently monitored as a matter of routine specifically in relation to the Service by either the HSC Trusts or the current Service provider. Collating information in this way is not a requirement that the HSCB has made of Trusts or the current Service provider up to now. Consultation carried out with the HSC Trusts and the Service provider for this Screening exercise has specifically highlighted the sensitivities around asking service users and carers to provide this information, the potential for such questions to complicate or undermine the integrity of the engagement between service users and the Trust/Service provider, and the



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resource implications for systematic data collection and analysis.

Notwithstanding these acknowledged difficulties, as a result of the lack of systematic monitoring, there is no specific data available in relation to people's access to the Service correlated with gender, age, religion, political opinion, marital status, ethnicity, or sexual orientation.

Under the new contract, the HSCB will seek to work with both Trusts and the new Service provider to strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield more informative statistics to help shape a truly accessible service.

### Gender

#### General population:

In 2011, the Northern Ireland population was determined to include 1,810,863 people, of whom 49% were male and 51% were female (Census, 2011).

The size of the resident population in Northern Ireland at 30 June 2017 was estimated to be 1,870,834 people.<sup>1</sup> Just over half (50.8%) of the population were estimated to be female, with 950,600 females compared to 920,200 males.<sup>2</sup>

Limited data is available on the number of transgender people in Northern Ireland. However, research suggests that for the population as a whole:

- 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%

<sup>1</sup> Northern Ireland Statistical and Research Agency (NISRA) data published online on 30 June 2018. Available at: <https://www.nisra.gov.uk/news/2017-mid-year-population-estimates-northern-ireland>

<sup>2</sup> See Northern Ireland Statistical and Research Agency (NISRA) infographic available at: <http://www.ninis2.nisra.gov.uk/InteractiveMaps/DataVis/NI%20Population%202017.pdf>

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- have sought some medical care 0.025%
- having already undergone transition 0.015%

The number that 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 young people 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 2018) N=1,881,600:

- 18,816 people who do not identify with gender assigned to them at birth
- 470 likely to have sought medical care
- 282 likely to have undergone transition.

### **Service users:**

There is no data to suggest that the gender profile of service users and carers requiring access to this service varies substantially from the general population. The available data also suggests it is reasonable to assume that transgender people will be under-represented among those in need of the Service. This highlights the importance of finding sensitive ways to monitor uptake of services by transgender people, ensuring that the Service is sensitive to the research findings discussed above and maximising opportunity of access and safety for transgender individuals.

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<b>Age</b>	<p><b>General population:</b> Mid-year population estimates published by the Northern Ireland Statistics and Research Agency (NISRA) in 2018<sup>3</sup> show that the general population falls into the following age categories:</p> <ul style="list-style-type: none"><li>▪ 0-19 yrs (inclusive) = 483,978 (26.0% of all NI population)</li><li>▪ 20 – 34 yrs = 366,619 (19.7%)</li><li>▪ 35 – 49 yrs = 370,263 (19.9%)</li><li>▪ 50 - 64 yrs = 343,522 (18.4%)</li><li>▪ 65 – 74 yrs = 166,059 (8.9%)</li><li>▪ 75 – 89 yrs = 118,965 (6.4%)</li><li>▪ 90+ yrs = 12,731 (0.7%)</li></ul> <p>HSCB current service user data draws on the NISRA statistics published in 2018, to show the age distribution of the Northern Ireland population across the five HSC Trust areas in three bands: 0 to 17 years (Children / Young People); 18 to 64 years (Adults); over 65 years (Older People). The data shows that the vast majority of the population across the five HSC Trust areas is concentrated in the 18-64 years age band.</p> <p><b>Service users:</b> The current Service is specifically procured to deliver and <i>Advocacy Service for Deaf Adults</i>, and therefore caters specifically for individuals who are aged 16 and older. Given the wider trend of an ageing population profile, it can be anticipated that service users and carers requiring access to the Service will include increasing numbers of adults and older people into the future.</p>
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<sup>3</sup> See:

[http://www.ninis2.nisra.gov.uk/InteractiveMaps/Population%20Pyramid/2007\\_2017MYE/NINIS\\_Pyramid\\_2017.html](http://www.ninis2.nisra.gov.uk/InteractiveMaps/Population%20Pyramid/2007_2017MYE/NINIS_Pyramid_2017.html)

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<b>Religion</b>	<p><b>General population:</b></p> <p>At a population level, the most recent Census (2011) reveals that:</p> <ul style="list-style-type: none"><li>- 45.14% (817, 424) of the population were either Catholic or brought up as Catholic.</li><li>- 48.36% (875, 733) stated that they were Protestant or brought up as Protestant.</li><li>- 0.92% (16, 660) of the population belonged to or had been brought up in other religions and Philosophies.</li><li>- 5.59% (101, 227) neither belonged to, nor had been brought up in a religion.</li></ul> <p>Whilst the majority of the population identify as either Catholic or Protestant, the demographic of the Northern Ireland population is changing. Other religions and philosophies represented in Northern Ireland, involving 16,600 people, include Judaism, Islam, Hinduism, and the Bahá'í Faith.</p> <p><b>Service users:</b></p> <p>Service user information in relation to religion is not currently monitored in relation to the current Service, by either the HSC Trusts or the current Service provider. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to religion.</p> <p>Based on the available data discussed above, however, it can be reasonably assumed that people from all religious backgrounds and none may require access to the Service, however, individuals from religions other than Catholic and Protestant backgrounds may be under-represented.</p>
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<b>Political Opinion</b>	<p><b>General population:</b></p> <p>At a population level, the Northern Ireland Life and Times (NILT) survey is a key source that provides important insight into political opinions held by people in this region. It asks the question: “Generally speaking, do you think of yourself as a unionist, a nationalist, or neither?” The responses to this question in the most recent survey (2017)<sup>4</sup> are shown in Table 4 below.</p> <p><b>Table 4: NILT Survey Question: <i>Generally speaking, do you think of yourself as a unionist, a nationalist, or neither?</i></b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Category</th> <th style="text-align: right;">Percentage of respondents</th> </tr> </thead> <tbody> <tr> <td>Unionist</td> <td style="text-align: right;">32%</td> </tr> <tr> <td>Nationalist</td> <td style="text-align: right;">21%</td> </tr> <tr> <td>Neither</td> <td style="text-align: right;">45%</td> </tr> <tr> <td>(Other)</td> <td style="text-align: right;">1%</td> </tr> <tr> <td>Don't know</td> <td style="text-align: right;">2%</td> </tr> </tbody> </table> <p>A significant proportion of the Northern Ireland population does not vote in our elections, including young people in particular. No data exists on the political opinion of the population of those from other religions and philosophies outlined in Section 3.1.4.</p> <p><b>Service users:</b></p> <p>Service user information in relation to religion is not currently monitored in relation to the current Service, by either the HSC Trusts or the current Service provider. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to political opinion.</p> <p>Based on the available data discussed above, however, it can be reasonably assumed that people from all political philosophies and none may require access to the Service.</p>	Category	Percentage of respondents	Unionist	32%	Nationalist	21%	Neither	45%	(Other)	1%	Don't know	2%
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<sup>4</sup> For details of the Northern Ireland Life and Times (NILT) survey and its findings, see: <https://www.ark.ac.uk/nilt/results/polatt.html>

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<b>Marital Status</b>	<p><b>General population:</b> The most recent census (Census, 2011) showed that, across the Northern Ireland population:</p> <ul style="list-style-type: none"><li>- 47.56% (680,840), or almost one in two of people aged 16 or over were married.</li><li>- 36.14% (517,359) were single.</li><li>- 0.09% (1,288) were registered in same-sex civil partnerships.</li><li>- 9.43% (134,994) were either divorced, separated, or formerly in a same-sex partnership.</li><li>- 6.78% (97,058) were either widowed or a surviving partner.</li></ul> <p>Annual Reports of the Registrar General for NI show that between 2005 and 2017 inclusive, 1,202 civil partnerships were registered in NI.</p> <p><b>Service users:</b> Service user information in relation to marital status is not currently monitored in relation to the Service. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to service users' marital status.</p> <p>Based on the available data, it can be reasonably assumed that the people who need to access the Service include individuals who identify with the full range of marriage status groups (i.e. married, single, same-sex civil partnership, divorced, separated, formerly in a same-sex partnership or widowed / surviving partner).</p>
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<b>Dependant Status</b>	<p><b>General population:</b> Dependant status relates to both parenting and wider care responsibilities, i.e. looking after an ill, older, or disabled family member, friend, or partner for few hours a week, or full time.</p>
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The most recent census (Census, 2011) revealed that 33.9% of all households in Northern Ireland, which equated to 238,094 households, had dependent children. Of this number, 115,959 were lone parent households. 16,691 of these were male-headed households, and 99,268 were female-headed households.

The census (Census, 2011) also showed that approximately one-in-eight residents in Northern Ireland have carer responsibilities, which equates to around 220,000 people. Data that is available in relation to the characteristics and circumstances of carers shows that:<sup>5</sup>

- More than 60% of carers are aged between 35 and 64 years old.
- A substantial proportion of carers have a long-term health issue or disability themselves.
- Many carers report that caring results in a negative and often lasting impact on their general physical and mental health.
- Many carers report that caring responsibilities create and exacerbate financial hardship, especially when the role requires them to leave work or reduce working hours.
- Young carers account for 4% of all carers in Northern Ireland.
- Around 6,700 young people (aged 0-17) provide between 1 and 19 hours of unpaid care per week. An additional 960 young people provide 20 – 49 hours of unpaid care per week, and around 820 for 50 hours or more per week.

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<sup>5</sup> See: Russell, R. (2017). *Background Information and Statistics on Carers in Northern Ireland – Research and Information Service Briefing Paper*. Belfast: Northern Ireland Assembly. Available at: <http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2017/health/2517.pdf> ; and See: Carers NI. (2017). *State of Caring in Northern Ireland 2017*. Available at: <https://www.carersuk.org/northernireland/policy/policy-library/state-of-caring-in-northern-ireland-2017-2>

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In 2017 the Northern Ireland Life and Times (NILT) survey<sup>6</sup> found that women were more likely than men to confirm that they carry carer responsibilities.

Analysis of Carers Allowance claims by the Northern Ireland Council for Voluntary Action (NICVA) and the Detail Data shows that 64% of carers are women. The same research suggests that almost half of carers have been caring for 35 hours or more a week for longer than five years.<sup>7</sup>

Research published by the Department of Health and Public Health Agency in 2016 shows that while the needs of carers from minority ethnic communities in Northern Ireland are relatively poorly understood, it is apparent that they require specific supports to improve their access to relevant services.<sup>8</sup> The report notes the importance of:

- improving monitoring of black and minority ethnic carers going forward, to consolidate and develop a better understanding of needs,
- building and developing enhanced networks of support for black and minority ethnic carers, and
- enabling access to both English language training for black and minority ethnic carers and improved language and cultural awareness training for frontline staff.

All of this information shows that intersectionality is an important consideration in relation to carers and their needs and access to services. This information is relevant to this particular service, insofar as deaf people themselves may be carers, and/or may rely on carers for support in different ways and at different times

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<sup>6</sup> For details of the Northern Ireland Life and Times (NILT) survey and its findings, see: <https://www.ark.ac.uk/nilt/results/polatt.html>

<sup>7</sup> See: <http://data.nicva.org/article/who-cares-about-carers>

<sup>8</sup> *Minority Ethnic Carers in Northern Ireland: A Report* (2016) – available on request at: <http://www.southerntrust.hscni.net/about/3408.htm>



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in their lives.

### **Service users:**

Service user information in relation to dependant status is not currently monitored in relation to the Service. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to service users' dependant status.

Given the profile of the Service as a person-centred information and advocacy facility, however, it is reasonable to conclude that people with dependants and carers are likely to require access to it, whether as Deaf Adults who have caring responsibilities of some kind, or as people who care for Deaf Adults, and will continue to need it into the future.

### **Disability**

#### **General population:**

The most recent census (Census, 2011) revealed that 20.69% of the population (or 374,668 people) regard themselves as having a disability or long-term health problem, which has an impact on their day to day activities. 68.57% of the population (1,241,709 people) have no long-term health condition.

Specific long-term health conditions identified across the population (Census, 2011) include:

- Deafness or partial hearing loss – 5.14% (93,078 people)
- Blindness or partial sight loss – 1.7% (30,785 people)
- Communication Difficulty – 1.65% (29,879 people)
- Mobility or Dexterity Difficulty – 11.44% (207,163 people)
- A learning, intellectual, social or behavioural difficulty – 2.22% (40,201 people)
- An emotional, psychological or mental health condition – 5.83% (105,573 people)
- Long-term pain or discomfort – 10.10% (182,897 people)
- Shortness of breath or difficulty breathing – 8.72%

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(157,907 people)

- Frequent confusion or memory loss – 1.97% (35,674 people)
- A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy) – 6.55% (118,612 people)
- Other condition – 5.22% (94,527 people)

On Census Day 2011, two-fifths (40%) of households contained at least one person with a long-term health problem or disability. Of those households, 9.2% had dependent children, and 31% none.

The most recent official statistics collected via the Health Survey NI (2019)<sup>9</sup> show that:

- 43% of respondents reported a longstanding illness (32% limiting and 11% non-limiting illness);
- Females (44%) were more likely than males (40%) to have a long-term condition.
- Prevalence also increased with age with 22% of those aged 16-24 reporting a long-term condition compared with 70% of those aged 75 and over.
- Around a fifth of respondents (21%) scored highly on the GHQ12 suggesting they may have a mental health problem; and
- Respondents in the most deprived areas (22%) continue to be more likely to record a high GHQ12 score than those in the least deprived areas (15%).

Importantly, these datasets reveal that the experience of disability is **intersectional**, i.e. people who live with a particular kind of disability may also experience *other* disabilities, which may vary in terms of intensity, impact, and duration.

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<sup>9</sup> For more information on Health Survey NI (2017/18) see: <https://www.health-ni.gov.uk/news/health-inequalities-annual-report-2019>

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	<p><b>Service users:</b></p> <p>Given the profile of the Service as a person-centred information and advocacy facility for Deaf Adults, it is reasonable to conclude that people with both hearing impairment and any combination of other disabilities or illnesses may require access to it both now and into the future.</p>
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<b>Ethnicity</b>	<p><b>General population:</b></p> <p>The most recent census (Census, 2011) revealed that 1.8% of the usual resident population (or 32,596 people) belonged to minority ethnic groups. Information collected as part of the census shows that the ethnic distribution of the population is as follows:</p> <ul style="list-style-type: none"><li>- White: 98.21% (1,778,449)</li><li>- Chinese: 0.35% (6,338)</li><li>- Indian: 0.34% (6,157)</li><li>- Other Asian: 0.28% (5,070)</li><li>- Mixed: 0.33% (5,976)</li><li>- Black African: 0.13% (2,354)</li><li>- Irish Traveller: 0.07% (1,268)</li><li>- Pakistani: 0.06% (1,087)</li><li>- Black Other: 0.05% (905)</li><li>- Bangladeshi: 0.03% (543)</li><li>- Black Caribbean: 0.02% (362)</li><li>- Other: 0.13% (2,354)</li></ul> <p>Migration patterns have changed in Northern Ireland in the intervening period, and it can be expected that this ethnic breakdown is currently changing.</p>
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Data compiled by the Northern Ireland Assembly Research and Information Service in 2016 (Russell, 2016)<sup>10</sup> found that:

- 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 & Craigavon (9,300) and Newry, Mourne & 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 live in Northern Ireland, mainly 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% of all births in Northern Ireland each year. In 2014, 18% of all births in the Mid Ulster local government district were to non-UK and Ireland mothers, followed by Armagh, Banbridge & Craigavon (15%), Belfast (15%), Fermanagh & Omagh (14%) and Newry, Mourne & Down (14%).

In 2017, the Northern Ireland Policing Board conducted a *Thematic Review of Policing Race Hate Crime* (NIPB, 2017)<sup>11</sup>

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<sup>10</sup> See: Russell, R. (2016). *International Migration in Northern Ireland: an Update – Research and Information Service Research Paper*. Belfast: Northern Ireland Assembly. Available at: <http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2016/general/3916.pdf>

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which reported the following:

- In Northern Ireland, a race hate incident is reported approximately every seven hours.
- Racist hate crimes are the second most common type of hate crime recorded by PSNI, with sectarian hate crime being the most common.
- The levels of racist hate crimes recorded by PSNI began to decline in 2010/11 following a peak in 2009/10 however they began to increase again in 2012/13.
- There was a significant increase in reported racially motivated hate incidents in Northern Ireland in 2014/15 when racist hate crime reached its highest level ever recorded: 1,356 incidents within which there were 920 crimes.

The HSC Interpreting Service statistics reveal a trend of increasing numbers of ethnic minority groups requiring support to access healthcare services in the region over the last 15 years. These data show a dramatic rise in requests for interpreters from 1,850 in 2004-2005 to 106,541 requests in 2016-2017.

### **Service users:**

Service user information in relation to ethnicity is not currently monitored in relation to the current Service. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to ethnicity.

Nonetheless, the available data highlights that while current demand for this and other services among people from BME communities may be very small in terms of numbers, there is a growing need for services for a steadily increasing population of BME communities. In terms of accessibility, the development and delivery of these services needs to take account of both

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<sup>11</sup> Northern Ireland Policing Board (NIPB). (2017). *Thematic Review of Policing Race Hate Crime*. Available at: <https://www.nipolicingboard.org.uk/sites/nipb/files/media-files/race-hate-crime-thematic-review.PDF>

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	<p>practical access requirements, such as a person's language (in terms of the sign language they understand), and broader considerations, such as cultural sensitivity, and making adjustments to support people who may be subject to discrimination, intimidation, and hate crimes.</p>
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<b>Sexual Orientation</b>	<p><b>General population:</b></p> <p>Publicly available statistics on sexual orientation at a population level suggest that between 5% and 10% of the population may identify as lesbian, gay or bisexual.</p> <p>In 2016, the Annual Population Survey (APS)<sup>12</sup> showed that:</p> <ul style="list-style-type: none"><li>- 93.4% of the UK population identified as heterosexual or straight and</li><li>- 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:<ul style="list-style-type: none"><li>o 1.2% identifying as gay or lesbian</li><li>o 0.8% identifying as bisexual</li></ul></li><li>- 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.</li><li>- A further 4.1% refused or did not know how to identify themselves.</li><li>- The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).</li><li>- More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.</li><li>- The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.</li></ul> <p>With regard to public opinion towards gay, lesbian and bisexual</p>
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<sup>12</sup> See: <https://beta.ukdataservice.ac.uk/datacatalogue/series/series?id=200002#!/access>

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people in Northern Ireland: there is a disconnect between legislation, which prohibits same-sex marriage, and public opinion. The 2018 Northern Ireland Life and Times Survey has found that 68% of the population believes that marriages between same-sex couples should be recognised by the law as valid, with the same rights as traditional marriages.<sup>13</sup>

### **Service users:**

Service user information in relation to sexual orientation is not currently monitored in relation to the Service. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to sexual orientation.

Based on the available data, however, it can be reasonably assumed that the prevalence of lesbian, gay, and bisexual people reflected in the statistics cited above will be represented in the population accessing this Service. Furthermore, the available data highlights that while current demand for this and other services among people from LGBTQ+ communities may be relatively limited in terms of numbers, there is likely to be a growing need for services for this group of people, as they feel more confident about disclosing their sexual orientation or 'coming out' as public opinion increasingly supports them to do so.

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<sup>13</sup> See: [https://www.ark.ac.uk/nilt/2018/LGBT\\_Issues/SSEXMARR.html](https://www.ark.ac.uk/nilt/2018/LGBT_Issues/SSEXMARR.html)

## 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.**

<b>Category</b>	<b>Needs and Experiences</b>
<b>Gender</b>	<p><b>Note:</b> <i>The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of gender. This Service is delivered on the basis of identified need for support, and this access is not determined by gender.</i></p> <p>Regional and international research highlights the following:</p> <ul style="list-style-type: none"> <li>▪ Men are less likely than women to display positive help-seeking attitudes in relation to health and care needs;<sup>14</sup></li> <li>▪ The help-seeking behaviours of transgender people are limited for reasons specifically associated with being trans or having a trans history, and are more likely to report having negative experiences associated with accessing health care;<sup>15</sup> and</li> <li>▪ There is an increased risk of negative health outcomes for transgender people and for men.</li> </ul> <p>This qualitative information suggests that:</p> <ul style="list-style-type: none"> <li>• Transgender individuals may be less likely to avail of the Service if they feel they may encounter negative reactions and attitudes, and</li> </ul>

<sup>14</sup> Northern Ireland Life & Times Survey (2004) – *Men’s Life and Times*: datasets available at: <https://www.ark.ac.uk/nilt/results/menslt.html>

<sup>15</sup> McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans mental health study 2012*. Available at [https://www.gires.org.uk/wp-content/uploads/2014/08/trans\\_mh\\_study.pdf](https://www.gires.org.uk/wp-content/uploads/2014/08/trans_mh_study.pdf)



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- Men may need additional support to access the Service.

This information underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training.

### Age

**Note:** *The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of age. While this Service is delivered specifically to adults, in every instance this will be on the basis of identified need for support, and not further determined by an individual's age.*

Regional research (Northern Ireland Life and Time Survey, 2014) into attitudes and behaviours towards older people shows that a significant minority (30%) of people believe that health and social care workers treat older people differently, and specifically worse than others, based on their attitudes to them.<sup>16</sup> In contrast to this finding, when respondents aged 50 and over were asked 'Have you ever felt that you were treated with less dignity and respect by people in the health and social care professions because of your age?', 90% reported that they have *not* experienced negative treatment on the basis of their age.<sup>17</sup>

These findings have implications for the design and delivery of this Service, in terms of understanding the potential for perceived negative attitudes to service users based on their age, and for the potential for people to feel they are being treated negatively on the basis that they are older.

This information underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training.

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<sup>16</sup> Northern Ireland Life & Times Survey (2014) – *Attitudes to Older People*. Available at: <https://www.ark.ac.uk/nilt/results/olderpeople.html>

<sup>17</sup> Northern Ireland Life & Times Survey (2014) – *Attitudes to Older People*. Available at: <https://www.ark.ac.uk/nilt/results/olderpeople.html>

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<b>Religion</b>	<p><b>Note:</b> <i>The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of religion. This Service is delivered on the basis of identified need for support, and this access is not determined by religion.</i></p> <p>Contemporary analysis of the structures and dynamics of Northern Ireland society highlights persistent segregation between Catholic/ Nationalist/ Republican (CNR) groups and communities on one hand, and Protestant/ Unionist/ Loyalist (PUL) communities on the other hand. In 2007, it was estimated that 35–40 per cent of Protestants and Catholics live in communities divided along ethno-sectarian lines, and more recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious and political divisions.<sup>18</sup></p> <p>As noted in relation to the quantitative data on religion discussed above, it can be reasonably assumed that people from all religious backgrounds and none may require access to the Service, however, individuals from religions other than Catholic and Protestant backgrounds may be under-represented. Taking this into account, it is notable that the Health Alliance has identified the failure of some services to meet migrants’ cultural or religious needs as one of the difficulties encountered by minority ethnic communities when trying to access health and social care services.<sup>19</sup></p> <p>The information discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered in premises free from religious markers, in areas that are not perceived as enclave or single-identity territories, and by staff with relevant equality and diversity awareness and training.</p>
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<sup>18</sup> Gray, A. M., Hamilton, J., Kelly, G., Lynn, B., Melaugh, M. & Robinson, G. (2018). Northern Ireland Peace Monitoring Report Number 5. Belfast: Community Relations Council. Available at: <https://www.community-relations.org.uk/publications/northern-ireland-peace-monitoring-report>.

<sup>19</sup> See: <http://healthallianceni.com/health-social-wellbeing/bme-groups/>

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### Political Opinion

**Note:** *The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of political opinion. This Service is delivered on the basis of identified need for support, and this access is not determined by political opinion.*

As noted above, contemporary analysis of the structures and dynamics of Northern Ireland society highlights persistent segregation between Catholic/ Nationalist/ Republican (CNR) groups and communities on one hand, and Protestant/ Unionist/ Loyalist (PUL) communities on the other hand. In 2007, it was estimated that 35–40 per cent of Protestants and Catholics live in communities divided along ethno-sectarian lines, and more recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious and political divisions.<sup>20</sup>

As noted previously, it can be reasonably assumed that people from all political backgrounds and none may require access to the Service. This being the case, the information discussed above underlines the importance of ensuring that the Service procured by the HSCB can be made available to in premises free from political markers, in areas that are not perceived as enclave or single-identity territories, and by staff with relevant equality and diversity awareness and training.

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<sup>20</sup> Gray, A. M., Hamilton, J., Kelly, G., Lynn, B., Melaugh, M. & Robinson, G. (2018). Northern Ireland Peace Monitoring Report Number 5. Belfast: Community Relations Council. Available at: <https://www.community-relations.org.uk/publications/northern-ireland-peace-monitoring-report>.

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<b>Marital Status</b>	<p><b>Note:</b> <i>The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of marital status. This Service is delivered on the basis of identified need for support, and this access is not determined by marital status.</i></p> <p>As noted in the quantitative data section above, it can be reasonably assumed that the people who need to access the Service include individuals who identify with the full range of marriage status groups (i.e. married, single, same-sex civil partnership, divorced, separated, formerly in a same-sex partnership or widowed / surviving partner).</p> <p>Those who do not have the support of a partner or spouse may have less of a push to initially contact the service, and may also find it more difficult to access the service in terms of getting to appointments etc.</p> <p>This information underlines the importance of ensuring that the Service procured by the HSCB is delivered HSCB is delivered by staff with relevant awareness and training to enquire sensitively about family relationships and social networks in a person's life, and identify appropriate supports both through this advocacy Service and signposting to other relevant services.</p>
<b>Dependant Status</b>	<p><b>Note:</b> <i>The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of dependant status. This Service is delivered on the basis of identified need for support, and this access is not determined by dependant status.</i></p> <p>The nature of the Service is to assist Deaf Adults to access HSC services, thereby maximising the benefit of that support, promoting independence, modifying the impact of their sensory impairment, and promoting choice. People who are carers of deaf Adults, as well as Deaf Adults who themselves have caring responsibilities, are therefore core users of this service. This observation underlines the importance of ensuring that the</p>

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	<p>Service procured by the HSCB is delivered by staff with relevant awareness and training to enquire sensitively about dependant status and caring responsibilities, and identify appropriate supports both through maximizing access to relevant HSC services and offering additional signposting to other services on that basis, ensuring any barriers to access due to caring responsibilities are overcome.</p>
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<b>Disability</b>	<p><b>Note:</b> <i>The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of disability, whether in terms of deafness specifically or other sensory or physical disability. This Service is delivered on the basis of identified need for support, and this access is not determined by a person's disability status.</i></p> <p>In 2008, the Northern Ireland Life and Times Survey found that 79% of people who identified as having a disability reported that this disability limits their activities, and in 2009, 77% reported that their disability has a substantial adverse effect on their ability to carry out normal day-to-day activities.<sup>21</sup> While the survey data interrogates people's experiences of healthcare and addressing personal health issues, the results are not disaggregated to reflect the experience of people with disabilities.</p> <p>Notwithstanding this lack of qualitative data at a population level, it is reasonable to note the following:</p> <p>The nature of the <i>Advocacy Service for Deaf Adults</i> is to facilitate, support, and ensure equality of access for deaf adults to Health and Social Care services. People with disabilities, both in terms of deafness and potentially other sensory and physical disabilities, are therefore core users of this Service. This observation underlines the importance of ensuring that the</p>
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<sup>21</sup> See: <https://www.ark.ac.uk/nilt/results/disability.html>

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	<p>Service procured by the HSCB is delivered by staff with relevant awareness and training to identify disabilities and their impacts that may be additional to hearing loss or Deafness, and to identify appropriate supports both through maximizing access to relevant Health and Social Care services and offering signposting to other services on that basis. The objective in every case should be to support a Deaf Adult, whether they have additional disabilities or otherwise, to gain unimpeded access to Health and Social Care and make informed choices.</p> <p>It is important that qualitative learning obtained through this process is more closely monitored in future, to identify and mitigate against any identified barriers to access. On that basis, under the new Service contract, the HSCB will seek to work with both Trusts and the new Service provider to strengthen data collection, monitoring, and reporting that reflects the complexity and intersectionality of identity and disability status, and seeks to deliver outcomes-focused results and impact in the lives of the people accessing the service.</p>
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<b>Ethnicity</b>	<p><b>Note:</b> <i>The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of ethnicity. This Service is delivered on the basis of identified need for support, and this access is not determined by ethnicity.</i></p> <p>According to the Health Alliance, many minority ethnic communities have close social networks and strong cultural beliefs and practices, which can promote health and social wellbeing.<sup>22</sup> However, the National Institute for Health and Care Excellence (NICE) has demonstrated that some black, Asian and other minority ethnic groups face major health inequalities, and</p>
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<sup>22</sup> See: <http://healthallianceni.com/health-social-wellbeing/bme-groups/>

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multiple health issues and risk factors for ill health are more prevalent in minority ethnic communities.<sup>23</sup> There is a need for more local data collection and monitoring of ethnicity and race categories across health and social care and other sectors, to provide more accurate data to inform targeted action to address health inequalities.

The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care. These include:

- Language difficulties;
- Lack of awareness and lack of appropriate information on the services available;
- The need for a permanent address in order to register with a General Practitioner;
- Fears about entitlement to health care;
- Difficulty in coming to grips with a health care system that is different to what exists in their country of origin;
- The failure of some services to meet migrants' cultural or religious needs;
- Institutional racism and the negative attitudes of some health care staff; and
- Immigration restrictions.<sup>24</sup>

Wider contextual information that is important to take into account in this regard includes the fact that migrants arriving in Northern Ireland may arrive as refugees or asylum seekers, and may have survived abuse and violence prior to the challenges and potential isolation they may experience in this country. The existing HSC *Ethnic Minorities Mental Health Toolkit* considers these and a range of other factors that may impact on the wellbeing of individuals from migrant and BME communities, and

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<sup>23</sup> National Institute for Health and Care Excellence (NICE). (2017) *Health and social care directorate - Quality standards and indicators: Briefing paper*. (Available at: <https://tinyurl.com/y33hhr42>.)

<sup>24</sup> See: <http://healthallianceni.com/health-social-wellbeing/bme-groups/>

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their needs in terms of accessing HSC services.

A review of the monitoring returns submitted by the current Service provider over the past 12 months shows that no-one with foreign sign language translation and interpretation needs has accessed the Service in that recent period. While very small numbers of potential service users may be expected in this context, given the very small number of black and minority ethnic people in Northern Ireland, it is important that this trend is more closely monitored in future, to identify and mitigate against any potential barriers to access. To this end, under the new Service contract, the HSCB will seek to work with both Trusts and the new Service provider to strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield more informative statistics to help shape a truly accessible service. The information discussed above also underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training.

### **Sexual Orientation**

**Note:** *The person-centred focus of the Advocacy Service for Deaf Adults is a crucial mitigation against potential impacts arising on the basis of sexual orientation. This Service is delivered on the basis of identified need for support, and this access is not determined by sexual orientation.*

Research has demonstrated that LGB people report poorer experiences when accessing health and social care, are likely to delay access to healthcare based on previous negative experiences and fear of negative attitudes of health workers specifically in relation to their sexual orientation, and may have poorer health outcomes than their heterosexual peers.<sup>25</sup>

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<sup>25</sup> See: Elliot, M. et al. (2015). Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey, *Journal of General Internal Medicine*, 30 (1): 9-16; Light, B. et al. (2011). *Lesbian, Gay & Bisexual Women in the North West: A Multi-Method Study of Cervical Screening Attitudes, Experiences and Uptake*. The Lesbian & Gay Foundation and University of Salford.



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The negative impacts of experiences of discrimination and marginalisation, both direct and indirect, on LGBTQ+ individuals and groups are also well established.

A report published by the Rainbow Project (O'Hara, 2013), based on research conducted with more than 500 individuals that identified as "LGB&T," found that the respondents reported common experiences of invisibility, homophobia/transphobia, and a range of violence from threats to physical violence, whether direct or indirect. As a result of their actual or perceived sexual orientation and/or gender identity:

- 65.8% had been verbally assaulted at least once;
- 43.3% had been threatened with physical violence at least once;
- 33% had been threatened to be 'outed' at least once;
- 34.7% had experienced discrimination in accessing goods, facilities or services at least once.

The research noted this evidence indicates a level of intolerance that is a common experience for LGB&T people in Northern Ireland, and that this intolerance is a clear indicator for risk of experiencing poorer health and wellbeing outcomes.

This qualitative information is important for the design and delivery of this Service. It is noted that the Service does not have a remit to control for the numbers of people from the LGB community who engage with the Service. However, in terms of the people who do come forward for assistance, it can mitigate against any barriers arising associated with sexual orientation at that point in the process. For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training.

## 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.**

In considering potential impacts for each Section 75 equality category in sections 2.2 and 2.3 above, the HSCB acknowledges the complexity of intersectional identity and lived experience, and that individuals may identify with more than one group descriptor.

The engagement carried out with HSC Trusts and the current *Advocacy for Deaf Adults* Service Provider has highlighted that the current provider has an important role to play in terms of offering a constructive challenge to HSC service provision, when obstacles to access for Deaf people are identified, from a person-centred value base. This role is critical to the effective delivery of this Service specifically with regard to ensuring access for all service users, taking into account the inevitable intersectionality and complexity of their identities and needs. In procuring the new Service, the HSCB will ensure to make explicit the requirement for the successful provider to have demonstrated capacity and experience in providing such person-centred advocacy.

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### 2.5 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?

<i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i>	<i>What do you intend to do in future to address the equality issues you identified?</i>
<p><b>Gender</b>                      The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's gender.</p> <p>The Service will be required to create a safe and accessible environment for service users.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p> <p>The Service will be procured with specific requirements to demonstrate that the provider's staff undergo relevant equality and diversity awareness and training.</p> <p>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.</p>	<p>Across all areas: <i>the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
<p><b>Age</b>                      The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's age, and the delivery of the Service will be required to take cognizance of an individual's age and</p>	<p>Across all areas: <i>the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting,</i></p>

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<p>be adjusted accordingly to meet the individual's needs.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p>	<p><i>developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
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<p><b>Religion</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's religion.</p> <p>The Service will be required to create a safe and accessible environment for service users.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p> <p>The Service will be procured with specific requirements to demonstrate that the provider's staff undergo relevant equality and diversity awareness and training.</p> <p>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
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<p><b>Political Opinion</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's political opinion.</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting,</i></p>
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<p>The Service will be required to create a safe and accessible environment for service users.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p> <p>The Service will be procured with specific requirements to demonstrate that the provider's staff undergo relevant equality and diversity awareness and training.</p> <p>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.</p>	<p><i>developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
<p><b>Marital Status</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's marital status.</p> <p>The Service will be required to take cognizance of an individual's family and support networks and be adjusted accordingly to meet the individual's needs.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
<p><b>Dependant Status</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and</i></p>

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<p>dependant status.</p> <p>The Service will be required to take cognizance of an individual’s caring responsibilities and be adjusted accordingly to meet the individual’s needs, for example, by facilitating home visits and guaranteed access to advocacy via email communication or video-based information dissemination.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p>	<p><i>strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
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<p><b>Disability</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual’s particular disability, whether in terms of deafness or other sensory or physical disability.</p> <p>The Service will be required to create a safe and accessible environment for service users. This includes taking cognizance of an individual’s disability/ies and making adjustments accordingly to meet the individual’s needs – for example, ensuring the clarity and accessibility of information provided to service users.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p> <p>The Service will be procured with specific requirements to demonstrate that the</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
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## MITIGATING ACTIONS

<p>provider’s staff undergo relevant equality and diversity awareness and training.</p> <p>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.</p>	
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<p><b>Ethnicity</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual’s ethnicity.</p> <p>The Service will be required to create a safe and accessible environment for service users and carers, including taking cognizance of an individual’s ethnicity and cultural norms, and be making adjustments accordingly to meet the individual’s needs – for example, giving careful consideration to the clarity and accessibility of information provided to service users, and working to deliver access to provision of neutral foreign sign language interpreters where required.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p> <p>The Service will be procured with specific requirements to demonstrate that the provider’s staff undergo relevant equality and diversity awareness and training.</p> <p>The Service will be held accountable for the</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
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MITIGATING ACTIONS

<p>delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.</p>	
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<p><b>Sexual Orientation</b></p> <p>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual’s sexual orientation.</p> <p>The Service will be required to create a safe and accessible environment for service users.</p> <p>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.</p> <p>The Service will be procured with specific requirements to demonstrate that the provider’s staff undergo relevant equality and diversity awareness and training.</p> <p>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.</p>	<p><i>Across all areas: the HSCB will seek to work with both Trusts and the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.</i></p>
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## GOOD RELATIONS

### 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)**

<i><b>Group</b></i>	<i><b>Impact</b></i>	<i><b>Suggestions</b></i>
Religion	NONE	N/A
Political Opinion	NONE	N/A
Ethnicity	NONE	N/A

## CONCLUSION

### (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)**

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

**Please tick:**

Major impact	<input type="checkbox"/>
Minor impact	<input checked="" type="checkbox"/>
No further impact	<input type="checkbox"/>

**Please tick:**

Yes	<input type="checkbox"/>
No	<input checked="" type="checkbox"/>

#### **Please give reasons for your decisions.**

The nature of the *Advocacy Service for Deaf Adults* is to facilitate, support, and ensure equality of access for deaf adults to Health and Social Care services.

This is an explicitly person-centred Service underpinned by collaborative decision making that ensures and respects informed choice. The Service is accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.

Based on the information reviewed in this Equality Screening, the *Advocacy Service for Deaf Adults* has a positive impact on all Section 75 groups. As discussed above, the procurement of the new contract will include measures to further strengthen this positive impact, by including steps to further improve the capacity of the Service to identify and address potential barriers to access as they arise, and by improving sensitive data collection and monitoring procedures, in partnership with the Service provider and HSC Trusts.

**(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?**

<b><i>How does the policy or decision currently encourage disabled people to participate in public life?</i></b>	<b><i>What else could you do to encourage disabled people to participate in public life?</i></b>
<p>The nature of the <i>Advocacy Service for Deaf Adults</i> is to facilitate, support, and ensure equality of access for deaf adults to Health and Social Care services.</p> <p>Tenders to provide this Service are welcomed from Disabled People User Lead Organisations (DPULOs), charities, and social enterprise companies which encourage disabled people to participate in public life. This is informed by the successful service delivery model achieved through the current contract, which has been held by a DPULO from 2015 to date.</p>	<p>The specification for the new contract will make explicit reference to encouraging disabled people to participate in public life, and will include a requirement for the Service provider to participate in policy and service development fora and training events that deliver and promote the same message.</p> <p>The monitoring arrangements for the contract will include the requirement to collect and reflect on service user feedback, ensuring that the voices, compliments, complaints, and recommendations of disabled people inform and shape this public service.</p>

**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?**

<b><i>How does the policy or decision currently promote positive attitudes towards disabled people?</i></b>	<b><i>What else could you do to promote positive attitudes towards disabled people?</i></b>
<p>The nature of the <i>Advocacy Service for Deaf Adults</i> is to facilitate, support, and ensure equality of access for deaf adults to Health and Social Care services.</p> <p>People with disabilities are therefore core users of this Service, and by accessing the support available, their potential to participate in daily life and integrate with their communities is improved – this in turn aims to normalise and de-stigmatise disability, and promote positive attitudes towards disabled people.</p> <p>In addition, the current contract includes the requirement for the Service provider to deliver regional training to HSC Trusts and other relevant stakeholders on the needs of Deaf Adults and how to improve access to services in light of those needs. This training promotes better understanding of disabled people’s experiences and needs, and positive attitudes towards them. This will continue to be a requirement of the Service under the new contract.</p>	<p>The specification for the new contract will make explicit reference to promoting positive attitudes towards disabled people, and will include a requirement for the Service provider to participate in service development fora and training events that deliver and promote the same message.</p>

MONITORING

**(5) CONSIDERATION OF HUMAN RIGHTS**

**5.1 Are Human Rights relevant?  
Complete for each of the articles**

<b>ARTICLE</b>	<b>Yes/No</b>
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
1 <sup>st</sup> protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	NO
1 <sup>st</sup> protocol Article 2 – Right of access to education	NO

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

MONITORING

**5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision have a potential positive impact or does it potentially interfere with anyone's Human Rights?**

<b>List the Article Number</b>	<b>Positive impact or potential interference?</b>	<b>How?</b>	<b>Does this raise any legal issues?*</b>  <b>Yes/No</b>

*\* 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.**

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**(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**

The HSCB will continue to monitor service user information in relation to this Service, as per the monitoring arrangements set out in the current contract.

As noted above, the HSCB will seek to work with the new Service provider to strengthen data collection, monitoring, and reporting in relation to Section 75 information, developing approaches to data collection that are sensitive to the client and yield more informative statistics to help shape a truly accessible service.

**Disability Duties**

Noting that the Service has a positive impact in terms of the HSCB's Disability Duties: the monitoring arrangements for the new contract will include the requirement to collect and reflect on service user feedback, ensuring that the voices, compliments, complaints, and recommendations of disabled people inform and shape this public service.

**Human Rights**

Noting that the Service has a positive impact on human rights: the HSCB will continue to monitor service user information and service user feedback with reference to the human rights impact screening tool included in this template.

Approved Lead Officer: SARA TEMPLER

Position: Project Manager, Social Care and Children's Directorate, HSCB

Policy/Decision Screened by:

Signed:  
Date: \_\_\_\_\_

## MONITORING

**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 produced November 2011**

If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 95363961 (for Text Relay prefix with 18001); fax: 028 9023 2304