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?

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 Portal - Screening Resources & Evidence.

SCREENING TEMPLATE

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Physical Activity Referral Scheme (PARS)

1.2 Description of policy or decision

Background

Regular physical activity is proven to help, prevent and treat a range of non-communicable diseases such as heart disease, stroke, diabetes and some cancers. It also helps prevent hypertension, overweight and obesity and can improve mental health, quality of life and well-being. Epidemiological research demonstrates that being obese can increase the risk of a range of health conditions including Type II diabetes, some cancers and heart disease.

One of the main objectives included in "the Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012 – 2022 "A Fitter Future for All" is to increase physical activity levels, in line with CMO guidelines. The PHA seeks to improve health and wellbeing by a range of methods, including by creating an environment that promotes a physically active lifestyle. PHA is working with a range of partners to address the key objectives of this strategy which seeks a 4% reduction in obesity in adults and a 3% reduction in overweight and obesity adults.

The 2015-2019 revised outcome framework for "Fitter Future for All" identifies a number of actions relating to physical activity in order to address the problem of overweight and obesity. One of these is "increased promotion of physical activity within health and social care settings through development of physical activity referrals pathways". [1]

[1] DoH. A Fitter Future For All. Outcome Framework revised for 2015-2019. Available at https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/fitter-future-for-all-outcomes-framework-2015-2019.pdf

The Health Survey for Northern Ireland 2017-18 found that overall, 64% of adults surveyed were either overweight (37%) or obese (27%).[2] The most recent statistics show that in 2016/17, 55% of adults in Northern Ireland (19 and over) were currently meeting the CMO guidelines of 150 minutes per week. 45% were not meeting recommended levels of physical activity. Physical activity levels vary according to income, gender, age, ethnicity and disability. Generally women are less active than men and people tend to be less active as they get older.

In the UK, PARS (also known as exercise referral schemes) are one of the most common interventions used by primary care practitioners to encourage sedentary individuals and individuals with long term conditions to become more physically active. PARS vary in format, the mechanism of referral and content. They include structured, tailored and supervised activities delivered by a specialist physical activity and exercise instructor, and can be delivered at a number of different levels. Level 3 PARS are designed for those who have risk factors for disease, such as being overweight, having raised blood pressure or cholesterol levels, or have mild depression, anxiety or stress. Level 4 PARS are designed to manage chronic and complex specific health conditions or for rehabilitation following recovery from a specific condition. This includes cancer, cardiac and pulmonary rehabilitation programmes. Level 4 PARS are delivered by specialist Exercise Instructors, with training in one or more specific medical conditions.[3]

In Northern Ireland (NI), Level 3 PARS (previously known as exercise referral schemes) have been operational in many areas for 10 plus years. These schemes all operated independently and were initially commissioned under legacy arrangements and funded from various funding streams. Previous schemes were delivered up to a Level 3 standard. Each scheme had its own inclusion/exclusion criteria, resulting in different referral criteria for different areas of NI. Schemes also differed in terms of client charging mechanisms, programme duration, content and monitoring arrangements.

The Public Health Agency (PHA) has worked with providers of these legacy exercise referral schemes to develop a new regional PARS. The introduction of this regional

[2] Department of Health, 2017. Health Survey NI, 2017/18 https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland

[3] Register of Exercise Professionals. Available at https://www.exerciseregister.org/exercise-referral

scheme will ensure that each of the legacy schemes across NI adheres to regional standards and criteria including; the same inclusion/exclusion criteria, charging mechanism and an agreed specification for programme delivery supported by the implementation of a regional database for referral management, monitoring and evaluation.

A pilot regional scheme has been developed and is being rolled out across NI. The new regional PARS will provide patients with the opportunity to engage in a structured 12 week programme of physical activity or exercise under the guidance of a suitably qualified exercise professional (Level 3 trained). Referrals are made to the programme from a range of health care professionals including GPs, other practice based staff and ther registered health care professionals who can confirm that the client has no contra-indications to exercise. Patients with any absolute contraindications should not exercise until such conditions are stabilised or adequately treated. Information about the scheme, including referral criteria has been shared with referrers. GPs and Practice based staff have access to the referral mechanism (i.e. the Clinical Communication Gateway (CCG)) as part of their normal roles and therefore are not required to register before referring. Non-practice based staff eg Hospital based Physiotherapists must however request access to the CCG system from the PARS team before they can begin to refer.

The PHA commissions local Councils and some Healthy Living Centres (HLCs) to provide the regional PARS.

Aim and objectives

PARS is an obesity prevention funded initiative, sitting under the Regional Obesity Implementation Plan. The overall aim of PARS is to increase physical activity levels in adults in line with the Chief Medical Officer Physical Activity guidelines with a primary focus on those who are overweight/ obese (i.e. people with a BMI >25kg/m^2 to <40kg/m^2). The regional PARS will now adhere to regional standards and guidelines for Level 3 exercise referral programmes.

Objectives of the programme include:

- offering a high quality PARS within each Council area to overweight/ obese

clients who are inactive and who have an existing health condition or other risk factors for disease;
- improving the physical and mental health of overweight/ obese clients participating in the scheme, and;
- increasing clients' long term adherence to physical activity.

Inclusion criteria

PARS is an obesity prevention funded initiative with a finite budget. The programme seeks to maximise the potential benefits that can be achieved within existing resources, and make effective use of public resources.

After engagement at a regional and local level with service providers across Northern Ireland, a set of interim referral criteria were developed, targeting those in greatest need of the service and reflecting NICE guidance. It is important to note that these may need to be reviewed following evaluation of the programme.

During the interim year of the new regional scheme, PARS has used the following referral criteria (see paragraph below).

Clients must be:

- Overweight/ obese (with a BMI of ≥ 25kg/m^2 and <40kg/m^2)
- Aged 19 years or over (in line with age regulations for CMO physical activity guidelines) and
- Inactive (i.e. not currently meeting the PA guidelines of 150 minutes of moderate activity or 75 minutes of vigorous activity per week) and
- Willing to join the programme.

In addition only the clients who have another co-morbidity should be referred, including:

1. Hypertension
2. Hyperlipidaemia
3. Impaired glucose levels or diabetes
4. Family history of heart disease
5. Asthma, bronchitis or COPD
6. Musculoskeletal conditions
7. Mild or moderate mental health conditions.

Rationale for referral criteria

1. **Overweight/ obese (i.e. BMI of ≥ 25kg/m^2 and <40kg/m^2)**: National Standards suggest PARS Level 3 programmes should be designed for those who have risk factors for disease, such as being overweight.[4] Currently, exercise professionals cannot train individuals with a BMI > 40 on a Level 3 programme and need additional training to deliver programmes for individuals with BMI >40, due to the additional health risks associated with morbid obesity.

2. **Aged 19 years or over**: The new PARS programme is now in line with age regulations issued by the CMO for physical activity. The most recent CMO guidelines for physical activity (2019) specifically describe exercise goals for daily activities for different age groups, recommending 150 minutes per week for those aged 19 and over.

3. **Inactive**: One of the aims of the programme is to increase adults' levels of physical activity in line with CMO guidelines of 150 minutes a week. Inactivity is described by the Department of Health as a "silent killer".[5] Evidence is emerging that sedentary behaviour, such as sitting or lying down for long periods, is bad for health. This programme targets all those not currently meeting the recommended 150 minutes and deems these people inactive.

3. **Willing to take part**: To ensure best use of resources, and ensure participants get best use out of the programme, it is important that participants are willing to take part, motivated to change and want to complete the programme.

4. Other co-morbidities, including Hypertension; Hyperlipidaemia, Impaired glucose levels or diabetes, Family history of heart disease; Asthma, bronchitis or COPD; Musculoskeletal conditions; and/ or Mild or moderate mental health conditions: These criteria have been chosen for the new regional PARS for a number of reasons. Nice Guidance states that "Policy makers and commissioners should not fund exercise

[4] Register of Exercise Professionals. Available at https://www.exerciseregister.org/exercise-referral

[5] NHS Choices (2018) Benefits of Exercise. Available at https://www.nhs.uk/live-well/exercise/exercise-health-benefits/

referral schemes for people who are sedentary or inactive but otherwise apparently healthy. Primary care practitioners should not refer people who are sedentary or inactive, but otherwise apparently healthy, to exercise referral schemes.[6] As mentioned above, the new regional PARS is a Level 3 programme. National Standards suggest Level 3 programmes should be designed for those who have risk factors for disease, such as having raised blood pressure or cholesterol levels, or have mild depression.[7] National Standards for Exercise programmes are reflected in the referral criteria for this programme, with hypertension, hyperlipidaemia, impaired glucose levels or diabetes, and a family history of heart disease key risk factors associated with Coronary Heart Disease.

Previous PARS included some of the current referral criteria for the new regional programme, including health conditions such as hypertension; impaired glucose levels or diabetes; asthma, bronchitis or COPD; musculoskeletal conditions, and/or mild or moderate mental health conditions. The new regional PARS has been designed to keep referral criteria as closely aligned as possible to previous PARS.

Alternative physical activity programmes for certain clients not eligible for this programme (i.e. those who are normal weight, and not necessarily overweight/ obese) are commissioned by PHA. These include Active Travel, which is supported in three settings: schools (Active Schools Travel), workplaces (Leading the Way with Active Travel), and communities (Community Active Travel Programme in 12 disadvantaged communities in Belfast). Other programmes include Walking For Health, or Couch to 5 K. The Daily Mile scheme is being promoted in schools and work is ongoing to expand this throughout NI. In addition, there are other opportunities for physical activity offered by other Departments and/or district councils, and community and voluntary organisations (e.g. the Park Run, which is a volunteer led programme).
It is recognised that individuals who have specific or chronic healthcare needs will fall outside the referral criteria for the new regional Level 3 PARS. However, Level 3 programmes are not designed to manage specific health care conditions or for

[6] NICE Guidance. Physical Activity : exercise referral schemes. Available at https://www.nice.org.uk/guidance/PH54/chapter/1-Recommendations#exercise-referral-for-people-who-are-sedentary-or-inactive-but-otherwise-healthy

[7] Register of Exercise Professionals. Available at https://www.exerciseregister.org/exercise-referral

rehabilitation following recovery from chronic health care conditions. These individuals have specific physical activity and medical needs that are reflected in the National standards for Level 4 programmes. Level 4 programmes include condition-specific physical activity programmes, such as cancer rehab, pulmonary rehab, and cardiac rehab. The PHA commissions Level 4 programmes in some council areas and local HSCTs may also deliver Level 4 programmes.

Links to other physical activity programmes and opportunities not specifically for people who are overweight/ obese will be included in the PHA Choose To Live Better website.

Cost

The 12 week programme is free. However, some councils at their own discretion include a nominal fee for joining the scheme e.g. £20 at start. This enables the client to avail of leisure facilities outside PARS programme hours e.g. free swimming etc. or enables them to participate in a continuation programme for a number of weeks at a reduced cost after the PARS programme has completed.

1. What are the key constraints? (for example financial, legislative or other)

Who the constraint applies to	Constraints	Measures to Address Constraints
The Public Health Agency and Providers	1. Scale of Funding - Only a limited budget is available and there is variation of funding across PHA teams/localities.	Review funding regionally and locally and consider restructuring funding as necessary. Review criteria for admission to programme. Apply for / secure further funding Reduce targets

	2. Variability in Each Area	No cost contribution from participants for core programme. Consider restructuring funding as necessary / agree regional cost per completer. Target variation. Consider additional funding (eg Council contribution if not already). Agree and implement regionally standardised specification for referrals in and delivery of scheme.	
	3. <u>Annual Funding</u> - uncertainty re contracts may mean staff leave post.	Local discussions with providers. Consider offering 3-5 year contract agreements (on level of funding), allowing providers to offer staff longer term contracts if they wish.	
PHA	4. <u>Current Providers</u> – A number of providers in situ and these will remain at present.	Regional Specification of Schemes Regional Standardisation	

		of monitoring	
PHA and Current Providers	5. <u>Existing Schemes –</u> exercise referral schemes have been in operation for 10+ years and these vary across Northern Ireland – inequitable at present.	Regional Specification in line with evidence and NICE Guidance. Agree Outcomes including monitoring via regional ICT system.	
Providers	6. <u>Training and Registration –</u> minimum Level III trained and REPs or CIMPSA registered.	Regional Standards – must be trained and registered accordingly. Training requirements and registration detailed in Service Level Agreement.	
Service Referrers and Providers	7. <u>Scheme Criteria</u> – specific inclusion and exclusion criteria for new scheme which will differ from current schemes.	New Scheme which will be communicated to all providers and referrers. Analyse new scheme including criteria on an ongoing basis. Open to changing criteria based on activity levels/referrals. A consultation on criteria following transition year of regional scheme will commence in 2020. Make information available on alternative pathways for clients not eligible for this	

		programme. For example, if someone who has a health condition (e.g. mental health condition) who is not overweight or obese, they can avail of other programmes such as Walking For Health, Couch to 5 K, and other council funded programme. Links to local physical activity opportunities not specifically for people who are overweight/ obese are included in the Choose To Live Better website.	

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

Service Users
Clients who need the service and those who use the service.
Providers of the service

- District Councils
- Leisure Service Providers (eg GLL, Serco)
- Healthy Living Centres

Referrers to the Service

- GPs
- Other Practice based staff
- Other NHS Registered Health Care Professionals

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

Other Physical Activity programmes/ pathways

- Level 4 PARS: The Public Health Agency also commissions a number of Level 4 exercise referral programmes. These include programmes such as; cardiac rehabilitation, pulmonary rehabilitation, cancer rehabilitation and diabetes rehabilitation. These programmes are treatment and management programmes and are only available in some Council areas. There are also programmes offered through voluntary organisations and community groups. For example, in Northern Ireland Macmillan have also funded the "Move More" programme which offers exercise referral for clients who have had cancer.

- General physical activity programmes: Information is available on the PHA "Choose to Live Better" website on alternative opportunities for clients not eligible for this programme. For example, if someone who has a health condition (e.g. mental health condition) who is not overweight or obese, they can avail of other physical activity programmes. These include; Walking For Health, Couch to 5 K, allotment and community garden projects, active Travel projects in schools, workplaces and communities. There are also 'Healthy Towns' initiatives in some council areas which bring together a range of programme areas at local level; work place health initiatives and range of other programmes provided by local council and community and voluntary sector organisations. Physical activity co-ordinator posts in local HSCTs also run a range of training for trainers courses to build capacity for the delivery of physical activity programmes in local areas.

Relevant strategic documents include:

- Making Life Better, A Whole System Strategic Framework for Public Health (DHSSPSNI, 2013 – 2023)
- "Fitter Future for All" a 10 year Framework for Preventing and Addressing

Overweight and Obesity in Northern Ireland (DHSSPNI, 2012-2022)

- NICE Guidelines, Exercise Referral Schemes to Promote Physical Activity: (NICE public health guidance 54, Sept 2014).
- Draft Programme for Government 2016 – 2021
- PHA Corporate Plan 2017 – 2021.
- Sport Northern Ireland (Sport NI) Disability Mainstreaming Policy since 2006.
- Active Living No Limits 2021

(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.

- Information was gathered at a number of stakeholder engagement events, including events with exercise professionals and other council staff. Discussions were also held at a local level, with local providers to discuss referral criteria and programme management.
- Census 2011: Detailed Characteristics for Northern Ireland on Health, Religion and National Identity
- GIRES (2014). The Number of Gender Variant People in the UK - Update 2011. Available at http://www.gires.org.uk/prevalence.php
- Department of Health, Health Survey NI 2016/17. Available at https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland
- Department of Health, Health Survey NI 2017/18. Available at https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland
- Department of Health. 2017/18 Raw disease prevalence trend data for Northern Ireland. Available at https://www.health-ni.gov.uk/publications/201718-raw-disease-prevalence-trend-data-northern-ireland
- Department of Health, 2016. A Diabetes Strategic Framework. https://www.health-ni.gov.uk/publications/diabetes-strategic-framework
- Department of Health, 2001. A fitter future for all: Consultation report
- Nice Guidance:
    - PH54 – Physical activity: exercise referral schemes
    - PH44 – Physical activity: brief advice for adults in primary care
    - PH35 - Type 2 diabetes prevention: population and community-level interventions
- NICE. Hypertension in adults: diagnosis and management, 2016. https://www.nice.org.uk/guidance/cg127/chapter/introduction

- NICE, Health and Social Care Directorate, Quality standards and Indicators, Briefing paper, 2015. https://www.nice.org.uk/guidance/qs167/documents/briefing-paper
- Mental Health Foundation, 2016. Fundamental Facts About Mental Health 2016. https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf
- Continuous Household Survey 2013-14
- Public Health England (2015). High cholesterol, beating the build up. Available at https://publichealthmatters.blog.gov.uk/2015/10/12/high-cholesterol-beating-the-build-up-during-cholesterol-month/
- Diabetes UK, 2014. Third of adults in England have prediabetes. Available at https://www.diabetes.org.uk/about_us/news/third-of-adults-have-prediabetes
- NISRA mid-year population estimates for June 2019. Available at https://www.nisra.gov.uk/statistics/population/mid-year-population-estimates
- Public Health England, 2018. Health Matters: combating high blood pressure. https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-high-blood-pressure
- Allender et al. 2008 Coronary Heart Disease Statistics 2008 edition. https://www.bhf.org.uk/informationsupport/publications/statistics/coronary-heart-disease-statistics-2008
- The Statistics Portal, 2018. Share of health conditions diagnosed in individuals in Northern Ireland in 2013 by gender and disease. https://www.statista.com/statistics/348887/health-conditions-by-gender-in-northern-ireland/
- Gov.uk, 2016. Press release: 3.8 million people in England no have diabetes. https://www.gov.uk/government/news/38-million-people-in-england-now-have-diabetes
- Information Analysis Directorate. (2015). Health Inequalities in Northern Ireland: Key Facts 2015. Information Analysis Directorate. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscims-2015-key-facts.pdf.
- NHS Digital, 2014. Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014.
- NHS Choices (2018) Benefits of Exercise. Available at https://www.nhs.uk/live-well/exercise/exercise-health-benefits/
- Department of Communities. Secondary analysis of the Continuous Household Survey 2013/14. https://www.communities-ni.gov.uk/sites/default/files/publications/dcal/engagement-in-culture-arts-and-

leisure-by-adults-in-northern-ireland-analysis-by-section-75-groups-201213.pdf
- Active Lives. https://activelives.sportengland.org/
- Troubled consequences: A report on the mental health impact of the civil conflict in NI. Available at https://www.cvsni.org/media/1435/troubled-consequences-october-2011.pdf

- Carers UK, 2012. In sickness and in health: A survey of 3,400 UK carers about their health and well-being. https://www.carersuk.org/for-professionals/policy/policy-library/in-sickness-and-in-health
- Mental Health Foundation. Mental health statistics: family and parenting. https://www.mentalhealth.org.uk/statistics/mental-health-statistics-family-and-parenting
- Social Care Institute for Excellence. The prevalence of parental mental health problems in Great Britain. https://webcache.googleusercontent.com/search?q=cache:oXP37OpWvKAJ:https://www.scie.org.uk/assets/elearning/parentalmentalhealthandfamilies/deploy/module2/assets/common/pdfs/prevalence_of_parental_mental_health_problems_in_great_britain.docx+&cd=3&hl=en&ct=clnk&gl=uk
- NIA Research and Information service Research Paper (2014) Provision for sport for those with a disability. Available at http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2014/culture_arts_leisure/14214.pdf
- Public Health England. Health Matters: getting every adult active every day. https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day
- NHS England. NHS Right Care Pathway: Diabetes. https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/11/rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf
- Adult Psychiatric Morbidity Survey (AMPS) 2014
- Gov.UK (2017/18). Overweight adults. https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest
- GOV.UK. Ethnicity Facts and Figures: Physical Activity. https://www.ethnicity-facts-figures.service.gov.uk/health/exercise-and-activity/physical-activity/latest#
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- Public Health England, 2010. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document. https://www.london.gov.uk/sites/default/files/LGBT%20Public%20Health%20Outcomes%20Framework%20Companion%20Doc.pdf
- NICEM (2014). The Annual Human Rights and Racial Equality Benchmarking Report 2013/14. Northern Ireland Council for Ethnic Minorities: Belfast. http://nicem.org.uk/wpcontent/uploads/2014/06/Final-Benchmarking-Full-Report-NICEM-web.pdf
- Health Alliance NI See: http://healthallianceni.com/health-social-wellbeing/bme-groups/

- 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.

Documents and data sources are referenced throughout.

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.

- **Overweight and Obesity:** The Health Survey for Northern Ireland 2017-18 found that overall, 64% of adults surveyed were either overweight (37%) or obese (27%).
  - Obese 1 – Moderately obese (BMI 30.0-34.9): 19%
  - Obese 2 – Severely obese (BMI 35.0-39.9): 5%
  - Obese 3 – Very severely obese (BMI > 40) 3%

- **Physical Activity:** The Health Survey for Northern Ireland 2016/17 found that 55% of the adults aged 19 years and older surveyed are meeting the CMO's guideline recommended levels of physical activity per week. Physical activity is low amongst certain Section 75 groups, as outlined below.

- **Hypertension:** Data from the 2018 Quality and Outcomes Framework (QOF) reported that there were 268,400 patients in Northern Ireland with diagnosed hypertension which represented 14% of all GP registered patients.
- **Hyperlipidaemia (High Cholesterol):** According to Public Health England, around 6 in 10 adults have high cholesterol. .
- **Impaired Glucose and Diabetes:** In 2018, according to the DoH Diabetes Strategic Framework, there were 96,114 adults aged 17 years and older in Northern Ireland on the Diabetes Register, representing 4.9% of the population. Diabetes UK estimates that 1 in 3 adults have pre-diabetes.
- **Heart Disease:** 78,835 people in Northern Ireland are living with Coronary Heart Disease, representing 4% of the population.
- **Asthma/COPD:** In 2018, there were 122,178 people on the Asthma register and 40,955 on the COPD register in NI, representing almost 9% of the NI population.
- **Musculoskeletal (Osteoporosis and Rheumatoid Arthritis):** In 2018, there were 5,785 patients on the Osteoporosis and 12,381 patients on the rheumatoid arthritis register. This is approximately 1% of the overall NI population.
- **Mental Health:** In 2017/18 there were 17,849 adults in Northern Ireland on the mental health register, representing 1% of the population. The Health Survey NI 2017/18 found that around a fifth (18%) of Northern Ireland adults aged 19 years and older have a high GHQ12 score which could indicate a mental health problem.

Data on the health of the population of Northern Ireland by Section 75 category (with the exception of age and gender) is limited. There is no information readily available on people who have obesity and each co-morbidity, so we have considered each referral criteria separately. Data is presented below.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	Figures from the most recent Census (2011) show that within the NI population of adults aged 19 years and older (n=1,354,804) 51% are female (700,968) and 49% are male (n=653, 836)[8]

[8] Census 2011: Detailed Characteristics for Northern Ireland on Health, Religion and National Identity. http://www.nisra.gov.uk/Census/detailedcharacteristics_stats_bulletin_2011.pdf

The Gender Identity Research and Education Society (GIRES)[9] estimate the number of gender nonconforming employees and service users:

- Gender variant to some degree 1%
- Have sought some medical care 0.025%
- Having already undergone transition 0.015%

Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2019) N=1,881,600 (approx.):

- 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.

Overweight/ obesity: The prevalence of both overweight and obesity were higher in males than females:

- 43% of females surveyed were a normal weight (including underweight) compared to 27% of males;
- 30% of females surveyed were overweight compared to 46% of males;
- 27% of females surveyed were obese compared to 26% of males

These figures are broadly in line with the 2016/17 survey and both overweight and obesity rates have remained fairly stable across females and males since the first Health Survey for Northern Ireland 2010/11.

Physical Activity: Men are both more likely to meet the recommended physical activity levels (61%; n=469) than women (51%; n=562) and are also less likely to be inactive (22%; n=169) than women (28%; n=308). Men report to be more active than females across all age groups, the percentage of adult males (aged 19-64) reaching the recommended physical activity levels is 67% compared to 60% of women of the same age, whereas for older adults (65-74 years), the proportions are 49% for men and 35% for females[10]. The gender breakdown of sedentary behaviour of adults in Northern Ireland is not known or is not available.

[9] GIRES. The Number of Gender Variant People in the UK - Update 2011. Available at http://www.gires.org.uk/prevalence.php

[10] Department of Health, 2017. Health Survey NI, 2016/17 https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland

* Inactivity is defined as less than 30 minutes per week of moderate activity or less than 15 minutes per week of vigorous activity.

Gender	**Hypertension:** Data from the 2018 Quality and Outcomes Framework (QOF) reported that there were 268,400 patients in Northern Ireland with diagnosed hypertension which represented 14% of all GP registered patients Data on hypertension prevalence by gender for the population of Northern Ireland is not known or available. Data is available for England and will be used for the purposes of this screening exercise to gain insight into the relationship between gender and hypertension; however this needs to be caveated by the significant difference in prevalence data between England and NI. High blood pressure affects more than 1 in 4 adults in England (12.5 million adults). In terms of gender, the Health Survey for England has found that for any given age up to 65 years, women are less likely to have hypertension compared to men. However, between the ages of 65 to 74, women are more likely to have hypertension compared to men of the same age[11]. **Hyperlipidaemia (High cholesterol):** Data on the prevalence rates of hyperlipidaemia by age for the population of Northern Ireland are not available. According to 2011 NHS figures, around half of all adults aged 18 years and older have a total cholesterol level above the recommended level of 5mmol/L. Men tend to be at higher risk earlier in life than women, whose risk increases, though, after menopause. In both England and Scotland, between 16 and 44, more men than women have high cholesterol. However, between 45 and 75+, more women than men have high cholesterol[12]. **Impaired Glucose and Diabetes:** In 2013, 6% of men and 4% of women were on the Diabetes Register[13]. Public Health England have also found that diabetes rates are higher in men (9.6%) compared to women (7.6%)[14]. Of those with Type 2 diabetes in England, 56% are men and 44% are women.

[11] Public Health England, 2018. Health Matters: combating high blood pressure. https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-high-blood-pressure

[12] Allender et al. 2008 Coronary Heart Disease Statistics 2008 edition. https://www.bhf.org.uk/informationsupport/publications/statistics/coronary-heart-disease-statistics-2008

[13] The Statistics Portal, 2018. Share of health conditions diagnosed in individuals in Northern Ireland in 2013 by gender and disease. https://www.statista.com/statistics/348887/health-conditions-by-gender-in-northern-ireland/

[14] Gov.uk, 2016. Press release: 3.8 million people in England no have diabetes. https://www.gov.uk/government/news/38-million-people-in-england-now-have-diabetes

Gender	Although it is estimated that approximately a third of people have impaired glucose levels, the prevalence of pre-diabetes by gender is not known.[15] **Family history of heart Disease:** Siblings and children of younger heart attack victims have a higher risk of heart disease. There are no statistics on the numbers of people who have a family history of heart disease. However, more men than women in Northern Ireland have Coronary Heart Disease. In 2016/17 almost twice as many men (9798) as women (4464) were hospitalised with Coronary Heart Disease . This reflects trends across the UK, the prevalence of Coronary Heart Disease is 5.7% in males in England compared to 3.5% in females[16]. **Asthma:** In 2012, 12,565 females per 100,000 and 12,033 males per 100,000 had asthma. Asthma occurred slightly more frequently in females (12.6%) than males (12.0%) throughout the years 2004–12.[17] **Musculoskeletal (Osteoporosis and Rheumatoid Arthritis):** In 2018, there were 5,785 patients on the Osteoporosis and 12,381 patients on the rheumatoid arthritis register. There was no published gender breakdown on Musculoskeletal (Osteoporosis and Rheumatoid Arthritis) data. **Mental Health:** The Health Survey NI 2017/18 found that around a fifth (18%) of Northern Ireland adults aged 19 years and older have a high GHQ12 score which could indicate a mental health problem, levels were similar in men (17%) and women (18%). However, there are significant inequalities in the prescription of medication for mental health problems in Northern Ireland: the prescription rate for mood and anxiety disorders in 2013 was 66% higher among women, than men.[18] Data from England indicates that women are more likely to have a mental health problem than men. A review of mental health data in England from 1993 – 2014 revealed that 1 in 6 adults have a common mental disorder, and the prevalence is higher in women (1 in five) than men (1 in 8)[19]. This higher incidence of mental

[15] Diabetes UK, 2014. Third of adults in England have prediabetes. https://www.diabetes.org.uk/about_us/news/third-of-adults-have-prediabetes

[16] British Heart Foundation, 2018. Heart and Circulatory Diseases Statistics 2018. https://www.bhf.org.uk/what-we-do/our-research/heart-statistics/heart-statistics-publications/cardiovascular-disease-statistics-2018

[17] British Lung Foundation. Asthma Statistics. Available at https://statistics.blf.org.uk/asthma

[18] Information Analysis Directorate. (2015). Health Inequalities in Northern Ireland: Key Facts 2015. Information Analysis Directorate. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscims-2015-key-facts.pdf.

[19] NHS Digital, 2014. Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014.

<table>
<tr><td></td><td>health problems in NI is explored in more detail below in the Section 75 category of Political Opinion.

Evidence suggests that people who identify as transgender are at a higher risk of experiencing poor mental health. This includes a higher risk of a range of mental health problems, including depression, suicidal thoughts and self-harm, and alcohol and substance misuse. [20]

Summary: Summarising the data on gender it would suggest that males may need the service more as there are more men than women overweight/obese. Men are also more likely to have heart disease, diabetes, high blood pressure (up to age 65), higher cholesterol (between 45 and 75). Women however are less physically active and increasing physically active levels is the core aim of this programme.</td></tr>
<tr><td>Age</td><td>The most recent census data showing the age breakdown of the NI population of adults aged 19 years and older (n=1,354,804) is displayed in the table below.

<table><tr><th>Age (years)</th><th>Percentage of NI Population</th></tr><tr><td>19</td><td>1.37</td></tr><tr><td>20-24</td><td>6.96</td></tr><tr><td>25-29</td><td>6.85</td></tr><tr><td>30-44</td><td>20.65</td></tr><tr><td>45-59</td><td>19.21</td></tr><tr><td>60-64</td><td>5.21</td></tr><tr><td>65-74</td><td>8.04</td></tr><tr><td>75-84</td><td>4.79</td></tr><tr><td>85-89</td><td>1.17</td></tr><tr><td>90+</td><td>0.56</td></tr></table>
Overweight/ obesity: Levels of overweight were lowest amongst 16-24 year olds (17%) and were highest amongst those aged 75 years and older (43%) and levels of obesity were lowest amongst 16-24 year olds (17%) and highest amongst 55-64 year olds (35%), see table overleaf for overweight and obesity prevalence by adult age groups.</td></tr>
</table>

[20] Mental Health Foundation, 2016. Fundamental Facts About Mental Health 2016. https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

	Age Group (Years)						
	16-24	25-34	35-44	45-54	55-64	65-74	75+
Underweight	6%	1%	1%	1%	1%	1%	0%
Normal weight	61%	41%	38%	28%	27%	28%	34%
Overweight	17%	38%	35%	38%	37%	39%	43%
Obese	17%	20%	26%	33%	35%	32%	23%
Unweighted base	*198*	*351*	*436*	*528*	*517*	*453*	*246*

Physical Activity: The Health Survey for Northern Ireland 2016/17 found that adults aged 35-44 are most likely to meet the CMO's physical activity guidelines (70%) and those aged 75 years and older are least likely (10%). A lower proportion of adults aged 45 years and over are achieving the CMO's physical activity guidelines compared to those at any given age between 16 and 44 years. From 45 to 75+ years, the proportions of Northern Ireland adults who achieve the recommended levels of physical activity decreases significantly between each consecutive 10 year age band. The percentage of adults by age group and gender meeting the CMO's physical activity guidelines is outlined in the table below.

Percentage of adults by age group and gender meeting the CMO's physical activity guidelines[21]

Age-group	Male	Females
19 - 24	77%	60%
25 – 34	66%	68%
35 – 44	75%	67%
45 – 54	68%	58%
55 – 64	49%	45%
65 – 74	49%	35%
75+	14%	8%

Hypertension: Research has shown that hypertension is strongly influenced by age.[22] The prevalence of hypertension in Northern Ireland adults increases with age. In 2013 6% of those aged 16-24 years had hypertension with the prevalence

[21] Health Survey for Northern Ireland 2016/17

[22] NICE. Hypertension in adults: diagnosis and management, 2016. https://www.nice.org.uk/guidance/cg127/chapter/introduction

	increasing to 56% in those aged 75+. **Hyperlipidaemia:** The prevalence of high cholesterol by age is not available for the population of Northern Ireland. However, in Scotland, fewer individuals aged 16 – 24 years (approximately 24%) have high cholesterol (i.e. total cholesterol of 5mmol/L), compared to those aged 45-54 years (approximately 77%).[23] **Impaired Glucose and Diabetes:** Prevalence data from GPs is limited in terms of age breakdown however in 2019 the prevalence is more than double for the over 50s (144 per 1000 or 14%) as compared to the over 18s (65 per 1000 or 6.5%).[24] **Heart Disease:** Prevalence data from GPs is limited in terms of age breakdown however prevalence is almost double for the over 50s (107 per 1000 or 11%) as compared to the over 18s (48 per 1000 or 5%).[25] **Asthma and COPD:** Prevalence data from GPs is limited in terms of age breakdown however the prevalence is almost double for the over 50s as for the over 18s. Prevalence of asthma and COPD for those aged 18 and over is 107 per 1000 or 11%, compared to a prevalence rate of 238 per 1000 for those aged over 50 years (24%).[26] **Musculoskeletal (Osteoporosis and Rheumatoid Arthritis):** Prevalence data from GPs is limited in terms of age breakdown however the prevalence is almost double for the over 50s (3%) as for the over 18s (1%) (28 per 1000 compared to 13 per 1000 respectively).[27] **Mental Health:** The Health Survey Northern Ireland 2017/18 found that GHQ12 scores fluctuate at each age point between 16 and 75+ years in adults across Northern Ireland with no clear relationship between age and mental health. Females aged 55-64 (23%) and males aged 16-24 (21%) are most likely to have a high GHQ12 score and females aged 25-34 (12%) and males aged 65-74 (10%) are least likely to have a high GHQ12 score. The prevalence of a high GHQ12 score by

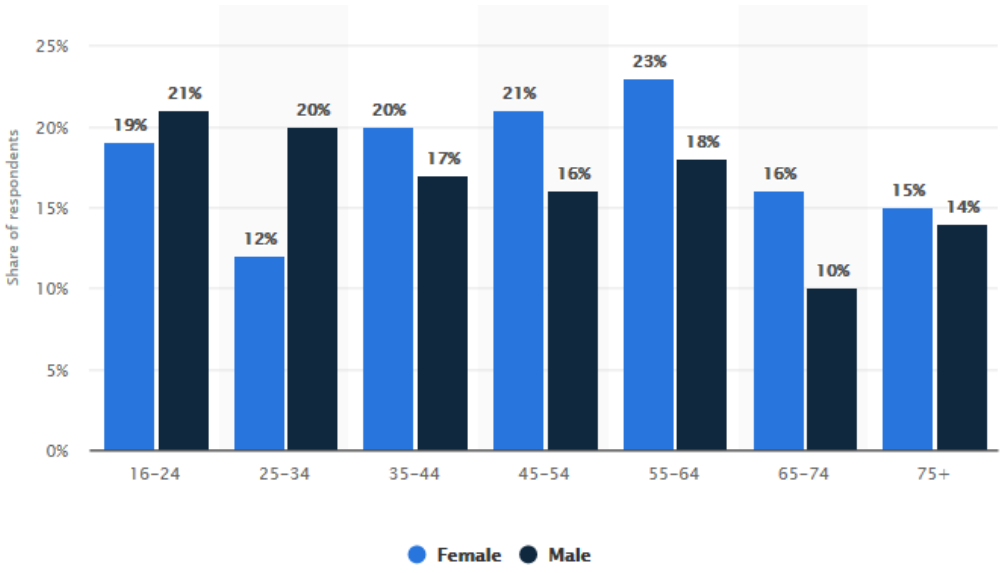
[23] Allender et al. 2008 Coronary Heart Disease Statistics 2008 edition. https://www.bhf.org.uk/informationsupport/publications/statistics/coronary-heart-disease-statistics-2008

[24] https://www.health-ni.gov.uk/publications/201819-raw-disease-prevalence-trend-data-northern-ireland

[25] https://www.health-ni.gov.uk/publications/201819-raw-disease-prevalence-trend-data-northern-ireland

[26] https://www.health-ni.gov.uk/publications/201819-raw-disease-prevalence-trend-data-northern-ireland

[27] https://www.health-ni.gov.uk/publications/201819-raw-disease-prevalence-trend-data-northern-ireland

	age and gender is shown in the graph below. **Individuals with possible psychiatric disorder and referred to as a high GHQ12 score in Northern Ireland 2017/18, by age and gender[28]**  **Summary:** Obesity rates increase with age, particularly in mid-life where the total % of those overweight or obese average 71% (age 45 – 74). Physical activity levels decrease with age, again there is a decline in levels from 45 onwards. Whilst age data is limited almost all of the risk factors or conditions included within the PARS referral criteria also increase with age. Mental health identified using the GHQ12 score fluctuates at each age point with no clear relationship between age and mental health.
Religion	Census data suggests that within the NI population of adults aged 19 years and older (n=1,354,804) the Religion or Religion an individual was brought up in is: • 39.26% - Catholic • 43.52% - Protestant and other Christian religions • 0.86% - Other religion • 9.83% - No religion • 6.51% - Not stated **Overweight/ obesity:** There is no significant difference in the levels of obesity between adults of various religious groups in Northern Ireland.[29]

[28] Health Survey Northern Ireland 2017/18

	Physical Activity: The Continuous Household Survey 2013-14 found that no difference in physical activity levels between Catholics and Protestants. However, adults with other or no religious background were more likely to be physically active than either Catholics or Protestants[30]. These findings are in line with the Active Lives Survey from England which also found that adults with no religion are more likely to meet the recommended levels of physical activity (72%) than those from any other religious background[31]. The prevalence of hypertension, hyperlipidaemia, impaired glucose, heart disease, Asthma and COPD, Musculoskeletal (Osteoporosis and Rheumatoid Arthritis) and mental health illness by religious group is not known or available for the population of Northern Ireland or the UK. **Summary:** The data on religion in terms of the referral criteria for PARS is very limited. The BMI and physical activity data would suggest that there are no significant differences across religious group.
Political Opinion	Census data suggests Nationality breakdown of the general population of Northern Ireland (n=1,810,863) is: • 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% (1,847) • British and Irish only - 0.66% (11,952) • Other - 5.00% (90,543) Census data outlining Nationality by age group is outlined the table below:

[29] Department of Health, 2001. A fitter future for all: Consultation report. https://www1.bps.org.uk/sites/www1.bps.org.uk/files/Obesity%20Prevention%20Framework%20%28NI%29%20-%20consultation%20paper.pdf

[30] Department of Communities. Secondary analysis of the Continuous Household Survey 2013/14. https://www.communities-ni.gov.uk/sites/default/files/publications/dcal/engagement-in-culture-arts-and-leisure-by-adults-in-northern-ireland-analysis-by-section-75-groups-201213.pdf

[31] Active Lives. https://activelives.sportengland.org/

		National identity			
	All usual residents	British only	Irish only	Northern Irish only	Other
All usual residents	**1,810683**	**723,379**	**457,482**	**379,267**	**251,735**
Aged 0 to 15	**379,323**	139,348 (36.7%)	106,666 (28.1%)	82,456 (22.0%)	50,853 (13.4%)
Aged 16 to 34	**471,572**	159,763 (33.9%)	134,108 (28.4%)	99,498 (21.0%)	78,203 (16.6%)
Aged 35 to 54	**502,686**	202,590 (40.3%)	126,928 (25.2%)	101,063 (20.0%)	72,105 (14.3%)
Aged 55 and over	**457,282**	220,678 (48.3%)	89,780 (19.6%)	96,250 (21.0%)	50,574 (11.1%)

The prevalence of hypertension, hyperlipidaemia, impaired glucose, heart disease, Asthma and COPD, Musculoskeletal (Osteoporosis and Rheumatoid Arthritis) by political opinion is not known or available for the population of Northern Ireland or the UK.

Mental health: Evidence suggests that those who have been disproportionately affected by the NI Conflict are more likely to experience poorer mental health, including anxiety, mood, substance or impulse-control disorder.[32] There are significant inequalities in the prescription of medication for mental health problems in Northern Ireland: the prescription rate for mood and anxiety disorders in 2013 was twice as high in the most deprived areas (which are often associated with high levels politically-motivated civil unrest) than the least deprived areas. [33]

Summary - Data on the health of the population of Northern Ireland by nationality is extremely limited. However, research suggests higher levels of mental ill-health in areas disproportionately affected by Troubles related violence.

Marital Status	Census data indicates that half (50.2%) of the Northern Ireland population of adults aged 19 and over (n=1354,804) are married, a third (32.5%) are single and 1,243 people are (0.09%) are in a registered same-sex civil partnership. 10% are either separated (4.2%) or divorced (5.8%) and the remaining 7.2% of people are

[32] Troubled consequences: A report on the mental health impact of the civil conflict in NI. Available at https://www.cvsni.org/media/1435/troubled-consequences-october-2011.pdf

[33]Mental Health Foundation. Mental Health in Northern Ireland: Fundamental Facts. Available at: https://www.mentalhealth.org.uk

	either widowed or a surviving partner from a same-sex civil partnership. **Overweight/ obesity:** The Northern Ireland Health and Social Wellbeing Survey 2005/06 showed that those who are single are less likely to be overweight or obese (42%) compared to those who are married (68%), separated (66%), divorced (64%) or widowed (64%), It is important to note that Civil Partnership Act came into force in Northern Ireland on 05/12/2005 and so a corresponding category was not included in the 2005/06 HSWB marital status question. This may be linked to age, as single people tend to be younger, and are also less likely to be overweight or obese. **Physical Activity:** Data on the relationship between marital status and physical activity is limited. The Continuous Household Survey 2013-14 found that a lower proportion of widowed people participated in sport or physical activity compared with people of any other marital status. Married adults were less likely to participate in sport or physical activity than adults who were single, while divorced or separated adults were less likely to participate in sport or physical activity than married adults[8]. However, again, it is important to note that single people tend to be younger and younger people tend to be more physically active. The prevalence of hypertension, hyperlipidaemia, impaired glucose, heart disease, asthma, COPD, musculoskeletal and mental health illness by marital status is not known or available for the population of Northern Ireland or the UK. **Summary**: Data on the health of the population of Northern Ireland by marital status is limited. Adults who are single are less likely to be overweight/obese and more likely to participate in physical activity although this could be related to age.
Dependent Status	The Northern Ireland Health Survey 2016/17 revealed that 13% of adults surveyed (n=3,887) reported having caring responsibilities and women were more likely to have caring responsibilities (15%) than men (10%). Adults aged 55-64 were most likely to have caring responsibilities (23%) and adults aged 16-24 (7%) were least likely to have caring responsibilities. The Northern Ireland Census 2011 revealed that one-third (34%) of households (n=703,275) have a least one dependent child[10]: • 66% of households have no dependent children • 14% have one dependent child • 12% have two dependent children • 5% have three dependent children

	• 2% have four or more dependent children **Physical Activity:** Data on the relationship between dependent status and physical activity is limited, this is an area that warrants further research for the population of Northern Ireland and UK wide. The Continuous Household Survey 2013-14 found that adults who do not have dependants were less likely to participate in sport or physical activity than adults who have dependants. In a UK survey of 3,400 carers, 34% of carers reported exercising a lot less as a result of caring[34]. **Hypertension:** In a UK survey of 3,400 carers 22% reported that they have high blood pressure. **Mental Health:** It is estimated that 68% of men and 57% of women with mental health problems are parents[35]. On the evidence of the high-quality, large, national surveys of psychiatric conditions, it is probable that, in a population of non-elderly adults, at any given time, around 9 to 10 % of women and 5 to 6 % of men in Great Britain will be parents with mental health problems[36]. In a UK survey of 3,400 carers, 87% stated that caring had a negative impact on their mental health and 57% of carers reported having a mental health condition such as anxiety or depression. Of the Northern Ireland participants, 88% reported that caring had a negative impact in their mental health. Carers UK's annual survey (2015) of over 5,000 carers across the UK found that 84% of carers feel more stress, 78% feels more anxious and 55% reported that they suffered depression as a result of their caring role. The prevalence of: obesity/overweight; hypertension; hyperlipidaemia; impaired glucose and diabetes; heart disease; asthma; COPD; and musculoskeletal conditions by dependent status is not known or available for the population of

[34] Carers UK, 2012. In sickness and in health: A survey of 3,400 UK carers about their health and well-being. https://www.carersuk.org/for-professionals/policy/policy-library/in-sickness-and-in-health

[35] Mental Health Foundation. Mental health statistics: family and parenting. https://www.mentalhealth.org.uk/statistics/mental-health-statistics-family-and-parenting

[36] Social Care Institute for Excellence. The prevalence of parental mental health problems in Great Britain. https://webcache.googleusercontent.com/search?q=cache:oXP37OpWvKAJ:https://www.scie.org.uk/assets/elearning/parentalmentalhealthandfamilies/deploy/module2/assets/common/pdfs/prevalence_of_parental_mental_health_problems_in_great_britain.docx+&cd=3&hl=en&ct=clnk&gl=uk

<table>
<tr><td></td><td>Northern Ireland or the UK.

Summary: - The limited data on dependents and the range of referral criteria for PARS makes it very difficult to draw any strong conclusions. However, evidence suggests that those who have caring responsibilities may have poorer mental health than those who are not carers.</td></tr>
<tr><td>Disability</td><td>Data from the last census in 2011 shows that of the population of Northern Ireland (n=1,810,063), 31.4% (n=569,078) reported having a long-term condition or disability, and 20.7% (n=374, 683) reported that their day-to-day activities were limited because of a long-standing health problem or disability.

Long-Term Health Problem or Disability in Northern Ireland

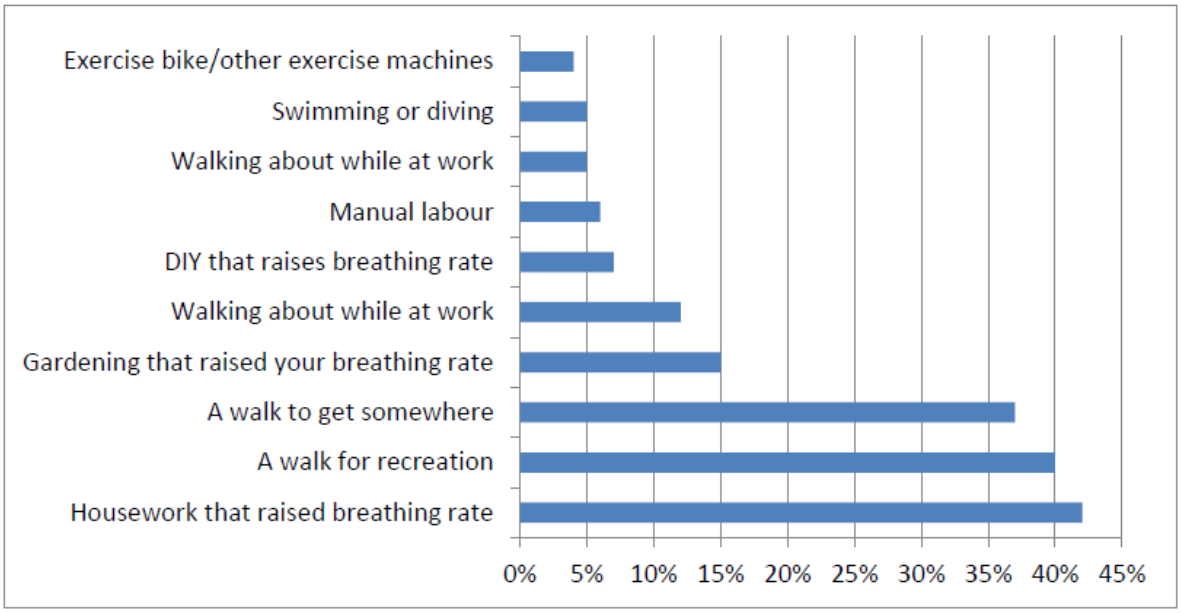
<table>
<tr><th></th><th>Number of people</th><th>% of population of Northern Ireland (n=1,810.863)</th></tr>
<tr><td>Deaf of partially hearing impaired</td><td>93,091</td><td>5.1</td></tr>
<tr><td>Blind of partially vision impaired</td><td>30,862</td><td>1.7</td></tr>
<tr><td>Communication difficulty</td><td>29,871</td><td>1.6</td></tr>
<tr><td>Mobility of dexterity difficulty</td><td>207,173</td><td>11.4</td></tr>
<tr><td>Learning, intellectual or social or behavioural difficulty</td><td>40,177</td><td>2.2</td></tr>
<tr><td>Emotional, psychological or mental health condition</td><td>105,528</td><td>5.8</td></tr>
<tr><td>Long-term pain or discomfort</td><td>182,820</td><td>10.1</td></tr>
<tr><td>Shortness of breath or difficulty breathing</td><td>157,890</td><td>8.7</td></tr>
<tr><td>Frequent periods of confusion or memory loss</td><td>35,616</td><td>2.0</td></tr>
<tr><td>Chronic illness</td><td>118,554</td><td>6.5</td></tr>
<tr><td>Other Condition</td><td>94,617</td><td>5.2</td></tr>
<tr><td>No health condition</td><td>1,241,785</td><td>68.6</td></tr>
</table>

Overweight/ obesity: There is a difference in the levels of obesity between adults in Northern Ireland who have a disability compared to those who do not. Those who have a long standing illness, disability or infirmity have higher rates of obesity (33%) than those who do not (19%), however levels of overweight are similar (36% compared to 34%).

Physical Activity: Adults with a disability in Northern Ireland exercise less than those without a disability. 19% of people with disabilities in Northern Ireland</td></tr>
</table>

participate regularly in physical activity, compared with 37% of non-disabled adults.[37] The table below provides a breakdown of the kinds of physical activity carried out by people with a disability.

Forms of physical activity undertaken by adults with disabilities in Northern Ireland.



The relationship between disability and physical activity in adults in Northern Ireland reflects the trends also observed in England which show that disabled people are half as likely as non-disabled people to be active. Additionally, data from Public Health England has found that only 1 in 4 people with learning difficulties take part in physical activity each month compared to over half of those without a disability.[38]

Impaired Glucose and Diabetes: The prevalence of diabetes by disability status is not available for the population of Northern Ireland. Data on the prevalence of diabetes by disability status for the UK is limited. Data from GP practices in England 2014-15 showed higher prevalence rates of Type 2 diabetes in people with a learning disability compared to the general population.[39]

[37] NIA Research and Information service Research Paper (2014) Provision for sport for those with a disability. Available at http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2014/culture_arts_leisure/14214.pdf

[38] Public Health England. Health Matters: getting every adult active every day. https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day

[39] NHS England. NHS RightCare Pathway: Diabetes. https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/11/rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf

<table>
<tr><td></td><td>Mental Health: The prevalence of mental health illnesses amongst adults with a disability in Northern Ireland is not available.

People with learning disabilities have a higher prevalence of mental health problems compared to those without (25% and 17.2% respectively).[40]
A 2012 report published by The King's Fund and Centre for Mental Health highlighted that individuals with physical health problems are at an increased risk of poor mental health, particularly depression and anxiety. The report showed that 30% of people with a long-term physical health condition also have a mental health problem and 46% of people with a mental health problem also have a long-term physical health problem.

The prevalence of hypertension; hyperlipidaemia; impaired glucose and diabetes; heart disease; asthma; COPD; and musculoskeletal conditions by disability status is not available for the population of Northern Ireland or the UK.

Summary: Adults with a disability in Northern Ireland have a higher rate of obesity and exercise less than those who do not have a disability. Data from also suggest that those with a physical disability are at higher risk of poor mental health. In particular those with a learning disability present with a higher prevalence of mental health problems.</td></tr>
<tr><td>Ethnicity</td><td>The Northern Ireland 2011 Census provides details on the ethnic make-up of the wider population in Northern Ireland. Statistical analysis of the census data found that 98% of the people that usually resident in Northern Ireland were white, with the remaining 2 per cent split between people from Asian, Black, Mixed or Other ethnicities. However, it is recognised that immigration patterns have changed since the time of the census.

Total Population size of differing population groups in Northern Ireland: Northern Ireland.

<table>
<tr><td></td><td>Population Size</td><td>Percentage</td></tr>
<tr><td>ALL</td><td>1,810,863</td><td>100%</td></tr>
<tr><td>White</td><td>1,778,449</td><td>98.21%</td></tr>
<tr><td>Chinese</td><td>6,303</td><td>0.35%</td></tr>
<tr><td>Irish travellers</td><td>1,301</td><td>0.07%</td></tr>
<tr><td>Indian</td><td>6,198</td><td>0.34%</td></tr>
</table>
</td></tr>
</table>

[40] Adult Psychiatric Morbidity Survey (AMPS) 2014

Pakistani	1,091	0.06%
Bangladeshi	540	0.03%
Other Asian	4,998	0.28%
Black Caribbean	372	0.02%
Black African	2,345	0.13%
Black other	899	0.05%
Mixed	6,014	0.33%
Other	2,353	0.13%

Overweight/ obesity: Data on the BMI on the population of Northern Ireland by ethnicity is not known or is not available. However, anecdotal information suggests that certain ethnic groups, e.g. Roma Community, may be more susceptible to overweight/obesity. However, 2017/18 data from England suggests that Black adults were the most likely out of all ethnic groups to be overweight or obese (73%). Adults from the Chinese ethnic group were the least likely out of all ethnic groups to be overweight or obese (34%). [41]

Physical Activity: Levels of physical activity by ethnicity is not known or is not available for the population of Northern Ireland. However, data from England shows that levels of physical activity do differ by ethnicity. For the purpose of this equality screen, data from England will be used to provide an insight into the relationship between ethnicity and physical activity. The Active Lives Survey 2015-16 found that people from a Mixed background were the most likely to be physically active (69%). The percentage of physically active people in the Asian, Black, Chinese and Other ethnic groups was lower than the national average and ranged from 54% to 56%. People in the Asian ethnic group least likely to be active (49%). [42]

In addition, people from the Asian, Black, Chinese and Other ethnic groups were more likely to be inactive, at 31%, 29%, 31% and 30% respectively, than people from the White British, White Other and Mixed ethnic groups, at 25%, 23% and 19% respectively.[43]

[41] Gov.UK (2017/18). Overweight adults. https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest

[42] GOV.UK. Ethnicity Facts and Figures: Physical Activity. https://www.ethnicity-facts-figures.service.gov.uk/health/exercise-and-activity/physical-activity/latest#

	Hypertension: Data on hypertension rates by ethnicity for the population of Northern Ireland is not known or available. Research indicates that there is differential risk of heart related health problems, including hypertension, for different population subgroups.[44] In England, people from Black African and Black Caribbean ethnic groups have a higher risk of hypertension than the general population. **Impaired Glucose and Diabetes:** The prevalence of diabetes by ethnicity is not known or is not available for the population of Northern Ireland. People of South Asian family origin living in the UK are up to six times more likely to have Type 2 diabetes than the white population (DH 2001). People of African and African-Caribbean descent are three times more likely to have type 2 diabetes than the white population. Type 2 diabetes is also more common among Chinese and other non-white groups than among white European populations.[45] **Heart Disease:** The prevalence of heart disease by ethnicity is not known or available for the population of Northern Ireland. The British Heart Foundation has outlined that the prevalence of CVD is highest in the Irish ethnic group and the general population (around 15%). Indian and Pakistani men (11% and 12% respectively) have the next highest rates, with Black African men (2%) having the lowest. The prevalence of CHD is highest in Indian (6%), Pakistani (8%) and Irish (6%).[46] **Mental Health:** Data on mental health by ethnicity is not known or is not available for the population of Northern Ireland. The 2014 Adult Psychiatric Morbidity Survey (APMS) found the prevalence of common mental health problems to vary significantly by ethnic group for women, but not for men. Non-British white women were the least likely to have a common mental health problem (15.6%), followed by white British women (20.9%) and black British

[44] NICE, Health and Social Care Directorate, Quality standards and Indicators, Briefing paper, 2015. https://www.nice.org.uk/guidance/qs167/documents/briefing-paper

[45] NICE, Public Health Guideline [PH35]. https://www.nice.org.uk/guidance/ph35/chapter/2-public-health-need-and-practice

[46] British Heart Foundation, 2010. Ethnic Differences in Cardiovascular Disease 2010 edition. https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKEwiYo8fd767fAhXzThUIHUprCFMQFjABegQICBAC&url=https%3A%2F%2Fwww.bhf.org.uk%2F-%2Fmedia%2Ffiles%2Fresearch%2Fheart-statistics%2Fhs2010fc_ethnic_differences_in_cardiovascular_disease-full-copy.pdf&usg=AOvVaw1CT_uyRbxma3ORynW3MPgv

	women (29.3%). Black adults were also found to have the lowest treatment rate of any ethnic group, at 6.2% (compared to 13.3% in the white British group).[47] It is recognised that in Northern Ireland there is minimal uptake of mental health services by BME communities, believed to be attributed to a range of barriers including cultural beliefs, language barriers, structural challenges, stigma and shame. This is recognised as increasingly problematic as migrants are at higher risk of poor mental health due to underemployment, communication difficulties, literacy issues, lack of access to support services, transitional upheaval, and social isolation.[48] The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care, including immigration restrictions, and the need for a permanent address in order to register with a General Practitioner in order to access care.[49] **Musculoskeletal (Osteoporosis and rheumatoid arthritis, Hyperlipidaemia, and Asthma and COPD:** Data on the prevalence of Musculoskeletal (Osteoporosis and rheumatoid arthritis, Hyperlipidaemia, and Asthma and COPD in adults by ethnicity are not known or available for the population of Northern Ireland or the UK. **Summary**: Data on the health of the population for ethnicity is very limited for NI and as such it is difficult to draw any firm conclusions for NI specifically. Evidence from elsewhere suggests that individuals from the black ethnic group were more likely to be overweight or obese and similar to Asians were less like to be physically active. Black African and Black Caribbean groups also have higher rates of hypertension and type 2 diabetes. Evidence also suggests BME groups are less likely to seek help, or to use medical services.

[47] Mental Health Foundation, 2018. Mental health statistics: black, Asian and minority ethnic groups. https://www.mentalhealth.org.uk/statistics/mental-health-statistics-black-asian-and-minority-ethnic-groups
Public Health England, 2010. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document.
https://www.london.gov.uk/sites/default/files/LGBT%20Public%20Health%20Outcomes%20Framework%20Companion%20Doc.pdf

[48] NICEM (2014). The Annual Human Rights and Racial Equality Benchmarking Report 2013/14. Northern Ireland Council for Ethnic Minorities: Belfast. Retrieved from http://nicem.org.uk/wpcontent/uploads/2014/06/Final-Benchmarking-Full-Report-NICEM-web.pdf

[49] See: http://healthallianceni.com/health-social-wellbeing/bme-groups/

Sexual Orientation	**<u>Obesity/ overweight:</u>** Data on BMI by sexual orientation is not known or available for the population of Northern Ireland. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework published by Public Health England provides an overview of the relationship between BMI and sexual orientation. Research suggests that gay and bisexual men are less likely to be overweight than heterosexual men, with research indicating that 44% of gay and bisexual men are overweight or obese compared to 70% of men in general. However, further research is needed, particularly in relation to lesbian and bisexual women, and trans people.[50] **Physical Activity:** Levels of physical activity by sexual orientation is not known or is not available for the population of Northern Ireland. However, data from England shows that levels of physical activity do differ by sexual orientation. The Active Live Survey November 2016/17 found that more bisexual people (77%) and gay or lesbian people (72%) are meeting the CMO's recommended physical activity levels compared to heterosexual people (64%) and those from the other sexual orientation group (62%). **Mental Health:** 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 homophobia/transphobia, and a range of violence from threats to physical violence. 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 negative impacts of experiences of discrimination and marginalisation, both direct and indirect, on LGB individuals and groups are also well established. Evidence suggests that people who identify as lesbian, gay, or bisexual are at a higher risk of experiencing poor mental health. This includes a higher risk

[50] Public Health England, 2013. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document. https://www.basw.co.uk/system/files/resources/basw_104255-2_0.pdf

	of a range of mental health problems, including depression, suicidal thoughts and self-harm, and alcohol and substance misuse.[51] National English Survey using 2009–10 data found that 27,497 of respondents registered with the NHS who described themselves as gay, lesbian or bisexual were two to three times more likely to report having a psychological or emotional problem compared to their heterosexual counterparts. Mental health inequalities such as these have been found across the UK, in England, Scotland and Wales. 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 have poorer health outcomes than their heterosexual peers.[52] **Hypertension; Hyperlipidaemia; Impaired Glucose and Diabetes; Arthritis: COPD; Osteoporosis; Rheumatoid Arthritis and Heart Disease**: Prevalence by sexual orientation is not known or available for the population of Northern Ireland or the UK. **Summary**: Data is limited on the health of the population by sexual orientation in Northern Ireland. Limited data from England suggests that bisexual, gay and lesbian people are more active than the general adult population and that gay and bisexual are less likely to be overweight. Evidence suggests that those who identify as lesbian, gay, and bisexual are at a higher risk of experiencing poor mental health. 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.

[51] Mental Health Foundation, 2016. Fundamental Facts About Mental Health 2016. https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

[52] 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.

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	**Initial access to PARS** Health literature shows that men are less likely to access health services and GP services compared to women. This is explored in more detail under marital status. Research has shown that women tend to be in less well-paid jobs than men. This could mean that any additional cost associated with the programme may have a disproportionate impact on women. **Design and delivery of the service** Women who have dependents and caring responsibilities may not be able to attend PARS only held during 'office hours', rather needing services to be local and provided at flexible times. It is recognised that certain groups e.g. BME women / pregnant women may prefer the provider to be of the same gender as them. Some women may also prefer women only exercise groups. Pregnant or post-partum women may have additional needs when exercising or doing certain physical activity. Also individuals who identify as transgender may have specific requirements as to regards to changing and showering facilities in order to avoid embarrassment or harassment. **Outcome of the Service** There are no differences based on gender as to the outcomes. This will be explored in further detail in the evaluation.
Age	**Initial access to PARS** Due to changes in NICE guidance, the new regional PARS is only available to adults aged 19 plus, individuals aged 16-18 will no longer

	be able to avail of this service as they did in some of the old legacy schemes. There is a gap in service provision for 16 – 18 year olds. Older people (particularly pensioners) may have a lower household income than younger people. This could mean that any additional cost associated with the programme may have a disproportionate impact on older people, and act as a barrier to accessing the service. **Design/ delivery of the service** There is a need for programme content to be age specific, i.e. older people may require the programme content to be different as they will have different capacity/ strength in terms of physical activity compared to younger people. A need for female exercise professionals to deliver the programme to older women has been identified
Religion	**Initial access to PARS** There are no specific needs or experiences on the basis of religion in accessing this service, as individuals can choose which GP to attend, and these are usually within their local area. **Design/ Delivery of the Service** It is recognised that individuals from certain religious communities may feel uncomfortable attending programmes held in areas perceived to be 'belonging' to the opposite religious/ political community or where access routes involve travelling through such areas.
Political Opinion	**Initial access to PARS** There are no specific needs or experiences on the basis of political opinion in accessing this service, as individuals can choose which GP service to attend, and these are usually within their local area. **Design/ delivery of the service** Cognisance will be given to the political sensitivities that may exist within local areas. It is recognised that individuals from certain political backgrounds or communities may feel uncomfortable attending programmes held in areas perceived to be 'belonging' to the opposite

	religious/ political community or where access routes involve travelling through such areas
Marital Status	**Initial access to PARS** Previous work has shown that men, particularly those who do not have the support of a partner or spouse are less likely to access healthcare and particularly GP services. This may limit their access to the new regional PARS. Households headed by a single adult have been shown to have lower incomes than those headed by two adults. This could mean that any additional cost associated with the programme may have a disproportionate impact on single people. **Design/ delivery of the service** In relation to participants accessing the service, cognisance will need to be given to the needs of single parents as these may differ from couples. A flexible service (in terms of location/times) will be required to meet the needs of single parents.
Dependent Status	**Initial access to PARS** There are no discernible differences in initially accessing the service based on dependent status. People who are carers and those who are single parents have been shown to be more at risk of poverty and tend to have lower household incomes – if there is a cost for non-core programmes, this will be more likely to impact negatively on these groups compared to the rest of the population. **Design of the service/ Delivery of the Service** People who are carers and those who are single parents have been shown to be more at risk of poverty and tend to have lower household income, travel costs may limit access to the service. These people are also more likely to be disproportionately affected by any cost levied on the scheme by Councils. Access to crèche facilities may be required for some individuals to enable them to use the service, as childcare issues may be problematic for some parents, particularly single parents.

Disability	**Initial access to PARS** The inclusion criteria includes a BMI>25 and <40 kg/m^2. Statistics show that people who are disabled are more at risk of obesity, although it is not known if disabled people are more at risk of morbid obesity (i.e. BMI>40kg/m^2) However, it is possible that a larger proportion of those with disabilities are morbidly obese. The referral criteria limiting participation of those with a BMI>40kg/m2 may therefore impact more on those with disabilities. **Design/ delivery of the service** The programmes need to be held in buildings/areas which are accessible and which have good transport links as people with disabilities may be more reliant on public transport to access goods and services. Service providers need to be cognizant of the various disabilities individuals' may present with and adapt the programme content according to their needs. For example some individuals with certain physical disabilities may have a specific need for certain types of physical activity (e.g. arm chair exercises). Programmes will need to be based on individual needs. Some disabled individuals or individuals with mental health problems may find it difficult to attend every week, or may find participation in group activities more difficult Those people with disabilities may experience communication difficulties and may have particular needs regarding communication and information (particularly those with learning disabilities, hearing impairments or sight impairments). There may be a need to deliver to targeted groups together eg, learning disabled, deaf people etc. to ensure they receive the best service possible. However, this will be decided alongside the client, with their wishes taken into account.

Ethnicity	**Initial access to PARS** Some ethnic groups may have particular needs regarding communication / language. It is also recognised that in order to access the scheme, people need to be registered with a GP, which can be an issue for migrants and asylum seekers. In terms of the referral criteria, that certain ethnic groups are over-represented amongst those with a BMI >40kg/m2, for example a higher proportion of Roma, or Black people may not meet the BMI criteria. Certain ethnic groups (e.g. migrants, asylum seekers) tend to be in less well-paid jobs and more at risk of poverty than the rest of the NI population. This could mean that any additional cost associated with the programme may have a disproportionate impact on these groups of people. **Design/ delivery of the service** It is recognised (see comments above) that individuals from some ethnic groups may prefer PARS providers of the same gender as themselves. Some ethnic minorities may experience communication difficulties and may have particular needs regarding communication and information.
Sexual Orientation	**Initial access to PARS** **/ Design / delivery of the service** It is recognised that people who identify as lesbian, gay or bisexual (LGB) are more likely to report negative experiences in accessing services. LGB individuals have reported incidents of homophobia and heterosexism when trying to access services, including health and social care services.

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.

Physical Activity Referral is a population based intervention that is available for the whole population who meet the criteria for the programme. There may be instances when the scheme impacts on people with multiple identities, e.g. older disabled females.

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?***
Gender: Programmes and information provided will be gender appropriate. Staff will be trained appropriately for this (including any specific training required for delivering to pregnant women). Service providers will be asked to provide the service at various times for participants to ensure it is flexible and accessible, for example, to single parents, to those with dependents or those who work. The service specification requires providers to be as flexible as possible in the delivery of the scheme and the following wording has been included: "A PARS should be available to clients across a range of days/times including evenings	The service specification for the delivery of the scheme will be kept under review and updated as necessary to ensure issues identified are raised with service providers. PHA will discuss with providers the need/opportunity to provide an exercise referral programme for clients between the ages of 16 – 19. Other Physical Activity opportunities will continue to be promoted. PHA will liaise with providers to ensure that staff delivering the programme have received all relevant training including

and weekends". Increased the number of venues offering the service in liaison with providers. The number of venues providing the service now stands at 58 and additional funding is being sought to enable the provision of further programmes which may also enable providers to increase the number of locations in which this service is provided. Encouragement will be given for providers to promote the scheme through the community and voluntary sector, including targeting Men's Sheds, in order to improve access for men (particularly those who do not have the support of a partner) as mentioned above. Cognisance will be given to certain groups e.g. BME women / pregnant women who may prefer the provider to be of the same gender, or who may prefer to exercise in same-gender groups. However, it may not always be possible to facilitate this, although efforts will be made to accommodate individual requests as much as possible. Cognisance will also be given to Transgender and gender nonconforming individuals, and flexibility will be offered where possible. Clients will be able to choose from a range of different leisure centres, some of which will have family/ unisex changing areas. **Age**: The target group for this programme are adults aged 19 and over (in line with NICE Guidance), who are overweight/obese, inactive and have another comorbidity.	training on equality and diversity. PHA will liaise with providers to establish which facilities providing PARS have family or unisex changing rooms, this information will be made available on CCG so referrers have access to this at time of referral. A full consultation on the referral criteria will be held in Summer 2020 following transition year of implementation of the regional scheme. Any equality issues identified will be considered. The programme will seek the views and experiences of service users through the monitoring of compliments and complaints and actively seek feedback as part of the evaluation process. As highlighted above, a greater proportion of BME groups and certain disabilities may be more likely to be obese. Although this PARS scheme is designed to be a Level 3 programme or individuals without morbid obesity (i.e. BMI<40kg/m^2) due to the additional health risks associated with physical activity amongst this group and the additional health care needs. If this is an issue following consultation, the PHA will need to reconsider the criteria and train at least one trainer from each provider to a Level 4 standard.

The gap between 16 – 18 year olds has been addressed to some degree by the promotion of other physical activity programmes, such as Active Travel Programmes, Couch to 5 K etc advertised on the PHA website. Programme should be patient centred, with some providers grouping clients on ability, bringing clients for induction and group according to need. Everyone receives an initial assessment so physical activity needs of elderly people must be taken into consideration. All staff trained to deliver the scheme will undergo the relevant fitness instructor qualification that will include age appropriate content regarding physical activity / exercise. **Religion/ political opinion**: The programme will be provided in a range of locations across Northern Ireland to facilitate potential clients / personal preference (in line with commissioning arrangements for the scheme). Participants, at the point of referral, will be given a choice of location from a list of providers across NI. There are currently 58 providers of the PARS regionally. Additional funding is being sought to enable the provision of further programmes which would also enable providers to increase the number of locations in which this service is provided. **Disability**: Information will be provided in a variety of formats, in accordance with the PHA's Accessible Format's policy. Sign	

language interpreters will also be made available to those with hearing impairments. Providers will make reasonable adjustments where necessary in using the service. There may be a need to deliver to targeted groups together, e.g. learning disabled, deaf people etc. It is also recognised that some disabled individuals may prefer/need 1-1 training as opposed to group based activities. This flexibility has been reflected in programme design. Relevant training will be made available to providers e.g. the need for training for providers to raise awareness of working with clients with a learning disability has already been identified and appropriate training will be put in place. The 11 Councils (main providers of PARS) have disability hubs and there should be access to appropriate equipment to enable disabled participants to partake of the programme. The programmes will be held in buildings/areas which are accessible and which have good transport links. It is recognised that people with certain disabilities (e.g. learning disabilities/ some physical disabilities) may be more likely than the rest of the population to be morbidly obese, and therefore not suitable for a Level 3 programme. This PARS scheme is for individuals without morbid obesity (i.e. BMI <40) due to the additional health risks associated with physical activity amongst this group and the additional health care needs.	

Ethnicity: Written information about the programme will be provided in a variety of languages as needed, in accordance with the PHA's Accessible Format's policy. All of the referral agents have access to the HSC Translation services in order to address the needs of those whose first language is not English. Also, interpreters will be made available if necessary when delivering the PARS programme. It is recognised that BME individuals are less likely to access services, particularly around mental health. It is also recognised that in order to access the scheme, people need to be registered with a GP, which can be an issue for migrants and asylum seekers. However, The Public Health Agency, in collaboration with others, currently supports a range of programmes to promote minority ethnic and migrant health and social wellbeing improvement. One partnership initiative is the regional Northern Ireland New Entrant Service (NINES), a holistic service which provides an introduction to health and social care in NI, signposting and onward referral, in addition to comprehensive health assessments, screening, immunisation and health promotion for new immigrants and families. As highlighted above, a greater proportion of BME groups can have a higher BMI. This PARS scheme is for individuals without morbid obesity (i.e. BMI <40kg/m^2) due to the additional	

health risks associated with physical activity amongst this group and the additional health care needs. **Dependents:** It is recognised that certain groups (e.g. single parents; carers) may have difficulties in attending PARS on a regular basis and balancing this with their caring responsibilities. A flexible service will be introduced to meet these needs. Programmes are currently available across 58 sites in 11 Council areas in Northern Ireland and most offer programmes in a flexible manner outside 9am-5pm. It is also recognised that single parents who may have a child of a different gender to themselves may need family or unisex changing areas, or may need crèche facilities. Clients will be able to choose from a range of different leisure centres, some of which will have family/ unisex changing areas, and crèche facilities. **Sexual orientation**: The service specification will be updated to include: "The service provided should promote social inclusion, addressing issues around disadvantage, sexual orientation, gender identify, ethnicity and rural/urban communities." Providers have to ensure that staff delivering the programme have relevant training on equality and diversity. **Cost implication:** Some providers are applying an additional charge when	

people start PARS. This allows access to services within the venue (e.g. swimming pool) outside the core PARS or to participate in a continuation programme at reduced cost after the 12 week PARS ends. This additional cost levied varies depending on provider. This screening has shown that levying a charge to access PARS may disproportionately affect a number of equality groups who tend to have lower household incomes or are more at risk of poverty (e.g. females, carers, single parents, certain ethnic minority groups, and elderly people). The impact of this will be explored in the EQIA.	

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	None
Political Opinion	No impact identified at this time	None
Ethnicity	No impact identified at this time	None

(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	x
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	x
No	

Please give reasons for your decisions.

As a number of issues were raised in the screening of the programme including the restricted eligibility criteria and additional costs of the programme for some clients which have a major impact with regards to equality issues there is a need to carry out a full EQIA and consultation.

(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?*
	The programme will seek the views and experience of participants through monitoring of compliments and complaints and actively seek feedback as part of the evaluation process of the programme. Promote PARS through the Active Living No Limits Project Board, and explore how disabled people can provide feedback on the programme design and delivery.

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?*
The PHA promotes positive attitudes towards disabled people and values their views. This is reflected in the contracts with providers. The 11 Councils (main providers of PARS) have disability hubs and there should be access to appropriate equipment to enable disabled participants to partake of the programme.	Relevant training will be made available to providers, e.g. the need for training for providers to increase their awareness/knowledge of working with clients with a learning disability has already been identified and appropriate training will be put in place. Any literature promoting the PARS will include inclusive images and positive portrayals of disabled people.

(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
PARS IT system currently collects and monitors data on age and gender. PHA will explore the opportunity to amend the PARS referrals and management system to request and collate additional data. PHA also require contract holders (providers of PARS) to complete quarterly monitoring returns and within which they are asked to detail how the project addressed Equality (Section 75) and how this information was captured.	Providers will be expected to seek inclusion of disabled participants within the programme and it is expected that they will be afforded the same opportunities available to everyone else. PHA will explore the opportunity to amend the PARS referrals and management system to request and collate additional data to meet the requirements of this policy.	Data on promoting a culture of respect for human rights within the PHA. PHA require contract holders (providers of PARS) to complete quarterly monitoring returns and within which they are asked to detail how the project addressed Human rights and how this information was captured.

Approved Lead Officer: Colette Brolly

Position: Health and Social Wellbeing

Date: 10th July 2020

Policy/Decision Screened by:

Business Unit and contact details Health Improvement

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

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