Health and Social Care Board

# Equality, Good Relations and Human Rights SCREENING

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

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

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

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

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

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

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

**For information (evidence, data, research etc) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website**:
http://www.hscbusiness.hscni.net/services/1798.htm

Health and Social Care Board

# Equality, Good Relations and Human Rights
# SCREENING TEMPLATE

## (1) INFORMATION ABOUT THE POLICY OR DECISION

### 1.1 Title of policy or decision

Independent Information, Advice, and Advocacy Service to Support Independent Living

### 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 *Independent Information Advice and Advocacy Service to Support Independent Living* (hereafter, the Service) is a contract procured by the Health & Social Care Board (HSCB).

**AIM**

The aim is to deliver an accessible regional Service that will provide information, advice, and advocacy for service users and carers in Northern Ireland in relation to Self Directed Support (SDS) and the Independent Living Fund (ILF).

**Self Directed Support (SDS)** is part of the *Transforming Your Care* strategic approach to developing person centred services and is designed to aid the transformation of Social Care Services from a "service led" system to one that promotes peoples' autonomy and independence. SDS describes the ways in which Health and Social Care provides individuals and families with informed choice about the way care is provided to them. It includes a range of service delivery options including Direct Payments for exercising those choices.

Through a partnership approach to needs assessment, individual outcomes are agreed and options are considered within available resources, allowing people to choose how their care is provided, and giving them as much control as they want over their personal budget.

SDS includes a number of options for getting support. The individual's personal budget can be:

- Taken as a ***Direct Payment*** (a cash payment).
- A ***managed budget*** (where the Health & Social Care Trust holds the budget, but the person is in control of how it is spent).
- The Health & Social Care ***Trust can arrange a service***.
- ***Cost neutral*** i.e. sign-posting/onward referral to existing services.

Individuals can choose a ***combination*** of the different types of SDS.

Throughout this document there is reference to service users and carers being recipients of SDS. It is of note that carers have a right to a carer's assessment and support plan which is specific to their needs and not the person they care for. Carers can have services in their own right even if the person they care for refuses services. Tables 2 and 3 on page 18 of this document, outlines service users and carers as distinct recipients of SDS from the HSC Trusts.

SDS is available to service users and carers across all Programmes of Care, i.e. to children, young people, and adults with physical and sensory disabilities; older people; people with learning disabilities; and people with physical and mental health conditions.

The **Independent Living Fund (ILF)** was a UK-wide approach to delivering personalised support for people with disabilities financed by the UK central government that pre-dated the current SDS arrangements in Northern Ireland. In 2015, the fund closed to new recipients; from that time onwards, the Northern Ireland Government decided residents from Northern Ireland who remained in receipt of support from the ILF UK would receive their funds through ILF Scotland, when it was established. ILF Scotland continues to provide funding for around 450 people in Northern Ireland. The current Service provider offers its services to the reducing number of individuals in receipt of this support.

***To summarise, taking into account this more detailed insight into SDS and ILF:*** The aim is to deliver an accessible and regional independent advice, information, and advocacy Service to service users and carers accessing SDS or ILF, thereby addressing health and social care needs and promoting the independence and choices of people with assessed needs. This may include people with physical and sensory disabilities, people with learning disabilities, older people, and people with physical and mental health conditions, as well as adults and children without disabilities but who have an assessed need

## HOW WILL THE AIM BE ACHIEVED?

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

As part of this Service, the supplier will be required to:

- Provide advice and information on SDS to service users and carers to help them understand their role as an employer.
- Accept referrals from a number of sources: self-referrals; carers; health and social care personnel; other statutory providers and community and voluntary organisations.
- Participate in and provide training to HSCTs in relation to SDS.
- Take an active role in the promotion of SDS and policy development related to independent living.
- Ensure access to a payroll service that can be engaged by service users and carers.

## KEY CONSTRAINTS

- **Cost:** The contract has a budget of £362,449 annually. This budget is based on the delivery of the Service in previous years, taking account of reasonable increases in line with inflation and steady increase of SDS uptake.

- **Procurement – process and timescales:** The current contract to deliver this Service expires on 31 March 2020. The current contract has run from the 1.4.16 – 31.3.19, with an additional 1 year extension to 31.3.20. Procuring this Service is subject to public procurement rules and legislation and will be via the Official Journal of the European Union. Accordingly, the HSCB must comply with strict timescales: in summary, the tender specification must be completed in mid-2019, to allow for the correct advertisement period, assessment period and process, contract award, and potential Transfer of Undertakings (Protection of Employment) (also referred to as TUPE) actions, prior to commencement of the new contract on 1 April 2020.

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

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

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

## 1.3 Main stakeholders affected (internal and external)

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

- Actual and potential service users and carers.
- Health and Social Care Trusts (HSCTs) – all five regional HSCTs make referrals into the current Service and will continue to do so.
- Health and Social Care Board (HSCB) Social Care Directorate – this is the commissioning body.
- Department of Health – the funder, with responsibility for overarching

policy and strategic direction.

- Disabled People User Lead Organisations (DPULO) and Community and Voluntary Sector Organisations – these bodies deliver services and support to people from across all Programmes of Care across Northern Ireland, and therefore interface with the current and any new Service provider to provide holistic and locally-accessible services and support to service users and carers.
- Personal Assistants: individuals who are employed by service users and carers utilising their Self Directed Support (SDS) allocation, to provide the required service.
- Care brokerage services.

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

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

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

- **Self Directed Support (SDS)** and the **Independent Living Fund (ILF):** These programmes are integral to this Service: its core purpose is to facilitate and maximise the delivery of support through these channels and the positive outcomes they envisage (see outline detail at Section 1.2 above). For this reason, monitoring data, stakeholder engagement, and consultation findings pertaining to SDS have strongly informed this Equality Screening Exercise (see Section 2.1 below).

- **The Children (Northern Ireland) Order 1995**

- **The Young Carers (Needs Assessments) Regulations 2015:** Section 2 outlines the general requirements;

In carrying out the assessment, the local authority must, in particular, have regard to—

(a)the young carer's age, understanding and family circumstances;

(b)the wishes, feelings and preferences of the young carer;

(c)any differences of opinion between the young carer, the young carer's parents and the person cared for, with respect to the care which the young carer provides (or intends to provide); and

(d)the outcomes the young carer seeks from the assessment.

- **Carers and Direct Payments Act (Northern Ireland) 2002:** Section 2 outlines services to carers; Where an authority carries out an assessment under section 1(1) in respect of a carer, it shall consider the assessment and decide—

(a)whether the carer has needs in relation to the care which he provides or intends to provide;

(b)if so, whether they could be satisfied (wholly or partly) by services which the authority may provide; and

(c)if they could be so satisfied, whether or not to provide services to the carer.[1]

- **Transforming Your Care (2011):** This historic Department of Health (DOH) strategy sets an overarching agenda for developing person centred services. (Available at: https://tinyurl.com/k8beo4u).

- **Health and Wellbeing 2026: Delivering Together (2016):** The current DOH strategy builds on *Transforming Your Care*, reinforced the value and centrality of the personalisation agenda. The responsibility for delivering on this strategy is shared across the Health and Social Care System. (Available at: https://tinyurl.com/j5eut4m.)

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

- **Draft Programme for Government (2016)** – noting in particular: Outcome 4 (*We enjoy long, health, active lives*), Outcome 8 (*We care for others and we help those in need*), Outcome 9 (*We are a shared, welcoming and confident society that respects diversity*), Indicator 5 (*Satisfaction with health and social care*) and Indicator 42 (*Average life satisfaction score of people with disabilities*). These overarching outcomes and indicators will inform the development and delivery of the Service specification and monitoring arrangements. (Available at: https://tinyurl.com/y4c53ln5.)

- **Physical and Sensory Disability Strategy (2012-15/18)** – while the strategy has now closed, the principle that the services commissioned and provided by Health and Social Care organisations for people with disabilities should develop in such a way that they: "…support disabled people to become well informed and expert in their own needs and encourage the social inclusion of disabled people and work to address the stigma associated with disability" still applies. Conducting this Equality Screening, and thereby giving due regard to Disability Duties (see section

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[1] http://www.legislation.gov.uk/nia/2002/6/section/2

4 below), forms part of this consideration. (Available at: https://tinyurl.com/y6439dhl.)

- **Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy March 2009.** The DOH strategy supports the aims and objectives of the DOH *Our Children and Young People, Our Pledge, 10 year strategy* and sets out the vision for improving support and services for families and children.

## (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 following information has been used to inform this Equality Screening:

**Primary research and statistical data:**

- The final report of the ***Equality Impact Assessment (EQIA) on Self Directed Support*** **(Health & Social Care Board, 2015)** (available at: https://tinyurl.com/y68y4pch). This report is a vital source of information for this Screening, since it involved extensive research, stakeholder engagement, and public consultation with direct and specific relevance to the Service. It focused in particular on information relevant to people with a disability, older people, younger people, and people with dependants (carers). For four of the nine categories – gender, marital status, political opinion, and sexual orientation – there was no evidence of differential impacts of Self Directed Support. For two of the nine categories – religion and ethnicity – some minor positive impacts were identified. For three of the nine categories – age, disability, and dependants a number of potential impacts were identified, and clear mitigating actions outlined. These findings apply equally to this Screening process, which has sought to bring the information up to date and give due regard to the impact for all Section 75 groups that may require access to the Service.

- **Current service-user data collated by the SDS Project Team** within the Health & Social Care Board.

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

- **An internal service user survey conducted by the current Service provider** (2018).

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

- **The Health and Social Care Board staff who have managed the current contract:** This has involved collective reflection on the strengths and limitations of the current contract, and opportunities for improvement in the procurement of the new contract.

- **The five regional Health & Social Care Trusts:** This engagement has involved face to face meetings with SDS service leads, Physical Disability service leads, and Assistant Directors, to reflect on their teams' experience of the current Service. This included representatives from both adults' and children's Programmes of Care. Specifically, there has been detailed discussion of strengths and limitations of the current provision, consideration of potential barriers to accessing the Service, and opportunities for continuous improvement in the procurement of the new contract. This detailed discussion has taken into account diverse service-user and carer feedback shared by these staff members based on their work experience in this area.

- **The current supplier,** Centre for Independent Living NI (https://www.cilni.org/). This included site visits to all regional offices and face to face meetings with staff, including those covering rural areas (regional offices located in: Belfast, Armagh, Magherafelt, Omagh).

- **Potential suppliers:** a public market sounding and engagement event was held on 23 May 2019. This was publicised on the HSCB website and www.communityni.org, inviting engagement with any and all interested parties.

- **The Patient and Client Council (PCC):** a questionnaire has been circulated via the PCC newsletter to obtain primary service-user and carer feedback in relation to the current Service. This was carried out over June-July 2019, and closed on 5 July 2019.

**Other published sources:**

- **Delegated Statutory Functions Report, DOH website.**

- **Physical and Sensory Disability Strategy (2012-15/18):** This strategy includes a section on *Prevalence*, which has informed this Screening. (Available at: https://tinyurl.com/y6439dhl.)

- **A recent Patient and Client Council research report on Self Directed Support:** *Our experiences of self-directed support: Service users and carers share their views* (February 2019) (Available at: https://tinyurl.com/y4xv999b.)

- **Department of Health publications relevant to Self Directed Support and the provision of social care to people with disabilities, older people, and people with physical and mental health issues:**

  - *"Design your own social care" – a statistical article on direct payments* (2016) (Available at: https://tinyurl.com/y4xv999b.)

  - *Quarterly direct payments statistics March 2019* (Available at: https://tinyurl.com/y5ebq9pf.)

- **Population-level data:** Northern Ireland Census (2011) and Northern Ireland Statistics and Research Agency (NISRA) statistics (available at: https://tinyurl.com/y2fl3nnz), including the most recent mid-year population estimates (2018, published 2019) (available at: https://www.nisra.gov.uk/publications/2018-mid-year-population-estimates-northern-ireland).

- **Data in relation to potentially 'hard to reach' or marginalised groups defined under Section 75 as follows:**

  - Belfast Health & Social Care Trust (BHSCT) & Aware Defeat Depression. (2014). *Ethnic Minorities: Mental Health Toolkit – A Guide for Practitioners*. Available at: https://tinyurl.com/yy3qsjza.

- Carmel, T. C. & Erickson-Schroth, L. (2016). ‘Mental Health and the Transgender Population’, *Journal of Psychosocial Nursing & Mental Health Services*, 54 (12): 44–48.
- Elliot, M. et al. (2015). Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey. *Journal of General Internal Medicine*, 30 (1): 9-16.
- Gray, A.M., Horgan, G., & Leighton, A. (2013). ARK Policy Brief: *Moving towards a Sexual Orientation Strategy for Northern Ireland.* Available at: https://tinyurl.com/yynqj55q.
- McBride, R. (2011). *Healthcare issues for transgender people living in Northern Ireland.* Belfast: Institute for Conflict Research. Available at: https://tinyurl.com/yydozoru.
- Northern Ireland Health Survey (2017) Available at: https://tinyurl.com/y5o3y3x5.
- O’Doherty, J. (2016). *OUTstanding in your field. Exploring the needs of LGB&T people in rural Northern Ireland*. Available at: https://tinyurl.com/yxwb369c.
- Sneddon, H. (2018). *Mental Health and Wellbeing of Asylum Seekers and Refugees: Evidence Review and Scoping.* Belfast: Public Health Agency.
- Northern Ireland HSC Interpreting Service Report**:**1 April 2017 - 31 March 2018.

## 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 issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?*** |
|---|---|

**Note:**

As identified in the report of the ***Equality Impact Assessment (EQIA) on Self Directed Support*** **(Health & Social Care Board, 2015)** (available at: https://tinyurl.com/y68y4pch), which involved extensive research, stakeholder engagement, and public consultation, the key Section 75 groups involved in accessing Self Directed Support (SDS) are people with a disability, older people, younger people, and people with dependants (carers). This observation applies equally to the current Screening exercise.

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

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

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

Notwithstanding these acknowledged difficulties, as a result of the lack of systematic monitoring, there is no specific data available in relation to people's access to the Service correlated with gender, age, religion, political opinion, marital status, ethnicity, or sexual orientation. The category of disability is recorded, albeit in a one-dimensional rather than intersectional way, in terms of the service user or carer's primary Programme of Care. Recording of dependant status is incomplete as it was not requested by the Commissioners: while the HSC Trusts record SDS allocation to carers, this distinction is not made in the data collected by the current Service provider.

These limitations have been addressed in the current Screening process by engaging with stakeholders with lived experience of referring into and delivering this Service, and by reviewing the Service user data available in conjunction with a range of published information sources – as outlined in section 2.1 above.

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

In completing this equality screening exercise reference was made to the 2011 Census. The census collects information every 10 years about people and households in Northern Ireland and whilst the 2011 document is currently 8 years old it is the most recent. It is of note however that some conditions will not be specified in the census and therefore data, for example on some aspects of disability, cannot be gleaned from this source. To address this issue more recent sources of information have also been identified in this equality screening exercise.

| | |
|---|---|
| **Gender** | **General population:**<br>In 2011, the Northern Ireland population was determined to include 1,810,863 people, of whom 49% were male and 51% were female (Census, 2011).<br>The size of the resident population in Northern Ireland at 30 June 2018 was estimated to be 1,881,600 people. Just over half (50.8%) of the population were estimated to be female, with 955,400 females compared to 926,200 males.[2]<br>Limited data is available on the number of transgender people in Northern Ireland. However, the Gender Identity Research and Education Society (GIRES) provide the following estimates for numbers of gender nonconforming people, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014):<br>• gender variant to some degree 1%<br>• have sought some medical care 0.025%<br>• having already undergone transition 0.015%<br>The number of people who have sought treatment seems likely to continue growing at 20% per annum or even faster. While few younger people currently present for treatment, most gender variant adults report experiencing the condition from a very early age, and presentation for treatment among young people is growing rapidly (50% p.a.).<br>Applying GIRES figures to the NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600 estimates that:<br>• 18,816 people do not identify with gender assigned to them at birth;<br>• 470 are likely to have sought medical care, and;<br>• 282 are likely to have undergone transition. |

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[2] Northern Ireland Statistical and Research Agency (NISRA) data published online on 26 June 2019. Available at: https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/MYE18-Bulletin.pdf

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

| | |
|---|---|
| **Age** | **General population:**<br>Mid-year population estimates published by the Northern Ireland Statistics and Research Agency (NISRA) in 2019[3] show that the general population falls into the following age categories:<br><br>0-19 yrs (inclusive) = 485,064 (25.7% of all NI population)<br>20 – 34 yrs = 364,623 (19.3%)<br>35 – 49 yrs = 366,967 (19.5%)<br>50 - 64 yrs = 356,790 (19.0%)<br>65 – 74 yrs = 169,725 (9.0%)<br>75 – 89 yrs = 125,334 (6.6%)<br>90+ yrs = 13,138 (0.7%)<br><br>HSCB current service user data draws on the NISRA statistics published in 2019, to show the age distribution of the Northern Ireland population across the five HSC Trust areas in three bands: 0 to 17 years (Children / Young People); 18 to 64 years (Adults); over 65 years (Older People). The data shows that the vast majority of the population across the five HSC Trust areas is concentrated in the 18-64 years age band. |

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[3] See: https://www.nisra.gov.uk/publications/2018-mid-year-population-estimates-northern-ireland

**Service Users & Carers:**

Current data monitoring for the Service reflects age distribution of service users by specifying the Programme of Care in which they belong: under this system, Children with a Disability occupy a discrete category, as do Older People (65+), while all Adult service users (aged 18-64) are recorded in sub-categories according to their Programme of Care. There is currently no distinction in those under 18 years with all data being captured under the children with a disability category.

Data recorded in this way by the current Service provider for the past three years is shown in **Table 1** below. This data collection does not distinguish service users into distinct service users and carers, but refers to *all* of the provider's clients as 'service users.'

**Table 1: Service User Data according to Programme of Care – as provided by current Service Provider (2016/17-2018/19)**

| Support Allocated | Contract year | Programme of Care Information | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **Physical Disability (Adults)** | **Learning Disability (Adults)** | **Older People** | **Mental Health (Adults)** | **Children with Disabilities** | **Other** | **Total** |
| **Direct Payments** | 2018/19 | 1872 | 954 | 2550 | 360 | 1463 | 138 | 7337 |
| | 2017/18 | 1720 | 1054 | 2580 | 306 | 1437 | 140 | 7237 |
| | 2016/17 | 2099 | 1090 | 2381 | 401 | 1529 | 200 | 7700 |
| **Total** | | **5691** | **3098** | **7511** | **1067** | **4429** | **478** | **22274** |
| **Self-Directed Support** | 2018/19 | 852 | 323 | 839 | 138 | 630 | 94 | 2876 |
| | 2017/18 | 806 | 277 | 704 | 130 | 517 | 79 | 2513 |
| | 2016/17 | 422 | 162 | 330 | 46 | 210 | 86 | 1256 |
| **Total** | | **2080** | **762** | **1873** | **314** | **1357** | **259** | **6645** |
| **Independent Living Fund** | 2018/19 | 124 | 110 | 43 | 1 | 18 | 4 | 300 |
| | 2017/18 | 88 | 163 | 27 | 2 | 11 | 20 | 311 |
| | 2016/17 | 118 | 93 | 23 | 8 | 12 | 17 | 249 |
| **Total** | | **330** | **366** | **93** | **11** | **41** | **44** | **885** |

| | |
|---|---|
| **Age** | **Service Users & Carers (continued):** |

**(continued)**

**Table 1** shows that in 2018/19, of a total of 10,513 service users 2,111 or 20% were children under the age of 18, 4,734 or 45% were adults over the age of 18, and 3,432 or 33% were aged 65 and older. 236 or just over 2% were not categorised in this way.

At the end of December 2018, the five regional Health and Social Care Trusts reported a total of 23,249 combined service users and carers using, or having had, an operational SDS package *since the implementation of SDS in June 2015*. **Tables 2 and 3** below show the summary information that is available in this dataset in relation to recipients of SDS from 2015 to December 2018, organised by *service user* and *carer* category respectively. Within each of these tables, as per the current Service provider data, the categories are further sub-divided according to the Programme of Care.

**Table 2: SDS Data according to Programme of Care – as provided by Regional Health & Social Care Trusts – SERVICE USERS (2015-2018)**

| | ACTIVE SERVICE USERS | CEASED SERVICE USERS | ONE OFF SERVICE USERS | OVERALL SERVICE USERS |
|---|---|---|---|---|
| CAMHS | 0 | 0 | 0 | 0 |
| Childrens Disability | 1303 | 123 | 89 | 1515 |
| Family & Child care | 0 | 1 | 1 | 2 |
| Learning Disability | 1541 | 67 | 368 | 1976 |
| Mental Health | 399 | 56 | 20 | 475 |
| Older People Services | 9438 | 2163 | 316 | 11917 |
| Primary Health & Adult Community | 0 | 0 | 0 | 0 |
| Physical & Sensory Disability | 2705 | 615 | 67 | 3387 |
| Grand Total | 15386 | 3025 | 861 | 19272 |

**Table 3: SDS Data according to Programme of Care – as provided by Regional Health & Social Care Trusts – CARERS (2015-2018)**

QUANTITATIVE DATA

| | ACTIVE CARERS | CEASED CARERS | ONE OFF CARERS | OVERALL CARERS |
|---|---|---|---|---|
| CAMHS | 0 | 0 | 1 | 1 |
| Childrens Disability | 7 | 5 | 237 | 249 |
| Family & Child care | 0 | 0 | 12 | 12 |
| Learning Disability | 116 | 24 | 779 | 919 |
| Mental Health | 0 | 1 | 459 | 460 |
| Older People Services | 519 | 183 | 1156 | 1858 |
| Primary Health & Adult Community | 0 | 0 | 1 | 1 |
| Physical & Sensory Disability | 73 | 19 | 385 | 477 |
| Grand Total | 715 | 232 | 3030 | 3977 |

**Age (continued)**

**Service Users & Carers (continued):**
Taken together, **Tables 1, 2, and 3** show a pattern of age distribution that reflects the general population in Northern Ireland. Given the wider trend of an ageing population profile, it can be anticipated that service users and carers requiring access to the Service will include increasing numbers of older people into the future. This is in keeping with Table 2 and 3 which demonstrates that the largest users of SDS services within Trusts, for both service users and carers, are in the older people's programme of care.

**Religion**

**General population:**
At a population level, the most recent Census (2011) reveals that:

- 45.14% (817, 424) of the population were either Catholic or brought up as Catholic.
- 48.36% (875, 733) stated that they were Protestant or brought up as Protestant.
- 0.92% (16, 660) of the population belonged to or had been brought up in other religions and Philosophies.
- 5.59% (101, 227) neither belonged to, nor had been brought up in a religion.

Whilst the majority of the population identify as either Catholic or

Protestant, the demographic of the Northern Ireland population is changing. Other religions and philosophies represented in Northern Ireland, involving 16,600 people, include Judaism, Islam, Hinduism, and the Bahá'í Faith.

**Service Users & Carers:**
Information in relation to religion is not currently monitored in relation to SDS or the current Service, by either the HSC Trusts or the current Service provider. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to religion.

Based on the available data discussed above, however, it can be reasonably assumed that people from all religious backgrounds and none may require access to the Service, however, individuals from religions other than Catholic and Protestant backgrounds may be under-represented.

**Political Opinion**

**General population:**
At a population level, the Northern Ireland Life and Times (NILT) survey is a key source that provides important insight into political opinions held by people in this region. It asks the question: “Generally speaking, do you think of yourself as a unionist, a nationalist, or neither?” The responses to this question in the most recent survey (2017) [4] are shown in Table 4 below.

**Table 4: NILT Survey Question: *Generally speaking, do you think of yourself as a unionist, a nationalist, or neither?***

| Category | Percentage of respondents |
|---|---|
| Unionist | 32% |
| Nationalist | 21% |
| Neither | 45% |

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

| | |
|---|---|
| (Other) | 1% |
| Don't know | 2% |

A significant proportion of the Northern Ireland population does not vote in our elections, including young people in particular.

No data exists on the political opinion of the population of those from other religions and philosophies outlined in Section 3.1.4.

**Service Users & Carers**
Information in relation to political opinion is not currently monitored in relation to SDS by either the HSC Trusts or the current Service provider. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to political opinion.

Based on the available data discussed above, however, it can be reasonably assumed that people from all political philosophies and none may require access to the Service.

**Marital Status**

**General population:**
The most recent census (Census, 2011) showed that, across the Northern Ireland population:

- 47.56% (680,840), or almost one in two of people aged 16 or over were married.
- 36.14% (517,359) were single.
- 0.09% (1,288) were registered in same-sex civil partnerships.
- 9.43% (134,994) were either divorced, separated, or formerly in a same-sex partnership.
- 6.78% (97,058) were either widowed or a surviving partner.

Annual Reports of the Registrar General for NI show that between 2005 and 2017 inclusive, 1,202 civil partnerships were

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| | registered in NI.[5]<br>**Service Users & Carers:**<br>Information in relation to marital status is not currently monitored in relation to SDS by either the HSC Trusts or the current Service provider. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to service users' marital status.<br>Based on the available data, it can be reasonably assumed that the people who need to access the Service include individuals who identify with the full range of marriage status groups (i.e. married, single, same-sex civil partnership, divorced, separated, formerly in a same-sex partnership or widowed / surviving partner). |

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| **Dependant Status** | **General population:**<br>Dependant status relates to both parenting and wider care responsibilities, i.e. looking after an ill, older, or disabled family member, friend, or partner for few hours a week, or full time.<br>The most recent census (Census, 2011) revealed that 33.9% of all households in Northern Ireland, which equated to 238,094 households, had dependent children. Of this number, 115,959 were lone parent households. 16,691 of these were male-headed households, and 99,268 were female-headed households.<br>The census (Census, 2011) also showed that approximately one in eight residents in Northern Ireland have carer responsibilities, which equates to around 220,000 people. Data that is available |

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[5] Available at https://www.nisra.gov.uk/statistics/births-deaths-and-marriages/registrar-general-annual-report Accessed 31/07/2019

in relation to the characteristics and circumstances of carers shows that: [6]

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

In 2017 the Northern Ireland Life and Times (NILT) survey[7] found that women were more likely than men to confirm that they carry carer responsibilities.

Analysis of Carers Allowance claims by the Northern Ireland Council for Voluntary Action (NICVA) and the Detail Data (2016) shows that 64% of carers are women. The same research suggests that almost half of carers have been caring for 35 hours or more a week for longer than five years.[8]

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

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

[8] See: http://data.nicva.org/article/who-cares-about-carers

Research published by the Department of Health and Public Health Agency in 2016 shows that while the needs of carers from minority ethnic communities in Northern Ireland are relatively poorly understood, it is apparent that they require specific supports to improve their access to relevant services.[9] The report notes the importance of:

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

All of this information shows that intersectionality is an important consideration in relation to carers and their needs and access to services.

**Service Users & Carers:**
Current data monitoring for the Service reflects the age distribution of service users by specifying the Programme of Care in which they belong: under this system, Children with a Disability occupy a discrete category, as do Older People (65+), while all Adult service users (aged 18-64) are recorded in sub-categories according to their Programme of Care. Data recorded in this way by the current Service provider for the past three years is shown in **Table 1** above (p.16). This data collection does not distinguish service users into distinct service users and carers, but refers to *all* of the provider's clients as 'service users.'

**Tables 2 and 3** above (p.17) show the summary information that is available from the Health & Social Care Trusts in relation to

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

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| | recipients of SDS from 2015 to December 2018, organised by *service user* and *carer* category respectively. Within each of these tables, as per the current Service provider data, the categories are further sub-divided according to the Programme of Care.<br>As shown by these datasets, and in line with the whole purpose of SDS as a programme of personalised support, it is clear that carers are a core group of people who currently access the Service, and will continue to need it into the future. |

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| **Disability** | **General population:**<br>The most recent census (Census, 2011) revealed that 20.69% of the population (or 374,668 people) regard themselves as having a disability or long-term health problem, which has an impact on their day to day activities. 68.57% of the population (1,241,709 people) have no long-term health condition.<br>Specific long-term health conditions identified across the population (Census, 2011) include:<br>- Deafness or partial hearing loss – 5.14% (93,078 people)<br>- Blindness or partial sight loss – 1.7% (30,785 people)<br>- Communication Difficulty – 1.65% (29,879 people)<br>- Mobility or Dexterity Difficulty – 11.44% (207,163 people)<br>- A learning, intellectual, social or behavioural difficulty – 2.22% (40,201 people)<br>- An emotional, psychological or mental health condition – 5.83% (105,573 people)<br>- Long-term pain or discomfort – 10.10% (182,897 people)<br>- Shortness of breath or difficulty breathing – 8.72% (157,907 people)<br>- Frequent confusion or memory loss – 1.97% (35,674 people)<br>- A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy) – 6.55% (118,612 people) |

- Other condition – 5.22% (94,527 people)

On Census Day 2011, two-fifths (40%) of households contained at least one person with a long-term health problem or disability. Of those households, 9.2% had dependent children, and 31% none. As referenced above however, not all aspects of disability were specified in the census and are therefore not captured in the data. One example of this being autism spectrum disorder with the Autism Act (Northern Ireland) 2011coming into force later than the census.

The most recent official statistics collected via the Health Survey NI (2017)[10] show that:

- 42% of respondents reported a longstanding illness (30% limiting and 12% non-limiting illness);
- 27% of Males reported a limiting longstanding illness, while 12% reported a non-limiting longstanding illness;
- 33% of Females reported a limiting longstanding illness, while 12% reported a non-limiting longstanding illness;
- Prevalence of disability increases with age: limiting longstanding illness increases from 15% among young adults aged 25 -34 years to 61% among those who are aged 75 years old;
- Around a fifth of respondents (18%) scored highly on the GHQ12 suggesting they may have a mental health problem; and
- Respondents in the most deprived areas (22%) continue to be more likely to record a high GHQ12 score than those in the least deprived areas (15%).

**Service Users & Carers:**
Current data monitoring for the Service reflects the age distribution of service users by specifying the Programme of

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[10] For more information on Health Survey NI (2016/17) see: https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland

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|---|---|
| | Care in which they belong: under this system, Children with a Disability occupy a discrete category, as do Older People (65+), while all Adult service users (aged 18-64) are recorded in sub-categories according to their Programme of Care. Data recorded in this way by the current Service provider for the past three years is shown in **Table 1** above (p.16). This data collection does not distinguish service users into direct service users and carers, but refers to *all* of the provider’s clients as ‘service users. In addition there is currently no distinction in those under 18 years with all data being captured under the children with a disability category.<br>**Tables 2 and 3** above (p.17) show the summary information that is available from the Health & Social Care Trusts in relation to recipients of SDS from 2015 to December 2018, organised by *service user* and *carer* category respectively. Within each of these tables, as per the current Service provider data, the categories are further sub-divided according to the Programme of Care.<br>All three of these datasets demonstrate that the individuals accessing support through SDS and ILF do so on the basis of assessed needs relating to disability, illness, or impaired functioning or mobility.<br>As shown by these datasets, and in line with the whole purpose of SDS as a programme of personalised support for people with social care needs, it is clear that collectively, people with a disability or multiple disabilities constitute a primary group of people who currently access the Service and will continue to need it into the future. |

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| **Ethnicity** | **General population:**<br>The most recent census (Census, 2011) revealed that 1.8% of the usual resident population (or 32,596 people) belonged to minority ethnic groups. Information collected as part of the census shows that the ethnic distribution of the population is as |

follows:

- White: 98.21% (1,778,449)
- Chinese: 0.35% (6,338)
- Indian: 0.34% (6,157)
- Other Asian: 0.28% (5,070)
- Mixed: 0.33% (5,976)
- Black African: 0.13% (2,354)
- Irish Traveller: 0.07% (1,268)
- Pakistani: 0.06% (1,087)
- Black Other: 0.05% (905)
- Bangladeshi: 0.03% (543)
- Black Caribbean: 0.02% (362)
- Other: 0.13% (2,354)

Migration patterns have changed in Northern Ireland in the intervening period, and it can be expected that this ethnic breakdown is currently changing.

Data compiled by the Northern Ireland Assembly Research and Information Service in 2016 (Russell, 2016)[11] found that:

- Between 2000 and 2014, an estimated 175,000 long-term international migrants came to Northern Ireland, while 143,000 left, leaving a net total of 32,000. Local government districts in the west and south-west of Northern Ireland saw the largest net inflow of new residents, in particular: Mid Ulster (9,800), Armagh, Banbridge & Craigavon (9,300) and Newry, Mourne & Down (6,000).
- Poland continues to be the most popular country of origin for international migrants coming to live in Northern Ireland. During 2014 and 2015, however, migration from

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

Romania rose substantially, albeit from a low baseline.

- Around 1,000 members of the Roma community, mostly from Romania, are thought to live in Northern Ireland, mainly South Belfast.
- International migration impacts upon the host community in a myriad number of ways, including maternity services, school enrolments, social housing, health and social care, and hate crime.
- Births to mothers born outside the UK and Ireland now account for over 10% of all births in Northern Ireland each year. In 2014, 18% of all births in the Mid Ulster local government district were to non-UK and Ireland mothers, followed by Armagh, Banbridge & Craigavon (15%), Belfast (15%), Fermanagh & Omagh (14%) and Newry, Mourne & Down (14%).

In 2017, the Northern Ireland Policing Board conducted a *Thematic Review of Policing Race Hate Crime* (NIPB, 2017)[12] which reported the following:

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

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

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| | It is of note that the figures cited above are in relation to reported hate crimes.  Due to issues of under reporting the actual figures may therefore be higher.<br>The HSC Interpreting Service (also referred to as Regional Interpreting Service RIS) statistics reveal a trend of increasing numbers of ethnic minority groups requiring support to access healthcare services in the region over the last 15 years.  These data show a dramatic rise in requests for interpreters from 1,850 in 2004-2005 to 114,382 requests in 2017-2018.<br>The most popularly requested languages in 2017-18 were:<br>1. Polish 30292<br>2. Lithuanian 15763<br>3. Arabic 11360<br>4. Romanian 9908<br>5. Portuguese 8524<br>6. Tetum 6162<br>7. Slovak 5320<br>8. Bulgarian 5154<br>9. Chinese - Mandarin 5011<br>10. Hungarian 2887<br>Data from the Interpreting Service revealed that in 2017-18, the largest proportion of requests came from the SHSCT area (47.27%), followed by the BHSCT (29.38%). Slightly more than 1 in ten requests originated in the NHSCT (11.57%), while 6.31% and 5.47% of total requests were from the SEHSCT and WHSCT respectively.<br>The information highlighted above in relation to black and minority ethnic carers (see ‘Dependant Status’ on p. 21) is also noted here.<br>**Service Users & Carers:**<br>Information in relation to ethnicity is not currently monitored in relation to SDS by either the HSC Trusts or the current Service provider.  Furthermore, in a more general sense, the HSC family |

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| | of organisations does not routinely or consistently collate information in relation to ethnicity.<br>Nonetheless, the available data highlights that while current demand for this and other services may be very small in terms of numbers, there is a growing need for services for a steadily increasing population of BME communities, who may be subject to discrimination, intimidation, and hate crimes. |

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| **Sexual Orientation** | **General population:**<br>Publicly available statistics on sexual orientation at a population level suggest that between 5% and 10% of the population may identify as lesbian, gay or bisexual.<br>In 2016, the Annual Population Survey (APS)[13] showed that:<br>- 93.4% of the UK population identified as heterosexual or straight and<br>- 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:<br>○ 1.2% identifying as gay or lesbian<br>○ 0.8% identifying as bisexual<br>- A further 0.5% of the population identified themselves as “Other”, which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories.<br>- A further 4.1% refused or did not know how to identify themselves.<br>- The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).<br>- More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.<br>- The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at |

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[13] See: https://beta.ukdataservice.ac.uk/datacatalogue/series/series?id=200002#!/access

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| | 70.7%.<br>With regard to public opinion towards gay, lesbian and bisexual people in Northern Ireland: there is a disconnect between legislation, which prohibits same-sex marriage, and public opinion. The 2018 Northern Ireland Life and Times Survey has found that 68% of the population believes that marriages between same-sex couples should be recognised by the law as valid, with the same rights as traditional marriages.[14] As data monitoring develops to capture statistics on people from LGBQ+ communities and as people become feel more confident about disclosing their sexual orientation as public opinion increasingly supports them to do so, it is expected that there will be an increase in the current numbers recorded.<br>**Service Users & Carers:**<br>Information in relation to sexual orientation is not currently monitored in relation to SDS by either the HSC Trusts or the current Service provider. Furthermore, in a more general sense, the HSC family of organisations does not routinely or consistently collate information in relation to sexual orientation.<br>Based on the available data, however, it can be reasonably assumed that the prevalence of lesbian, gay, and bisexual people reflected in the statistics cited above will be represented in the population accessing this Service. |

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[14] See: https://www.ark.ac.uk/nilt/2018/LGBT_Issues/SSEXMARR.html

## 2.3 Qualitative Data

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

| ***Category*** | ***Needs and Experiences*** |
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| **Gender** | Regional and international research highlights the following:<br>▪ Men are less likely than women to display positive help-seeking attitudes in relation to health and care needs;[15]<br>▪ The help-seeking behaviours of transgender people are limited for reasons specifically associated with being trans or having a trans history;[16] and<br>▪ There is an increased risk of negative health outcomes for transgender people and for men.<br>This qualitative information suggests that:<br>• Transgender individuals may be less likely to avail of the Service if they feel they may encounter negative reactions and attitudes, and<br>• Men may need additional support to access the Service and maximise the benefit of their SDS allocation.<br>Taking this qualitative data into account, while the Service cannot control the numbers of people of all genders accessing SDS, in terms of the individuals accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against |

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[15] Northern Ireland Life & Times Survey (2004) – *Men's Life and Times*: datasets available at: https://www.ark.ac.uk/nilt/results/menslt.html

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

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| | barriers arising at that point in the process. For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training. |

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| **Age** | The nature of the Service is to assist people in receipt of SDS to maximise the benefit of that support, promoting independence, modifying the impact of disability, and promoting choice. People of all ages with various levels of capacity and ability who require support to live full and independent lives are therefore core users of this service.<br>Research and consultation in relation to SDS has found that:<br>▪ Younger people may be under-represented in SDS; and<br>▪ Older people may feel unable to manage the responsibilities of employing a Personal Assistant using a direct payment.[17]<br>This qualitative information is directly relevant to the design and delivery of this Service. It is noted that:<br>• While the Service cannot control the numbers of younger people in SDS, in terms of those who do access the Service to utilise their SDS allocation to maximum benefit, it can mitigate against barriers arising at that point in the process.<br>• The person-centred focus of the Service takes specific steps to support people, including older people, to make informed choices and decide the extent to which they feel comfortable managing various responsibilities. |

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[17] *Equality Impact Assessment (EQIA) on Self Directed Support* (Health & Social Care Board, 2015) (available at: https://tinyurl.com/y68y4pch)

| **Religion** | Contemporary analysis of the structures and dynamics of Northern Ireland society highlights persistent segregation between Catholic/ Nationalist/ Republican (CNR) groups and communities on one hand, and Protestant/ Unionist/ Loyalist (PUL) communities on the other hand. In 2007, it was estimated that 35–40 per cent of Protestants and Catholics live in communities divided along ethno-sectarian lines, and more recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious and political divisions.[18]<br>As noted in relation to the quantitative data on religion discussed above, it can be reasonably assumed that people from all religious backgrounds and none may require access to the Service, however, individuals from religions other than Catholic and Protestant backgrounds may be under-represented. Taking this into account, it is notable that the Health Alliance has identified the failure of some services to meet migrants' cultural or religious needs as one of the difficulties encountered by minority ethnic communities when trying to access health and social care services.[19]<br>While the Service to be procured by the HSCB cannot control the representation of people of all religions and none accessing SDS, in terms of the individuals accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against barriers arising at that point in the process. For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered in premises free from religious markers, in areas that are not perceived as |
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[18] Gray, A. M., Hamilton, J., Kelly, G., Lynn, B., Melaugh, M. & Robinson, G. (2018). Northern Ireland Peace Monitoring Report Number 5. Belfast: Community Relations Council. Available at: https://www.community-relations.org.uk/publications/northern-ireland-peace-monitoring-report.

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

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| | enclave or single-identity territories and by staff with relevant equality and diversity awareness and training. |

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| **Political Opinion** | As noted above, contemporary analysis of the structures and dynamics of Northern Ireland society highlights persistent segregation between Catholic/ Nationalist/ Republican (CNR) groups and communities on one hand, and Protestant/ Unionist/ Loyalist (PUL) communities on the other hand. In 2007, it was estimated that 35–40 per cent of Protestants and Catholics live in communities divided along ethno-sectarian lines, and more recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious and political divisions.[20]<br>While it can be reasonably assumed that people from all political backgrounds and none may require access to the Service, the Service to be procured by the HSCB cannot control the representation of people of all political backgrounds and none accessing SDS. However, in terms of the individuals accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against barriers arising at that point in the process. For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered in premises free from political markers, in areas that are not perceived as enclave or single-identity territories and by staff with relevant equality and diversity awareness and training. |

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

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| **Marital Status** | Research and consultation in relation to SDS has found no equality impacts associated with marital status,[21] and as noted in the quantitative data section above, it can be reasonably assumed that the people who need to access the Service include individuals who identify with the full range of marriage status groups (i.e. married, single, same-sex civil partnership, divorced, separated, formerly in a same-sex partnership or widowed / surviving partner).<br>The Service to be procured by the HSCB cannot control the numbers of people of different marital status accessing SDS. However, in terms of the individuals accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against barriers arising at that point in the process. For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant awareness and training to enquire sensitively about family relationships and social networks in a person's life, and identify appropriate supports both through maximizing their SDS allocation and offering additional signposting to other services on that basis. |

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| **Dependant Status** | The nature of the Service is to assist people in receipt of SDS to maximise the benefit of that support, promoting independence, modifying the impact of disability, and promoting choice. People who are carers of individuals who have disabilities, or older people, are therefore core users of this service.<br>Research and consultation in relation to SDS has found that:<br>▪ Flexibility and independence offers valuable benefits for |

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[21] *Equality Impact Assessment (EQIA) on Self Directed Support* (Health & Social Care Board, 2015) (available at: https://tinyurl.com/y68y4pch)

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| | many Carers when they are providing care;<br>▪ It is important to consider issues of capacity, consent and information sharing with Carers, particularly for people with learning disabilities and mental health issues.[22]<br>Consultation carried out with HSC Trusts and the current Service provider for this Screening exercise has highlighted that individuals who care for people in receipt of SDS frequently also have additional caring and/or parenting responsibilities. For these people, the availability of a responsive telephone service, email facility, and home visits is vitally important, enabling them to balance their caring duties with the process of accessing the information, advice, and advocacy they need to maximise the benefit of the support offered through SDS.<br>Taking this into account, and in line with the whole purpose of SDS as a programme of personalised support, it is clear that careful consideration of the dependant status of both service users and their carers is key to the effective delivery of the Service.<br>The data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant awareness and training to enquire sensitively about dependant status and caring responsibilities, and identify appropriate supports both through maximizing SDS allocation and offering additional signposting to other services on that basis, ensuring any barriers to accessing services due to caring responsibilities are overcome. |

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| **Disability** | The nature of the Service is to assist people in receipt of SDS and ILF to maximise the benefit of that support, promoting independence, modifying the impact of disability, and promoting |

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[22] *Equality Impact Assessment (EQIA) on Self Directed Support* (Health & Social Care Board, 2015) (available at: https://tinyurl.com/y68y4pch)

choice. People with disabilities are therefore core users of this Service.

Research and consultation in relation to SDS and ILF has found that people with complex needs and learning disabilities may feel unable to manage the responsibilities of employing a Personal Assistant using a direct payment.[23]

Consultation carried out with HSC Trusts and the current Service provider for this Screening exercise has also highlighted the following qualitative considerations in relation to disability:

- The recording systems currently in place across both Trusts and the current Service provider do not consistently distinguish between physical and sensory disability needs; anecdotally, however, relatively few people with sensory needs are currently referred to the current provider. Potential reasons for this low uptake in this category were explored. It was noted that this may be because service users who primarily have sensory needs use SDS mainly for access to managed budgets and social integration, rather than Direct Payments. There is also an issue associated with current monitoring systems: in the HSC Trusts, service users and carers are typically counted for monitoring purposes once only, under their ‘primary’ programme of care, and secondary needs are not reflected in the statistics. Many individuals have a range of needs, and frequently sensory needs are recorded second or third in the list. Similarly, Older People with Mental Health needs are recorded primarily under Older People’s services. This approach, while practical in some senses, limits the quality of the data returned. This feedback has been shared with the SDS Project Team for review and monitoring going forward.

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[23] *Equality Impact Assessment (EQIA) on Self Directed Support* (Health & Social Care Board, 2015) (available at: https://tinyurl.com/y68y4pch)

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| | • Communication skills and accessibility considerations are important: it is vital that people in receipt of SDS and on that basis accessing the Service are included in discussion and appraisal of options to meet their needs, and that information is formatted, delivered, and pitched in appropriately accessible formats, maintaining integrity of the overarching commitment to a person-centred and empowering approach (e.g. care must be taken to ensure communication with people with learning disabilities, acquired brain injury, etc. is appropriate and clear). This feedback has been shared with the SDS Project Team.<br>• There is relatively low uptake of SDS and the Service in the mental health programme of care. Potential reasons for this low uptake in this category were explored. It was noted that adopting the personalisation agenda is still a work in progress and part of a culture shift in mental health services: the emphasis is still more on clinics, hospitals, and treatment than on community support. Furthermore, the relatively small number of people from this Programme of Care who do access Direct Payments typically seek access to social integration services offered by agencies.<br>All of this qualitative information is directly relevant to the design and delivery of this Service. It is noted that:<br>• The Service does not have a remit to control for the types of disability represented in the numbers of people allocated SDS and on that basis referred to the Service. However, in terms of the people accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against any barriers arising associated with disability at that point in the process.<br>• The person-centred focus of the Service takes specific steps to support people, including those with disabilities, to make informed choices and decide the extent to which |

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|  | they feel comfortable managing various responsibilities associated with their SDS allocation.<br>Recognising that it is important that the qualitative insights identified above are more closely monitored in future, to identify and mitigate against any potential barriers to access, under the new Service contract the HSCB will seek to work with the new Service provider to strengthen data collection, monitoring, and reporting. |

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| **Ethnicity** | According to the Health Alliance, many minority ethnic communities have close social networks and strong cultural beliefs and practices, which can promote health and social wellbeing.[24] However, the National Institute for Health and Care Excellence (NICE) has demonstrated that some black, Asian and other minority ethnic groups face major health inequalities, and multiple health issues and risk factors for ill health are more prevalent in minority ethnic communities.[25] There is a need for more local data collection and monitoring of ethnicity and race categories across health and social care and other sectors, to provide more accurate data to inform targeted action to address health inequalities.<br>The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care. These include:<br>- Language difficulties;<br>- Lack of awareness and lack of appropriate information on the services available;<br>- The need for a permanent address in order to register with |

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

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

a General Practitioner;
- Fears about entitlement to health care;
- Difficulty in coming to grips with a health care system that is different to what exists in their country of origin;
- The failure of some services to meet migrants' cultural or religious needs, including for example preference for a clinician of the same gender as the patient;
- Institutional racism and the negative attitudes of some health care staff; and
- Immigration restrictions.[26]

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

Consultation carried out with Health & Social Care Trusts and the current Service provider for this Screening exercise has highlighted that very few people with foreign language translation and interpretation needs and/or from minority ethnic communities, are referred to the current provider to maximise the benefit of an SDS allocation. While small numbers may be expected in this context, given the very small number of black and minority ethnic people in Northern Ireland, it is important that this trend is more closely monitored in future, to identify and mitigate against any potential barriers to access. To this end, under the new Service contract, the HSCB will seek to work with the new Service provider to strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield more

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

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| | informative statistics to help shape a truly accessible service.<br><br>This qualitative information is directly relevant to the design and delivery of this Service.  It is noted that the Service does not have a remit to control for the representation of black and minority ethnic individuals in SDS.  However, in terms of the people accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against barriers arising at that point in the process.  For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training. |

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| **Sexual Orientation** | Research has demonstrated that LGB people report poorer experiences when accessing health and social care, are likely to delay access to healthcare based on previous negative experiences and fear of negative attitudes of health workers specifically in relation to their sexual orientation, and may have poorer health outcomes than their heterosexual peers.[27]<br><br>The negative impacts of experiences of discrimination and marginalisation, both direct and indirect, on LGBQ+ individuals and groups are also well established.<br><br>A report published by the Rainbow Project (O’Hara, 2013), based on research conducted with more than 500 individuals that identified as “LGB&/T,” found that the respondents reported common experiences of invisibility, homophobia/transphobia, and a range of violence from threats to physical violence, whether direct or indirect.  As a result of their actual or perceived sexual orientation and/or gender identity: |

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[27] 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.

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

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

This qualitative information is important for the design and delivery of this Service.  It is noted that the Service does not have a remit to control for the numbers of people from the LGB community who are allocated SDS and on that basis referred to the Service.  However, in terms of the people accessing the Service to utilise their SDS allocation to maximum benefit, it can mitigate against any barriers arising associated with sexual orientation at that point in the process.  For example, the data discussed above underlines the importance of ensuring that the Service procured by the HSCB is delivered by staff with relevant equality and diversity awareness and training.

## 2.4 Multiple Identities

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

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

As noted above, the engagement carried out with HSC Trusts for this Equality Screening has identified an important issue associated with current monitoring systems: in the HSC Trusts, service users accessing SDS are typically counted for monitoring purposes once only, under their ‘primary’ programme of care, and secondary needs are not reflected in the statistics. Many individuals have a range of needs, and frequently sensory needs are recorded second or third in the list. Similarly, Older People with Mental Health needs are recorded primarily under Older People’s services. This approach, while practical in some senses, limits the quality of the data returned. This feedback has been provided to the SDS Project Team.

A further important point identified in the engagement carried out with HSC Trusts and the current Service provider is that there is a balance to be struck between respecting the professional assessment of need and recommendations made by HSC staff and the individual service user’s and carer’s perspective on that assessment. Feedback gathered as part of this screening exercise suggests that the current provider fulfils its advocacy role effectively, in terms of offering a constructive challenge to Trust assessments of need/decisions. This capacity is critical to the effective delivery of this Service specifically with regard to ensuring access for all service users and carers, taking into account the inevitable intersectionality and complexity of their identities and needs. In procuring the new Service, the HSCB will make explicit the requirement for the successful provider to have demonstrated capacity and experience in providing such person-centred advocacy.

## MITIGATING ACTIONS

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

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

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| and the delivery of the Service will be required to take cognizance of an individual’s age and be adjusted accordingly to meet the individual’s needs.<br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected. | *collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

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| **Religion**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual’s religion.<br>The Service will be required to create a safe and accessible environment for service users and carers, delivered in premises free from religious markers, in areas that are not perceived as enclave or single-identity territories and by staff with relevant equality and diversity awareness and training.<br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.<br>The Service will be procured with specific requirements to demonstrate that the provider’s staff undergo relevant equality and diversity awareness and training.<br>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services. | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

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| **Political Opinion**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's political opinion.<br>The Service will be required to create a safe and accessible environment for service users and carers, delivered in premises free from political markers, in areas that are not perceived as enclave or single-identity territories and by staff with relevant equality and diversity awareness and training.<br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.<br>The Service will be procured with specific requirements to demonstrate that the provider's staff undergo relevant equality and diversity awareness and training.<br>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services. | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

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| **Marital Status**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's marital status.<br>The Service will be required to take | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection* |

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| cognizance of an individual's family and support networks and be adjusted accordingly to meet the individual's needs.<br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected. | *that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

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| **Dependant Status**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's dependant status.<br>The Service will be required to take cognizance of an individual's caring responsibilities and be adjusted accordingly to meet the individual's needs, for example, by facilitating home visits and guaranteed access to advisers via telephone.<br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected. | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

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| **Disability**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's particular disability.<br>The Service will be required to create a safe and accessible environment for service users and carers. This includes taking cognizance of an individual's disability and making adjustments accordingly to meet the | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible* |

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| individual's needs – for example, ensuring the clarity and accessibility of communication and information provided to service users and carers, including but not limited to sensory impairment, learning disability or acquired brain injury-related needs, etc.<br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.<br>The Service will be procured with specific requirements to demonstrate that the provider's staff undergo relevant equality and diversity awareness and training.<br>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services. | *service.* |

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| **Ethnicity**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's ethnicity.<br>The Service will be required to create a safe and accessible environment for service users and carers, including taking cognizance of an individual's ethnicity and cultural norms, and be making adjustments accordingly to meet the individual's needs – for example, but not limited to:<br>• giving careful consideration to the clarity and accessibility of information provided | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

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| to service users and carers,<br>- ensuring access to provision of foreign language interpreters that do not have a conflict of interest, and<br>- were possible and requested, providing access to advisers who are the same gender as the service user.<br><br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected.<br><br>The Service will be procured with specific requirements to demonstrate that the provider's staff undergo relevant equality and diversity awareness and training.<br><br>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services. | |

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| **Sexual Orientation**<br>The Service will be procured with specific requirements to ensure parity of access across the region irrespective of an individual's sexual orientation.<br><br>The Service will be required to create a safe and accessible environment for service users and carers.<br><br>Collaborative decision making and ensuring informed choice at every stage of the Service will also be respected. | Across all areas: *the HSCB will seek to work with the new Service provider to continually improve and strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield increasingly informative statistics to help shape a truly accessible service.* |

MITIGATING ACTIONS

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| The Service will be procured with specific requirements to demonstrate that the provider’s staff undergo relevant equality and diversity awareness and training.<br>The Service will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services. | |

## 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 | NONE | N/A |
| Political Opinion | NONE | N/A |
| Ethnicity | NONE | N/A |

## (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.**

An Equality Impact Assessment (EQIA) on Self Directed Support (Health & Social Care Board, 2015) (available at: https://tinyurl.com/y68y4pch) was completed in 2015. This report is a vital source of information for this Screening, since it involved extensive research, stakeholder engagement, and public consultation. This Screening process has sought to bring the information up to date and give due regard to the impact for all Section 75 groups that may require access to the Service.

The nature of this Service is to assist people in receipt of SDS to maximise the benefit of that support, promoting independence, modifying the impact of disability and illness, and promoting choice. This is an explicitly person-centred Service underpinned by collaborative decision making that ensures and respects informed choice. The Service is accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services.

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

## (4) CONSIDERATION OF DISABILITY DUTIES

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

| ***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 nature of this Service is to assist people in receipt of SDS to maximise the benefit of that support, promoting independence, modifying the impact of disability, and promoting choice.<br>People with disabilities are therefore core users of this Service, and by accessing the support available, their capacity to participate in public life, should they choose to, is improved.<br>Tenders to provide this Service have been encouraged via the Market Sounding Event on 23 May 2019 from Disabled People User Lead Organisations (DPULOs), charities, and social enterprise companies which encourage disabled people to participate in public life. This is informed by the successful service delivery model achieved through the current contract, which has been held by a DPULO from 2016 to date. | The specification for the new contract will make explicit reference to encouraging disabled people to participate in public life, and will include a requirement for the Service provider to participate in policy and service development fora and training events that deliver and promote the same message.<br>The monitoring arrangements for the contract will include the requirement to collect and reflect on service user and carer feedback, ensuring that the voices, compliments, complaints, and recommendations of disabled people and their carers inform and shape this public service. |

## 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 nature of this Service is to assist people in receipt of SDS to maximise the benefit of that support, promoting independence, modifying the impact of disability, and promoting choice.<br>People with disabilities are therefore core users of this Service, and by accessing the support available, their potential to participate in daily life and integrate with their communities is improved – this in turn aims to normalise and de-stigmatise disability, and promote positive attitudes towards disabled people.<br>In addition, the current contract includes the requirement for the Service provider to deliver regional training to HSC Trusts and other relevant stakeholders on SDS and the provision of information, advice, and advocacy to people with disabilities and other independent living needs. This training promotes better understanding of disabled people's needs, and positive attitudes towards them. This will continue to be a requirement of the Service under the new contract.<br>Tenders to provide this Service have been encouraged via the Market Sounding Event on 23 May 2019 from Disabled People User Lead Organisations (DPULOs), charities, and social enterprise companies which promote positive | The specification for the new contract will make explicit reference to promoting positive attitudes towards disabled people, and will include a requirement for the Service provider to participate in service development fora and training events that deliver and promote the same message. |

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| attitudes towards disabled people.  This is informed by the successful service delivery model achieved through the current contract, which has been held by a DPULO from 2016 to date. | |

## (5) CONSIDERATION OF HUMAN RIGHTS

### 5.1 Are Human Rights relevant?
### 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 onto to 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 have a potential positive impact or does it potentially interfere with anyone's Human Rights?**

| List the Article Number | Positive impact or potential interference? | How? | Does this raise any 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.**

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| |

## (6) MONITORING

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

| **Equality & Good Relations** |
|---|
| The HSCB will continue to monitor service user information in relation to this Service, as per the monitoring arrangements set out in the current contract.<br>As noted above, however, in conducting consultation and engagement with HSCT Trusts and the current Service provider as part of this Screening exercise, it has been identified that Section 75 information is not currently monitored as a matter of routine specifically in relation to SDS by either the HSC Trusts or the current Service provider. Collating information in this way is not a requirement that the HSCB has made of Trusts or the current Service provider up to now.<br>Our engagement has specifically highlighted the sensitivities around asking service users and carers to provide this information, the potential for such questions to complicate or undermine the integrity of the engagement with the Trust/Service provider, and the resource implications for systematic data collection and analysis.<br>Notwithstanding these acknowledged difficulties, as a result of the lack of systematic monitoring, there is no specific data available in relation to people's access to the Service correlated with gender, age, religion, political opinion, marital status, ethnicity, or sexual orientation. The category of disability is recorded, albeit in a one-dimensional rather than intersectional way, in terms of the service user or carer's primary Programme of Care. Recording of dependant status is incomplete: while the HSC Trusts record SDS allocation to carers, this distinction is not made in the data collected by the current Service provider.<br>These limitations have been addressed in the current Screening process by engaging with stakeholders with lived experience of referring into and delivering this Service, and by reviewing the Service user data available in conjunction with a range of published information sources. |

## MONITORING

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| Under the new contract, the HSCB will seek to work with the new Service provider to strengthen data collection, monitoring, and reporting, developing approaches to data collection that are sensitive to the client and yield more informative statistics to help shape a truly accessible service. |
| **Disability Duties** |
| Noting that the Service has a positive impact in terms of the HSCB's Disability Duties: the monitoring arrangements for the new contract will include the requirement to collect and reflect on service user feedback, ensuring that the voices, compliments, complaints, and recommendations of disabled people and their carers inform and shape this public service. |
| **Human Rights** |
| Noting that the Service has a positive impact on human rights: the HSCB will continue to monitor service user information and service user feedback with reference to the human rights impact screening tool included in this template. |

Approved Lead Officer: Ruth Donaldson

Position: Social Care Lead Older People & Adults

Policy/Decision Screened by: Catherine Cassidy

Signed: Catherine Cassidy

Date: 9.11.21

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

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

**Template produced November 2011**
If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Equality Unit:

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