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 Transforming Your Care, Strategic Implementation Plan

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)** **Background, Aims & Objectives** In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. The resulting report - *Transforming Your Care* (TYC) - was published in December 2011 and sets out a compelling case for change in the light of demographic projections for Northern Ireland, and strong evidence that fundamental change is necessary if we are to be able to meet future demand for health and social care services. It sets out a proposed future model of integrated care together with 99 recommendations with the aim of achieving greatest impact and better outcomes for patients, users and carers, and ensuring we have a safe, high quality and

resilient health and social care system into the future. TYC was adopted as policy by the Minister and the Department of Health, Social Services and Public Safety (DHSSPS).

Following the publication of *Transforming Your Care,* in December 2011, the Health and Social Care Board (HSCB) and Public Health Agency (PHA) were asked by the DHSSPS to draw up plans to implement many of the recommendations it sets out. This equality screening is within the context of agreed policy.

How will this the achieved?

The Strategic Implementation Plan (SIP), and the 5 local area Population Plans which underpin it, set out the strategic direction for the implementation of those recommendations for which the Health and Social Care Board and the Public Health Agency has responsibility. It is recognised that this will be both a critical and a challenging journey, and it is one that has already been started – in many ways TYC is bringing together a process of existing and on-going changes already happening across the services into a clear and coherent picture.

The proposed future model of care is centred on the individual and proposes the following:

- People will get support to stay healthy, make good health decisions or manage their own conditions
- More services will be provided locally with opportunities to access specialist hospitals where needed
- Where it's safe and appropriate to do so, more people will be cared for at home
- People will have more choice and greater control over the types of services they are able to access
- Investment in new technology will help people stay at home or receive care locally rather than in hospitals
- Doctors, nurses, social workers and everyone providing care will work together in partnerships to help keep people healthy and prevent them going to hospital when that's not necessary
- Everyone working in health and social care services will be supported in helping to make the changes set out in Transforming Your Care

The Minister asked the HSCB to lead a public consultation process on the overall strategic direction. To support this process, a consultation document was developed and was the basis for public consultation on the overarching strategic

direction, led by the HSCB on behalf of the Minister for HSSPS. The consultation ran from the 9th October 2012 until the 15th January 2013. Prior to this period of consultation, the Patient and Client Council ran a series of road shows, in collaboration with the HSCB, on Transforming Your Care between September and November 2012, on the theme of "Transforming Your Care: What does it mean for me and my family?"

The major initiatives and drivers of the transformation are summarised below
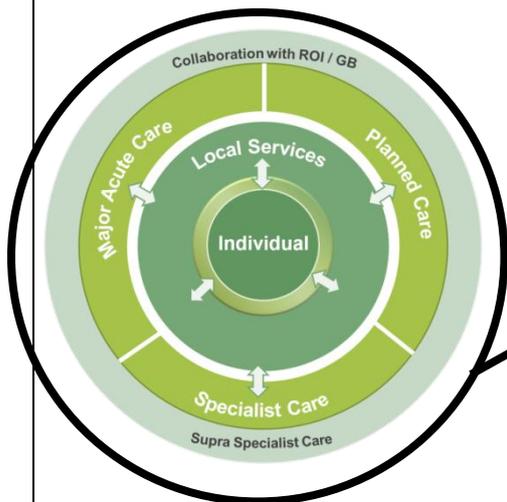
Population health & well-being

- **Implement the new Public Health Strategic Framework**
- Expand / introduce evidence-based programmes to support **parents and families**
- Extend the **Roots of Empathy** programme in primary schools
- Implement **Fitter Futures for All** to reduce obesity, and the **new tobacco strategy** to reduce smoking rates.
- Tackle alcohol and drug misuse

Local Services - **At home and in the community**

- **17 Integrated Care Partnerships** – bringing together health and social care providers, to work as collaborative networks, improving care pathways focusing initially on Older People and aspects of Long term Conditions; namely Diabetes; Stroke Services and Respiratory disease. Benefits include:
  - o *Supporting a more co-ordinated, person-centred approach to how treatment and care are planned and delivered for specified Long Term Conditions;*
  - o *Reducing ED attendances and admissions for Older People*
- **Reablement** – promoting greater independence for older people at home using planned short-term support services following a hospital admission or health or social care crisis at home
- **Falls prevention** programme to identify those at risk of falls and fragility fractures and provide targeted interventions
- **Personalised care**, with individual budgets to promote patient/client control over care and services
- Reduction in statutory residential care homes for older people
- Increase support for carers and improved access to respite care
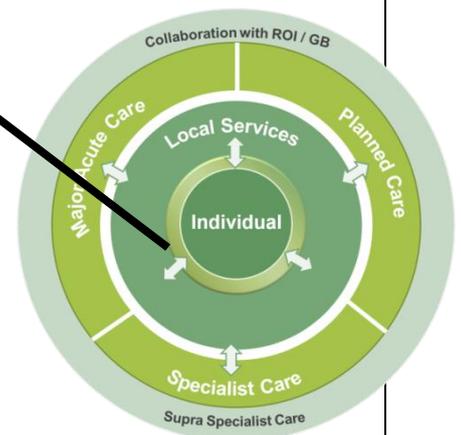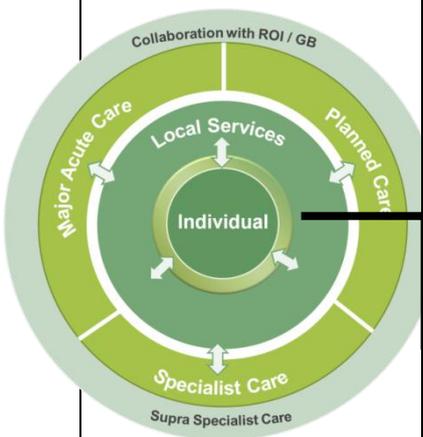
Family and child care

- **Fostering schemes** for children hardest to place
- Embed **family support hubs** to focus on early intervention
- Reduce reliance on residential care homes.
- Develop Child and Adolescent Mental Health Services.

Mental health

- **6 Admissions units** – one in each 5 of local areas plus one more unit in the Western area
- **Significant reduction in institutional care** and the number of inpatient beds across the region by 2015
- **Improved focus** on community-based treatment**.**

Physical disability and sensory impairment

- **Care closer to home**, keeping as many people with a physical disability out of hospital where possible, improve rehabilitation
- **Enhance links** between community and voluntary services, create broader range of respite

Learning disability

- Move **clients into community based options** such as supported housing, and as a consequence reduce the number of people in institutional care
- The service will **resettle** all people with a learning disability living in hospital by March 2015 to community living options with appropriate support.
- Provide **support for families and carers** including short breaks/respite and day opportunities to enable people with a learning disability to remain at home

Maternity & child health

- All children to be offered **universal child health programmes** as a means of supporting them and their families to have the best start in life.
- Safe and sustainable maternity services
- Development of **MLUs with effective links to consultant led care**
- Provide women with choice and promote normalisation of births
- Implement **Family Nurse Partnerships** to improve the health and wellbeing of children and families

Palliative care & end of life

- **Public and staff involvement** and awareness of Palliative and End of Life care (End of life care refers to the last year).
- Identification, assessment and **advance care planning**
- **Co-ordination of care** across organisational Boundaries
- Improving the **availability** of services
- Increase the number of **staff confident and competent** in core principles of palliative and end of life care

4

Acute care

- **5 – 7 networks** of hospitals to guarantee safe and sustainable services – Address fragility of services in terms of throughput and staffing levels. Changes to services provided at hospitals, localising services where possible, centralising services where necessary, creating centres for major acute services and elective services for local populations.

- 1 **regional trauma centre** for Northern Ireland

- 24/7 access to safe sustainable **cardiac cath labs**, with an investment of £8m

- A **review of paediatric services** will be undertaken in 2012/13 to take account of the recommendations as outlined in the Maternity and Child health section of TYC. This review will focus on the commissioning and provision of effective and sustainable hospital and community services, and will also incorporate paediatric palliative and end of life care.

- Ensure safe, sustainable arrangements are in place for the provision of **Paediatric Congenital Cardiac Surgery** and **Paediatric Interventional Cardiology** for the population of Northern Ireland

- Modernisation of **pathology**

- Expansion of **orthopaedic services** in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 years

- Enhanced **ambulance services** bringing patients to destination with best outcomes - Introduction of "111" urgent care number; neo-natal retrieval service for babies below 1500g

Increase our collaboration with our colleagues in ROI and GB

- Where we do not have the volumes to support specialist services we will access quality services in neighbouring health services.
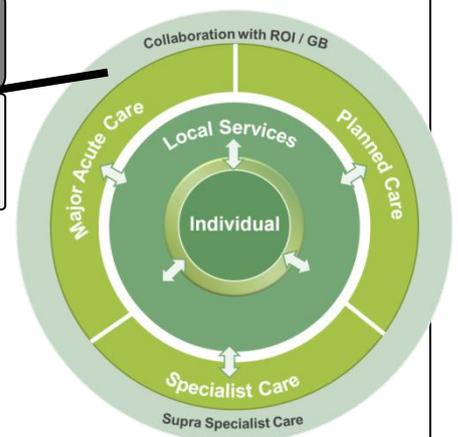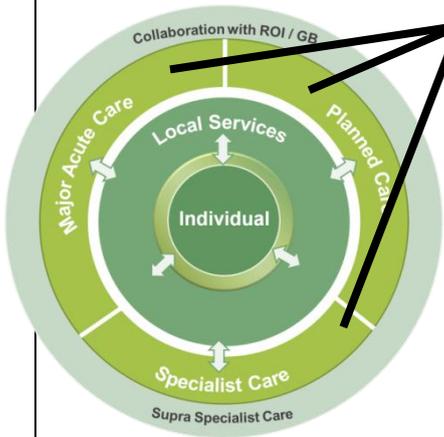
It is important to note that for each decision taken to move forward following consultation with any proposals set out in the SIP or Population Plans, then each proposal which constitutes a significant service change will also be subject its own consultation, and equality screening / impact assessment, in line with our consultation and equality schemes. Screening is completed at the earliest opportunity in the policy development or review process.

Key Constraints

The SIP and the Population Plans set out the HSCB and PHA proposed model of care and the changes we propose to put in place to achieve it. The pace at which we can achieve and implement the TYC strategy will be in part determined by the financial budgets within which we need to operate, the need to support and transition the workforce in sensitive, practical and sensible way, and how we support the independent and voluntary and community sectors to build their capacity and capability to support the shift of care into home and community settings.

TYC is not about cutting our investment and spending in health and social care services, it is about working within our budget and making the best use of the resources we have. We know our budget for the next few years. But we also know that demand will increase and that our current model will become unaffordable in the medium to long term. There is simply a financial reality that the money will not be available in line with demand. We therefore need to think about how we can do things differently whilst improving quality and safety for our patients and users.

We are committed to having a structured and sensible implementation of the TYC proposals set out in this document. The new or different services must, and will, be developed and be working well before we step down other parts of the service. For example, through demonstrating that more older people can be cared for in their own home, through the support of community nursing and support staff before making possible changes to the level of hospital services. This is critical.

TYC indicated that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15 The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to make this happen.

1.3 Main stakeholders affected (internal and external)

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

Given the wide range of proposals across all population areas and each programme of care, and systemic nature of Transforming Your Care, there is a wide range of stakeholders:

The population of Northern Ireland - with a focus on patients, clients and carers and their advocates

- Assembly Health Committee
- MLAs, MPs and local councillors
- Designated political party spokespersons on health and social care
- City, Borough and District Councils
- Community and voluntary groups (including those groups representing the interests of Section 75 interest groups).
- Independent sector (GPs, pharmacists, opticians, residential nursing home provision)
- Trades Unions
- HSC Board (HSCB) and Public Health Agency (PHA) directors and staff – it is recognised that there will be an impact on staff and this is set out in the SIP. Details of how they will be impacted is not yet known, as this will be subject to detailed planning following decisions taken after consultation period is completed.
- The Minister for Health
- Department of Health, Social Services and Public Safety
- Health and Social Care Trusts and staff
- Local Commissioning Groups (LCGs) and Primary Care Partnerships (PCPs)
- Professional representative bodies
- Patient and Client Council
- The Press and Media
- Public organisations with an indirect impact on health e.g. housing, education

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

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

As the TYC Strategic Implementation Plan, and Population Plans which underpin it, cover a range of services, a large number of major policies and decisions have impacted on its development, including inter alia:

- Acute Services Reconfiguration, DHSSPS 2012
- Commissioning Plan 2012-13, HSCB
- Bamford Action Plan 2009-2011
- Commissioning Specifications 2012-13, HSCB 2012
- Developing better services; Modernising Hospitals & Reforming Structures, 2002, DHSSPS
- Falls & Osteoporosis Strategy 2012 - 2016, Falls and Osteoporosis Strategic Implementation Board
- Draft Fit and Well: Changing Lives (out for consultation), DHSSPS, 2012
- Fitter Futures for all; Obesity Prevention Framework for Northern Ireland 2011-2021
- Healthy child, Healthy futures strategy; A framework for the Universal child health Promotion Programme in Northern Ireland, May 2010, DHSSPS.
- Infant Mental Health Strategy; Supporting families in NI. Regional family and parenting strategy, June 2011, (WHSCT)
- Investment strategy for Northern Ireland 2011-2021, Strategic Investment Board, November 2011
- Living matters, dying matters. A Palliative and End of End of Life Care Strategy for Adults in Northern Ireland, March 2010, DHSSPS.
- Maternity Strategy for Northern Ireland 2012-2018, DHSSPS
- Northern Ireland Dementia Strategy; Improving Dementia Services in NI – A regional strategy, 2010, DHSSPS.
- Northern Ireland Executive Economic Strategy, Northern Ireland Executive, January 2011
- Personal & Public Involvement Strategy, January 2011, DHSSPS
- Physical Disability and Sensory Strategy 2011 – 2015, DHSSPS
- Programme for Government 2011-15, a four year Programme published by

the Office of the First Minister and Deputy First Minister
- Psychological therapies strategy; A strategy for the development of psychological therapy services, Dec 2008, DHSSPS
- Public Health Strategy: Investing for Health, 2010, DOH
- Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland
- Ten Year Tobacco Control Strategy for Northern Ireland, 2010
- The Northern Ireland Personality disorder strategy; Personality Disorder; a diagnosis for inclusion, June 2010, DHSSPS
- The Northern Ireland Suicide Prevention Strategy & Action Plan 2006 – 2011. DHSSPS.
- Transforming Your Care: A Review of Health and Social Care in Northern Ireland, 2011

(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.

During the Review of Health and Social Care in Northern Ireland an extensive period of engagement was undertaken to inform the recommendations, which underpin the proposals set out in the Strategic Implementation Plan. This included:

- Household and Online Surveys

- Clinical and Sector Workshops

- Public Meetings

- Meetings with key stakeholders including the Equality Commission and Trade Union Side

During the development of the Population Plans and the Strategic Implementation Plan, a wide range of stakeholders were engaged to inform the proposals. This included engagement with clinicians (including Trusts and GPs) and contact and meetings with councils and public representatives, voluntary and community groups, and public meetings.

In the development of this Equality Screening, advice, information, data and support has been provided by the HSC BSO Equality Unit

A wide range of statistical data sources were used to inform this screening, including the statistical information available from Northern Ireland Statistical Research Agency (including Census information from 2011) and the NI Health and Social Care Inequalities Monitoring system Reports and bulletins.

A period of consultation on the proposals outlined in Transforming Your Care: Vision to Action ran for 12 weeks ending on the 15th January 2013.

The stated aim of the consultation was to be clear and transparent about what we are doing in a co-ordinated way rather than introducing piecemeal changes which people cannot see or fully understand. It was to focus on those areas which would see the most significant change and be as specific and explicit as

possible, to enable everyone to contribute to the difficult choices ahead.

In achieving this aim, it was important to make the consultation as accessible as possible using all established methods of engagement, such as printed materials in a range of formats, up-to-date online information and face-to-face contact through a variety of meetings and events, as well as embarking on new channels of engagement through social media.

During the consultation exercise on Transforming Your Care: Vision to Action, the TYC team was ever mindful of its duties under Section 75 to give due regard to the views of the specified groups. Actions such as mailing leaflets to every household in Northern Ireland or placing advertisements in local newspapers were engineered towards the population as a whole, to ensure all members of the public were given to opportunity to be involved.

An additional effort was made to engender engagement from the section 75 groups. For instance for those with particular issues such as sensory impairment, an audio leaflet was posted to each person registered with RNIB in Northern Ireland. In addition braille, Easy Read and audio versions of key documents were produced.

John Compton, Chief Executive of the HSCB, wrote to over 500 individuals and organisations on our stakeholder list at the launch of the consultation and again to publicise the public meetings. This list of stakeholders contains organisations representative of the section 75 groups. A number of these stakeholders were contacted directly to encourage response and offer focussed meetings or support to respond.

A number of specific stakeholder meetings were held to hear the views of section 75 groups and representative bodies and to encourage responses to the consultation. This included:

- Meetings with the Equality Commission
- Meetings with the Human Rights Commission
- Two workshop events with Northern Ireland Action Mental Health (NIAMH)
- Event with Women's Institute
- Events organised by Voluntary and Community umbrella groups; Volunteer NOW, NICVA, CO3. These events included representatives from a range of organisations.

The table below sets out usage information on these channels of engagement.

Communication and Contact Activity	Number of contacts
Household leaflet	758,780
Hard Copy documents distributed	2000 circa
Requests for alternative formats[1] of consultation document	8
Public Meetings	16
Numbers in attendance at public meetings	533
Stakeholder Meetings	26
Numbers in attendance at stakeholder meeting	280
Website Unique Visitors[2] Website Total Hits[3]	6,258 26,140
Facebook likes	40
Twitter Followers	145
Tweets/ Interactions	182 / 156

Finally, a number of activities were undertaken to raise awareness of the consultation exercise, including media briefings, press releases and articles in local and regional press at the launch and during the period. Adverts were placed in local press providing details of the public meetings being held across Northern Ireland. Every effort was made to ensure these events were as accessible as possible for people in wheelchairs and that loop systems were present for those with hearing aids. Sign Language interpreters were in attendance at public meetings organised by the TYC team, to allow deaf attendees to actively participate to the discussion.

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In addition to public meetings which were open to the general public and interest groups, there were some specific engagements with organisations such as NI Council for Voluntary Action (NICVA), senior clinical staff in Trusts and Staff Side

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[1]Alternative formats include: Braille, Audio, Large Print, Easy Read
[2] Unique visitors is the number of unduplicated (counted only once) visitors to the website during the consultation
[3] Total number of times pages were viewed during the consultation period

partners.

In total, 2242 responses were received during the consultation process. The TYC read and logged the comments from every single response to ensure that the final consultation document reflected the comments received. In addition, the questions and key points in the discussion from each public meeting were all written up and incorporated to the final consultation report.

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?
Gender	On 27 March 2011 there were **1,810,900** people resident in Northern Ireland *(Reference: Northern Ireland Statistics and Research Agency, based on 2011 Census figures)*. This equates to a 7% increase over the last 10 years. This is the highest ever recorded population in Northern Ireland. *Further detail is available from* www.nisra.gov.uk/Census/2011_results_population.html The population is comprised of 887,300 males and 923,500 females, representing 49% and 51% of the population respectively. Accurate figures on the number of transgender persons are not currently available. McBride, Ruari-Santiago (2011): Healthcare Issues for Transgender People Living in Northern Ireland estimated that the number of people who have presented with gender dysphoria in Northern Ireland is 8 per 100,000 (120) people (aged 16 and over). In Northern Ireland, it is recognised that there is a higher proportion of male to female transitions. McBride and Hansson (2010) suggest that there are between 140 and 160 individual affiliated with the three main trans support groups in Northern Ireland: The Butterfly Club, The Purple Group and the Oyster Group. It is important to note that both of these figure refer to trans individuals who are out, as trans, to some degree and are therefore both likely to be an underestimate of the number of individuals who experience gender variance in Northern Ireland. There is a higher level of disability among adult females (23%) compared to adult males (19%). Girls (4%) are less likely to be disabled than boys (8%).
Age	Compared with other UK jurisdictions, Northern Ireland had the fastest-growing and youngest population during 2001 – 2011, with an estimated increase of 7.5%. It is projected to have the youngest population during 2011-2021. This equates to 24% or 432,814 children and young people aged less than 18 years. Source: NISRA 2009 Mid-year Population

Estimates.

At the 31st March 2011 there were 2511 looked after children (LAC). This increased 5% to 2,644 by March 2012.

Within this group, 74% were in Foster Care, 11% were place with family, 8.7% were living in residential care and 6.5% were living in specialist placements.

Northern Ireland is projected to have the highest fertility rate during 2011 – 2021.
http://www.economist.com/node/2516900

Population projections indicate that the most significant change in age structure will occur in the older age bands.

In 2008, the median age in Northern Ireland was 36.5 years, projected 37.0 years in 2011, 38.8 years in 2021 and 41.9 years in 2031.

People over 60 in Northern Ireland make up 19% of the population and the number of older people is increasing rapidly.
The number of people aged 65 plus continues to rise after 2023. By 2041 it is estimated that 42% of the population will be over 50 years, 25% will be pensionable age and 14% over 75 years.

The number of older people over 65 has increased by 16% since 1999 and will show a similar increase from the current figures of 255,000 by 2015. This will include a rise of 29% in the number agreed over 85.
The number of people aged over 65 with dementia will increase by 30% from the current figure of 15,400 to almost 20,000 by 2017.

Disability prevalence increases with age.

Religion	In Northern Ireland most data is recorded on Christian Faiths. As indicted in the table below. There are gaps in the information base regarding those of non-Christian faiths and those with no faith.

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On Census Day 2011, the usual population of Northern Ireland was 1,810,863 and they indicated the following:

Religion	Per cent
Catholic	40.76
Presbyterian Church in Ireland	19.06
Church of Ireland	13.74
Methodist Church in Ireland	3
Other Christian (including Christian related)	5.76
Other religions	0.82
No religion	10.11
Usual residents who did not state religion	6.75

Source: NISRA (2012) Table KS211NI

Political Opinion

There is limited data available, however data on the first preference votes per party in NI Assembly Elections 2011, from the Electoral Commission can be used as proxy information:
DUP -198, 436
Sinn Fein – 178,222
UUP – 87,531
SDLP – 94,286
Alliance – 50,875
Other - 52,384
(Electoral Office NI, 2011)

Marital Status

The table below reveals that almost half (48 per cent) of people aged 16 years and over on Census Day 2011 were married, and over a third (36 per cent) were single. Just over 1,200 people (0.1 per cent) were in registered same-sex civil partnerships. A further 9.4 per cent of residents were either separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8 per cent were either widowed or a surviving partner.

The urban areas of Belfast and Derry had the largest proportions of

single people (47 per cent and 42 per cent respectively), while Ards and Banbridge (both 54 per cent) contained the highest proportion of married people.

Marital Status	Count	Per cent
All usual residents aged 16+ years	1,431,540	1,431,540
Married	680,831	47.6
Single	517,393	36.1
Same-sex civil partnership	1,243	0.1
Separated	56,911	4.0
Divorced	78,074	5.5
Widowed or surviving partner	97,088	6.8

Source: NISRA (2012) Table KS103

Dependant Status	At the time of the 2011 Census the total number of households totalled 703,275 of which 238,272 households contain dependent children.

Number of dependent Children in Household	Number of Households
One dependent child	103811
Two dependent children	84970
Three or more dependent children	49491
Total Households with dependent children	238272

[See NISRA Univariable table: Families with Dependent Children: QS115NI (administrative geographies)]

The number of dependent children in households was 439896.

Census Respondents were asked whether they provide any unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health / disabilities, or problems related to old age. Twelve per cent of the population
(213,980) provided such unpaid care, around a quarter (26 per cent) of whom did so for 50 or more hours per week, a total of 56,000 persons.

In the time between the 2001 Census and the 2011 Census there has been an increase in the provision of unpaid care.

Care Provided	2001 Census		2011 Census	
	Count	Per cent	Count	Per cent
Provides no unpaid care	1,500,201	89.0	1,596,883	88.2
Provides 1-19 hours unpaid care per week	110,407	6.6	122,301	6.8
Provides 20-49 hours unpaid care per week	28,000	1.7	35,369	2.0
Provides 50+ hours unpaid care per week	46,659	2.8	56,310	3.1
Total	1,810,863		1,685,267	

[See NISRA Univariate table UV021])(2001 numbers)
[See NISRA (2012) Table KS301 – Health and unpaid care] (2011 numbers)

*The term 'care' covers any unpaid help, looking after or supporting family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems related to old age.

Based on the most recent information from Carers Northern Ireland, the following facts relate to carers:
- 1 in every 8 adults is a carer
- There are approximately 207,000 carers in Northern Ireland
- One quarter of all carers provide over 50 hours of care per week
- People providing high levels of care are twice as likely to be permanently sick or disabled than the average person
- Approximately 30,000 people in Northern Ireland care for more for than one person
- 64% of carers are women; 36% are men

(June 2011)

		Count	Per cent

Disability	The term disability covers such a wide range and combination of conditions that no standard method or single source of information is available.

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It is however estimated that between 17 – 21% of our population have a disability, affecting 37% of households.21% adults and 6% children have a disability.

37% of households include at least one person with a disability and 20% of these contain more than one person. The multiple needs are explained by the fact that there is a higher prevalence of disability among adult females (23% compared with 19% adult males). Prevalence of disability also increases with age from 5% among young adults to 67% among those who are 85 plus years.
(Northern Ireland Statistics and Research Agency (NISRA) 2007)

Census figures show that in 2011, just over one in five of the resident population (21 per cent) had a long-term health problem or disability which limited their day-to-day activities, similar to the proportion in 2001 (20 per cent). Strabane and Belfast (both 24 per cent) had the highest proportions of residents with a long-term health problem or disability.

	Count	Per cent
Long-term health problem or disability: Day-to-day activities limited a lot	215,232	11.9
Long-term health problem or disability: Day-to-day activities limited a little	159,414	8.8
Long-term health problem or disability: Day-to-day activities not limited	1,436,217	79.3

Source: NISRA (2012) Table KS301 – Health and unpaid care

A high proportion of the 1860 people receiving Direct Payments have a physical or sensory disability (32% at January 2011).

In Northern Ireland there are approximately 16,500 persons with a learning disability. An indication of the extent of the disability is reflected in the sub-groupings that are traditionally used; viz mild, moderate, severe and profound learning disabilities (Equality Commission NI, 2006).
http://www.equalityni.org/archive/tempdocs/LiteratureRev(F)l.doc

	78.9% of 0 -19 year olds with a learning disability are described as having 'moderate' disabilities while 21.1% are described as 'severe/profound' (N=8150). Children and young people (0-19 years) represent the larger grouping of all the age levels (20-34 years, 35-49 years and 50+ years). McConkey *et al* (2006) predict that the population of adult persons in NI with a learning disability will increase by 20.5% by 2021 (N=10,050). This compares to an estimated increase of 16.2% in England. The percentage of persons aged over 50 years in 2021 will increase to 35.7% in Northern Ireland (up from 26.8% in 2002). The Northern Ireland Survey of Activity Limitation and Disability 2006/7 provide information on disability and other Equality categories. Gender: Almost one-quarter (23%) of adult females in Northern Ireland households indicated that they had some degree of disability, compared with around one-fifth (19%) of adult males. The somewhat higher prevalence of disability amongst adult females, in part, reflects the greater longevity of women and the higher incidence of disability that is associated with increased age. Age: The prevalence of disability amongst adults varies significantly with age, ranging from a low of 5% amongst young adults aged 16-25 to 60% amongst those aged 75 and above. Indeed, amongst the very elderly, aged 85 and above, the prevalence of disability increases to almost 67%. For both males and females the prevalence of disability increases with age. The prevalence of disability is particularly high for females aged 75 and above (at 62%). Figures 7 and 8 show that it is only amongst the youngest adults aged 16 to 25, that male prevalence rates (at 6%) are higher than the equivalent for females (4%). [See Northern Ireland Survey of Activity Limitation and Disability (2006/07)]
Ethnicity	Since the time of the 2001 Census, Northern Ireland has seen a marked change in its ethnic diversity. On Census Day 2011, 1.8 per cent (32,400) of the resident population of Northern Ireland belonged to minority ethnic groups, more than double the proportion in 2001 (0.8 per cent).

The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3 per cent of the resident population. Irish Travellers comprised 0.1 per cent of the population.

Compared with 2001, the minority ethnic count rose from 14,300 to 32,400. Gains were recorded for all groups with the exception of Irish Travellers, whose numbers fell from 1,700 in 2011 to 1,300 in 2011.

Minority Ethnic Group	Census 2001		Census 2011		Difference 2001 - 2011
Ethnic Group	Count	Per cent	Count	Per cent	Count
Total residents	1,685,267		1,810,863		
White	1,670,988	99.2	1,778,449	98.2	107,461
Chinese	4,145	0.2	6,303	0.4	2,158
Indian	1,567	0.1	6,198	0.3	4,631
Mixed	3,319	0.2	6,014	0.3	2,695
Other Asian	194	0	4,998	0.3	4,804
Other	1,290	0.1	2,353	0.1	1,063
Black African	494	0	2,345	0.1	1,851
Irish Traveller	1,710	0.1	1,301	0.1	- 409
Pakistani	666	0	1,091	0.1	425
Black Other	387	0	899	0.1	512
Bangladeshi	252	0	540	0	288
Black Caribbean	255	0	372	0	117
Total ethnic pop	**14,279**		**32,414**		**18,135**

Source: NISRA, Table KS06 (2003); KS201 (2012)

Belfast (3.6 per cent), Castlereagh (2.9 per cent), Dungannon (2.5 per cent) and Craigavon (2.1 per cent) had the highest proportions of residents from minority ethnic groups.

Those residents born outside Northern Ireland in March 2011 accounted for 11 per cent (202,000) of the proportion, compared with 9 per cent (151,000) in April 2001. This change was largely a consequence of inward migration by persons born in the 12 countries which have joined the European Union since 2004 (EU 12). These EU 12 countries accounted for 2 per cent (35,700) of Northern Ireland residents on

Census Day 2011, compared with 0.1 per cent in 2001.

The remainder of the population born outside Northern Ireland consisted of 4.6 per cent born in Great Britain, 2.1 per cent born in the Republic of Ireland, 0.5 per cent born in countries which were EU members before 2004 and 2 per cent born elsewhere.

Country of Birth	Count	Per cent
Northern Ireland	1,608,853	88.8
Outside Northern Ireland	202,000	11.2
England	64,717	3.6
Scotland	15,455	0.9
Wales	2,552	0.1
Republic of Ireland	37,833	2.1
EU prior to 2004	9,703	0.5
EU 12 Accession countries	35,704	2.0
Other	36,046	2.0

Source: NISRA (2012) Table KS204

The number of requests received by the NI HSC Interpreting Service has risen from 10,257 in 2005/6 to 63,868 in 2011/12.

According to the All-Ireland Traveller Health Study (AITHS), the Traveller population in Northern Ireland is estimated at 3905, with 1562, families. The age profile of this community is markedly different from that of the general population with 70% of Travellers aged 30 or under, and only 1% aged 65 and over. This reflects in part a higher birth rate, higher mortality rates and inward migration rates

The number of births to mothers outside the UK and Ireland have increased over the past decade with 2347 births in 2008 compared with 661 in 2001 (9% of all registered births).

The School Census (October 2008) shows that 4300 primary school children have a language other than English. (Source: Evidence collated as part of the Audit of Inequalities 2010).

Sexual Orientation	Accurate figures are not readily available, and estimates vary considerably. NISRA along with other UK census Offices concluded that the census was not an appropriate vehicle to capture such information. The 2011 census does provide some information based on same-sex

civil partnerships.

The Equality Commission's website comments that research conducted by the HM Treasury reports that between 5% - 7% of the UK population identify themselves as gay, lesbian, bisexual or ´trans´ (transsexual, transgendered and transvestites).

A 2003 briefing produced by Diversity Matters has suggested that the Kinsey statistic of 1 in 10 people within any population being lesbians and gay men is widely accepted.

Recent large scale studies would however suggest that the figures for people identifying as LGB are considerably lower. The 2010 Northern Ireland Life and Times survey (1205 adults) reported the figure as identifying as LGB was 1% and the Office for National Statistics (ONS) 2010 report (450,000 respondents) found that 92.5% reported that they were heterosexual and 0.9% of respondents identified as LGB in Northern Ireland although 0.4% reported as other and 6.2% reported that they didn't know or declined or refused to respond.

Between 2005 and 2011, there have been 537 Civil Partnerships recorded (NISRA)

Qualitative Data

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

Category	*Needs and Experiences*
Gender	In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. Female life expectancy has consistently been higher than that for males however this gender gap has declined in recent years. In addition, the influence of social conditions and lifestyle behaviours is evident when comparing life expectancy for men and women across geographical areas – males living in the 10% least deprived areas in NI could expect on average to live almost 12 years longer than those living in the 10% most deprived areas. For females, the gap is more than 8 years. Men and women are prone to different types of diseases at different ages, and there is different prevalence of health behaviours. For example: - Smoking prevalence – 25% males, 23% females - Around a quarter of males (27%) drank above weekly limits compared with 16% of females - A similar proportion of males and females were obese, however males were more likely to be overweight than females (44% and 30%) - Males are more likely than females to meet the recommended level of physical activity (44% and 35%) - Females were more likely to show signs of a possible mental health problem (23% and 17%) - On average, the suicide rate is twice as high in deprived areas and males are three times more likely than females to die by suicide. - Young males in deprived areas are particularly vulnerable, as are marginalised groups such as those who are unemployed, or people with mental illness and addiction problems. - Men are 3 times more likely to be killed in a road accident, die of a heart attack and twice as likely to die from lung cancer.

	- Men are at significantly greater risk than women from nearly all common cancers that occur in both sexes (with the exception of breast cancer) - Transgender individuals have higher level of mental health issues and are more likely to attempt suicide. - Suicide rate in Traveller men is 6.6% times higher than the general population In addition, evidence suggests that men have higher levels of risk behaviour but are less likely to attend their GP or leave it late to attend. The impact of leaving attendance at GPs too late is that men are more likely to attend Accident and Emergency Services (Evidence collated for Audit of Inequalities 2010). Responses to the Vision to Action Public Consultation from The Women's Support Network and Women's Resource and Development Agency noted that women are more likely than men to have caring responsibilities. The Northern Ireland Society of Social Workers (NISAW) agreed adding that the proposals could "increase the burden on this section of the community." Carers NI drew attention particularly to women bringing up their own children while simultaneously caring for a parent. Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey http://www.csu.nisra.gov.uk/survey.asp29.htm The differences in life expectancy, health behaviours and the prevalence levels of some conditions and disabilities indicates the impact of the new model of care proposed by TYC will be different across this Equality category.
Age	According to the 2010/11 Health Survey Northern Ireland (HSNI) the proportion of respondents reporting their health as not good increased with age (3% of 16-24 year olds, compared with 25% aged 75 or over). Similarly the proportion of respondents indicating they have a long standing illness increased with age from 14% of 16-24 year olds to 70% in the age group of 75 and over. Over the next 40 years as society ages dementia will become more common. There are differences across the genders as women live longer than men.

A review by The Kings Fund across the NHS found evidence that older people may be being denied treatment offered to younger patients, and in some hospitals, the standard of hygiene and nutrition given to older people can fall below minimum standards. The Kings Fund concluded that while there are many examples of excellent care for older people, there is also much unfair treatment which was age related.

http://www.kingsfund.org.uk/publications/old_habits_die.html

Some evidence on the attendees at Accident and Emergency Services suggests that attendees are younger 22-44 years and attend at peak times (mid night to 2pm). (Audit of Inequalities Evidence 2010)

In terms of Children in Need there are 23807 children recorded in this way. A total number of 2357 are registered on the Child Protection Register (Children's Order Statistical Tables May 2011).

Looked After Children are not a homogenous group but rather their needs are complex and diverse, many will have experienced some degree of trauma prior to becoming looked after. The incidence of mental health problems is markedly higher amongst this group when compared to the general population and many also face complex and enduring interpersonal problems which may make it difficult for them to accept help and support or maintain therapeutic relationships.

The proposals set out in TYC and in the SIP will have impact on all age groups. Within this however, specific proposals in relation to older people (including proposals relating to statutory residential care and re-ablement), integrated care partnerships, mental health, maternity and child health, and family and child care will have differential impacts on particular age groupings.

Age discrimination was referred to by a number of respondents during the Consultation process, with the Equality Commission making reference, in a stakeholder meeting, to the possible introduction of new age discrimination legislation, and for account to be given to the possible effect of this. Care for the elderly was commonly presented as an area of concern, with a small number of respondents interpreting the reduction of statutory residential care as age discrimination.

The need for flexible and "age appropriate" services was addressed by individuals and by the Patient Client Council. The disparity between

children's and adult services in learning disability has been mentioned by a number of respondents, with the period of transition from childhood into adult services indicated as an area that needed particular attention.

Of those who responded using a questionnaire format 73% agreed or strongly agreed with the proposals relating to Older People. This endorsed the proposals for older people and welcomes the aspiration to provide care for older people closer to home where possible and appropriate. Respondents did stress there must be choice in the models of care available because people's needs are different. For some older people, care closer to home may not be suitable to meet their needs, considering their health and social circumstances.

The majority of consultation responses from those who disagreed with the proposals for older people were related to Statutory Residential Homes.

Some respondents on this proposal were anxious that if some statutory residential facilities closed, there would be a gap in provision of service for people for whom support was currently provided in such settings. It was clear that the public wish to have detail on what alternative support services would exist in each locality to address the needs that are currently being met by statutory residential care, and to be reassured that these would be as good if not better than the current arrangements.

Also some asked for consideration of issues of social isolation and the role that statutory residential homes currently play in providing social interaction for people by virtue of sharing accommodation. Respondents wanted to be reassured that this issue would be given priority status in any planning to reduce residential provision so that people who received an alternative form of care to statutory residential care in future would still have the opportunity to spend time with other people.

Some concerns were noted around the process of moving current residents to different settings if their current home closed, and how this process would be managed to minimise distress to residents and families. Reminders were provided that for residents, this is their home.

Religion	Once social needs are accounted for religion does not have a significant independent influence on health status or uptake of services. There is no evidence that there will be a differential impact on this category related to the model and proposals set out in TYC and the SIP
Political Opinion	A DHSSPS literature review into equality and human rights issues in relation to access to health and social care explained the difficulty with determining how well statutory health and social services are performing in relation to political opinion. This difficulty lies, in part, with the current lack of research into how political opinion impacts upon equity of access to health and social care services. http://www.dhsspsni.gov.uk/eq-literature-review There is no evidence that there will be a differential impact on this category related to the model and proposals set out in TYC and the SIP
Marital Status	The Section 75 Analysis of Mortality Rates in NI 2003 – 2007 Report found that those who were married or co-habiting (partnered living) experience lowest mortality rates and highest life expectancy rates. It is also generally considered that partnered living is associated with higher psychological well-being than being single. There is some evidence that the incidence of cancer is higher amongst those who are separated, widowed or divorced There is limited evidence that the model or proposals set out within TYC and the SIP will have a significant differential impact in relation to this Equality category, although it is recognised this has a close link to the dependent status as in many cases the carer is also the spouse or partner.
Dependent Status	Carers often neglect their own physical and mental wellbeing and are Twice as likely to be sick or permanently disabled More likely to experience high levels of psychological distress, including anxiety, depression and loss of confidence and self-esteem than non-carers.

Women are more likely to be informal carers than men.

Also, it is recognised that persons with dependents can find it more difficult to access in hours unscheduled care and have difficulties regarding the flexibility of appointment times in order to access health care services

Carer experience: Carers indicate that they are often viewed by staff as additional competitors for scarce resources rather than as equal partners in the care of the person. They sense staff ambivalence rather than the prospect of collaboration. Trust training programmes include development sessions on this for staff, yet day-to-day practice still lags behind the aspirations of partnership. (HSCB Audit of Inequalities 2010)

Short breaks - Respite care: There is little consistency in targeting carers in need of respite – a Trust may have several sets of criteria. Better methods of assessing the strain and stress of caring as experienced by carers are required (HSCB Audit of Inequalities 2010). Young adult carers experience the move from being supported as a young person through Children's Services to the support provided as an adult as inappropriate. (HSCB Audit of Inequalities 2010).
There are also multiple needs experienced by parents and carers who themselves have disabilities but who are looking after their children

There is a lack of information on the needs of fathers who care for their disabled children and on the needs of minority ethnic groups and single fathers and on the needs of single fathers who are carers

(See review entitled *"Emerging Themes Across Health and Social Care(2010*)

Improving support for carers is one of the key objectives of TYC and the proposals set out in the SIP, and those proposals in relation to respite and support will have a disproportionate impact on those with dependents. Also in the shift towards more care in community settings and reduction of long term residential care there is evidence that the proposals will have a significant impact on those who make up this Equality category.

The issues that affect carers were highlighted more frequently than any other issue in the consultation responses, with the exception of local acute hospital comments. The general public, Voluntary and

Community sector groups and staff organisations all stressed the importance of being better at identifying carers, assessing their needs and putting resources in place to support them.

"The quality, planning and delivery of community care with carers at the core must be fully resources and supported." – Carers Trust

Respondents frequently referred to the planned shift of services from hospital to community settings, and stressed how this depended in some cases on the availability of carers, and how this could be a potential problem given changes in social structures in recent decades.

Promoting greater awareness of the role of carers, greater uptake of Carers' Assessments and a more robust response on the part of HSC to supporting carers was felt to be the core of a better approach to this issue. The provision of appropriate respite that is flexible to meet the different needs of different populations, was felt by most people to be a critical component of providing better support for carers. It was also viewed as important that carers were engaged effectively when planning and delivering services.

"Carers need to be involved in any planning group that is working on respite/short break models" – Carers NI

Whilst TYC and *Vision to Action* recognises the importance of carers, and there are specific proposals within some Programmes of Care, we are committed to further enhancing the plans we have drafted for the implementation of TYC as follows, subject to the Minister's approval to proceed:

- Review the Strategic Implementation Plan for TYC to ensure that supporting carers is given sufficient profile and priority in taking forward TYC. We will develop a specific overarching section or project to address carers' needs, recognising the challenges experienced in the past with developing a regional view of the approach to carers' needs and respite.
- Actively engage with carers in the design of new care pathways, where appropriate.
- Take every opportunity to promote Carers' Assessments and encourage service partners to do likewise. Ensure senior management review data on uptake rates for Carers' Assessments to track progress at promoting wider access to

	these. • Ensure that the health and social care needs assessment process incorporates findings from Carers' Assessments where available so that there is a much better regional understanding of the range of services carers need most, including respite, that is then fed into the service redesign and commissioning processes.
Disability	In Northern Ireland people experience the lowest disability free life expectancy (Age NI, 2010). Our mental health needs are 25% higher than the rest of the UK and yet we spend 25% less to address them. Only a small proportion of the disabled population in Northern Ireland is in regular contact with HSC services, approximately 16,500 contacts are made with Trust disability services each year. 400 people are in nursing or residential care but the heaviest reliance is on community based day and domiciliary care, specialist equipment and therapeutic interventions. In general people with disabilities are likely to be less well qualified, much less likely to be economically active and therefore in employment, much more likely to be poverty, much less likely to enjoy active social life and more likely to suffer poor health including poor mental health. Given the wide range and combination of conditions, those with physical and sensory impairments face a range of accessibility, attitudinal and communication barriers when accessing health and social care services and information. People with a learning disability are more likely to experience major illnesses, to develop them younger and die of them sooner than the population as a whole. UK reports indicate they have higher rates of obesity, respiratory disease, some cancers, osteoporosis, dementia and epilepsy. It is estimated that those with a learning disability are 58 times more likely to die prematurely. The prevalence of psychiatric disorders is significantly higher among adults with learning difficulties when compared to general population rates. However, even with such a dramatic health profile, the learning disability population are less likely to receive the screening, check and

	treatments they need. They continue to face challenges in accessing services and information about services, as set out the TYC Report. The model and proposals set out in TYC and the SIP target those within this Equality category with the aim of addressing health inequalities experienced by those within this category. In addition the specific proposals relating to increased personalisation of care, diversity of choice in service provision, and resettlement of those in long stay residential care will have a significant impact on those in this category.
Ethnicity	National research suggests that there are differences within Black and Minority Ethnic (BME) groups generally when compared with the white population and they experience worse health outcomes. Ill health often starts at an earlier age. There are variations from one health condition to another. There are also differences across the age groups with the greatest variation in worse health amongst the older ethnic minority groups. For example minority ethnic groups have greater rates of cardiovascular disease than white people but lower rates of many cancers. Diabetes is more common in BME groups and hypertension is more common in Asian groups Evidence suggests that there is a lack of knowledge amongst BME groups about social care services, including respite services for people with disabilities. In particular services for those with dementia and their carers. Employed men and women in the Pakistani, Bangladeshi and Indian communities have particularly high rates of caring, and therefore the proposal in relation to respite and support for carers will impact on this group in particular. There is an increased rate of mental health issues for those newly arrived in the country, and those seeking asylum, in particular children. In relation to Travellers, the All Ireland Traveller Health Study found that: • Parents rate their children's health positively and update of immunisations and dental care is high • There is no evidence of a higher prevalence of disability that limits daily activity • Overall mortality is 3.5 times higher than in the general population for both genders

	- Life expectancy is much lower – 11 years less for females and 15 years less for males - Infant mortality rates are also higher than in the general population - There is a higher burden of chronic diseases - Male Travellers have a significantly higher suicide rate – 6.6 times that in the general population. This study also found that Travellers access health service more frequently than the general population with attendances at A&E and hospitals rated as more positive that than experiences in primary care / GPs. As more health and social care services will be accessed through primary and community care settings, this may indicate a disproportional impact on the category Consultation responses voiced concerns relating to the proposed shift of services into the community. With some respondents noting worries about the availability of foreign language interpreters and signers for deaf patients following these changes.
Sexual Orientation	A number of reviews have concluded that people who are *Gay, Lesbian and Bi Sexual and* 'Trans' (Transsexual, Transgendered, and Transvestites) (LGBT) are at significantly higher than average risk of mental health disorder with higher rates of anxiety, depression, self-harm and suicides alongside higher problem drug and alcohol use. These issues often relate to homophobia (including internalised homophobia) have a profound effect on self-esteem, discrimination, family rejection and isolation. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people in BMC Psychiatry in June 2008 showed that LGBT people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. The results of this meta-analysis demonstrate a two-fold excess in risk of suicide attempts in the preceding year in men and women, and a four-fold excess in risk in gay and bisexual men over a lifetime. Similarly, depression, anxiety, alcohol and substance misuse were at least 1.5 times more common in LGB people. Findings were similar in men and women but lesbian women were at particular risk of substance dependence, while lifetime risk of suicide attempts was especially high in gay and bisexual men.

	Young people who identify as LGBT are – • At least 2.5 times more likely to self-harm. • 5 times more likely to be medicated for depression. • At least 3 times more likely to attempt suicide • 20 times more likely to suffer from an eating disorder than their heterosexual counterparts. The model and proposals set out in TYC and the SIP, particularly in relation to accessing support and services for mental health issues, especially for young people may have a differential impact on those in this category as they are more likely to need to access these services, when compared to the general population.

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.

It is recognised that people are complex and the ways in which we define ourselves are complex. Our physical characteristics, histories, influences, behaviours, cultures and subcultures are all exceptionally intricate narratives that we use to identify ourselves .We are all constantly defining and redefining different aspects of ourselves.

The model and proposals set out in Transforming Your Care and the Strategic Implementation Plan also acknowledges the cross cutting needs of the equality groupings. It recognises the need to take into account geographical differences and issues facing people who live in areas of high deprivations. This is important because, for example, people from minority ethnic groups, lone parents and disabled people are over represented in the areas of greatest deprivation. The 20% of most deprived areas in Northern Ireland represent nearly 340,000 people.

There is clear evidence of health inequalities in Northern Ireland, the consequences being poorer health outcomes observed in the most deprived areas than in the region generally such as:
- lower life expectancy;
- 33% higher rates of emergency admission to hospital;
- 72% higher rates of respiratory mortality;
- 59% higher incidence rates of lung cancer;
- 82% higher rates of suicide;
- self-harm admissions at more than twice the Northern Ireland average;
- 55% higher rates of smoking related deaths; and
- 124% higher rates of alcohol related deaths.

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?

The Transforming Your Care (TYC) Strategic Implementation Plan (SIP) sets out a strategic direction of travel, based on the model of care described in the Transforming Your Care Report and in response to the proposals set out in TYC outlining the proposed key service changes over the next 3 to 5 years.

A 14 week consultation period will take place until January 2013, after which decisions will be taken on the way forward. Each of service change proposals set out in the Strategic Implementation Plan will be subject to equality screening, consultation and where relevant equality impact assessment, in accordance with the HSCB schemes.

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?*
During the Review of Health and Social Care in Northern Ireland, a number of equality issues were identified through research and widespread engagement with stakeholders from across the HSC organisations and with external stakeholders. As a result, the reduction of health inequalities, such as those described in this document, emerged as one of major reasons for why transformational change was required across our health and social care system, and became one of underpinning principles of change. In the development of the TYC recommendations and subsequently the SIP, it is explicitly recognised that many of the proposals are not new but rather bring together and accelerate on-going service changes. Examples include proposals in relation to the Bamford groups, the implementation of the Maternity Strategy and the proposals for palliative and end of life care. The equality aspects these policy decisions have already been considered and assessed as appropriate in the development of these policies.	We intend to • Build in Equality and Human Right issues as a core element on the Project Initiation Documentation for all initiatives under the HSCB TYC Programme • Screen and undertake Equality Impact Assessments (EQIA's) in any service change or new proposals • Ensure there is ongoing participation from the TYC Programme in the HSCB Equality and Human Diversity Working Groups • Seek to meet regularly with the Equality Commission and Human Rights Commission. Report to the TYC Programme Board on a bi-annual basis on equality issues, or more regularly as needed • Ensure that all staff within the TYC Programme team receive training on equality and related issues • Work closely with the information teams to identify appropriate data measures for TYC initiatives, including equality

Specific recommendations designed to address inequalities identified were also included in both TYC and the draft plans.

During the development of the Population Plans which underpin the SIP, each of the local areas conducted engagement processes to involve range of stakeholders in the development of their plans. This included councils and public representatives, voluntary and community groups, and in some areas, public meetings.

The TYC Programme Team met with the Human Rights Commission in advance of the publication of the consultation document, this resulted in amendment to the question asked on human rights in the consultation process.

During the TYC Consultation Process, questions which focused specifically on the perceived impact of the proposals on equality issues were posed, and responses were analysed and reported on in the subsequent Consultation Report. Which can be found on the Transforming Your Care website:
www.tycconsultation.hscni.net

data; ensure this is a core element of the service and workforce planning models going forward

• Work closely with the commissioning teams to ensure that equality data is shared and up to date

2.6   Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (Refer to guidance notes for guidance on impact)

Group	Impact	Suggestions
Religion	No impact has been identified at this point	None
Political Opinion	No impact has been identified at this point	None
Ethnicity	No impact has been identified at this point	None

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

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

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

Please tick:

Major impact	✓
Minor impact	
No further impact	

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

Please tick:

Yes	
No	✓

Please give reasons for your decisions.

The plan outlines an overall strategic direction of travel, through which one of the stated objectives is the reduction in health inequalities and the promotion of equality of opportunity.

Many of the proposals in the TYC Strategic Implementation Plan are not new. Rather, TYC seeks to bring these together in a clear and coherent picture and bring all the changes into a managed programme of transformation to avoid haphazard changes which could potentially have unintended consequences for patients, staff, users and carers.

Therefore many of the policies underpinning the proposals have already been screened or assessed as appropriate to the policy or decision and in accordance with the relevant schemes. For those service changes which will new or represent a significantly different way to provide health and social care services, it is recognised that the impact will be felt across the region and that some groups will be impacted more than others.

However, given the strategic nature of the plans set out in the SIP and the Population Plans, the detail of implementation is currently being worked out, and would take place over the next 3 to 5 years (subject to the availability of resources). As these become clearer, and further evidence on the nature of the impact on each group becomes clearer, all such changes would be subject to robust screening, Equality Impact Assessment (EQIA), where applicable, and public consultation. Similarly in relation to impact on staff the Strategic Implementation Plan recognises that the service changes proposed would have

an impact on some staff in terms of a change in role. Also, the working assumption, as set out in the consultation document, is that the overall HSC workforce may reduce by 3%. There are no proposals which would involve the transfer of staff to an organisation outside the HSC. The detailing planning of how this would take place, and who within the HSC workforce may potentially be impacted, can now be considered as part of the implementation planning following the consultation period.

The equality issues as identified in this screening exercise and as an outcome of the associated consultation would inform these future screening exercises. It is at this point that the impact of the changes upon equality of opportunity would be clearer and can be properly assessed in a more meaningful way. In addition as the overall TYC Programme progresses detailed plans would be drawn up to set out the implementation activities, equality and human rights would be considered as a core element of this process.

During the public consultation process there were there were calls from a small number of organisations for a full Equality Impact Assessment (EQIA) to be undertaken for the entire TYC programme at the earliest opportunity. Northern Ireland Council for Ethnic Minorities believes that, a full EQIA is required as:
"TYC represents a new strategic direction with particular vision, aims and priorities and thereby represents a fundamental shift in the delivery of all existing health and social care provision." – NI Council for Ethnic Minorities

Whilst we acknowledge the calls for an EQIA at this point, we remain of the view that it would not be meaningful to conduct an assessment on an overarching strategic vision, rather it would be more meaningful for specific service changes to be subject to full impact assessment as the specific impact on Section 75 groups can be fully assessed once detailed plans are known. This view also recognises that some of the proposals have already been subject to screening and EQIA when they were developed as policy. We are therefore not proposing to conduct a full EQIA at this point, but will continue to keep this under review.

(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?*
Not specifically. As a model of care, TYC promotes the principle of increased independence and personalisation of care for those with disabilities.	The HSCB is committed to engaging with all its stakeholders in the planning and implementation of its obligations under TYC. The relevant workstreams and project teams will actively, and on an on-going basis, seek to identify opportunities to engage with disabled people in the development and implementation of their plans. The central TYC Programme will put in place active engagement of a wide range of stakeholders.

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?*
Not applicable	Not applicable

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

Transforming Your Care will inevitably impact on the lives of individuals in Northern Ireland, as the overall aim is to ensure that the citizens of Northern Ireland have access to safe, high quality and sustainable services which responsive to their needs and delivered close to home, where it is safe and appropriate to do so.

It is intended that the principles outlined in Transforming Your Care would positively impact on people. Hence, there are no known issues or adverse impact on human rights at this point in time. Cognisance was taken of the human rights particularly Articles 2, 3, 5, 6, 8 and 14.

In consideration of the impact on Human Rights cognisance has also been taken of the right to health as enshrined in a number of international treaties, including Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR). Discussions are on-going with the Human Rights Commission to ensure that any potential human rights impact or interference presented by the proposals in the SIP are identified during the consultation process

Also as the specific service change proposals set out in Transforming Your Care and the Strategic Implementation Plan are further screened and taken forward (subject to consultation) the human rights aspects of decisions would be examined in order to identify any areas of impact or interference, and how it might be possible to limit this.

ARTICLE	Yes/No
Article 2 – Right to life	Yes
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	Yes
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	Yes
Article 6 – Right to a fair & public trial within a reasonable time	Yes
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.	Yes
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	Yes
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 interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise any legal issues?* Yes/No
2, 3, 5, 6, 8 and 14.	Specific service changes or new proposals will consider the implications of human rights in the context of those identified. In many instances the proposals will be to help promote of human rights. Where there is potential interference due regard will be given to this and legal advice sought where necessary.		

* 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.

As the TYC Programme progresses, it is our intention to meet on an on-going basis with the Human Rights Commission to discuss and better understand how we can monitor and assess human rights impacts of changes in health and social care provision as a result of TYC.

Human Rights awareness will be a core element of training for TYC Programme Team members. It will form a core element of the Project Initiation Documentation required by each project started though the TYC Programme and reporting on this element of TYC will be collated and presented to the TYC Programme Board on a bi-annual basis, or as required.

In a wider context, the HSCB is also considering best practice in relation to adopting and promoting a Human Rights Based Approach. Once pilot activity is undertaken in one Directorate it is our intention to consider the wider applicability including to TYC Programme.

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights
On-going monitoring and screening of TYC project plans in accordance with Section 75	On-going monitoring of patient and carer involvement in key working and planning groups related to TYC with an emphasis on disability groups to monitor their participation in the planning and implementation of TYC	Further discussion with the Human Rights commission to identify appropriate data indicators and data sets

Approved Lead Officer: John Compton

Position: Chief Executive

Policy/Decision Screened by: Emma Holden and Pamela McCreedy

Signed:

Date: 28th June 2013

Please note that having completed the screening you will need to ensure that a consultation on the outcome of screening is undertaken, in line with Equality Commission guidance.

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