Equality and Human Rights Screening Template

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

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

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

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

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

SCREENING TEMPLATE

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

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Retender of the Workplace Health and Well-being Support Service

1.2 Description of policy or decision

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

The PHA will be re-tendering for the Workplace Health and Wellbeing Support Service to commence in March 2025. This Service was established in 2015 and contracts were awarded initially to 3 Service Providers working across 5 Lots. The service was retendered again in 2020 for 3 years with an option to extend for a further 2 years taking the tender up to March 2025. The service was awarded to 2 Service Provider across 5 Lots.

The retender and continuation of an evidence-based approach based on the WHO Framework will afford the opportunity to build on its successes and continue to deliver an effective and consistent approach to workplace health and well-being. The Workplace Health Service will provide support to businesses and organisations which will involve assessing and addressing all employee needs. Providers will continue to target support towards Small to Medium Enterprises, larger organisations would also benefit from the Service. The focus will be employees at risk of poor health and well-being, starting with sedentary workers, transport staff, low paid and migrant employees, employees with long term conditions, minority ethnic groups, S75 employees, and employees who are carers or working parents. The Service will provide accessible health and well-being information and support and will help reduce health inequalities.

The Public Health Agency has previously examined the evidence base for workplace health and well-being and reviewed suggested approaches. Subsequently PHA advocates the World Health Organization (WHO) Healthy Workplace Framework and Model as an approach to promoting healthier workplaces (WHO 2010) www.who.int/occupational_health/healthy_workplace_framework.pdf

The preferred model for supporting businesses to undertake effective workplace health action involves effective engagement with employees to assess and address employee needs, developing an action plan and accessing support from providers of workplace health and well-being support. Employee engagement is key to identify the needs of employer and employee and prioritise action to improve Health and Well-being, and promote a positive psycho-social and safe environment within the workplace.

Objectives of the Service

- Increase awareness of the importance of workplace health and well-being by maintaining the PHA workplace health service in response to identified needs throughout 2025 -2031 and in line with agreed KPIs.
- Deliver workplace health and well-being support services to Small to Medium Enterprises, Large businesses and public sector organisations with employees at particular risk of ill health and well-being throughout 2025-2031.
- Support businesses with identifying and prioritising employee health and well-being needs using effective employee engagement throughout 2025-2031.
- Provide support with the development and delivery of workplace health and well-being action plans tailored to meet the needs of employees throughout 2025-2031
- Deliver workplace health and wellbeing events/interventions.
- Provide effective workplace health champion training and learning network support throughout 2025-2031 ensuring an enhanced focus on Mental Health Early intervention.
- Develop a formal mechanism for recognising progress and excellence throughout 2025-2031.

Key Constraints

A) Getting buy-in from workplaces. This can be achieved by regular communication flow, information processes, and consultations etc.
B) Cost savings – Current financial climate is challenging however we have confirmation and support from Director of Public Health to proceed with this work.
C) Timeframes – We have a deadline of March 2025 to have the service in place. timescales will also be subject to support from PaLs in taking forward the procurement.

In line with the WHO framework the PHA has identified 3 distinct levels of commitment from employers, which are part of a continuum in which all participating businesses are expected to work towards within an on-going continual improvement process for Workplace Health and Well-being (WHO 2010). Key performance indicators are required to be collectively met by contract holders working in the 5 HSCTs areas.

Level 1 commitment (KPI 180 businesses pa)

Leaders of organisations or businesses will be asked to sign a 'Register of Intent'. This would identify businesses which are interested in progressing Workplace Health and Well-being and willing to receive further information.

Level 2 commitment (KPI 145 businesses pa)

Workplaces will complete a meaningful and effective assessment of employee well-being, methods should involve an anonymous on-line questionnaire or focus groups, and or written anonymous questionnaire.

Level 3 commitment (KPI 80 businesses pa)

Implementation of a 3-year action plan which is based on staff needs, prioritizes areas for action, provides health information and support, evaluates effectiveness and incorporates a continual improvement process.

Providers are required to demonstrate how they have met KPIs and these will be recorded within quarterly Progress Monitoring Reports to PHA. Priority is given to small and medium businesses and to those with employees at particular risk of ill health, such as sedentary workers, low income, migrant employees, persons named in Section 75, LGBTQIA+, the travelling community, lone/isolated workers & those working irregular hours/nightshift workers.

- When targeting businesses, Providers must ensure that businesses located in both rural and urban settings are considered.
- Providers must ensure that methods used in the delivery of the Service are appropriate to meet the needs of Service Users including any vulnerable groups within the workplace.
- Premises must be accessible to all Service Users. For the purposes of this clause accessible means, as far as possible, ensuring the removal of barriers, or potential barriers, to the full participation of those with disabilities e.g. wheelchair access etc.

1.3 Main Stakeholders affected

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

Those most directly affected by the proposals are employees in Northern Ireland.

The internal stakeholders include PHA Workplace local leads, Regional Workplace Lead, PHA Information Governance Team and the PHA procurement team.

The service has potential to influence workplace health initiatives externally to NI, in UK and ROI, this involves using any available opportunities to share best practice and report on progress to colleagues in the Health Service Executive Ireland and Public Health England.

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

- **what are they?**
- **who owns them?**

Programme for Government (PfG) Our Plan: Doing What Matters Most

The Executive's highest-level strategic document, the Programme for Government (PfG), was published in draft on September 5th 2024. This PfG is constructed around a framework of wellbeing outcomes, expressing the ambitions of the Executive for everyone in society.

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

"Subject to Executive approval, the PfG propose to introduce new Employment Rights Legislation and a Good Work Charter to ensure better quality jobs and promote a healthy work-life balance. These initiatives aim to make workers feel valued and supported in their workplace highlighting the importance of a healthy working environment".

Making Life Better – Strategic Framework for Public Health (2013

Making Life Better our Public health whole system framework emphasises the importance of the workplace setting and through strengthened co-ordination and partnership working the framework is seeking to create the conditions for individuals and communities to take control of their own lives, and to move towards a vision for Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential. In Making Life Better the importance of the workplace is noted under; Empowering Communities; Outcome 16: *'Effective workplace health programmes can make a real difference to the health and wellbeing of employees, businesses and the communities in which people live and work. Support systems to encourage and maximise the commitment of employers to health and wellbeing and share effective practice will need to be in place'.*

"Achieve better health and wellbeing for everyone and reduce inequalities in health." The vision and aims make clear that a societal effort is required. Many contributions need to be made at all levels – from government, to regional and local levels – and in many settings, such as communities, workplaces, schools, and homes.

'Making Life Better' also details (9.17) 'Effective workplace health programs can make a real difference to the health and wellbeing of employees, businesses and the communities in which people live and work. Support systems to encourage and maximize the commitment of employers to health and wellbeing and share effective practice will need to be in place'.

Theme 2: Equipped throughout the life

Outcome 5- Employment, Lifelong learning and participation

There is a clear link between work and the health of individuals and their families. Being in good employment is protective of health. Conversely, unemployment and poor-quality employment contribute to poor health. Employment with a reasonable wage is the best path out of disadvantage and poverty, therefore getting people into such work is of critical importance for reducing health inequalities. However, jobs need to be sustainable and be of sufficient quality, to include not only a decent living wage, but also opportunities for development, the flexibility to enable people to balance work and family life, and protection from working conditions that can damage health.

Theme 3: Empowering healthy living

Outcome 7: Improved health and reduction in harm

Outcome 8: Improved mental health and wellbeing, and reduction in self harm and suicide

Outcome 9: People are better informed about health matters

Outcome 10: Prevention embedded in services

People's behaviours, whether they smoke, how much they drink, what they eat, whether they take regular exercise are widely recognised as affecting their health and risk of dying prematurely. Several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower socio-economic groups and with lower levels of education being more likely to exhibit multiple lifestyle risks. This work argues for a move away from a silo approach to promoting particular healthy behaviours, towards interventions which adopt a more holistic and integrated approach. The "clustering" of lifestyle with medical risk factors is the most important issue related to risk and will require integrated approaches which take account that many people will present with several risk factors at the same time.

Men and women are prone to different diseases and prevalence of health behaviours. In addition, some population groups such as ethnic minorities including travellers, LGB&T, people with disabilities face specific challenges to their health and wellbeing including

vulnerability to certain conditions and to broader issues such as social exclusion. Programmes and services at regional and local level should be accessible and address specific needs and risk factors, including those of vulnerable groups.

Theme 5: Empowering Communities

Outcome 16: Safe and healthy workplaces

key statutory responsibility for employers is to protect the health and safety of their workforce. Control of risks is important in all work areas but particularly so in some – for example the construction and farming environments.

A good working environment, where people are protected and valued, has the potential to increase wellbeing, and there is clear evidence that actively promoting health at work contributes not just to workforce health but also to improved business performance and productivity through, for example, reduction in illness-related absence, increased motivation among staff and improved working atmosphere, leading to more flexibility, better communications and improved use of resources.

Effective workplace health programmes can make a real difference to the health and wellbeing of employees, businesses and the communities in which people live and work. Support systems to encourage and maximise the commitment of employers to health and wellbeing and share effective practice will need to be in place.

Health and Wellbeing 2026: Delivering Together

Health and Wellbeing 2026: Delivering Together was published by the Department of Health in 2016 and set out a vision for transforming health and social care services in response to the Expert Panel Report on Health and Social Services in Northern Ireland – Systems not Structures (the Bengoa Report). The goal is the transformation of the whole system of health and social care in order to underpin a more holistic model of person-centred care focussed on prevention of ill health, early intervention and supporting independence and wellbeing.

The Mental Health Strategy 2021-2031:

The Mental Health Strategy sets out a clear direction of travel to support and promote good mental health, provide early intervention to prevent serious mental illness, provide the right response when a person needs specialist help and support, as well as outlining how the system will work to implement these changes.

The Strategy outlines that *Prevention of mental health problems in the workplace is of particular importance, both in terms of its impact on economic productivity, but also in light of the impact of the COVID-19 pandemic on working practices. Increased isolation due to home working, coupled with increased stress, particularly for those working on the front line or in public facing roles, means that it is more important than ever to invest in strategies and measures to support the wider workforce in staying mentally well.*

Under Theme 1 within the strategy "Promoting mental wellbeing, resilience and good mental health across society" PHA takes the lead on delivery of Actions 1 and 2.

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

The MHS Early Intervention & Prevention Action plan includes the requirement to "Create supportive environments where people engage in daily activities, through a settings approach with an initial focus on workplaces.

A recent paper from the Organisation for Economic Co-operation and Development (OECD) "New approaches to mental health challenges" outlines that living with mental ill-health – which affects an estimated 20% of the population at any given time (OECD, 2021[3]) – makes it 35% more likely that young people will repeat a school grade and increases school dropout, makes it 20% less likely to be employed, and reduces average pay by 17% compared to workers without a mental health condition (Ibid). Mental ill-health drives economic costs equal to more than 4.2% of GDP, some of which are the direct costs of treatment, but more than a third of which come from indirect costs related to lower employment rates and reduced productivity (OECD, 2021[1])

PHA Corporate Plan 2017-2021

This plan set out the corporate and strategic direction for the agency for the four years of 2017-2021.The document outlines the vision of the agency through the services it commissions across HSC Trusts and in the community.

The vision: *All people and communities are enabled and supported in achieving their full health and wellbeing potential, and inequalities in health are reduced.*

The corporate plan highlights five key outcomes that the agency will thrive to deliver against. The Work will contribute to the delivery of the following four of five outcomes through each of the services engagement of young people and associated activities.

- All older adults are enabled to live healthier and more fulfilling lives
- All individuals and communities are equipped and enabled to live long healthy lives.
- All health and wellbeing services should be safe and high quality.
- Our organisation works effectively.

(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.

The PHA Work Well Live Well Programme has been commissioned since 2015. PHA currently hold monitoring data from commencement of the current programme in 2020.

An evaluation of the previous programme took place in 2018 which was reviewed and subsequently informed the development of the current programme.

The PHA held PPI stakeholder consultation events in May 2024 across various locations throughout Northern Ireland (Urban and Rural). This provided an opportunity for employers engaged in the service, employees, workplace champions and those interested in Workplace Health and Well-being to provide feedback on the existing service and to shape the development of the future Service. Around 50 different stakeholders attended the events online or face to face as well as some providing comments by email. An Online questionnaire was also issued to all organisations who had participated in the programme during the last 4 years

Sources of information which have been used and will continue to be referred to include the World Health Organisation Workplace Health and Well-being framework (WHO 2010) this evidence-based framework recognises that a healthy workplace should provide an open, accessible and accepting environment for people with differing backgrounds, demographics, skills and abilities. It should also ensure that disparities between groups of workers or difficulties affecting specific groups of workers are minimized or eliminated.

Relevant reports and information considered;

- Northern Ireland facts and figures - N92000002 - ONS
- Labour Force Survey Annual Summary Report 2022 (nisra.gov.uk)
- Northern Ireland Labour Market Report (2024)
- PfG draft 2024-2027: Doing What Matters Most (northernireland.gov.uk)
- Making Life Better - A Whole System Framework for Public Health 2013-2023 (health-ni.gov.uk)
- Labour Force Survey Tables for Local Government Districts 2009-2023 | Northern Ireland Statistics and Research Agency

- Section 75 of the Northern Ireland Act 1998.
- Northern Ireland Survey of Activity Limitation and Disability (2007)
- Employers' Forum on Disability NI http://www.efdni.org/
- ACAS (2014) A guide for employers and employees, Sexual orientation and the workplace)
- Census 2021 data
- NISRA (November 2023): Monthly Labour Market Report November 2023.
- Equality Commission (2021): Fair Employment Monitoring Report No.32
- Carers NI: Valuing Carers 2021 Northern Ireland

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.

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	**Population level data:** The size of the resident population in Northern Ireland 1,903,175 Available at Census 2021 main statistics for Northern Ireland (phase 1) | Northern Ireland Statistics and Research Agency (nisra.gov.uk) In 2024, the employment rate for NI was estimated at 70.3%. This was a decrease of 1.2pps over the quarter and a decrease of 0.3pps over the year. The number of employed persons aged 16 to 64 in 2024 was estimated at 867,000, an increase of 5,000 over the year. The table below shows the employment rates for NI and for males and females over the last 10 years. It shows that the NI employment rate in 2022 (71.9%) has returned to the pre-pandemic level of 71.9% in 2019. The employment rate has been higher for males than for females over the whole time period. The employment gap between males and females was the smallest in the series in 2021 (4.3pps) but has since widened to 6.9pps in 2022.

Year	Male Employment Rate (%)	Female Employment Rate (%)	NI Employment Rate (%)
2012	70.8	63.3	67
2013	71.4	62.9	67.1
2014	72.4	63.1	67.7
2015	73.3	63.7	68.4
2016	74.3	64.5	69.4
2017	72.9	65.3	69.1
2018	73.5	66.5	70
2019	75.8	68.1	71.9
2020	74.6	65.2	69.8
2021	72.4	68.1	70.2
2022	75.4	68.5	71.9

75.4% of working age males are in employment compared with 68.5% of females.

Labour Market Profile - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)
Available at:
NILT | ARK - Access Research Knowledge

Finalised Suicide Statistics in Northern Ireland 2015 to 2021 (nisra.gov.uk)

Mental Health
Males are more at risk of mental ill health during 2015-2021

176 (74.3 per cent) of the total suicide deaths were males and 61 (25.7 per cent) were females. The suicide death rate (standardised for age) for both males and females has been on a general upward trajectory since 2019. The rate for males increased from 19.1 per 100,000 males in 2019 to 21.5 in 2021, while for females, the equivalent rate increased from 6.0 per 100,000 females in 2019 to 7.3 in 2021.

Northern Ireland's most deprived areas had a suicide rate that was almost twice that of the least deprived areas in 2020 (19.7 deaths per 100,000 in the most deprived areas, 10.8 per 100,000 in the least deprived)

Smoking

In 2022/23, 14% of respondents were current cigarette smokers; this is a decrease compared with the 2021/22 finding of 17%. Smoking prevalence has decreased from 24% in 2010/11. Around a quarter (24%) of those living in the most deprived areas smoke (down from 40% in 2010/11) compared

	with 7% of those living in the least deprived areas (down from 14% in 2010/11). Around one in ten respondents (9%) reported that they currently use e-cigarettes or vaping devices (up from 7% in 2021/22). Males (10%) were more likely than females (8%) to report current use. Use decreased with age, ranging from 17% of those aged 16-34 to 1% of those aged 75 and over. Those living in the most deprived areas (13%) were around twice as likely to use e-cigarettes as those in the least deprived areas (7%). Similarly, those living in urban areas (11%) were more likely to use e-cigarettes than those living in rural areas (6%). Source: Health Survey (NI): First Results 2022/23 **Alcohol** over three-quarters (77%) of respondents aged 18 and over reported that they drank alcohol. This was similar to 2021/22 (79%). A quarter of male respondents (25%) reported drinking above recommended weekly limits (14 units per week), while this was true for around a tenth of female respondents (9%). Male drinkers (16%) were more likely than female drinkers (10%) to report drinking on three or more days per week. Source: Health Survey (NI): First Results 2022/23 **Obesity** Over a quarter of adults (27%) were classed as obese with a further 38% classed as overweight; this is an increase in the obesity rate from the 2010/11 finding of 23%. Whilst obesity levels were similar, males were more likely than females to be overweight. Around three-quarters of children aged 2-15 were classed as either normal weight (69%) or underweight (5%), while 20% were classed as overweight and 6% were classed as obese. Since 2010/11, the proportion of children classed as overweight or obese has remained at relatively similar levels. The 2022/23 NI Health Survey also reports that females (43%) were more likely than males (37%) to have a long-term condition. **Source:** Health Survey (NI): First Results 2019/20 **Transgender - social attitudes & good relations** Research by the Equality Commission (2012) suggested that transgender people experience a particularly high level of negative attitudes compared with other groups. The social attitudes survey revealed that 35% of respondents would mind (a little or a lot) having a transgender person as a

work colleague. This may create additional pressures in the workplace for transgender people.
This figure has improved significantly in the 2016 survey results to 14% of respondents experiencing a high level of negative attitudes. These survey results suggest attitudes towards transgender people may be improving

PHA Staff Data:

Section 75 Area	Category	% Dec 24
Gender	Male	23.12%
	Female	76.88%

Age

Population Level data:

Mid-year population estimates published by NISRA in 2022 show that:

Age (years)	Number (persons)	Percentage of population (%)
00-03	89,200	4.7
04-11	199,745	10.5
12-16	122,805	6.4
17-19	66,726	3.5
20-24	110,306	5.8
25-29	115,941	6.1
30-44	375,601	19.7
45-59	381,087	20.0
60-64	113,927	6.0
65-69	93,947	4.9
70+	235,278	12.4

Available at:
Census 2021 main statistics demography tables – age and sex | Northern Ireland Statistics and Research Agency (nisra.gov.uk)

Census 2021
of the 1.515 million adults aged 16 and over, Census 2021 recorded 849,000 (56%) in employment, 42,000 (2.8%) who were unemployed and

624,000 (41%) who were economically inactive (e.g. retired, long-term sick or disabled);

PHA Staff Data:

Age Group	16-24	6.16%
	25-29	10.81%
	30-34	5.47%
	35-39	9.58%
	40-44	10.53%
	45-49	9.85%
	50-54	14.09%
	55-59	14.77%
	60-64	10.26%
	>=65	8.48%

Religion

Population Level data:

Religion or Religion brought up in

- 45.7% (869,753) of the population **were e**ither Catholic or **brought up** as Catholic.
- 43.4% (827,545) stated that they were Protestant or **brought up** as Protestant.
- 1.5% (28,514) of the population belonged to or had been **brought up** in other religions and Philosophies.
- 9.3% (177,360) neither belonged to, nor had been brought up in a religion.

(Census 2021)

Currently identifying as:

Catholic 42.3% (805,151)

Presbyterian Church in Ireland 16.6% (316,103)

Church of Ireland 11.55% (219,788)

<table>
<tr><td></td><td>Methodist Church in Ireland 2.35% (44,725)

Other Christian(including Christian related) 6.85% (130,385)

Other religions 0.78% (14,849)

No religion 17.39% (330,983)

Did not state religion 1.60% (30,529)

(Census 2021)

Those in employment in organisations that fall under the Fair Employment and Treatment monitoring provisions have the following religious profile:

Total 566,495
Protestant 246,544 [44.3%]
Roman Catholic 244,516 [43.9%]
(Fair Employment Monitoring report No 31, Annual Summary of monitoring returns, Equality Commission 2022)

PHA Staff Data:

<table>
<tr><td rowspan="7">Community Background</td><td>Perceived Protestant</td><td>1.50%</td></tr>
<tr><td>Protestant</td><td>12.31%</td></tr>
<tr><td>Perceived Roman Catholic</td><td>0.41%</td></tr>
<tr><td>Roman Catholic</td><td>13.41%</td></tr>
<tr><td>Neither</td><td>1.23%</td></tr>
<tr><td>Perceived Neither</td><td>0.00%</td></tr>
<tr><td>Not assigned</td><td>71.14%</td></tr>
</table>
</td></tr>
<tr><td>Political Opinion</td><td>Population Data:

In Census 2021, 814,600 people (42.8%) living here identified solely or along with other national identities as ‘British’. This is down from 876,600 people (48.4%) in 2011.

In Census 2021, 634,600 people (33.3%) living here identified solely or along with other national identities as ‘Irish’. This is up from 513,400 people (28.4%) in 2011.</td></tr>
</table>

	In Census 2021, 598,800 people (31.5%) living here identified solely or along with other national identities as 'Northern Irish'. This is up from 533,100 people (29.4%) in 2011. PHA Staff Data:

Political Opinion	Broadly Nationalist	1.09%
	Other	2.87%
	Broadly Unionist	0.96%
	Not assigned	92.75%
	Do not wish to answer	2.33%

Marital Status	**Population Level data:** Employers and employees will include individuals who are single, married, divorced and in a long term relationships, as well as those who are widowed. • 45.59% (690,509) of those aged 16 or over were married • 36.14% (576,708) were single • 0.09% (2,742) were registered in same-sex civil partnerships • 9.80% (148,400) were either divorced, separated or formerly in a same – sex partnership • 6.36% (96,384) were either widowed or a surviving partner (Census 2021) **PHA Staff Data:**

Marital Status	Divorced	0.55%
	Mar/CP	22.98%
	Other	0.27%
	Separt	0.14%
	Single	5.61%
	Unknwn	70.45%
	Widw/R	0.00%
	Not assigned	0.00%

Dependent Status	**Population level data:** • 12.41% (222,213) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill – health/disabilities or problems related to old age. • 3.84% (68,691) provided 50 hours care or more. • 29.20% (224,539) of households contained dependent children. • 33% (258,537) contained a least one person with a long – term health problem or a disability. (Census 2021) **Carers NI State of Caring 2023** Annual survey (UK wide, including NI) • 38% of people with unpaid caring responsibilities in Northern Ireland are also in full or part-time employment • 47% provide 90 hours or more of care per week, 15% care for 50-89 hours, 24% care for 20-49 hours, and 15% care for 1-19 hours per week. Available at cni-soc22web.pdf (carersuk.org) **Northern Ireland Life and Times (2022)** o 12% respondents were carers: 13% of women and 11% of men. **Health Survey NI (2021/2022)** • 17% have caring responsibilities **Parents with dependent children (Census 2021)** Responsibility for dependent children: 224,539 households (29.2% of all NI households) **NI Lone parent families** = 111,083, with 198,335 dependent children in family (Census 2021). **Gender disparity**: Of the 111,083 lone parents, 14,455 are males and 96,928 are female. (Census 2021) the-impact-of-caring-on-health-in-northern-ireland.pdf (carersuk.org)

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According to the Census 2021, there are 2.5 million unpaid carers in employment (excluding full-time students) in England and Wales.
On average, 600 people a day leave work to care – with over 500,000 people leaving work to provide unpaid care pre-pandemic (Carers UK, Juggling Work and Care).
75% of carers in employment worry about continuing to juggle work and care (Carers UK, State of Caring 2022).
1 in 3 NHS staff provide unpaid care (NHS staff survey, 2022).
Between 2010 and 2020, more than 1.9 million people in paid employment became unpaid carers every year (Petrillo and Bennett, 2022)

PHA Staff Data:
<table>
<tr><td rowspan="3">Dependents</td><td>Yes</td><td>5.47%</td></tr>
<tr><td>Not assigned</td><td>91.79%</td></tr>
<tr><td>No</td><td>2.74%</td></tr>
</table>
</td></tr>
<tr><td>Disability</td><td>
Population Level data:

Disability Employment Gap in Northern Ireland 2020

In 2020 the employment rate for people with disabilities was 38.1%, the employment rate for people without disabilities was 80.3%. The disability employment rate gap was 42.2 percentage points (pps).
The disability employment gap for males and females in 2020 were 49.2pps and 35.5pps respectively

Source: https://www.nisra.gov.uk/statistics/labour-market-and-social-welfare/labour-force-survey

Data from the Census (2021) found that 44.86% (344,865) of respondents regard themselves as having a disability or long – term health problem, which has an impact on their day to day activities.

65.33% (1,243,371) of residents did not have long – term health condition.

Deafness or partial hearing loss – 5.75% (109,457)
Blindness or partial sight loss – 1.78% (33,961)
Learning Difficulty – 3.15% (59,888)
Autism or Asperger syndrome 1.86% (35,367)
Mobility of Dexterity Difficulty – 10.91% (207,589)
Intellectual, social or learning disability – 0.89% (16,923)
An emotional, psychological – 8.68% (165,127) or mental health condition

</td></tr>
</table>

- Long – term pain or discomfort – 11.58% (220,328)
- Shortness of breath or difficulty breathing – 10.29% (195,754)
- Frequent confusion or memory loss – 1.99% (37,789)
- Other condition – 8.81% (167,752)
- No Condition – 65.33% (1, 243, 371)

Source: Census 2021

Stress in day-to-day life
In 2022/23 the five most common things that respondents reported as stress in day to day life were their own work situation (18%), financial situation (13%), own physical health problem or condition (10%), physical / mental health of family (10%), and time pressures (7%). Stress due to financial situation had risen from 8% in 2021/22

Source: Health Survey (NI): First Results 2022/23

Employee Jobs

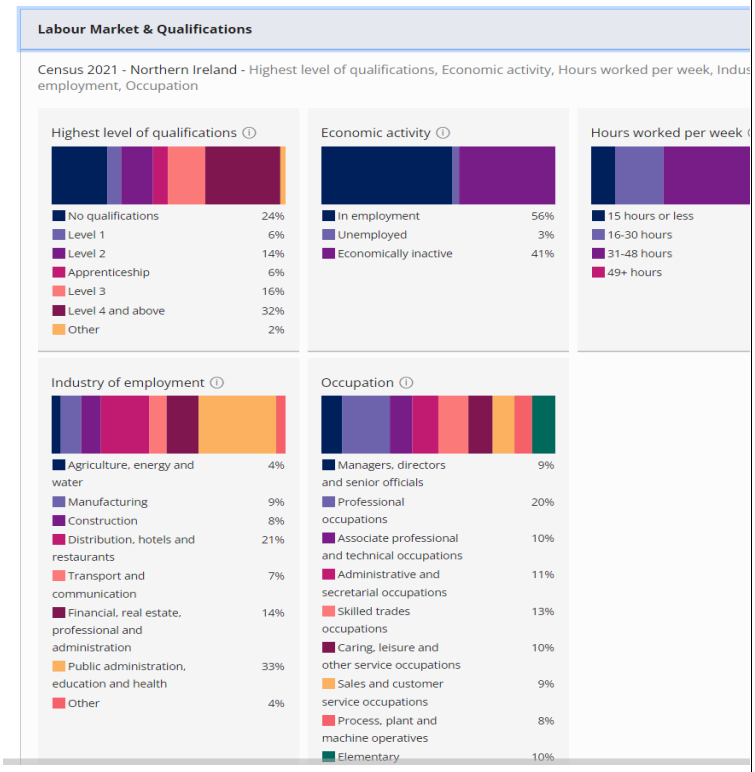
The seasonally adjusted employee jobs total in Northern Ireland at September 2022 was 805,848 an increase of 13,222 (1.7%) since September 2021.

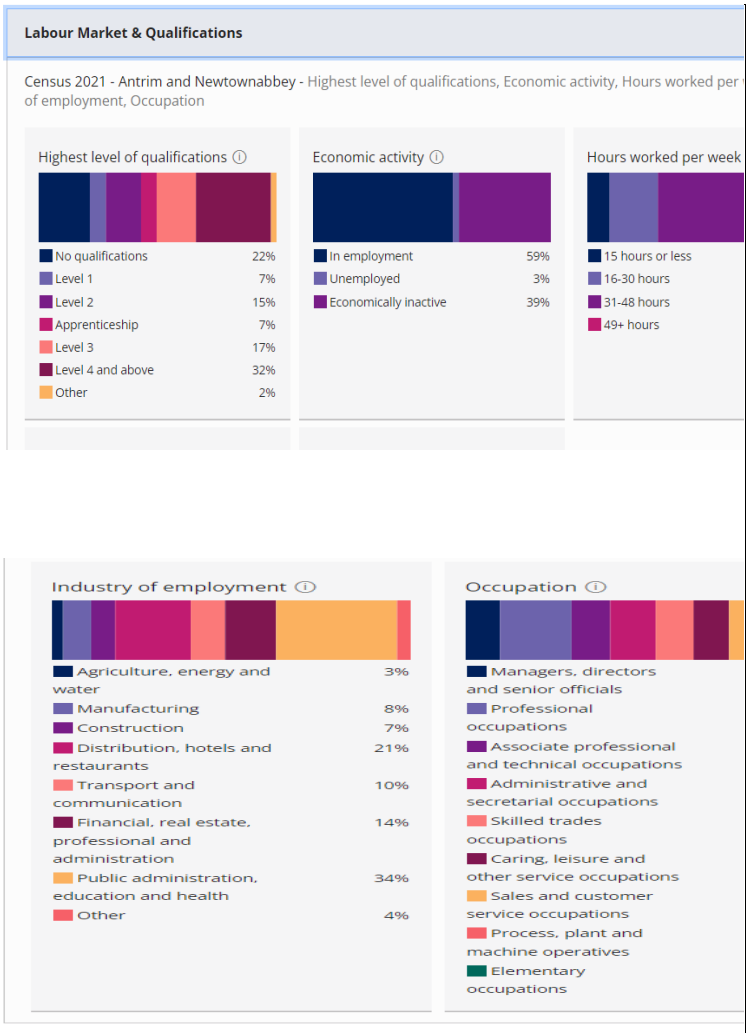
- The increase in employee jobs was mainly driven by growth in the Service industry (11,193 jobs) which was responsible for 85% of the total increase.
- Construction jobs continued to grow with an increase of 2.2% (829 jobs) over the year to September 2022.
- The Manufacturing sector increased by 1,323jobs (1.5%) over the year to September 2022. Growth remained the same as the previous year (1.5%)
- All district council areas in Northern Ireland saw an increase in employee jobs except for Mid and East Antrim, which saw a small, insignificant decline of 20 jobs. Lisburn and Castlereagh experienced the largest percentage increase, with 2,018 (3.3%) additional jobs

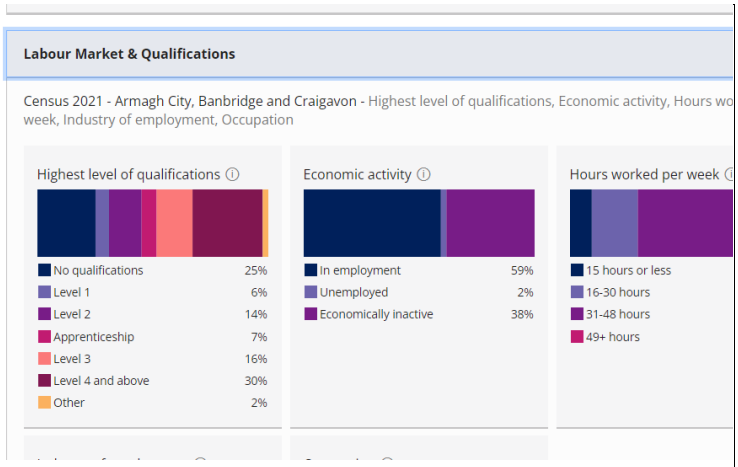
Table 1: Employment is the sum of employees and working owners. Employment by Headline Industry, 2022

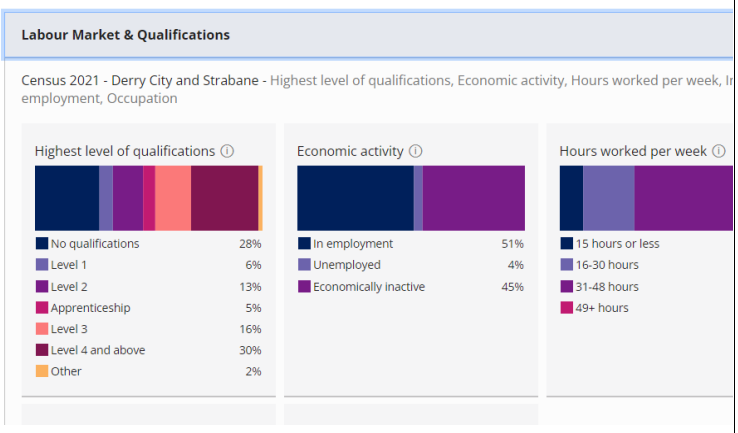
Headline Industry	Employment
Construction	44,146

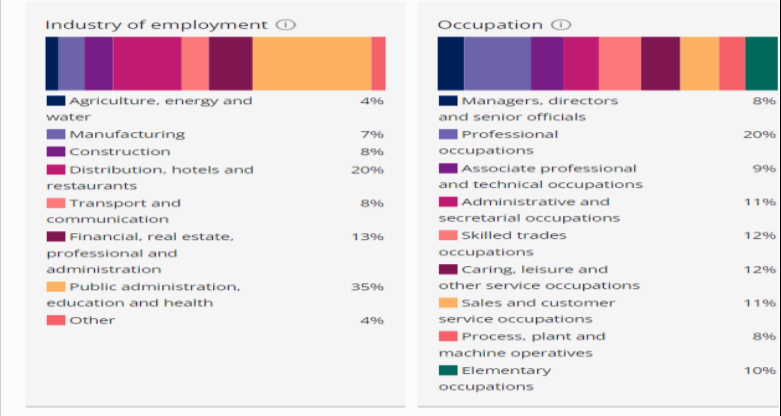
Manufacturing	90,287
Services	677,336
Other	25,104
Total:	**836,873**




Labour Market & Qualifications
Census 2021 - Antrim and Newtownabbey - Highest level of qualifications, Economic activity, Hours worked per
of employment, Occupation
Highest level of qualifications
No qualifications 22%
Level 1 7%
Level 2 15%
Apprenticeship 7%
Level 3 17%
Level 4 and above 32%
Other 2%
Economic activity
In employment 59%
Unemployed 3%
Economically inactive 39%
Hours worked per week
15 hours or less
16-30 hours
31-48 hours
49+ hours
Industry of employment
Agriculture, energy and water 3%
Manufacturing 8%
Construction 7%
Distribution, hotels and restaurants 21%
Transport and communication 10%
Financial, real estate, professional and administration 14%
Public administration, education and health 34%
Other 4%
Occupation
Managers, directors and senior officials
Professional occupations
Associate professional and technical occupations
Administrative and secretarial occupations
Skilled trades occupations
Caring, leisure and other service occupations
Sales and customer service occupations
Process, plant and machine operatives
Elementary occupations


Labour Market & Qualifications
Census 2021 - Armagh City, Banbridge and Craigavon - Highest level of qualifications, Economic activity, Hours wo
week, Industry of employment, Occupation
Highest level of qualifications
No qualifications 25%
Level 1 6%
Level 2 14%
Apprenticeship 7%
Level 3 16%
Level 4 and above 30%
Other 2%
Economic activity
In employment 59%
Unemployed 2%
Economically inactive 38%
Hours worked per week
15 hours or less
16-30 hours
31-48 hours
49+ hours


Labour Market & Qualifications
Census 2021 - Derry City and Strabane - Highest level of qualifications, Economic activity, Hours worked per week, I
employment, Occupation
Highest level of qualifications
No qualifications 28%
Level 1 6%
Level 2 13%
Apprenticeship 5%
Level 3 16%
Level 4 and above 30%
Other 2%
Economic activity
In employment 51%
Unemployed 4%
Economically inactive 45%
Hours worked per week
15 hours or less
16-30 hours
31-48 hours
49+ hours



PHA Staff Data:

Disability	No	19.70 %
	Not assigned	78.93 %
	Yes	1.37%

Ethnicity

Population Level Data:

Census 2021
3.4 per cent of our population, or 65,600 people, belonged to ethnic minority groups. This is around double the 2011 figure (1.8 per cent – 32,400 people) and four times the 2001 figure (0.8 per cent – 14,300 people)

The usual resident population belong to the following ethnic groups:

White – 96.55% (1,837,575)
Chinese – 0.50% (9,495)
Irish Traveller – 0.14% (2,609)
Indian – 0.52% (9,881)
Pakistani – 0.08% (1,596)
Other Asian – 0.28% (5,244)
Black African – 0.42% (8,069)
Black Other – 0.16% (2,963)

Mixed – 0.76% (14,382)
Other – 0.76% (3,568)

Language (Spoken by those aged 3 and over);

English – 95.37% (1,751,510)
Polish – 1.10% (20,134)
Lithuanian – 0.49% (8,978)
Irish (Gaelic) – 0.32% (5,969)
Portuguese – 0.27% (4,982)
Slovak – 0.13% (2,333)
Chinese – 0.18% (3,329)
Tagalog/Filipino – 0.07% (1,339)
Latvian – 0.09% (1,700)
Russian – 0.09% (1,605)
Hungarian – 0.12% (2,172)
Other – 0.74% (13,578)

(Census, 2021)

PHA Staff Data:

Ethnicity	Not assigned	89.47%
	White	10.53%
	Other	0.00%
	Black African	0.00%
	Indian	0.00%
	Chinese	0.00%

Lesbian Gay and Bisexual

Population level data:

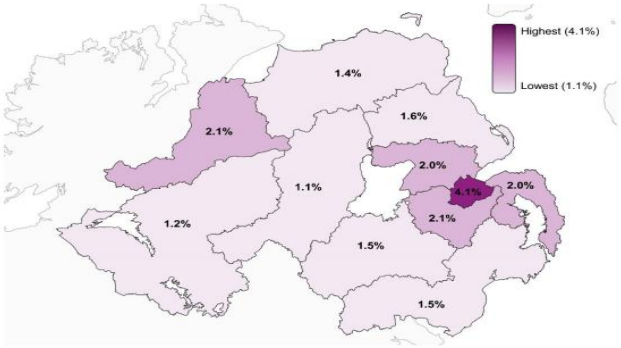
LBTQIA+ and heterosexual population will be represented.

The latest figures from the NI Continuous Household Survey and the NI Life and Times Survey are shown in the table below:

	Northern Ireland Continuous Household Survey	Northern Ireland Life and Times Survey
Heterosexual	97.3%	93%
Gay/Lesbian	0.7%	3%
Bisexual	0.6%	3%
Other	0.3%	1%
Don't Know/Refusal	5.9%	0%

Data published by ONS for 2020 showed that 1.2% (CI 0.6-1.9) of Northern Ireland survey respondents identified as lesbian, gay or bisexual.

Figure 4: Percentage of population aged 16 and over who identified as LGB+ by LGD (Census 2021)



Census 2021 Main statistics for Northern Ireland - Statistical bulletin - Sexual orientation

PHA staff data:

Sexual Orientation	Do not wish to answer	0.55%
	Not assigned	92.34%
	Opposite sex	6.43%
	Both Sexes	0.00%
	same sex	0.68%

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	Lifestyle factors and ill-health may be different for males, females and the transgender population. There are differences in levels of obesity, smoking, alcohol and drug misuse by gender. **Transgender - social attitudes & good relations**

	Research has shown that transgender people frequently experience high levels of bullying, including mis-gendering and inappropriate provision of facilities min the workplace such as male/ female toilets/ changing areas- ADD TO THIS . Providers will be expected to support employers to undertake meaningful engagement with employees with the opportunity to feedback anonymously as part of staff surveys.
Age	Prevalence of long-term conditions increases with age with Overall, 21.7% of respondents aged 16-64 in Northern Ireland (Apr-Jun 2017) reported a long-term illness and a disability. In the UK overall, the figure was 17.4%. The most prevalent conditions across all ages are mobility/dexterity difficulties and long-term pain or discomfort. For most long-term conditions, the proportion of the population with the condition increases with age. The exceptions to this are learning, intellectual, social or behavioural difficulties; emotional, psychological or mental health conditions. Providers will be expected to support employers develop initiatives/programmes for workplaces ageing workforce for example Menopause programmes.
Religion	Consideration must be given to training venues and services that could be more accessible to one group than another. Higher levels of engagement with one religion than another.
Political Opinion	Consideration must be given that businesses may be affiliated to a particular party.
Marital Status	Those experiencing domestic abuse may require additional help and support in the workplace as it is often an escape from the situation, especially in relation to their mental health.
Dependent Status	Working parents and carers can be overwhelmed with the demands of work and home. Access to flexible working, information and support will help contribute to maintaining good health and well-being. They are also likely to have particular needs as to the design of interventions. For example, any face to face interventions need to be scheduled to allow participation by part-time workers or those on flexi schemes (amongst whom people with dependants are highly represented). Likewise, the particular needs of working parents and carers need to be explored in any assessments.
Disability	Research has shown that people with disabilities are less likely to fulfil their potential in education, employment and relationships, and are also more likely to experience feelings of isolation and loneliness. There will

Commented [KM1]: Add more to this point.

	also be a need for Sign language interpreters for those who are D/deaf sign language users.
Ethnicity	Specific consideration has been given to targeting workplaces with Migrant workers and those from the traveller community. Both groups are more likely to be a lower paid worker and less likely to access services. This programme will help recognise their needs and signpost them to available support. Some ethnic minority employees may also experience language barriers. Providers therefore need to consider developing written information in translation and the inclusion of interpreting services for face to face interventions. Research by the Equality Commission (2016) suggests that Travellers also experience a high level of negative attitudes of all equality groupings. The social attitudes survey revealed that 25% of respondents would mind (a little or a lot) having a Traveller person as a work colleague. This may create additional pressures in the workplace for Traveller people.
Sexual Orientation	The approach being commissioned will recommend training for HR departments to increase awareness of the needs of employees. Any interventions need to take account of the fact that a considerable share of workers are not in employment, for fear of experiencing negative attitudes, inappropriate behaviour or discrimination by colleagues.

2.4 Multiple Identities

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

In valuing diversity this proposal would ask employers to recognise and address the needs of all employees regardless of their identities and give consideration to any particular needs arising from their identities.

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

Health inequalities are the unfair and avoidable differences in the health of people in our society. They are the result of imbalances of power, wealth and resources and are produced and shaped by factors such as quality of housing, educational attainment, employment opportunities, physical environment, access to services and level of social connections known as the social determinants. These imbalances mean that no one's health is as good as it could be in Northern Ireland. There is a social gradient in health – the lower a person's social position, the worse his or her health is likely to be. Those who live in areas of disadvantage

are most likely to experience the worst health outcomes, with shorter life expectancy and more years with chronic illness and/or disability. Whilst we have seen improvements in the overall health of the population, the gap between the most affluent and least affluent persists and in some instances is widening. Poverty is a significant determinant of health and a challenge given that an estimated 23% of children in Northern Ireland are reported to live in poverty (Poverty in Northern Ireland, Joseph Rowntree 2018 https://www.jrf.org.uk/report/poverty-northern-ireland-2018)

In Northern Ireland many people die prematurely. In 2013-15 the life expectancy for men living in the most deprived areas was 73.9 years, seven years less than those in the least deprived areas (81.2 years). Inequalities are also evident in a range of groups such as young men, ethnic minorities, migrants, carers, lesbian, gay, bisexual and transgender people, people experiencing homelessness, and people with a disability.

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

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

Older workers are more likely to be challenged by long term conditions. Younger women with children may have more pressures associated with working outside the home.

2.5 Making Changes

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

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The proposed specification will include the need for workplace and well-being support to	In evaluating the effectiveness of the services each workplace advisor will be asked to review the demographic of the

include best practice with regard to inclusion and valuing diversity. It will require providers to identify and address particular needs based on the nine equality groupings as outlined under 2.3. All employees will benefit from inclusion in workplace well-being surveys regardless of their equality grouping. The specification will require providers to ensure that surveys are designed in such a way that they are accessible to people with a disability and those who experience language barriers. Also, surveys should include prompts that focus on particular needs based on any of the nine equality groupings. Engagement with all employees will be recognised as central to the success of this approach. Providers are required to give consideration to targeting particular groups of employees who may be less likely to engage, such as ethnic minorities. The provider will be asked to ensure employers understand Human Rights legislation and that it is enshrined in workplace health and well-being programmes.	businesses involved and the make-up of the workforce. Diversity and equality will be included in the workplace health and well-being training provided by those who are awarded the tender. Businesses engaged will be asked to develop equality guidance as part of their workplace well-being action plans. Businesses engaged will be asked to develop policies on supporting workers with disability as part of their workplace well-being action plans. Workers with disabilities encouraged to engage with employers to improve understanding and develop good practice

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	Training venues and services could be more accessible to one group than another. Higher levels	In offering services to businesses proactive approaches should be targeted towards businesses that cross religious divides and where

	of engagement with one religion than another.	a business is situated where one religion predominates the workplace advisor will be asked to monitor equity of access and services.
Political Opinion	Some businesses may be affiliated to a particular party.	Be politically aware and spread support evenly.
Ethnicity	The workers benefiting do not include adequate representation from ethnic minority groups.	Proactively engage with those businesses who employee a higher percentage of migrant workers.

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

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

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

Please tick:

Major impact	

Minor impact	✓
No further impact	

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

Please tick:

Yes	
No	✓

Please give reasons for your decisions. A full Equality Impact Assessment is unlikely to provide any further information on any equality issues associated with the service.

(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?***
Disabled workers will be encouraged by those awarded the tender to complete a health and well-being assessment as agreed by PHA. This will provide the opportunity to provide feedback to employers as part of an overall employee survey. PHA has provided a resource guide which will support businesses with workplace well-being programmes to signpost to disability support organisations.	Disabled workers will be asked to feed into the evaluation of this project. In developing the programme further organisations supporting disabled workers will be involved in future stakeholder events.

Well-being teams within businesses will be asked to include any disabled employees in the action planning process.	

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 as an organisation actively promotes the inclusion of disabled people in service planning, monitoring and evaluation such as through Personal and Public Involvement initiatives and advisory groups. This strategy includes disabled workers in the planned work and will proactively encourage involvement of disabled workers as workplace health champions. Disability awareness will be included in the workplace well-being training provided by the provider awarded the tender	On-going awareness and involvement in all well-being activities within the workplace. Always ensure that face to face meetings and training venues are completely accessible. Seek to ensure that timings of programmes are such that attendees can use public transport and provide appropriate car parking facilities. Businesses could be asked to ensure disabled workers are involved within trade union organisations and in developing workplace policies.

(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
PHA require contract holders to complete quarterly monitoring returns and within they are asked to detail how the project addressed TSN, Equality (Section 75) and Human Rights and how this information was captured. As part of this project providers will also be required to support employers to undertake meaningful engagement with employees, feedback will be obtained through staff surveys and forums and this data used to prioritise action to address health and well-being. The surveys will include collection of data on gender, age, dependants and health needs. Workplace programme teams within organisations will be asked to ensure there is equal representation and that diversity is valued within actions taken. The specific needs of workers	Providers will be expected to seek inclusion of disabled employees as workplace health champions and within health and well-being programmes. It will be expected that disabled staff will be afforded equal opportunity to access health information and to participate in activities. Staff surveys will be undertaken to assess need and disabled workers will be facilitated to participate. Businesses receiving support from providers will be asked to develop policies on supporting workers with disability as part of their workplace well-being action plans. PHA will require contract holders to submit quarterly monitoring returns which will require reporting against	The provider will be asked to ensure employers understand Human Rights legislation and that it is enshrined in workplace health and well-being programmes. In undertaking staff health and well-being assessments the opportunity will be provided to feedback on any human rights issues of concern. PHA will require contract holders to submit quarterly monitoring returns which will require reporting against objectives relating to protecting the human rights of employees.

and their ethnic background will be considered and actions to support well-being evaluated across all groups of employees. PHA will require contract holders to submit quarterly monitoring returns which will require reporting against objectives relating to ensuring equality and good relations within the workplace.	objectives relating to support for disabled employees.	

Approved Lead Officer:	Diane McIntyre
Position:	Interim Head of Health and Social Wellbeing Improvement (B&SE)
Date:	20th November 2024

Policy/Decision Screened by: Bernadette Miller

Business Unit and contact details

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

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

Template updated January 2015

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