Equality, Good Relations and Human Rights Screening Template

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:

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)

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

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

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 (follow the links).

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

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

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Commissioning Plan 2012/13

The Plan takes full account of the financial parameters set by the Executive and DHSSPS, and is consistent with the direction and priorities set out in the Minister’s Commissioning Direction and Indicators of Performance for 2012/13.

1.2 Description of policy or decision

- What is it trying to achieve? (aims and objectives)

The Commissioning Plan aims to provide a clear roadmap for the development of health and social care services for the population of Northern Ireland. The Plan builds upon the work in previous years and also is fully consistent with and supportive of the long-term direction set out within Transforming Your Care and in the Quality 2020 Strategy. While the primary focus of the Plan is on the 2012/13 financial year, many of the changes signalled will be implemented over a much longer timescale, up to and beyond 2015.

This Plan sets out the level of service that the population of NI can expect to receive, and the changes that are necessary to existing services to secure this.

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. The plan outlines a direction of travel.

Many of the changes outlined within the plan will be subject to individual screening, public consultation and / or equality impact assessment prior to implementation.

- How will this be achieved? (key elements)

The Health and Social Care Board (HSCB) has organised its commissioning teams to reflect key service areas. Commissioning proposals are therefore presented in the following service areas:

1. Health and Social Wellbeing Improvement, Health Protection and Screening
2. Unscheduled Care
3. Elective Care
4. Cancer Care
5. Palliative and End of Life Care
6. Long Term Conditions
7. Maternity and Child Health
8. Community Care, Older People and Physical Disability
9. Children and Families
10. Mental Health and Learning Disability
11. Prison Health
12. Specialist Services

Each service area has a dedicated team which is tasked with working with stakeholders to identify and deliver on the commissioning priorities within their service area for the year. During the course of the year, teams will work up detailed plans which outline how the priorities will be met. Detailed equality screening and impact assessments may be required in relation to a number of the priorities identified and these will be completed in advance on any service changes being taken forward.

The Board is also supported by five Local Commissioning Groups (LCGs). LCGs have developed a wide range of relationships with their local communities and are responsible for working with Trusts and other stakeholders in bringing forward Local Economy Population Plans during May 2012.

- **What are the key constraints? (for example financial, legislative or other)**

Key drivers for change are identified in the Commissioning Plan:

**Demography** – a rising population in Northern Ireland

**Quality 2020** – sets the focus clearly on improving quality and making Northern Ireland a leader for excellence in health and social care

**Programme for Government 2011-15** – a four year programme directing positive action on public health, vulnerable adults and children, tackling obesity and improving elective care through reform and modernisation

**Health and Social Care Resources** - maximising the productivity of resources already available

**Transforming Your Care** – guiding the recommended model of delivery of HSC

**Workforce** – the need to plan the transition of staff from acute to community settings in line with reform and to ensure service quality directed by the above

**Information Communication Technology** – helping the service to work smarter
and more efficiently.

Commissioning decisions will be explicitly stated whether these are concerned with cost reduction and / or quality improvement.

The overall direction of the Commissioning Plan is to improve quality and effectiveness. Commissioners will take decisions in an informed and sensitive manner that takes into account the potential implications for individuals and communities. As with every year there are no neutral decisions. Unnecessary preservation of an existing pattern of service delivery will in all probability mean denial of new developments. Making choices is a reality for any commissioning system. This is vitally important to understand in the financial climate that commissioning is entering.

1.3 Main stakeholders affected (internal and external)

- 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, pharmacists, residential nursing home provision)
- Trades Unions
- HSC Board (HSCB) and Public Health Agency (PHA) directors and staff
- 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
- Voluntary and Community Sectors
- 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?
A large number of policies and decisions have impacted on the Commissioning Plan, including:

- Transforming Your Care, the review of health and social care that describes a future vision for health and social care in Northern Ireland;
- Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland;
- Programme for Government 2011-15, a four year Programme published by the Office of the First Minister and Deputy First Minister;
- Healthy Child, Healthy Future – A framework for the Child Health Programme in Northern Ireland;
- The consultation on the Child and Adolescent Mental Health Service (CAMHS) Policy Guidance issued by the DHSSPS;
- Healthy Futures, 2010-2015 – The contribution of Health Visitors and School Nurses in Northern Ireland (NI);
- New Strategic Direction for Alcohol and Drugs (Phase 2 December 2011);
- Hidden Harm Action Plan;
- Young People's Drinking Action Plan;
- A Healthier Future;
- A Fitter Future for All – Addressing and Preventing Obesity in NI (June 2011);
- Tobacco Control Strategy for NI (2011);
- Skin Cancer Prevention Strategy and Action Plan (June 2011);
- Sexual Health Promotion Strategy and Action Plan;
- Home Accident Prevention Strategy and Action Plan (Under review)
- Breastfeeding Strategy (under development);
- The NI Civil Contingencies Framework (OFMDFM November 2005);
- The National Risk Register of Civil Emergencies (Cabinet Office);
- The UK’s Strategy for Countering Chemical, Biological, Radiological and Nuclear (CBRN) Terrorism (Home Office 2010);
- UK Influenza Pandemic Preparedness Strategy (November 2011);
- DHSSPS Policy Circular HSC (PHD) 01/2010 – Emergency Preparedness for HSC organisations;
- Bamford Action Plan 2009-2011 (2009);
- Tackling Sexual Violence and Abuse 2008-2013;
- Tackling Violence at Home;
- Cooperating to Safeguard Children 2003;
- Building the Community Pharmacy Partnership;
- Tobacco Action Plan;
- Best Practice Best Care – April 2001;
- Minimum care standards for:
  - Residential Homes – January 2008;
  - Nursing Homes – January 2008;
  - Domiciliary Care Agencies – July 2008;
- Further standards for Residential Family Centres, Adult Daycare, Daycare and Childminding for Children Under 12, and Dental Care and Treatment (updated 2011);
- Safety First – March 2006;
- Cleanliness Matters (revised strategy 2011/12);
- Changing the Culture 2010 – Strategic regional action plan for the prevention and control of healthcare-associated infections in NI (Published January 2010);
- Implementation of the recommendations made by the Public Inquiry into Clostridium Difficile in Northern Trust Hospitals;
- Regional Decontamination Strategy – 27 February 2004 (HSS (SC) 3/04) – Revised 9 October 2008 (RDS/0802);
- Endorsed National Institute for Clinical Excellence (NICE) guidance, and pay due regard to best practice guidance issued by the Social Care Institute for Excellence and Global Alliance for Improved Nutrition;
- Service Framework for Cardiovascular Health and Wellbeing (Directive Letter Ref – BOARD DIR 01 2009-10). (Note: this was sent while Dr McBride was
Acting Permanent Secretary, letter was sent on 12th June 2009);

- Service Framework for Respiratory Health and Wellbeing (Directive Letter ref – AMCC 2864);
- Mental health Service Framework – due to be launched for implementation planning later in 2011;
- HSC (SAFETY, QUALITY & STANDARDS DIRECTORATE) Circulars on safety matters – A list of all circulars and letters can be found at DH1/10/107373;
- HSC (SAFETY, QUALITY & STANDARDS DIRECTORATE) Learning Letters;
- SAFETY, QUALITY & STANDARDS DIRECTORATE letters relating to Confidential Inquiry reports;
- Regulation and Quality Improvement Authority (RQIA) three-year review programme 2009-2010 (and related reports);
- Ward Sister’s Charter;
- Get your Ten a Day – The Nursing Care Standards for Patient Food in Hospitals;
- Promoting Good Nutrition – A strategy to improve nutritional care for adults in all care settings;
- Developing Services to Children and Young People with Complex Healthcare Needs (July 2009);
- Improving the Patient and Client Experience – 5 Standards;
- Living Matters, Dying Matters – a Palliative and End of Life Care Strategy for Adults in NI (March 2010)
- Adoption Minimum Standards for NI – under development;
- Regional Standards for Leaving Care Services in NI – under development;
- Standards for Young Adults Supported Accommodation Projects in NI – under development;
- Kinship Care Standards – under development;
- Eyecare Services Strategy for NI – (consultation outcomes being considered)
- The NI Civil Contingencies Framework (OFMDFM November 2005);
• DHSSPS Controls Assurance Standard – Emergency Planning (updated and reissued 2011);
• BS25999 – British Standard for Business Continuity;
• Evaluation of Neonatal Services – 2011;
• Legal issues relevant to donation after circulatory death (non-heart-beating organ donation) in NI –March 2011;
• Regional Review of Dental Hospital Services –2011;
• Cancer Framework 2008;
• Recommendations for the Future of Pathology Services in NI –December 2007;
• Improving Stroke Services in NI –July 2008;
• Improving Services for Major Trauma –February 2009;
• Review of Adult Neurology Services 2002;
• Promoting Quality Care: guidance on risk assessment and management in mental health and learning disability services (2010);
• Reform Implementation Team Standards and Guidance 2008;
• Making it Better – published in 2004;
• Pharmaceutical Clinical Effectiveness Programme;
• NI Formulary;
• People First;
• Caring for People Beyond Tomorrow – October 2005;
• Developing Better Services – announced February 2003;
• Caring for Carers;
• Families Matter – issued March 2009;
• Care Matters –September 2009;
• Adult Safeguarding in NI;
• Aging in an Inclusive Society (cross government);
• Children and Young People’s Strategy (cross government);
• Tackling Sexual Violence and Abuse 2008-2013;
• Tackling Violence at Home (2005);
• Acquired Brain Injury Action Plan (2010);
• Speech and Language Therapy Action Plan (2011);
• Challenge and Change (2005);
• Proposals for the Reform of the NI Wheelchair Service (2008);
• A Strategy for the Development of Psychological Therapy Services (2010);
• Personality Disorder: A Diagnosis for Inclusion (2010);
• Autistic Spectrum Disorder Action Plan (Regional Reference Group) (2009);
• Autism Act (NI) 2011;
• Low Secure Report: A scoping paper to inform future mental health service provision (2010);
• A range of service frameworks in Cardiovascular, Respiratory, Cancer and Mental Health Services;
• Guidelines for Maternity Services Liaison Committees (May 2009);
• The Children (NI) Order 1995 Guidance and Regulations Volumes 1-8;
• Circular CCPD 1/10 – Guidance on Delegated Authority to foster Carers in NI issued February 2010;
• Circular CCPD 2/10 – Guidance on Conditions to be considered on the Continued Placement of an 18 Year in Registered Children’s Home issued October 2010;
• Delivering Excellence: Supporting Recovery: A Professional Framework for Mental Health Nurses in NI (2011-2016);
• Revised criteria for accessing publically funded fertility services – published March 2009;
• Making It Better – A Strategy for Pharmacy in the Community;
• A guide to implementing nurse and pharmacist independent prescribing;
• HSC (SAFETY, QUALITY & STANDARDS DIRECTORATE) 29/07 – Guidance
- on Strengthening Personal and Public Involvement in Health and Social Care – currently under review, and revised guidance will issue in 2011;
- Complaints in Health and Social Care – issued April 2009;
- Complaints handling in Regulation Establishments and Agencies – issued April 2009;
- NI HSC Services Strategy for Bereavement Care – published June 2009;
- Advocacy Policy – a guide for commissioners (planned for July 2011);
- Managing Public Money NI;
- HSS (F) 29/2000 and a range of other circulars;
- Workforce Learning Strategy;
- A Partnership for Care – NI Strategy for Nursing and Midwifery;
- Midwifery 2020 – Delivering Expectations;
- NI Executive: Sustainable Development Strategy Implementation Plan: Awaiting Publication;
- The Ionising Radiation (Medical Exposure) (Amendment) Regulations (NI) 2010: SI 2010 No 29: 9 February 2010;
- Pharmaceutical Clinical Effectiveness Programme;
- NI Drug Tariff;
- Dementia Strategy;
- Physical and Sensory Disability Strategy;
- Learning Disability Service Framework;
- Long Term Conditions Policy;
- Draft Service Framework for Older People.
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 data listed informed the screening of the Commissioning Plan and this will be scrutinised further as decisions are taken and recommendations made by commissioning teams and Local Commissioning Groups during 2012/13.

Many of the Commissioning Teams used the same data which contributed to last year’s plan.

- Demographic information on the population of NI
- Information on deprivation indicators on health.
- Cancer Registry data
- Analysis of health and social care information systems
- Results of Patient and Client Council Survey *The People’s Priorities* (2011)
- Local and national research studies and needs assessment
- Consultations with patients & professionals in relation to the development of the Service Framework documents
- Bamford Review of Mental Health and Learning Disability (2006)
- Through patient and public involvement at both local and regional level.
- Through engagement with Trusts and clinicians (for example, through Managed Clinical Networks and other established fora).
- Complaints
- Consultation with Unions and Professional Bodies.

Preparing for the HSC Equality Action Plans - Audit of Inequalities: Section 75 Equality Groups - Emerging Themes (October 2010)

Information sources produced for Audit of Inequalities and Action Plans (2010):
• A Sure Start to Later Life Ending Inequalities for Older People
• A Social Exclusion Unit Final Report, Office of the Deputy Prime Minister January 2006
• Heenan D, 2010 Rural Ageing in NI: Quality of Life Amongst Older People University of Ulster


• Age Gender costs
http://www.dhsspsni.gov.uk/cfrg5-_presentation_delivered_as_part_of_the_consultation__capitation_formula_review_group.pdf

And

• Projections for people aged 85+ for Northern Ireland: http://www.nisra.gov.uk/demography/default.asp134.htm

• Northern Ireland Life and Times Survey 2008 http://www.ark.ac.uk/nilt/2008/ (attitudes to age issues)

• GP Patient Survey in Northern Ireland Commentary Report 2009 -2010
http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof/gp_patient_survey.htm

Gender

• Birth proportions – NISRA
http://www.nisra.gov.uk/demography/default.asp8.htm

• Life expectancy by gender NI-NISRA
http://www.nisra.gov.uk/demography/default.asp130.htm

• Death risk ratios – DPH annual report 2008 Core Tables


- Focus on Gender September 2008 Office of National Statistics Report From Seminar It’s a Man’s World – or is it? PHA seminar held on Tuesday 15 June 2010 - [http://www.publichealth.hscni.net/news/mens-health-seminarits-mans-world-or-it](http://www.publichealth.hscni.net/news/mens-health-seminarits-mans-world-or-it)

**Religion**

- McClelland A 2008 Differences in Mortality Rates in Northern Ireland 2002-2005: A Section 75 and Social Disadvantage Perspective OFMDFM Equality Directorate Research Branch


**Marital /Civil Status**


Race and Ethnicity


- Black and Ethnic Minority Worker mapping - January 2010: NIHE


- NCB NI and ARK YLT 2010 Attitudes to Difference: Young People’s Attitudes to and Experiences of Contact with People from Different Minority Ethnic and Migrant Communities http://www.ofmdfmni.gov.uk/attd_web_final-2.pdf


- Half a million voices: Improving support for BAME carers (CARERS UK 2011)


Specific information in relation to Travellers

http://www.dohc.ie/publications/aiths2010/ExecutiveSummary/AIT HS2010_SUMMARY_LR_All.pdf?direct=1)


- Promoting School Inclusion Working Group on Travellers 2007 Final report of the Promoting School Inclusion Working Group on Travellers Belfast: OFMDFM.


- The All Ireland Travellers Health Study, 2010 (AITHS)


- The Effectiveness of Interventions to Address Health Inequalities in the Early Years: A Review of relevant Literature, The Scottish Government, 2008

- Early Years Evidence-Based Paper, Department of Education, 2010


http://www.deni.gov.uk/attendance_at_grant_aided_primary_postprimary_and_special_schools_200809_detailed_statistics.pdf


- Northern Ireland Life and Times Survey 2005 ARK.

www.ark.ac.uk/nilt

- NCB NI and ARK YLT 2010 Attitudes to difference: Young people’s attitude to and experiences of contact with people from different minority ethnic and migrant communities in Northern Ireland. Belfast: NCB NI.

- All Ireland Traveller Health Study Team 2010 All Ireland Traveller Health Study Technical Report 1: Health Survey Findings. Dublin:
Sexual Orientation / LGB&T

  Jarman N and Tennant A 2003, n acceptable prejudice? - Homophobic violence and harassment in Northern Ireland Institute for Conflict Research
  
  http://www.ofmdfmni.gov.uk/phobic.pdf

  
  http://www.ofmdfmni.gov.uk/equalitymainstreamingjune07.pdf

- Hansson U and Hurley M 2007 Research Equality Mainstreaming - Policy and Practice for Transgender Institute for Conflict
  
  http://www.ofmdfmni.gov.uk/transgenderequality22may07.pdf

- Breitenbach E 2004 Researching lesbian, gay, bisexual and transgender issues in Northern Ireland. University of Edinburgh
  
  http://www.ofmdfmni.gov.uk/orientation.pdf

  


- Cancer Research UK. Policy Statement the Health inequalities in Cancer and Lesbian, Gay, Bisexual, Transgender (LGBT) communities
  
  http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@pol/documents/generalcontent/crukmig_1000ast-3350.pdf
• A Sure Start to Later Life 2006 Ending Inequalities for Older People. A Social Exclusion Unit Final Report, Office of the Deputy Prime Minister


• A Flourishing Society 2009 - Aspirations for Emotional Health and Wellbeing in Northern Ireland. Northern Ireland Association for Mental Health

• Best Practice Guidance : 2009 Sexual orientation: A practical guide for the NHS Department of Health/EHRG

• Equality Impact Assessment for National Sexual Health Policy: 2010 Department of Health


• Breitenbach E 2004 Researching Lesbian, Gay, Bisexual And transgender Issues In Northern Ireland : OFMDFM

• McNamee H 2006 Out On Your Own: An Examination of the Mental Health of Young Same-Sex Attracted Men, http://www.rainbow-project.org/aboutus/publications


• Council for the Homeless NI, 2008 Young People Tell it like it is’ Research into the Accommodation and Support Needs of Homeless 16 - 21 year olds in Northern Ireland

• CHNI (2007) No Straight Answers;The Experiences of LGBT Homeless Users and of Service Providers
• Through Our Eyes. Experiences of Lesbian, Gay and Bisexual People in the Workplace, 2011 (The Rainbow Project)

• A Mighty Silence, A report on the needs of lesbians and bisexual women in Northern Ireland, 2002 (Lesbian Advocacy Services Initiative – LASI)

Disability

• Hate Crime Against People with Disabilities 2009 Institute for Conflict Research


• Gordon DS, Graham L, Robinson M, Taulbut M. Dimensions of Diversity Population differences and health improvement opportunities. Glasgow: 
  NHS Scotland 2010

• A Sure Start to Later Life 2006 Ending Inequalities for Older People: A Social Exclusion Unit Final Report, Office of the Deputy Prime Minister

• Equality and Inequalities in Health and Social Care in Northern Ireland : 2004 A Statistical Overview DHSSPS

• 2001 Census Data on Limiting Long Term Illness: 

• Is it my turn yet? 2010 Access to GP practices in Northern Ireland for people who are deaf, hard of hearing, blind or partially sighted: 
  A survey by RNID, RNIB and BDA (Northern Ireland)

• 2009/10 GP Patient Survey in Northern Ireland Commentary Report 
  http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof/gp_patient_survey.htm
Dependants

- Scullion F and Hillyard P 2006 Carers in Northern Ireland http://www.ofmdfmni.gov.uk/carers-2.pdf
- Fiona Scullion and Paddy Hillyard 2005 Poverty and Social Exclusion Project: Carers in Northern Ireland Bulletin No 7 OFMDFM NI.
- Carers NI policy briefings http://www.carersuk.org/policy-pages-ni/policy-briefings-ni
- DHSSPS : Inspection of Social Care Support Services for Carers of Older People
  http://www.dhsspsni.gov.uk/index/ssi/ssiinspection_of_social_care_support_services_for_carers_of_older_people

Poverty

The Health Impacts of Cold Homes and Fuel Poverty: The report of the Marmot Review Team; NI Fuel poverty research OFMDFM, Friends of the Earth & the Marmot Review Team; May 2011.

Warmer Healthier Homes; A new fuel poverty strategy for Northern Ireland, Department for social development, 2011.

Policy briefing; the impact of fuel poverty on children (Save the Children, 2008).

Older People

“The Billion Dollar Question: embedding prevention in older people’s services – 10 “high impact” changes – Policy Paper 8. (Health Service Management Centre, University of Birmingham, 2010).

National Service Framework for Older People (Department of Health, 2001).

National Institute of Clinical Excellence - Falls: the assessment and prevention of falls in older people (NICE, 2002).

Falls and Fractures: effective interventions in health and social care (Department of Health, 2009).

Promoting Well-being: Developing a Preventive Approach with Older People (Lewis, Fletcher, Hardy, Milne and Waddington (National Institute for Health, Leeds, 1999).

Proven Strategies to Improve Older People’s Health: a Eurolink Age report for the European Commission (Eurolink Age, 2000).

Older People’s Inquiry for the Joseph Rowntree Foundation – (Raynes et al, 2006).

Ageing Strategies (CARDI April 2011).

Mental health promotion and suicide prevention


• Making it effective: A guide to evidence based mental health promotion.

  http://www.scmh.org.uk/pdfs/makingiteffective.pdf

• UK Inquiry into mental health and wellbeing in later life, 2006.

  http://www.mhilli.org/index.aspx?page=stage2promotion.htm#Inquiryreport

http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf

• Foresight report. Mental capital and wellbeing project, 2008.


NICE guidelines/guidance documents.
http://www.nice.org.uk

• Antenatal and postnatal mental health clinical management and service provision, 2007.
• Social and emotional wellbeing in primary education, 2008.
• Social and emotional wellbeing in secondary education, 2009.
Promoting mental wellbeing at work, 2009.
Mental wellbeing and older people, 2008.
Social Care Institute of Excellence (SCIE).

Think child, think parent, think family: a guide to parental mental health and child welfare, 2009.


Alcohol and Drugs


  www.nice.org.uk/nicemedia/live/11812/35975/35975.pdf

  www.nice.org.uk/nicemedia/live/11813/35997/35997.pdf


Prisons and Prisoner Health


• A new mental health and emotional wellbeing strategy is in development and will be consulted on during 2012-13.

• Service Framework for Mental Health and Wellbeing, 2011.

• New Strategic Direction for Alcohol and Drugs – Phase 2, 2011-2016.

Additional references
Indicators of equality and diversity

• Jamison J, Buchanan R, Carr-Hill R, McDade D and Dixon P 2007 Indicators of equality and diversity in Northern Ireland
• Literature review (PDF 579 KB)
• Report of consultation (PDF 564 KB)
• Buchanan R, McDade D and Jamison J
• Patterns of social difference
• Section 1 - chapters 1 and 2 (PDF 4.54 MB)
• Section 2 - chapters 3 and 4 (PDF 4.68 MB)
• Section 3 - chapters 5 and 6 (PDF 3.24 MB)
• Section 4 - chapters 7 to 10 (PDF 1.74 MB)
• Section 5 - chapters 11, 12 and annex (PDF 1.36 MB)

• Fit Futures – this was published in 2006 and sought to address childhood obesity.

• A Fitter Future for All – a 10 year cross-sectoral integrated life course framework to prevent and address obesity in Northern Ireland for 2011-2021. Consultation document issued end 2010 and final document awaiting Ministerial approval.


Commissioning, by definition, involves determining local health and social well-being requirements and securing services to meet these. We acknowledge at the throughout the Commissioning Plan that individuals and groups have equality of
opportunity to benefit from health and social care commissioned by the Health and Social Care Board and the Public Health Agency. But inequalities in health between different groups are well documented and long-standing. Evidence also suggests that health and social needs and outcomes are far from homogenous. There are different barriers to accessing services; there may be different obstacles for interventions consequently it is necessary that we understand each group’s experiences.

The Commissioning Plan 2012/13 therefore impacts on service users, their carers, the public and staff. It is relevant to all nine equality strands as identified under Section 75 of the Northern Ireland Act 1998. These include: age; gender; disability, ethnicity dependents, political opinion, sexual orientation marital status, and religion. In addition the Commissioning Plan is particularly important in the context of deprivation, geography and human rights.

Tables 2.2 and 2.3 have been completed taking into account some generic demographic factors and other equality data. The tables also identify some of the more generic equality and human rights issues and barriers faced by groups covered by Section 75 Categories.

During 2012/13 commissioning teams will be asked to review these and the arrangements for on going screening of decisions.

For each of the 12 service teams please see the additional screening evidence that service teams will be using as the work directed by the commissioning plan is taken forward (see after Section 2.4).

The HSCB will continue, as part of its work in relation to Section 75 Equality Duties – Audit of Inequalities, to ensure that all aspects of the commissioning process improve the use of information available, ensure it is kept up to date with the most relevant sources and adhere to equality screening best practice.

The Commissioning Directorate will work with the Equality, Human Rights and Diversity Group to ensure that robust screening and reporting action is enacted by the commissioning teams during 2012/13.
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.

The following generic equality and human rights issues and barriers have been identified, some of which had been used for the previous plan. The information is still relevant. All updates provided by the commissioning teams has been included.

<table>
<thead>
<tr>
<th>Category</th>
<th>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?</th>
</tr>
</thead>
</table>
| Gender   | The population of N Ireland is – 1.799 (June 2010). (Reference: Northern Ireland Statistics and Research Agency) [http://www.nisra.gov.uk/demography/default.asp17.htm](http://www.nisra.gov.uk/demography/default.asp17.htm)

Female 49%  Male 51%


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), 74% of whom were placed in Foster Care, the majority of whom are aged 12-15yrs. 62 LAC were placed for adoption. Leaving / After Care population comprises of 1,264 young people aged 16 – 21+ based on DSF data for March 11.

Northern Ireland is projected to have the highest fertility rate during 2011 – 2021. [http://www.economist.com/node/2516900](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. Catholic 40%, Church of Ireland 15% Presbyterian 21% Methodist 3%. The Remainder are other non Christian faiths, not stated or no religion.

There are gaps in the information base non Christian faiths and those with no faith.

Political Opinion
Limited data available

Marital Status
See Marriage trends – NISRA
http://www.nisra.gov.uk/demography/default.asp11.htm

Northern Ireland Health and Wellbeing survey 2005/6 NISRA
http://www.csu.nisra.gov.uk/survey.asp5.htm

Dependant Status
In Northern Ireland there are around 92,000 lone parents with 150,000 children. 25% of all children are from one parent families, nearly half separated or divorced. The current estimated number of carers is 207,000 (one in every eight adults); 150,663 of these carers are people of working age.

Any one of us has a 6% chance of becoming a carer.

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

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)

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

Learning disability is a life-long condition.

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).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Traveller population in N Ireland is estimated at 3905.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>The School Census (October 2008) shows that 4300 primary</td>
</tr>
</tbody>
</table>
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 but it is estimated that 5-7% of the population are from the gay and lesbian or bisexual community. |

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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Needs and Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>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. Men die five years earlier. They are 3 times more likely to commit suicide, be killed in a road accident, die of a heart attack and twice as likely to die from lung cancer. 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). Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey <a href="http://www.csu.nisra.gov.uk/survey.asp29.htm">http://www.csu.nisra.gov.uk/survey.asp29.htm</a> Women are more likely to have mental health problems and in the past were more likely to develop life limiting illness though there is evidence that the gap that this is increasing for men. Transgender individuals have higher level of mental health issues and are more likely to attempt suicide.</td>
</tr>
<tr>
<td>Age</td>
<td>Over the next 40 years as society ages dementia will become more</td>
</tr>
</tbody>
</table>
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](http://www.kingsfund.org.uk/publications/old_habits_die.html)

Some evidence on the attendees at Accident ad Emergency Services suggests that attendees are younger 22-44 years and attend at peak times (mid night to 2pm). ([Audit of Inequalities Evidence 2010](http://www.kingsfund.org.uk/publications/old_habits_die.html))

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](http://www.kingsfund.org.uk/publications/old_habits_die.html)).

Records suggest some difficulties in the recording of religion or ethnicity ([Source: HSCB Corporating Parenting Report, 1st April 2010-30th September 2010](http://www.kingsfund.org.uk/publications/old_habits_die.html)).

**Religion**

Once social needs are accounted for religion does not have a significant independent influence on health status. The variations by religion within age groups are a reflection of the correlation between various additional social needs and indicators. ([Source: evidence collated as part of Audit of Inequalities 2010](http://www.kingsfund.org.uk/publications/old_habits_die.html))

**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](http://www.dhsspsni.gov.uk/eq-literature-review)

**Marital Status**

The DHSSPS literature review also highlights important factors that influence access such as laws around who can adopt, access to fertility services, the male/female split in lone parenting (8% and 92% respectively) and the general lack of research in this area. Further information is available at the link below. [http://www.dhsspsni.gov.uk/eq-literature-review](http://www.dhsspsni.gov.uk/eq-literature-review)

**Dependent Carers**

Carers themselves are twice as likely to be sick or permanently
Status

disabled. People providing high levels of care are twice as likely to be permanently sick or disabled.

Women are more likely to be informal carers than men.

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 dearth 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


Disability

In Northern Ireland people experience the lowest disability free life expectancy (Age NI, 2010).

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. Source: A Physical and Sensory Disability Strategy 2011-2014 (DHSSPSNI Consultation Report 2010).

A high proportion of the 1860 people receiving Direct Payments have
a physical or sensory disability (approximately 32% at Jan 11).

Northern Ireland’s mental health needs are 25% higher than the rest of the UK and yet we spend 25% less to address them.

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.

| Ethnicity | National research suggests that there are differences within Black and Minority Ethnic 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. Variations occur across genders and across geographical areas. Source: Parliamentary Office of Science and Technology Postnote January 2007 Number 276 [www.parliament.uk/post](http://www.parliament.uk/post). Travellers have a higher burden of chronic diseases.

Certain groups experience additional disadvantage for example, male Travellers life expectancy is 15 years less and females 10 years less than the adult population as a whole.


Issues facing people of ethnic minority groups include language and communication, awareness of services and attitudes of staff. |

| Sexual Orientation | People who are Gay, Lesbian and Bi Sexual and Transgender: (LGBT) have significantly higher than average rates of anxiety, depression, self-harm and suicides alongside higher problem drug and alcohol use.

LGBT people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. The results of the meta-analyses 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.

Sources

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.


See also Out on Your Own – An examination of the Mental Health of Young Same-Sex Attracted Men. McNamee 2006 [http://www.rainbow-project.org/assets/publications/out_on_your_own.pdf](http://www.rainbow-project.org/assets/publications/out_on_your_own.pdf)

See also our Health and Well-being Your Business Guidelines on Lesbian and Bisexual Women’s Health and Social Care in Northern Ireland by Marie Query (2011).
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?

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 Commissioning 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.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are:

- Lower life expectancy than the Northern Ireland average
- 23% higher rates of emergency admission to hospital
- 66% higher rates of respiratory mortality
- 65% higher rates of lung cancer

The evidence base used by each of the 12 service teams to inform commissioning priorities is outlined below:

1. Health and Social Wellbeing Improvement, Health Protection and Screening.

Evidence based research has determined the strategic direction of the organisation as well as informing the commissioning of services and programmes. Action has also been developed to address the needs of specific groups. Examples, which are highlighted through thematic action plans, have included:
• Equality and Human Rights: Access to health and social services in Northern Ireland (DHSSPS 2006): The DHSSPS commissioned a literature review in 2006 to assist with the Equality Impact Assessment Programme. The review covered each of the nine dimensions set out in Section 75 of the Northern Ireland Act 1998. In relation to ethnicity, the review identifies the barriers many Minority Ethnic groups face when accessing health and social care services. It is divided into 4 categories: identification of common barriers to accessing health and social care; a focus on the language barrier; difficulties faced by specific Minority Ethnic communities and difficulties experienced by those residing in rural areas.

• Health and Social Needs among Migrants and Minority Ethnic Communities in the Western area (Jarman, 2009): A report examining the health and social wellbeing needs of settled and migrant ethnic groups in the Western Health and Social Care Trust area. This included an analysis of the legislative framework, local demographics, a review of the literature on racism and other factors impacting on health and wellbeing as well as the findings from a survey of migrants’ views and experiences and those of service providers and support groups.

• Barriers to Health: migrant health and wellbeing in Belfast. A study carried out as part of the EC Healthy and Wealthy Together project (Johnston, Belfast Health Development Unit 2010): A report exploring migrant health and wellbeing in Belfast. This included an analysis of current information on migrant demographics, legislation on immigration, work, health and social services and social security entitlements in Belfast.

• A study of issues faced by migrant, asylum seeking and refugee children in Northern Ireland (National Children's Bureau (NI) 2010)

• A Need to Belong. An Epidemiological Study of Black and Minority Ethnic Children’s Perceptions of Exclusion in the Southern Area of Northern Ireland (Biggart, O'Hare and Connolly, Queen’s University Belfast 2009): A report prepared for the Southern Area Children and Young People’s Committee focussing on children’s perceptions of their health, psychological and social wellbeing.


• Relating to Community development - Professor Sir Michael Marmot in Fair Society, Healthy Lives (2010), stated that tackling health inequalities requires action across all the social determinants of health. The report makes clear that there is a need for individuals and local communities to define the problems and develop community solutions through effective participatory decision-making at local level. Without such participation and a shift of power towards individuals and communities, he contends that it will be difficult to achieve the penetration of interventions needed to impact effectively on health inequalities.
• **Relating to LGB&T** – The “Through Our Eyes – Experiences of lesbian, gay and bisexual people in the workplace’ report highlighted continuing difficulties for many employees working in the public and private sector. The research findings reported:
  – Almost 1 in 4 (24.5%) respondents from the public sector conceal their sexual orientation in the workplace.
  – 40% of public sector employees who responded have heard negative comments about LGB people from a colleague or colleagues in the workplace. 13.7% from the public sector have been subjected to negative comments about their sexual orientation from a colleague or colleagues outside their workplace.
  – More than 1 in 4 (26.9%) respondents across all workplace sectors have had reason to make a complaint relating to their sexual orientation or perceived sexual orientation.

• **Relating to Older people** - there is a growing body of evidence and guidance related to the wider health and wellbeing needs of older people. These include the following:
  – National Service Framework for Older People (Department of Health, 2001);
  – National Institute of Clinical Excellence - Falls: the assessment and prevention of falls in older people (NICE, 2002);
  – Falls and Fractures : effective interventions in health and social care (Department of Health, 2009);
  – Promoting Well-being: Developing a Preventive Approach with Older People (Lewis, Fletcher, Hardy, Milne and Waddington (National Institute for Health, Leeds, 1999);
  – Proven Strategies to Improve Older People’s Health: a Eurolink Age report for the European Commission (Eurolink Age, 2000)
  – Older People’s Inquiry for the Joseph Rowntree Foundation – (Raynes et al, 2006).

• **Relating to Travellers** - The 2001 Census identified around 1,700 Travellers in Northern Ireland. The All Ireland Travellers Health Study (2010) carried out by University College Dublin, showed that the age profile of the Traveller community in Northern Ireland is markedly different from that of the general population with 75% of people under the age of 30. Only 1% of Travellers are over 65 years compared to over 15% of the settled population. This evidence offered huge differences in life expectancy and points to the considerable health and social wellbeing challenges that exist.

• Although there is currently no Regional Travellers Strategy for Northern Ireland, the PHA and Health and Social Care Board (HSCB) undertook to establish a Regional Travellers Health and Wellbeing Forum. The Forum, representing the PHA, HSCB, Health and Social Care Trusts, Cooperation and Working Together (CAWT), Patient & Client Council and Traveller
support organisations have agreed to commit themselves to undertake actions based on the findings and recommendations of the study.

2. **Unscheduled Care**

The Unscheduled Care Commissioning Team has taken account of the Patient Client Council People’s Priorities document and has drawn available information on patient experience. Moreover the Team has taken account of emerging evidence on delivering unscheduled care from Britain, including models to increase access and promote appropriate unscheduled care delivered in the most appropriate setting, which is not generally an Emergency Department. The Team has a great deal to do to extend its evidence base which is an integral part of its Year One Action Plan.

The DHSSPS Commissioning Direction 2012 has set targets to ensure that 95% of patients attending any A&E Department are either treated and discharged home, or admitted within four hours of their arrival in the department, and no patient waits longer than 12 hours. Targets have also been set in relation to ambulance response times.

Performance at a number of hospital sites across Northern Ireland has been significantly below the 4 hour minimum standard set by the Department. These standards are routinely achieved in England.

In the last 5 years, the total number of attendances per annum at emergency care departments has increase by 3.1% to 731,000. This means that on average 2,000 patients attend A&E each day in Northern Ireland. Of the patients who attend A&E approximately one in four are admitted to a hospital bed. Rates of attendance and admission are both considerably higher than in England.

Northern Ireland has approximately a quarter more acute beds (per 1000 population) than England. However, these beds are less intensively used and patients tend to stay in hospital for longer periods than the equivalent patient in England.

Unscheduled care and admission to hospital for children also varies across Northern Ireland. In some cases, children are admitted via a children’s A&E department but, in the majority of cases, they will be admitted via general hospital emergency department. Some departments do on have a designated area for children. People from deprived areas are overrepresented in attendances at A&E and emergency admissions.
3. **Elective Care**

The commissioning priorities for elective care have been informed by the DHSSPS Commissioning Direction and in particular the need to ensure that all urgent operations are completed in a timely manner and that patients waiting for routine assessment or treatment should wait no longer than the maximum times set by the Department.

Each year nearly 600,000 people are referred to hospital for specialist assessment by their GPs or dentists. Every year around 450,000 people receive planned inpatient or day case operations.

The overriding priority for the elective care system in Northern Ireland is to ensure that all urgent operations are completed in a safe and timely manner and that patients waiting for routine assessment or treatment should wait no longer than the maximum times set by the Department. This is achieved by ensuring that:

- There is sufficient elective capacity to meet need;
- Appropriate referral pathways, including appropriate alternatives to acute assessment and treatment are agreed through work with General Practitioners and other referrers.
- Assessment and treatment protocols linked to higher value procedure pathways are developed in conjunction with consultants, GPs and other clinicians.

4. **Cancer Care**

Cancer was responsible for 27% of all deaths occurring in Northern Ireland in 2009, (NISRA Deaths in Northern Ireland, 2010)

In Northern Ireland one in three of the population develops a cancer by the time they reach 75 years of age. Excluding the rarely fatal non-melanoma skin cancer (NMSC) the risk for both males and females is about one in four. The risk of dying from cancer before the age of 75 is lower than that for developing cancer but varies by gender; among males the risk is one in seven while in females it is one in nine. In general men are at significantly greater risk than women from nearly all of the common cancers that occur in both genders (with the exception of breast cancer) (White 2009, Wilkins 2006, DH 2007). Even after allowing for higher risk factors in smoking and alcohol consumption it has been suggested that additional influences of symptom awareness and treatment avoidance may be impacting on this.

Rates of new cases of cancer in Northern Ireland are fairly static although the actual number of cases is increasing due to the ageing of the population. Despite this, as survival continues to improve mortality rates are decreasing in Northern
Ireland along with other countries in the UK. However as the recent International Cancer Benchmarking Partnership study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older.

Cancer can develop as a result of factors related to environment, lifestyle, and heredity. While our current understanding of the causes of cancer is incomplete, many risk factors that increase the possibility of getting cancer have been identified. These include age, history of cancer in the family, tobacco use, alcohol consumption, lack of balanced diet, lack of physical activity, obesity, exposure to ultraviolet radiation from sunshine or sun beds, exposure to certain chemicals and gases such as asbestos, benzene or radon gas, exposure to ionising radiation, infections such as human papillomavirus (HPV), treatments such as exposure to oestrogen through Hormone Replacement Therapy (HRT), late or lack of reproduction in females and lack of breast feeding in females. While most people with a particular risk factor for cancer will not contract the disease, the possibility of developing cancer can increase as exposure to a risk factor increases.

The standardised incidence rate for all cancers has been consistently higher in the most deprived areas than the NI average however the gap between the rates has declined from being 20% higher in 1999 to 9% higher in 2006. The male gap reduced from 22% to 7% while the female gap fell from 18% to 11% over the period. Much of this reflects variation in risk factors particularly tobacco consumption which are substantially higher in more deprived areas. This is reflected in the difference in lung cancer incidence rates between deprived areas and NI as a whole. These have narrowed from being 81% higher in the most deprived areas in1999 but remained 65% higher in 2006.

The socio-economic gradient in incidence and survival varies by cancer. (NI Cancer registry 2007 report)

The proportionate decreases between 2001 and 2008 in the standardised death rates due to cancer in deprived areas and NI as a whole were broadly similar which meant that the inequality gap remained around a third higher in deprived areas than the Northern Ireland average. The gap for males was higher (35%) than that for females (28%). This is consistent with UK data which showed that unskilled workers are twice as likely to die from cancer as professionals.

Downing et al focused upon women with breast cancer and found that those living in deprived areas were:

- More likely to be diagnosed with advanced cancer
- More likely to have a mastectomy, rather than breast conserving surgery
- Less likely to receive radiotherapy
• Less likely to have surgical treatment
• Less likely to have survived five years

Cancer Research UK’s ‘Reduce the Risk’ survey in the UK found that there was a socioeconomic gradient to knowledge of all the major risk factors or awareness of symptoms relating to cancer; with the wealthier more likely to have knowledge of cancer risk factors compared to those lower down the socioeconomic scale. Twice as many people from the most deprived group could not name any cancer symptoms (20 per cent) compared to those from the least deprived group (9 per cent). For all the main risk factors, the wealthier an individual, the more likely they are to be aware of its link to cancer. They also identified differing levels of awareness between Black and Minority Ethnic communities and the general population.

A range of harder to reach groups have unmet need relating to information, support and cancer services. There is evidence of inequalities at each stage of the patient pathway, from information provision through to palliative care. UK data shows that in addition to a greater likelihood of being diagnosed with certain cancers, people from the most deprived communities have poorer outcomes once they have been diagnosed.

UK Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40 per cent of the population and that only 30 per cent of GPs surgeries have accessible information for people with learning disabilities.

Language can be a significant barrier to accessing cancer services for many people from BME groups, particularly (but not limited to) asylum seekers and refugees. UK data in the report Focus on social inequalities found that 41 per cent of people with additional language needs had no one to help with interpreting when visiting a GP or health centre. The 2009/10 NI survey of GP patients while not dealing specifically with cancer patients highlighted issues about access and information for non ethnic white populations and elderly patients with chronic conditions.

The Social Exclusion Unit in UK found that those with low literacy were six per cent less likely to attend cervical screening than women with higher basic skills. Screening rates are low in women with learning disability although higher rates of the risk factors of obesity and overweight have been found in those with learning disabilities and mental health problems. Concerns have been raised in local survey data and nationally re lesbian and bisexual women having higher behavioural risk factors but being less likely to be screened.

There has been some evidence in the UK of older patients receive differing care to their younger counterparts. Evidence, given in the Cancer Reform Strategy in England, found that older women were less likely to receive standard management, such as radiotherapy, for their breast cancer even after taking
account of tumour type 215 and that older patients with lung cancer were less likely to receive radical treatment for their disease.

A recent International Cancer Benchmarking Partnership study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older. This report compared the international differences in survival across Colon, Lung, Breast and Ovarian, and showed the age standardised relative survival at one and five years.

This showed that for colorectal cancer, 8% of patients in Northern Ireland died between 1995 and 2007 within one month of diagnosis compared with 11% in England and Wales. One in ten women with ovarian cancer died within one month of diagnosis in Northern Ireland, while 12% died in England and 13% in Wales. The survival rates for patients with breast, lung and colorectal cancers looked at in this report have improved in Northern Ireland from 1995 to 2007. However, ovarian cancer is included as an example of a less common cancer with large variations in survival across countries. The specific variations for ovarian are shown \[http://eu-cancer.iarc.fr/cancer-16-ovary.html\#block-9-27\]

The international survival trends showed persistence differences between countries, although the trends in cancer incidence and mortality were broadly consistent with the trends in survival. This work has provided the basis for the priorities of the Cancer Commissioning Team. A copy of the full report can be obtained from \[http://www.lshtm.ac.uk/eph/ncde/cancersurvival/icbp_paper1.pdf\]

5. Palliative Care and End of Life Care

The commissioning priorities for the Palliative Care Service Team have been determined by the regional strategy, Living Matters Dying Matters. It is estimated that two thirds of all deaths in Northern Ireland would benefit from the palliative care approach in the last year of life but do not receive it. This approach is appropriate for those with chronic non cancer conditions such as respiratory disease, heart failure, neurological, renal and other degenerative conditions such as dementia and those elderly people who are approaching the end of their life.

The Centre for Policy on Ageing report for the Department of Health London 2009 identified that in England people under 65 had disproportionate access to palliative care and older people had unmet needs in palliative care and pain management. There was evidence that palliative care in nursing homes for older people was poorly organised and that older people were experiencing persistent pain without appropriate assessment and treatment.

Until recently the emphasis on generalist palliative care services in N Ireland has been mainly for those with cancer conditions, which account for only a quarter of
all deaths. The biggest inequalities are therefore between those with cancer conditions and non cancer conditions, regardless of all other aspects. These are often conditions which affect older people. There is therefore a marked commissioning emphasis on the identification of palliative care needs across non cancer conditions, as outlined above; and also particularly for people who live in nursing homes.

Over the last five years 51% of all deaths and 44% of all cancer deaths occurred in hospital, again showing inequality between cancer and non cancer conditions. Surveys from the UK show that most people would prefer to die at home (including nursing home). This information is not available for N Ireland, but will shortly be measured through Service Frameworks. A key priority will be to develop pathways and services which support people to die at home when that is appropriate and their preferred place of death.

Specific studies from the UK suggest inequalities in access to specialist palliative care driven by gender, age, condition, socio-economic status, race and ethnicity. Again specialist palliative services in N Ireland are mainly provided for those with non cancer conditions and we are focusing again on the identification of needs of those with these conditions to improve access, including again residents of nursing homes. In N Ireland there are no inequalities in access to hospices on the basis of socio-economic status.

In terms of information provision UK Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40% of the population. There is no similar study in N Ireland, but an information group, supported by the Palliative Care Service Team, is being set up to consider what information needs are and how these can be met.

Research amongst varied BME groups in the UK generally identified different cultural practices relating to death and preparation for burial which required to be sensitively handled by service providers. Bereavement co-ordinators in each Trust are taking forward these issues and developing training for staff and information for those who are bereaved.

Many studies have shown that carer needs are key in many cancer and long term conditions as well as in those with palliative and end of life care needs. Again we have asked that carer needs are identified and that specific processes are put in place to give key information and support to families and carers, for example through the implementation of the key worker function.

6. **Long Term Conditions**

The commissioning priorities for long term conditions relate to heart disease, vascular disease, respiratory disease, stroke and diabetes in adults and children. It is essential that care should be provided close to home.
The commissioning priorities for long term conditions have been informed by:

- The Service Framework for Cardiovascular Health and Wellbeing
- The Health Impact Assessment for the Cardiovascular Service Framework
- The Service Framework for Respiratory Health and Wellbeing
- The Annual Reports of the Director of Public Health
- The CAWT Hospital Diabetes Audit
- The Northern Ireland Stroke Strategy 2008
- The Stephen Green Review of Cardiology Capacity.

7. Maternity, Paediatrics and Child Health

The priorities for maternity services were evidenced from a range of Royal College, national and regional guidelines and recommendations from the Centre for Maternal and Child Enquiries. These include:

- DHSSPS endorsed the following NICE guidelines as applicable to maternity services in NI:
  - Post natal care (2008)
  - Perinatal mental health (2008)
  - Intrapartum care (2008)
  - Antenatal care (2008)
  - Induction of labour (2009)
  - Diabetes in pregnancy (2009)
- Maternity standards produced jointly by the Royal College of Obstetrics and Gynaecology, the Royal College of Midwives, the Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health
- ‘Safer Childbirth: Minimum standards for the organisation and delivery of care in labour’ 2007 includes standards for obstetric and anaesthetic staffing for labour wards in consultant obstetric units
- ‘Standards for Maternity Care’ 2008 covers the pathway from pre-pregnancy to parenthood.

While the latter Royal College documents have not been formally endorsed by the DHSSPS, they are viewed by professionals as ‘gold standards’ and the Regulation and Quality Improvement Authority used the ‘Safer Childbirth’ standards in its review of intrapartum care in NI which was published in May 2010.

The Centre for Maternal and Child Health Enquiries (CMACE) has produced reports on maternal and perinatal mortality and on specific topics such as diabetes and obesity in pregnancy. NI has taken part in the work of CAME and Trusts are expected to implement the recommendations of the CMACE reports ‘Saving Mothers’ Lives (2008) and joint CMACE and Royal College of Obstetricians and Gynaecologists guidance on the management of obesity in pregnancy (2010).
In terms of maternal obesity the Centre for Maternal and Child Enquiries report on Maternal Obesity in the UK (2010) indicates the extent to which the prevalence of maternal obesity is a concern and the risks to both mother and baby. In Northern Ireland the prevalence women with a Body Mass Index ≥35 in pregnancy is 5.3% and those with a Body Mass Index ≥40 is 2%.

Using the index of multiple deprivation score this report also shows as confirmed in other studies that social deprivation is associated with a significantly increased risk of maternal obesity.

The UK Infant Feeding Survey 2010 confirms the need for action to increase breastfeeding rates and reduce smoking in pregnancy. NI has the lowest uptake of breastfeeding in UK with 64% breastfeeding at birth compared to 81% in the UK. Those least likely to breastfeed include young mothers and women who have never worked.

The Infant Feeding Survey also identified that in Northern Ireland significantly more women smoke before and during pregnancy than the rest of the UK with 41% of women here who never worked smoking throughout pregnancy compared to 21% in the UK.

8. **Community Care, Older People and Physical Disability**

Our population is ageing and this demographic change will have significant implications for health and social care as older people are major users of services. The number of people over 65 has increased by 16% since 1999 and will show a similar increase from the current figure of 255,000 by 2015. This will include a rise of 29% in the number aged over 85. The number of people over 65 with dementia will increase by 30% from the current figure of 15,400 to almost 20,000 by 2017.

In Northern Ireland we have a relatively high proportion of people living in care homes. This is at odds with the demand for greater independence and needs to be reduced substantially. Other significant initiatives will be the implementation of the Northern Ireland Single Assessment Tool as a way of delivering needs led services alongside the further development of regional safeguarding arrangements to protect those at risk of abuse or exploitation.

It is estimated that between 17 – 21% of our population have a disability affecting 37% of households. Recent research indicates that approximately 8,800 people have a visual impairment, 11,700 are hearing impaired and over 35,000 have a mobility problem.

Until recently the reform agenda within disability services has been focused on specific services resulting in initiatives aimed at reforming wheelchair services,
prosthetics, brain injury services, sensory impairment provision and thalidomide survivors. A more strategic approach will be adopted as a result of the new Regional Disability Strategy. It will be followed by the Report of the Joint Housing Adaptaions Steering Group which is designed to improve joint working between HSC and housing.

Evidence has been used from:

- Demographic trends/data sources
- Patient & Client Council Reports
- Centre for Ageing Research and Development in Ireland publications/research
- Serious Adverse Incident/Untoward events reporting
- Social Care Procurement Unit data
- Age Sector Platform – The Peoples Parliament Report
- Age (NI) Policy briefings.
- Disability e-zine

The commissioning priorities have also been informed by the DHSSPS Commissioning Direction 2012.

9. **Children and Families**

The Children and Families Programme is heavily prescribed by legislation and associated regulations and guidance which set out the parameters within which services should operate and which also require to be taken into account when services are commissioned. For the priorities identified within the Commissioning Plan this includes legislation pertaining to children looked after, care leavers, children with a disability including autism, early years services, children with mental health concerns and those involved in Intercountry Adoption.

In addition to legislation there are also policy and procedures which stipulate the standards which require to be adhered to in engaging with service users across the various sub groupings. It is imperative that actions are premised on acting in the best interests of children and that account is taken of the principles contained within the United Nations Convention on the Rights of the Child and the European Convention on the Rights of the Child. This also allows the HSCB, PHA and Trusts to garner whether sufficient attention is being afforded to the equality and human rights issues.

The infrastructure within which children’s services operates also provides the opportunity to look at commissioning and service provision in a holistic sense in that a range of partnerships are available where significant thought has been given to ensuring inclusivity and that the interests of Section 75 groups are
appropriately represented and that challenge can be exercised when required. These partnerships include:

- The Children and Young People’s Partnership
- The Childcare Partnerships
- The Bamford Taskforce
- The Regional Child Protection Committee
- The Regional Autism Spectrum Disorder Network
- N.I. benchmarking forum for 16+ services
- Regional Fostering and Adoption Project.
- Regional Hidden Harm Implementation Group
- The Children Order Advisory Committee

Additionally, where applicable, account is taken of the NICE and SCIE guidance to ensure that recent research and best practice has been taken into account. The Strategic Partnership has developed a research sub group which will assist in informing the range of stakeholders on what works well for families and also where changes are required. Account will also be taken of local research such as the Care Pathways and Outcomes Study which is being progressed. The Regulation and Quality Improvement Authority will also include consideration of equality and human rights matters in its inspection processes with the outcome factored into commissioning priorities where required. In the past few years there has been a significant focus (inspection) on safeguarding within children’s services and also an inspection into Child and Adolescent Mental Health Services which is reflected within the commissioning plan.

It should also be noted that a number of the priorities relate to review processes and staff involved are aware of the need for equality screening as needed. There are instances where this has already been progressed such as the Bamford action plans and with the development of the multidisciplinary teams for children with a disability. The Commissioning Plan is also seeking to address the needs of care leavers as a vulnerable group and audits have been completed with service providers including Trusts and the Housing Executive has been closely involved as a partner agency. A series of pilot inspections by RQIA have also assisted in shaping the future work programme and facilitated a focus on equality issues.

It can be seen in reviewing the priorities which are contained within the Children and Families section that the section 75 groups being considered explicitly include age and disability. The other groups either have been or will also be taken into account in that if gender is a particular issue for the reconfiguration of residential child care provision this will be stated in any such review. It is also intended that the views of service users will be integrated within the work schedule, either through representatives or with direct engagement of users which already applies to some of the working groups in place.

Reference has been made previously to best practice and learning from other areas and the work to be taken forward on reviewing speech and language
therapy support in special schools will be informed by a model of practice which has been successfully introduced in Scotland and will provide a template for local discussion.

Equally the review of Intercountry Adoption Practice will take account of models operating in other parts of the UK. The adoption legislation in NI is different than that which applies in other parts of the UK as unmarried or gay couples cannot jointly adopt. This matter is currently the subject of a judicial review.

10. **Mental Health and Learning Disability**

A key priority in the areas of mental health and learning disability is to take forward the recommendations and actions arising from the Bamford Review. The Board and the Public Health Agency, in partnership with Trusts, established a range of working groups across the region in partnership with Local Commissioning Groups. Within the Taskforce service users and carers have been incorporated as equal partners.

Within Learning Disability the key focus for service delivery will be the continuation and promotion of inclusion and independence in line with ‘Equal Lives’. This will support people with a learning disability in the areas of housing, training, further education and employment opportunities.

Some additional strategic drivers include:

- ‘Protect Life’, Suicide Prevention and Promoting Mental Health and Wellbeing Strategy
- New Strategic Direction for Drugs and Alcohol
- Psychological Therapies Strategy
- Personality Disorder Strategy

The Board and PHA will also work with Trusts and other stakeholders to ensure that targets relating to mental health and learning disability as set out in the DHSSPS Commissioning Direction for 2011/12 are also delivered.

11. **Prison Health Service**

From 1 April 2008 the DHSSPS has had responsibility for Prison Health Services. The commissioning of Prison Health Services is now a function of the HSC Board and the management of prison health systems is the responsibility of the South Eastern Health and Social Care Trust. A Prison Partnership Board has been set up to coordinate prison health strategies and policies and to take forward the aims of the Prison Health Partnership Agreement.
The commissioning priorities for prison health have been informed by The Health Care to Prisoners in Northern Ireland: Needs Assessment Review, November 2009.

12. **Specialist Services**

Specialist Services for acute care include highly specialist tertiary services delivered through a single provider either in Northern Ireland or via a service level agreement with a tertiary centre in GB. They further include services which are in the process of evolving from a single provider model to provision in a number of local settings. High cost specialist drugs also fall within the remit of this branch of commissioning.

Some individual specialist services will display a particular age and gender profile reflecting the nature of their service. For example, treatment of age related wet AMD is exclusively for the treatment of an eye disease which is prevalent in older people. Cancer drugs are condition targeted and this can result in differences in expenditure between men and women and also between social class (lung, throat and tongue cancers associated with smoking, emerging volumes of obesity related cancer - both of which are associated with social class which could be linked to race, age, dependencies or disabilities). However, cancer drugs are commissioned on an annual basis with new regimes becoming available each year – the availability of which is exclusively dependent upon whether or not they gain NICE approval rather than a commissioning determination to target one specific form of cancer.

Specialist services are relatively low volume and Northern Ireland has small population of 1.8m.

The key issue in respect of inequalities for specialist care is access to services. Specialist care is primarily provided in Belfast with only one or two specialist services provided elsewhere. This can mean journey times in excess of 1.5 to 2 hours each way for some patients. The cost of travel for people less well able to afford it or the degree of increased difficulty (dependencies, disabilities or age) experienced by some groups of people may create inequalities in access to care.

The profile of patients receiving specialist care forms part of any new service development or growth. This will include data regarding waiting times and activity volumes recorded by hospital data systems. Waiting times for all baseline services are also monitored. Specific data monitoring is also routinely collected for biologics for rheumatoid conditions, biologics for psoriasis, Wet AMD, disease modifying therapies for Multiple Sclerosis and haemophilia blood products. Specialist Services has established forums focusing on nephrology and transplantation, biologics for rheumatoid conditions, Wet AMD for macular degeneration, orphan enzymes, paediatric cardiac surgery, rare diseases, disease
modifying therapies for MS, and vulnerable paediatrics. All of these have representation from Trust management and clinicians, HSCB and the PHA. Some of the groups have representation from DHSSPSNI, voluntary organisations and patients.

Specialist services also utilise data and guidance from NICE and other nationally recognised policy documentation (NHS, Department of Health and DHSSPSNI and PCC publications).

The recently completed capacity planning exercise provided intelligence regarding the productivity and efficiency of current services based on working practices and national peer benchmarking systems.
On the basis of the analysis undertaken by the 12 Commissioning Teams, the key inequalities are identified as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>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?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Elective Care</td>
</tr>
</tbody>
</table>

Variation is not necessarily inequality of service particularly in relation to usage of the multi–faceted services we call elective care - from paediatric surgery to geriatric medicine or urology. The academic literature suggests a complex interaction of underlying need reflecting hereditary factors, risk behaviours, age, gender and for some conditions ethnicity. This is then influenced by health seeking behaviour and attitudes/knowledge or perceived barriers to access or expectations on either the patient or clinicians part.

Individual specialties or conditions will reflect a specific age and gender profile. Access and outcome of services can be driven by physiological and behavioural characteristics eg the suitability of a particular surgical intervention for an individual will be influenced by the impact of co-morbidities which may be related to age or risk factors such as smoking or obesity which may in turn have higher prevalence in more deprived groups or those with particular disabilities. Hence we can have differential need and differential outcomes between individuals and groups.

Access from primary care to secondary care may vary reflecting individual health seeking behaviour or primary care attitudes. What would appear to be substantial variations in referral patterns from primary care are currently under investigation by LCGs.

Health Inequalities monitoring data showed that people from the most deprived areas in 2001/02 had 9% higher age and gender standardised elective admission levels than the Northern Ireland average across the combined basket of all elective specialties. More recent data appears to show deprived areas slightly below the Northern Ireland average and rural areas have overtaken urban areas in usage.

Survey or focus or interest group work has identified some broader communication issues that can arise around appointments or providing information at clinics or in hospital - for BME, elderly, disabled or those with literacy problems. A phone call through partial booking may be problematic to elderly, hard of
hearing or someone for which English is not their first language while those with dependents may have difficulties regarding the flexibility of appointment times.

**Specialist Services**

Gender profile accessing specialist acute care should reflect the gender profile of Northern Ireland as care is available on demand on the basis of clinical need. The pattern of uptake will be similar to that of general acute care. It would be inappropriate to take any action to address this as service provision is in line with clinical need.

**Unscheduled Care**

Non-elective admissions and the bed days associated with them are broadly similar for men and women but vary reflecting different age groups. Admissions for men peak in their late sixties and seventies while admissions for women peak in their late seventies and eighties. This reflects known differentials in life expectancy and the higher death rate at an earlier age for men in relation to cardiovascular, respiratory and cancer conditions. In contrast the age profile of A&E attenders tends to be much younger.

Health Inequalities monitoring data showed that people from the most deprived areas in 2001/2 had 37% higher age and gender standardised non-elective admission levels than the Northern Ireland average. More recent data shows admissions from deprived areas at 23% above the Northern Ireland average. The higher levels of non elective admissions are in seen in both respiratory (+24%) and circulatory disease (+8%). There appear to be geographical differences across NI in admission levels.

**Cancer**

The standardised incidence rate for all cancers has been consistently higher in the most deprived areas than the NI average however the gap between the rates has declined form being 20% higher in 1999 to 9% higher in 2006. The male gap reduced from 22% to 7% while the female gap fell from 18% to 11% over the period. Much of this reflects variation in risk factors particularly tobacco consumption which are substantially higher in more deprived areas. This is reflected in the difference in lung cancer incidence rates between deprived areas and NI as a whole. These have narrowed from being 81% higher in the most deprived areas in 1999 but remained 65% higher in 2006.
The proportionate decreases between 2001 and 2008 in the standardised death rates due to cancer in deprived areas and NI as a whole were broadly similar which meant that the inequality gap remained around a third higher in deprived areas than the Northern Ireland average. The gap for males was higher (35%) than that for females (28%). This is consistent with UK data which showed that unskilled workers are twice as likely to die from cancer as professionals.

Downing et al focused upon women with breast cancer and found that those living in deprived areas were:

- More likely to be diagnosed with advanced cancer
- More likely to have a mastectomy, rather than breast conserving surgery
- Less likely to receive radiotherapy
- Less likely to have surgical treatment
- Less likely to have survived five years

A recent International Cancer Benchmarking Partnership study of four main cancers showed that for colorectal cancer, 8% of patients in Northern Ireland died between 1995 and 2007 within one month of diagnosis compared with 11% in England and Wales. One in ten women with ovarian cancer died within one month of diagnosis in Northern Ireland, while 12% died in England and 13% in Wales. The report highlights that the survival rate for patients with breast, lung and colorectal cancers have improved in Northern Ireland from 1995 to 2007. However, ovarian cancer is included as an example of a less common cancer with large variations in survival across countries. The specific variations for ovarian are shown [http://eu-cancer.iarc.fr/cancer-16-ovary.html,en#block-9-27](http://eu-cancer.iarc.fr/cancer-16-ovary.html,en#block-9-27)

The international survival trends showed persistence differences between countries, although the trends in cancer incidence and mortality were broadly consistent with the trends in survival. This work has provided the basis for the priorities of the Cancer Commissioning Team. A copy of the full report can be obtained from [http://www.lshtm.ac.uk/eph/ncde/cancersurvival/icbp_paper1.pdf](http://www.lshtm.ac.uk/eph/ncde/cancersurvival/icbp_paper1.pdf)
Older People

There are differences in the incidence of dementia according to gender with a higher proportion of men in the ages 65-74 years and a higher proportion of women aged over 75 having dementia. There will also be differences in the nature of care required according to the gender of individuals.

Children and Families

Evidence exists on the relationship between the exposure to poor social conditions and unhealthy behaviours for young women in the care system, the risk of early pregnancy and poor mental health.

Mental Health and Learning Disability

It is crucial that services in relation to mental health takes into account the needs of marginalised women. High levels of mental ill health among women with disabilities and lesbians.

Prison Health

English data showed that almost half of all prisoners have no educational qualifications and were unemployed prior to entering prison. The same psychiatric census identified that female prisoners reported very high levels of domestic violence and previous sexual abuse and over a quarter of both male and female prisoners were in local authority care as children.

Long Term Conditions

Stroke and diabetes are more common in men but women have higher levels of morbidity and premature mortality.

Age

Specialist Services

Age profile accessing specialist acute care should reflect the age profile of Northern Ireland as care is available on demand on the basis of clinical need. The pattern of uptake will be similar to that of general acute care where there may be more of a bias towards older age groups. It would be inappropriate to take any action to
address this as service provision is in line with clinical need.

Cancer

In Northern Ireland one in three of the population develops a cancer by the time they reach 75 years of age. Excluding the rarely fatal non-melanoma skin cancer (NMSC) the risk for both males and females is about one in four.

The risk of dying from cancer before the age of 75 is lower than that for developing cancer but varies by sex; among males the risk is one in seven while in females it is one in nine. In general men are at significantly greater risk than women from nearly all of the common cancers that occur in both sexes (with the exception of breast cancer) (White 2009, Wilkins 2006, DH 2007). Even after allowing for higher risk factors in smoking and alcohol consumption it has been suggested that additional influences of symptom awareness and treatment avoidance may be impacting on this.

Rates of new cases of cancer in Northern Ireland are fairly static although the actual number of cases is increasing due to the ageing of the population. Despite this as survival continues to improve mortality rates are decreasing in Northern Ireland along with other countries in the UK. However as the recent ICBP study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older.

There has been some evidence in the UK of older patients receiving differing cancer care to their younger counterparts. Evidence from the Cancer Reform Strategy in England found that older women were less likely to receive standard management such as radiotherapy for their breast cancer even after taking account of tumour type and older patients with lung cancer were less likely to receive radical treatment for their disease.

Palliative Care

The Centre for Policy on Ageing Report for the DOH (2009) identified that people under 65 had disproportionate access to palliative care and older people had unmet needs in palliative care and pain management. There was evidence that palliative care in nursing homes for older people was poorly organised and
that older people were experiencing persistent pain without appropriate assessment and treatment. While no similar report is available locally.

A recent International Cancer Benchmarking Partnership study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older. This report compared the international differences in survival across Colon, Lung, Breast and Ovarian, and showed the age standardised relative survival at one and five years.

**Older people**

In terms of dementia the incidence of dementia increases with age but it is far from being inevitable and is certainly not a natural consequence of the ageing process. There is some evidence that age equality in psychiatry services is taken to mean ‘one size fits all ages’ approach.

**Mental Health and Learning Disability**

There is a tendency to overlook the needs of older people with mental health problems

**Long Term Conditions**

Long term conditions are more common in older age groups. Children with diabetes have a lower life expectancy than children without diabetes.

<table>
<thead>
<tr>
<th>Religion</th>
<th>Services are available on the basis of need irrespective of religion. Those areas with the highest incidence rates of cancer have higher percentages of protestants (8%) than in NI overall.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Opinion</td>
<td>Political opinion is not a determining factor for access to health care.</td>
</tr>
</tbody>
</table>
| Marital Status | Cancer  
In terms of incidence of cancer there is a higher proportion of people who are separated / widowed / divorced (5% higher) in the fifth of wards with the worst incidence rates. |
**Children and Families**

Less than 3% of lone parents are teenagers. The majority, (80%) are aged 25-49 years. In the UK as a whole 1 in 4 families is headed by a single parent who is bringing up 3 children. Statistics show that a high percentage of lone parents are living on low incomes, in rented accommodation, without savings and may be experiencing debt. Lone parents with a disability or with a child with a disability who lack family support are vulnerable to stress.

<table>
<thead>
<tr>
<th>Dependent Status</th>
<th>Unscheduled Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There is recognition that persons with dependents can find it more difficult to access in-hours unscheduled care.</td>
</tr>
</tbody>
</table>

**Elective care**

Those with dependents may have difficulties regarding the flexibility of appointment times.

**Cancer**

In terms of the incidence of cancer there is a higher proportion of households without dependent children (8% higher) than the average in the fifth of wards with the worst incidence rates.

**Disability**

There is an inadequacy of service knowledge based practice relating to groups of disabled parents. More research is also needed on groups of disabled adults who care including adults with a learning disability who care for their children or care for older parents. As parents get older the caring role often reverses. Negative attitudes or anticipation of negative attitudes can act as a barrier to people seeking support from social services for example parents with mental health problems, learning disability or those with drug or alcohol problems. Parents with a disability are least likely to have information made available to them in a way that meets their needs.

**Long Term Conditions**

Gestational diabetes is more common in overweight and obese women. These women are more common in deprived areas.
<table>
<thead>
<tr>
<th>Disability</th>
<th>Specialist Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evidence</strong> would suggest that there is a differential risk of cancer reflecting different risk behaviour such as smoking, alcohol and diet. Cancer drugs are condition targeted and this can result in differences in uptake between men and women. Lung, throat and tongue cancers and obesity related cancers are associated with social class which could be linked to race, age, dependencies or disabilities.</td>
<td></td>
</tr>
<tr>
<td><strong>Access and outcome of services</strong> can be driven by physiological and behavioural characteristics, for example the suitability of a particular intervention for an individual will be influenced by the impact of co-morbidities which may be related to age or risk factors such as smoking or obesity. This may in turn have higher prevalence in more deprived groups or those with particular disabilities.</td>
<td></td>
</tr>
<tr>
<td><strong>Unscheduled Care</strong></td>
<td></td>
</tr>
<tr>
<td>Unscheduled care can create particular problems for those with learning difficulties, those are hearing or sight impaired, have language issues in both Accident and Emergency or when being admitted.</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
</tr>
<tr>
<td>There is a higher proportion of disabled people in the fifth of the wards with the worst cancer incidence rates than in NI overall.</td>
<td></td>
</tr>
<tr>
<td>UK Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40% of the population and that only 30% of GP surgeries have accessible information for people with learning disabilities.</td>
<td></td>
</tr>
<tr>
<td>The Social Exclusion Unit in UK found that those with low literacy were 6% less likely to attend cervical screening than women with higher basic skills. Screening rates are low in women with a learning disability although higher rates of the risk factors of obesity and overweight have been found in those with learning disabilities and mental health problems.</td>
<td></td>
</tr>
<tr>
<td><strong>Sensory Disability</strong></td>
<td></td>
</tr>
<tr>
<td>There is inappropriate communication support for people with a hearing impairment when accessing health and social care...</td>
<td></td>
</tr>
</tbody>
</table>
services. For example, lack of availability of sign language interpreters and often loop systems are not available to enhance communication.

**Learning Disability**

People with a learning disability are more likely to have a visual impairment when compared to the general population. Approximately 40% of people with a learning disability are reported to have a hearing impairment, with people with Down’s syndrome at particularly high risk of developing vision and hearing loss. Those living independently or with family are significantly less likely to have had a recent eye examination than those living with paid support staff.

**Children and Families**

Disabled children and their families frequently raise issues about poor or late assessments of needs. Services to meet these needs are not always available. Over 20% of children under 18 year suffer mental health problems.

Young carers are recognised in the HSCB’s Audit of Inequalities and Action Plan (2010) as having specific needs. This is particularly important for those aged 16-24 years who often remain hidden. The Action Plan requires that appropriate services be developed for young carers including transition planning; an identification of the supports required for young carers and redesign carer support for this group the need.

**Mental Health Issues in Learning Disability**

The prevalence of psychiatric disorders is significantly higher among adults whose learning disabilities are indentified by GPs, when compared to general population rates. Challenging behaviours (agression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49. In some instances, challenging behaviours result from pain associated with untreated medical disorders. Reported prevalence rates for anxiety and depression amongst adults with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population and higher amongst people with Down’s syndrome (Based on UK figures).
Ethnicity

**Unscheduled Care**

The All Island Travellers Health Study highlighted that travellers access health services more frequently than the general population, with attendances at A&E departments/hospitals rated as more positive than those at GPs. Perceived communication issues (not listening, unempathetic doctors), Travellers’ literacy problems and difficulties in following prescribed instructions are seen as contributors to such negative experience, with waiting lists (46.8%) and embarrassment (50.0%) cited as major barriers to access. Men in particular delay access of health care when needed and present generally late and then more so in A&E departments.

**Elective Care**

Variation is not necessarily inequality of service particularly in relation to usage of the multi–faceted services we call elective care - from paediatric surgery to geriatric medicine or urology. The academic literature suggests a complex interaction of underlying need reflecting hereditary factors, risk behaviours, age, gender, and for some conditions, ethnicity. This is then influenced by health seeking behaviour and attitudes/knowledge or perceived barriers to access or expectations on either the patient or clinicians part.

**Cancer**

99% of cancer cases occurred in white people in both the worst fifth wards and NI overall. Incidence did not appear to be related to ethnicity.

Language can be a significant barrier to accessing cancer services for many people from BME groups, particularly but not limited to asylum seekers and refugees. UK data in the report Focus on social inequalities found that 41% of people with additional language needs had no one to help with interpreting when visiting a GP or health centre.

**Maternity**

In terms of maternity services births to mothers born outside the UK and Ireland have increased considerably over the last decade. In 2001 this figure was 661, 31% of births registered for that year. By 2010, births to mothers born in countries other than
the UK or ROI have increased to 2473 representing almost 10% of births registered that year.

**Older People / Physical Disability**

Evidence suggests lack of knowledge by BME groups about social care services and about social services’ functions and lack of awareness about some services particularly services such as respite services for people with disabilities.

Public information campaigns to support the Dementia Strategy do not always reach ethnic minorities so targeted campaigns may be necessary to raise awareness of dementia within these groups.

There is also an issue as to whether current services for people with dementia take account of cultural differences.

A Dementia UK report noted that ethnicity can be a significant factor in the extent to which dementia is understood or acknowledged, or in people’s willingness to seek help. Current services may not meet the needs of BME groups with dementia or their carers.

Employed people men and women in the Pakistani, Bangladeshi and Indian communities have particularly high rates of caring. Bangladeshi men are 3 times more likely to be carers than white men. Overall age population of black and minority ethnic population is younger than white population of carers this has additional socio economic impacts.

**Children and Families**

63% of travellers are aged under 25 compared with 35% nationally; 42% of Travellers are under 15 years of age compared with 13% nationally.

There is an increased rate of mental illness among children in child asylum seekers in Northern Ireland. A number of barriers exist that may prevent parents of these children seeking health and social care services. These include language barriers, no permanent address; lack of awareness of GP services and social isolation. Absence of child facilities operating in hours of shift work causes particular difficulties for BME families.
<table>
<thead>
<tr>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is evidence of high rates of mental ill health for Traveller women. Traveller men often deny that they have depression.</td>
</tr>
<tr>
<td>Women from ethnic minorities are particularly vulnerable to mental illness with women of Asian descent having higher suicide and self harm rates.</td>
</tr>
<tr>
<td>For those newly arrived in the country who often arrive to join partners there is evidence of depression, including post natal depression, and feelings of isolation and low self esteem. Similarly depression amongst asylum seekers tends to be high.</td>
</tr>
<tr>
<td>There is a increased rate of mental illness among child asylum seekers in Northern Ireland. Additionally there is often a lack of expertise amongst social care workers in identifying the mental health problems experienced by children seeking asylum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes is more common in BME groups and hypertension is more common in Asians.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Specialist Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>In terms of investment in HIV care, research indicates that 44% of new cases of HIV relate to men who have had sex with men.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns have also been raised in local survey data and nationally regarding lesbian and bisexual women having higher behavioural risk factors but being less likely to be screened.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Care / Elderly / Physical Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Studies on the experience of lesbian, gay, bisexual and transgender people have not been identified in relation to dementia. However, lesbian women and gay men are likely to face particular challenges in caring for partners or friends with dementia which are not faced by others in society.</td>
</tr>
<tr>
<td>No robust data is available on carers by sexual orientation. Some studies point to networks and communities that are a useful resource for lesbian, gay, bisexual and transgender carers for emotional and practical support. Evidence suggests however that</td>
</tr>
</tbody>
</table>
existing networks cannot always be relied on for this support and there is also unequal access to these networks.

**Mental Health**

There are high rates of mental health issues among lesbian, gay bisexual and transgender people. This is higher than average for rates of anxiety, depression, self harm and suicidal behaviours including problems associated with smoking, drugs and alcohol use. 1 in 4 young gay men in NI have attempted suicide.

**Prison Services**

Data on ethnicity or literacy is not routinely available here although Scottish and English data suggests low literacy levels. The All Ireland Travellers Health Study 2010 did not include NI prisons due to the relatively small numbers of Travellers in Northern Ireland however data from ROI showed that the risk of a male traveller being imprisoned was between 5-12 times that of the general male population and for women 11-35 times.

<table>
<thead>
<tr>
<th>Multiple Issues</th>
<th>Specialist Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialist Care</strong></td>
<td></td>
</tr>
<tr>
<td>Having reviewed the range of specialist services within the context of the Section 75 Groups the Specialist Services Commissioning Team has taken the view that the key issue in respect of inequalities for specialist care remains access to services.</td>
<td></td>
</tr>
</tbody>
</table>

**Elective Care**

Health Inequalities monitoring data showed that people from the most deprived areas in 2001/2 had 37% higher age and gender standardised non-elective admission levels than the Northern Ireland average. More recent data shows admissions from deprived areas at 23% above the Northern Ireland average. The higher levels of non elective admissions in seen in both respiratory (+24%) and circulatory disease (+8%). There appear to be geographical differences across NI in admission levels.
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?

Ensuring successful screening during the commissioning year remains a key objective. The reliance of previously used data collection echoes one of the findings that emerged out of the HSCB’s Audit of Inequalities.

Through the newly convened Equality and Human Diversity Working Group arrangements will be made to ensure equality and decisions that affect equality are informed by robust and up to date information.

Specific actions include:

- Ensure each commissioning team and local commissioning office has systems in place to build and update relevant policy and population based information.

- Ensure that all staff receives training on equality and related issues.

- Develop the capacity of staff to use the information to inform policy or decision making and regularly reviewed.

- Regular updates to Commissioning Programme Board on equality reviews and equality issues from the commissioning teams.

These efforts will include mechanisms to engage with ethnic minorities, people with disability, gay lesbian, bisexual and trans-gender people, older people and younger people, who often face barriers in engaging in Commissioning processes.

<table>
<thead>
<tr>
<th>In developing the policy or decision what did you do or change to address the equality issues you identified?</th>
<th>What do you intend to do in future to address the equality issues you identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Social Wellbeing Improvement</td>
<td>In order to address these needs the PHA and HSCB intends, through its commissioning activities to monitor, evaluate and respond to the needs of those groups facing health inequalities and deprivation. We will continue to collect data to highlight population deprivation in Northern Ireland and ensure that staff are trained to deliver</td>
</tr>
</tbody>
</table>
groups (ME), Lesbian, Gay, Bisexual and Transgender (LGB&T), older people, poverty; as well as community development. Consideration of minority groups has influenced the strategic direction of the PHA, and one of the key pillars for achieving our objectives is to 'ensure a decent standard of living for all'.

Specific examples of work undertaken in 2011 included:

- the creation of a Forum for LGB&T employees following employee engagement surveys and events;
- development of a costed LGB&T Action Plan;
- research commissioned to engage with minority ethnic groups;
- a regional steering group for ethnic minorities has been established and a report produced on migrant health and action plan;
- analysis conducted of the All Ireland Travellers Health report;
- establishment of a Regional Travellers forum and action plan;
- PHA working in partnership with other health and social care organisations, and sectors including DHSSPSNI;
- ensured there was community involvement in each aspect of decision making.
- Development of an Older services to those groups affected by health inequalities.
People’s Action Plan

The health improvement teams will continue to commit to advocating the importance of the equality agenda by ensuring consideration to those groups named under Section 75 within our action plans. Any evidence or research which has been undertaken and endorsed will form the basis for commissioning plans which address the issues of health inequalities in Northern Ireland.

Specialist Services

During 2011/12 investment of over £650,000 was made in vulnerable specialist paediatric services to ensure their continued safety and sustainability to maintain access within Northern Ireland. This involved additional staffing and initiation of clinical networks in a number of areas. Support was also given to the services in the RBHSC in order to provide network support across the region into local paediatric services in managing more care locally. Paediatricians with a specialist interest in local centres will also be supported through this investment.

This work will be supported by a specifically funded Network Co-ordinator.

Investment in Wet AMD services in the West as well as Belfast in 2011/12 will support a higher degree of local access for older people with this condition.

Investment in biologics for Rheumatoid conditions in all Trusts will support better geographic access for this group of patients who will have a
degree of disability.

Investment in radiotherapy capacity in the West will support a higher degree of local access to this form of therapy for patients with cancer.

Investments in rare genetic conditions will support improved outcomes for some ethnic groups.

<table>
<thead>
<tr>
<th>Elective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>During 2011/12 The Board funded additional capacity in the Trusts and in the Independent Sector to ensure equity of access for all patients who required treatment.</td>
</tr>
<tr>
<td>The Board also held Trusts to account for delivering agreed maximum waiting times for specialties.</td>
</tr>
<tr>
<td>The commissioning team will strive towards agreeing detailed data returns for selected specialties from Trusts which identify patient numbers in relation to the categories in 2.2 /2.3</td>
</tr>
<tr>
<td>This data will be used to identify any inequalities in service provision.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Team has arranged two seminars with Older Peoples and Disability constituencies to share Commissioning intentions and to take feedback from them.</td>
</tr>
<tr>
<td>Equality issues were not strongly articulated in the discussions by voluntary sector representatives.</td>
</tr>
<tr>
<td>Ensure effective user/carer input to implementation arrangements.</td>
</tr>
<tr>
<td>Ensure regular dialogue with voluntary/user representatives as a feature of Commissioning Team functioning.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer</th>
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<tbody>
<tr>
<td>Research suggests that cancer survival could be improved by as much as 40% with improved awareness of the early signs and symptoms and early detection. It is known that awareness of early signs and symptoms is related to deprivation and BME. Work will commence in year to</td>
</tr>
</tbody>
</table>
undertake a baseline survey to identify current levels of knowledge and awareness and to identify key messages for a public awareness campaign. This campaign will consider how best to target hard to reach groups, including BME.

<table>
<thead>
<tr>
<th>Unscheduled Care</th>
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<tbody>
<tr>
<td>Plans to develop dedicated paediatric assessment units are evidence of the importance of having dedicated unscheduled care pathways for children.</td>
</tr>
<tr>
<td>Consideration will also be given to the development of unscheduled care pathways for patients with long term conditions, most of whom will be older people with complex needs.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Palliative Care</th>
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</thead>
<tbody>
<tr>
<td>The development of a palliative care service specification for nursing homes will improve the access to palliative care for older people.</td>
</tr>
<tr>
<td>The development of disease specific service specifications for non cancer conditions such as heart failure, renal failure, cystic fibrosis etc will address age and gender inequalities in relation to palliative care services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The development of a programme of enhanced primary care management of cardiovascular risk factors will address health inequalities.</td>
</tr>
</tbody>
</table>
The review of the pilot projects on pre pregnancy care and structured patient education programmes for children and adolescents.

### Maternity and Child Health

Maternity and pregnancy related gynae services are available at point of need for all women who are pregnant. The Commissioning priorities have been established based on the evidence above, relevant data and an understanding of the variance between services here and standards set nationally. The soon to be published regional Maternity Strategy will provide guidance for future commissioning and service offering priorities for Maternity services in Northern Ireland and will direct commissioning priorities in future years.

One specific priority, the Family Nurse Partnership pilot programme targeting 100 teenage mothers who will be recruited up to the 28th week of pregnancy in the Western area is being taken forward by the Public Health Agency to provide enhanced services to pregnant young women during and after their pregnancy. The outcomes for this target group are demonstrably poorer than for other mothers and this pilot will test a proven effective model of service delivery for this group in Northern Ireland for the first time.

Provision of safe services for all women in obstetric emergencies has been highlighted as a commissioning priority to ensure the most positive outcomes for women and their babies.
regardless of their geographical location.

Ensuring intra partum services for women are safe and sustainable has been identified as a commissioning priority for the service team and to that end it will support the SE LCG in its evaluation of the two stand alone Midwife Led Units in its locality beginning with the Downe MLU in 2011 / 2012.

<table>
<thead>
<tr>
<th>Physical Disability</th>
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</thead>
<tbody>
<tr>
<td>Address the recommendations of the Physical Disability Strategy, in particular the needs of carers.</td>
</tr>
<tr>
<td>Introduction of a re-ablement model to promote rehabilitation, self care and independence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children and Families</th>
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</thead>
<tbody>
<tr>
<td>The priorities which are contained within the Children and Families section of the Commissioning Plan demonstrate that the Section 75 groups being considered explicitly include age and disability. The other groups either have been or will also be taken into account in that if gender is a particular issue for the reconfiguration of residential child care provision this will be stated in any such review. It is also intended that the views of service users will be integrated within the work schedule, either through representatives or with direct engagement of users, which already applies to some of the working groups in place.</td>
</tr>
</tbody>
</table>
Reference has been made previously to best practice and learning from other areas and the work to be taken forward on reviewing speech and language therapy support in special schools will be informed by a model of practice which has been successfully introduced in Scotland and will provide a template for local discussion.

Equally the review of Intercountry Adoption Practice will take account of models operating in other parts of the UK. The adoption legislation in NI is different than that in other parts of the UK in that unmarried or gay couples cannot jointly adopt. This matter is currently the subject of a judicial review.

Mental Health and Learning Disability

It is widely evidenced that people with a learning disability have increased mortality and live with higher levels of illness both physical and mental than the non learning disabled population.

Previously the HSCB/PHA commissioned a Directed Enhanced Service for Learning Disability. This DES ensures that all adults with a learning disability have an annual health screening for both physical and mental health with their GP. It also follows up the health plans put in place and any secondary care referrals made to ensure that better health results can be monitored. The DES relies on dedicated health facilitator in each Trust to contact hard to reach patients.

During 2011/2012 the HSCB/PHA began implementing the Specialist Visual Assessment Clinics for
Learning Disability across all Trusts. This service delivers specialist visual assessment clinics in settings where people with a learning disability live and attend for day support. It aims to pick up undiagnosed visual acuity problems and address these through treatments or prescriptions. It also makes referral to secondary services where more serious conditions are found.

Recognising the higher levels of mental ill health allocated to learning disability and to young adults generally the HSCB/PHA invested in Transition Services in 2011/2012 to put in place a greater capacity and range of post school day opportunities to promote inclusion in training, further education and vocational settings. There is also further investment in specialist services which aim to support people with a learning disability who also have mental health issues, which often manifest themselves in challenging behaviour which in turn can lead to admissions to hospital.

Additional investment has been provided to help assist those people with a mental illness and who have particularly challenging/complex problems. This includes the development of services for people with forensic mental health problems and also services for people with a personality disorder. Individuals within these services tend to have, in general, much higher levels of ill health and morbidity than the general population. These services endeavour to provide person centred care and assistance to the particularly vulnerable cohort of clients/individuals referred to them. Regionally, the
HSCB/PHA have brought together service providers within Network arrangements to promote best practice and more standardised care within these services. In turn, the output of these groups aims to improve outcomes for/care provided to people with serious mental illness.

**Prison Health**

The commissioning priorities for prison health services are based in the principal of providing an equivalent health service to prisoners as that provided to the general population. The provision of health care is, however, subject to a number of restrictions due to the nature of the prison environment. Priorities include:

- Improve the committal process for people with complex needs; including substance misuse, diabetes and epilepsy.

- Work with the South Eastern Trust to ensure the introduction of the stepped care model within prisons to address mental health problems.

- Encourage the development of appropriate care pathways for prisoners with a learning disability.
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)

Please note: When detailed implementation plans are available in relation to each of the theme areas, these will be subjected to equality screening and will take full account of good relations.

<table>
<thead>
<tr>
<th>Group</th>
<th>Impact</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td></td>
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<tr>
<td>Political Opinion</td>
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<td></td>
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<tr>
<td>Ethnicity</td>
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</tbody>
</table>

(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.

The plan outlines an overall direction of travel. The detail of implementation has yet to be worked out. When the implementation plans become clearer, specific actions within the plan will be subject to robust screening and where applicable EQA and public consultation.

**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:

<p>| | |</p>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
<td>x</td>
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</table>

Please give reasons for your decisions.

The Commissioning Plan impacts on the population of the whole of Northern Ireland so consideration of inequality, deprivation and geography is an integral part of it.

Through our commissioning activity we believe that we can increase the probability that decisions will better promote equality of access and outcomes. We recognise however that in some instances an assessment of the equality and human rights implications can be limited by lack of local data or evidence including the or lack of disaggregated data.

Data collection will therefore be a key consideration, as are our organisational efforts to embed equality and human rights in our commissioning activity; promote personal and public involvement and engagement; work in partnership with community, voluntary and other public sectors and increase the capacity of staff to use the evidence, including disaggregated data on the equality categories, in decision making processes. This remains a key consideration by Service teams who are taking forward the themes identified throughout the Commissioning Plan.

As the Commissioning Plan is implemented we are committed to assessing potential effects on particular populations in a rigorous way, through further equality and human rights screening.
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?

<table>
<thead>
<tr>
<th><strong>How does the policy or decision currently encourage disabled people to participate in public life?</strong></th>
<th><strong>What else could you do to encourage disabled people to participate in public life?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled people are involved in many working groups and Committees which will play a critical role in the delivery of the plan and contribute to the ongoing identification of commissioning priorities:</td>
<td>The organisation is committed to engaging with all its stakeholders in the identification and delivery of its commissioning priorities. The relevant service teams will actively, and on an ongoing basis, seek to identify opportunities to engage with disabled people in the development and delivery of their priorities.</td>
</tr>
<tr>
<td>• Bamford task groups - service user and carer representation on all groups. Steps are underway to facilitate service user representation at Taskforce meetings.</td>
<td>For example, the Community Care Team will ensure effective implementation arrangements are established with PPI Steering Group.</td>
</tr>
<tr>
<td>• Regional Brain Injury Review and Implementation</td>
<td></td>
</tr>
<tr>
<td>• Older peoples service framework</td>
<td></td>
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<tr>
<td>• Sensory impaired regional group</td>
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<tr>
<td>• Children services planning</td>
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</tr>
<tr>
<td>• Think Family, Think Child</td>
<td></td>
</tr>
<tr>
<td>• Autism implementation groups - active participation of users and carers on the regional reference group and local Trust groups</td>
<td></td>
</tr>
<tr>
<td>• Direct payment regional group</td>
<td></td>
</tr>
<tr>
<td>• Self directed support forums/groups</td>
<td></td>
</tr>
<tr>
<td>• Safeguarding forums</td>
<td></td>
</tr>
<tr>
<td>• Regional Wheelchair Reform (awarded the first engage award in NI for its involvement of service users)</td>
<td></td>
</tr>
</tbody>
</table>

There are a number of upcoming strategies, which will be critical in guiding commissioning. The HSCB will be establishing working groups to take forward priorities identified in these strategies. Patient and / or carer involvement will be central to that
process.
- Advocacy strategy
- Physical Disability Strategy
- Dementia Strategy

The PDSI strategy strongly reinforces, and explicitly states, the need for the involvement of disabled people in public life with clearly identified responsibilities placed on a number of public agencies to ensure this happens.

The plan also seeks to enhance and to underpin the key legislative and good practice arrangements for children with disabilities and their carers.

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?

<table>
<thead>
<tr>
<th>How does the policy or decision currently promote positive attitudes towards disabled people?</th>
<th>What else could you do to promote positive attitudes towards disabled people?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with groups advocating on behalf of specific groups needs. This plan will positively enhance and support CWD and their carers by reference to the legislative and rights based requirements which will inform commissioning and service provision</td>
<td>Seek to examine impact of communication materials and make resources available in various formats.</td>
</tr>
</tbody>
</table>
(5) CONSIDERATION OF HUMAN RIGHTS

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

The Commissioning Plan will inevitably impact on the lives of individuals in Northern Ireland so by its very nature it will impact on people’s human rights. The overall aim in commissioning as identified in the Commissioning Plan is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. This also relates to people’s human rights. It is intended that Commissioning outcomes will positively impact on people. Hence, there are no known issues at this point in time. As the precise elements of the Commissioning Plan are further screened and implemented the human rights aspects of decisions will be examined in order to identify any areas of potential interference and how it might be possible to limit this interference.

<table>
<thead>
<tr>
<th>ARTICLE</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 2 – Right to life</td>
<td></td>
</tr>
<tr>
<td>Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment</td>
<td></td>
</tr>
<tr>
<td>Article 4 – Right to freedom from slavery, servitude &amp; forced or compulsory labour</td>
<td></td>
</tr>
<tr>
<td>Article 5 – Right to liberty &amp; security of person</td>
<td></td>
</tr>
<tr>
<td>Article 6 – Right to a fair &amp; public trial within a reasonable time</td>
<td></td>
</tr>
<tr>
<td>Article 7 – Right to freedom from retrospective criminal law &amp; no punishment without law</td>
<td></td>
</tr>
<tr>
<td>Article 8 – Right to respect for private &amp; family life, home and correspondence.</td>
<td></td>
</tr>
<tr>
<td>Article 9 – Right to freedom of thought, conscience &amp; religion</td>
<td></td>
</tr>
<tr>
<td>Article 10 – Right to freedom of expression</td>
<td></td>
</tr>
<tr>
<td>Article 11 – Right to freedom of assembly &amp; association</td>
<td></td>
</tr>
<tr>
<td>Article 12 – Right to marry &amp; found a family</td>
<td></td>
</tr>
<tr>
<td>Article 14 – Prohibition of discrimination in the enjoyment of the convention rights</td>
<td></td>
</tr>
<tr>
<td>1st protocol Article 1 – Right to a peaceful enjoyment of possessions &amp; protection of property</td>
<td></td>
</tr>
<tr>
<td>1st protocol Article 2 – Right of access to education</td>
<td></td>
</tr>
</tbody>
</table>
If you have answered no to all of the above please move on to **Question 6** on monitoring

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

<table>
<thead>
<tr>
<th>List the Article Number</th>
<th>Interfered with? Yes/No</th>
<th>What is the interference and who does it impact upon?</th>
<th>Does this raise any legal issues? Yes/No</th>
</tr>
</thead>
</table>

* 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 part of the training provided to Commissioning Teams on improving the links between Equality, Inequalities, Human Rights and Commissioning human rights issues were also addressed. This should assist in on-going work in relation to implementation of the Commissioning Pan including any screening activity and engagement.

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 Commissioning.
(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?)

In some instances an assessment of the equality and human rights implications can be limited by lack of local data or evidence including the or lack of disaggregated data.

Data collection will therefore be a key consideration, as are our organisational efforts to embed equality and human rights in our commissioning activity; promote personal and public involvement and engagement; work in partnership with community, voluntary and other public sectors and increase the capacity of staff to use the evidence, including disaggregated data on the equality categories, in decision making processes. This remains a key consideration by Service teams who are taking forward the themes identified throughout the Commissioning Plan and specifically addressed in Section Two.

<table>
<thead>
<tr>
<th>Equality &amp; Good Relations</th>
<th>Disability Duties</th>
<th>Human Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing monitoring and screening of health and social wellbeing plans in accordance with Section 75, equality legislation and human rights legislation.</td>
<td>Ongoing monitoring of patient and / or carer involvement in key planning / working groups with an emphasis on disability groups to monitor their participation in commissioning.</td>
<td>Monitoring of complaints &amp; Serious Adverse Incidents</td>
</tr>
<tr>
<td>Monitoring of complaints</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Approved Lead Officer: Dean Sullivan
Position: Director of Commissioning
Policy/Decision Screened by: Veronica Gillen Alan Marsden
Signed: September 2012
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.

If you have any queries contact: Anne McGlade, Equality Manager, Business Services Organisation Email: anne.mcglade@hscni.net Telephone 028 90535577

Template revised April 2012